A MODEL TO ENHANCE SUPPORT FOR NEWLY-QUALIFIED REGISTERED NURSES IN SELECTED HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA

by

Tinyiko Sophie Sadike

Student Number: 18012563

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Department of Advanced Nursing Sciences

School of Health Sciences

University of Venda

Promoter	**Co-Promoter**
Prof D.U. Ramathuba	Dr K.G. Netshisaulu

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DECLARATION

I, **Tinyiko Sophie Sadike**, declare that the thesis, **"A Model to Enhance Support for Newly-Qualified Registered Nurses in Selected Hospitals of Limpopo Province, South Africa,."** hereby submitted to the **University of Venda** for the **Doctor of Philosophy (PhD) in Health Studies** degree, is my own work and that all sources used have been duly acknowledged in the text and the list of references. This thesis has not been submitted previously for a degree at this or any other institution.

Tinyiko Sophie Sadike	**:**	
Student Number	**:**	18012563
Place	**:**	University of Venda
Date	**:**	December 2021

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DEDICATION

This thesis is dedicated to my late mother, Fanisa Elizabeth Mathye, for her endless effort to motivate me to pursue education. She used to say: "VARI DYONDZO AYI LUMI N'WANANGA", meaning that 'they say education does not bite my child' although she did not have formal education.

Special gratitude goes to my caring and loving husband, Pastor Rhasalanavho John Sadike, my siblings, Tsakani and Elvis, my sons Dantry, Irvin, Excellent and Ebeneza, my daughters-in-law Nana and Vanessa, for their incredible support during the hectic period of this study, and my granddaughters, Nsovo, Andziso, and Xongile (Amahle).

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ABSTRACT

Background: Despite newly-qualified registered nurses (NQRNs; R.683) being in possession of previous nursing experience, and that on graduation as registered nurses, they were allocated in units where they had previously worked as enrolled nurses (ENs). The change of identity, roles, responsibilities and adopting a new scope of practice with increased accountability became a source of stress. It is evident that NQRNs (R.683) were prematurely placed in nursing units and expected to lead shifts on graduation as registered nurses. However, it was uncertain as to how these NQRNs (R.683) were being supported in clinical practice areas within their initial period of employment. Currently, there seemed to be no model in Limpopo Province to support NQRNs (R.683).

Purpose: The purpose of this study was to develop a model to enhance support for NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.

Methodology: The study was done in four phases, namely, empirical, concept analysis, model development and validation. In Phase 1, a concurrent mixed method approach was used. For the qualitative component in Phase 1A, seven (7) focus group interviews were used for NQRNs (R.683) (n=51). For the quantitative component in Phase 1B, unit nurse managers or experienced registered nurses (n=265) were recruited using convenient sampling, and a self-administered questionnaire was used for data collection. In Phase 2, Rodgers & Knafl's six steps guided the analysis of the concept 'support'. In Phase 3, Dickoff, James & Wiedenbach's survey list guided the framework for model development, based on Chinn & Kramer's approach. In Phase 4, the model was validated following Chinn & Kramer's criteria of clarity, simplicity, generality, accessibility and importance.

Results: The results from both the qualitative and quantitative components revealed the need for a support model. The findings formed the basis for the development of a model to enhance support for NQRNs (R.683). The model comprised of the following components: Agent, Recipient, Context, Dynamics, Procedure and Terminus.

Conclusion: Support for NQRNs is a widely echoing concept used in clinical settings in many countries, SA inclusive. However, a variety of challenges associated with supporting NQRNs (R.683) have been identified by both NQRNs (R.683) and Unit Nurse Managers (UNMs). Shortage of staff, negative staff attitude and behaviour, inadequate support from UNMs were highlighted as impacting negatively on the effectiveness of support. The dire need for a model to enhance support for NQRNs (R.683) cannot be overemphasized. This model will direct the planning and execution of supportive procedures by UNMs to enhance the effectiveness of support for NQRNs (R.683) in the nursing units.

Recommendations: The model should be disseminated to NQRNs and UNMs through in-service training, workshops and scheduled clinical meetings for acceptance and support. The developed model and guidelines for operationalizing the model should be incorporated as part of clinical nursing practice frameworks by policymakers. The model should be piloted to identify areas that will further enhance effectiveness of support. Follow-up studies on the effectiveness, practicability and relevance of the model are recommended.

Keywords: bridging programme, enrolled nurse, newly-qualified or new graduate, model, professional or registered nurse, support

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LIST OF ABBREVIATIONS AND ACRONYMS

ARNP	Advanced Registered Nurse Practitioner
A.S.	Associate of Science
B.S.	Bachelor of Science
BScN	Bachelor of Science in Nursing
CAN	Certified Nursing Assistant
CPD	Continuous Professional Development
DHIS	District Health Information System
DoH	Department of Health
EI	Emotional Intelligence
EN(s)	Enrolled Nurse(s)
ENAs	Enrolled Nursing Auxiliaries
EPN(s)	Experienced Professional Registered Nurse(s)
FGI(s)	Focus Group Interview(s)
HIV	Human Immunodeficiency Virus
ICN	International Council of Nurses
ICU	Intensive/High Care Units
MHCU	Psychiatric/Mental Health Care Units
	Licensed Practical Nurse
MMR	Miixed Method Research
LP	Limpopo Province
NEI(s)	Nursing Education Institution(s)
NQPN(s)	Newly-qualified Professional Nurse(s)
NQRN(s)	Newly-qualified Registered Nurse(s)
NZ	New Zealand
ONM(s)	Operational Nurse Manager(s)
OPD	Outpatients Department

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PM/PME	Performance Management/Performance Management Evaluation
PN(s)	Professional Nurse(s)
QUAL	Qualitative
QUAN	Quantitative
RN(s)	Registered Nurse(s)
SA	South Africa
SANC	South African Nursing Council
SOPs	Standard Operating Procedures
TB	Tuberculosis
UNM(s)	Unit Nurse Manager(s)
UK	United Kingdom
US	United States
USA	United States of America
UVHDC	University of Venda Higher Degrees Committee
UVREC	University of Venda Research Ethics Committee
WHO	World Health Organization

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction and Background

Even though the health care system is ever-changing, the demands for nurses remains unchanged. Internationally, nurses comprise the largest group of personnel who provides essential health services in the health care system (Rispel, 2015:1). Therefore, training and education of nurses is the foundation of the nursing profession and the products of training and education of nurses who are required to possess basic nursing knowledge and skills (Deng 2015:96). Newly qualified registered nurses acquire the skills, knowledge, attitudes and professional culture through professional socialisation. These basic knowledge and skills differs from country to country (Brown & Crookes, 2016:1).

In the United States (US), training and education of nurses is provided by several levels ranging from the lowest level to the highest (Deng, 2015:97) providing nurses in US the opportunity to upgrade their qualifications. These levels are: the Certified Nursing Assistant (CAN) who trained for 75-hours vocational course, the Licensed Practical Nurse (LNP) who trained for one-year vocational course, Registered Nurse (RN) who trained as Associate of Science (A.S.) in nursing or Bachelor of Science (B.S.) in nursing, as well as an Advanced Registered Nurse Practitioner (ARNP) which is a postgraduate education in specialized aspect of nursing and RN licensure (Deng, 2015:97; https://en.mwikipedia.org/wiki/Nursing-in-the-United-States). Furthermore Baumann, Blythe, Kolotylo and Underwood (2004:5) in International Council of Nurses

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[ICN] (2000) reported that in US there are three avenues to be registered as a nurse (RN), either undergoing a two-year associate degree, a three-year diploma or a four-year degree.

In Canada, there are three regulated nursing categories; Registered Nurses (RNs), License/Registered Practical Nurses (LPNs/RPNs) and Registered Psychiatric Nurses (RPNs) (Baumann, et al., 2004:5; Deng, 2015:97). A person who finishes two or three years of education in technical secondary can only be an assistant nurse. It is further stated that the one who completes three year junior college education program qualifies for the examination leading to Registered Nurse (RN). In addition, after four-year of Bachelor's education they are entitled to participate in community medical care services (Deng, 2015:97).

In some countries such as Philippines, there is a single route to be registered as professional nurses, as all nurses complete a baccalaureate degree (Barcelo, 2002 cited in Baumann, et al., 2004:6). Same as in France, there is only one main category of nurses with a Bachelor degree requirement to align with other European countries (Health Workforce Policies, 2016:1). The International Council of Nurses (ICN) (2000) cited in Baumann, et al. (2004:6) assents that Denmark, Ireland, New Zealand and Spain also have a single program for qualifying as a nurse.

In Brazil, there are nursing technicians/ auxiliaries who perform less complex technical health care activities under the supervision of the nurse professional with a Bachelor's degree (Garcia, Rocha, Pissinati, Martiale, Cameilo & Haddad, & 2017:1). Australia also has two regulated categories of nurses; the Enrollled Nurse (EN) and Registered Nurse (RN) with three-year Bachelor's degree (Baumann, et al., 2004:5).

In Kenya the Nursing Council of Kenya (NCK) regulates the education and practice of nurses based on set standards (Segor, 2012:8). Nurses in Kenya are trained at three

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levels; Enrolled Nurse (EN) certificate, Registered Nurse (RN) diploma and Bachelor of Science in Nursing (BScN) degree (Segor, 2012:7). Segor (2012:8) further outlined that like other countries Kenya requires nurses to obtain continuous professional development (CPD) which will provide them credits to renew their practice license.

South Africa as like other countries had three categories of nurses: Enrolled Nursing Auxiliary (ENA) who trained over a period of one academic year (R.2176 of 19 November 1993, as amended); Enrolled Nurse (EN) who trained over a period of two academic years (R.2175 of 19 November 1993, as amended). Both these two categories (ENAs and ENs) were delegated tasks and practice under the direct or indirect supervision of the Professional Nurse (PN) or Registered Nurse (RN) which was the third category of nursing.

A Professional nurse is a nurse who trains over a period of four academic years (R.425 of 22 February 1985, as amended) with midwifery. In addition, prior 1990 there were Registered Nurses who trained over a period of three academic years without midwifery. The focus of the study is on the Registered Nurses who trained over a period of two academic years upgrading from Enrolled Nursing through Bridging programme to be registered as General Nurses (R.683 of 14 April 1989, as amended), who have trained either in the public or private nursing education institutions.

Although the educational systems differ from country to country as highlighted earlier, the R.2175 programme for EN training which ran for two academic years in South Africa (SA) was similar to the two-year training programme in Australia (Cubit & Ryan 2011:65) as well as in the United States of America (USA), the United Kingdom (UK) and New Zealand (NZ) (Cubit & Lopez 2012:206). However, ENs in South Africa could upgrade their qualification (Du Toit 2016:1) through two-year bridging course programme leading to registration as a General Nurse (R.683 of 14 April 1989, as

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amended). In the South African context, the term General Nurse, Registered Nurse and Professional Nurse are used interchangeably.

The term General Nurse is mostly used to Registered Nurses who have undergone Bridging Course for Enrolled Nurses leading to Registration as a General Nurse or Psychiatry as per SANC Government Notice No.: R.683 of 14 April 1989 as amended. Whereas, the term Professional Nurse is preferably used for Registered Nurse and Midwife who trained four year Diploma or Degree in General (Psychiatry, Community) and Midwifery Nursing Sciences as per Government Notice No.: R.425 of 22 February 1985 as amended. Although, these categories differ in their years of training, they both enter the workplace as Newly-Qualified Registered or Professional Nurses with basic academic and practical skills (Ebrahimi, Hassnkhani, Negarandeh, Gillespie & Azizi, 2016:11).

Internationally, literature outlines different terms about the Newly-qualified Registered Nurse but not specifically those who had upgraded from Enrolled Nursing. In their study Johnstone, Kanitsaki and Currie (2008:46) referred NQRNs as neophyte graduates; Deasy, Doody and Tuohy (2011:109) called them new registered nurses; Kramer, Maguire, Halfner and Budin (2012:156) referred to them as newly-licensed registered nurses; Bjerknes and Bjørk (2012:1) referred to them as new qualified nurses; Teoh, Pua and Chan (2013:143) referred to them as newly-qualified registered nurses; Sargent and Olmedo (2013:603) called them new graduate nurse practitioner; Missen, McKenna and Beauchamp (2014:2431) referred to them as new nursing graduates and Ortiz (2016:19) referred to them as new graduate nurses. Du Toit (2016:1) referred to this category as Newly-Qualified Professional Nurses (NQPNs).

As it has already been clarified that the term General Nurse, Registered Nurse and Professional Nurse are used interchangeably in SA; the researcher prefers to use

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Registered Nurse focusing on the category of Newly-Qualified Registered Nurses who had previously trained as ENs. The bridging course programme was developed to provide ENs who have limited career development opportunity (Ralph, Birks, Chapman, Muldoon & McPherson, 2013:225) to attend college or university in less time to proceed to the registered nurse position. Newly qualified registered nurses (R.683) have an essential role in the delivery of health care (Mills, Salaun, Harrison, Yates & O'Shea, 2016:1), hence they should be retained.

In Limpopo Province (LP) like in other provinces in South Africa, each accredited nursing school used to train its own ENs to RNs in public hospitals, but due to transformation, ENs were sent to different Nursing Education Institutions (NEIs) as allocated in the provincial approved study leave document for two years upgrading within the province, and some train in private NEIs as part-time learners (students). Upon successful completion of their two-year programme, they occupy posts in the institutions of their origin as newly qualified registered nurses (NQRNs) (R.683), and as NQRNs (R.683), they are expected to be able to practice independently and to be autonomously responsible and accountable for the care they provide (SANC, 2005:25).

As NQRNs with previous enrolled nurse's experience, NQRNs (R.683) experienced a turning point from being an enrolled nurse who used to function under the protective 'umbrella' of direct or indirect supervision of an experienced RN to NQRN (R.683) role, where they are expected to be practice ready (El Haddad, Moxham & Broadbent, 2017:392). Despite being in possession of previous experience in nursing, the change in identity, roles, responsibilities and adopting a new scope of practice, and the associated increased accountability become a source of stress (Ebrahimi et al., 2016:184) to NQRNs.

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It is assumed that NQRNs (R.683) with previous EN experience may enter the new RN role more seamlessly than those qualified without previous nursing experience (Brown, Baker, Jessup & Marshall, 2015:197). Consequently, they were expected to manage complex patients, prioritize unit activities, make decisions, delegate and supervise subordinates and maintain positive relationships with colleagues. If Newly Qualified Registered Nurses (R.683) are unsupported in their new RN role, they may feel overwhelmed and exhausted coupled with performance anxiety (Hofler & Thomas, 2016:133).

Despite the type of programme of training and education of nurses, all Newly Qualified Registered Nurses entering the nursing profession experienced significant level of stress and anxiety because they had to adjust to the new role. Nonetheless, due to limited number of experienced RNs and for cost containment reasons, unit nurse managers use NQRNs (RR.683) to fill the gap by deploying them into patient care assignments prematurely (Saintsing, Gibson & Pennington, 2011:357; Dyess & Sherman, 2009:403), therefore, they should be supported. Sönmez & Yildirim (2015:104) maintained that the newly-graduated nurses experience stress, anxiety, and disappointment during the first months (up to 9-12 months) of their employment due to insufficient clinical skills, heavy workload, and inability to spare enough time for patients, prioritization and decision-making. As the NQRNs (R.683) struggle to manage this unreasonable workload due to fear of failure, they become exhausted and stressed and thus medico-legal hazards exist (Hussein, Everett, Ranyan, Hu & Salamonson, 2017:2).

When Newly Qualified Registered Nurses (R.683) upgraded from being ENs to RNs, it benefited the nursing profession and institutions because there were increased registered number of nurses. However, newly qualified registered nurses (R.683) who upgraded their professional identity experience mixed feelings of a sense of

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achievement after qualification, and frustration and overwhelmed (da Silva, de Souza, Trentini, Bonetti & Mattosinho, 2010:506) as they resume increased responsibility and accountability in the new role. Fields (2017:32) concurred that the increased responsibility of the RN role compared with EN role and difficult adjustment to the new role were identified as additional challenges. Da Silva et al. (2010:506) reported similar findings.

The journey of entry to the new role helped NQRNs (R.683) to adjust in terms of knowledge, skills and responsibility as they interact with other health care team members (da Silva *et al*., 2015:506). However, poor interpersonal relationships with colleagues may retard support to be provided to NQRNs by experienced RNs. In addition NQRNs (R.683) are expected to be competent and confident when making decisions and supervising subordinates. This is consistent with the findings of Odland, Sneltvedt & Sörlie (2014:543) in that NQRNs in Ireland were expected to be competent with leadership and management skills, even though development of these skills takes around three years. It is evident that there is lack of a structured transition programme. Therefore, the authors recommended development of a model to ensure preparedness for transition during newly educated nurses' education period. The discrepancies that exist between the academic and clinical practice world evoke fear and frustration to newly qualified registered nurses, as they travel the lonely journey from being an enrolled nurse to the new RN role. In a study conducted by Cubit and Lopez (2012:209) reported that newly qualified registered nurses suffered frustration as experienced RNs left them behind to run units by themselves. Gallagher (2012:22) maintained that pressure placed on NQRNs to be 'hitting the ground running' because they possess previous EN experience that leads to lack of support resulting in increased anxiety and lack of confidence.

Similar findings have been reported by Brown, Baker, Jessup & Marshall (2015:202),

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namely, that some newly qualified registered nurses struggled with role ambiguity between EN to registered scope of practice. Therefore, Edwards, Hawker, Carrier & Rees (2015:1268) suggested that combination of support strategies such as formal mentorship and preceptorship is imperative as it smoothens the journey from NQRNs to competent qualified nurse. Assumptions that new graduates with previous enrolled nursing experience have been socialized and are familiar with the environment, culture and values of nursing deny them an opportunity to be supported. Cubit and Lopez (2012:210) argued that placing new graduates in an area where they worked as ENs posed some challenges of being taken for granted and not supported; which have a negative impact on their future professional development and practice. Hence, the authors suggested that unit nurse managers should know that role transition from EN to RN is frightening and uncertain; therefore, transition support strategy should be employed during the transition period.

Gallagher (2012:22) concurs that new graduates are not mentored nor given constructive feedback leading to increased anxiety and stress. Based on this information, it is imperative to provide workplace support to NQRNs (R.683). In their study Pineau, Spence, Regan & Wong (2015:196) recommended that management of structural empowerment such as access to information, and support networks enhance professional growth and job satisfaction. In the study conducted by Oman, Al Awaisi, Cooke & Pryjmachuk (2015:1732), consensus was reached that the internship programme was important in supporting newly-qualified nurses during their transition period and assisting with their role transition. Another study conducted by Dlamini, Mtshali, Dlamini, Shabangu & Tsabedze (2014:155), also expressed concern that after graduation there is no support provided to new graduate nurses in their new role. Contrary to some authors who reported that NQRNs with previous EN experience felt anxious and unprepared in their new role, Dlamini et al. (2014:155) argued that diploma qualified nurses who had been trained in the apprenticeship model reported

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to be ready to work autonomously upon graduation, while those graduated under the Bachelor of Nursing Science (BN) degree seemed to be struggling as they enter employment.

Furthermore, newly qualified registered nurses expressed being frustrated as they were expected to function beyond their capabilities, as experienced staff placed unreasonable expectations upon them leading to a compromised relationship amongst nursing staff. Ebrahimi *et al. (*2016:185) asserted that unrealistic expectations others have on newly qualified registered nurses is exacerbated by poor working relationships through lateral violence. Hence, newly qualified registered nurses pleaded for support as they could not be left alone to manage the unit (Dlamini *et al.*, 2014:152) as they had no structured transition support. Pertiwi and Hariyati (2019:612) affirmed that well developed orientation programmes have positive effects on NQRNs and patient care in the hospital.

In South Africa, the SANC in accordance with Government Notice No. R.683 of 14 April of 1989, as amended, stipulated that NQRN must be competent to be able to render quality and effective patient care. On completion of training, they were expected to practice independently and accept responsibility thereof (SANC, 1989). However, this seemed to be difficult as NQRNs felt unprepared for independent functioning due to lack of support exacerbated by expert assumption labelled towards NQRNs with previous nursing experience. Parker, Giles, Lantry & McMillan (2014:155) concurred that the pressure on new graduates with unreasonable expectations to be work ready by the first day on duty is high. This is coupled with limited support predisposing new graduates to be dissatisfied and frustrated. Bjerknes and Bjørk (2012:3) suggested that new graduate nurses in hospitals should have mentors to support them during the first 4 or 5 months in the wards. Furthermore, Strauss et al. (2015:2) stated that throughout the difficult period of 6 to 9 months formal support should be provided to

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NQRNs. However, shortage of experienced RNs compromised the support to be given to new graduates due to busy unit routines.

Rush et al. (2015:152) reported that new graduates who participated in the transition programme displayed improvement in planning, prioritizing, communication and leadership skills. Hence, sustainable supportive relationships are required in the culture of nursing. Bjerknes and Bjørk (2012:6) emphasized that collegial, mutual supportive and empathetic relationships should be employed in nursing. In a study conducted in South Africa, Ndaba and Nkosi (2015:1157) maintained that transition of NQRNs is difficult, coupled with negative attitudes displayed by both senior and junior staff, high professional role demands as well as shortage of resources. It is, therefore, imperative for new qualified registered nurses to be supported.

Although, Brown et al. (2015:203) asserted that NQRNs with previous nursing experience would cope easy with the new role, it is further argued that being in possession of previous EN experience do not automatically reduce transition stress and licensed the NQRN to ‘hit the ground running’ (Brown et al., 2015:203). Hence, it is deemed necessary for NQRNs (R.683) to be supported. However, there seemed to be no evidence that NQRNs (R.683) were formally supported in public hospitals, and no specific structured orientation programme for NQRNs (R.683). Hence, the researcher aimed to develop a model to enhance the support for NQRNs (R.683) in selected hospitals in Limpopo Province, South Africa.

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1.2 Problem Statement

It is a prerequisite that any new qualified professional nurse, who intends to register with the SANC for the first time as a South African citizen, must perform the remunerated community service for a period of one year at a designated public health institution as stipulated in regulation R.765 (SANC 2005:29; SANC 2007:7). The purpose of this placement is for community service practitioners to be orientated, supported and mentored, as required. According to the guidelines of practice for the R.425 clause 2.1.1 and R.683 clause 3.2.1.3, both qualified practitioners from Bridging and Comprehensive (four-year) programmes are mandated by the same scope of practice: Government Notice No. R2598 of 30 November 1984, as amended (SANC, 1984:2).

However, the qualifications differ pertaining to performance of community service (Government Notice No. R.765 of 24 August 2007). Regulation 8(a) of R.765 states that the transition provisions are applicable to those who did the R.425 programme, but Regulation 8(b) clearly stipulates that no provision is made for those completing Bridging Course (BC) for ENs according to R.683 (SANC, 2007:3), although the programme objectives stipulated that on completion of training NQRNs should practice independently and accept responsibility therefor (SANC 1989:3). The researcher is a lecturer who is conducting bridging course in one of the training institutions, during clinical accompaniment, NORNs (R.683) expressed the frustration of being expected to be work-ready. This was based on their previous experience disregarding the fact that there was a change in their scope of practice. They further verbalized that newly qualified registered nurses who were performing compulsory community service were supported and mentored because there was a report to be compiled for them at the end of their community service. Contrary, NQRNs (R.683) immediately after completion, were allocated on night shift as RNs in-charge or day shift where they mostly run the shift alone. Brown *et al.* (2015:203) affirmed that newly qualified

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registered nurses with previous EN experience would adapt to the new role easy.

On the contrary, Cubit and Lopez (2012:210) argued that possession of previous EN experience did not automatically mean that NQRNs will ‘hit the floor running’. Despite them being allocated in units where they had previously worked as ENs, NQRNs experienced anxiety, insecurity and uncertainty. Da Silva *et a*l. (2010:506) concur that taking charge of the nursing team caused a challenge for NQRNs due to role changes. Therefore, the need for ongoing support and guidance when managing the unit within their first 18 months of employment is imperative. Several studies confirmed that newly qualified registered nurses are inadequately prepared for their role as nurses (Bjerknes & Bjørk, 2012:1).

It is evident that bridging course programme graduates are placed in nursing units and expected to lead shifts on graduation as RNs. Furthermore, there is no orientation programme specifically for NQRNs (R.683) post graduation. However, it is uncertain as to how these NQRNs (R.683) were being supported in clinical practice within their first 18 months. In addition, there seemed to be no model currently in Limpopo Province to support NQRNs (R.683). This prompted the researcher to develop a model to enhance support for NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.

1.3 Purpose of the Study

The purpose of this study was to develop a model to enhance support for NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.

1.4 Research Objectives

The study was guided by the following objectives:

- **Phase 1A: Qualitative Research Approach**

- Explore and describe the challenges encountered by NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.

Phase 1B: Quantitative Research Approach

- Identify support structures available for NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.

Phase 2: Contextualization of Concepts

- Analyze concepts emerging from the data.

Phase 3: Model Development

- Develop a model to enhance the support for NQRNs (R.683) in selected hospitals by nurse managers.
- Validate a developed model to enhance support for NQRNs (R.683) in selected hospitals by nurse managers.

1.5 Research Questions

The study was guided by the following research questions:

What are the challenges encountered by newly qualified registered nurses (R.683) in selected hospitals of Limpopo Province, South Africa?

What support structures are available for newly-qualified registered nurses (R.683) in selected hospitals of Limpopo Province, Soiuth Africa?

How can a model to enhance support of newly qualified registered nurses (R.683) be developed?

1.6 Significance of the study

The exploration of support challenges encountered by NQRNs (R.683) will shed light on the support gap encountered by NQRNs (R.683), which would guide the development of a model to enhance support for NQRNs (R.683) within the first 18 months of their employment in clinical areas. The researcher is convinced that the study findings may make a significant contribution to the existing body of knowledge within the health care system.

Although the bridging course programme was currently being phased out as SANC has introduced new programmes and qualifications, SANC Circular 14 of 2020 on examinations conducted by SANC, clause 5.1.2 states that the end date of the SANC conducted examinations for the legacy qualification for bridging course for ENs leading to registration as a General or Psychiatric Nurse, in line with Government Notice No. R.683 of 14 April 1989, as amended, is extended to November 2023. Therefore, the findings could be helpful to support NQRNs (R.683) who are in the programme to adjust effectively in their new role and run the unit independently.

The findings of this study highlighted to unit nurse managers and policymakers in selected hospitals of Limpopo Province, South Africa, the challenges encountered by NQRNs (R.683) and their support needs. Furthermore, the study findings led to a better understanding of availability of support structures, the lack thereof and the effects on NQRNs (R.683). The outcomes of the study raised awareness of the need to support NQRNs (R.683). The outcomes of this study contributed to the development of a model that enhance support for NQRNs. The model should benefit nurse managers to enhance support for NQRNs in their institutions and, in turn, cultivate competent and confident RNs. Newly Qualified Registered Nurses that are supported acquire skills and knowledge earlier and thus commit less medico-legal hazards and enhance quality patient care and so benefit institutional management with decreased lawsuits.

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Accordingly, policymakers should review R.683 programme and curriculum developers to strengthen clinical competence for nurse trainees and prepare them for professional roles.

1.7 Paradigmatic Perspective of the Study

According to Babbie & Mouton (2001:31-32), a paradigm is a framework for organizing our observations and reasoning; a statement taken for granted or considered to be true even though it has not been scientifically tested (Grove & Gray, 2019:174) or a basic set of beliefs that guide the researcher's action (Creswell, 2014:35) and is also viewed as a lens that aids the researcher to have a focal point on the phenomenon of interest (Polit & Beck, 2008:17). In this study, the researcher used pragmatic assumptions because different research methods were applied. The researcher used a mixed method design with a quantitative phase and qualitative phase to answer the research question. The assumptions were rationally applied, guided by a pragmatic and paradigmatic perspective to develop a model to enhance support for NQRNs (R.683) in public hospitals in Limpopo Province.

1.8 Philosophical Assumptions of the Study

Philosophical assumption refers to the researcher's worldview that guides the questions asked and methods applied to conduct a study (Grove, Burns & Gray, 2013:57). This study is guided by the philosophy of pragmatism to answer the overall research question. Contrary to methods focused, pragmatists are problem-centered as they embrace the importance of addressing research problems (Creswell, 2014:39). In addition, pragmatists are pluristic as their focus is on multiple data collection and analysis methods.

Pragmatists have freedom to choose the methods as they are not committed to a single system of philosophy and reality. Therefore, they mix the data collection methods and

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analysis procedure within the research process (Creswell, 2014:40). In this study, the researcher collected and analyzed data using both quantitative and qualitative approaches that best addressed the research problem of support challenges. The paradigmatic perspective of this research includes ontological, epistemological, methodological, axiologic and rhetorical assumptions.

1.8.1 Ontological Assumptions

Ontological assumptions refer to the inquiry about realities as constructed by individuals (Polit & Beck, 2012:13). The research question to be answered in ontological assumptions is "What is the nature of reality as perceived by research participants?." The ontology of pragmatism guided this study because it focused on solving problems using methods that fit the question (Grove & Gray, 2019:431). Positivist ontology ensured that data related to the stable external reality was discovered in an objective manner, while constructivist ontology allowed the researcher to interact with the research participants because reality was constructed through the subjective interactive process (Polit & Beck, 2012:12).

The researcher explored the experiences of NQRNs to ascertain their own life experiences in their own working environment through observation, interviewing and collection of field notes to present the multiple social constructs or reality. Positivist ontology ensured that data related to the stable external reality was discovered in an objective manner using self-administered questionnaires to nurse managers on the practices of implementing support measures to NQRNs. Therefore, by using pragmatic arguments about the truth, the focus was more on demonstrating that the results were effective for the overall research question.

1.8.2 Epistemological Assumptions

Epistemological assumption refers to the way the researcher, as an inquirer, interacts

with those being researched and the findings resulting from this interaction process (Polit & Beck, 2012:13) and the relationship between the inquirer and the participants (Brink, van der Walt & van Rensburg, 2018:19). Pragmatic epistemology ensures that the researcher has freedom of interaction with the research participants. However, to ensure that the researcher collect data that is truly objective there must be objective detachment or value freedom from research participants (Guba & Lincoln, 1994:108). The values of the study refer to the development of a model to enhance support for NQRNs (R.683) which could add value to nursing practice. Therefore, the findings of the study on the support challenges encountered by NQRNs (R.683) informed the researcher on the support they needed.

1.8.3 Axiological Assumptions

Axiological assumptions refer to the role of values in the inquiry at hand (Polit & Beck, 2012:13). Pragmatic axiology addresses the values that are closely related to the study. In this study context, the researcher abided by the ethical code and principles of the University of Venda. In the context of this study, the researcher maintained ethical principles during the interactions by not harming the participants, showed respect and explained the purpose of the study and that they were free to consent or withdraw.

1.8.4 Rhetorical Assumptions

Rhetorical assumptions refer to the language that influences the writing style of research report. In the context of this study, the researcher used statistics in the sections concerning quantitative results, while qualitative findings were presented in a narrative format using a pattern of themes.

1.8.5 Methodological Assumptions

Methodological assumptions refer to the way researchers obtain knowledge, or ways

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of knowing about the reality of research inquiry (Brink *et al*., 2018:19). In pragmatism, both quantitative and qualitative research processes are deemed most appropriate to justify that the truth is ‘what works’ best to answer a research question. The methodology of this study is described in detail in Chapter 3.

1.9 Theoretical Framework

Lazarus & Folkman’s Transactional Model of Stress and Coping (1986:63) served as the theoretical framework of this study because it explained the relationship between individuals and their environment. The following theoretical assumption relate to this study: stress is a person-situation interaction whereby the person’s environment is shaped by internal appraising processes. It is believed that stressful experiences result from transactions between individuals and the environment (Kagwe, Ngigi & Mutisya, 2018:19).

In this study, the NQRN (R.683) is a person who enters the new RN role where s/he evaluates the effects of the new role on her/his role expectations. It is dependent on the subjective cognitive judgement that arises from the interplay between the person and the environment. The evaluations depend on the NQRN’s expectations and the meaning s/he imparts to the demands of the new role. There is no event/situation that is inherently stressful; instead, the stressor is defined by the subjective judgement of the situation that is appraised as threatening, harmful or taxing of available resources (Lazarus & Folkman, 1986:63). If the NQRN (R.683) evaluates the new role as a challenge, s/he may have positive outcomes, but when s/he feels threatened it will impose strain to her/him which will require some coping mechanisms to deal with the challenging event (Kagwe *et al*., 2018:19).

Lazarus & Folkman (1984:141) defined coping as ‘constantly changing and behavioural efforts to manage specific external and internal demands that are

appraised as taxing or exceeding the resources of the person'. The authors further categorize the stress coping mechanisms into two, namely: emotion-focused and problem-focused. In emotion-based coping, the person tries to avoid or minimize the harmful, threatening or challenging environmental events that s/he is unable to modify. Whereas, in problem-based coping is whereby a person learns new skills to find an alternative way of dealing with the challenging event such as seeking social support for emotional reasons (Tremolada, Bonichini & Taverna, 2016: 1859; Kagwe *et al*, 2018:19).

1.10 Definition of Concepts

Concepts are terminologies that should be defined both conceptually and operationally. A conceptual definition conveys the general meaning of the concept which is the way it was defined in a dictionary or textbook, while the operational definition provides specificity and direction for the concept to guide the development of the research plan, in other words, it shows how one intends to define each term specifically for the study (Akinsola, 2005:54). The key concepts of this study are a model, enhance, support, newly-qualified registered or professional nurse, EN, bridging programme.

1.10.1 A Model

A model denotes a symbolic representation of a set of concepts that is created to depict relationships in a diagrammatic form to assist researchers to structure the way they can perceive a situation or event (Chinn & Kramer, 2018:186; Brink *et al*., 2018:20; LoBiondo-Wood & Haber, 2014:580). It is a pattern of articulating words logically outlining how a certain structure can be followed. In this study, a model is the way concepts were arranged to explain and display how NQRNs can be supported in selected hospitals of Limpopo Province, South Africa.

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1.10.2 Enhance

Enhance means changing the way things were done and improve the performance (Longman Dictionary, 2009:561). In this study, the support which is currently provided for the NQRNs, if any, will be improved for the betterment of the selected hospitals of Limpopo Province, South Africa.

1.10.3 Support

Support is a means of encouraging someone, hoping that s/he will attain the desired goal (Ramathuba, 2015:74) In this study, support means further helping stressed NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa, to acquire their management or administrative skills.

1.10.4 Newly-Qualified Registered Nurse

According to section 16(2) of the repealed *Nursing Act*, 50 of 1978, in South Africa, a registered nurse is a person ceritified as such by SANC. The registered nurse who successfully completed the prescribed programme (R.683 of 14 April 1989, as amended), and acquired the stipulated qualifications to be registered to practice as a general nurse. In this study, NQRN refers to a person who has just completed the bridging course nursing programme, achieved the minimum requirements as set by the statutory body to hold a professional position; and registered with SANC in accordance with Government Notice No. R.683 of 14 April 1989, as amended. The person would not have more than eighteen months working experience as a registered nurse.

1.10.5 Registered Nurse or Professional Nurse

A registered or professional nurse is a person registered as such in terms of Section 3 (1)(a) of Nursing Act, No. 33 of 2005, who is qualified and competent to practice nursing independently in the manner and to the best level prescribed by SANC. The

person is also capable of assuming responsibility and accountability for such practice. In this study, RN refers to an individual who has completed a two-year bridging course programme, whereas a professional nurse has received training in a four-year course in Nursing (General, Psychiatric and Community) and Midwifery (SANC, 1985), as specified by the term comprehensive who is competent to independently perform her/his activities in a responsible and accountable manner as expected of a person of her/his calibre.

1.10.6 Bridging Programme

Bridging programme refers to a programme specifically designed to assist a person who already has a qualification, to attend college or university and achieve a higher qualification in the same field of study within a shorter time than an entry-level student. In this study, the bridging programme for ENs is a two-year programme that permits professional development for ENs to progress to the RN level.

1.10.7 Enrolled Nurse

An EN is a person who is enrolled with SANC under Government Notice R.2175 of 19 November 1993. According to the Scope of Practice Government Notice R2598 of 30 November 1984, this category of nurse is permitted to work under the direct or indirect supervision of the registered person, in this study, the RN (SANC, 1984).

1.10.8 Unit Nurse Manager

Nurse manager refers to the RN who is employed in an administrative position at a hospital or in a clinical setting (Govender, Brysiewicz & Bhengu, 2016:62). Nurse managers may be classified according to job titles such as: Nursing Manager who manages nursing staff, Deputy Nurse Manager who is the second in charge of nursing staff and Unit Manager who are Operational Managers of Nursing Units (Govender *et al.*, 2016:62). In this study, a nurse manager is the experienced RN who supervises

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and supports nursing staff and oversees patient care in the clinical area. Therefore, the term nurse manager, unit nurse manager or experienced registered nurse will be used interchangeable throughout the study.

1.11 Research Design and Methodology

This study followed a mixed method research (MMR) approach. Creswell (2014:281) argued that in a concurrent mixed method research design, qualitative (QUAL) and quantitative QUAN) data collection occurs simultaneously in one phase of the study. Schoonenboom and Johnson (2017:109) described MMR as the type of research that combines elements of QUAL and QUAN research approaches for the broad purposes of breadth and depth of understanding and corroboration. The point of integration or mixing occurs in the analytic or results stage. The aim of this study was to develop a model to support newly-qualified registered nurses (R.683) in Limpopo Province.

1.11.1 Phase 1: Explorative and Descriptive Survey

The first phase was a situational analysis where empirical data were collected. In Phase 1A, the qualitative research approach explored and described the challenges encountered by NQRNs (R.683) and, in Phase 1B, the quantitative approach identified the support structures in place to support NQRNs.

1.11.2 Phase 2: Concept Analysis

Concept analysis entails synthesizing existing views of a concept and distinguishing it from other concepts with the purpose of resolving inconsistencies in the knowledge base of the discipline (Knalf & Deatrick, 2000:39). The researcher conducted concept analysis of the concept ‘support’ to elucidate the meaning of the concept as used in the clinical work setting to improve knowledge and skill competencies to work independently as a RN.

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1.11.3 Phase 3: Model Development

The results of concept analysis led to the development of the support model. The identified concepts of support within nursing practice were conceptualized using the six elements of practice theory as described by Dickoff, James & Wiedenbach (1968:434), namely, context, agent, recipient, dynamic, procedure and purpose.

1.11.4 Phase 4: Validation of the Model

The developed model was validated following the guidelines conceptualized by Chinn & Kramer (2018:203). The following five components guided the validation of the model: clarity, simplicity, generality, accessibility and importance.

1.12 Measures to Ensure Trustworthiness/Validity and Reliability

Trustworthiness refers to the degree of confidence qualitative researchers have in their data (Polit & Beck, 2014:394). In this study, the researcher ensured trustworthiness of the data by applying the following criteria: credibility, dependability, confirmability and transferability. Validity is the degree to which the instrument measures what it is supposed to measure (Brink, 2012:487; Creswell, 2012:205). In this study, validity refers to what extent the quantitative research was going to measure support received by NQRNs (R.683) in the clinical area and ensure the expected outcome of the study.

1.13 Ethical Considerations

Ethical principles are standards upon which the researcher's conduct is based to minimize participants to unnecessary physical, emotional or financial harm (Grove & Gray, 2019:95). To ensure the safety and well-being of participants (Taylor, 2014:194), the researcher complied to the following ethical principles: permission to conduct the study, informed consent, beneficence and non-maleficence, right to self-determination, confidentiality and anonymity.

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1.14 Outline of the Study

1.14.1 Chapter 1: Overview of the Study

This chapter outlines the introduction and background of the study, the problem statement, purpose, objectives, research questions and significance of the study. It highlights the paradigmatic perspective and philosophical assumptions of the study, defined concepts, identified the theory which guided the study and outlined the study chapters.

1.14.2 Chapter 2: Literature Review

This chapter outlines the introduction of the literature review regarding challenges encountered by NQRNs with previous nurse experience within their first 18 months of practice in the clinical area, support needed and support strategies were reviewed.

1.14.3 Chapter 3: Research Methodology

This chapter describes the research setting, design, approach, population, sampling, data collection, measures to ensure trustworthiness/validity and reliability, data analysis procedure, steps for concept analysis, model development and validation, and ethical considerations.

1.14.4 Chapter 4: Presentation and Discussion of the Qualitative Results

In this chapter the findings of Phase 1A (quantitative phase) are analyzed, interpreted, discussed and controlled through literature.

1.14.5 Chapter 5: Analysis, Presentation and Description of the Quantitative Findings

In this chapter the findings of Phase 1B (quantitative phase) are analyzed, interpreted and supported with literature. The findings of both qualitative and quantitative strands are integrated, interpreted, discussed and controlled with literature.

1.14.6 Chapter 6: Concept Analysis

This chapter outlines the six steps of concept analysis as highlighted by Rodgers & Knafl (1993:90).

1.14.7 Chapter 7: Model Development

This chapter outlines model development following Dickoff, James & Wiedenbach's (1968) survey list.

The model is described under the following sub-headings: an overview of the model, the structure, context, purpose, relational statements and assumptions on which the model is based.

1.14.8 Chapter 8: Guidelines to Operationalize the Model and Model Validation

This chapter presents the guidelines to operationalize the model, and model validation is highlighted based on the criteria proposed by Chinn & Kramer (2018:203).

1.14.9 Chapter 9: Justifications, Contributions, Recommendations, Limitations, and Conclusions

This chapter exhibits the summary of the study, justifications and contributions to the body of knowledge, limitations and recommendations.

1.15 Conclusion

In this chapter the introduction and background of the study was briefly discussed, and the problem statement, the study purpose and objectives, and the research question which guided the study and significance of the study were outlined. It also, illuminated the paradigmatic perspectives, philosophical assumptions that guided the study. The theoretical framework was briefly mentioned, followed by the operational definitions of key concepts applicable to the study. The thesis structure in terms of chapter outline

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was also presented. Chapter 2 focuses on the literature review.

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CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Chapter 1 provided an overview of the study. In Chapter 2, the researcher discusses the literature reviewed. A literature review is a condensed report of what is known on the topic of interest, often prepared to put a research problem in context. It is the researcher's presentation of what has been researched previously to lay a foundation on which to base new evidence (Polit & Beck, 2012:58). Burns & Groves (2011:189) affirmed that a literature review provides background information about a specific problem. Creswell (2014:28) stated that a literature review provides a framework for establishing the importance of a study as well as a benchmark for comparing results found in literature sources.

A literature review also, helps researchers to develop a theoretical or conceptual framework for the topic under study (Brink, Van der Walt & Van Rensburg, 2018:58). In this study, the focus of the literature review was to analyze the findings of previously conducted research on the challenges encountered by NQRNs and to develop a model to enhance their support. Since the focus of the study was to explore and describe the challenges encountered by NQRNs (R.683) in their new role in hospitals, the researcher was prompted by the fact that there is a plethora of studies on student nurses' transition to new graduate nurses. However, a paucity exists in studies conducted on the challenges encountered by NQRNs who have previously trained as ENs.

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In this chapter, the reviewed literature assisted the researcher to reach a comprehensive understanding of what other scholars found regarding challenges faced by newly-qualified nurses and the support they have received in their new role from a global perspective, as well as in a South African context. The reviewed literature provided a theoretical framework which guided the study. Furthermore, the findings of the literature review assisted the researcher in selecting an appropriate research methodology for the study.

Therefore, to identify the most relevant sources to the problem (Brink, Van der Walt & Van Rensburg, 2018:187), the researcher followed the process of literature review encompassing the focus question, search strategy, search profile, appraisal of identified studies, as well as themes and sub-themes that emerged from the literature.

2.2 Methodology

2.2.1 Focus Questions

The research questions below guided this study:

What are the challenges encountered by newly qualified registered nurses (R.683) in selected hospitals of Limpopo Province, South Africa?

What support structures are available for newly-qualified registered nurses (R.683) in selected hospitals of Limpopo Province, Soiuth Africa?

How can a model to enhance support of newly qualified registered nurses (R.683) be developed?

As a literature search is based on a clearly formulated question, this question steered the literature search strategy adopted in this study.

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2.2.2 Search Strategy

The researcher began by selecting keywords of the study, and used the same to search for literature sources (Brink *et al*., 2018:61). The researcher commenced the literature search in the University of Venda (Univen) library where the researcher was a doctoral candidate. Several databases were searched for existing literature sources relevant to the study topic. Examples of the databases searched include EBSCOhost, Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, BMC Health Services Research, Global Business and Technology, Contemporary Nurse, and SAGE, Google Scholar, and Google.

2.2.3 Search Terms

The following search terms were used during the literature search process: newly-qualified registered nurse, enrolled nurse to registered nurse, support. The researcher also, used the Boolean operators 'and' and 'or'. The search term newly-qualified registered nurse was merged with 'or' newly-qualified nurses 'or' new licensed nurses; support, preceptor, mentor. The researcher outlined the inclusion and exclusion criteria to guide and direct the search for literature sources (Table 2.1).

Table 2.1: Inclusion and exclusion criteria for literature sources

Inclusion Criteria	Exclusion Criteria
✵ Articles on challenges and enrolled nurse to new registered nurse. ✵ Articles that explored enrolled nurses who had completed a bridging course programme for entry into registered nurse role. ✵ Articles published in English. ✵ Articles published from 2010-2020, unless there was relevant information from that study from years prior to the year 2010.	✵ Articles involving enrolled nurses not transited to registered nurses. ✵ Articles not published in English. ✵ Articles published before 2010.

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2.2.4 Emergent Themes

The following themes emerged from the literature sources reviewed: unpreparedness, unreasonable expectations, workload, lack of support, unprofessional behaviour, and mentorship. Limpopo is a rural province in which most people use public hospitals for health care services. There is a burden of diseases coupled with shortage of staff. Therefore, there is a need for well-prepared and supported NQRNs to meet the health requirements of the residents of this province. However, little is known about the challenges encountered by NQRNs who transited from EN and the support they have received.

2.3 Challenges Encountered by NQRNs with Previous Enrolled Nurse Experience Within Their First Months of Practice in the Clinical Area

A challenge is when a person is being faced with an unpleasant situation that needs great mental and physical effort to successfully resolve it and thus it tests a person's ability (Cambridge Online Dictionary). NQRNs with pre-existing enrolled nursing knowledge and skills are aware of what is happening in the hospital setting. However, upgrading from being an EN to a RN role is challenging and stressful as NQRNs are expected to 'hit the ward running' based on their previous experience (Kilstoff & Rochester, 2004:16). Based on the findings of the study conducted in Singapore, Woo & Newman (2020:88) revealed that NQRNs experienced stress because employers had expected them to be work prepared upon transition. In an Australian study, Parker *et al.* (2014:155) asserted that seniors expected NQRNs to be work ready by day one when they enter the workforce.

Although, some NQRNs with previous enrolled nursing experience post-graduation continue working in their familiar ward, the loss of familiarity of their EN roles and lack of preparation for real clinical RN role can be particularly stressful (Ashley, 2017:30),

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as they must adjust to a changed role and identity (Wong *et al*., 2017:30). Initially, NQRNs felt adequately prepared for their RN role, but later reported being grappling with performance of some skills such as decision-making, managerial skills, huge caseload and patient acuity (Woo & Newman, 2020:82). Missen, McKenna & Beauchamp (2015:33) asserted that the majority of NQRNs with previous EN experience were inadequately prepared for their clinical practice role as they were task-focused and failed to make autonomous managerial decisions. The authors further indicated that NQRNs (R.683) had difficulty in performing clinical skills independently on commencement of their employment (Missen *et al*., 2015:33). Similarly, Tembo, Kabuluzi, Gondwe & Mbakaya (2019:6) interviewed ten NQRNs in Malawi, and described NQRNs' feeling that transition to RNs' role is difficulty.

The findings of the study conducted by Mellor & Gregoric (2017:2) revealed that NQRNs were denied opportunity to master their skills during undergraduate clinical placement as they were shielded from full responsibility of performing RNs' role. Similarly, NQRNs in Singapore were reported to have been deprived opportunity for hands on practice during their nursing education period (Woo & Newman, 2020:88), hence, it is not surprising for NQRNs finding it difficult to perform tasks independently and they often needed more time to adjust to their new RN role (Missen *et al*., 2015:35).

Despite being incompetent in some skills, NQRNs, during their first months of employment, were confronted with challenges of managing and prioritizing unit routine tasks and heavy workloads. This was compounded by unrealistic expectations, shortage of staff, high patient acuity and bullying (Phillips, Kenny, Esterman & Smith, 2014:107). As NQRNs (R.683) enter a novel role with extended responsibility and accountability (Whitehead & Holmes, 2011:21), their scope of practice of being working under the direction and supervision of the RN changed.

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NQRNs had to leave their nest and test their wings by learning how to fly independently (Hunt 2015:121) without an experienced RN's support. This lack of experienced RNs to direct and supervise the NQRNs made them to struggle in their work performance (Zinsmeister & Schafer, 2009:29). Blevins (2018:199) perceived this to be the most vulnerable time where NQRNs require socialization to their clinical units, because they faced change in professional identity and relationships (Woo & Newman, 2020:82). Lim, Teoh, Holroyd & Chan (2013:43) concurred that NQRNs in Singapore were challenged with new responsibilities, forging new relationships and acquiring new nursing knowledge required for their RN role. When unsupported, NQRNs become anxious and perform less than expected resulting in poor patient care, job dissatisfaction and decide to leave the profession (Parker, Giles, Lantry & McMillan, 2014:151; Blevins, 2018:199). This is supported by Ebrahimi (2016:185) who reported that the absence of a support system in the NQRNs' new role can result in reduced confidence, sense of inadequacy and job satisfaction leading them to quit their jobs. This aggravates shortage of nursing staff.

Despite being in possession of previous nursing experience, NQRNs who upgraded from EN through bridging course (R.683) still encounter challenges similar to NQRNs without prior nursing knowledge and skills (Gallagher, 2012:1). They are confronted with complex and stressful transition from EN through bridging course to NQRN (Gardiner & Sheen 2016:8), especially during their first year of employment (Lim, Teoh, Pua, Holroyd & Chan 2013:42).

The pressure on the health care system and the need for NQRNs to 'hit the ground running' was exacerbated by shortage of experienced RNs worldwide (Wolff 2010:1; Kilstoff & Rochester 2004:17). Shortage of experienced RNs predisposed NQRNs to receive limited support in the clinical area. Lea & Cruickshank (2015:2832) concurred that lack of senior staff reduce the capacity to support NQRNs through precepting or

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mentoring. The fact that NQRNs have previous EN experience had negative influence toward their support. In a study conducted by Phillips *et al. (*2014:108), participants reported that senior nurses assumed that new graduate nurses who had previous experience didn't require same degree of support with those NQRNs trained via other modes (Jacob *et al*., 2014:652).

The literature affirmed that most newly-qualified nurses faced a lack of support as they cannot access the experienced mentors and coaches (Hofler & Thomas, 2016:133; Whitehead & Holmes 2011:22; Wong, Che, Cheng *et al*., 2017:33; Maddalena, Kearney & Adams 2012:75). Some studies demonstrate that NQRNs in clinical areas lacked support from unit staff, and perceived transition as being 'thrown into the deep end' (Draper, 2018:92) or set out to fail (Hussein, Everett, Ramjan, Hu & Salamonson, 2017:8).

Except the assumption that NQRNs with previous EN experience were work ready based on their previous nursing experience, there were identified stumbling blocks to adequately support this group of NQRNs. In busy units where there were high workloads, NQRNs may be deprived support as senior staff may be concentrating to push the unit routine and view support to NQRNs as extra workload to them. Gardiner & Sheen (2016:11) concurred that there were workload pressures that prevented mentors to adequately support NQRNs.

Workloads may also, compromise NQRNs' ability to consolidate their theory with practice. An Australian study by Mellor & Greenhill (2014:57) revealed that coping without a mentor and receiving less feedback on clinical practice performance is fraught with danger, as unsupervised NQRNs resort to 'trial and error' as a coping mechanism. In situations where both unit staff and NQRNs are busy they may not be able to provide quality patient care but may cut corners. Therefore, heavy workloads

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may negatively impact NQRNs' support in their new role. NQRNs also encounter the challenge of interpersonal relationships, and unprofessional behaviour of the staff, as noted in the literature. The unwelcoming spirit is among the interpersonal problems encountered. In such situations, NQRNs are afraid to ask for help and this hinders their support (Mellor, Gregoric & Gillham, 2017:9). Similar outcomes were observed by Freeling and Parker (2015:e42) that negative staff attitudes are barriers of newly qualified registered nurses support.

Similarly, in a longitudinal explanatory sequential mixed method, cohort study conducted in United Kingdom, participants reported ineffective communication such as shouting and being ridiculed in front of juniors and patients, which was disturbing, resulting in poor interpersonal relationships (Halpin, Terry & Curzio, 2017:2582). Good interpersonal relationships between NQRNs, senior nurses, junior nurses and other health team members in the clinical area is imperative for adequate support to occur. Adequate support occurs in a conducive environment where there is performance engagement leading to professional growth and development of critical thinking skills.

The literature revealed that moving from the ideal world of theory to the real clinical world gives rise to feelings of vulnerability, insecurity, inadequacy, lack of confidence and incompetence (Woo & Newman, 2020:82). This is because there is mismatch between the level of responsibility that NQRNs previously held as ENs and their RN level of responsibility. NQRNs, when faced with the reality of the clinical practice, experience fear and anxiety. McKenna, Wood, Williams *et al.* (2019:84) described how NQRNs grappled with their unfamiliar new responsibility.

Wong, Che, Cheng *et al.* (2018:35) in their qualitative study interviewed eight newly-qualified nurses to explore their challenges during the transition, discussed how NQRNs expressed concerns regarding their feelings of stress and anxiety regarding

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their RN role. NQRNs expressed concerns regarding their level of knowledge and skills, but also, found the workplace challenging in terms of workload and shortage of staff. Many believed they moved out of the undergraduate ‘umbrella’ of being shielded to carry out huge responsibility (Wong *et al.*, 2018:35).

Similarly, Flinkman & Salanterä (2015:1054), in a qualitative study in Finland, described NQRNs’ feelings of anxiety and insecurity as they took up their new role. Kumaran & Carney (2014:608) reported similar findings. NQRNs felt being abandoned and thus felt like leaving the profession temporarily or permanently (Chandler 2012:106; Flinkman & Salanterä 2015:1054). Ndaba (2013:68) reported how NQRNs felt surprised when presented with unwelcoming and unprofessional behaviour from senior and junior staff. Kumaran, Suji & Carney (2014:608) revealed that newly qualified nurses expressed being amazed by the sudden change in attitude by other team members post-graduation.

In a cross-sectional study conducted in Ghana, Kokoroko & Sanda (2019:345) revealed that NQRNs displayed being overwhelmed with large number of patients, especially during their 1-4 months during transition (Duchsches, 2009:1105). Gallagher (2012:22) concurred that although NQRNs with previous EN experience were familiar to manage five to six patients, the increased responsibility and the reality of being faced with independent decision-making made it difficult for them, as it is for all NQRNs (Brown *et al.*, 2015:199).

Wall, Fetherston & Browne (2020:399) asserted that NQRNs grappled to adapt to new routines and form new relationships in a new role within an unfamiliar situation. As NQRNs, they used to be classified as juniors being supervised hierarchically by more experienced nurses. So, when they are unable to perform some activities independently resulting in being a risk to patients’ lives, the majority of NQRNs

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experience self-doubt and self-accusation (Wang, Ding, Hu *et al*., 2016:359), because they thought that their previous EN experience will make their transition easy (Brown *et al*., 2015:2020). The study conducted by Hylton (2005:521) described NQRNs with previous EN experience as 'relearning how to learn'. Hence, during frequent unit rotations, NQRNs were repeatedly exposed to stressors as they were meeting new staff and unfamiliar new registered role activities. Although NQRNs with previous enrolled nursing experience are familiar with some units' surroundings and routine activities, entry into the new RN role cause stress. Gallagher (2012:22) outlined stressors for NQRNs as the challenges of striving to cope with new RNs' roles, uncertain of what to do as intended, self-doubt and reduced confidence of being able to perform tasks of their new role in a safe and competent way as well as swift increased responsibility and accountability (Gallagher, 2012:22).

Sönmez & Yildirim (2015:104) maintained that the newly-graduated nurses experienced stress, anxiety, and disappointment during the first months (up to 9-12 months) of their employment due to insufficient clinical skills, heavy workloads, and inability to spare enough time for patients, prioritization and decision-making. As the NQRNs struggle to manage this unreasonable workload due to fear of failure, they become exhausted and stressed and thus medico-legal hazards exist (Hussein, Everett, Ranyan, Hu & Salamonson, 2017:2).

A study conducted by Flinkman & Salanteriä in Finland revealed that participants reported descriptions of negative behaviours exhibited by senior nurses that left NQRNs on their own to work, learn and cope, evidenced by this quote: '*I felt that I was just thrown in there -'do what you do - screw up what you screw up and everyone knew that if you fail, no one will stand by you*' (Flinkman & Salanteriä, 2015:1054). Additionally, NQRNs in this study felt isolated and abandoned as their anxiety were not acknowledged though they expected nurse managers to support them. Blevins

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(2018:199) argued that upon graduation, NQRNs could not simply ‘hit the ground running’. Hence, they require mentoring to cope with the uncertainty of the new role. Henderson, Ossenberg & Tyler (2015: 226) in their study indicated that support from unit staff reduces the sense of isolation that NQRNs can feel.

Freeling & Parker (2015: e48) in their critical review to explore the experienced nurses’ attitudes, views and expectations of NQRNs, found that NQRNs often experience negative behaviour such as negative criticism, belittling and bullying behaviours. Hawkins, Jeong & Smith (2019:41) in their findings maintained that negative workplace behaviour in nursing has undesirable results upon NQRNs, the nursing profession, the institution as well as the patient as recipient of care. Rosi, Contiguglia, Millama & Rancati (2020:112) in their qualitative phenomenological Italian study conducted through face-to-face interviews with 21 participants to investigate the direct and indirect experiences of horizontal violence. These authors asserted that NQRNs are essential health care resources that need to be supported and protected to retain them and thus reduce attrition and turnover (Rosi *et al.*, 2020:1566).

Communication was also, distorted. Schultze (2017:112) reported that participants frequently expressed having difficulty in communicating with doctors, peers, patients and their relatives. Hence, NQRNs need the encouragement of all health care team members to be successfully socialized in the clinical area. Schultze (2017:113) further argued that communication and socialization are imperative for NQRNs’ success in the workplace. And their ability to harmoniously work with all team members is beneficial to patient care. Hence, affirms that a warm and inviting personality assists in reducing some stressful feeling experienced by NQRNs (Schultze, 2017:113)

Expectations of senior nurses from NQRNs may have a significant impact on the opportunities and experiences available to them during transition to practice, and thus

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may affect their performance. Gallahger (2012:22) indicated that managerial and peer expectations of NQRNs' transition to the new RN role would be unchallenging due to possession of previous EN experience. Furthermore, this assumption resulted in NQRNs' increased anxiety and reduced confidence (Gallagher 2012:22). It is evident that there are great expectations for NQRNs to enter the practice environment being work ready, and able to function safely and independently in provision of patient care (Woods, West, Mills, Park, Southern & Usher 2015:360). This predisposes them to anxiety and stress. Hence, Cubit & Lopez (201:209) reported that NQRNs with previous enrolled nursing experience reported to need support, as much as any other NQRNs in the new role.

Dlamini & Mtshali (2014:155) reported that NQRNs with previous EN experience are adequately equipped for RN role and that they are prepared and don't need transition support as they were referred as competently 'walked into practice' (Dlamini & Mtshali, 2014:155). In contrast, Cubit & Lopez 2012:209; Phillips *et al.*, 2014:110) emphasized that NQRNs with previous enrolled nursing experience need to be supported like any NQRNs in clinical practice. Gallagher (2012:22) revealed that NQRNs with previous experience were stressed by anxiety and fear of making errors, lack of knowledge of what is expected of them and increased responsibility and accountability related to new roles (Gallagher, 2012:22). Rush *et al. (*2015:153) suggested that NQRNS should be supported after graduation and structured mentorship should be provided at least a year. Haggerty *et al. (*2013:169) highlighted the positive effects of mentorship on NQRNs.

Malouf & West (2011:8) reported that study participants avoided to seek help from experienced staff for fear of being labelled inadequate, and they sham knowledge and thus jeopardize patient safety. This report demonstrated the crucial role to be played by mentors to identify the stress and anxiety experienced by NQRNs when faced with

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new and unfamiliar situations, to avoid them feeling being isolated and abandoned (Melrose & Gordon 2011:34). NQRNs revealed that they continued to practice unsafely due to lack of guidance from experienced senior nurses (Mellor & Greenhill, 2014:57). Similarly, in their New Yolk study, Castronovo, Pullizzi & Evans (2016:210) asserted that the majority of newly qualified nurses reported performing tasks that could compromise patient safety rather than asking help from their co-workers. Hence, Bvumbwe & Mtshali (2018:71), in their multi-methods design study conducted in Malawi, reported that NQRNs require adequate support, particularly when they enter a new environment with unfamiliar expectations and roles.

In an Australian study, a mixed method cross-sectional design study was conducted with 282 participants to explore new graduates' experiences in their first year of practice (Parker *et al.*, 2014:150). Parker *et al.* (2014:155) revealed that new graduates described their transition as challenging, stressful and difficult, exacerbated by inadequate support, unreasonable workload and expectations as well as horizontal violence and staff attitudes. Whilst there were assumptions that transition from EN to RN might be easier, some studies refute this notion. Cubit & Lopez (2012:210) argued that the fact that NQRNs had previous EN experience does not necessarily mean that they can 'hit the floor running'.

Despite their previous nursing experience, NQRNs pleaded to be supported like any other new graduates. Hence, others hid their previous enrolled nursing status for fear of being deprived adequate support as other unit staff anticipate these NQRNs can cope with excessive workload than other new graduates (Cubit & Lopez 2012:210). Similarly, Brown, Barker, Jessup & Marshall (2015:203) in an Austrian study on EN2RN-transition to a new scope of practice found that due to increased scope of practice, accountability and responsibility, NQRNs require support like other new graduates regardless of their previous EN experiences.

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The feeling of difficulty to cope with the new role was exacerbated by limited support structures and resources as well as changes in skills mix within clinical settings. Lea & Cruickshank (2015:2832) and Mellor & Greenhill (2014:56) reported that a limited number of senior nurses resulted in NQRNs assuming managerial positions of being shift leaders prematurely. Lack of support from experienced staff to validate decisions made by NQRNs led to trial and error practice. This puts more pressure on NQRNs resulting in stress and fear of making mistakes during clinical practice; and thus, compromise NQRNs' decision-making ability (Mellor & Greenhill, 2014:57).

Malouf & West conducted in-depth interviews with nine newly graduate nurses in an Australian study on 'Fitting in: A pervasive new graduate nurse need'. Participants felt fitting in was difficult as they had to move from one ward to another through rotations. And that during the process they had to be part of the social group (Malouf & West, 2011:6). Similarly, Feltrin, Newton & Willets (2019) conducted a grounded theory study to investigate how new graduate nurses participated in transition programmes in two Australian hospitals. Newly graduated RNs used various methods to adapt and 'fit in' in clinical practice (Feltrin *et al*., 2019). During ward rotations, NGRNs observed ward routine performed by unit staff and learn how to fit in. the majority of participants reported not fitting in, as they felt not attuned with staff members or not feeling a sense of belonging to the team (Feltrin *et al*., 2019). Participants claimed that frequent rotations disrupted their ability to establish concrete social bonds and to fit in with colleagues (Malouf & West 2011:13).

In their study, Phillips *et al. (*2014a:106), on examining the needs of graduate nurses in their transition to a new role, identified that although the majority of NGRNs were pleased with the transition process some were not. NQRNs reached consensus that individual and team support can successfully enhance their transition, especially if there is collegial respect (Phillips *et al*., 2014a:106). Whilst exploring supporting new

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graduate nurses transition method, Phillips, Kenny & Esterman (2017:124) heightened the importance of team and individual preceptor support as an enabler of successful new graduates' transition method.

The literature discussed various transition programmes depending on countries where they are being provided to support NGRNs. There is limited consistency across programmes internationally, as they vary in length and teaching methods. There are preceptorship, residency, internship or mentorship in clinical practice provided to support NGNs during the transition process to professional role (Brook, Aitken, Webb, Maclaren & Salmon, 2019).

In Ontario, a longitudinal study that examined the impact of a government-sponsored extended orientation and mentorship programme intended to facilitate the transition of new graduate nurses to professional practice (Hunsberger *et al*., 2013:73). The findings revealed that the programme was instrumental in empowering new graduate nurses to practice independently. Furthermore, it reported that mentoring enhanced the NGNs' confidence to make safe and protected clinical decision-making without fear of making mistakes. The authors concluded that the programme provided successful safe journey support for NGNs to professional roles (Hunsberger *et al*., 2013:73).

The transition from EN to RN is challenging because despite being in possession of previous nursing experience, NQRNs (R.683) enter the workforce with extended scope of practice coupled with increased responsibility and accountability. This is exacerbated by self and other's unrealistic expectations anticipating that they are self-resourceful to can hit the floor running. Participants in the study conducted by Lea & Cruickshank (2015:2832) confirmed that NQRNs were prematurely counted as staff and they were expected to 'hit the decks running'. When NQRNs encounter new and unfamiliar tasks to be performed in a new professional, role fear and anxiety set in. In

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the study conducted by Kumaran *et al.* (2014:609), participants reported experience of fear and frustration when they were faced with disparity between the ideal academic world and real clinical practice world. Nonetheless, as nurses with previous EN experience, NQRNs refrained from asking questions from colleagues fearing to be labelled as incompetent or inadequate. In the study conducted in New Zealand, the findings affirmed that participants were reluctant to ask for help which they fear may be a sign of professional failure (Walton, Lindsay, Hales & Rook 2018:66). This lack of self-esteem or confidence, incompetent and unwelcoming atmosphere, lead to poor workplace relationships. All these evoke stress to NQRNs. Woo & Newman (2020:82) concurred that a feeling of stress was exacerbated by increased self-doubt about their competence while struggling to adjust to extended responsibility and accountability assigned to them.

For NQRNs to cope with challenges and stress of the new role, require support in the initial months of their transition period to ease transition. Whitehead (2017:19) advocated preceptorship to support these NQRNs in their early months of transition to overcome their stressful experiences. The literature addressed preceptorship and mentorship differently, and although these two terms are not the same, they were used interchangeably in some studies.

2.3.1 Support Received by NQRNs

Dziczkowski (2013:353), in respect of mentoring and leadership development, indicated that mentors take various roles, and 'like chameleons transform their roles to fit the needs of their mentees', they can be coaches, supporters, counsellors, educators or sponsors. Depending on the prominent need of the NQRNs at that time, the main role of the mentor is to help acclimatize the mentees to the workplace climate and build upon their prior experiences (Dziczkowski, 2013:353). Wilson (2014:316) maintained that RNs should ensure that mentoring is embedded in the culture in which

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it is to exist so that mentoring goals and values are aligned with the organizational goals (Setati & Nkosi, 2017:135). Mentors are role models to be emulated by NQRNs (Setati & Nkosi, 2017:135). Hence, Dziczkowski (2013:357) argued that mentors benefit from improved self-esteem and infused professional, coaching and communication skills to reduce stress. The author had identified three challenges and barriers to establish and maintain a successful mentoring relation which are: time constraints, incompatible pairing and poor selection, and training of mentors. In a study conducted in New Zeeland, Haggerty, Holloway & Wilson (2013:168) reported that NQRNs hoped to be mentored by any senior RN in the unit. However, the study findings revealed that the supportive role of NQRNs was successfully provided by a dedicated mentor who was willing to offer his/her time to advise and guide NQRNs based on their identified learning needs (Haggerty *et al.*, 2013:169).

There are multiple and varying definitions of mentorship or mentoring from literature. Temitayo, Adepoju, Segun & Adetona (2019:21) defined mentorship as an official connection in which a more proficient, skillful and erudite senior staff member supports and guides a less knowledgeable and inexperienced staff member focusing on imparting new role-related skills to enhance personal growth and career advancement. Webster (2016:12) defined mentorship as a one-to-one communal relationship between the experienced and less experienced person with the goal of sharing knowledge and expertise between mentor and mentee.

The fundamental aim of mentorship for new graduate nurses focused mainly supporting, socializing, building new graduate nurses' level of confidence, thus promoting job satisfaction, teaching effective communication, professional conduct and making decision under pressure (Webster, 2016:16). Temitayo *et al.* (2019:21), concurred with Webster (2016:12) when indicating that a mentor inspires the mentee's personal and career development by sharing expertise, skill, experience and

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knowledge, and thus through their interaction, the mentee becomes a fully knowledgeable and functioning professional. Shek & Lin (2015:351) asserted that mentoring is when an experienced senior employee coaches, guides, supports and role model to inexperienced employees.

Dunn (2012:401) concurred that as newy qualified registered nurses have different needs in the clinical area, the mentor has to wear many hats and fill many roles to meet the newly qualified registered nurses' identified needs. No wonder why Dziczkowski (2013:353) referred to mentors 'like chameleons', because they can transform their roles to fit the needs of their mentees as coaches, supporters, counsellors, educators or sponsors. Dunn (2012:401) revealed that mentorship facilitates and eases transformation from a fledgling graduated nurse to an independent professional. Haggerty *et al. (*2013:168) reported that the presence of a well-prepared and dedicated mentor yields positive results on the NQRNs' success and experience in the clinical area. Walton *et al. (*2018:66) affirmed that arming new graduates with skills required for the new role would ease their transition. It is evident that NQRNs struggle with their new responsibilities due to lack of experience and confidence to make decisions (Kumaran *et al*., 2014:210).

Therefore, the importance of support to successful transition is imperative. As mentoring is a two-way teaching and learning mechanism, the mentor emancipates the mentee to 'step off the rock and test the waters of their own minds' by supporting and encouraging them to be confident to proceed (Dunn 2012:401). Rush, Janke, Duchscher, Phillips & Kaur (2019:151) revealed that mentorship and the availability of a mentor-mentee relationship enhanced new graduate nurses' perceptions of support. Furthermore, new graduates described the six months they have received mentoring as a success because it boosted their confidence, comfort, and experience, and helped them to build relationships with staff members.

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In an Australian study conducted by Henderson, Ossenberg & Tyler (2015:230), newly qualified registered nurses appreciated the supernumerary status of working alongside the experienced senior nurses as part of transition support programmes. This opportunity made them feel supported as NQRNs rather being thrown in the deep to swim on themselves. Hussein *et al*. (2017:7) indicated that participants who reported receiving supernumerary support applauded having been welcomed as a member of a team and thus they could 'find their feet' and 'fit in'. This affirms the need for unit staff to understand newly qualified registered nurses' clinical capability and learning needs rather than placing unreasonable expectations on them.

The self-doubt of feeling being unprepared was eased because new graduate nurses had a social bond with team members to an extent of having resourceful people to consult in case of any uncertainty without any pressure of workload (Rush *et al*., 2019:155). Kramer, Brewer & Maguire (2011:350) asserted that role acquisition and learning in the clinical area is mostly attained through participative engagement while interacting and cooperating with other team members. Therefore, for the NQRN to become a fully-fledged qualified RN who can practice autonomously and independently with responsibility and accountability, s/he needs the support of an experienced qualified RNs to model his/her role. The support from the experienced RNs will impart knowledge and skill and thus helps the NQRNs to practice nursing in a safe and competent manner with full of confidence free from stress.

Blevins (2018:199) asserted that supported NQRNs feel comfortable to seek advice from caring and approachable people, therefore, creating a conducive milieu which is supportive and imperative. Similarly, a willing and dedicated mentor successfully assists in reducing the anxiety and fear felt by NQRNs as being labelled ill-prepared (Rosi *et al*., 2020:1565). A healthy supportive environment motivates NQRNs to quickly adapt and become competent in performing activities of the new RN role with

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confidence, as it will be easy for them to ask questions if the need arises (Rosi *et al.*, 2020:1565). Support is important as it is like a fast vehicle that can hasten the NQRNs to quickly attain the expectations of the new RN role. In their study, Aldeeb, Basal, Ebrahem & Elnagar (2016:21) suggested that support can be provided by the organization or individuals. In addition, the authors recommended that support can be provided in a form of feedback, debriefing and praise by nursing colleagues in the unit (Aldeeb *et al.*, 2016:21). Furthermore, they also recommended that the institutions can provide structured mentorship programmes to enhance job satisfaction and reduce stress and anxiety as well as boosting the confidence of NQRNs (Aldeeb, 2016:21).

2.4 Conclusion

In this chapter, literature that informed this study has been discussed. The discussion focused on the challenges encountered by NQRNs with previous EN experience within their initial months in the clinical practice, what was expected from NQRNs by senior experienced nurses (supervisors or managers) and other nurses as well as the support they have received in the unit after graduation when they enter their new RN role. Chapter 3 outlines the research methodology used to achieve the study objectives.

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CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

Chapter 2 discussed the literature that formed the foundation of this study. Chapter 3 presents the research methodology followed to conduct this study which is mixed methods. Research methodology requires thoughtful planning and organizing with determination (Brink *et al*., 2018:2). In this chapter, the research methods are discussed in detail to reveal how the study was conducted. It unpacks the purpose of the study, research objectives and questions that guided the study. The study setting and process of gaining access to and selecting study participants are discussed. Methods used for data collection and analysis are also discussed.

3.2 Research Setting

Research setting refers to a specific area or site where data collection takes place (Brink *et al*., 2018:47). This study was conducted in different units of selected hospitals in Limpopo Province. Among the nine provinces of South Africa, Limpopo Province is regarded as the most rural with an estimated population of 5,982,584 (StatsSA 2019:vi). The challenges encountered in Limpopo Province are: the rural poor status of the province, the migrant population, majority of the population is being served by the public health services and the units experience an overflow of patients with chronic conditions. Despite the availability of clinics and community health centres in each district, the majority of people with chronic conditions such as tuberculosis (TB), human immunodeficiency virus (HIV), diabetes and hypertension are still admitted in public

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hospitals. About 84,6% in Limpopo Province depend on public health services (Department of Health 2016:7). Limpopo Province is divided into five districts: Capricorn, Mopani, Sekhukhune, Vhembe and Waterberg as shown in Figure 3.1. There are 38 public hospitals spread among the five (5) districts of Limpopo Province. From the five districts, only two districts, namely, Mopani and Vhembe as shown in Figure 3.2 were selected because most of the training that occurs in these districts is R.683 from Nursing Schools and the University.

Figure 3.1: Map of Limpopo Province with its five districts

The hospitals in these two districts are classified as regional, specialized and district. Seven (7) hospitals formed part of the study setting where one regional hospital and two district hospitals were from Mopani district. From Vhembe district, four district

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hospitals were selected. These hospitals were accessible and enabled a demographic mix. Educational institutions accredited to train R.683 in Mopani is Letaba Hospital Nursing School, and in Vhembe Elim Hospital and Tshilidzini Hospital Nursing Schools as well as the University of Venda.

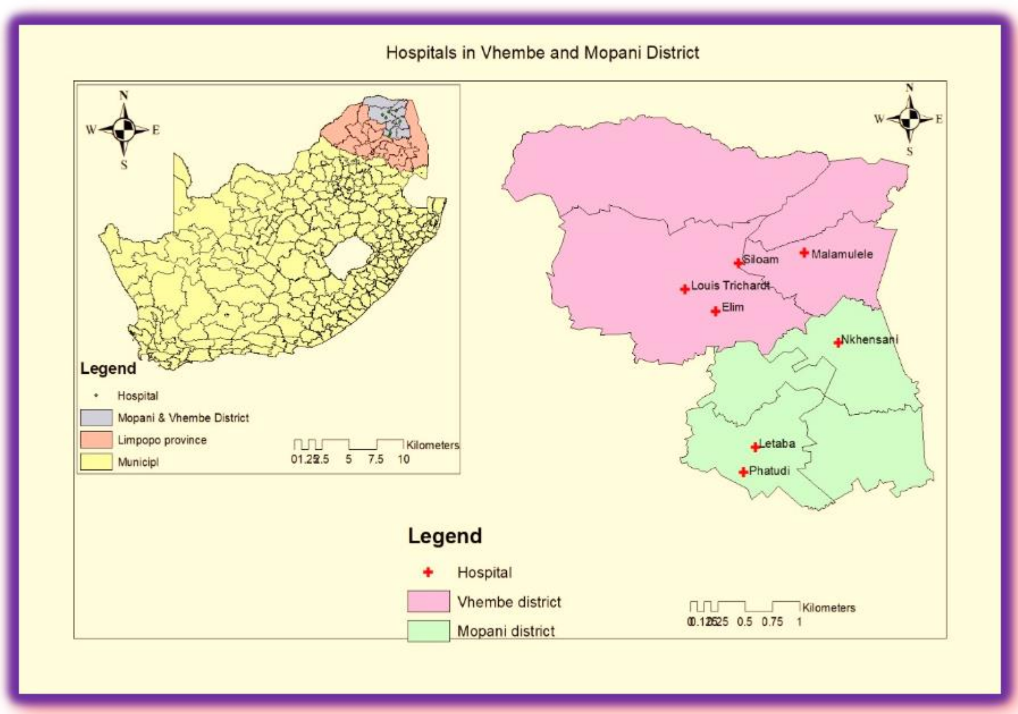

Figure 3.2: Selected hospitals in Vhembe and Mopani districts

3.3 Research Design

Polit & Beck (2012:58) referred to a research design as the researcher's choice of the appropriate methods with which to answer the research question. The research design guides the researcher in planning and implementing the study in a way that is most likely to achieve the proposed purpose (Grove & Gray, 2019:481). Pragmatists are flexible to use the research design that is suitable to address the question at hand. Similarly, mixed method researchers (MMRs) use various methods for data collection and analysis (Creswell 2014:39), to confirm the research results through triangulation

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(Brink *et al*., 2018:111). Even though there are many types of mixed method designs, in Phases 1A and 1B of this study, concurrent mixed method design was employed. Creswell (2014:281) argued that in a concurrent design both qualitative (QUAL) and quantitative (QUAN) data collection occurs concurrently in one phase of the study. A concurrent mixed method was used to strengthen knowledge claims on support experiences in relation to the variables that were under investigation. Furthermore, the data collection process in a concurrent design was cost-effective as data from focus group interviews (FGIs) and from questionnaires were collected simultaneously in one phase. A concurrent mixed method design used in this study is displayed in Figure 3.3. Each phase is discussed in the following section, based on the objectives of the study. Table 3.1 outlines the summary of how the study was approached.

3.4 Phase 1A

3.4.1 Qualitative Phase

In Phase 1A of this study on a model to enhance support for NQRNs (R.683), qualitative, exploratory, descriptive and contextual designs were used to answer the research questions of the study.

What are the challenges encountered by newly qualified registered nurses (R.683) in selected public hospitals in Limpopo Province, South Africa?

What support structures are available for newly qualified registered nurses (R.683) in selected hospitals of Limpopo Province, South Africa?

How a model to enhance support of newly qualified registered nurses (R.683) be developed?

Qualitative research refers to a systematic approach that allows interaction between the researcher and participants, to listen to their life experiences and infer meaning from them (Grove, Gray & Burns, 2015:509; Creswell 2014:234). In this phase, the qualitative approach was employed to ensure interaction with NQRNs (R.683) in FGIs, i.e., gathering information about the challenges they encountered and the support they have received from unit nurse managers.

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QUALITATIVE DATA COLLECTION

QUALITATIVE DATA ANALYSIS

FOCUS GROUP

THEMATIC INTERVIEW

INTEGRATION OF RESULTS

INTEPRETATION OF RESULTS

QUANTITATIVE DATA COLLECTION

QUANTITATIVE DATA ANALYSIS

STRUCTURED QUESTIONNAIRE

SPSS 24

Figure 3.3: Concurrent mixed method design

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Table 3.1: Summary of the study approach

PHASE 1: EMPERICAL STUDY		
Research design	**Mixed method concurrent design**	
Objectives: Phase 1A	**Qualitative research approach**	
	⁕	To explore and describe the challenges encountered by NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.
Phase 1B	**Quantitative research approach**	
	⁕	To identify support structures available for NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.
Population	⁕	NQRNs (R.683) (qualitative phase)
	⁕	Experienced registered nurses/nurse managers (quantitative phase)
Sampling	⁕	**Non-probability purposive sampling**
Data collection	⁕	Focus-group interviews
	⁕	Self-administered questionnaires
Data analysis	⁕	Thematic analysis (qualitative)
	⁕	Statistical Package for the Social Sciences (SPSS)Version 24.0
PHASE 2: CONCEPT ANALYSIS		
Concept analysis by Rodger & Knafl (1993:90)		
Data from NQRNs and experienced registered nurses		
PHASE 3: DEVELOPMENT OF A MODEL TO ENHANCE SUPPORT NQRNs		
Integration of concepts within a theoretical framework as described by Dickoff, James & Wiedenbach (1986:434)		
PHASE 4: VALIDATION OF THE MODEL		
Validation of model according to Chinn & Kramer (2018:203)		

A qualitative research design was used to achieve objectives 1 and 2, as illustrated in Figure 3.4, to generate more knowledge of human experience (Gordon, 2018:2).

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3.4.1.1 Exploratory Design

Explorative refers to deep investigation intending to find more about the unknown or less known phenomena under investigation. Exploratory research was employed to gain new insights and understanding of the phenomena under study; to justify or assess the existing conditions or to plan for improvement (LoBiondo-Wood & Haber, 2014:578).

OBJECTIVE 1

To explore and describe the challenges encountered by newly qualified registered nurses (R.683) in selected hospitals of Limpopo Province, South Africa.

Figure 3.4: Objective to inform qualitative approach

In this study, the researcher explored the challenges encountered by NQRNs (R683), as well as the support provided by experienced RNs and operational managers during their first 18 months of their employment in the new role. The semi-structured FGI used for this study consisted of open-ended questions, which allowed participants the opportunity to express themselves freely. Findings assisted the researcher to develop a model to enhance support for NQRNs (R683) in selected hospitals of Limpopo Province, South Africa.

3.4.1.2 Descriptive Design

Descriptive research refers to an accurate picture of the characteristics of individuals or groups, situations and phenomena as they naturally happen (Polit & Beck, 2012:226; Grove & Gray, 2019:204; Tavakoli, 2012:160). Descriptive research was appropriate for this study as it enabled the researcher to depict new knowledge and impart meaning on the phenomenon about what was not known and increased understanding thereof. It served as a starting point to generate or develop theory. In

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this study, the researcher described the challenges NQRNs (R.683) encountered in hospitals. A descriptive approach was chosen because the study was conducted in natural settings where the NQRNs (R.683) narrated their lived experiences. The involvement of the researcher as a research instrument assisted her to merge various data collection strategies (triangulation). The researcher was able to observe, listen, take notes and record the FGIs.

3.4.1.3 Contextual Design

Hayes & Stratton (2012:60) defined a context as an environment where a phenomenon happens. Holloway & Galvin (2017:26) reasoned that in qualitative research people's experiences are context-bound. These authors further maintained that researchers need to be context-sensitive because interaction between participants and the researcher happens in a context (Holloway & Galvin, 2017:26). Participants are inseparable from their life or work environment as their behaviour is influenced by their historical, social, political and cultural milieu.

This study was contextual because the researcher collected data in a non-manipulative and non-controlling context to fully understand participants' behaviour in their natural world. Creswell (2014:234) asserted that researchers do not bring individuals into the laboratory nor do they typically send instruments for individuals to complete, but they collect data in the field, at the site where participants experience the problem under study. In this study, the contextual design assisted the researcher in understanding the challenges and support of the NQRNs (R.683) employed in selected hospitals of Limpopo Province, South Africa within their first 18 months of employment in their new role.

3.5 Population

Population refers to the entire group of people of the study with common attributes that

meet the inclusion criteria in which the researcher is interested (Brink *et al*., 2012:131; Creswell, 2012:142; Grove *et al*., 2015:250). In this phase, the population were NQRNs (R.683) within the first eighteen (18) months' experience after completing their qualification working in the selected hospitals in Vhembe and Mopani districts of Limpopo Province. The population in this study had the characteristics as outlined in 3.6.3.

3.6 Sampling

Sampling refers to a process of choosing a part of the population to represent the whole population (Polit & Beck, 2012:519). Hence, a subset is drawn from the population to represent the entire population to be part of the study participants (Brink *et al*., 2018:117). Sampling was done to create a relatively small sample and maximize the variety of experience related to the phenomenon of interest (Sönmez & Yildirim, 2016:105). For this study, sampling was done for both hospitals and participants.

3.6.1 Sampling of Hospitals

Purposive sampling as a subset of non-probability sampling was used to choose the hospitals. In purposive sampling the researcher selected information-rich cases that could inform the researcher a great deal about the purpose of the study (Grove & Gray, 2019:249). Purposive sampling was best for the study because the main objective is to produce a sample that could be considered to have the characteristics of the population (Grove & Gray, 2019:249).

In Limpopo Province, all hospitals send ENs who have been granted study leave for the bridging course (R.683) and, on completion, they are qualified as General Nurses (Registered Nurses without Midwifery). They are then allocated in the same hospitals in different units, hence, the seven hospitals were purposively selected from Mopani and Vhembe districts. The selected hospitals were Elim District Hospital, Louis

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Trichardt Memorial District Hospital, Malamulele District Hospital, Siloam District Hospital, Nkhensani District Hospital, Letaba Regional Hospital and Dr CN Phatudi District Hospital. Selected hospitals with their categories and abbreviations are displayed in Table 3.2.

Table 3.2: Selected hospitals in Mopani and Vhembe districts

District	Category	Hospital	Abbreviations
Mopani	Regional	Letaba Hospital	LRH
	District	Nkhensani Hospital	NDH
	District	Dr CN Phatudi Hospital	DDH
Vhembe	District	Elim Hospital	EDH
	District	Siloam Hospital	SDH
	District	Malamulele Hospital	MDL
	District	LTT Memorial Hospital	LDH
Two districts	*Two categories*	*Seven hospitals*	

3.6.2 Sampling of Participants

In sampling of participants, the researcher selected a group of NQRNs (R.683) that represents the total study population (Grove *et al.*, 2015:511). The researcher purposely selected participants who have been through an experience as they were knowledgeable about the phenomenon under study (Polit & Beck, 2012:279). In this phase, the convenience sampling technique was used to select the NQRNs (R.683) who were knowledgeable about the phenomenon under study as they happened to be available in the units at the right time (Grove & Gray, 2013:363).

3.6.3 Inclusion Criteria

Inclusion criteria are standards used to determine who may participate in a research study. Inclusion criteria helped the researcher to identify suitable participants (Grove & Gray, 2019:473). For the present study, in this phase, the inclusion criteria were as

follows:

- NQRNs (R.683) who have upgraded from enrolled nursing through bridging course either from private or public educational institutions.
- Both males and females, irrespective of age.
- Within eighteen (18) months experience employed in the new role as RN.
- Willing to participant in the study.

3.6.4 Sample

Sample refers to a subset of a population drawn by the researcher to participate in a study (Polit & Beck, 2012:742). The sample comprised NQRNs (R.682) from different units of each selected hospital, who met the criteria. In this study, the sample size was 51 who were all NQRNs (R.683) in the new role within the first 18 months.

3.7 Data Collection

Data collection refers to a process of gathering of information to address a research problem (Polit & Beck, 2012:725). Data collection was done following the preparatory, interview and post-interview phases.

3.7.1 Negotiating Access

Preparatory phase refers to the planning of data collection, from requesting permission to conduct the study, gaining entry to the research site, recruitment of participants before commencing with the actual FGIs. During this phase, after receiving ethical clearance (SHS/19/PDC/05/0104) from University of Venda Research Ethics Committee (Annexure A), the researcher wrote letters to request permission from Limpopo Provincial Health Research Committee (Annexure B1), Mopani and Vhembe districts Executive managers (Annexure C1) and the various hospital Chief Executive

Officers (CEOs) (Annexure D1) where the study was conducted. The content of the letter included the research topic, the purpose and objectives of the study and contact details of the researcher, the supervisor. According to Polit & Beck (2012:542) the researcher needs to anticipate the tools that will be used during the course of the study. In this study, the researcher used the following tools: a notebook with a pen, an audiotape with batteries, a laptop, external hard drive and identification cards for the focus group participants.

3.7.1.1 Recruitment of Participants

After receiving approval letters from relevant stakeholders **(Annexures B2, C2, C3, D2-D8)**, the researcher telephonically secured appointments with respective nurse managers of the selected hospitals. This was done to secure a convenient time to meet and recruit participants to avoid disturbing unit routines. The nurse managers in all hospitals agreed that the researcher must come on Wednesdays as it was a conducive day where more staff are on duty between ten and eleven in the morning. In this phase, a homogenous group of NQRNs (R.683) who were working in selected hospitals with an experience within the first eighteen (18) months were recruited for the study. The researcher chose to use FGIs to promote comfortable group dynamics and to generate rich information (Burns & Grove, 2015:85). An invitation letter was furnished to the potential participants who were on duty through the help of the unit nurse managers (UNMs). Kelak, Cheah & Safii (2018:2) suggested that prior interviews, the purpose and process of the study must be explained to the participants by the researcher. Therefore, the researcher explained the whole process to NQRNs (R.683).

3.7.1.2 Interview Setting

In FGIs, participants were gathered in a setting that was permissive and non-threatening (Burns *et al.*, 2015:85; 504). Hence, a quiet place that offered privacy and protection from noise and interruption (Polit & Beck, 2012:535) was needed. The

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researcher negotiated with nurse managers of various selected hospitals to allocate a quiet staff room, office or boardroom that was free from noise and interruptions. As the venues were within the selected hospitals, they were convenient and accessible to participants and the researcher. Different venues were used as allocated by hospital management, three interviews were conducted in boardrooms, three in consulting rooms, and two in study rooms.

3.7.2 Focus Group Interview (FGI) Phase

Interview phase refers to a process whereby the researcher and participants start their conversation aiming at obtaining data regarding the research problem. The researcher created a conducive and non-threatening milieu by welcoming and appreciating the participants' preparedness and willingness to participate in FGIs. Frangos (2015:178) defined a FGI as a group of interacting individuals having common interest or characteristics, brought together by a moderator, who uses the group and its interaction to gain information about a specific issue. The researcher chose focus group because participants were a homogeneous group that was free to express their thoughts, feelings and behaviours candidly (Grove & Gray, 2019:79). Even though Polit & Beck (2014:290) and Brink *et al*. (2018:144) indicated that a focus group involves about five (5) to ten (10) or fifteen (15) participants whose opinions are requested simultaneously; in this phase, three to ten participants were allocated per group based on the number of participants consented to be part of the study and the allocated venue. Padgett (2017) cited in Brink *et al. (*2018:144) alluded that although five to seven participants are ideal, three can also suffice provided sufficient opinions can be generated. Seven FGIs were conducted and data saturation was reached with the fifth interview.

The researcher used a semi-structured interview guide to gather information during the eight focus group interview sessions which composed of three to ten participants

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of NQRNs (R.683) working within their first eighteen (18) months in the new role in selected hospitals under Mopani and Vhembe districts in Limpopo Province. Participants were given hard copies of information leaflets with informed consent (Annexures F and G), and they were given an opportunity to read the copies. The researcher recapped the information to enhance understanding of the study requirements. Participants who needed clarification were attended to by the researcher.

Prior signing of the informed consent form, the researcher explained the purpose of the study and purpose of the FGI to all participants, and ensured that ethical measures were applied. Kelak, Cheah & Safii (2018:2) affirmed that the researcher must explain the purpose and process of the study before the interviews. On the process, the researcher emphasized the following: informed consent, confidentiality of the shared information and anonymity; guarantee of beneficence and the participant's right to withdraw from research without prejudice. All focus group participants who were willing demonstrated understanding of the content of the information leaflet by subsequently signing the informed consent (Annexure G) to affirm their preparedness to be part of the study.

English was used as a medium of instruction because is used for communication among nursing professionals and that participants opted to use English. The researcher asked questions as per interview guide (Annexure H). An interview guide is an instrument used to guide interview questions (Creswell, 2014:244). The researcher probed to elicit more detailed information from the participants during interviews (Brink *et al*., 2018:144). In this study, probing was used to explore the challenges and support received by NQRNs (R.683) in their new role. The researcher followed up with questions after the participants' comments to get clarity and meaning. For example, one participant said: "*Sometimes you find that you are not sure about*

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what you are doing so even the self-esteem". To be clarified, the researcher probed and asked "*What do you mean by even the self-esteem?.*"

The researcher while interacting with participants in different focus group sessions was listening attentively to what participants were saying. All the body language or body cues such as head nodding to indicate interest of what is being discussed or by stating 'Ok' was being noted. The researcher also paraphrased the participants' words by asking follow up questions in order to obtain more information, for example "So, you are indicating that after four o'clock [*eem, nodding head* P3 responding] when you are knocking off at seven o'clock [*they can left me alone in the ward, P3 responding],* if you say alone do you mean alone as an individual or may be alone as a senior nurse with other junior nurses". Permission to use voice recorder and to take field notes during the interview was obtained from all focus group participants. The voice recorder was used to capture precise information and to allow the researcher to concentrate on how the interview was proceeding. In addition, field notes were taken to capture non-verbal cues that could not be captured by voice recorder and minimize loss of data. Field notes are a written account of what the researcher had seen, heard, experienced and thought during the interview process (De Vos *et al*., 2011:359).

3.7.3 Post-Interview Phase

On completion of each FGI session, the researcher summarized the key points of the discussion and verified with the participants the accuracy of the generated information. As there was no psychological or physical harm, no participant was referred for counselling. The researcher expressed gratitude to all participants for their precious time spent in the focus group sessions. The captured information was used for verification purpose and the researcher also listened to the voice recorder checking for audibility. All recorded interviews were audible and where there was background noise or inaudible tracks, comparison with field notes was done. After listening to the

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recorded information, the researcher immediately transferred the information to the laptop and external hard drive for backup purposes. Folders were created to store this information and a password created.

3.8 Data Analysis

In qualitative research, data analysis involves a process of creating sense out of the information generated during the research study (Creswell, 2014:245). The author further alluded that data analysis is a process of "peeling back the layers of an onion." and reorganizing it (Creswell, 2014:245). In this study, the researcher became acquainted with the data by immersing self, organizing, arranging and interpreting facts that were generated by the participants. There are several methods of data analysis, but for this study the researcher selected Braun & Clark's six steps for Thematic Analysis (Braun & Clark, 2006). These six steps were appropriate to the study on the challenges and support of the NQRNs (R.683) working within the first eighteen months in their new role in the selected hospitals in Limpopo Province. As qualitative data analysis is time consuming and massive in amount, data analysis required a lot of the researcher's time and hard work (Creswell 2014:245). In this study, the researcher analyzed the data using a thematic method that provided flexibility to the researcher during data analysis as it is not linear. Table 3.3 outlines the thematic analysis steps applied in this study.

Table 3.3: Thematic method of qualitative data analysis

Step	Description	Method
1	Becoming familiar with the data	The researcher transcribed audio recorded data precisely, read all the transcriptions and field notes to get a sense of the whole.
2	Generating initial codes	The researcher repeatedly went through each transcript, marked similar information with the same colour highlighter and even in the field notes. The researcher read transcripts verbatim line by line and made preliminary coding. Anything that came to mind was jotted down and highlighted too.
3	Searching for or generating themes	The researcher started by looking at the created preliminary codes and identified how often do they appear in the text. Codes that did

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		not appear very often in the data were winnowed or discarded.
4	Reviewing themes	The researcher checked on themes that were related to each other, and checked if there were meaningful and changed themes which were not relevant.
5	Defining and naming themes	The researcher checked all themes and detected the exact meaning of each theme and its helped in understanding the data. The researcher found the appropriate descriptive wording for the themes.
6	Writing up	The researcher read the entire field notes, listened to the recorded information to have a clear understanding and meaning of the existing data. The researcher compiled a report of the conducted research. Direct quotations from the participants were used to support each major theme, theme and sub-theme.

3.9 Measures to Ensure Trustworthiness

Trustworthiness refers to the degree of confidence qualitative researchers have in their data (Polit & Beck, 2014:394). In this study, the researcher ensured trustworthiness of the data by applying the following criteria: credibility, dependability, confirmability and transferability.

3.9.1 Credibility

Credibility refers to confidence of the truthfulness of the data and the interpretation of the study findings (Grove *et al.*, 2015:399; Brink *et al.*, 2018:158). The researcher ensured that the study findings and interpretation thereof were provided with confidence to the reader reflecting the views of the participants (Grove & Gray, 2019:362). The researcher ensured credibility by employing the following techniques: prolonged engagement, triangulation, member checking and peer debriefing.

3.9.1.1 Prolonged Engagement

Prolonged engagement refers to the investment of sufficient time in data collection (Polit & Beck, 2012:599). In this study, the time spent by the researcher with participants during the time of data collection helped them to establish a good rapport and trust toward each other. Korstjens & Moser (2018:121) maintained that investing

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sufficient time to become acquainted with the setting and context assist researchers in building trust, clearing misinformation as well as understanding and obtaining rich data. This harmonious relationship and trust enabled participants to be free to provide accurate information to the researcher, and thus enhanced the researcher's understanding of the phenomenon under study.

The time spent by the researcher allowed participants to share the challenges encountered in their new role as NQRNs within the first eighteen months. The researcher had adequate time to interact with participants during the preparatory, interview and post-interview phases. In her initial meeting with participants, the researcher did self-introduction, distributed and read the information leaflet with participants and clarified points where necessary. The researcher also, assisted participants to sign the consent form (Annexure G) after they have been clarified about the purpose and benefits of the study as outlined in the information leaflet (Annexure F). The researcher further conducted eight FGIs to explore the challenges encountered and support received by NQRNs (R.683). In the post-interview phase, the researcher summarized what was discussed about and provided participants an opportunity to respond and ask questions. Participants affirmed that the researcher's feedback summary was exactly what they have said.

3.9.1.2 Triangulation

Triangulation refers to the employment of multiple methods to collect and interpret data aiming to converge on an accurate representation of reality (Polit & Beck, 2012:745). For this study, triangulation was ensured through the used of FGIs from different seven selected hospitals. The researcher also asked follow-up questions to probe during the FGI sessions. Voice-recorded information and field notes were used to compile the report of collected data. To ensure confidence in the truth of the findings, the researcher repeatedly listened to voice recordings and reread field notes and

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transcribed all information verbatim. The two experienced research supervisors and an independent co-coder were used to check the data against the emerged themes.

3.9.1.3 Member Checking

Member checking refers to continuous verification of the accurateness of the data, and extracted themes with participants to allow their reaction before drawing a conclusion of the data finding (Polit & Beck, 2012:599). Verification of data accuracy was done during the process of FGI sessions through paraphrasing, and at the end of the session by giving feedback to participants by summarizing the data (Polit & Beck, 2017:622). In this study, both approaches were employed, member checking was achieved by the researcher paraphrasing what NQRNs (R.683) said about their challenges and support. The researcher also returned to participants to provide feedback by discussing and confirming the emerged themes from the data if that was the true reflection of what they have said (Brink *et al.*, 2018:159; Polit & Beck, 2012:591). Post discussions, participants affirmed the interpretation of data to be truthful and also clarified by adding some points.

3.9.1.4 Peer Debriefing

Peer debriefing is a quality enhancement strategy that involves external verification and involves sessions with peers to review and explore various aspects of the inquiry (Polit & Beck, 2012:594). The researcher could either present written or oral summaries of collected data and emerging categories and themes and data interpretation.

For this study, the researcher presented her summary of the findings to her supervisor and independent co-coder to validate the coded data. Suggestions for improvement were made and incorporated in the findings.

3.9.2 Dependability

Dependability refers to the stability or reliability of collected data over time and over conditions (Grove *et al*., 2015:392; Polit & Beck, 2012:584). In dependability, the researcher checks if the study can be replicated with similar participants in the same context and produce stable and consistent research results. Similarly, dependability refers to the guaranteed evidence that if the study is repeated with similar participants in a similar context, the findings may be the same (Brink *et al*., 2018:159).

In this study, the researcher collected eight FGIs, transcribed voice recordings and field notes and open-coded data analysis confirmed the same data findings. The independent co-coder verified the raw data collected during FGIs that were consistent. The methods and processes followed to collect, analyze and interpret the data were clearly and accurately described to enable research report readers to have an insight of the effectiveness of the study methods.

The emerged themes and sub-themes were checked and discussed, suggestions for theme modification were made and incorporated.

3.9.3 Confirmability

Confirmability refers to the degree to which the study findings are derived from characteristics of participants and the study context, and not from the researcher's imagination (Polit & Beck, 2012:175). Furthermore, the study findings can be affirmed by the potential for congruency between two or more individuals about the accuracy, relevance and meaning of the collected data (Polit & Beck, 2012:585). Confirmability corresponds with objectivity or neutrality of data and interpretation (Polit & Beck, 2012:723), and its main concern is to ensure that the collected data's interpretations and findings are precisely derived from the data rather than figments of the researcher's imagination (Polit & Beck, 2012:585).

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For this study, the researcher used confirmability audit and reflexivity to authenticate confirmability. The researcher kept field notes of each FGI session during the research process to verify the study findings. During report writing, a literature control was done to confirm the research findings with existing information from the literature. Throughout the research process the researcher reflected on her own background knowledge's influence on the study and minimized it.

3.9.4 Transferability

Transferability refers to the extent to which the study findings can be generalized or applied to other settings or groups (Polit & Beck, 2012:585; Brink *et al.*, 2018:159). It is concerned with the clear and accurate description of the study context, observed transactions and processes. In this study, the researcher provided a detailed description of the study setting, participants, recruitment process, sampling criteria, exclusion and inclusion criteria; to enable the research report reader to objectively determine whether or not the results are likely to be applicable in other research settings (Grove *et al.*, 2013: 598).

3.10 Phase 1B

3.10.1 Quantitative Phase

According to Polit & Beck (2012:739), quantitative research refers to an investigation of phenomena that lend themselves to precise measurement and quantification, often involving a rigorous and controlled design. For this study, quantitative approach was used to assess the knowledge of existing support structures in place for NQRNs (R.683) at selected hospitals of Limpopo Province, South Africa. Furthermore, quantitative research is a formal, objective, rigorous and systematic process used to describe variables in numerical form, test relationships and examine cause-and-effect interactions among variables (Grave, Burns & Gray 2013:706; Grove & Gray, 2019:480).

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For this phase, the researcher was convinced that knowledge of existing support structures which were in place for NQRNs (R.683) in selected hospitals of LP, SA, could be obtained through structured questionnaires and concentrated on collecting numeric data which was then statistically analyzed. The purpose and objectives of the study guided the researcher to choose the appropriate methodology to generate the data required to answer the research question. In this study, quantitative research was used to cover objective number three which was to identify support structures available for NQRNs (R.683) in selected hospitals of LP, SA.

3.10.2 Research Methods

The research methods are discussed according to research population, sample selection, sampling frame, sample size, sampling technique, sample description, research setting, data collection, validity and reliability of data collection, data analysis.

3.10.2.1 Research Population

The population is the aggregate of cases that meet the inclusion criteria and are available for the study (Polit & Beck, 2012:273). The population in this phase was composed of all experienced RNs or operational managers who had experienced of working with NQRNs (R.683) in selected hospitals of LP, SA.

3.10.2.2 Sample Selection

A sample is a selected subset of an accessible population to represent an identified study population (Grove & Gray, 2019:229; Polit & Beck, 2012:742) and sampling implies a process of selecting a representative group of people from a population under study (Grove & Gray, 2019:482). The inclusion criteria considered in this phase were:

- All participants in this phase should be currently registered with SANC for practice.

- Regietered Nurses with five and more years' experience working in units where NQRNs (R.683) were allocated.
- Unit nurse managers who are in-charge of units where NQRNs (R.683) are allocated.

3.10.2.3 Sampling Frame

Sampling frame refers to a list of all members of the population, from which the sample is drawn (Polit & Beck, 2012:280; Grove *et al.*, 2013:709). Table 3.4 shows the sampling frame of this study.

3.10.2.4 Sample Size

A sample size is a number of study participants recruited and consented to participate in a study as well as examined (Grove *et al.*, 2013:708; Grove & Gray, 2019:482). Polit & Beck (2012:59) deemed it should be specified in advanced how many participants would be recruited for the study.

Table 3.4: Sampling Frame of Phase 1B Quantitative Phase

Hospital	Number of Experienced Registered Nurses/Unit Nurse Managers in each hospital working with NQRNs (R.683)	Number of respondents	Percentage
Dr CN Phatudi	20	10	3
Elim	106	54	25
Nkhensani	40	20	6
Letaba	110	56	25
Malamulele	50	26	10
Louis Trichardt Memorial	41	21	6
Siloam	103	53	25
Total	**470**	**240**	**100**

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As there is no simple rule formula to determine how large a sample should be, though larger is better than smaller (Polit & Beck, 2014:1810; Mellish, 2019:110). Polit & Beck (2012:284) further recommended that the larger sample more represents the possible population and thus a smaller sampling error. Sampling error refers to difference between a sample statistic used to estimate a population's numerical value and the unknown actual value of the parameter (Grove *et al*., 2013:708).

For this study, the sample size was determined by using Slovins' formula for calculation.

- The sample size was calculated using the formula below where:

  n=sample size of the adjusted population.

  N=population size

  e=accepted level of error set at 0.05.

$$n = \frac{N}{1 + N(e)^2}$$

n=470/(1+470x$(0.05)^2$

n=470/(1+1.13)

n=470/2.13

Sample size (n)=220

- The sample size was increased with 10% to leave room for non-response (n=220+20=240).

- To compute the number of respondents to be drawn from each hospital the researcher used the formula given above.

- Number of respondents=(number of unit managers per hospitalx240)/470
- For example, for Siloam Hospital, the number of respondents: n=20x240/470=10

3.10.2.5 Sampling of Hospitals and Participants

Sampling of hospitals was done as stated in section 3.6.1 and Table 3.2. Similar hospitals from the selected districts were used in this phase. Within each hospital, experienced registered professional nurses (EPNs), operational nurse managers (ONMs) who met the inclusion criteria were conveniently sampled.

3.10.2.6 Sample Description

The sample size was pre-determined in advance, based on calculations as displayed in Table 3.4. However, of the 300 questionnaires that were distributed. 265 were returned complete, 10 were returned incomplete, and 25 were not returned at all, and on follow up they could not be traced.

3.11 Data Collection

In this phase, quantitative data were obtained by using structured questionnaire (**Annexure L**) as a data collection tool. A questionnaire refers to a printed self-report form designed to elicit information that can be obtained through written responses (Grove *et al.*, 2013:425;706). In this quantitative phase, self-administered questionnaires (SAQs) were used for data collection. Post reading the questionnaires, respondents gave their answers by writing in the space provided as directed. Data were collected between March and July 2019.

3.11.1 Questionnaire Development

The researcher started by writing the purpose, objectives and research questions to

ask relevant questions while designing the questionnaire. A literature search was done and relevant information extracted to help with the development of the questionnaire. The questionnaire used in this phase was designed by the researcher in consultation with the supervisors. The questionnaire comprised of the sections outlined in Table 3.5: Section A: Demographic information; Section B: Knowledge of nurse managers' management role and Section C: Support measures provided to NQRNs by experienced nurse managers.

The questionnaire was developed to be suitable for data collection in the study context. The content of the developed instrument comprised of 59 items. The questionnaire was developed in English, which is the language of instruction used by health professionals. Section A required participants' demographic information with 13 items, Section B has six items that measured information about knowledge of nurse managers' management role. Section C probed support measures provided to NQRNs (R.683) under planning with 14 items, under organizing with 9 items, under directing or leading 9 items and under control 8 items. The self-administered questionnaire contained closed-ended as well as open-ended questions where respondents answered them all.

Table 3.5: Sections of the structured questionnaire

Section	Number of items	Information
A	1-13	Demographic Information
B	1-6	Knowledge of nurse managers' management role
C		Support measures provided to NQRNs (R.683) by experienced nurse managers under:
	1-14	Planning
	15-23	Organizing
	24-32	Directing or leading
	33-40	Control

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3.11.2 Validity and Reliability

3.11.2.1 Validity

Validity is the degree to which the instrument measures what it is supposed to measure (Brink, 2012:487; Creswell, 2012:205). In this study, validity referred to what extent the quantitative research was going to measure on NQRNs (R.683) support received in the clinical area and get the expected outcome of the study. Validity was maintained as correct and complete quantitative data were collected by using a pre-tested questionnaire. To ensure content, face and construct validity, the researcher addressed objective number three which aimed to identify support structures that were available for NQRNs in selected hospitals of Limpopo Province, South Africa. This study was found valid, as it ensured the following different types of validity:

Content Validity

Content validity is an assessment of how accurate the measuring instrument represents all the components of the variable to be measured (Brink *et al.*, 2018:152). In this study, the questionnaire covered the management functions of the RN, namely: planning, organising, directing or leading and control functions. This type of validity is used mainly in the development of questionnaires, interview schedules or interview guides (Creswell, 2012:166). In this study, the researcher used content validity to develop the questionnaire to identify support structures available for NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.

Face Validity

Face validity means that the instrument appears to measure what it is supposed to measure, based on the experts' intuitive judgement (Brink *et al.*, 2018:152). In this study, to ensure face validity, the researcher presented the instrument to the supervisor and colleagues for evaluation if it appears to measure what it is supposed

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to measure (Creswell, 2012:166). Comments made were incorporated in the final questionnaire. Some comments required certain statements to be deleted while others required rewording.

Construct Validity

Construct validity focuses on determining whether the measuring tool measures the theoretical construct that it is intended to (Grove & Gray, 2019:266). The researcher fostered construct validity by defining and explaining the meaning of concepts of interest in the study. In addition, the validity of the questionnaire was verified by presenting it to the supervisor for the contributions and inputs for the researcher to identify errors and ambiguity and improve on the structuring of the instrument. Adjustments were done.

3.11.2.2 Reliability

Reliability is a measure of the degree to which a research instrument yields the same results on repeated trials (Brink *et al.*, 2018:155). Reliability refers to the consistency of the research measuring tool. The questionnaire was pilot-tested to check reliability to use it for the main study.

Pilot-Testing of Questionnaire

The researcher conducted questionnaire pilot-testing before the main study. The purpose was to check the feasibility of the study in terms of availability of participants, time and financial resources (Brink *et al.*, 2018:45). In this study, the pilot-testing of the questionnaire was done with six experienced RNs and four unit nurse managers who met the inclusion criteria, at Messina Hospital, which was not part of the main study to determine validity and reliability of the questionnaire.

The results assisted the researcher to identify ambiguous items on the questionnaire

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that needed clarification and that the questionnaire was measuring the intended purpose. The pilot-testing also assisted the researcher in determining the amount of time needed to complete the study, which was 45-60 minutes. After pilot-testing of the questionnaire, the researcher noticed that some questions needed modification to be clearly understood by the respondents. Thus, corrections and adjustments were made.

Process to Data Collection and Questionnaire Administration

The researcher made appointment telephonically with the nurse managers to agree on the date and time of the meeting. Thereafter, the researcher confirmed telephonically if the appointment still stands and met with the participants on the agreed date, time and venue. She distributed questionnaires to participants and explained the process of completing them. In one institution the researcher was hosted in a separate room to clarify to the respondents' issues that were not clear.

Participants took 45-60 minutes to complete the questionnaire. After completion, the researcher collected the questionnaires. The researcher took 3 months (June-August 2019) collecting data due to distance from district to district with different hospitals in Limpopo Province. In five institutions questionnaires were hand delivered to the nurse managers' offices who opted to distribute questionnaires during managers' meetings as it was not feasible to gather them at the same time. In another institution, the researcher distributed questionnaires to all respondents and gave them a chance to complete and collected them the next day as agreed. Three hundred (300) questionnaires were hand-delivered to respondents. Two hundred and sixty-five (265) questionnaires were returned complete. Ten (10) were returned incomplete and twenty-five (25) were not returned. Completed questionnaires were collected by the researcher from the respondents' area of work. No questionnaires were sent by email or post. The questionnaire comprised of 10 pages and took at least 45-60 minutes to answer. All items, according to sections on the questionnaire, were responded to.

3.12 Data Analysis

Data analysis refers to the process of reducing, organizing and giving meaning to data (Grove & Gray, 2019:45). Quantitative data were analyzed through descriptive statistics and organized into visual representations or pictures, tables and graphs (Brik *et al*., 2012:179). In this study, data were analyzed through the computerized Statistical Package for the Social Science (SPSS) version 24.0. Graphs and tables were used to help the researcher in describing, explaining, and exploring data. The results of the quantitative phase are presented in Chapter 5.

3.13 Phase 2: Concept Analysis

In this phase, concepts emerging from the data were identified using concept analysis following the steps conceptualized by Rodger & Knalf (1993:90).

3.13.1 Concept

A concept refers to a building block of a bigger spectrum that the researcher wants to follow (Foley & Davis, 2017:70). Concept is a mental image that cannot be clearly expressed verbally, unless there is some agreement about the meaning of the concept (Cronin, Ryan & Coughlan, 2008:6). A concept bears different operational meanings per discipline. Therefore, for concepts to be commonly understood and have consistent meanings, concepts analysis and clarification is needed (Cronin *et al*., 2008:6). In this study, the researcher defined the concept 'support' and ensured a common understanding as used within the discipline of nursing.

3.13.2 Concept Analysis

According to Knalf & Deatrick (2000:39), concept analysis entails synthesizing existing views of a concept and distinguishing it from other concepts with the purpose of resolving inconsistencies in the knowledge base of the discipline. Concept analysis is when a concept is dissected into simpler elements to promote clarity while providing

mutual understanding within a discipline (Foley & Davis, 2017:6). In this study, the researcher conducted concept analysis of the concept 'support' to elucidate the meaning of the concept as presently used as well as for future development of the of the support model (Figure 3.5).

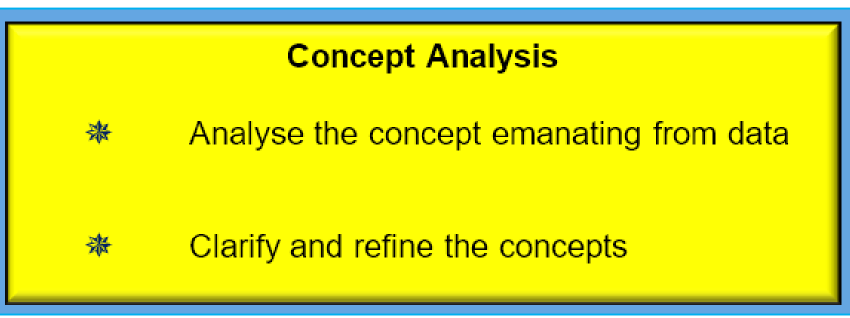

Figure 3.5: Objectives to inform Phase 2 of the study

In this study, Rodger & Knafl's (1993:90) method was used for data analysis. The researcher was guided by the following steps during concept analysis:

- Identify and name the concept of interest.
- Identify surrogate terms and relevant use of the concept.
- Identify and select an appropriate realm (setting and sample) for data collection.
- Collect data regarding the attributes of the concept, along with surrogate terms, references, antecedents and consequences.
- Identify concepts related to the concept of interest.
- Identify a model case of the concept.

3.14 Phase 3: Model Development

The results of concept analysis led to the development of the support model. The identified concepts of support within nursing practice were conceptualized using the

six elements of practice theory as described by Dickoff, James & Wiedenbach (1968:434), namely, the context, agent, recipient, dynamic, procedure and the purpose (Table 3.6).

Table 3.6: Elements of Practice Theory

In what context is the activity performed?	**Context:** The context includes a setting, location.
Who performs the activity?	**Agent:** is a person that executes an activity.
Who is the recipient of the activity?	**Recipient:** any person who is the receiver of the activity.
What is the energy source of the activity?	**Dynamic:** the influence that the source of power has on the execution of an activity.
What is the guiding procedure?	**Process**: the path, steps or general patterns on the way to the attainment of the goal.
What is the endpoint of the activity?	**Purpose:** represents the achievement of the activity and this activity is characterized in terms of its endpoint.

3.15 Validation of the Developed Model

The developed model was validated essentially as described by Chinn & Kramer (2018:203). The following five components of Chinn & Kramer guided the validation of the model: clarity, simplicity, generality, accessibility and importance.

3.16 Ethical Considerations

Ethics refers to the quality of research procedures, regarding their adherence to professional, legal, and social obligations to the research participants and deals with moral values (Polit & Beck, 2012:727). As this research involved human participants, it was therefore necessary to adhere to set ethical principles. Ethical principles are standards upon which the researcher's conduct are based to minimize participants to unnecessary physical, emotional or financial harm (Grove & Gray, 2019:95). To ensure safety and well-being of participants (Taylor, 2014:194), the researcher complied to the following ethical principles: permission to conduct the study, informed consent,

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beneficence and non-maleficence, right to self-determination, confidentiality and anonymity.

3.16.1 Permission to Conduct the Study

The researcher upheld honesty and integrity before and during the execution of this study (Brink *et al.*, 2018:28) by seeking permission and approval from the gatekeepers at different levels. After submitting the proposal, the ethical clearance to conduct the study was obtained from the University of Venda Higher Degrees Committee (UVHDC) and University of Venda Research Ethics Committee (UVREC) with Ethical Clearance number: SHS/19/PDC/05/0104 (Annexure A). Subsequently, permission to conduct a study was also, sought and granted by the following authorities:

- The Limpopo DoH Provincial Research Committee (Annexure B2).
- Limpopo DoH District Offices/Vhembe and Mopani Districts (Annexures C2 and C3).
- Permission from the Chief Executive Officers (CEOs) from the respective institutions was obtained to access the institutions and to ensure that the rights of participants were protected (Annexures D2-D8).
- The study had no direct risks for participants as the study was based on the challenges encountered by NQRNs (R.683) and support received within the first eighteen months in their new role, and participation was voluntary.
- No physical harm nor psychological distress was observed or reported amongst the participants before, during and after the FGI sessions in Phase 1A, and respondents who completed the questionnaires in Phase 1B.

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3.16.2 Informed Consent

Informed consent refers to the provision of full information to participants and that they understood the research project in which they are requested to participate. Polit & Beck (2012:158) defined informed consent as the means of providing adequate information to participants regarding the research. And that participants can comprehend the information as well as having the power of free choice, enabling them to consent or decline participation voluntarily without any coercion. In this study, participants were provided with an information leaflet (Annexure F) and after reading and clarifications they voluntary gave consent without any duress. The participants were provided ample time to review the consent form as a legal document before signing. Thereafter, the researcher asked them to willingly sign an informed consent form (Annexures G and K).

3.16.3 Beneficence and Non-Maleficence

Beneficence refers to the ethical principle of doing good, as well as protecting participants from all sorts of discomfort and harm (Polit & Beck, 2012:171; Grove & Gray, 2019:96), whereas non-maleficence refers to avoiding harm to the study participants. Ethically, researchers are expected to minimize harm and maximize benefits for the good of research participants (Grove & Gray, 2019:96). In this study, there was no anticipated physical, emotional, social, psychological or economic harm and, therefore, the study continued to the end and there was no referral for counselling done.

Prior FGI sessions, all participants were simultaneously given adequate information regarding the risks and benefits of the study to enhance honesty and trust. Based on this information, all participants were at liberty to participate or withdraw from the study. The researcher did not inflict any harm of some sort to the participants, but only asked them questions as per the semi-structured interview guide (Annexure H) and probing

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with follow-up questions.

In this study, FGI sessions were conducted during working hours as granted by the management of selected hospitals. Each FGI session lasted for 30 to 45 minutes as agreed with participants. In addition, those who completed the questionnaires in the presence of the researcher lasted for 45-60 minutes, and some nurse managers indicated that questionnaires should be left and they completed them in their own free time.

Even though it was planned to have refreshments during lunch time, it did not suffice because Wednesday was a changeover day; most participants after interview reported to be hurrying to in-services, some to continue with unit routines and others for transport as they finished their shift. The researcher honoured participants' decisions. To protect and avoid exploiting participants, the researcher highlighted that their participation was voluntary and that they could withdraw at any time from the study without any penalty. The researcher reassured participants that the study findings would be used to develop a model to enhance support for NQRNs (R.683) not to discredit the participants for whatever they have said.

3.16.4 Right to Self-Determination

The right to self-determination is based on the ethical principle of respect for the participants' human dignity (Polit & Beck, 2008:171). Participants were given precise information about the study and what was expected of them during the FGI sessions. After being given the information leaflet (Annexure F) and reading it, participants were provided ample time to ask questions and decide whether to participate or decline. It was emphasized that their declining or withdrawal from participation was voluntary and no penalty or prejudice shall be imposed against them.

Participants were also informed that there was no remuneration for participating in this

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study as outlined in the information leaflet. Furthermore, the risks and benefits were also, explained to enable participants sign an informed consent with understanding. The researcher did not use her position as a principal investigator to pressurize participants to consent for the study. Post-information sessions, participants were given consent forms (Annexure G) to voluntary sign prior commencement with FGI sessions, and before completion of questionnaire (Annexure K). During the interview session, participants were advised to withhold any information that they think they are not comfortable to share without any punishment.

3.16.5 Confidentiality and Anonymity

Confidentiality refers to withholding collected data from participants against unauthorized people (Polit & Beck, 2012:162; Grove & Gray, 2019:172). Even though the researcher and focus group members were aware of the identity of some participants; to protect participants, prior FGI sessions, all participants were asked to sign focus group confidentiality agreement form (Annexure I).

The researcher pledged that the information from participants would not be released to any person without their permission and that data would be anonymously released in scientific journals without linking it to their identity based on their will. Anonymity refers to the fact that no person, even the researcher, should be able to link participants to what they have said (Polit & Beck 2012:162; Grove & Gray, 2019:172).

In this study, the researcher gave all participants identification cards as participant number one or two (P1 or P2) to hide their identity, and even explained to other participants to address them as such during the FGI sessions. In addition, even the questionnaire did not have an area where respondents or participants had to reveal their identity.

No person gained access to the information as it was locked up in a cupboard and the

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one in the computer folder was password encrypted and only the researcher knew the password. During the interview hospitals were also not mentioned by their names. The tapes with voice recordings will be destroyed after completing the study, but the study documents will be kept safe for 5 years and destroyed post study findings publication.

3.17 Data Protection

Data were captured on a computer secured by a password known only by the researcher. The voice recorders and transcripts were kept in a locked cupboard which could only be accessed by the researcher. Hard copies will be kept by the university for future reference.

3.18 Conclusion

Chapter 3 addressed the research methodology, research setting, research design, population, sampling, data collection methods and data analysis method employed, the measures adopted to ensure the trustworthiness of the study as well as the ethical principles for protecting the study participants. The layout of concept analysis, model development and validation were also described. Chapter 4 presents the results and discussion of Phase 1A (Qualitative Phase).

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CHAPTER 4

PRESENTATION AND DISCUSSION OF THE QUALITATIVE FINDINGS

4.1 Introduction

Chapter 3 presented the research methodology which included the research designs, methods as well as the process employed to address the research question of the study. Chapter 4 outlines the realization of data collection, presentation of the research findings and literature integration to either support the findings of this study or present the study findings as unique. The study findings in this chapter addressed the first and second objectives for Phase 1A (qualitative phase) as illustrated below (Figure 4.1).

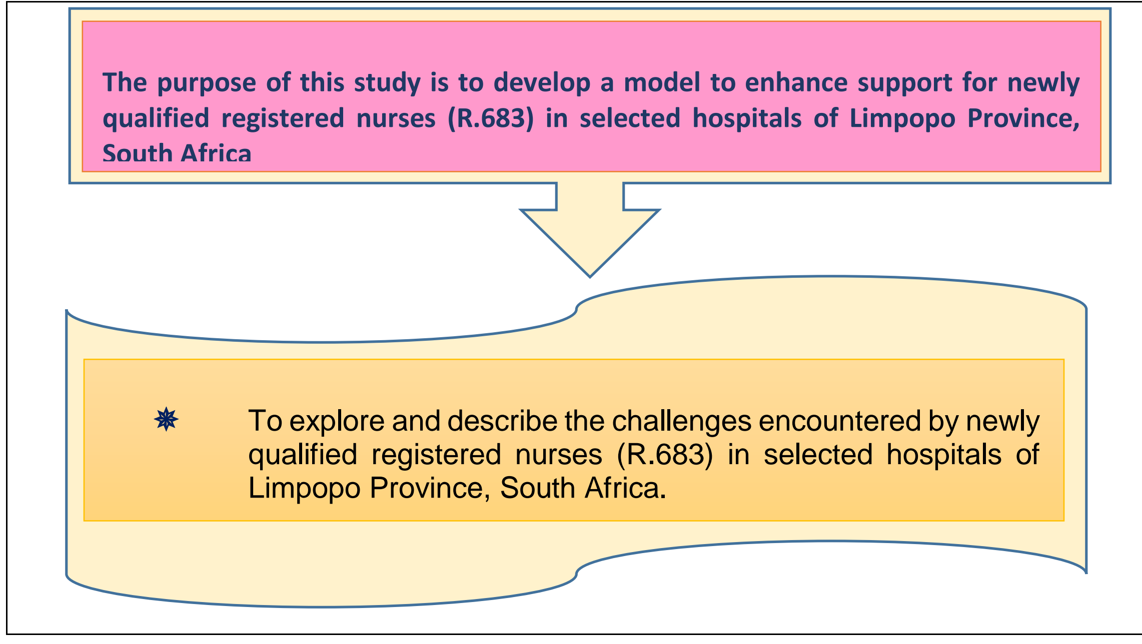

Figure 4.1: Schematic representation of Phase 1A objectives

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4.2 The Realization of Data Collection

In this phase, eight (8) focus group were supposed to be conducted as agreed. However due to some unforeseen circumstances one hospital was excluded and the sample composed of seven focus groups that consisted of three to ten NQRNs (R.683) per group (n=51), inclusive (Table 4.1). Among the participants, some were reserved, the interviewer probed and intervened to call the most silent participant to be free to share their experiences. Flick (2014:252) suggested that during a FGI session the moderator needs to facilitate group members to contribute openly both their experiences and opinions.

Table 4.1: Selected hospitals with participants

Hospital and Category	Abbreviation Used for this Study	Number & Abbreviation of Focus Group	Number & Abbreviation of Participants, NQRNs (R.683)	Participants' Identity for this Study
Letaba Regional	LRH	FG8 [1]	P1-9 [9]	e.g., FG8, P1, F
Elim District	EDH	FG3 & FG4 [2]	P1-8 & P1-9 [17]	e.g., FG3, P1, M
Siloam District	SDH	FG1 & FG2 [2]	P1-4 & P1-3 [7]	e.g., FG1, P1, F
Nkhensani District	NDH	FG6 [1]	P1-2 as one excused self [2]	e.g., FG6, P1, M
Malamulele District	MDH	FG7 [1]	P1-6 [06]	e.g., FG7, P1, F
Louis Trichardt Memorial District	LTDH	FG5 [1]	P1-10 [10]	e.g., FG5, P1, M
Total (n)		**7**	**51**	

Data were collected through semi-structured FGIs.

The following questions were asked to NQRNs (R.683) to guide the study as outlined in the interview guide (**Annexure H**):

- Explain the challenges you have encountered in your new role as a RN.

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- As you are expected to function independently and accountably as a RN, how do you feel about your preparedness for the RN role?
- Since you have started in this new role, when did you feel that you were ready and safe to practice independently?
- What types of support structures are available in your unit?
- What kind of support did you receive when you started your new role as a RN?
- Who provided such a support?
- What can be done to enhance your support?
- What type of support can be provided to NQRNs in future?

In this chapter, the discussion of the research findings is presented as emerged during data analysis using Braun & Clark's six steps of Thematic Analysis as illustrated in Table 3.3. The presentation of the study findings described the major themes, themes and sub-themes that have emerged during data analysis. These are supported by the participants' direct quotations and literature integration.

Literature integration is done to support the findings of the current study with the existing literature to verify whether the findings of the study are in concordance or are in contradiction with what is already known about the phenomenon under study (Flick, 2014:70). This is done for quality purposes to substantiate a research report (Flick, 2014:68). The initial target population was 65 and per hospital were: DDH=4, EDH=18, LRH=9, LTDH=10, MDH8, NDH8 and SDH=8. For discussion of the findings of Phase 1A, the settings, i.e., the selected hospitals with participants where data were collected is displayed in Table 4.1. Fifty-one NQRNs (R.683) from the six selected hospitals in

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Mopani and Vhembe districts of Limpopo Province participated in the semi-structured FGIs.

Focus group one had four participants and focus group two had three and both were from Siloam district hospital in Vhembe district. Focus group three had eight and focus four had nine participants both from Elim District Hospital in Vhembe district. Focus group five had ten participants from Louis Trichardt Memorial District Hospital in Vhembe district.

Focus group six had two participants from Nkhensani District Hospital in Mopani district as one excused herself for personal reasons and the other five did not turn up as agreed without informing the interviewer. Although Padgett (2017) cited in Brink (2018:144) alluded that three participants can suffice provided sufficient opinions can be generated, the researcher interviewed two participants as they were ready as promised to generate their opinions to be compared with other participants. Focus group seven had six participants from Malamulele District Hospital in Vhembe district, and focus group eight had nine participants from Letaba Regional Hospital in Mopani district. Dr CN Phatudi District Hospital did not have participants in this phase because they were released after agreeing on the date of the interview to go and prepare themselves to start night duty by their managers.

4.3 Presentation of the Findings

The research findings emanated from the responses of the participants to the research questions. This section provides the study findings based on data analysis. Following the data analysis from the collected qualitative data in Phase 1A accruing from the eight FGIs, three major themes emerged, namely: Challenges experienced by NQRNs (R.683) in their new role as RNs; State of readiness and preparedness for a RN's role, and Support expected from experienced or senior staff members, coupled with five

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themes and twelve sub-themes as displayed in Table 4.4.

Participants' indented direct quotes are given in italics to highlight meaning to the reader and to improve the credibility of the study findings. The presentation of the findings was done simultaneously with the literature control.

4.3.1 Demographic Data of the Participants

The demographic data of participants are used in qualitative data as a means of ensuring transferability, as participants' characteristics are described to allow for comparability of findings in settings similar to the one studied (Bryman, Hirschsohn, DosSantos, Du Toit, Masenge, Van Aardt & Wagne, 2014:45). For this study, presentation of demographic data was for the reader to understand the sources of the information obtained. The demographic data of the focus groups participants are displayed in Table 4.2.

Table 4.2: Demographic characteristics of the focus groups participants

Age	Number of participants (n)	Gender		Work experience in new role
		Female (n)	Male (n)	
31-35 years	12	11	1	4-6 months
36-40 years	6	6	0	7-9 months
41-45 years	16	14	2	10-12 months
46-50 years	9	8	1	13-15 months
51-55 years	7	7	0	16-18 months
56-60 years	1	1	0	No response
Total	**51**	**47**	**4**	

In this study, all focus group participants were NQRNs who upgraded from EN through the bridging course from six selected hospitals in Limpopo Province. Participants in one hospital did not participate because they were allocated to night duty at short

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notice. Participants were all graduates with Diploma in General Nursing (R.683) from nursing schools and university. All participants were within their first 18 months of employment in their new role. Most participants were females and, traditionally, nursing is regarded as a female dominated-profession, which continues to date (Haigh, 2015:1). There is evidence that nursing is still perceived as a female dominated profession (Achora, 2016:25). In Limpopo Province (LP), there are 12 639 RNs, 1 641 of whom are males (SANC Geographical Distribution, 2018). This is confirmed in this study because out of the seven (7) focus groups from the six hospitals based at Mopani and Vhembe districts in LP, only four (4) were males and forty-seven (47) were females. The four male participants' ages ranged between 31 and 50 years, whereas the forty-seven female participants were aged between 31 and 60 years. Table 4.3 shows the current work unit placements of the participants.

Table 4.3: Current work unit placements of the participants

Work Unit		**n**
Medical wards		10
Surgical wards		5
Pediatrics wards		8
Outpatients		7
Casualty		8
Theatre		3
Maternity	Postnatal wards	1
	Neonatal wards	2
Gynaecology ward		1
High Care		3
Acute Mental Health Unit		1
Wellness Clinic		1
Occupational Health Clinic		1
Total		**51**

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Even though the selected hospitals differed according to their levels and locations, participants were allocated mostly to similar units. Many participants were allocated to Casualty and Pediatric units where there were eight (8) participants from those units, followed by Outpatients Department (OPD) with seven (7) participants and female medical with five (5) participants. Male medical, Operating Theatre, High Care and General or Combined units had three (3) participants and Neonatal, Male Surgical and Female Surgical had two (2) participants per unit whereas Gynaecology, Psychiatric or Mental Health Care unit, Postnatal, Wellness Clinic and Occupational Health Clinic have been allocated one (1) participants per unit at the time of this study.

4.3.2 Thematic Presentation of Findings Focus Group Discussions

The following section provides an overview of the results based on themes and sub-themes that emerged from analysis of the FGI transcripts and field notes gathered to gain an understanding of the phenomenon under study. Three major themes emerged and twelve sub-themes which are presented in Table 4.4.

4.3.2.1 Major Theme 1: Challenges Experienced by NQRNS (R683) in Their Role as Registered Nurses

Understanding the challenges experienced by NQRNs (R.683) during their first 18 months of employment is significant. This study highlighted several findings that were of concern. Negatuve attitudes and behaviours, bullying, lack of orientation, shortage of staff, insubordination, double role, denied opportunity to develop were some of the challenges they encountered. These challenges coupled with inadequate support induced stress and impaired the quality of care (Wong *et al.*, 2018:35). The study findings highlighted five themes as presented in Table 4.4.

4.3.2.1.1 Theme 1.1: Negative Workplace Environment

In line with other studies, the participants in this study encountered negative workplace

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environment which caused them enormous stress (Hung, Lam & Wong, 2018:5) due to change of environment and role (O'Shea & Kelly, 2007:1541; Tsang, Sham, Law, *et al.*, 2016:130). A negative work environment may cause anxiety, stress, depression and physical symptoms, such as migraines and muscle pain. These problems can impair work performance and result in adverse job outcomes (Mutisya, 2019:8).

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Table 4.4: Major themes, themes and sub-themes that emerged from analyzed data

Major Theme		Theme		Sub-Theme	
1.	**Challenges experienced by newly-qualified registered nurses (NQRNs, R.683) in their new role as registered nurses**	1.1	Negative workplace environment	1.1.1	Negative attitudes and behaviour in the workplace
				1.1.2	Workplace bullying
				1.1.3	Lack of orientation
				1.1.4	Shortage of staff
				1.1.5	Insubordination of junior staff members
		1.2	Emotional resilience	1.2.1	Increased level of responsibility and accountability
				1.2.2	Negative working relationship with senior colleagues
		1.3	Role confusion: Whether you are a registered nurse, enrolled nurse or enrolled nursing auxiliary	1.3.1	Dual status
				1.3.2	Denied opportunity to practice as a registered nurse
2.	**State of readiness and preparedness for a registered nurse's role**	2.1	Perfectly ready and well-prepared	2.1.1	Sense of Independence
3.	**Support expected form experienced or senior staff members**	3.1	Insufficient support	3.1.1	Mentoring
				3.1.2	In-service education or training

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4.3.2.1.1.1 Sub-Theme 1.1.1: Negative Attitudes and Behaviour in the Workplace

Participants indicated challenges of an unfriendly and unwelcoming workplace, lamenting about the appalling staff attitudes, and professional jealousy by some members of the staff.

Here is how one participant expressed her concerns:

> *"…when you are newly-qualified registered nurse, there is this attitude that you are new and is like a game sort of according to myself, that you are new you don't know anything. So, from the supervisor to the juniors they want to see what mistake you are about to do." (**FG4, P6, Female**).*

The findings concur with Ndaba (2013:58) who reported that newly qualified professional nurses experienced positive and negative attitudes from senior to lower categories they worked with during their first year of employment. Layne, Nemeth, Mueller & Martin (2019:7), in their study on negative behaviours of health care professionals, concurred that participants reported experiences of contributing factors of negative behaviours, such as rude behaviour, job stress, as well as reporting a higher perception of the seriousness of negative behaviours. Hawkins, Joeng, Smith and Sim (2022:9) reported 30% prevalence of exposure to negative workplace behaviour among nurses. This may increase attrition rate (Çamveren, Yürümezoğlu & Kocaman, 2020:519) and lower performance (Keil & Ward, 2020:30). The copying strategy chosen by NQRNs (R.683) when faced with negative workplace behaviour was often influenced by their coping resources (Callaghan, Tak-ying & Wyatt, 2000). The fact that they did not opt to leave the workplace means that they had control over the situation.

A welcoming and supportive atmosphere should be established for newly qualified

registered nurses (R.683) to ensure a successful workforce as they encourage employees to perform to their highest ability. A stressful working environment and precarious atmosphere create a breeding place for workplace bullying.

4.3.2.1.1.2 Sub-Theme 1.1.2: Workplace Bullying

Participants in this study indicated how they experienced bullying when they were blamed, yelled at, punished and harassed psychologically.

One participant verbalized blame game as follows:

> *"Due to the workload that we are given working alone and doing everything alone you find that maybe you forgot to write something and whenever it is discussed they blame you and shout at you." (**FG3, P2, Female**).*

Similarly, Hawkins et al. (2020:9) in their study reported that 78% of the participants referred work-related bullying to being given excessive workload. Too much work was regarded as one of the sources of stress (Callaghan *et al.*, 2000).

Furthermore, another participant indicated her concerns as:

> *"Someone will be expecting you to do a mistake to the client so that you get reported so that you are out of work. This is how bad it is when you are newly-qualified nurse." (**FG4, P6, Female**).*

Hussein, Everett, Ramjan, Hu & Salamonson (2017:8), in their study of newcomer perceptions of transitional support in a clinical speciality, reported that some new graduates felt they were being 'set up to fail' and deflated by lack of clinical support.

4.3.2.1.1.3 Sub-Theme 1.1.3: Lack of Orientation

Orientation could be defined as time set to familiarize new graduates to their workplace

environment, staff, protocols, policies and procedures as well as the new graduates' job description (Innes & Calleja, 2018:64). Tembo, Kabuluzi, Gondwe & Mbakaya (2019:7), in their study of NQRNs' perceptions of the transition from student to qualified RNs, reported that some participants felt that they had inadequate orientation as they were only showed the layout of the ward. In this study, the findings reveal that orientation was done, however, not to the satisfaction of all participants because the focus was mostly on the environment.

One participant commented as follows:

> *"They concentrate more on ward orientation than on what we are supposed to do." (**FG3, P2, Female**).*

The findings concur with Thopola, Kgole & Mamogobo (2013:173) who reported that some newly-qualified nurses during their twelve months mandatory services indicated being showed the layout of the ward on orientation. Lack of orientation to NQRNs (R.683) who had prior nursing experience with an assumption that they were already socialized into the health care environment, and that they can begin to practice into a new role with easy have a negative impact as some newly-qualified nurses are still uncertain of the nature and values of the new role.

One participant espoused by stating the following:

> *"As a newly-qualified registered nurse as we are coming from school some of the things you are not aware of in the ward…." (**FG4, P4, Female**).*

Furthermore, the discourse of 'hitting the floor running' is becoming increasingly vociferous where new graduate RNs are expected to enter the workplace ready to practice a new role post-graduation (El Haddad, Moxham & Broadbent, 2017:392).

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Participants in this study reported how they were expected to be practice-ready without any orientation in the new role.

One participant indicated the fact that as NQRNs who completed the course and graduated did not mean they knew everything:

> *"They don't orientate us. After completion of our course they don't have time to orientate us…they said you are graduating, you are supposed to know everything." (**FG1, P3, Female**).*

In addition, another participant reiterated by indicating that:

> *"They didn't orientate us, they thought as I was working there I just know all the things at the end of the day I just want to ask everything." (**FG3, P7, Female**).*

Another participant commented that:

> *"They don't give us support, they don't orientate us. So, you find that Eeh when you come from school you do work alone." (**FG4, P9, Female**).*

The findings concur with Missen, McKenna & Beauchamp (2015:35) who reported that the majority of new RNs who had previously worked as ENs struggled with role transition which was difficult and stressful. Cubit & Lopez (2012:210) confirmed that NQRNs with previous EN experience did not automatically 'hit the floor running', especially when left alone to run the unit without the support they required throughout their graduate nurse journey.

The authors further indicated that NQRNs who had previously practised as ENs preferred to conceal their previous nursing experience, because they feared being

treated by their nurse supervisors as already capable of practicing as RNs. The manner in which NQRNs (R.683) perceive the situation necessitated the outcome of the strategy the chose to deal with the challenge they encountered. Therefore, they need ongoing support like any other newly-qualified nurse (Cubit & Lopez, 2012:210).

4.3.2.1.1.4 Sub-Theme 1.1.4: Shortage of Staff

Shortage of staff is a global concern and when coupled with workload has been cited to be the principal cause of stress in the nursing profession (Mutisya, 2019:3) where nurses were unable to cope with unmanageable workload. Esmaeili, Moosazadeh, Alizadeh & Afshari (2015:458) reported that a nursing shortage increases the nursing workloads. The shortage of newly qualified RNs is noted as an obstacle in rendering quality care as well as having negative impact in supporting NQRNs (Mebelane, Mavincowitz, Ogunbanjo & Govender, 2016:9).

Most participants blamed shortage of staff for their seniors' inability to support them within their 18 months of entry to the new RN role.

Below are their concerns:

> *"I'm working the duties for staff nurses and the duties for professional nurses but without any support." (**FG1, P3, Female**).*

> *"I was working in maternity ward, I was a newly-qualified professional nurse, sometimes there was a shortage in the ward while I was supposed to be left alone in the ward while I was not having midwifery." (**FG8, P7, Female**).*

Furthermore, participants in the study conducted by Nkoane and Mavhadu-Mudzusi (2020:7) complained of excessive shortage of staff, particularly staff nurse categories (enrolled nurses) resulting in a high workload. This had negative effects on participants'

physical and psychological well-being leading to increased stress level. Some participants felt that they had to cover up the gap left by ENs and indicated the frustration of not having sufficient staff in the unit as the cause of their tiredness.

One participant stated that:

> *"Immediately when you pass when we got in the unit they give us professional nurses work/duties…seemingly is just like there are no more staff nurses…they are shortened because everybody is being trained. So, you will find out that you are having burdened by the duties…So, to us when we reach home we are damnely tired because we are working from assistant work, staff nurse to professional nurse duties being alone." (**FG1, P1, Female**).*

The findings concur with Cubit & Lopez (2012:209) who reported that one paticipants in their study said. "So what worried me most was 1 day you were an EN, the next day you're an RN and all of a sudden you're sort of in-charge. I thought…how am I going to know everything? How am I going to remember everything? So that frightens me a bit''.

In addition, another participant stated her concern as:

> *"In my ward as a newly-qualified professional nurse what I have encountered is that they leave you alone and do run the ward as a newly-qualified professional nurse, and the problem is that we are getting very tired because we have a shortage of professional nurses, then, we are supposed to knock off at nineteen hour (19h00) every day when Wednesday come you are very-very tired that is the challenge we are having." (**FG8, P1, Female**).*

Esmaeili *et al.* (2015:1459) concurred that shortage of staff and being overworked lead to severe stress and job dissatisfaction. Hence, NQRNs (R.683) require support.

One participant in this study related her concerns as:

> *"In the ward because you work very hard even we have shortage of staff you will find that we are four in the ward. Male surgical is a too much work, bandaging of the patient dressing, giving oral medication and injections. You find that no one can do that that way." (**FG1, P4, Female**).*

Furthermore, Kobe, Downing & Poggenpoel (2020:6) indicated that participants reported that patient overload versus shortage of nurses was tiring to new graduate nurses. In this study, patient overload seemed to be stressful and exceeding NQRNs' ability to perform, especially as they used to nurse few patients under supervision, but now they are on their own with many patients. Many participants expressed finding it difficult to reach the expectations the unit supervisors had on their ability and capacity to work alone with patient load as NQRNs (R.683).

They expressed their frustration as follows:

> *"Myself I encountered that they will leave you alone running the medical ward and that ward is so heavy you cannot manage while you are still new, you need somebody who will be there may be some years. So, you find yourself nursing 44 patients, 45 alone as a professional nurse and which is not good because they need to support us…." (**FG8, P6, Female**).*

> *"So, you find that there is a lot of challenges maybe patients are many…80 patients with newly-qualified registered nurse you knock off at nineteen (19h00) you find that there is no other staff the shortage is killing you and you end up doing some mistakes…the unit is very busy." (**FG8, P2, Female**).*

In addition, shortage of staff lead participants to bemoan patient load and multiple tasks as indicated by the participants below:

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> *"I was working in medical ward still there was a shortage…and then I came across…there is a lot of patients." (**FG8, P7, Female**).*

> *"There is not enough time to do things correctly, when it comes to the duties some of the duties because of the shortage you must go and be hands on working with the patient and with the other duties to account like working with papers like admin staff to updates all things in the unit." (**FG4, P6, Female**).*

The findings concurred with Sönmez & Yildirim (2016:108) who reported that time shortage due to workload because of shortage of staff and patient to nurse ratio causes inability for new graduates to spend enough time with patients, rushing tasks and fearing making mistakes due to hasty decisions and taking care of multiple patients and tasks at a time. A work-related stress affected at least a third of the workforce in any one year (Maakie, 2006:20).

4.3.2.1.1.5 Sub-Theme 1.1.5: Insubordination of Junior Staff Members

New graduates within their first year of professional practice encounter a new challenge of insubordination. Insubordination could be defined as a tendency of undermining or belittling one's senior by refusing to carry out assigned tasks or activities. Ndaba (2013:68) reported that auxiliary nurses who had been in the institution for a long time, refused delegation of duties from newly-qualified professional nurses. Nearly all participants in this study indicated challenge of being undermined and disrespected by their subordinates due to age.

One participant expressed her concern:

> *"As a younger registered nurse when you tell others like a staff nurse because is older to you when you say do this he will tell you that you do it because you want me to do it." (**FG3, P3, Female**).*

Furthermore, another participant expressed:

> *"With me the challenge that I have encountered is that my age is very young, my juniors they are older than me,,,and some they will tell you 'wuri' 'phela wena' you are younger than me, is like sometimes when you want to send them to X-ray department they will tell you that you have to send them on your own…those junior nurses like assistant nurse when we want to send them to laboratory maybe you have put some blood there they don't want to take them and send to the laboratory." (**FG2, P3, Female**).*

The participant continues:

> *"The time that I wrote delegation and the junior she came to me she told me on the delegation you delegated me this today why do you delegate me this? … and she was very cross." (**FG2, P3, Female**).*

In addition, another participant said that:

> *"If I send someone to do the job or I send to do things they undermine me especial the RAN the RANs (registered auxiliary nurses) they don't do things when I send them." (**FG3, P4, Female**).*

Some participantd stated the challenge to manage the older subordinates because they could not accept her delegation and expressed their concerns:

> *"My challenge in my unit the junior nurses sometimes they refuse when ask something to do for example, when I wrote a delegation some they refuse to sign the delegation as the junior…." (**FG6, P1, Female**).*

> *"The junior nurses when you delegate them they will tell you that you went to school alone. So, you did not come here with the nurse…." (**FG8, P3, Female**).*

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The findings concur with Nkoane (2015:55) who reported that newly appointed nurses experienced insubordination from older ENs and nursing auxiliaries who were sometimes difficult to work with and even refused delegation from the newly qualified registered nurses. This resulted in new graduates feeling belittled and disrespected by their subordinates in their units and eventually negatively affecting rendering of health care. Shongwe (2018:47) concurred that newly-qualified nurses felt it difficult to work with other staff members as they undermined them because they were young. Younger nurses commonly experience more stressors within the workplace (Sawafta, Mao, Tian *et al.*, 2016:10). Thus, NQRNs (R.683) need support.

4.3.2.1.2 Theme 1.2: Emotional Resilience

Nursing is a profession which is physically and emotionally demanding as it often exceeds the limits and capabilities of human performance (Cope, Jones & Hendricks, 2014:1). However, emotional resilience can enable a person to become adapted to this difficult work environment as well as maintaining a healthy and stable emotional functioning. Therefore, emotional resilience could be defined as an intrinsic drive to help a person to persist while going through a difficult time by accepting the situation and adapting to hard circumstances (Yilmaz, 2017:10). Despite facing negative workplace experiences coupled with overwhelming responsibility and accountability, newly qualified registered nurses could flourish within the practice environment based on their resilience to overcome challenging hard times (Allen, Emlund, Kozdronkiewicz, Bayer & Bland, 2018:1). Newly qualified registered nurses with prior experience in nursing understand some dynamics of workplace culture where they could be able to identify and sometimes avoid difficult staff and negative situations (Parker, Giles, Lantry & McMillan, 2014:154).

One participant acknowledged the value of perseverance in hard situations in nursing by stating that:

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"I was thrown into paediatric care and then there is shortage of staff and you have to do most of the things there like a professional nurse who is specialist paediatrician, but when you work in you are allocated in your cubicle, you are also expected to work in that cubicle where the trained professional nurse work you have to leave what you are doing and then you go and also help in that cubicle. But now I became used to it and I'm prepared." (FG8, P8, Female).

Emotional resilience could assist new graduates to adapt positively to stressful working conditions, managing emotional demands as well as enhancing their well-being (Grant & Kinman, 2014:24). An improved well-being leads to job satisfaction and thus retention in the workplace. Newly qualified registered nurses (R.683) who feel challenged instead of threatened have a high self-esteem and thus have control over their situation (Da Silva *et al.*, 2010:505). Hence, NQRNs (R.683) should be provided an opportunity to perform different activities related to their new role to boost their morale and reduce stress.

4.3.2.1.2.1 Sub-Theme 1.2.1: Increased Level of Responsibility and Accountability

As previous ENs, participants worked under the direct or indirect supervision of the RN, but as NQRNs the responsibility is heavier because they are now accountable for their acts and omissions. In the new professional identity, NQRNs are expected to work independently without or with less supervision (Wong, Che, Cheng, Cheung, Lee, So & Yip, 2018:33). Participants attested that they are being left alone unsupervised with huge responsibility and accountability.

One participant shared her overwhelming experience as:

> *"I'm working in female ward immediately after I obtained the results I was told that now I should start acting or working as a professional nurse where I was given a cubicle which is the hardest in the unit it was cubicle B which is medical, believe me it was hectic! no one to*

*supervise me…." (**FG7, P3, Female**).*

Other participants stated that:

*"…you had to do everything from the scope of the juniors to the from the nursing assistant to nursing the staff nurses and then you also, do your work as a professional nurse which you got tired at the end of the day." (**FG8, P3, Female**).*

*"I was allocated in postnatal night duty alone with an assistant nurse. We have to receive patients from theatre, we have to receive those who have who got birth NVD and then the whole night we have to look after their newborn child-their children then I have to give treatment during the night. So, there was no orientation to me I was just told that you have to go to night duty." (**FG7, P5, Female**).*

A decrease in the number of ENs was perceived by participants to be the reason that NQRNs had increased responsibility.

One participant expressed her concern as:

*"…in the ward where we are working we have challenges of shortage. So, as a newly-qualified registered nurse you have increased responsibility and accountability to all what is happening in the ward. So, you find that sometimes you don't reach the goal you are supposed to reach on a daily basis." (**FG4, P6, Female**).*

Furthermore, participants felt overwhelmed by numerous responsibilities as a lot was expected from them as NQRNs (R.683). Participants felt being answerable to various stakeholders who expected them to immediately cope with the increased responsibility. These huge responsibilities resulted in compromised full attention to patients and their next-of-kin.

One participant expressed her experience as follows:

> *"So, with that from being an enrolled nurse you find that you had certain responsibility but now you are a new registered nurse you have increased responsibility. So, what is expected from you is a lot from the client and from supervisors. So, to me it was a big challenge…you must be accountable…to the SANC…to the patient…to the visitors. So, with that overall duty on you and having shortage some of the things you don't reach, like…maybe some of the visitors want to be attended with a challenge you do talk to them but…you find that you did not attend to them the way you want to because of time." (**FG4, P6, Female**).*

The findings are in line with Wong *et al*. (2018:32) who reported that heavy workload coupled with insufficient manpower led to newly qualified registered nurses lacking time to communicate with patients and relatives as well as increased conflicts and misunderstanding as patients and their relatives had high expectations of high quality care and thus further stressed newly qualified registered nurses (Wong *et al*., 2018:34).

In addition, Zaayman (2016:42) reported that participants felt the level of responsibility was huge as they were expected to take charge of the unit.

One participant expressed similar concerns below as:

> *"I'm new they give every sister a cubicle where you have to take all the responsibility for that cubicle and on the cubicle, sometimes we have eight patients…So, you must take all the responsibility for that eight patients being alone." (**FG4, P3, Female**).*

Participants also experienced little support where some junior nurses were unwilling to assist them, which is why they had to carry on all responsibility.

One participant expressed this as:

> *"…you will find that us as newly-qualified registered nurse we have a lot of work because you find that…assistance nurse will do some vital signs from eight o'clock until ten and the newly one will be busy…do a lot of work because she is still busy learning and practice there and there." (**FG2, P3, Female**).*

Similarly, Maria, Mei & Stanley (2018:5), in their study on the transition challenges faced by new graduate nurses in their first year of professional experience, reported that the sudden increase in responsibility and accountability hinders new graduate nurses' self-expectation to render quality care in a hectic and understaffed ward situation. NQRNs (R.683) expressed being assigned huge responsibility and accountability with little support as too demanding. Wiles, Simko & Schoessler (2013:170) revealed that new graduate nurses were expected to move above their ability in developing clinical and decision-making skills, hence, they strived to balance between their autonomous actions and seeking assistance from experienced nurses. Participants expressed the uncertainty and misery of being overwhelmed with too many responsibilities. Here is how one participant expressed her frustration:

> *"So, sometimes is being tough. So, you find yourself not knowing what to get help…sometimes you go miserable not knowing what to do." (**FG4, P3, Female**).*

The fear of making mistakes as a result of increased responsibility and clinical skill deficit when faced with complex conditions and having to cope working in emergency department are stressful factors for NQRNs (Tastan, Unver & Hatipoglu, 2013:410).

Another participant reiterated as:

> *"You find that even the doctor is an intern he needs more from you and you also, new so, that one it becomes a hazard is so straining…you have a patient from accident that patient needs a*

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> *trauma nurse and you'll be alone there without trauma. So, it becomes a challenge when you should run to recuse and you should apply the skills." (**FG8, P2, Female**).*

Similarly, Smith (2014:98), in a study on new baccalaureate nurse graduates' transition into rural acute care, reported that with no on-site doctor or nurse graduates were required to be resourceful and self-reliant in prioritizing and managing critical situations on their own. Whilst trying to adjust to the new professional identity, newly-qualified nurses experienced fear and anxiety caused by responsibility and accountability assigned to them as RNs (Draper 2014:2).

One participant expressed feeling of being overwhelmed and ill-prepared to cope with the challenges of the new role.

> *"I thought I was prepared but then I was thrown into paediatric care and then there is shortage of staff and you have to do most of the things there." (**FG8, P8, Female**).*

In addition, Slone (2012:46) indicated that graduates reported being overwhelmed when assigned unfamiliar tasks in addition to their increased responsibility which was different from their educational preparation. Participants in this study felt being tasked with a wider range of responsibilities was hectic and discouraging to them.

One participant expressed her feeling as:

> *"It was difficult to me to cope with the units and then I also…report to say I'm not coping with the ward…was a lot of things that discouraging me…because I'm just a professional…not on the post working in a ward where it was supposed to have a specialist. So, it was hectic to me." (**FG7, P5, Female**).*

The findings concur with Govender, Brysiewicz & Bhengu (2017:18) who reported that

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participants felt overwhelmed by the huge responsibility they were given. Hence, others felt that they were unprepared for responsibilities that were expected of them. Gardiner & Sheen (2016:8) reported that new graduate nurses, in their first year as RN, experienced being stressed and overwhelmed by bearing the nurses' responsibility.

The NQRNs encountered many forms of stress during their first eighteen months in practice, such as fear of uncertainty and making mistakes due to deficit in clinical skills while working with emergency situations, shortage of staff with additional responsibility and accountability associated with the new role. Newly qualified registered nurses (R.683)' change in the professional role can be perceived as a challenge as new skills and attitudes are required (Da Silva *et al.*, 2010:505). The fact that hospitals in Limpopo Province have NQRNs (R.683) who are assigned to run the units prematurely makes it necessary to have a model to enhance their support.

4.3.2.1.2.2 Sub-Theme 1.2.2: Negative Working Relationship with Senior Colleagues

When NQRNs convert their status from EN to RN, they are faced with changes in both roles and expectations which are stressful and challenging. As assimilation into a new role can be stressful for any nurse, increased patient loads, interpersonal relationship without adequate support and guidance can contribute to high turnover (Squillaci, 2015:5). Manyisa (2016:228) reported that interpersonal relationships are challenging amongst health care workers where NQRNs face poor communication, disrespect and negative attitude from experienced RNs as well as lack of managerial support which lead to negative interpersonal relationships. Participants acknowledged that they have experienced pretentious relationship by both senior and junior staff.

One participant voiced her concern as:

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> *"The relationship is pretendance…at first before you go to the college there were that thing of educating all those things…but immediately after… completing they are no longer interested on showing you on how things are done." (**FG1, P1, Female**).*

It is evident that participants were affronted by endless streams of stressful encounters from unit staff.

Another participant reiterated that:

> *"So, when you hear them talk the supervisors, the juniors…even the managers when they call you is like you are somebody who is not from training especially with us bridging nurses, because we have trained ourselves using our money now we are from the university is like we are not from a learning institution somehow with this attitude that they are showing us." (**FG4, P6, Female**)*

Another participant expressed how disrespectful supervisors and managers are while communicating with them as follows:

> *"You become demoralized if maybe like you have done, ah! Is you, even you have sent yourself to school because you don't want to wait for the line. You-you 'U tsutsumela swilo' (**You are being too forward**) that thing it makes you feel like 'yuu' its like I'm not gona go further." (**FG8, P9, Female**).*

As participants were qualified as RNs, they were even expected to get on with the new role in the absence of further support from experienced nurses (Halpin, 2015:154). Even though no participant in this study reported feelings of resigning, most participants expressed a feeling of being neglected and demoralized.

One participant's concern was:

> *"Sometimes you can find that…those who are seniors from us you can find that they left us alone after, maybe after four (16h00) if I'm going to knock off at seven (19h00). They can leave us alone after four (16h00 expecting that I'm going to do everything whereas I'm not yet…I'm not yet experienced like that." (**FG1, P3, Female**).*

Furthermore, participants reported experience of lack of supervision and they were expected to be on their own running the unit.

One participant expressed her concern as:

> *"In our hospital there is lack of staff, there is of lack of supervision to different units. They just leave us as we are…they just say you are long been working here. So, you should learn that now you are newly-qualified registered professional nurse. So, you have to stand on your own and do whatever they expected us to do." (**FG5, P5, Female**).*

The findings concur with Thopola, Kgole & Mamogobe (2013:174) who reported that most participants indicated lack of supervision or mentoring from experienced nurses. They were expected to deliver as they had completed the course. Govender *et al.* (2016:7), in their study on perceptions of newly-qualified nurses performing compulsory community service in KwaZulu-Natal, reported that participants experienced being left literally alone resulting in feelings of professional isolation.

Participants in this study felt neglected in specialized units with no one to monitor or direct their performance. The challenge of being left alone unsupported was exacerbated by shortage of staff in the units where NQRNs were allocated. Hansen-Salie & Martin (2014:538) reported that newly-qualified professional nurses were expected to be competent in leadership capacities immediately after graduation due to staff shortages.

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Here are two participants' accounts:

> *"I have a challenge in being…left in the ward as a newly-qualified professional nurse. And left alone…I don't have qualified professionals who are specialized in such area of orthopedic and you find that you are left alone you are expected to do better in all areas…You find that seniors put trust on you to run the ward." (**FG5, P6, Female**).*

> *"The challenge that I had when I come back, they said huu! Welcome now you are a registered nurse. I'm working in a specialized ward, sometimes they just left us with no specialized nurse, when we ask them they say we won't do anything because we are short staffed." (**FG4, P7, Female**).*

Halpin (2015:143) reported that newly-qualified nurses had no mentor as experienced nurses barely interacted with them. Zaayman (2016:49) concurred that unit staff had negative attitude towards the new graduates performing compulsory community service and were unsupportive to them when they entered the service. The author further reported that unit staff were critical towards newly qualified registered nurses which resulted in workplace tension and thus poor relationships.

One participant expressed her concerns below:

> *"As a new registered nurse, I have encountered that our supervisors they neglect us and they left everything for us to do so the workload is too much for us. They just neglect everything and give us everything to do and they do nothing. Some of them are just sited, they play with their phones, some of them they just answer the phone. And some of them they are just doing the paper work." (**FG3, P2, Female**).*

The findings concur with Danzl (2015:22) who reported that new graduate nurses felt

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professionally isolated as they were left alone and unsupported. In addition, Tseng & Hsu (2018:2) reported that newly-qualified nurses felt scared and nervous due to lack of support and poor nursing role model with deficit in clinical skills. This lack of interaction between experienced RNs and NQRNs (R.683) affected the working relationship with senior nurses as expressed below.

> *"You find that this newly-qualified nurse she made a mistake in a patient. So, there is this old 'gogos' there in the unit which used to say ja! we have been preaching this one she can't do it, those things they demoralize us." (**FG8, P2, Female**).*

Similarly, ten Hoeve, Kunnen, Brouwers & Roodbol (2018:e1616) in their study of novice nurses' first experiences in a clinical setting reported that novice nurses experienced feeling of being ignored and belittled as well as not being treated as professionals. Despite several encountered challenges reported, no participant indicated a feeling to resign. Their positive perception towards challenging situations have contributed to their emotional resilience to stay.

In their study Wong *et al. (*2018:36) reported similar findings that positive personal attitude may contribute to fresh nurses' perseverance despite several challenges reported. As excessive responsibility and accountability exacerbated with lack of support are of major concern, provision of adequate support with less expectations from NQRNs in terms of huge responsibility and accountability as well as treating them like professionals can boost their morale and enhance retention and performance. Pennbrant, Nilsson, Öhlén & Rudman (2013:744) highlighted that nurses experiencing supportive relationships felt less stressed to master their professional role. Therefore, for NQRNs (R.683) to adapt to this challenging work environment require support from experienced RNs.

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4.3.2.1.3 Theme 1.3: Role Confusion

Despite possession of previous nursing experience, participants were uncertain about their professional role. NQRNs experienced role confusion as they were sometimes being used as ENs or nursing auxiliaries rather than RNs where they occupy dual roles because of their previous practice. Entering a new RN role and being responsible and accountable for patients is often associated with feelings of confusion, uncertainty and stress (ten Hoeve, 2018:e1613). Lack of role clarification causes stress to NQRNs in the 18 months of employment. Therefore, for NQRNs (R.683) to be professionally capable of functioning independently depends on how NQRNs were exposed and permitted to participate in unit tasks as well as their interaction with positive role models. Depending on the intensity of the health care setting, NQRNs (R.683) might not always be afforded opportunities to effectively participate and learn. Without the influential mentor, NQRNs(R.683) may be denied opportunities to practice challenging and complex tasks and instead be restricted to their proficient routine unit activities (Newton, Billett & Ockerby, 2009:3), resulting in lack of experience and skills to perform RNs' activities.

4.3.2.1.3.1 Sub-Theme 1.3.1: Dual Status

NQRNs with previous EN experience perceived their role transition process as difficult and stressful because they felt overwhelmed by increased responsibility (Missen, McKenna & Beauchamp, 2015:35). Participants in this study felt dissatisfied and stressed due to unclear roles in their new position. Below are the concerns of two of the participants:

> *"You find that in the morning when you start doing all those routinely things, they expect you to be a junior (voice raised), when is now time to take blood, to give injections, to insert the jelco and everything, you are supposed to do that, you know you are a professional nurse you must do it…then it leaves us being, is just like*

> *punishment. Yes, because I'm a jack of all trades I'm going from down, to up…." (**FG1, P1, Female**).*

> *"…if you are a registered nurse, newly as a registered nurse when you come back to the ward if you come from another ward you find that the senior do not get tired you end up doing the things what you were doing when you were an enrolled nurse, giving oral medication or everything that the staff nurses is done you don't do the duties that you have to do as a registered nurse." (**FG4, P7, Female**).*

There was uncertainity on the amount of work delegated to NQRNs (R.683) either being over or under delegated. These could be the reason NQRNs (R.683) were eager to practice as registered nurses as per their qualifications. Lack of role definition caused NQRNs (R.683) to be vulnerable to stress (Govender, Brysiewicz & Bhengu, 2017:20).

In addition, participants complained of being treated as supplementary staff where there was shortage of RNs as stated below.

> *"I don't know where they are taking us because the senior when they write off duties where there are shortages somewhere they want to balance they including us as new registered nurses, they are balancing with us, because me now is for the third time when want to balance they change me go to this shift on Sunday go off they do the way they want. So, is uncomfortable with that because always one person they do balance with her always." (**FG4, P3, Female**).*

The findings concur with Govender, Brysiewicz & Bhengu (2017:19) who reported that NQRNs experienced role confusion as they held double titles, by being considered as students, and on the other hand acted as replacements for RNs' shortages during the 12 months of mandatory service.

4.3.2.1.3.2 Sub-Theme 1.3.2: Denied Opportunity to Practice as a Registered Nurse

Lack of NQRNs' participation in some unit activities led them to experience difficulty to benefit from the clinical exposure. Hezaveh, Rafii, Khosravi & Seyedfatemi (2014:203) in their study reported that participants complained of exploitation and not being allowed to participate in unit discussions. Newly-qualified nurses who were often not given the opportunity to practice according to their level of education felt that they were denied the opportunity to utilize the knowledge and skills gained during training (Mshweshwe, 2015:52). Similarly, participants in this study felt frustrated because they were expected to carry on with ENs' routine activities such as administration of oral medication and injections which denied them an opportunity to focus on duties that need to be learned like doctor's rounds, duty roster and management of drugs. And this seems to be a common challenge as expressed by a participant who said:

> *"The challenges that I have encountered…in my unit…you are not allowed to do anything except to do the work of enrolled nurses."* (***FG5, P8, Female***).

It was also, noted from the interviews that some senior, experienced RNs preferred to perform certain tasks such as doctor's round themselves rather than allowing NQRNs to do the task. NQRNs' involvement in task-oriented care is among the factors impending their intention to apply the acquired knowledge and skills to perform RNs' tasks. Senior, experienced RNs focused on getting the job done (Kumaran & Carney, 2014:610) rather than empowering NQRNs as reiterated below:

> *"…some seniors they don't want us to take rounds or to learn a lot because…we expect that a newly registered nurse, they give us a chance to take some rounds. So, you find that when the doctors come…they send us to give the medicine and the injections. So, is difficult to go there when there is a lot of work that is need to be*

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> *done." (**FG2, P1, Female**).*

Furthermore, competence is based on the knowledge and skill taught to new graduates during their training and clinical exposure. Therefore, inadequate preparation of new graduates when entering the clinical environment disturbs their professional development (Jamshidi, Molazen, Sharif, Torabizadeh & Kalyani, 2016:5) leading to anxiety and stress when expected to perform certain administrative tasks as expressed by this participant:

> *"The problem is when you arrive there in the unit they see you with those white epaulets they tell you that oral medication. So, there is no chance for learning anything which is being done by registered nurses. After that they expect you after you have pass to do the work of professional nurses but they didn't give you that chance to practice during our training. Even the off I can tell you I never written the offs but now they expect me to do it." (**FG7, P4, Male**).*

New graduate RNs appreciate that being engaged in challenging tasks creates learning opportunities (Guay, 2013:72) and facilitate them to manage new assigned tasks in the unit in a satisfactory manner (Ingvarsson, Verso & Rosengren, 2019:6). New graduates do not have sufficient time to practice and repeat certain skills to completely enter the practice environment (Jamshidi *et al*., 2016:5). It is apparent that senior, experienced RNs could not trust NQRNs to be assigned challenging tasks to perform as described below:

> *"…as a newly-qualified professional nurse my senior colleagues they don't want to give us chance to work sometimes because they don't have hope to us that we will do the relevant things with regard because they know that sometimes they doubt…." (**FG5, P7, Female**).*

Another participant complained that:

> *"The only thing that they didn't even give us is the keys for drug cupboard. Of which even now is hard for them to believe that we are registered nurses, we can hold the keys for the drug cupboard and you even saw for yourself because every now and then when they are counting the drugs they won't even call you (laughing). They will do them as seniors and then you are a junior for that." (**FG1, P1, Female**).*

Another participant reiterated that:

> *"Even issuing, you will call them come and give me Tramadol !...They won't even give you the keys to go say you are a professional nurse go and take… duties like doing ward rounds you just fight for it no let me go with the doctor today, and then you will see them that they are not free for you to do…you can take orders but not doing ward rounds." (FG1, P2, Female).*

Mshwehswe (2015:53), in the study of experiences of professional nurses regarding clinical placement exposure during compulsory community service, reported that some participants experienced being denied the opportunity to administer scheduled drugs even though they felt at that level they needed to be given some RNs' responsibility, and instead they were delegated to perform tasks that are traditionally performed by nurse subcategories.

4.3.2.2 Major Theme 2: State of Readiness and Preparedness for a Registered Nurse's Role

Work preparedness and being able to achieve performance expectations result in newly qualified registered nurses feeling a sense of enjoyment, confidence and job satisfaction and this enhances performance.

4.3.2.2.1 Theme 2.1: Perfectly Ready and Well-Prepared

NQRNs' readiness to practice is referred as their ability to practice safely and

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independently as knowledgeable and skillful nurse practitioners after graduation (AlMekkwawi & Khalil, 2020:2). Initially, new graduate nurses rely on experienced nurses seeking their opinions when encountering uncertain situations in the ward to validate their decisions. However, with confidence and experience, new graduates start to trust themselves and feel more comfortable with their abilities to perform independently (Purling & King, 2012:3558).

4.3.2.2.1.1 Sub-Theme 2.1.1: Sense of Independence

A sense of independence refers to ones' ability to organize, make decisions without seeking any person's opinion. Missen, McKenna & Beauchamp (2015:36), in their study of work readiness of nursing graduates, reported that some graduate nurses acknowledged the value of their previous EN experience in assisting them to cope with general nursing care. However, even though NQRNs have previous EN experience, it is impossible to be prepared for every situation in the nursing profession. Odland, Sneltvedt & Sörlie (2014:541) indicated that newly educated nurses require recognition and support from experienced nurses to develop professional competence and professional pride according to their professional identity. Participants in this study indicated a sense of accomplishment, excitement, work readiness and confidence to assume huge responsibilities to keep the unit going independently.

Participants expressed their work readiness as experiences as follows:

> *"…ready because the matron will say…you know everything is long you have been here. So, you felt like hoo! I must do what I know what I do like every day. I'm a professional nurse now. I was practicing this thing since I was a staff nurse." (**FG7, P2, Female**).*

> *"For me, I think that I'm prepared because they trust me, they leave me with the unit with the junior." (**FG4, P7, Female**).*

> *"I'm prepared because I'm working sometimes they left me with the ward and I didn't see any problem." (**FG6, P1, Female**).*

> *"I didn't encounter any problem because I have been working in such section for long time. So, even though when I come back I didn't feel any problem of working because I've been working independently for a long time…." (**FG5, P9, Female**).*

> *"I feel that I'm prepared to be left in the ward alone when I received my post because all along I was working…when I came from school…I was preparing to be a newly-qualified registered nurse." (**FG4, P4, Female**).*

The findings concur with Govender, Brysiewicz & Bhengu (2017:20) who reported that community nurse practitioners benefited from assuming more responsibilities such as being unit-in-charge as well as supervising junior nurses. And compulsory community service was perceived as an opportunity to gain experience and acquire additional professional skills. NQRNs with previous enrolled nursing experience might be advantageous of being work ready as they are likely to be familiar with the demands of work shift (Gallagher, 2012:22). Foster, Costa, Foster & Bruin (2017:508) indicated that it took about 3 months for new graduates to become comfortable and efficient in the ward, this is consistent with the findings of this study as stated below:

> *"I started to realized that I had to do things in a way I'm supposed to do as a professional nurse after three months being on the rank because when I started it was difficult then because they leave you in the unit being a professional nurse… alone you must learn from there…by yourself, to learn by asking people surrounding you…." (**FG7, P4, Male**).*

> *"I didn't have a challenge and another thing that encourages me that I mustn't be afraid or to be alone in the section is that I'm not scared…when like I see they are doing some procedures or doing*

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*something I go there uninvited to see how they are doing it so that I can learn myself." (**FG5, P3, Female**).*

*"I can say that experience mean a lot, we take a long time to this spirit of nursing and we can do anything for 'aniri' we were staff nurses we were doing everything…when we enter to the field of registered nurse we were prepared we had experience. I can say that I can work independently." (**FG2, P1, Female**).*

*"I felt ready after graduation, after graduation I felt that now I'm ready." (**FG1, P3, Female**).*

Participants expressed a realistic conceptualization of nursing by embracing accountability and responsibility as competent and independent nurse practitioners. The possession of previous experience in nursing enabled NQRNs (R.683) to have insight into what is expected to be a RN. Watt & Pascoe (2013:27) indicated that being knowledgeable of the real practice environment eases the stress experienced by newly qualified registered nurses and thus has a positive impact on practice readiness.

Below, a participant expressed her ability to can 'hit the floor running':

*"…after I saw my results that I have passed, I just said I made it! and the experience that I had and the knowledge that I had, I must render it to the patients… I think the long service and growth counts isn't that is long time we have been working, we started as the auxiliary nurses as enrolled. So, is being long that we have in the field. So, we know a lot of things. So, it makes me to feel more independently, hence I be also, accountable facing my responsibility. So, I don't have a problem I'm very much ready as even like now on I'm working night duty…I can do everything." (**FG2, P3, Female**).*

At six months, new graduates began to be more independent (Spector, Blegen, Silvestre, Barnsteiner, Lyn, Ulrich, Fogg & Alexander (2015:33). Guay (2011:69)

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indicated that new graduate RNs revealed that to mitigate their fear of independent practice, they must be knowledgeable of someone to turn to if they need consultation in case encounter some challenges.

Consistently, in this study, some participants reported that they felt work readiness and sense of independence at 6, 7, 13 months as individuals are unique, and knowing that they have someone to consult if they needed help reduced their stress level and enhanced work readiness and a sense of independence.

> *"I felt ready… after six months because I started to work night shift, I remember that time I was supposed to work with the other registered nurse and then he did not come the whole week seven days I did manage to work alone. Even to give blood, to resuscitate the child…but when I was having a problem I did call the other sister to tell me what to do." (**FG3, P3, Female**).*

Walker *et al*. (2017:510) indicated that it took about six months for graduate nurses to feel confident in their ability to provide good patient care, resulting in professional growth and enhanced self-esteem. There was a great willingness to trust personal resources and engage in ongoing learning as part of professional development rather than from feeling inadequate.

> *"I feel well prepared at around six months' qualification as a registered nurse because where I work neh! my manager used to praise me every day. So, I become excited-more excited yooh…yah! I'm doing well, she was praising me every day say this nurse she knows her things. So, became excited So, for long time I've been prepared." (**FG4, P3, Female**).*

> *"After seven months I felt that I was ready to practice independently, maybe due to because I was working night duty alone as a professional nurse the experience that I got there it made me felt*

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> *independently." (**FG3, P2, Female**).*

> *"I'm now thirteen months…as a registered nurse, to be honest I'm prepared, I love my job…I'm slow on another task to catch up easily. Even though I'm slow I'm ready." (**FG4, P2, Female**).*

Despite being new in the RN role, new graduates developed confidence in handling emergencies and being able to manage a complex unit independently. A feeling of sense of accomplishment gives work meaning and job satisfaction experience to newly qualified RNs. This results in NQRNs' positive outcomes that keep them engaged and wanting to remain in nursing (Harrison, 2018:168). Similarly, below is one participant's expression:

> *"There was the time where we had a horrible accident in casualty we received about 44 patients and they were critical traumatic injured. So, from that day I have learned so much. Yah! I can say from that day I become a competent nurse in unit…I then being left alone I can say since like last week I managed casualty… I see myself participating and doing work." (FG8, P2, Female).*

The findings concur with Roziers *et al. (*2014:95) who reported that newly qualified registered nurses felt a sense of achievement, confidence and excitement on completion of their course as they could successfully assume responsibility and manage the ward independently in the new role. Woods, West, Mills, Park, Southern & Usher (2015:365), in their study of undergraduate reported that 88.8% of participants strongly agreed that they felt ready for the newly qualified registered nurse role after completion of their 240 hours of clinical placement. However, the fact that at thirteen some NQRNs (R.683) are still slow to catch up needs support for critical thinking. Critical thinking in the study conducted by Willman (2020:57) NQRNs rated it to be the lowest. After 18 months of working experience, NQRNs were competent and function

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independently (Willman, 2020:58). Hence, the model to enhance support for NQRNs (RR.683) within their first 18 months of employment.

4.3.2.3 Major Theme 3: Support Expected from Experienced or Senior Staff Members

4.3.2.3.1 Theme 3.1: Insufficient Support

Entry to a new RN role from EN faces increased accountability and extended scope of practice which is challenging, overwhelming and stressful to NQRNs. Although they had previous nursing experience, NQRNs had no experience of the activities of the new RN role. Therefore, it is imperative for senior RNs and unit managers to mentor and guide NQRNs. Lack of support for NQRNs with previous EN experience could impact their future professional development and practice (Cubit & Lopez, 2012:210). In their study, Rush, Adamack, Gordon & Janke (2014:225) revealed that in their initial vulnerable months of employment, new graduates were unable to access support. Authors further reported that support was sometimes available only for some few NQRNs who were bullied (Rush *et al*., 2014:225). Mellor & Greenhill (2014:11) revealed that NQRNs experienced transition to practice to be too stressful coupled with insufficient clinical guidance, unless if patients were at risk.

Participants in this study stated that they were provided inconsistent support which was limited, particularly by senior RNs and unit managers which was inconsistent because sometimes they were supported or not in their work environments.

Two participants stated that:

> *"Sometimes we got support from our senior registered nurse and even the operational manager…." (**FG1, P3, Female**).*

> *"Is not enough because they just like they are withdrawing some of the information from us that they know…." (**FG1, P2, Female**).*

Studies reported the variability in the application of support to NQRNs. Parker, Giles, Lantry & McMillan (2014:155) reported that there was inconsistency in the application of support to NQRNs within the same institution in different nursing units. Ndaba (2013:47), Thopola, Kgole & Mamogobo (2013:174) and Shongwe (2018:44) reported inconsistency in supporting NQRNs in different institutions. In addition, the study findings concur with Shongwe (2018:48) who revealed that participants had been bullied, oppressed by enormous responsibilities and the staff also, withheld information about the work they were supposed to do. This identified limited and inconsistent support require improvement, hence a model to enhance support should be developed.

4.3.2.3.1.1 Sub-Theme 3.1.1: Mentoring

Mentoring serves as a career guider to assist NQRNs in their infancy stage of employment to advance their career. For NQRNs to access mentoring is recognized as an imperative opportunity for them to get a helping hand to climb the ladder for career advancement. Shek & Lin (2015:351) concurred that mentoring is when an experienced senior employee coaches, guides, supports and role model to an inexperienced employee. Webster (2016:12) defined mentorship as a one-to-one communal relationship between the experienced and less experienced person with the goal of sharing knowledge and expertise between mentor and mentee.

In their study on how to grow our own in New Zealand, Haggerty, Holloway & Wilson (2013:168) reported that the presence of a well-prepared and dedicated mentor yields positive results on the NQRNs' success and experience in the clinical area. Participants' lamentations as expressed below show the importance of mentor availability to support NQRNs in their early months of employment.

"I'm prepared to do the professional nurse' role, but the problem is I

> *think it was gona be fine…we need someone who is more experienced to be left with, I'm not yet free…." (**FG1, P1, Female**).*

> *"I think…when we come to a new post they should work hand-in-hand with us supervising us." (**FG3, P2, Female**).*

Ndaba's (2013:46) findings revealed that mentoring and support are beneficial in eradicating most of the transition challenges that cause stress and anxiety to NQRNs. Dunn (2012:401) asserted that mentorship facilitates and eases transformation from a fledgling graduated nurse to an independent professional. Therefore, for NQRNs (R.683) to perform successfully and fruitfully in their new role is when they feel the support and supervision of the nurse managers in their units. Kumaran & Carney (2014:610) reported that NQRNs struggle with their new responsibilities due to lack of experience and confidence to make decision. Participants expressed a sense of being anxious, insecure, worried and frustration because of being unsupported in specialized clinical areas. Hence, they pleaded for unit nurse managers to assign mentors to rescue them as follows:

> *"…my working unit is a specialized ward…sometimes when we knock off at seven o'clock (19h00) we are becoming shot staffed…when we have emergency …as a newly registered…we must have the supervisor…who have speciality." (**FG4, P9, Female**).*

> *"Sometimes…I don't feel free because ehmm I can say I'm working in an emergency unit. So, it needs some other professional nurses so that we can help the patient." (**FG6, P1, Female**).*

The first year of work experience is the most difficult phase for NQRNs that need provision of appropriate support to NQRNs. Rosi, Contiguglia, Millama & Rancati (2020:1565), in their study on new graduate nurses' experiences of horizontal violence, reported that effective mentoring alleviates anxiety and fear of being labelled

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incompetent. Ortiz's (2016:22) findings on the study in USA on new graduate nurses' experiences about lack of confidence, reported that at six month an employee felt s/he was confident than at the onset of his/her career, however still needed support to grow in professional confidence.

Participants in this study felt that they cannot be left alone in this critical phase of their employment, therefore they need a mentor, coach, role model and guider to be present for them for at least a period of six months.

Participants expressed their plea as follows:

> *"In my understanding as newly-qualified registered nurses we need to be allocated with the senior ones to mentor us, as in this stage they cannot leave us to work alone. We need to be guided and mentored. The senior must do the procedure first and allow the newly-qualified registered nurse to do it under her watch and do on the spot teaching in case there are some corrections to be done. This can be done at least for six months until we are competent to work independently." (**Follow up FG2, Female, P3 Female**).*

> *"…the nurse manager must make sure that he allocates the supervisor to supervise the newly-qualified professional nurse maybe three or six months working with them until they know that now they are fine and then they can do without them…ready to run the ward." (**FG8, P6, Female**).*

> *"They should give us give us a period maybe three to six months seeing that we are working under supervision, they make sure that we work with the old nurses where they guide us, they supervise us so that we learn more and avoid making those unnecessary mistakes." (**FG8, P3, Female**).*

> *"I think mentorship can be practiced in our wards it can benefit us as*

> *newly-qualified registered nurses. It makes one to work without fear of making mistakes because you know that someone is there for me." (Follow up **FG2, P2, Female**).*

Ekström & Idvall (2015:82) revealed that nurse managers are obliged to create a friendly and supportive atmosphere, guide, support and provide job descriptions and specifications for NQRNs as well organizing mentorship for effective support. A healthy supportive environment motivates NQRNs to quickly adapt and become competent in performing activities of the new RN role with confidence, as it will be easy for them to ask questions if the need arises (Rosi *et al.*, 2020:1565).

In their study, Aldeeb, Basal, Ebrahem & Elnagar (2016:21) recommended that institutions can provide structured mentorship programme to enhance job satisfaction and reduce stress and anxiety as well as boosting confidence for NQRNs. Dunn (2012:401) affirmed that mentorship facilitates and eases transformation from a fledgling graduated nurse to an independent professional.

4.3.2.3.1.2 Sub-Theme 3.1.2: In-Service Training

The nursing profession is dynamic as it is subject to change rapidly, therefore for NQRNs to go with the times, in-service training is imperative. Nurses who are updated with modern developments through in-service training render high quality nursing care in clinical areas. In-service training is a logical structured training which is conducted within normal working hours in the institution by a person with expertise knowledge on the topic to be delivered.

In-service training is a significant financial investment for supporting continued competence of the health care workforce (Bluestone, Johnson, Fullerton *et al.*, 2013:1). Nurses' in-service training plays an indispensable role in improving quality patient care, therefore, the use of in-service training to enhance support of NQRNs is

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an inevitable requirement. In-service training as a support approach benefits both the organization and employees. The organization's goals and employees' interests are met through in-service training. Through in-service training for NQRNs, the institution is investing in improving productivity and retaining nurses while developing their career resulting in job satisfaction and thus preventing attrition of nurses (Chaghari, Saffari, Ebadi & Ameryoun, 2017:26).

Norushe, Van Rooyen & Strupher (2004:65) indicated that in-service training is deliberately planned to close the available gap in technical and scientific information by teaching techniques and procedures that NQRNs should execute in their new RN role. Participants perceived the existing in-service training programme as inadequate as it excluded NQRNs. They experienced in-service training as addressing the needs of junior categories only. This predisposed them to job stress and dissatisfaction. Hence, NQRNs were suggestive of specific time to be taught basic lifesaving skills in the unit. Below is a participant's concern:

> *"I think they must do the procedure services that they do for the junior categories, because…you find that on Wednesdays they say…there is hand washing…or…bed bath procedure at Chapel…but I have never seen them calling the professional nurses to come to be serviced for their duties." (**FG1, P1, Female**).*

Letlape, Koen, Coetzee & Koen (2014:2) referred to in-service training as an informal on the job training focusing on improving NQRNs' professional knowledge, skills and attitudes based on the unit needs. Some of the purposes of in-service training is to rectify shortfalls in the NQRNs' knowledge, skills, attitudes and values, to prepare NQRNs for new developments in nursing services as well as for proactive risk management (Muller, 2009:351). Participants' concerns were based on the acquisition of new knowledge and skills to meet nursing units' demands and to prevent

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complications by being proactive, for example, knowing how to resuscitate the patient in case of an emergency. Below are their raised concerns which confirmed that NQRNs need ongoing in-service training:

> *"Maybe if every morning or every day we can have the…ward in-service about the conditions which we usually get on that specific unit maybe we… can change or we can learn more…." (**FG3, P5, Female**).*

> *"I think even programmes that can be done to every new qualified professional nurse because we don't have like programmes like resuscitation as an example, if each professional nurse can know how to resuscitate you know that is a lifesaving procedure…." (**FG8, P9, Female**).*

> *"Some of us we are not exposed to the resuscitation. So, I think on Wednesdays we can ask our supervisors to teach us because you find that sometimes…you are with the doctor and then there is a very ill patient and you are the only sister at that time and then when they call for emergency then you just stand and do nothing…." (**FG8, P7, Female**).*

> *"The type of support that I think should be provided in the future is in-service training because mostly when we go to the ward we don't know most of the things there. So, we need to be trained on what to do and what to expect so that we can act accordingly." (**FG8, P8, Female**).*

In their study, Chaghari *et al.* (2017:30) revealed that participative management is important. NQRNs should be part of the design and implementation of in-service training programmes to render the content materials desirably proportionate to the needs and desires of NQRNs. The content materials should be practical and proportionate to NQRNs' job description, hence, they should be part of the planning

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and implementation of the in-service training programme. Additionally, authors incorporated clinical performance monitoring to promote the professional knowledge and skills of NQRNs (Chaghari, 2017:30). Hence, participants in this study, deemed it necessary to recommend for evaluation and monitoring team of managers as follows:

> *"The management must have a team that will also, monitor us that are we practicing what we have learned after we have passed the professional nurse after we have received our results so when we want in-service training…we must also, contact the team of management that we need in-service training for this and this. That will help us to do quality care to our patients." (**FG5, P7, Female**).*

Similarly, Letlape *et al. (*2014:4), in their study on the exploration of in-service training needs of psychiatric nurses, reported that participants raised aspects which confirmed that psychiatric nurses need on-going in-service training. In-service training is a professional and personal educational activity for NQRNs to improve their efficiency, ability, knowledge and motivation in their professional work (Omar, 2014:2). In-service training can also, change the attitude and skills of NQRNs and further increase their performance and thus improves patients' outcomes.

4.4 Conclusion

Chapter 4 focused on the interpretation of the data collected from the eight (8) FGIs composed of NQRNs within their first eighteen (18) months in their new RN role from each selected hospital in Vhembe and Mopani districts of Limpopo Province. Collected data were based on the objectives of Phase 1A as outlined in Table 3.1. Newly Qualified Registered Nurses felt overwhelmed with high responsibility and extended scope of practice. Registered nurse roles were perceived as highly demanding. Newly Qualified Registered Nurses felt that the support they received from the senior experienced RNs and unit nurse managers was insufficient, as they were neither

mentored nor properly supervised and the environment was not conducive for career advancement. Therefore, a model to enhance their support is imperative. Chapter 5 focuses on the interpretation of the findings of Phase 1B.

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CHAPTER 5

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE QUANTITATIVE RESULTS

5.1 Introduction

Chapter 4 presented the findings of qualitative research of Phase 1A. In this chapter, the data analysis and interpretation of the quantitative findings is presented. The quantitative research in Phase 1B covered the objectives illustrated in Figure 5.1.

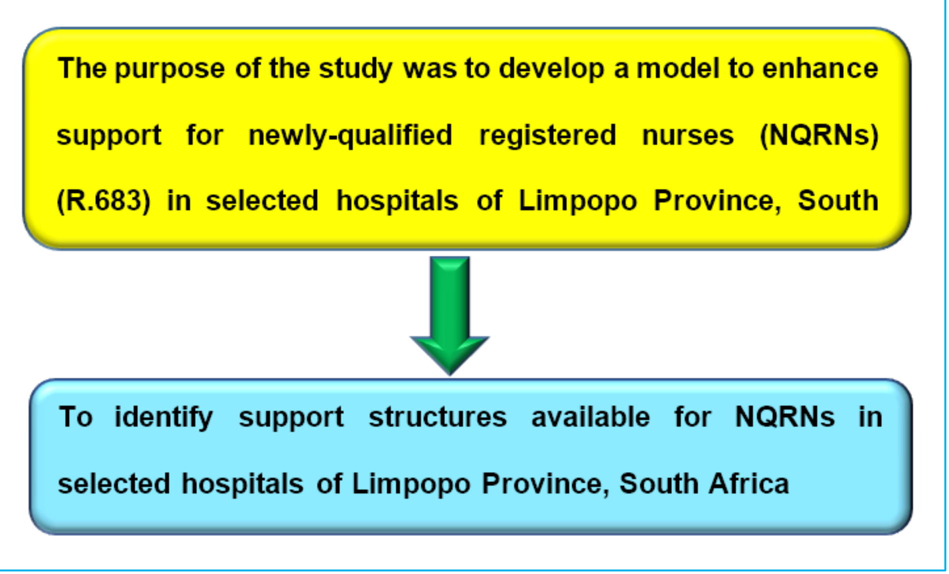

Figure 5.1: Schematic representation of Phase 1B objectives

The data were collected between May 2019 and July 2019 using a questionnaire. The population consisted of four-hundred and seventy (470) experienced RNs and nurse managers who had five years and above work experience as RNs.

No sampling was done due to the small number of respondents who were willing to be part of the study, and the total population sample was adopted. A total of three hundred (300) questionnaires were distributed, and two hundred and sixty-five (265) completed questionnaires were returned, ten were returned incomplete and twenty-five were not returned. The analysis was based on the 265 returned completed questionnaires.

5.2 Analysis of Demographic Data from Section A

Section A of the questionnaire presents the respondents' demographic data, that is, age, gender, population group, ethnic group, nationality, marital status, years as registered professional nurse, current position in the nursing position, years working in current position, highest academic qualification, days and hours work per week and unit allocated in. The demographic data were analyzed to give the reader a picture of the sample.

5.2.1 Age Distribution

Of the 265 respondents, the ages of respondents were between 25 and 65 years. It was established from the data obtained that the largest group was between 51 and 55 years (n=60, 22.64%). The smallest age group was older than 61 years (n=7) which accounted for 2.64%. Other age groups were between 46-50 years (n=53, 20%), 41-45 years (n=50; 18.87%), 36-40 (n=36, 13.58%), 56-60 years (n=26, 9.81%), 31-35 years (n=20, 7.55%) and 25-30 years (n=13, 4.91%). The results are presented in Table 5.1.

5.2.2 Gender Distribution

Of the 265 returned questionnaires for respondents, 89.4% (n=237) were females and 10.6% (n=28) were males as presented in Table 5.2. It is evident that nursing is a female-dominated profession.

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Table 5.1: Age distribution of the respondents (n=265)

Age in years (n=265)	Frequency	Percentage	Cumulative
25-30	13	4.91	4.91
31-35	20	7.55	12.45
36-40	36	13.58	26.04
41-45	50	18.87	44.91
46-50	53	20.0	64.91
51-55	60	22.64	87.55
56-60	26	9.81	97.36
61 and above	7	2.64	100.00
Total	**265**	**100.0**	

According to the statistics provided by the South African Nursing Council (SANC) for the year 2017, the numbers of female nurses superseded those of male nurses by far. The total number of female nurses for Limpopo Province in 2017 was 25 700 while the total number of male nurses was 3 019. This confirms how skewed the South African nursing profession is in terms of gender (Table 5.3).

Table 5.2: Gender distribution of the respondents (n=265)

Gender	Frequency	Percentage	Cumulative
Female	237	89.43	89.43
Male	28	10.57	100.00
Total	**265**	**100.00**	

Table 5.3: Number of female and male nurses in each category for Limpopo Province

Gender	Registered	Enrolled	Auxiliaries	Total
Female	10 567	5 833	9 300	25 700
Male	1 549	645	825	3 019
Total	**12 116**	**6 478**	**10 125**	**28 719**
(SANC Provincial Distribution 2017)				

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Table 5.4 shows that most of females were aged between 51-55 years (n=54; 90%), followed by age group 46-50 years (n=52; 98.1%), 41-45 years (n=45; 90%), age group 36-40 years (n=32;88.9%), age group 56-60 years (n=23; 88.46%), age group 31-35 years (n=15; 75%), age group 25-30 years (n=9; 69.23%) and age group above 61 years (n=7; 100%).

Table 5.4: Cross tabulation of age and gender of respondents

Age group	Females		Males		Total
	N	%	n	%	N
25-30	9	69.23	4	30.77	13
31-35	15	75	5	25	20
36-40	32	88.9	4	11.1	36
41-45	45	90	5	10	50
46-50	52	98.1	1	1.9	53
51-55	54	90	6	10	60
56-60	23	88.46	3	11.54	26
61 and above	7	100	0	0	7
Total	**237**		**28**		**265**

5.2.3 Population Group

Demographic Statistics of South Africa identified the majority (80%) of the South African population as Black African and White population group represented about 10% population distribution (Statistics SA General Household Survey, 2014:72). In this study, the Black African population is in the majority (n=264) accounting to 99.6% and the White population was the least (n=1), 0.4%. The results are presented in Table 5.5.

5.2.4 Ethnic Group

Of the 265 respondents, the majority were Vatsonga (n=145; 55%), followed by

Basotho (n=65; 25%), Vhavenda (n=49; 18%), Batswana (n=3; 1%), Bapedi (n=2; 0.75%) and Afrikaner (n=1; 0.38%) as presented in Table 5.6.

Table 5.5: Population group of the respondents (n=265)

Population Group	Frequency	Percentage	Cumulative
Black/African	264	99.62	99.62
White	1	0.38	100.00

Table 5.6: Ethnic group of the respondents (n=265)

Ethnic Group	Frequency	Percentage	Cumulative
Afrikaner	1	0.38	0.38
Bapedi	2	0.75	1.13
Batswana	3	1.13	2.26
Basotho	65	24.53	26.79
Vatsonga	145	54.72	81.51
Vhavenda	49	18.49	100.00
Total	**265**	**100.00**	

5.2.5 Nationality

All of the respondents (n=265) were South Africans.

5.2.6 Marital Status

Table 5.7 shows that the majority 55% (n=146) of respondents were married, followed by 32% (n=84) who were single, 8.7% (n=23) were divorced, 1.8% (n=5) were living together, 1.5% (n=4) were widowed and 1% (n=3) were never married.

5.2.7 Years of Experience as a Registered Professional Nurse

Of the 265 respondents, 27.2% (n=72) indicated that they have between 5 and 9 years as RNs similarly the other 27.2% (n=72) reported to be having between 10 and 15

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years, 13.6 (n=36) have between 16 and 20 years, 17% (n=45) have between 21 and 25 years, 8.0% (n=22) have between 26 and 30 years, while 7% (n=18) reported to be having 31 years and above experience as presented in Table 5.8.

Table 5.7: Marital Status of the respondents (n=265)

Marital Status	Frequency	Percentage	Cumulative
Divorced	23	8.68	8.68
Living Together	5	1.89	10.57
Married	146	55.09	65.66
Never married	3	1.13	66.79
Single	84	31.70	98.49
Widow	4	1.51	100.00
Total	**265**	**100.00**	

Table 5.8: Years of experience as registered professional nurse (n=265)

Years	Frequency	Percentage	Cumulative
5-9	72	27.17	27.17
10-15	72	27.17	54.34
16-20	36	13.58	67.92
21-25	45	16.98	84.91
26-30	22	8.30	93.21
31 and above	18	6.79	100.00
Total	**265**	**100.00**	

5.2.8 Current Position in the Nursing Profession

The majority of respondents (n=222; 83.77%) indicated that they were currently practicing as experienced RNs supervising units, followed by 16.23% (n=43) who were practicing in a nurse manger's position (Table 5.9).

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Table 5.9: Current position in the nursing position of the respondents (n=265)

Current Position	Frequency	Percentage	Cumulative
Experienced professional nurse	222	83.77	83.77
Nurse manager	43	16.23	100.00
Total	**265**	**100.00**	

5.2.9 Years Working in Current Position

As shown in Table 5.10, the majority of respondents were experienced RNs (n=11; 49.5%) supervising units for 5-9 years, while 44.18% (n=19) of the respondents were in a managerial position for 10-14 years.

Table 5.10: Years of experience working in current position of the respondents (n=265)

Years	Experienced Registered Nurse	Percentage	Nurse Manager	Percentage	Total
1-4 years	3	1.35	0	0	3 (100.00%)
5-9 years	110	49.5	9	20.9	119 (100.00%)
10-14 years	59	26.57	19	44.18	78 (100.00%)
15-19 years	16	7.20	5	11.62	21 (100.00%)
20-24 years	29	13.06	7	16.27	36 (100.00%)
25-29 years	3	1.35	3	1.35	6 (100.00%)
30-34 years	1	0.45	0	0	1 (100.00%)
35-39 years	1	0.45	0	0	110 (100.00%)
Total	**222**	**83.77**	**43**	**16.23**	**265 (100.00%)**

5.2.10 Highest Academic Qualification (n=265)

Table 5.11 shows that majority of respondents (n=99; 37.36%) had diploma in nursing with midwifery, followed by 26.04% (n=69) with diploma in nursing only, 23.02% (n=61) had degree in nursing with speciality, 8.7% (n=23) had degree in nursing, 3.4% (n=9) had diploma in nursing with speciality, 1.13% (n=3) had a master's degree and 0.38% (n=1) had a doctorate.

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Table 5.11: Highest academic qualification of the respondents (n=265)

Qualification	Frequency	Percentage	Cumulative
Diploma in nursing	69	26.04	26.04
Diploma in nursing with midwifery	99	37.36	63.40
Diploma in nursing with speciality	9	3.40	66.80
Degree in nursing (nursing admin & educ)	23	8.68	75.48
Degree in nursing with clinical speciality	61	23.02	98.50
Master's degree	3	1.13	99.63
Doctoral degree	1	0.38	100.00
Total	**265**	**100.00**	

According to the educational qualification, nurses that are experienced in supervisory or leadership roles had qualifications and background experience by years of service in the field. Among the respondents there were graduate nurses and those with clinical speciality which may create a conducive work environment if the skills are correctly applied.

Nurse leaders who occupy these positions must display certain characteristics, such as: having skills in interpersonal relationships, possessing the ability to make decisions, flexibility, creativity and innovation, as well as supporting and facilitating the development of work processes. Leadership, when grounded in knowledge and in technical, administrative and relational abilities strengthens the team competencies and creates security in the performance of activities (de Moura, Inchauspe, Dall'Agnol, de Magalhães & Hoffmeister, 2013:199).

5.2.11 Days Work Per Week

In terms of the number of days, as indicated in Table 5.12, 95.09% (n=252) of the respondents work 1-5 days per week and 4.91% (n=13) work 6-7 days per week.

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Table 5.12: Days work per week by the respondents (n=265)

Days	Frequency	Percentage	Cumulative
1-5 days	252	95.09	95.09
6-7 days	13	4.91	100.00
Total	**265**	**100.00**	

5.2.12 Hours Work Per Week

In terms of the number of hours, as indicated in Table 5.13, 99.25% (n=263) of the respondents work 40 hours per week and 0.75% (n=2) work 45 hours per week.

Table 5.13: Hours work per week by the respondents (n=265)

Hours	Frequency	Percentage	Cumulative
40 hours	263	99.25	99.25
45 hours	2	0.75	100.00
Total	**265**	**100.00**	

5.2.13 The Unit Where Respondents Were Working

Table 5.14 indicates that the majority of respondents (n=50; 18.87%) were stationed in the Medical Units, followed by 17.36% (n=46) working in Surgery Units, 12.08% (n=32) worked in Casualty, 11.32% (n=30) worked in TB and Gynaecology Units, 10.19% (n=27) worked in Outpatients Departments (OPD), 9.43% (n=25) worked in Paediatric Units, 4.91% (n=13) worked in Operating Theatres, 1.89% (n=5) worked in Nurse Manager's Offices, 1.50% (n=4) working in Psychiatric/Mental Health Care Units (MHCU) and 1.13% (n=3) worked in Intensive/High Care Units (ICU). Managers and experienced professional nurses placed in different units in order to mobilize the activities of the units in line with organizational goals. In the traditional organization of working groups, the figure of the person who directs, coordinates, supervises, controls, teaches and monitors those who make up the team managers. Furthermore, the nurse

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who is responsible for the important role of manager of the nursing staff, in the everyday situations on the unit, is an essential professional member of the group, in the search for attending to the needs of the service (de Moura *et al*, 2013:199).

Table 5.14: Unit where respondents stationed (n=265)

Unit	Frequency	Percentage	Cumulative
Surgical	46	17.36	17.36
Medical	50	18.87	36.23
TB	30	11.32	47.55
Casualty	32	12.08	59.63
Gynaecology	30	11.32	70.79
OPD	27	10.19	81.14
Paediatric	25	9.43	90.57
Operating Theatre	13	4.91	95.48
MHCU	4	1.50	96.98
ICU	3	1.13	98.11
Nurse Manager's Office	5	1.89	100.00
Total	**265**	**100.00**	

5.3 Analysis of Respondents' Knowledge of Nurse Manager's Management Role

Section B consisted of six questions which were objective type and close-ended in nature.

- **Question 1.1: Kind of Support being Provided to Newly-Qualified Registered Nurses When Managing the Unit (n=265)**

According to the responses, the majority of the respondents (n=245; 92.45%) reported mentorship, constructive feedback, preceptorship and coaching as the types of support being provided to NQRNs when managing the unit. Conversely, 4.15% (n=11) indicated similar support as above, but also included learning through trial and error, 3.02% (n=8) did not consider any given support to be used, while 0.38% (n=1)

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considered learning through trial and error as an only option (Table 5.15).

Table 5.15: Kind of support provided (n=265)

Support	Frequency	Percentage	Cumulative
Mentorship, constructive feedback, preceptorship and coaching	245	92.45	92.45
Mentorship, constructive feedback, preceptorship, coaching and trial and error	11	4.15	96.60
None of the above	8	3.02	99.62
Trial and error	1	0.38	100.00
Total	**265**	**100.00**	

Wagner (2018:218) indicated that nurse managers are expected to provide inspiration, guidance, and direction to nurses and other health care providers. They should supervise and influence the professional practice of the largest number of frontline nurses. Furthermore, the authors reiterated that nurse managers should constantly balance their responsibilities and accountabilities between the unit staff and the senior leadership as it will increase job satisfaction and decrease nurse turnover. In this study, majority of the respondents (n-245; 92.45%) indicated that mentorship, constructive feedback and coaching are provided this affirm that they are knowledgeable of their management role.

Question 1.2: What Management of the Unit Includes (n=265)

The majority of respondents (n=235; 88.7%) indicated patient care, personnel and material resources, supervising and teaching as managerial functions of the unit, 1.5% (n=4) indicated financial management only, 0.4% (n=1) indicated dictating to subordinates and 9.4% (n=25) indicated planning and organizing.

The nursing unit manager is responsible for the management of: patient care, all nursing staff within the unit, and resources associated with health care delivery in the

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unit (Armstrong, Rispel & Penn-Kekana, 2015:2). However, 0.4% (n=1) indicated dictatorship, which is not conducive to building teamwork required to improve work processes. This small number suggest that majority of the respondents understand their role as unit nurse managers.

Question 1.3: Management Functions Executed Daily to Support NQRNs (n=265)

Understanding RNs' and nurse managers' perceptions regarding day-to-day managerial functions will add value to the researcher's insight concerning what should be done to enhance support for the NQRNs within their first eighteen months of employment in a new role. The majority of respondents (n=235; 88.68%) indicated planning, organizing, leading and controlling, and 3.40% (n=9) indicated planning, organizing, leading, controlling and punishing staff, while 0.38% (n=1) indicated punishing staff only. The findings indicate management processes as being well-known, however, very few or less indicated punishment, which is generally regarded as negative by observers. However, Arvey & Jones (1985:370) suggested that social learning is a key function of organizational punishment. The authors indicated that personnel who observe someone being punished are less likely to engage in prohibited activity. Social learning from a punishment event will increase with the credibility and attractiveness of the supervisor and with the perceived similarity of the punished individual (Bandura, 1986).

A nurse manager is responsible and accountable for the day-to-day operations of the workplace. This includes employee selection, hiring, orientation, staff development and evaluation, resource allocation and management, risk management, patient safety, and financial accountability, among others (Wagner, 2018:217). Blevis & Vrba (2014) also concurred that all managers, regardless of the type of organization, should be engaged in four fundamental interrelated activities called management functions

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(planning, organizing, leading and controlling) to achieve organizational goals.

Question 1.4: Support Provided When NQRNs Perform Four-Fold Function (n=265)

The majority of of respondents (n=253; 95.47%) indicated the use of teachable moment or on the spot teaching as a form of support, while 3.02% (n=8) indicated daily rating of newly-qualified nurses' performance and 1.51% (n=4) indicated that they assist NQRNs to work according to their scope of practice.

Question 1.5: Support Provided to NQRNs When Drawing Duty Schedule for the Unit (n=265)

Of the respondents, 87.55% (n=232) indicated that they oversee the NQRNs' activities and guide them where there is a need. However, 7.92% (n=21) stated that they assist them to apply principles when drawing duty schedule, and 4.52% (n=12) reported that they advise NQRNs to follow their scope of practice. Literature affirmed that when the departmental rostering was delegated to newly qualified registered nurses may be authorised by the unit nurse manager prior release to the unit staff (Silvestro & Silvestro, 2000:527).

Question 1.6: Support Provided to NQRNs When Writing Delegation for the Unit (n=265)

Most of the respondents (n=232; 87.55%) indicated that they oversee the NQRNs' activities and guide them where there is a need, 7.92% (n=21) stated that they assist them to apply principles when writing delegating, and 4.52% (n=12) reported that they assist NQRNs to follow their scope of practice. Delegation or assignment of duties requires competency to facilitate unit effectiveness and efficiency of patients' assignment and requires that managers delegate effectively to improve skill development. Dubois & Singh (2009:2) indicated that skills management enables

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organizations to optimize patient outcomes while ensuring the most effective, flexible and cost-effective use of human resources. Wagner (2018:99) specified that the main important principle of delegation is the accountability of unit nurse managers (UNMs) to monitor the performance and completion of the delegated task.

Regular communication between the nurse manager and the NQRN is required during the initial delegation of task, throughout the performance until the completion of the delegated task (Wagner, 2018:99). Muller (2009:127) asserted that although the responsibilities are delegated, the delegator (UNM) remains accountable for the tasks s/he delegated. Though the employee who accepted the task is also personally accountable for the performance and the consequences of this performance the UNM must ensure that the employee can perform the task by exercising necessary guidance, supervision and control (Muller, 2009:128).

5.4 Analysis of Support Measures Provided to NQRNs by Experienced Registered Nurses or Nurse Managers (n=265)

Section C consisted of forty-four (44) closed-ended questions. These questions were described under the following four management functions: Planning, Organizing, Directing or Leading and Control. Data collected from first-line nurse managers were meant to provide the respondents' insight about support measures provided to NQRNs. Unit nurse managers play an important role in an organization's success as they are significantly involved in the day-to-day operations, guiding the employees through daily activities to help them accomplish the organizational goals. To do so successfully, management skills such as planning, organizing, directing, and controlling are required from every first-line manager (Luu, 2012:97). Management skills refer to a set of capabilities that includes the process of planning, organizing, directing or leading and controlling through utilization of various available organizational resources to accomplish the set organizational goals or performance

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objectives (Cherie, 2005:3; Beauvais, 2019:34).Tables 5.14 to 5.17 depict respondents' ratings of support measures provided to NQRNs by first-line nurse managers. The ratings were categorized as 'always', 'sometimes' and 'never'. The respondents' ratings were added and reflected in numbers and percentages. Scores for each item were combined and reflect the sufficiency of support measures provided.

5.4.1 Respondents' Ratings of the Provision of Support Measures on Their Planning Function

Most of the respondents (55.80%) pointed out that they always plan for the provision of support measures to NQRNs. Respondents perceived themselves as providers of support measures either sometimes (36.90%) or not providing (7.30%) support measures at all (Table 5.16). In item 1, the majority (n=178; 67.20%) pointed out that they have written vision, mission, philosophy and services standards, however, in item 2, 53.96% (n=143) were uncertain.

Chase (2010:9) affirmed that nurse managers have major responsibility for the implementation of the vision, mission, philosophy, core values, evidence-based practice standards of the organization, and nursing services within their defined areas of responsibility. Concealing information from NQRNs by first-line nurse managers could jeopardize quality patient care and smooth running of the unit due to lack of knowledge of the interpretation of the vision, mission, philosophy and services standards. Carrig & Snell (2020:40) indicated that it's easy for an employee to feel lost and become disengaged when they don't understand where they fit in the organizational hierarchy.

But when their goals are aligned with those of the company, they see the impact of their actions. It gives everyone a role to play and promotes accountability while providing natural points for recognition and celebration of good work. In item 3, majority 77.7% (n=206) agreed that they have teaching programme, and 61.51% (n=163)

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indicated that they have structured delegation of specific duties in item 4. This means that written support measures were available for NQRNs in the units. These provide NQRNs an opportunity to refer to these structures while performing in their new role. Nursing unit managers have the responsibility to fulfil the role of teacher, consultant, clinician and manager.

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Table 5.16: Respondents' ratings of their planning function (n=265)

Items from questionnaire: Reflected in percentages (n=265)	Always n & %	Sometimes n & %	Never n & %	Valid n & %
1. The unit has written vision, mission, philosophy and service standards.	178 67.20	77 29.00	10 3.80	265 100
2. All employees including the new ones have insight of the unit vision, mission, philosophy and service standards.	111 41.89	143 53.96	11 4.15	265 100
3. There is a written teaching programme to guide in achieving quality patient care.	206 77.70	51 19.30	8 3.00	265 100
4. There is a structured written delegation of specific duties to be performed by personnel.	163 61.51	90 33.96	12 4.53	265 100
5. There are enough staff in the unit compared with number of patients.	6 2.00	195 74.00	64 24.00	265 100
6. There are enough supplies and time required to ensure provision of quality patient care and effective unit management.	104 39.25	132 49.81	29 10.94	265 100
7. NQRNs are allocated and guided to:				
7.1 Write delegation of duties for unit staff.	133 50.19	97 36.60	35 13.21	265 100
7.2 Write duty roster/duty schedule/off-duties.	131 49.00	105 40.00	29 11.00	265 100
7.3 Order and control unit stock/supplies.	172 65.00	82 31.00	11 4.00	265 100

Continued/…

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Table 5.16: Respondents' ratings of their planning function (n=265) (continued)

Items from questionnaire: Reflected in percentages (n=265)	Always n & %	Sometimes n & %	Never n & %	Valid n & %
7.4 Conduct nursing audits and write unit improvement plans.	197 74.34	63 23.77	5 1.89	265 100
7.5 Draw and coordinate unit teaching programme.	166 62.60	84 31.70	15 5.70	265 100
8. There are climate meetings organized and conducted in the unit.	196 73.96	65 24.53	4 1.51	265 100
9. During climate meetings all available staff discuss their feelings and concerns.	126 47.60	115 43.40	24 9.00	265 100
10. Staff members are informed about value clarification.	139 52.46	100 37.74	26 9.80	265 100
11. Any identified conflict among staff members is resolved as soon as possible.	166 62.64	88 33.21	11 4.15	265 100
12. Remedial action is provided to counteract any identified negative outcomes.	201 75.85	55 20.75	9 3.40	265 100
13. There is promotion and encouragement of teamwork and co-determined decision-making and problem-solving in the unit.	190 71.70	69 26.04	6 2.26	265 100
14. There are debriefing sessions arranged for all staff members in case of stressful events like death under their care.	79 30.00	146 55.00	40 15.00	265 100
Average (%)	**55.80**	**36.90**	**7.30**	**100**

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There is an acknowledgment that they are responsible for creating and sustaining a positive learning environment that will provide appropriate teaching and learning opportunities in the clinical setting (Duffield, Wood, Franks & Brisley, 2001:245). However, in item 5, 74.00% (n=195) indicated 'sometimes' in the provision of enough staff compared with number of patients, meaning that they do not regard it as a norm to ensure that there are enough staff in the unit considering number of available patients. If there is no balance between the provision of nurses and the demand of care required, it can negatively affect the effectiveness in providing patient care. Poor nurse patient ratio leaves NQRNs unsatisfied and stressed with their job.

Sharma (2009:108) revealed that the majority (68%) of nurses in governmental hospitals felt dissatisfied due to poor nurse patient ratio. Inadequate staffing, nursing shortage and high patient-to-nurse ratio can jeopardize quality care and safety (Jarrar, 2015:330). A lower nurse-to-patient ratio results in a greater workload and poorer quality of care due to time pressures that affect a person's ability to implement best-practice standards. Several empirical studies and systematic reviews support this hypothesis and indicate that the numbers of nurses in a unit and the number of nurses per patient affect patient outcomes, including adverse events, readmissions and mortality (Dubois & Singh, 2009:3). Furthermore, nurses who are managing too many patients are at risk of becoming stressed out and making medical mistakes because of patient overload (Jarrar, 2015:326). This could mean that changes in a patient's condition as well as identification of medical errors and adverse events may go unnoticed (Hennerman, Gawlinski & Giuliano, 2012:e9). High patient-to-nurse ratios are strongly associated with emotional exhaustion, job dissatisfaction, and fatigue or burnout. Burnout has negative impact on nurses' performance and thus impede quality patient care putting patients' well-being and lives in danger (Heinen, Achterberg, Schwendimann, Zander & Matthews *et al.*, 2013:174).

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Burnout can be described by symptoms such as irritability, insomnia, headaches, backpain, weight gain, depression, and high blood pressure. Khamisa, Oldenburg, Peltzer & Ilic (2015:653), Laschinger, Wong & Grau (2013:541) and Mokhtar, Shikieri, Taha & Rayan (2019:34) affirmed that high workload and job demands, poor supervision and lack of support are associated with poor physical and mental outcomes. In their cross-sectional study conducted in ten (10) European countries, Heinen *et al. (*2013:174) revealed that nurses' intention to leave the profession was linked to burnout.

Burnout can be worsened by time pressure while performing tasks in the new role without adequate support measures. The key challenge of first-line nurse managers is the limited availability of time, this might be due to performance of numerous fragmented activities in the unit (Armstrong, Rispel & Penny-Kekana, 2015:8). Hence, when asked whether there are enough supplies and time required to ensure provision of quality patient care they reported *Sometimes*. Of the two hundred and sixty-five first-line nurse managers, the majority (n=132; 49.81%) pointed out that supplies and time required are insufficient. Material resources are important in mobilizing the effectiveness of patient care. Proper planning of first-line managers include procurement of supplies and utilization of time effectively. Armstrong *et al. (*2015:2) asserted that the UNM is held accountable for management of stock and equipment, especially in institutions where there are no specific departments to deal with unit supplies.

When it comes to work procedures from items 7.1 to 14, the majority of respondents reported *Always*. This means that NQRNs are supported in work procedures such as administrative tasks of delegation (n=133; 50.19%), designing duty roster (n=131; 49%), requisition (n=172; 65%), planning climate meetings (n=196; 73.96%) and conflict resolution (n=166; 62.64%). These activities provide NQRNs with the

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competencies required so that they develop skills, and this can be achieved through teamwork. Teamwork in health care is a way to organize the practice for a broad approach to health needs (de Souza, 2016:641). Lack of teamwork among nursing staff affects care delivery and unit operations (Kalisch & Begeny, 2005:550). The enhancement of teamwork among nursing staff is a universal goal of every nurse manager, hence, 71.70% (n=190) of unit nurse managers in item 13 pointed out that *Always* there is promotion and encouragement of teamwork, and co-determined decision-making and problem-solving in the unit. Kalisch, Curley & Stefanov (2007:77) stated that highly functioning teams have been shown to offer a wide range of support to inexperienced staff. Similarly, Korniewicz (2015:62) maintained that highly functional teams recognize potential problems, adjust their strategies accordingly and provide mutual support to each other.

Interestingly, though respondents indicated that climate meetings are organized and conducted in the unit, 47.55% (n=126) pointed out that all staff are *Always* free to discuss their feelings and concerns during the meeting, while 43.40% (n=115) indicated *Sometimes* in item 9. This is of concern because the results were below 50% for both, which shows that the work climate or relationships may be strained and staff members are either or not able to air their concerns.

Nursing staff in the unit encounter many unpredictable challenges such as sudden death, violence and overcrowding daily predisposing them to high levels of stress and burnout than other medical profession (Akbar, Elahi, Mohammadi & Khoshknab, 2017:199). In item 14, the findings indicate that debriefing sessions are not provided as reported by the majority 55% (n=146) of the respondents. Debriefing in nursing practice is important for emotional and psychological health of the nursing team. In their cross-sectional descriptive study conducted on 156 Western Australian emergency nurse, Ross-Adjie, Leslie & Gillman (2007:122) found that almost 60% of

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the 156 nurses reported that debriefing is not routinely offered and could be inadequate or non-existent. In addition, it was noted that there is often insufficient time within busy acute areas to participate in lengthy debriefs post critical incidents and a lack of clear guidance and policy may be a further barrier. Generally, in most units in public health care institutions there are no clear guidelines for debriefing (Clark & McClean, 2018:79).

5.4.2 Respondents' Ratings of the Provision of Support Measures on Their Organizing Function

In the organizing function, 58.43% of the respondents *Agree* that they organize for the provision of support measures to NQRNs, 33.34% *Somewhat Agree* with the statement, while 8.23% stated *Never* (Table 5.17). Respondents perceived themselves as effective organizers where 54.34% (n=144) in item 15 attested that the unit has a well-structured organogram, 52,83% (n=140) in item 16 indicated that the unit has adequate personnel per shift while 44.15% (n=117) indicated sometimes and in item 19, the majority 81.44% (n=215) of respondents *Agree* to providing and explaining job descriptions to NQRNs on arrival to the new position.

This shows that NQRNs were supported by the presence of senior experienced nurses who provided them with job descriptions and explained to them on arrival as well as sharing experience and expertise with them. These activities show that NQRNs have support structures in place. When NQRNs feel supported they are satisfied with their job, motivated and encouraged to perform better.

Hung, Cant & Wild (2016:233) emphasized that clarifying expectations upfront and clearly, and indicating the performance requirements of a job is good management practice. When employees do not have a clear purpose, they tend to lack enthusiasm and are less likely to become involved or take on new responsibilities.

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Table 5.17: Respondents' ratings of their organizing function (n=265)

Items from questionnaire: Reflected in percentages (n=265)	Always n & %	Sometimes n & %	Never n & %	Valid n & %
15. The unit has a well-structured organogram with all unit staff included.	144 54.34	76 28.68	45 16.98	265 100
16. The unit has adequate personnel per shift.	140 52.83	117 44.15	8 3.02	265 100
17. New employees are delegated based on their scope of practice, competencies, personal and professional development needs.	95 35.85	156 58.87	14 5.28	265 100
18. There is consideration of skill mix when delegating new employees or junior nurses with senior staff members.	172 64.90	80 30.20	13 4.90	265 100
19. All new employees are given and explained their job descriptions on arrival by a senior member of the staff.	215 81.44	27 10.23	22 8.33	265 100
20. There is an orientation policy in the unit.	299 86.40	35 13.20	1 0.40	265 100
21. The unit has a structured orientation programme in place.	189 71.32	45 16.98	31 11.70	265 100
22. Senior members of the staff mentor, coach, guide and support NQRNs in the unit.	100 37.70	138 52.10	27 10.20	265 100
23. NQRNs are part of unit Standard Operating Procedures formulation team.	109 41.13	121 45.66	35 13.21	265 100
Average (%)	**58.43**	**33.34**	**8.23**	**100**

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However, in item 17, the majority (n=156; 58.87%) of the respondents pointed out that NQRNs are *Sometimes* delegated according to their scope of practice focusing on their competencies, personal and developmental needs. This means that the majority of unit nurse managers do not delegate accordingly and either NQRNs (R.683) may be under-utilized or over-utilized resulting in work stress and fatigue. Being allocated patients with complex acuity beyond NQRNs (R.683)' scope has a negative impact on their confidence and engagement (Phillips, Kenny, Esterman & Smith, 2014:108). Nurses who are overworked often present with sickness, absenteeism due to psychological and emotional stress, eating disorders, etc., resulting in poor organization in the unit.

The unit nurse manager oversees the coordination of the unit's daily workload, and ensures that responsibilities are allocated appropriately and fairly, and that there is adequate skills mix to render quality service (Clement, 2015:24). Inadequate staffing per shift sometimes result in inappropriate skill mix forcing NQRNs to take charge prematurely (Halpin, Terry & Curzio, 2017:2584). However, in item 18, the majority of unit nurse managers (n=172; 64.90%) *Agree* that they consider skills mix when delegating new employees with senior staff members.

Furthermore, the findings show that there is orientation policy and structured orientation programme in place (items 20 and 21). Strauss, Ovnat, Gonen, Lev-Ari & Mizrahi (2016:425) revealed that the availability of a structured orientation programme in the unit makes NQRNs feel satisfied, adapted and more perceived support. However, for the majority of first-line managers to *Agree* that there is orientation policy and structured orientation programme does not mean that orientation of NQRNs is practically implemented. Orientation plays a critical role in NQRNs' job satisfaction and retention (Morton, 2014:2). Therefore, the implementation of the orientation programme proved to be highly beneficial to the recruitment and retention of nurses to the nursing profession (Thies, 2011:11). Malouf & West (2012:12) affirmed that

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orientation which is done by pairing NQRNs with senior RNs who are familiar with the unit routine and unit environment makes it swiftly accomplished. In item 22, the majority (n=138; 52.10%) of the respondents pointed out that they do not always mentor, guide and support NQRNs in the unit. This indicates that there is poor support that may lead to medical error, poor interpersonal relations resulting in NQRNs not learning or having poor skills development and lack of interest and burnout. A high level of stress was reported among nurses with poor social relations existed in the workplace, lack of control and social support were found (Galdikiené, 2016:13).

Most respondents (n=121; 45.66%) *Disagree* that NQRNs form part of unit Standard Operating Procedures formulation team, while 41.13% (n=109) *Agree* that they do. This is below 50% for both which shows that engagement of NQRNs to unit activities is either or not considered. Lack of engagement can be frustrating, leading to poor performance and high turnover in the sight of NQRNs. Henderson, Ossenberg & Tyler (2015:225) reported similar findings. NQRNs need to feel to be part of the staff or team members. If they are not included in staff or unit matters, they become isolated and despondent. NQRNs are vulnerable to feelings of uncertainty and isolation (Malouf & West, 2011:9).

5.4.3 Respondents' Ratings of the Provision of Support Measures on Their Directing or Leading Function

Most respondents (64%) rated themselves as always performing the directing or leading function to support NQRNs in their new role. Of all the management functions, directing or leading achieved the highest rating of being supportive by the respondents, while 30% rated *Sometimes* and 6% *Never* (Table 5.18). Respondents perceived themselves as effective in performing their directing or leading function in the unit by indicating *Always*, the majority (n=215; 81.13%) in item 24 *Agree* that they perform formal orientation to NQRNs, 83.40% (n=221) in item 25 orientate NQRNs on patients'

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Table 5.18: Respondents' ratings of their directing or leading function (n=265)

Items from questionnaire: Reflected in percentages (n=265)	Always n & %	Sometimes n & %	Never n & %	Valid n & %
24. Formal orientation of new employees is done by senior member of the staff.	215 81.13	45 16.98	5 1.89	265 100
25. NQRNs are orientated on patients' profile, services rendered, protocols, policies and procedures to be followed to in the unit.	221 83.40	40 15.09	4 1.51	265 100
26. As NQRNs have previous nursing experience, they are orientated only if there is something new which they don't know.	140 52.83	86 32.45	30 14.72	265 100
27. NQRNs are given and guided to sign performance agreement on arrival in the unit.	229 86.42	22 8.30	14 5.28	265 100
28. Senior staff members are allocated to be on standby to assist NQRNs while on night shift.	184 69.40	67 25.30	14 5.30	265 100
29. NQRNs are allocated a mentor to support and guide them.	77 29.06	166 62.64	22 8.30	265 100
30. NQRNs are placed being in-charge of the unit prematurely to counteract shortage of staff.	89 33.60	151 57.00	25 9.40	265 100
31. Senior members of the staff coordinate the teaching programme.	177 66.80	80 30.20	8 3.00	265 100
32. Delegation is done by a senior member of the staff capable to apply the principles.	201 75.85	56 21.13	8 3.02	265 100
Average (%)	**64**	**30**	**6**	**100**

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profile, services rendered, protocols, policies and procedures, while 52.83% (n=140) in item 26 indicated that they orientate NQRNs only on new work procedures as they already possess prior nursing knowledge, 86.42% (n=229) in item 27 give and guide NQRNs to sign performance agreements, 69.40% (n=184) in item 28 *Agree* being on standby to assist NQRNs, 66.80% (n=177) in item 31 coordinate a teaching programme and 75.85% (n=201) in item 32 apply principles of delegation as senior nurses. All these activities show that first-line managers direct or lead NQRNs in the unit while preforming activities of their new role.

However, 62.64% (n=166) in item 29 show that though NQRNs require the support and guidance of the mentor, it is not practiced as a norm. Ogashi (2019:24) noted that due to many direct reports and other responsibilities, nurse managers struggle to find time to adequately coach and mentor their staff. The pressure of being expected to do more without support contribute to stress placed on NQRNs, and inability to deal with this eventually will lead to burnout.

In addition, the majority (n=151; 57%) of respondents reported that *Sometimes* NQRNs are being placed prematurely to be in-charge of units to counteract shortage of staff. NQRNs are switching from a protected role where they used to function under the direction of the RNs as ENs, need time to adapt to a change of identiting roles and responsibilities (Wong, Che, Cheng *et al*., 2018:30). Therefore, premature placement, can cause anxiety and stress. Gregg *et al*. (2013:158) indicated that a source of distress was the anxiety associated with making medical errors.

Parker, Giles, Lantry & McMillan (2014:155) indicated that the degree to which new graduates experienced horizontal violence resulting from poor staff attitudes, together with unfair treatment associated with rostering, deployment and workload, was also of major concern. Overall, they suggested that their experience would be improved

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through the provision of sustained genuine support, reduced workloads, less expectations in terms of excessive responsibility early in their first year, fairer treatment by senior staff, fairer rosters, greater choice of placement options and critical constructive feedback on their performance.

5.4.4 Respondents' Ratings of the Provision of Support Measures on Their Control Function

Eight activities related to control were assessed. The control function scored the lowest among the management functions: 35% indicated they *Always* provide control, while the majority (49%) indicated *Sometimes* and 16% *Never* (Table 5.19). Item 38 assessment and development of competency to maintain standards and 53% (n=114) and item 39 under supervision, direction and correction that is motivating and not punitive was rated by 55% (n=146) as *Sometimes* which indicates that these are not a regular behaviour or practices in the institution, simply implying that performance management is poor or lacking which contradicts with item 33 where 55% (n=147) indicate that there is monitoring.

The results show that there is poor supervision where NQRNs are not directed nor corrected when performing activities in their new role. Lack of direction and correction result in poor motivation and empowerment. This is some of the severe stressors causing burnout. Performance Management (PM) is important as it monitors organizational outcomes to identify and feedback faults to promote corrective actions; to define, communicate and reinforce an organization's values, purposes and directions to encourage opportunity-seeking behaviours (Kollberg & Elg, 2011:430). Performance Management Evaluation (PME) system has also, been found useful in facilitating a system's transparency and accountability (Yuen & Ng, 2012:425). PM has helped implement many innovative and effective clinical practices in health care organizations for the benefit of patients.

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Table 5.19: Respondents' ratings of their control function (n=265)

Items from questionnaire: Reflected in percentages (n=265)	Always n & %	Sometimes n & %	Never n & %	Valid n & %
33. There is monitoring of staff's performance according to their job descriptions.	147 55.47	99 37.36	19 7.17	265 100
34. Unit staff are invited on a one-to-one meeting with the aim of reviewing and discussing their performance and key performance areas (KPAs) with the senior member of the staff.	171 64.53	80 30.19	14 5.28	265 100
35. Constructive feedback is provided to encourage and motivate them to improve their performance.	98 36.98	151 56.98	16 6.04	265 100
36. Praise is provided for those who performed outstandingly.	54 20.38	173 65.28	38 14.34	265 100
37. There is mentoring and peer support in which new qualified registered nurses are made to understand their roles and responsibilities.	44 16.60	204 76.98	17 6.42	265 100
38. There is assessment and development of competency as part of control, checking standards of patient care.	112 42.26	114 53.21	44 16.60	265 100
39. The supervision, direction, and correction done on personnel focuses on motivation and empowerment not punitive.	79 29.81	146 55.09	40 15.09	265 100
40. There is staff satisfaction questionnaire to be completed by NQRNs monthly to evaluate their views.	53 20.00	53 20.00	156 60.00	265 100
Average (%)	**35**	**49**	**16**	**100**

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However, its application in health care settings has been subject to some concerns and criticisms (Mesabbah & Arisha, 2016:211). Also, there is a disconnect between the rhetoric of managerialism and control inherent in PM, and the reality of the clinical and managerial processes involved in health care systems, where politics, negotiations and social aspects play important roles (Mesabbah & Arisha, 2016:211). The authors support the status quo happening in many public health institutions where the PM is not aligned with organizational strategic plan as illustrated in the item 38 that 53.21% (n=114) of the respondents are not assessed for competency or their performance is not assessed which relates translate that there is no provision of feedback on performance which also, refute the findings in item 34 indicating that staff are invited on a one-to-one meeting 64% (n=171).

The controlling function of management leaves room to be desired; the results indicate inefficiencies in the controlling function of respondents. Item 35 of providing constructive feedback is not satisfactory as the majority (n=151; 56.9%) indicated *Sometimes* which reflects that supervision is lacking. Though regular feedback was perceived as an indicator to measure NQRNs' clinical practice progress. In their findings, Saghafi, Hardy & Hillege (2012:26) revealed that there was no formal feedback provided from senior colleagues and nurse managers.

Limited feedback is among stressors that have been cited as increasing stress and anxiety (Phillips, Esterman & Kenny, 2015:119). This is consistent with literature that NQRNs experience stress and anxiety in the absence of feedback (Ostini & Bonner, 2012:247; Marks-Maran, Ooms, Tapping, Muir, Phillips & Burke, 2013:1429). NQRNs seek information and feedback (Phillips *et al.,* 2015:120) to feel supported. Some UNMs indicate that NQRNs refuse to accept feedback. This might be due to the way feedback is given. Though feedback lies between praise and criticism of the employee's performance, it is often linked to punitive or ridicule that might be confusing

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and threatening to the staff. Hence some NQRNs (R.683) become afraid to receive feedback. Likewise, some unit nurse managers are frightened to provide feedback since it could either hurt NQRNs' feelings or lead to 'stonewalling' (Marthouret & Sigvardsson, 2016:2). If feedback is not given to NQRNs they tend to lose interest, become passive and burnout develops. When NQRNs performs without any feedback, it leads to repeating similar mistakes and thus demotivation, isolation, inadequacy, stress and job dissatisfaction (Ebrahimi *et al.*, 2016:69).

The dissatisfied nurse performs poor (Mokhtar *et al.*, 2016:34) which impede provision of quality care putting patients' well-being and lives in danger (Heinen *et al.*, 2013:174). Newly Qualified Registered Nurses with high level of dissatisfaction may intend to quit the job. The intension to leave the employment or profession permanently is higher among stressed nurses (Rudman & Gustavsson, 2011:302; Heinen *et al.*, 2013:174; Kutney-Lee, Wu, Sloane & Aiken 2013:196; Phillips *et al.*, 2015:119; Helgesen, 2017:3).

Though mentoring was recommended to be part of the organizational culture and recognized structure with formalized processes, follow-up and evaluation (Jones, 2016:34), in item 37 providing mentoring and peer support is not satisfactory, as the majority (n=204; 76.98%) of the respondents indicated *Sometimes* which reflects that there is insufficient or poor mentoring and support. This might either be because UNMs were not available or reluctant to mentor NQRNs.

Sibiya (2018:131) revealed that lack of mentoring to nursing students caused stress and anxiety in the critical care clinical areas due to fear of making mistakes. The author further stated that peer mentoring was perceived as a significant strategy used to reduce anxiety and attrition in critical care setting (Sibiya, 2018:131). If there is insufficient or poor mentoring and support, NQRNs tend to be stressed and

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demoralized. Empowered nurses are more productive, experience less burnout and turnover, and commit fewer errors (Reed, 2019:27). Chornow (2020:24) reported that mentorship programmes lower nurse dissatisfaction and enhance their contentment. The more NQRNs are satisfied with their job the more they intent to stay. Jones (2016:32) stated that the study findings showed an increased in job satisfaction and intent to stay, similar to previously reported observations (De Simore, Plantar & Cicotto, 2020:136; Daniel *et al*., 2017:1163).

Item 38 of assessment and development of competency is not sufficient as the majority (n=114; 53.21%) of respondents indicated *Sometimes* which reflects insufficient support. If NQRNs' competency and standards of care are not assessed, there will be no skills development and improvement of patient care. Nurses provide daily care in a complex fast-changing clinical setting using acquired abilities through knowledge and skill from various sources of information.

NQRNs as part of the nursing staff are expected to take professional responsibilities for continuously providing direct care, protecting individual lives and supporting activities of daily living (Fukada, 2018:1). For NQRNs to accomplish these activities, it is imperative for them to improve their nursing competency for daily nursing practice. However, NQRNs' lack of confidence and competence coupled with medical errors due to increased workload and responsibilities, and shortage of staff may result in stress (Manoochehri, Imani, Atashzadeh-Shoorideh, *et al. (*2015:33).

Conducting a monthly satisfaction survey from NQRNs is imperative. Analysis of NQRNs satisfaction survey feedback results can provide UNMs with sufficient understanding of factors and areas that need improvement in their support and can lead to effective patient care. However, when asked whether NQRNs complete a monthly satisfaction questionnaire to evaluate their views in item 40, the majority

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(n=159; 60%) of UNMs pointed out that NQRNs never completed satisfaction questionnaires. Monthly evaluations will provide NQRNs an opportunity to reflect and examine issues of practice, enable them to focus on concerns such as, adequate orientation, availability of assistance from senior staff members (Abouelfettoh & Mumtin, 2015:492). NQRNs might have difficult in adjusting to their new roles and might be experiencing an increased stress associated with job expectations and incompetence (Cheng, Tsai, Chang & Liou, 2014:7).

However, if not given an opportunity to voice their views they may have burnout without anyone to identify and support them. Lack of surveys conducted with NQRNs might be due to fear of negative assessment related to UNMs. In their study, Hewitt & Letvak (2013:331) reported that most comments by novice nurses about management were negative. They cited unsupportive directors who were not in touch with employees and the work they do (Hewitt & Letvak, 2013:331).

5.5 Integration of the Findings

The convergent design occurs when the researcher collects and analyzes both quantitative and qualitative data during the same phase of the research process and then merges the two sets of results into an overall interpretation (Table 5.20). The purpose of the convergent design was “to obtain different, but complementary data on the same topic” to best understand the research problem.

The intent in using this design is to bring together the differing strengths and weaknesses of quantitative methods (large sample size, trends, generalization) with those of qualitative methods (small sample, details, in-depth). This design is used when the researcher wants to triangulate the methods by directly comparing quantitative statistical results with qualitative findings for validation purposes (Creswell, 2014:273).

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Table 5.20: Integration of qualitative and quantitative findings

Qualitative Strand	Quantitative Strand
Theme 1.1: Negative workplace environment **Sub-Theme 1.1.4:** Shortage of staff	**Item 5:** There is enough staff in the unit compared with number of patients 2% (n=6) *Always*, 74% (n=195) *Sometimes*, 64% (n=24) *Never.* **Item 16:** The unit has adequate personnel per shift 52.8% (n=140) *Always*, 44% (n=117) *Sometimes*, 24% (n=64) denoting that staff ratios in units can be problematic at times.
Sub-Theme 1.1.1: Negative attitudes and behaviour in workplace.	**Item 9:** During climate meetings, all available staff discuss their feelings and concerns 47.5% (n=126) *Always*; 43.4% (n=115) *Sometimes*; 9% (n=24) *Never.* This suggests that the relations are not at the best levels. **Item 23:** 45% (n=121) of respondents indicated that they are sometimes included as part of Standard Operating Procedures **Item 36:** Praise is provided for those who performed outstandingly, 20.38% (n=54) *Always*, 65.28% (n=173) *Sometimes*, 14.34% (n=38) *Never.* It indicates that it is not a regular occurrence or standard practice.
Theme 1.2: Emotional resilience **Sub-Theme 1.2.1:** Increased level of responsibility and accountability.	**Item 30:** NQRNs are placed being in-charge of the unit prematurely to counteract shortage of staff, 33.60% (n=89) *Always*; 56.9% (n=151) responded indicated that NQRN are placed being in-charge of the unit prematurely to counteract shortage of staff. **Item 17:** New employees are delegated based on their scope of practice, competencies, personal and professional development needs, 35.85% (n=95), *Always*, 58.87% (n=156) *Sometimes*, 5% (n=14) *Never.* **Item 38:** There is assessment and development of competency as part of control, checking standards of patient care, 42% (n=112) *Always*, 53.21% (n=114) *Sometimes*, 16.6% (n=44) *Never.*
Theme 3.1: Insufficient support **Sub-Theme 3.1.1:** Mentoring **Sub-Theme 3.1.2:** In-service education or training	**Item 22:** Senior members of the staff mentor, coach, guide and support NQRNs in the unit, 52% (n-=138) indicated sometimes, 37% (n=100) *Always*, 10% (n=27). **Item 29:** NQRNs are allocated a mentor to support and guide them 62.64% (n=166) *Sometimes*, 29% (n=77) *Always*, 8% (n=22) *Never.* **Item 35:** Constructive feedback is provided to encourage and motivate them to improve their performance 56.9% (n=151) *Sometimes*, 36.98% (n=98) *Always*, 6% (n=16) *Never.*

Continued/…

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Table 5.20: Integration of qualitative and quantitative findings (continued)

Qualitative Strand	Quantitative Strand
Theme 3.1: Insufficient support **Sub-Theme 3.1.1:** Mentoring **Sub-Theme 3.1.2:** In-service education or training (*continued*)	**Item 36:** Praise is provided for those who performed outstandingly 65.28% (n=173) *Sometimes*, 20% (n=54) *Always*, 14% (n=38) *Never.* **Item 37:** There is mentoring and peer support in which new qualified registered nurses are made to understand their roles and responsibilities 78.9% (n=204) *Sometimes*, 16% (n=44) *Always*, 6% (n=17) *Never.* **Item 38:** There is assessment and development of competency as part of control, checking standards of patient care 53.21% (n=114) *Sometimes*, 42% (n=112) *Always*, 16.6% (n=44) *Never.* **Item 39:** The supervision, direction, and correction done on personnel focuses on motivation and empowerment not punitive 55% (n=146) *Sometimes*, 29.8% (n=79) *Always*, 15% (n=40) *Never.* **Item 40:** There is staff satisfaction questionnaire to be completed by NQRNs monthly to evaluate their views 60% (n=159) *Never.*, 20% (n=53) *Always* and *Sometimes*

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5.5.1 Biographic Data

Fifty-one (51) NQRNs (R.683) from the six (6) selected hospitals in Mopani and Vhembe districts of Limpopo Province participated in the semi-structured FGIs and only four (4) were males and forty-seven (47) were females. The four male participants' ages ranged between 31 and 50 years, whereas the forty-seven female participants were aged between 31 and 60 years. Participants were allocated to Casualty (8), Paediatric Unit (8), followed by Outpatients Department (OPD) (7) participants and Female Medical with five (5) participants. Male Medical, Operating Theatre, High Care and General or Combined units had three (3) participants and Neonatal, Male Surgical and Female Surgical had two (2) participants per unit whereas Gynae, Psychiatric or Mental Health Care Unit, Postnatal, Wellness Clinic and Occupational Health Clinic have been allocated one (1). For the quantitative phase, two hundred and sixty-five (265) unit nurse managers from the seven (7) selected hospitals in Mopani and Vhembe districts of Limpopo responded to self-directed questionnaires and only twenty-eight (28) were males and two hundred and thirty-seven (237) were females.

The twenty-eight (28) males' ages ranged between 25 and 60 years, whereas the two hundred and thirty-seven (237) females' respondents were aged between 25 and 61+ years. Respondents were also, stationed to Medical (50), followed by Surgical (46) and Casualty (32). TB and Gynae Units had (30) respondents per unit followed by OPD (27) and Paediatric Unit (25). Operating Theatre (13), Nurse Manager's Office (5), Mental Health Care Unit (4) and (3) stationed in Intensive Care Unit (ICU). Regarding education, 26.04% (n=69) had Diploma in Nursing, 37.36% (n=99) had obtained Diploma in Nursing with Midwifery. In Limpopo Province, Diploma in Nursing and Midwifery is a pre-requisite for RNs to be registered for Post Graduate Diploma (post-basic qualification) training in nursing.

Respondents also comprised of 23.02% (n=61) with Degree in Nursing with speciality

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and managers with Master's degree 1.13% (n=3) and 0.38% (n=1) with Doctoral degree. Regarding work experience 49.5% (n=110) of respondents had between 5 and 9 years in current position followed by 26.57% (n=59) who had between 10 and 14 years and 13.06% (n=29) had between 20 and 24 years of experience in current position. All respondents had between 5 and 31 years as RNs, and between 5 and 39 years working in current position as unit nurse managers. This denotes that they are experienced in supporting NQRNs (R.683)

and their management function was based on their clinical experience and expertise in nursing. The findings indicate that both populations had more females than males, supporting the view that nursing is a female-dominated occupation.

5.5.2 Major Theme 1: Challenges Experienced by NQRNS in Their New Role as Registered Nurses

5.5.2.1 Theme 1.1: Negative Workplace Environment

Negative workplace environment was highlighted as negative attitudes and behaviour in the workplace, workplace bullying, lack of orientation, shortage of staff and insubordination of junior staff members. In the quantitative strand, Table 5.14, Item 5 regarding if there is enough staff in the unit compared with number of patients, two percent of respondents 2% (n=6) indicated *Always*, 74% (n=195) *Sometimes* and 64% (n=24) *Never.* Furthermore, on Item16, the unit has adequate personnel per shift, fifty-two percent 52.8% (n=140) indicated *Always*, 44% (n=117) *Sometimes*, and 3% (n=8) *Never.* This implies that staff ratios in units can be problematic at times.

Concerning negative attitudes and behaviour in the workplace, in Item 23, 45.66% (n=121) of the respondents indicated that they are sometimes included as part of Standard Operating Procedures and Item 36, indicates that praise is sometimes provided for those who performed outstandingly (n=173; 65.28%). The above findings

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do indicate that when there is shortage in personnel per shift it is impossible to orientate and mentor staff and mistakes are likely to happen which may trigger workplace bullying and insubordination among staff members. Negative attitudes are also, evident in inclusion of NQRNs in the climate meetings where they can have their concerns raised which is fifty-two percent. This indicates that problems or dissatisfaction can build up and go unnoticed and later results in burnout if unresolved or if not addressed in such platforms.

5.5.2.2 Theme 1.2: Emotional Resilience

Emotional resilience was linked to increased level of responsibility and accountability coupled with negative working relationship with senior colleagues and role confusion. In the quantitative strand, table 5.16 Item 30 pertaining to if NQRNs are placed being in-charge of the unit prematurely to counteract shortage of staff. Thirty-three percent, 33.60% (n=89) of respondents indicated *Always*, 57% (n=151) *Sometimes*, 9.40% (n=25) *Never.* Concerning increased responsibility and accountability, and role confusion, table 5.15 item 17 new employees are delegated based on their scope of practice, competencies, personal and professional development needs, 35.85% (n=95) respondents indicate *Always*, 58.87% (n=156) *Sometimes*, 5% (n=14) *Never.*

NQRNs are still finding their feet in their new role, burdening them with work outside their scope of practice and leaving them unsupported during shifts is more stressful. Stress levels and coping capabilities of individuals differ, some can adapt, but others may feel burnout that can result in negative behaviours in employees such as use of substance, absenteeism or sickness absenteeism related to stress. Furthermore, it can be detrimental to patient care. Furthermore, Table 5.17, Item 38, there is assessment and development of competency as part of control, checking standards of patient care, 42.26% (n=112) responded *Always*, 53.21% (n=114) *Sometimes*, 16.60% (n=44) *Never.* This indicates that there is poor supervision, guidance and teaching to NQRNs.

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A supervisor's role is to direct, guide, empower and teach. This is supported by the qualitative findings indicating that there is insufficient support pertaining to mentoring (Sub-Theme 3.1.1: Mentoring). In addition, concerning negative working relationships with senior colleagues (Table 5.20, Item 9) during climate meetings all available staff discuss their feelings and concerns 47.6% (n=126) respondents indicated *Always*, 43.4% (n=115) *Sometimes*, and 9% (n=24) *Never.*

These findings also, support the issue of being denied to practice in the new roles where other nurse managers were not giving NQRNs the opportunity to practice according to their newly acquired status, they were not allowed to take ward rounds with doctors, and some were under delegated as supported by Sub-Theme 1.3.1: Dual Status under qualitative findings. For NQRNs, performing activities that often exceed their limits and capabilities leads to role confusion, retards their competency development and weakens patient care standards. Again, when not given opportunity or equipped to practice, they become incompetent which result in poor patient care (Moeti, 2002:17).

5.5.3 Major Theme 3: Support Expected from Experienced Senior Staff Members

5.5.3.1 Theme 3.1: Insufficient Support

Insufficient support is linked to mentoring and in-service education or training which is inadequate. In the quantitative strand, Table 5.15, Item 22, regarding if senior members of the staff mentor, coach, guide and support NQRNs in the unit, 37% (n=100) of respondents indicated *Always*, 52% (n=138) indicated *Sometimes*, and 10% (n=27) *Never.* Furthermore, Table 5.16, Item 29 if NQRNs are allocated a mentor to support and guide them, 29% (n=77) indicated *Always*, 62.64% (n=166) *Sometimes*, and 8% (n=22) *Never.* In addition, Table 5.17, Item 37, if there is mentoring and peer support in which NQRNs are made to understand their roles and responsibilities,

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16.6% (n=44) of the respondents indicated *Never.*, 78.9% (n=204) *Sometimes*, 6.42% (n=17) *Never*, thus implying that NQRNs are not receiving sufficient support from senior staff members as intended. Regarding assessment, feedback and praise Table 5.17, Item 38, if there is assessment and development of competency as part of control, checking standards of patient care, 42.26% (n=112) responded *Always*, 53.21% (n=114) *Sometimes*; 16.6% (n=44) *Never*, and Item 40 if there is staff satisfaction questionnaire to be completed by NQRNs monthly to evaluate their views, 20% (n=53) of respondents indicated *Always* and *Sometimes*; 60% (n=159) *Never.*

Furthermore, Item 35, if constructive feedback is provided to encourage and motivate them to improve their performance, 36.98% (n=98) respondents indicated *Always*; 56.98% (n=151) *Sometimes*, 6% (n=16) *Never.* On Item 36, if praise is provided for those who performed outstandingly, 20.38% (n=54) responded *Always*, 65.28% (n=173) *Sometimes*, 14% (n=38) *Never.* On Item 39, if the supervision, direction, and correction done on personnel focuses on motivation and empowerment not punitive, 29.8% (n=79) indicated *Always*, 55% (n=146) *Sometimes*, 15% (n=40) *Never*, denoting that there is not sufficient assessment of performance, feedback and reward provided to NQRNs.

These findings reveal that lack of a designated mentor leads to NQRNs assuming managerial positions of being unit leaders prematurely. It is difficult for NQRNs to have mentors to serve as role models, guiders, coaches, supervisors, directors, assessors, correctors and supporters who will regularly assess their performance and offer feedback and praise for outstanding performance. Thus, NQRNs feel demotivated, uncertain about their capabilities regarding the requirements of their new role which impede their competency and ability to function independently. The findings reveal lack of assessment and feedback denoting that errors and mistakes remain unchanged and good performance will not be reinforced hindering empowerment, motivation and

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professional competency development.

5.6 Conclusion

This chapter discussed the findings of Phase 1B (quantitative results). It is apparent from the discussion that NQRNs are insufficiently supported which is in line with the researcher's intention to develop a model to enhance support for NQRNs (R.683) from selected hospitals of Limpopo Province, South Africa. Chapter 6 presents the concept analysis.

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CHAPTER 6

CONCEPT ANALYSIS

6.1 Introduction

Phase 1 discussed the findings obtained from the FGIs and self-administered questionnaires with reference to literature. This chapter analyzes the different concepts that emerged from data analysis in Phase 1. Analysis clarifies, refines concepts, statements or theories (Chinn & Kramer, 1999:74). The process of concept analysis involves dissecting the whole into parts for better understanding (Rodgers & Knafl, 1993:78). Support is the concept that has emerged from data analysis.

6.2 Objectives of this Chapter

This chapter was directed by the following objectives, i.e., to:

- Analyse the concept 'support,' using Rodgers & Knafl's steps (1993:78).
- Identify support characteristics that will provide definition for practice and future research.

6.3 Concept Analysis

Duncan, Cloutier & Bailey (2007:295) stated that concept analysis is a process of operationalizing a phenomenon so that it can be used for theory development or research measurement. According to Chinn & Kramer (2015:165), a concept is a "complex mental formulation of experience," and indicates that concepts are extracted

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from life as directly lived and as verified by others (Chinn & Kramer 2015:166). The process of concept analysis allows the researcher to formulate a theoretical and operational definition of the concept under study. The concept ‘support’ is central to this study as it is a strategy through which help to NQRNs by experienced senior staff members can be improved in selected hospitals of Limpopo Province in South Africa.

A concept has been defined as a ‘cluster of attributes’ (Rodgers, 2000:83). Rodgers’ evolutionary concept analysis was selected to explore the concept ‘support’ because this concept has evolved through contextual influences, therefore. Rodgers’ approach would be congruent with the development of the topic under study. Rodgers (1989) posited that concept development has the following three phases, significance, use and application. Concept analysis was guided by the steps as outlined by Rodgers & Knafl (1993:90) as indicated in Figure 6.1.

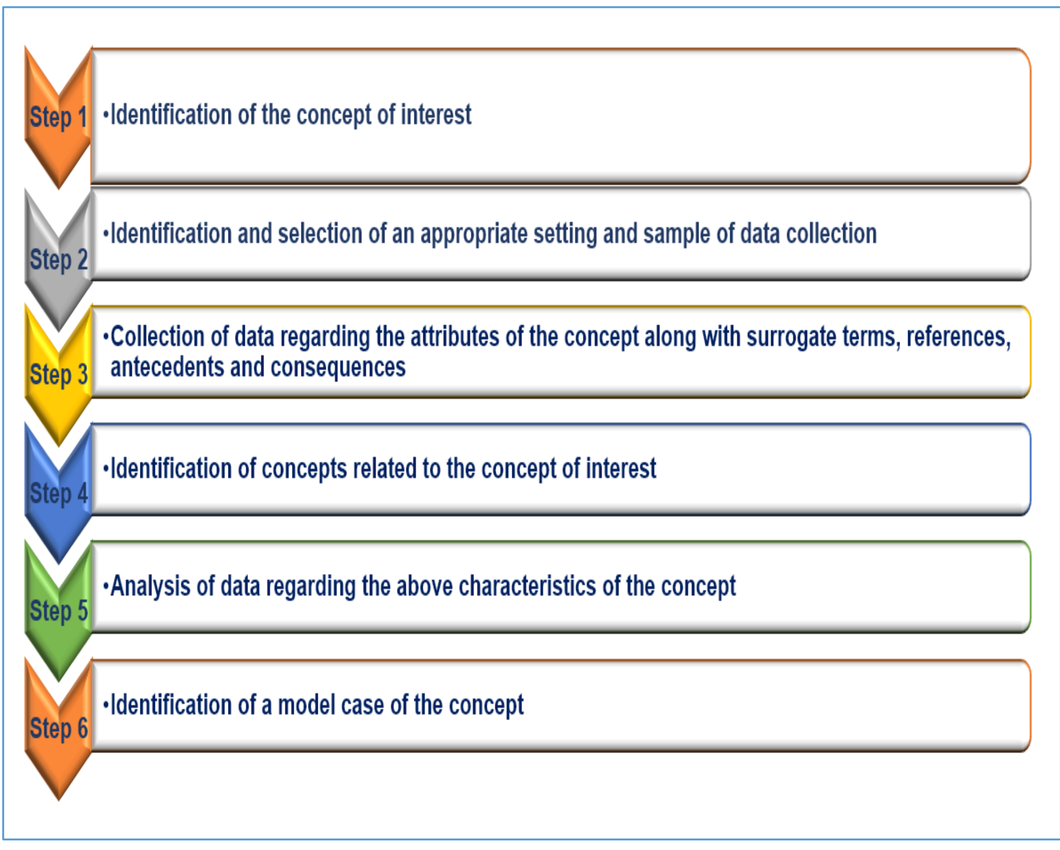

Figure 6.1: Six steps in concept analysis by Rodgers & Knafl (1993:90)

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6.3.1 Identification of the Concept of Interest

Rodgers (2000:85) described a concept as an 'idea or the characteristics associated with the word'. Walker & Avant (1995:40) explained identification of the concept as a way of choosing the concept that accurately describes the participants' experiences from the findings. The concept 'support' was identified as central to this study. It is central to this study as it was identified from the data that NQRNs (R.683) and experienced registered nurse support should provided. This help was deemed as lacking as NQRNs (R.683) were often left to run units by themselves prematurely and unsupported.

It was identified that unit nurse managers were mostly unavailable which predisposed NQRNs (R.683) to feel anxious, fearful and stressed. It was also identified that unwelcoming and unfriendly staff attitudes, poor working conditions such as heavy workloads, staff shortages, inappropriate skills mix and high patient acuity make NQRNs feel vulnerable, insecure, inadequate and incompetent (Dyess & Sherman, 2009:403; Regan, Wong, Laschinger, Cummings *et al.*, 2017:247).

It was concluded that support should be the central concept as it ensures that teamwork and skills mix, mentoring and peer support is possible (Murray, Sundin & Cope, 2019:21). It was identified that for support to take place, a positive supportive workplace environment should be created by all parties involved (Price & Reichert, 2017:10). In the present study, the meaning of the concept support was imperative so as to come up with a theoretical definition that would direct the description of the model to enhance support for NQRNs (R.683) in their new employment RN role.

Johnstone, Kanitsaki & Currie (2008:47) revealed various behaviours that participants found to be supportive, such as nursing staff being helpful, being patient, giving praise where due, enabling NQRNs to practice autonomously, being available to give

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assistance, encouraging and answering questions, providing non-judgemental guidance, acknowledging how stressful situations can be, making the NQRNs feel valued, and pairing NQRNs with mentors to help them become integrated into the workplace environment (Johstone *et al*., 2008:47).

6.3.2 Definition of the Concept of Interest

Support happens where there is an interaction between two or more people. The term support is used extensively in the English language as both a noun and a verb. Dennis (2003:321) described support as an Old French word ‘supporter’ which was originally acquired from Latin word ‘porto’ meaning ‘to carry’. Support is a positive interaction between two or more people where there is encouragement and help given to someone as a sign of approval aiming to see him or her successful (Oxford Advanced Learner’s Dictionary, 2010).

The Cambridge Advanced Learner’s Dictionary (2008) refers to support as to agree with and give encouragement and approval to enable someone to succeed. The Oxford Dictionary of Current English (1991) describes support as strengthening, encouraging, helping, backing up, and speaking in favour of or actively interested in someone to enable him or her to last out. Merriam Webster Dictionary (1991) points out that support is about assisting a person by one’s presence, giving moral or psychological support. Stoltz, Andersson & Willman (2007:1481) described support as assisting, encouraging someone or approving whatever task is being performed.

Reber & Reber (2001) understood support as offering help, encouragement or approval to an individual, and showing an active interest in them. In sociology, support is described as an array of social exchanges which involves encountering support, recognizing support and feeling supported (Taylor, 2007; Cora & Alwyn, 2008:371). Based on the above definitions, support in nursing is a complex and unspecified

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concept as it has many different meanings. Support is context bound, meaning that there is no general form of support that will work in every situation. Different people have preferences for a certain type of support. It is important to note, however, that the wrong type of support can actually have a detrimental effect, so it helps to know what type of support is needed in each situation.

In nursing, support is a complex process that aids, encourages, and strengthens and thereby gives courage and confidence to the newly-qualified nurse or group of newly-qualified nurses to practice competently, safely, and effectively in levels and areas they have been educationally prepared to work (Johnstone, Kanitsaki & Currie, 2008:52). Furthermore, for NQRNs to function independently, competently and safely depend on the presence of appropriate experienced staff members with appropriate attitude as well as clinically competent and knowledgeable attributes.

Support in psychology refers to the provision of assistance, guidance and responses to newly-qualified nurses' psychological and behavioural needs by more senior experienced nurses (Beetcroft, Santner, Lacy, Kunzman & Dorey, 2006). In addition, support also, means the provision of assistance or comfort to others with psychological or material resources, typically to help them cope with biological, psychological, and social stressors. As indicated that support is context-bound, the situation in which support takes place should be considered. This is because the context in which support is provided appears to determine the meaning, purpose, and expected outcome of the activity (Stoltz *et al.*, 2007). To enhance support, the environment should be conducive with adequate human and material resources.

Taylor (2008) stated that social support is the perception or experience that one is cared about by others, esteemed and valued, and is part of a social network of mutual assistance and obligations. Hence, Letourneau, Stewart & Barnfather (2004:515)

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explained support as the interactions with family members, friends, peers and health professionals that communicate information, understanding and respect for the individual. This means that there is social interaction between individuals. Cobb (1985:18) defined social support as information leading participants to believe that s/he is loved, esteemed, and belongs to a network of mutual obligation. In an environment where NQRNs feel being part of and accepted by the nursing team members, they would more likely share their feelings and concerns. However, this needs good supportive interpersonal relationships between NQRNs and the nursing staff, and active participation where NQRNs would feel involved in unit decision-making and problem-solving.

Generally, support affects people because of the contribution that they make to others in interpersonal relationships (Virtanen & Isotalus, 2011:26), where the total level of assistance or any services are provided (Ramathuba & Davhana-Maselesele, 2015:74), hence Stoltz, Andersson & Willman (2007:1482) suggested that social support could be the umbrella of choice. Gottlieb & Bergen (2010:512) refered social support as the social resources that people perceive to be available or that are actually provided to them in either formal support groups or informal helping relationships contexts. Social support is multidimensional with subtypes of supportive behaviours: emotional, instrumental, informational and appraisal support (Glanz, Rimer & Viswanath, 2008:190; Malecki & Demaray, 2003:232; Berkman, Glass, Brissette & Seeman, 2000:230; Greene & Burleson, 2003:554; Gottlieb & Bergen, 2010:513; Deelstra, Peeters, Schaufeli, Stroebe, Zijlstra & van Doornen, 2003:329). Emotional support, particularly in the workplace, occurs when the work environment is stressful, and includes the provision of comfort and security during times of stress leading to a person feeling being loved, esteemed or valued and cared for by others, where this distressed person can be helped through their upsets by listening to, empathizing and sympathizing with.

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The findings of the study revealed that NQRNs expressed feelings of fear, anxiety, frustration, depression and stress due to mismatch between the level of responsibility they held as students and their increased level of responsibility in their new RN role. Ebrahimi, Hassankhani, Negarandeh, Gillespie & Azizi (2016:12) reported that emotional support for NQRNs can reduce their stress and anxiety, increase their self-confidence as well as establishing a supportive relationship between NQRNs and experienced senior nurses. It is therefore vital that emotional supportive services be put in place for NQRNs.

Instrumental support is the direct support provided to a person in need through tangible help, material and human resources, aid or assistance and services such as taking care of needy persons or doing a chore for them (Schaefer, Coyne & Lazarus,1981:385; Glanz *et al*., 2008:190; Cohen & Wills, 1985:313). The research findings revealed increased shortage of RNs and ENs leading NQRNs to work extended hours and face demanding workloads. In their qualitative study in the Republic of Vanuatu Hospitals, Tamata, Mohammadnezhad & Tamani (2021:13) found that the majority of the nurses working in the hospital had experienced long shift hours up to 12 to 16 hours, or double the shift due to insufficient staff to do shift work or when other nursing staff are on leave.

Furthermore, nurses expressed that long working hours is very stressful and thus affects their work performance, as well as their social and family relationship (Griffiths, Dall'Ora, Simon, Ball *et al*., 2014:3; Tamata *et al*., 2021:13). Estryn-Béhar & Van der Heijden (2012:4283) also found that shift length is related to the effects of burnout. Therefore, it is imperative to ensure that NQRNs have instrumental support through adequate provision of personnel, modified work arrangements, flexible working hours, to allow opportunity for professional development and thus enhance job satisfaction (Price & Reichert, 2017:2).

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Informational support refers to giving of information, suggestions and advice which could help a person to address encountered problems and providing feedback about how a person is doing (Glanz *et al*., 2008:190; Schaefer,1981:386). Therefore, UNMs and senior experienced RNs must familiarize NQRNs about protocols, policies and procedures of unit management. Newly Qualified Registered Nurses should be involved in formulation of unit Standard Operating Procedures (SOPs) in order to be well informed and certain on how to execute them with confidence. Policy and procedure manuals should be reviewed and updated and made available for NQRNs to adhere to while managing the unit.

Appraisal support is the provision of advice or information that is useful for self-evaluation to give constructive feedback, or to help deciding which course of action to take (Glanz *et al*., 2008:190). The research findings revealed that NQRNs needed to be commended for the effort they were putting in regarding provision of patient care and unit management activities under stressful situations such as bullying, staff shortage, unreasonable expectations, increased responsibility and accountability, and inadequate support received from senior RNs. Non-monetary incentives such as rewards in the form of recognition or praise indicate respect and acknowledgement for NQRNs' outstanding performance. It is therefore necessary that management teams as well as senior experienced nurses be committed to provide appraisal support for the active involvement and willingness of NQRNs to be engaged. It is important that praises and constructive criticism be given when due as a way of motivating and encouraging them to strive for the best.

Social support in the workplace occurs through social interactions between NQRNs with coworkers and supervisors (Okamoto & Harasawa, 2009:139). Newly Qualified Registered Nurses who are involved in emotional work such as caring for patients at the end of life or death, and emergency situations, increased caseloads which further

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exacerbate their role conflict as they attempt to balance managerial expectations against day-to-day clinical demands (Skilbeck & Payne, 2003:526) need support as this could result in some degree of stress, hence, emotional support is imperative. It can be either verbally in a form of affirmative statements such as reassurance, empathetic and sympathetic encouragement and communication, or non-verbally by being near to someone (Skilbeck & Payne, 2003:527).

For senior experienced nurses and UNMs to be near and provide the opportunity to NQRNs to vent their feelings of anxiety, fear and frustration, is believed to be emotional support received, as nurses acknowledge senior nurses' concerns and this creates an atmosphere of acceptance to help NQRNs to endure the physical and emotional distress encountered in their new registered role. Received social support is provided support that can be objectively measured, the actual administered aid or the behaviour of engaging in positive interpersonal social exchanges (Tang, 2008). Social support benefits the well-being by protecting individuals from detrimental effects of stress.

6.3.3 Identification and Selection of an Appropriate Setting and Sample of Data Collection

An appropriate setting refers to the time period examined and types of literature included in the analysis (Rodgers & Knafl, 1993:90). The appropriate setting and context for this study is the hospital context and units where support from UNMs, peers, other staff members is expected to be provided to NQRNs (R.683). The sample for analysis was drawn from the literature that discussed support such as dictionaries, published national and international journals, books, etc. This study focuses on the support as experienced by NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa. The theoretical definition derived from the analysis directed the development and description of the model.

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6.3.4 Collection of Data Regarding the Attributes of the Concept Along with Surrogate Terms, References, Antecedents and Consequences

Rodgers & Knafl (1993:90) described this step as a phase which reflects all possible sources that were reviewed in the clarification of the concept. Various literature was read to get clarity regarding 'support' as the concept of interest. Among sources searched and reviewed to clarify the meaning of support for NQRNs (R.683) in their new role were dictionaries, books, internet, journal articles. Both primary and secondary sources were used to clarify the meaning of the concept support. The search strategy for these sources was based on the term 'support' from nursing, psychological and sociological contexts. The defined concepts were found to be covering the same areas of interest.

6.3.4.1 Identification and Defining of Attributes of the Concept

Attributes are key and repeated characteristics of concepts that allow for the definition of a concept in real world terms (Rodgers, 2000:91). Once the main concept has been identified and defined, defining attributes were listed, analyzed, and synthesized to form a definition of the concept of interest 'support'. Listing of the defining attributes assisted with identifying the occurrence of a specific phenomenon in order to differentiate it from similar or related terms. Furthermore, defining attributes might change as the understanding of the concept improved or developed. Hence, it was necessary to show clusters of the attributes most frequently associated with the concept to gain a broad insight into the concept (Chinn & Kramer, 1999:95).

In the present study, the concept support of NQRNs was revealed as a result of an interactive process of a supportive interpersonal relationship where an expert (UNM) give an opportunity to a less experienced NQRN to freely vent their feelings and experiences. Factors such as provision of adequate resources, assignment of clear

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reasonable expectations for performance with sufficient orientation, where the expert model the role by allowing the less experienced nurse to actively participate in unit management activities as well as sharing acquired knowledge and skills are strongly related to support. Additionally, the monitoring, appraisal, feedback of NQRNs' performance enhance confidence, competence, independence and quality care.

6.3.4.2 Defining Attributes of Support

The attributes are the elements that identify the concept being studied. The critical defining attributes of the concept 'support' are supportive interpersonal relationships, clear and reasonable expectations for performance, constructive feedback, adequate resources, role modelling, sufficient orientation, participation in unit management activities, opportunity to share emotions, feelings, experiences and acquired knowledge and skills.

6.3.4.2.1 Supportive Interpersonal Relationships

Although support of NQRNs (R.683) is expected from UNMs, experienced senior nurses and colleagues when they enter their new role, successful support cannot be sustained over time without an established mutual trust and respect between UNMs and unit staff, including NQRNs. This requires value clarification to assist UNMs to treat NQRNs (R.683) as unique beings with individual beliefs, values, knowledge and skills, and innate ability to learn, grow or develop. This will cement the relationship between the two parties and, as a result, UNMs will be willing and committed to understand the motivators that enable NQRNs to perform their unit activities as well as the eager for professional growth and development. As a response, NQRNs endeavour to meet the unit set goals and objectives through outstanding work performance. Supportive interpersonal relationship is developed when trust and respect between UNMs and NQRNs emerge over time. (Batson & Yonder, 2012:4).

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Ortiz (2016:22) revealed that building relationship contributes to development of professional confidence, and this interpersonal relationship elevates NQRNs' self-confidence. In this study, NQRNs were willing to engage in developmental activities as well as acting beyond their scope of practice as evidenced by a participant's narrative:

> *"You find that even the doctor is an intern he needs more from you and you also, new so, … you have a patient from accident that patient needs a trauma nurse and you'll be alone there without trauma. So… you have to run to rescuci and you have to apply the skills."*

6.3.4.2.2 Clear and Reasonable Expectations for Performance

NQRNs enter a new role being stressed due to unclear and expanding expectations. They experience lack of confidence or have self-doubt, and when they sought direction from others, a lack of clear direction occurs, which make NQRNs to feel neglected. NQRNs' support when entering their new role is crucial in clinical area as it enhances the development of self-esteem, self-confidence and motivation (Kamphinda & Chilemba, 2019:2). For NQRNs to be able to perform outstandingly it needs a conducive work environment with adequate resources, and clear and reasonable expectations. It is important for the UNM to assist NQRNs to merge their personal and professional growth and development motives to the unit's mission, vision, values and goals. This might happen when UNMs are supportive and provide guidance, direction and assistance to NQRNs in their new role.

6.3.4.2.3 Constructive Feedback

Feedback is a process of communication that helps the person consider a modification of behaviour and gives information about how they are perceived by others (Panneerselvam, 2018:266). To enhance unit goal achievement, NQRNs should be provided constructive feedback, as well as the opportunity to validate and respond to

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the given feedback on their performance. When UNMs give feedback which is timely, non-judgemental, objective and compassionate, it helps NQRNs identify shortcomings or opportunity to improve current performance. Feedback motivates the person to perform well by giving information about their performance and also clarifies any deviations between the preferred and the actual behaviour (Panneerselvam, 2018:266). Although NQRNs' support in the clinical area cause empowerment, particularly where UNMs monitor and appraise NQRNs' performance and provide constructive feedback. In hospital units where there is increased shortage of staff, it is impossible for UNMs to monitor, appraise and provide constructive feedback to NQRNs. Batson & Yonder (2012:5) revealed that one-on-one coaching with staff members cited as very time consuming by nurse managers. The findings of the study revealed that some UNMs were not interested in guiding, coaching or directing NQRNs and thus NQRNs were not satisfied with the support they received as indicated by a participant:

> *"They just neglect everything and give us everything to do and they do nothing…are just sited, they play with their phones…"*

For NQRNs to achieve personal and professional growth and development it needs the availability of willing and dedicated or committed UNMs. Constructive feedback provides NQRNs an opportunity to identify their learning needs and thus enhance performance. The absence of feedback confirms lack of support and mentoring received by NQRNs in their new role in the clinical setting. Regular feedback on NQRNs' performance could allay anxiety and uncertainty they experience regarding their performance in the new role (Taylor, 2015:107).

6.3.4.2.4 Adequate Resources

A conducive supportive environment is well-equipped and adequately staffed.

However, staff shortages have a negative impact on the support provided to NQRNs when they first enter the clinical setting. Due to the increased workload, the senior experienced nurses do not have enough time to support and oversee the new nurses, who, in most hospitals, are left prematurely in charge of shifts with insufficient experience and unable to promptly make the right decisions, and also, handle the stress of management and supervision where patients and staff are left in their hands while they themselves need help (Ebrahimi, Hassankhani, Crowley, Negarandeh, Sadeghian & Azizi, 2016:72).

The findings of this study concur as one participant said:

> *"I'm working in a specialized ward, sometimes they just left us with no specialized nurse, when we ask them they say we won't do anything because we are short staffed."*

Heavy workload coupled with insufficient human and material resources increased NQRNs' stress level (Wong, Che, Cheng *et al*., 2018:32). Ebrahim *et al.* (2016:74) revealed that support is a basic need for new nurses, since it increases their capabilities and reduces their stress. Therefore, management should address the challenge of shortages of resources to ensure that NQRNs provide quality and safety patient care with confidence without fear of failure. Support does not only refer to UNMs being accessible and approachable, but also includes provision of appropriate working conditions for NQRNs.

6.3.4.2.5 Role Modelling

Role models are defined as individuals whose behaviours, styles and attributes are emulated by others and desired to be like, whereas role modelling is described as "teaching by example and learning by imitation" (Olaolorunpo, 2019:45). Felstead & Springett (2018:66) defined role model as someone who influences behaviour by

portraying personal and professional attributes expected for nursing and therefore emulated by others. In this study, a role model is an experienced senior RN whose knowledgeable and skillful performance, and behaviour can be watched, copied and imitated by NQRNs. Knowledgeable and skillful role models could enable NQRNs to notice deep-rooted knowledge in clinical practice where they can work with and observe, internalize the role models' behaviour and build up on previous knowledge and experiences through reflection (Olaolorunpo, 2019:45).

Therefore, it is pivotal for UNMs as role models to portray positive attitude and being approachable as this is essential in supporting NQRNs in their new role in the workplace. NQRNs are more willing to follow a UNM who is consistent, trustworthy and respectful (Batson & Yonder, 2012:5). Zarshenas, Sharif, Molazem, Khayyer, Zare & Ebadi (2014:436) revealed that a role model is a great source of support to individuals and also cause improvement of internal motivation resulting in increased sense of being a nurse. The authors further reported that role models assist NQRNs to develop understanding of work roles and a sense of belonging. In turn, when NQRNs feel valued and accepted it strengthens their confidence and elevates their acceptance of responsibility and accountability.

6.3.4.2.6 Sufficient Orientation

Orientation is one of the most common approaches used by institutions to promote retention and increase engagement with new employees. According to Cuddy (2015:1), orientation provides new employees with the opportunity to be familiar with the organization's structure, culture and standards. Entry to new positions as NQRNs is a stressful and difficult time (Ivey, 2012:26), hence, NQRNs perceive orientation to a new role as arduous (Cheng, Tsai, Chang & Liou, 2014:2). Orientation is essential as it prepares NQRNs to be successful in their new positions and also, promote retention, productivity as well as professional growth and development (Cuddy,

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2015:29). Lack of orientation during the early months of entry to the new role caused role confusion as NQRNs were uncertain about which policies and procedures to follow and what was expected from them in the unit. Alghamdi & Baker (2020:3082) revealed that NQRNs in their entry to practice as professional nurses were uncomfortable while performing different procedures or skills independently. Therefore, early orientation will provide NQRNs with confidence in clinical skills and decision-making which, in turn, creates job satisfaction (Ivey, 2015:26) because they can manage to perform unit activities independently as competent nurse practitioners. Pertiwi & Hariyati (2019:613) concurred that supportive orientation increases job satisfaction in the unit. Even after NQRNs are assigned to patients, there should be some form of ongoing orientation (Gregg, Wakisaka & Hayashi, 2013:162).

6.3.4.2.7 Participation in Unit Management Activities

As NQRNs are inexperienced in their new role, integrating them in the clinical unit is important. In order to facilitate NQRNs' integration in the clinical area, UNMs must understand challenges encountered by NQRNs, provide an opportunity for experience and learning as well as supporting them (Gregg, Wakisala & Hayashi, 2013:161). Support is about receiving assistance, collegiality and guidance within the unit (Tuckett, Winters-Chang, Bogossian & Wood, 2015:363).

It is vital to engage NQRNs in performing unit management activities by working together with them in clinical units (Gregg *et al*., 2013:162). Working with NQRNs hand-in-hand, giving advice and motivating them in the unit elevates their confidence leading to competently and independently putting their skills into practice. Gregg *et al.* (2013:162) further reported that UNMs should endeavour to strengthen a sense of comradeship for both NQRNs and other nurses to ensure a supportive environment, where NQRNs can actively participate in unit management activities without any fear or stress.

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6.3.4.2.8 Opportunity to Share Emotions, Feelings, and Experiences

Support is when talking to someone about the problem encountered and gathering information on possible solutions and other resources in order to cope with the problem (Gumani, 2014:1). NQRNs encounter numerous challenges and a great amount of stress as they enter their new role (Ebrahimi, Hassankhani, Negarandeh, Gillespie & Azizi, 2016:11). The authors also reported that during the first few months in the new role, NQRNs frequently feel unqualified, inadequate, and helpless, as well as experiencing a range of emotions, such as anxiety, fear, depression, emotional exhaustion, helplessness, feeling of immense time pressures, and despair (Ebrahimi *et al.*, 2016:11). All these worries, concerns and a sense of a lack of control over their environment comes with a substantial need for emotional support.

The presence of an experienced senior nurse within the unit is crucial to NQRNs as a source of emotional support, as it reduces their stress, increases their motivation, self-confidence and satisfaction, as well as their professional competence resulting in enhanced commitment (Ebrahim *et al.*, 2016:12). This support serves as a problem-focused coping strategy which is geared towards gathering information in order to face the problem encountered, it is a buffer against psychological stress, which is a result of life- and work-related events (Gumani, 2014:1).

Collaboration between NQRNs and senior experienced nurses reduced the stress and resulted in creating an atmosphere of respect, support, trust and open communication between the two parties (Almost, Wolff, Mildon, Price, Godfrey, Robinson, Ross-White & Mecardo-Mallari, 2015:1). Stoltz *et al.* (2007:1483) described support as what happens in a meeting between people, co-created, as opposed to a service given and received. Ebrahim *et al.* (2016:12) expressed support as a mutually, interpersonal and context-dependent process that makes people feel respected, valued and loved by others. Hence, NQRNs felt supported during the interaction when asked questions

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about their needs and feelings by UNMs as well as attentively listening to their problems (Ebrahimi *et al.*, 2016:16). Therefore, an interaction between UNMs and NQRNs in the unit where an opportunity to share emotions, feelings and experiences is provided.

6.3.4.2.9 Acquired Knowledge and Skills

Providing care based on professional knowledge and skills includes the ability to collaborate with other health care professionals, develop intrapersonal relationships, educate and instruct, manage nursing care, ensure safety and quality of nursing and expand the capacity of nursing (Fukada, 2018:3). NQRNs provide daily care in fast-changing clinical settings using abilities acquired through knowledge and skill acquisition processes (Fukada, 2018:5). Gregg *et al.* (2013:157) reported that about 80% of new graduates revealed that they did not have sufficient knowledge and skills to work at their clinical unit.

In this case, support can be a formal tangible service that can be given and received such as unit visits for nursing rounds or on the spot teaching by UNMs where there is sharing or exchange of knowledge and skills as well as seeking help from others. Guay (2011:69) revealed that to mitigate their fear of independent practice, NQRNs must be knowledgeable of someone to turn to if they need consultation in case they encounter some challenges. Support for NQRNs is enhancing personal and professional competence. Ramathuba & Makhado (2021:3) defined support as a network of mutual exchange that is based on honesty, rewards and policies that value the contributions and cares about the well-being of its employees. This is seen as cited by participants: "*My manager used to praise me every day, "So, I become excited-more excited yoo yah! I'm doing well….*" Meaning that support can also, come through goal achievements, which is increased emotional, physical, psychological and social health and well-being of the NQRNs.

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6.3.4.3 Identification of Surrogate Terms

Rodger & Knafl (1993:83) defined 'surrogate' as a philosophical position that a concept may be expressed in different ways. According to Rodgers (2000), surrogate terms could be used to express a concept in multiple ways, and related concepts helped to increase the significance to the concept of interest. During the collection it was revealed that surrogate terms for the word support were:

6.3.4.3.1 Coaching

Coaching is a process of equipping people with the tools, knowledge, and opportunities they need to develop themselves and become more effective (Peterson & Hicks, 1996:14). Coaching is a tool of opening people's potential to develop self-confidence and maximize their performance to attain intended goals (Karise & Berg, 2020:4). NQRNs may have difficulties in adjusting to their new RN role due to increased levels of stress which may remain within one year of employment associated with inappropriate job expectations and lower clinical competence. Nurse managers who provide a supportive environment and coaching that meets NQRNs' needs during this period can help nurses establish higher levels of competence and decrease the subsequent clinical pressure (Cheng *et al.*, 2014:7).

6.3.4.3.2 Mentoring

Mentoring is a confidential supportive relationship between two people, in which a more experienced person guides a less experienced person with the goal of reaching their full potential (Hodgson & Scalan, 2013:389). In nursing, mentoring is described as a process in which an experienced, wise, and trusted nurse guides a less experienced nurse (Short, 2002:135) who has the potential to reach the desired goal. For mentoring relationship to be successful between the two parties, there must be a personal connection, mutual trust and respect. When a mentoring relationship is positive, it will be possible to share the valuable tacit knowledge through active

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engagement and respectful communication between the UNM and NQRNs and this allows NQRNs to develop skills and confidence. An existing trusting relationship between NQRNs and mentor results in them feeling safe to ask questions and seek support. Knowledge transfer from UNMs to NQRNs is crucial in maintaining quality patient care (Grover, 2015:17). Mentoring can be achieved through the sub-role functions of 'teaching, socializing, providing opportunity, sponsoring, coaching, guiding, protecting, advising and counselling, encouraging, inspiring, challenging, role modelling, supporting and befriending' (Hayes, 2005:442). Therefore, there is great need for UNMs to share and transfer their expertise and help developing NQRNs to become competent and independent nurse practitioners.

6.3.4.3.3 Guidance

Guidance refers to advice or information giving by an experienced person to a less experienced person aimed at resolving a challenge or problem faced with (Longman Dictionary of Contemporary English, 2009:779). Like mentoring, guidance can be achieved through advice, direction, instruction giving, counselling and teaching. Unit Nurse Managers can guide NQRNs by helping them understand and prepare for the challenges they may face in their new role. Doing so not only makes NQRNs more resilient, but also lowers the attrition rate, helps units run more smoothly, and improves delivery of care to patients (Chandler, 2012:104). New nurses should have ample opportunities to practice their skills and see positive outcomes. They should also feel welcomed, valued, and encouraged to ask questions (Tylor, 2015:24). All these can only occur when NQRNs feel nurse managers are there for them to rely on for guidance. Therefore, support and guidance from experienced registered nurses can enhance NQRNs' sense of belonging (Tylor, 2015:18).

6.3.4.4 Identification of References

The actual situation to which the concept support is applied is referred to as references

(Rodgers & Knafl, 1993:83). It assists to identify the extent of the concept in order to have insight and apply it appropriately. References is the term Rodgers (1989:334) used to refer to the 'events, situations, and phenomena' to which the concept has been applied. By identifying the empirical referents, the researcher will be able to determine the level of support for NQRNs. The empirical indicators were determined from the characteristics of support for NQRNs as shown in Table 6.1.

6.3.4.5 Identification of Antecedents

Rodger & Knafl (1993:83) defined antecedents as aspects that normally precede the word. In the present study, antecedents are those factors facilitating support for NQRNs (R.683) in their new RN role. As NQRNs are inexperienced entering a complex work environment that is resource constrained with unrealistic expectations that they will 'hit the floor running' may be challenging and stressful (Regan, Wong, Laschinger *et al.*, 2017:247).

This may be compounded by NQRNs' lack of sufficient clinical knowledge and self-confidence, and fear of making mistakes and accountability associated with the new role (Kumaran & Carney, 2014:5) as well as poor working conditions such as having to deal with an increased number of patients, shortage of nurses (Wolff, Regan, Pesut & Black:2010:1), inappropriate skills mix, and high patient acuity (Hussein, Everett, Ramjan, Hu & Salamonson, 2017:2), sudden increased level of responsibility and accountability that come with being a RN (Kumaran & Carney, 2014:4), and the lack of sufficient support both from the clinical environment postgraduation and from UNMs, colleagues and mentors (Hussein *et al.*, 2017:2) and being left alone without strategies to thrive (Mellor & Gregoric, 2016:331), resulting in stress and job dissatisfaction, leading to NQRNs leaving within the first year of employment (Flinkmn & Salanterä, 2015:1051; Simon, Müller & Hasselhorn, 2010:621) and, thus, an overall rise in attrition rate of NQRNs. The employee who feels that the manager is unfair or unfriendly will

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always feel like quitting the job (Ugoani, 2016:1064).

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Table 6.1: Empirical references for support

Attributes of theoretical definition of support	Empirical referents
Supportive interpersonal relationship within the initial months of entry to the new role	UNMs or experienced registered nurses have positive relationship with NQRNs. Both senior and junior nurses treat NQRNs with respect and treat them as professionals. Both parties interact positively, respecting each other's feelings. Unit managers accept NQRNs as novices who need coaching and guidance in the new role, and correct them in a professional manner without apportioning blame. NQRNs feel welcomed, loved and a sense of belonging where it is easy for them to ask questions and request assistance or help if required through the supportive relationship with nurse managers.
Positive workplace environment	NQRNs are professionally socialized in a positive workplace environment and provision is made for personal and professional growth and development. NQRNs are able to function independently with confidence, without fear or anxiety of making mistakes in their new role. There are adequate human resources to combat the challenge of shortage of staff and thus improves skill mix and working prescribed hours. There is adequate workload which enable NQRNs to apply their knowledge and skills with regard to unit management. There are policies, protocols or guidelines and regulations to regulate NQRNs to function within their scope of practice.
Sufficient orientation	Through sufficient orientation, NQRNs are familiar with their workplace environment, staff, protocols, policies and procedures as well as their job description. NQRNs are certain about the nature and values of the new registered nurse role. They are able to apply the principles of unit management and enhance performance.
Clear and reasonable expectation	NQRNs accept and cope with the assigned responsibility and accountability without extraordinary expectations that may cause stress. Nurse managers are aware of NQRNs level of competence and thus expect performance and behaviour based on their level of education. NQRNs are able to complete allocated tasks timely and thus boost their morale. NQRNs are able to express feelings of perceived support without stress that hinders them from coping.

Continued/…

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Table 6.1: Empirical references for support (continued)

Attributes of theoretical definition of support	Empirical referents
Active participation in unit management	NQRNs are involved in unit management activities to stimulate their learning, professional growth and development. NQRNs are able to utilize the knowledge and skills gained during their training. They are able to autonomously perform unit management activities such as taking rounds with doctors, planning duty roster for unit staff, managing scheduled substances, formulating unit Standard Operating Procedures (SOPs), etc.
Knowledge and skill sharing	Knowledgeable and skilled unit managers transfer their expertise to NQRNs. NQRNs receive on the spot teaching, on the job teaching or in-service education offered by the expert. They are able to utilize the acquired knowledge and skill to make decisions and solve problems in the unit independently.
Role modelling	UNMs working hand-in-hand with NQRNs enable them to observe their expertise in performing activities and emulate them. Positive role modelling mold future competent and responsible nurse practitioner who can render quality and safe patient care.
Constructive feedback	NQRNs improve in self-confidence, competence and job satisfaction. Unit managers stimulate NQRNs by encouraging their professional development, giving praise for outstanding performance. Acknowledgement of NQRNs' newly achieved skills such as decision-making, problem-solving or critical thinking skills makes them feel supported.
Opportunity to vent feelings and concerns	NQRNs are emotionally stable without fear or frustration of expressing their feelings. They are able to express their emotions, feelings and experiences in an honest manner. They are able to express perceived support and to cope with their emotions.

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Therefore, support can only occur if there are friendly and welcoming attitude, good interpersonal relationship of mutual trust and respect, good communication skills, willingness and commitment or dedication for personal and professional learning, growth and development, empathy and sympathy, openness, self-awareness, honesty and loyalty, team cohesion. For support to take place, both parties (front-line nurse managers and NQRNs) must be self-aware of the knowledge and skills which they possess or lack in order to be open and honest to each other so that they can share the information resulting in development of good interpersonal relationship with mutual trust and respect. Both parties should be empathetic and sympathetic to accept and treat each other in a professional way and thus enhance personal and professional growth and development. Therefore, good communication skills and team cohesion is imperative to cement the interpersonal relationships required for support to take place.

6.3.4.6 Identification of Consequences

Rodgers (1989) referred to consequences as the phenomena that result from the use of the concept. Consequences are defined as events or incidents that occur as a result or outcome of the concept (Walker & Avant, 2005:73). When applied to the present study, the consequences of support for NQRNs (R.683) in their new registered role should be considered. The following outcomes were identified as consequences of the concept of support: competence, confidence, independence, accountable for acts and omissions, and job satisfaction. These consequences are appropriate if NQRNs are supported when they enter their new RN role, they will display job satisfaction through provision of quality and safe patient care with confidence as competent independent nurse practitioners who are accountable for their acts and omissions.

6.3.4.7 Identification of the Concepts Related to the Concept of Interest

Related concepts are concepts that have some relationship with the concept, but do not have the same set of attributes as the concept (Rodgers, 2000). The terms related

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to the concept of support may aid in gaining insight and enhancing communication of the objectives of support. The following concepts were identified as concepts that were used interchangeably with the concept support: advocate, backup, assistance, encouragement, strengthens, providing means.

Advocate

Advocacy is derived from advocate, which is a 'person that pleads a case on someone else's behalf' (Oxford Online, 2006). Another source defines advocacy as 'the act or process of advocating or supporting a cause or proposal' (Merriam-Webster Online, 2006a). Advocacy has been defined as correcting a deficit of a client by another (Grace, 2001), informing a person of their rights and providing information (Segesten, 1993), supporting the client (Kohnke, 1982), and giving voice to silent patients (Gadow, 1989). Advocacy can be used by senior experienced nurses to support NQRNs in their new role as RNs to correct shortfalls and acting on their behalf.

Backup

Backup means providing support for someone or something, using extra personnel when additional help is required, standing by as alternative or substitutes, and giving moral support (Complete Wordfinder Dictionary and Thesaurus, 1993). The RN role is multifunctional and can lead to physical, emotional and psychosocial strain. This cause NQRNs struggling to fit in the workplace to an extent that they require backup.

Assistance or Aid

It is an action which contributes to the fulfilment of a need, or furtherance of an effort or purpose. It is an act of assisting, aiding, helping, in support of (Complete Wordfinder Dictionary and Thesaurus, 1993). The new RN role is challenging and uncertain, leading to anxiety and stress when expected to perform certain administrative tasks. Therefore, NQRNs should be assisted with mentoring or in-service training.

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Encouragement

This is a human act of giving hope or support to someone. It is an expression of approval and support, moral building or booster (Complete Wordfinder Dictionary and Thesaurus, 1993). NQRNs deserve non-monetary rewards in the form of praise or encouragement. They need to be recognized and acknowledged for their outstanding performance in their new role. Thus, UNMs need to maintain good interpersonal relationship, trust, respect and open and honest communication by always being visible to monitor and give praise. Perceived support increases job morale and dedication or commitment.

Provide

It is the provision of what is desired or needed, especially support for sustenance (Complete Wordfinder Dictionary and Thesaurus, 1993). For NQRNs to render quality care confidently as competent independent practitioners, they require adequate human and material resources. When materials are inadequate, it leads to low morale, job dissatisfaction, low performance, low productivity and stress. UNMs should ensure that they provide required support and resources so that NQRNs can reciprocate with effort and commitment.

6.3.5 Analysis of Data Regarding the Characteristics of the Concept 'Support'

Data depicted from the definition of the concept 'support' were analyzed for similarities and differences. The researcher read through the meaning of support in literature. Common words were underlined and clustered. Clusters were developed and themes were defined as reflected in Table 6.2. Prerequisite for support to occur is Theme 1 with the following antecedents: friendly welcoming attitude, good interpersonal relationship of mutual trust and respect, willingness and commitment or dedication for personal learning, growth and development, empathy and sympathy, openness, self-

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Table 6.2: Analysis of the concept support for NQRNs within their initial months of entry into the new role

Theme	Clusters
1. Prerequisite for support to occur	Friendly welcoming attitude, good interpersonal relationship of mutual trust and respect, willingness and commitment or dedication for personal learning, growth and development, empathy and sympathy, openness, self-awareness, honesty and loyalty, team cohesion (Johnstone, Kanitsaki & Currie, 2008:52; Ramathuba & Davhana-Maselesele, 2015:76).
2. Significant activities for support to occur	There must be interaction between experienced nurses and less experienced ones because support occurs where there is a supporter and the supported. Active participation is imperative for both parties. There should be willingness to share acquired knowledge and skills. An opportunity to freely vent their feelings and concerns. This happens if there is mutual interaction, cooperation and collaboration.
3. Process of support	Both parties should be willing to communicate openly and accept each other's shortcomings as well as constructive criticism. Providing an opportunity to use existing knowledge and skills to practice unit management skills. Changing negative attitude towards each other and treat each other in a professional manner.
4. Appropriate support	Support includes the presence of a committed friendly, reassuring, non-judgemental and respectful expert who is willing to aid, encourage and strengthen the less experienced individual who requires support and ready to request support from resourceful people (Johnstone *et al.*, 2008:52).

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awareness, honesty and loyalty, team cohesion (Johnstone, Kanitsaki & Currie, 2008:52; Ramathuba & Davhana-Maselesele, 2015:76). Hence, for support to take place, unit nurse managers and NQRNs must be self-aware of the knowledge and skills which they possess or lack in order to be open and honest to each other so that they can share the information resulting in development of good interpersonal relationship with mutual trust and respect (Ebrahimi *et al.*, 2016:12). Both parties should be empathetic and sympathetic to accept and treat each other in a professional way and thus enhance personal and professional growth and development. Therefore, good communication skills and team cohesion is imperative to cement the interpersonal relationships required for support to take place (Van Dyk & Van Rensburg[2], 2021:7).

Significant activities for support to occur was classified as theme two with the following activities: There must be interaction between experienced nurses and less experienced ones because support occurs where there is a supporter and the supported. Active participation is imperative for both parties. They should be willing to share acquired knowledge and skills. An opportunity to freely vent their feelings and concerns (Ebrahimi *et al.*, 2016:19). This happens if there is mutual interaction, cooperation and collaboration between them. For support to occur between the UNM and NQRNs there must be mutual interaction where both are ready and willing to cooperate and collaborate with each other (Oshod *et al.*, 2019:886). They must be committed and willing to share knowledge and skills. It is revealed that provision of NQRNs with an opportunity to utilize their existing knowledge and skills to practice enhances their courage and confidence to practice competently, safely, and effectively in their level of education and practice (Johnstone *et al.*, 2008:52).

Process of support is Theme 3 with the following processes for support to occur: Both parties must be willing to communicate openly and accept each other's shortcomings

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as well as constructive criticism. Providing an opportunity to use existing knowledge and skills to practice unit management skills. Changing negative attitude towards each other and treat each other in a professional manner. For support to happen, both parties must be aware of their strengths and weaknesses as well as willing to respect each other views even where there are differences. The experienced nurses must be ready and willing to acknowledge their own shortcomings and accept constructive criticism. Consequently, the less experienced nurses will emulate them and thus cement the working relationship. NQRNs learn easy from the person who is open and honest as they trust and respect him/her. Appropriate support is Theme 4 with the following descriptors: Support includes the presence of a committed friendly, reassuring, non-judgemental and respectful expert who is willing to aid, encourage and strengthen the less experienced individual who requires support and ready to request support from resourceful people (Johnstone *et al.*, 2008:52). In this theme, both parties will be aware that there is a need for support to take place.

6.3.6 Identification of a Model Case

Chinn & Kramer (2011:166) referred to a model case as an exemplary case, a true representation of a situation, event or experience to the best of one's current understanding. The role of the model case is to enhance the degree of clarification by providing an everyday example which includes the attributes of the concept (Rodgers & Knafl, 1993). According to the evolutionary perspective of concept analysis, model cases are not constructed, but identified from the interview data collected in order to understand the meaning of support as narrated by NQRNs who were new in their RN role. The following model case illustrated the defining attributes of support:

- **Model case of newly-qualified registered nurse, Miss Zyle, worked for fifteen (15) years as an enrolled nurse in different units of hospital X.**

She trained in a bridging course for ENs leading to registration as a general nurse

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(R.683) and completed her Diploma in General Nursing Science within two years as prescribed. During her training, Miss Zyle **was not allowed to take rounds with doctors, to write duty roster as well as manage schedule substances, but was allocated to continue with ENs' duties**, e.g., giving oral medication and injections. When senior RNs were counting and recording unit drugs **they did not involve her, but she used to go and watch what they were doing and learned from there**.

Post-graduation, Miss Zyle was immediately placed on night shift in a medical unit with various cubicles. She was told to start **acting as an in-charge of the cubicle with eight (8) patients alone,** which was the hardest in the unit. She was frowning and throwing hands while narrating her frustration and said: "Believe me, it was hectic! and I felt miserable."

Miss Zyle was not orientated nor supervised in her new RN role on night shift. When **she raised her concern to the operational manager**, she was told that it is long she has been working as a nurse in different units and she should be knowing everything.

Miss Zyle further complained of **the appalling attitudes of both senior and junior nurses in the unit and that their relationship was pretentious** as they were no longer interested in showing her how things were done in the unit. What worsened her situation was that **no one supported her while she was struggling with the expanded responsibility of a RN role**, but **when things went wrong seniors showed up and apportioned blame**, forgetting that she was new in that role and still needed to be supported.

She **was expected to do better in all areas** in that busiest cubicle with less experience, **she did not know what to do and where to get help**, which was challenging and stressful. As she did not have anyone to rely on, she opted to use her previous knowledge and skills acquired as an EN to manage that hectic cubicle.

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However, there was not enough time to do things correctly because of shortage of staff as she had to be hands-on with the patients and be accountable for updating the patients' records and administrative activities in that cubicle. In this model case, NQRNs expressed their feelings of frustration, misery and stress about the attitude and relationship with the unit staff in their new role which reduced their morale. They were dissatisfied by poor orientation and supervision as well as the manner in which they were being treated, particularly lack of involvement or participation in unit management activities. The workplace environment was not conducive as newly-qualified nurses were faced with resource constraints such as time and personnel which had a negative impact on their performance. They were also expected to carry out the expanded responsibilities of the new role alone without a shoulder to lean on, no role model to emulate and no one to give them constructive feedback to elevate their confidence and thus enhance their competence. Though they had previous nursing knowledge as ENs, the scope of the RN was not inclusive, hence, they were stressed and frustrated.

6.4 Support for NQRNs (R.683) Within the Initial 18 Months of Entry Into the New Role

Support refers to a friendly and non-judgmental professional assistance, guidance and coaching in the form of emotional, instrumental and informational aspects from an understanding, committed, empathetic, knowledgeable and skillful role model to a less experienced vulnerable NQRN who is willing to receive and accept feedback to elevate self-confidence and thus functions independently as a competent nurse practitioner (Emanated from the concept's identified attributes).

6.5 Conclusion

Chapter 6 discussed concept analysis following the 6 steps elucidated by Rodgers & Knafl (1993:90). The concept 'support' was identified and defined using different

identified characteristics of support. Chapter 7 focuses on model development based on Dickoff, James & Wiedenbach (1968:434-435).

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CHAPTER 7

MODEL DEVELOPMENT

7.1 Introduction

Chapter 6 discussed concept analysis following the steps of Rodgers & Knafl (1993:90). The concept 'support' was defined using the dictionaries and the subject. Data on support was analyzed and themes were developed. These gave clarity to how support could be enhanced when supporting NQRNs (R.683) within their first eighteen months of employment in clinical practice within selected hospitals of Limpopo Province, South Africa. Chapter 7 focuses on model development, using the framework of Dickoff, James & Wiedenbach (1968:434-435).

7.2 Obejective

The objective of this chapter was to:

- Develop a model to enhance support for NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.

7.3 Conceptual Framework for Model Development

Conceptual framework refers to a system of concepts, assumptions, expectations, beliefs, and theories that support and informs research (Maxwell, 2005:39). It guides both the researcher and reader to understand what takes place and how it happens in the study, and thus it is a vital part of the research design. Miles & Huberman (1994:18) defined a conceptual framework as a visual or written product that explains graphically

or in a narrative form, the main things to be studied and the key factors, concepts, or variables as well as the relationship among them (Miles & Huberman, 1994:18). In this study, the conceptual framework was constructed based on the findings of Chapters 4 and 5, and literature reviewed. The core concepts from the convergence study findings were identified and classified following 6 survey list elements of practice theory as follows: the agent, recipients, context, procedure, dynamics and terminus as well as their related questions (Dickoff, James & Wiedenbach, 1968:422-423). Figure 7.1 depicts the survey list and related questions.

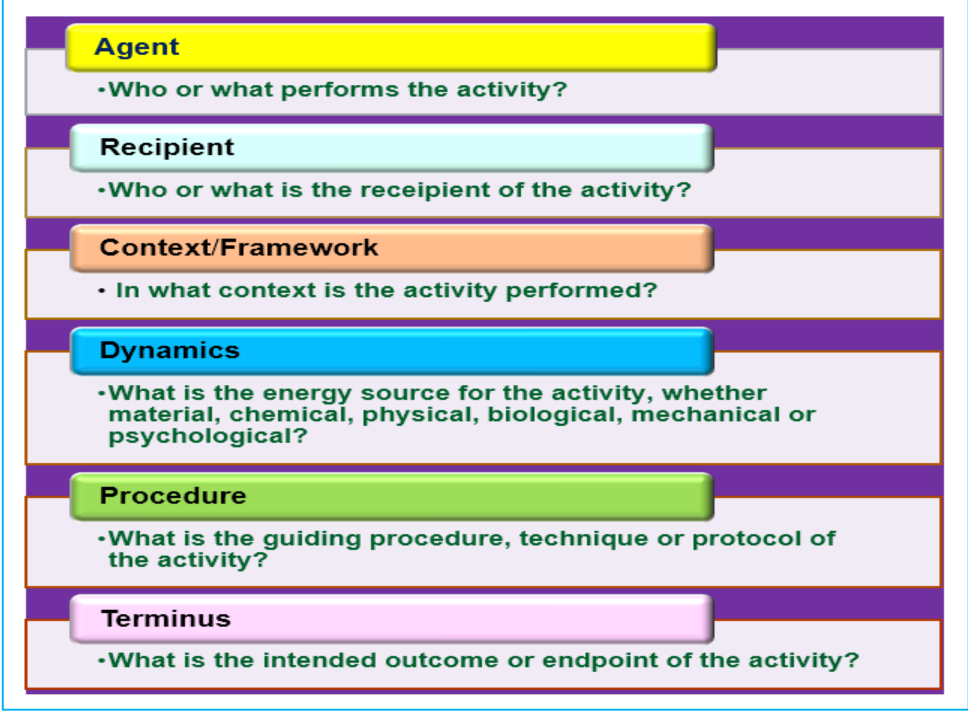

Figure 7.1: Survey list of activities and clarifying questions (Dickoff *et al.*, 1968:422-423)

7.3.1 Definition of Concepts Used in Developing the Conceptual Framework to Direct Model Development

7.3.1.1 The Agent

The agent is described as a person who performs an activity towards the relation of a goal (Dickoff *et al.*, 1968:425). Bodrick (2011:202) indicated that the nature of the agent

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stimulates activities that are creative, constructive and significant within performance that is aimed at goal accomplishment. In this study, the agents contributing to the realization of support are UNMs or experienced RNs as they are involved in planning, organizing, managing and controlling all unit activities, including both human and material resources. UNMs as agents supervise, coach, guide, mentor and evaluate NQRNs' learning needs during mentoring. They facilitate the implementation of the process to enhance support for NQRNs within their initial months of employment.

7.3.1.2 Recipient

A recipient is a person who receives action from the agents (Dickoff *et al.*, 1968:427). In this study, the recipients are NQRNs (R.683) as they receive support from UNMs or experienced RNs during their initial eighteen months of employment in their new role. Recipients were involved in the realization of the purpose of the model. They are the ones who should receive support from UNMs or experienced RNs during their initial months of employment to their new role. Support of newly-qualified nurses throughout the full first year of practice can promote the development of professional confidence (Pertiwi & Hariyati, 2019:613).

7.3.1.3 Context

According to The Oxford Advanced Learner's Dictionary (2010:314), a context is the situation within which something happens or occurs, and that can help to explain and understand it. Dickoff *et al.* (1968) referred context as a framework or as the environment in which activities take place. Context may also be regarded as a setting or circumstances. An activity cannot be performed, except when there is an environment where it will take place. The context specifies the milieu within which an activity will take place. For the purpose of this study, the context was the location or setting where the study was conducted, an environment where data were collected as well as the place where the model will be implemented because this study is contextual

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in nature. In this study, the context was any nursing unit in selected hospitals in Mopani and Vhembe districts of Limpopo Province where NQRNs (R.683) were currently employed and supported within their first eighteen months in the new role and the relevant legal frameworks.

7.3.1.4 Dynamics

Dynamics are chemical, physical, biological, or psychological power sources driving an activity or person towards goal attainment (Dickoff *et al.*, 1968:431). In order for NQRNs (R.683) to be supported by UNMs or experienced RNs, certain dynamics should occur. The dynamics may be barriers or enhancers of model implementation (Ntshingila, Temane, Poggenpoel & Myburgh, 2021:5). In this study, dynamics involve open communication, active listening, establishing a safe and supportive environment, information sharing, and having an unbiased demeanour or sense of objectivity.

7.3.1.5 Procedure

The procedure highlights the path, steps, or pattern according to which the activity is performed to attain the goal (Dickoff *et al.*, 1968:426). A procedure describes the sequence of steps, and specifies for each step what needs to be done, often including when the procedure should be executed and by whom. In this study, procedure refers to all activities involved in enhancing support for NQRNs in their early employment period. The procedure or process includes building rapport, facilitation or execution, and monitoring and evaluation.

7.3.1.6 Terminus

The terminus is the outcome or endpoint or an achieved goal of an activity (Dickoff *et al.*, 1968:). It is the intended end result after the implementation of the model. The UNMs as agents should bring about change by facilitating the support process by involving and guiding NQRNs towards the goal of the procedure. The expected

outcome after model implementation encompasses: effectively supported NQRNs resulting in empowered, competent, confident and independent RN. Figure 7.2 illustrates the conceptual framework for a model to enhance support for NQRNs (R.683) in their new role.

Concepts Identified from Research and Classified Based on Dickoff *et al.* (1968)

Concepts		Classification
1. Unit nurse managers (UNMs)	→	AGENTS
1. Newly-qualified registered nurses (NQRNs)	→	RECIPIENTS
1. Legal frameworks 2. Clinical practice areas	→	CONTEXT
1. Building rapport 2. Facilitation or Execution 3. Monitoring and Evaluation	→	PROCEDURE OR PROCESS
1. Communication 2. Active listening 3. Establishing safe environment 4. Information sharing 5. Unbiased or objectivity	→	DYNAMICS
Effective Support Empowered, competent, confident & independent RN	→	TERMINUS

Figure 7.2: Classification of concepts according to Dickoff *et al.*’s (1968) survey list

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7.4 Description of the Concepts and Their Application to Model Development

In this section, a detailed description of the concepts and their application in model development is outlined.

7.4.1 Agents

Unit Nurse Managers are skillful in facilitating the activities essential for the implementation of the model to enhance support for NQRNs (R.683) in selected hospitals of Limpopo Province. Therefore, agents should possess internal and external resources that are crucial to the realization of the goal (Dickoff *et al.*,1968). For the goal to be accomplished, UNMs as agents should possess the following values: empathy, courage, competence, commitment, confidence and motivation. They should also have knowledge and skills to be able to support NQRNs. The agents should+ have knowledge acquired through experience in the nursing field. However, for them to effectively support recipients they should keep their knowledge up to date as nursing is a dynamic profession with continuous changes and developments. Unit Nurse Managers should possess a wide range of skills to identify and understand the support needs of NQRNs.

Unit Nurse Managers should possess communication and listening skills. In addition, interpersonal relationship skills are imperative to build a goal-focused relationship with recipients (NQRNs). The success of a process depends on the quality of communication skills between UNMs as agents and NQRNs as recipients involved in the process. In addition, the following skills are also imperative in the process: planning, role assignment, management of unit resources, supporting unit staff, motivating, encouraging, and creating a supportive environment. Nurmeksela, Mikkonen, Kinnunen & Kvist (2021:10) indicated that although nurse managers play the role of unit management, it is equally significant that they set time to support and

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motivate their personnel.

Unit Nurse Managers by virtue of being experienced professionals, are competent, confident and have knowledge and skills regarding effective management of patient care. They should support NQRNs through orientation, coaching, supervision and mentoring. Utilization of these different strategies by UNMs plays a critical role in helping NQRNs to integrate into clinical units, which benefits their job satisfaction and eventually impacts the quality of care provided in the unit. In their study, Scott, Engelke & Swanson (2002:75) identified that orientation programmes are imperative in retaining and satisfying new graduate nurses. Coaching as another support strategy that benefits both NQRNs and the organization (Baxter, 2013:56).

Supervision is a managerial skill involving guiding, helping, inspiring, advising and leading newly-qualified nurses. It provides guidance which plays a significant role in the professionalization of newly-qualified nurses (Moeti, 2002:21). ElZenemy, Seada & El AleamEteny (2017:8) asserted that effective supervision empowers, supports and helps newly-qualified nurses to grow and develop professionally. Mentoring takes place when the experienced professionals offer support and guidance to junior or inexperienced staff member. The mentor acts as a teacher, friend or guide and is actively involved in the empowerment and professional development of the newly-qualified nurses (Meyer, Naudé, Shangase & van Niekerk, 2009:160).

Commitment of experienced professionals in provision of effective support to newly-qualified professionals is imperative in enhancement of graduates' ability to adapt to the new role. Hence, it is important for UNMs and newly-qualified nurses to have a relationship of trust and respect. Unit Nurse Managers as mentors should be approachable, have effective interpersonal skills, adopt a positive teaching role, be concerned about learning, be a supervisor and develop professionally on a continuous

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basis (Meyer *et al.*, 2009:161). Therefore, they should take time out to help newly-qualified nurses to learn during their initial months of professional development in order to progress towards attaining professional maturity and identity. For effective support to take place, the agent must be a good listener, and have a good insight of the objectives and activities towards goal achievement. Furthermore, agents should be able to maintain the established interpersonal relationship between themselves and NQRNs as well as having the ability to support them. From the findings of this study, participants indicated that they experienced negative attitudes and relationships from staff and senior nurses.

Therefore, UNMs as agents of this model should play a supportive role to NQRNs. Hence, this model will enhance support for newly-qualified nurses. Zare, Mahmoudirad & Vanaki (2015:5) indicated that nurses who perceive that they are working in an empowering working environment probably provide high-quality care which in turn provides them and their patients with greater satisfaction. Unit Nurse Managers or experienced RNs working in different units in public hospitals are registered with the SANC as registered or professional nurses whose understanding, knowledge, skills and capabilities add value, and quality on provision of adequate unit management activities by NQRNs. UNMs can delegate and guide NQRNs to:

- Perform unit management functions under the supervision of an experienced RN to be acquainted with unit management processes such as planning of duty rosters and delegation, organizing human and material resources for the unit, leading or directing in the unit and controlling.
- Perform unit rounds with doctors, nurse managers and other multidisciplinary team members.
- Participate in an occupational health and safety committee, auditing

committee, formulation of unit standard operating procedures (SOPs).

- Participate in drawing up unit orientation programmes.
- Participate in drawing unit in-service training programmes based on identified unit personnel's learning needs. The programme should be design to attend to the learning needs of NQRNs, and, relevant knowledgeable and skilled persons should be allocated to in-service unit staff who should embrace lifelong learning.
- Participate in unit staff's skills audit and assist in the designing of unit staff development programmes to cater for formal training, including staff who are offered study leave and those who should attend short courses.
- Unit Nurse Managers as role models in the nursing unit should facilitate the transfer of management skills to NQRNs by being available, approachable and accessible so that newly-qualified nurses can achieve their clinical autonomy.
- Encourage NQRNs to engage in a process of self-inquiry, development and learning through reflection in order to effectively realize their vision of practice as competent independent practitioners.
- Undergo training on topics that facilitate self-actualization that could be organized by the institution in collaboration with occupational health practitioners.

Figure 7.3 is a diagrammatic representation of the agents in this study, i.e., UNMs.

7.4.2 Recipients

Recipients are persons who receive action from the agents (Dickoff *et al.*, 1968:427).

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In this study, the recipients are NQRNs (R.683) as they receive support from UNMs or experienced RNs during their initial eighteen months of employment in their new role. Recipients were involved in the realization of the purpose of the model.

Figure 7.3: Agents in this study, i.e., unit nurse managers

They are the ones who should receive support from UNMs or experienced RNs during their initial months of employment to their new role. Support of newly-qualified nurses throughout the full first year of practice can promote the development of professional confidence (Pertiwi & Hariyati, 2019:613).

However, the study findings revealed that NQRNs were not orientated nor supported within their initial months of entry to the new role in the nursing unit. It was also, identified that NQRNs were deprived an opportunity to practice unit management activities. Therefore, NQRNs should be orientated about what is expected from them as well as what to expect in their new role. Supportive orientation helps newly-qualified nurses to assimilate into their new work environment, to adapt to their new scope of practice and thus enhances newly-qualified nurses' job satisfaction in the nursing unit (Pertiwi & Hariyati, 2019:613).

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Recipients should have determination to be involved and actively participate in the execution of the process of the model. They should be actively involved in the whole process of model implementation. The formulated guidelines include activities to guide the operation of their practice, particularly execution of unit management activities and to deal with challenges presented by participants. The ability to manage the unit as NQRNs within the initial period of employment in the new role is vital to NQRNs (R.683), particularly in relation to execution of unit management activities such as conducting doctor's rounds, management and control of scheduled substances in the unit, writing duty roster, etc. Empowering NQRNs with appropriate knowledge and skills will have positive impact on unit management activities. As long as both agents and recipients have positive attitudes towards each other, they will be able to address challenges encountered by NQRNs and thus improve guidance, mentoring and support from UNMs.

Freeling, Parker & Breaden (2017:23) highlighted that negative staff attitudes are the most powerful barriers to graduate nurse support. Nonetheless, nurses experiencing supportive personal relationships find it less stressful to master their professional role (Pennebrant, Nilsson, Öhlén & Rudman, 2012:744). Hence, participants indicated that UNMs should support them in the unit during their initial period of entry to the new role. As leaders, UNMs have two broad and independent functions. One dimension is production or task-oriented, and the other is employee-oriented with a focus on relationships, building teamwork, and employee identification within the organization (Feather & Ebright, 2013:65).

NQRNs as recipients in this study should be able to demonstrate their ability to:

- Independently perform unit management functions such as planning of duty rosters and delegation, organizing human and material resources for

the unit, leading or directing in the unit and controlling.

- Perform unit rounds with doctors, nurse managers and other multidisciplinary team members with confidence.
- Actively participate in the occupational health and safety committee, auditing committee, formulation of unit SOPs representing their units.
- Draw up unit orientation programme for new employees.
- Participate actively in drawing up unit in-service training programmes based on identified unit personnel's learning needs.
- Base the programme on the learning needs of the unit staff.
- Consider to allocate relevant knowledgeable and skilled persons to in-service unit staff and thus to encourage lifelong learning to unit staff.
- Perform unit staff skills audit and design the unit staff development programme to cater for formal training.
- Emulate UNMs to achieve their clinical autonomy.

Figure 7.4 is a diagrammatic representation of the recipients in this study, i.e., NQRNs.

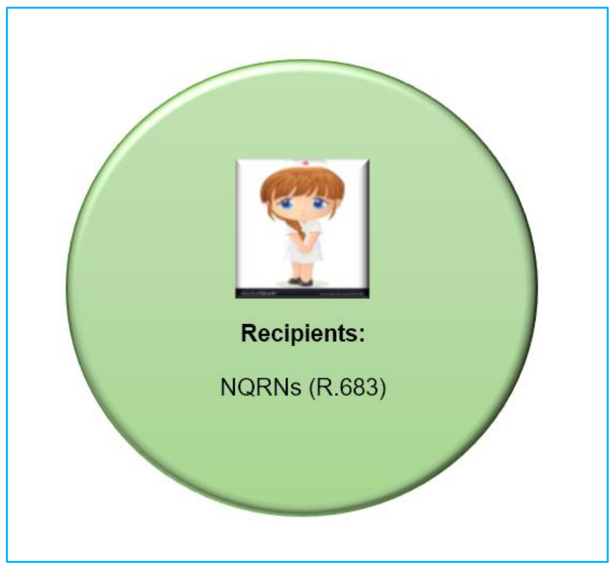

Figure 7.4: Recipients in this study, i.e., newly-qualified registered nurses

7.4.3 The Context

According to The Oxford Advanced Learner's Dictionary (2010:314), a context is the situation within which something happens or occurs, and that can help to explain and understand it. Dickoff *et al.* (1968:422) referred to the context as the framework. The context or framework is the environment, setting, situation or circumstances in which activities take place. An activity cannot be performed, except if there is an environment where it will take place from. The context specifies the milieu within which an activity will take place. For this study, the context was the location or setting where the study was conducted, an environment where data were collected as well as the place where the model will be implemented because this study is contextual in nature.

In this study, the context was any nursing unit in selected hospitals in Mopani and Vhembe districts of Limpopo Province where NQRNs (R.683) were currently employed and interacted with UNMs within their first eighteen months in their new role and within the relevant legal frameworks. Nursing units are clinical areas where NQRNs are empowered with various skills to practice competently and independently. The findings

of this study revealed that NQRNs worked in an unsupportive environment. Participants highlighted challenges that impede NQRNs' ability to learn, grow and develop professionally. To ensure effective support for NQRNs in the nursing unit, the nursing unit's context should be conducive for NQRNs to feel encouraged, safe, motivated and supported. The context in this study was developed for nursing units in selected hospitals.

Figure 7.5 illustrates the context. The **outer orange box** represents SANC's legal frameworks that regulate the nursing profession and nurse practitioners, while **the inner green box** represents the clinical practice context and the professional frameworks. The nursing profession is regulated by legal and professional statutes such as the Nursing Act 33 of 2005 and its regulations, National Health Act 61 of 2003, Batho Pele principles, Human Rights Charter, among others. Both UNMs and NQRNs should have access to these documents, become familiar with their content in order to adhere.

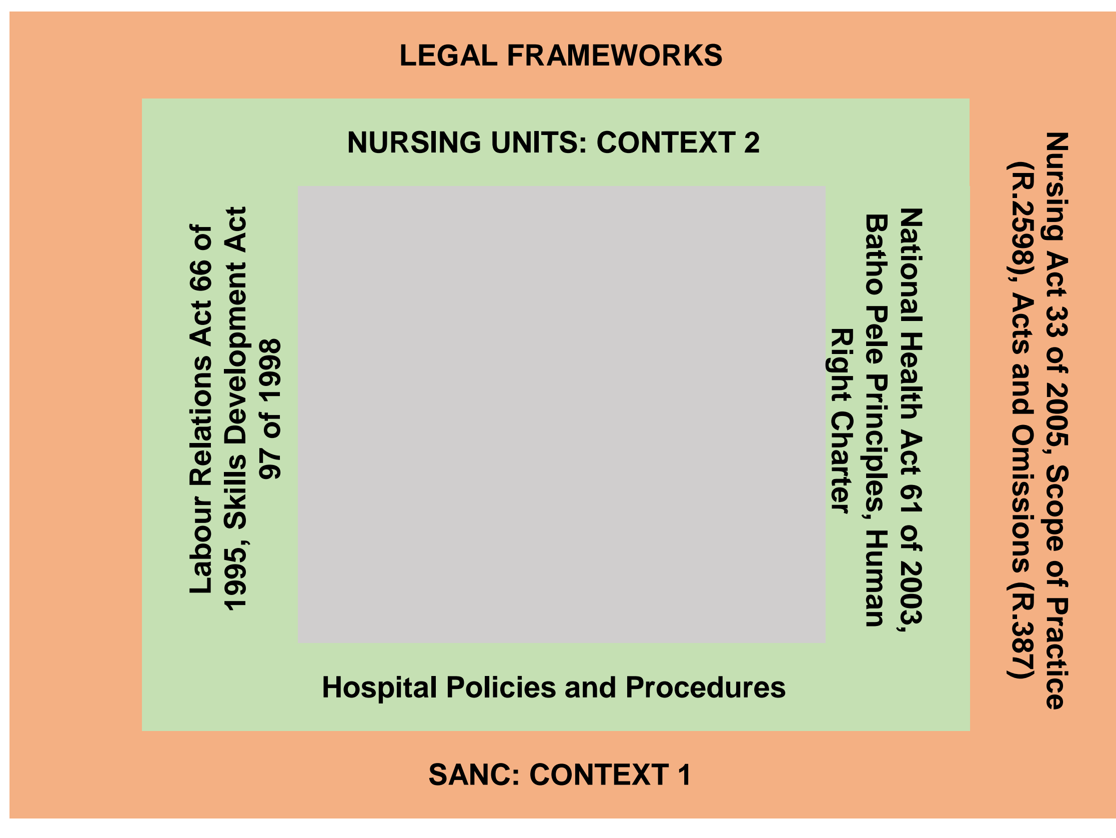

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Figure 7.5: Context as it relates to the model

Although NQRNs possess previous EN experience, the transformation from nursing student to RN role, involve changes in status, roles and responsibility leading to uncertainty, stress and disorientation for NQRNs (Jones, Benbow & Gidman, 2014:44). Therefore, it should be UNMs' top priority to ensure that NQRNs enter the new role with someone to support them in the process of learning, adjustment and socialization to the new role. The relationship between UNMs and NQRNs during their initial period of employment is the impetus for the establishment of a safe and supportive context of the model to enhance support for NQRNs (R.683). Figure 7.5 depicts the context as it relates to the model.

7.4.3.1 The South African Nursing Council (SANC)

In South Africa, the nursing profession is regulated by a statutory body known as the South African Nursing Council (SANC) which enacted by the South African Government in the interest of the public (Nursing Act, No. 33 of 2005:5). The Nursing Act (Act No. 33 of 2005) stipulates its objects in Section 3. Section 3(e) and (i) clearly state the objects of the Council amongst others, that it must maintain professional conduct and practice standards for practitioners within an ambit of any applicable law, and to uphold and maintain professional and ethical standards within nursing (SANC, 2005:7).

Section 4 stipulates the functions of the Council. Sections 4(l)(ii), (i), (iv) and (iii) of the maintain that the Council must determine the conditions under which nurses may practice their profession and the Scope of Practice of Nurses. The Council must determine the requirements for any nurse to remain competent in the manner prescribed, and the acts and omissions in respect of which the Council may take steps against any person registered in terms of this Act (SANC, 2005:7). The SANC provides

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newly-qualified nurses with the license to practice as competent, independent and safe nurse practitioners after completion of the education and training and, in this study, after completion of the bridging programme (R.683).

According to regulation (R.683 of 14 April 1989, as amended) after completion, newly-qualified nurses should be able to practice within the prescription of the relevant laws (R.683, 7(1)(d). Newly-qualified nurses are registered as nurse practitioners who are capable of assuming responsibility and accountability for nursing practice (Nursing Act, No. 33 of 2005:25). Therefore, UNMs should create a conducive supportive environment that will enhance professional development of NQRNs' ability to have critical, analytical and creative thinking capacity to act independently (SANC, 1993:6). According to the Nursing Act, the clinical environment should provide an opportunity for lifelong learning for newly-qualified nurses (Muller & Bester, 2016:500). The UNMs should mentor newly-qualified nurses, directly assisting and supporting them in order to develop competent, independent practitioners who are critical and creative thinkers.

7.4.3.2 Scope of Practice of Registered Nurses (R.2598 of 30 November 1984, as Amended)

There are twenty (20) activities or competencies based on the scope of practice of a RN (R.2598 of 30 November 1984, as amended) to be performed by RNs on completion of their training. On completion of the bridging course (R.683), the scope of practice of the RNs indicated that NQRNs should have the ability (knowledge, skills, values and attitudes) to make correct nursing diagnosis, prescribe, provide and execute a nursing regimen independently, as well as refer what is above their level of practice to registered persons (R.2598, 2(a). Without the supervision, guidance, direction and mentoring of UNMs, it might be challenging for NQRNs to be critical and analytical thinkers in the diagnosing and referral of health care users as prescribed by the relevant scope of practice.

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7.4.3.3 Nursing Unit Context

The context of this study is constituted by the different units in selected hospitals within which support for NQRNs (R.683) is expected to take place. Nurses operate in a health care context which is complex where they are faced with various legal, ethical and professional frameworks that put demands on the nursing units and newly-qualified nurses, who are expected to be competent and render high quality patient care. Pennebrant, Nilsson, Öhlén & Rudman (2012:744) indicated that many nurses work in complex situations, where they depend on assistance from co-workers and nurse managers to successfully transition from school to work. The UNMs should not only be acquainted with the nursing regulatory and ethical frameworks, but must be familiar with the scope of practice of various health care practitioners within the nursing unit (Muller, 2009:100).

The nursing units are core contexts where NQRNs acquire up-to-date knowledge, skills, values and attitudes inherent in the profession of nursing. Therefore, the UNMs should apply professional ethics, social and democratic values as guidelines to create a supportive environment. The SANC's policy in respect of clinical practicals gives guidelines that permits NQRNs to practice in the health services under the supervision of a RN. Therefore, UNMs are charged with the responsibility to create a positive atmosphere where newly-qualified nurses can actively participate as health team members to master unit management skills. The nursing unit environment should be supportive and enabling to facilitate capacity development.

The findings from this study revealed that UNMs have overwhelming workloads that do not allow them time to address NQRNs' learning needs during unit rounds or visits. Furthermore, there is a shortage of staff which resulted in UNMs losing interest in supporting NQRNs. Sodeify, Vanaki & Mohammadi (2013:196) revealed that poor working conditions such as inadequate staffing, high workload and lack of time to

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support newly-qualified nurses are considered as indicators affecting nurses' experience of lack of support.

From the study's findings, participants suggested that they should have mentors to mentor them in their new role. UNMs should provide a supportive learning environment to NQRNs by providing human resources needed to facilitate capacity development for NQRNs. Papathanasiou, Fradelos, Kleisiaris, Tsaras, Kalota & Kourkouta (2014:408) advocated that when staff believe that they have sufficient access to support, resources, and information, they are more likely to have confidence in managers and feel more determined and committed to the goals and policies defined by the hospital (Papathanasiou *et al*., 2014:408).

On orientation, UNMs of NQRNs should familiarize them with the contents of The Labour Relations Act 66 of 1995. It is imperative that they work normal hours as stipulated as well as taking leave as entitled by law. The National Health Act, No. 108 of 1996, as amended, indicated that escalating negative staff attitude towards the patients despite being attended to, therefore UNMs should be positive role models to be emulated by NQRNs and thus benefit patients and the organization.

The Patients' Right Charter emphasizes that referrals should be acceptable to either patients or their families (Muller, 2009:16). Failure to carry out these actions as the scope of practice permits, they are guilty of an offence and the council may institute disciplinary action against them according to rules relating to acts and omissions (R.387 of 15 February 1985, as amended). For them to assume responsibility and accountability for independent decision-making while practicing nursing care needs, the continuous guidance of the unit manager to ensure that unit objectives are met (Meyer *et al*., 2009:225). Newly-qualified nurses should be reminded about the consequences of failure to take care of the patients as required by law where they

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should be accountable for their acts and omissions in accordance with regulation R.387 of 15 February 1985, as amended.

To ensure effective service delivery to patients, newly-qualified nurses should be acquainted with and adhere to Batho-Pele Principles. However, UNMs should formulate a monitoring and evaluation tool to ensure compliance with these principles (Muller, 2009:19). Batho-Pele Principles can also be utilized by UNMs to create a conducive environment to enhance support for NQRNS in their new role.

7.4.3.4 Batho-Pele Principles

Batho-Pele Principles is part of the legal framework that harness government employees with the responsibility and accountability to deliver quality and safe service to the citizens of the republic. The Batho-Pele Principles include consultation, service standards, access, courtesy, information, openness and transparency, redress and value for money (Muller, 2009:19-20). The NQRNs should be acquainted with these principles for service delivery. The UNM should design a strategy to ensure compliance with Batho-Pele Principles to create a conducive environment for supporting newly-qualified nurses.

Consultation

For support to be enhanced, UNMs should involve newly-qualified nurses through consultation approach in case any decision is taken or problem is solved in the unit. This can be done during unit climate meetings where newly-qualified nurses form part of the discussion. The consultation approach assists in active participation by both parties and thus an interpersonal relationship develops as they would be able to cooperate with each other during the meeting or discussion. Hence, unit managers should consult NQRNs so that they feel being part of the team and supported.

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Service Standards

NQRNs enter their new role with new knowledge and skills from school, however, the nursing unit is different from the classroom milieu. The UNMs should inform NQRNs about what is expected from them and what they should expect from UNMs. These service standards enable UNMs to create a supportive environment through guiding, directing and supporting newly-qualified nurses as well as providing an opportunity for them to learn and develop personally and professionally.

Access

Despite the prior enrolled nursing experience NQRNs possess, they should access support like other nurses in the nursing unit. All newly-qualified nurses are entitled to equal access to supportive services from UNM. The increasing accountability, changes and expanding scope of practice for ENs who transited to RN were identified as challenging issues (Cubit & Lopez, 2012:209). Hence, UNMs should create a supportive environment which is conducive for newly-qualified nurses to adapt and cope with work demands and facilitate this equity principle. Cubit & Lopez (2012:209) revealed that graduate nurses expressed the fact that unit staff knew that they were previously ENs, they then left them behind to manage by themselves even though they needed support as much as any other new RNs in the graduate nurse programme.

Courtesy

As human beings are unique, and UNMs should respect and accept NQRNs despite differences in values. For NQRNs to understand and adjust to what is happening in their new role, UNMs should warmly and friendly welcome and treat them as professionals.

Information

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The nursing units have various legal frameworks and it is the role of UNMs to familiarize NQRNs and ensure compliance. The information can be easily received if there is good communication and relationship between the UNMs and NQRNs in the nursing units.

Openness and Transparency

UNMs should be open and transparent in everything they do in the unit. When NQRNs see how open and transparent unit managers are, they tend to trust and have confidence in them. Therefore, where there is trust and confidence towards each other, the environment is conducive for support to take place.

Redress

In the units, NQRNs encounter negative attitudes and bullying and sometimes fail to report due to fear of victimization. Therefore, UNMs should utilize redress as an approach to deal with any complaint or problem as they arise in the nursing units. This will enhance creation of a supportive environment conducive for newly-qualified nurses to work. When NQRNs are free to report and complain to UNM about any challenge they encounter in the unit, it displays an established open and transparent interpersonal relationships between them.

Value for Money

NQRNs who feel welcomed and respected, well-informed about the happenings in the unit, involved in decision-making and problem-solving in the unit and treated with dignity will have job satisfaction and desire to continue working and this saves costs. Social change comes with new challenges, therefore, nurses should have up-to-date knowledge and skills in order to meet the needs of the society at large. In the institution, human resource development department ensures that the Skills Development Plan is implemented based on the Skill Development Act by requesting skills gap analysis

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from each unit. It is the role of UNMs to analyze the skills gap for their personnel and submit to human resource development department for scheduling workshops and in-service trainings.

The organizational culture has an impact on the nature and outcome of performance in the workplace as well as the provision of support (Ramathuba & Makhado, 2021:4). The environment in which support should take place should be conducive in terms of relationships, learning, etc. Kieft, de Brouwer, Francke & Delnoij (2014:2) revealed that a conducive work environment is characterized by clinical competent nurses, autonomous nursing practice, nurse manager support, control over nursing care and a patient-centered care. The nursing unit is a context where UNMs and NQRNs perform their daily activities, UNMs are in charge of the nursing units and responsible for the well-being of the nursing personnel and patients. Newly-qualified nurses enter the new role in a complex context being uncertain of some managerial activities where they need support and guidance. Therefore, it is imperative for both UNMs and NQRNs to establish rapport which should be sustained. The supportive interpersonal relationship is vital between both parties because when NQRNs are stressed due to demands of the workplace and lack of knowledge and skills, it needs UNMs to intervene.

Wong *et al*. (2018:36) revealed that orientation and mentorship programmes can help NQRNs increase their job satisfaction and enhance their confidence in patient care and coping with stress. It is therefore significant to ensure that UNMs are committed and willing to provide effective support in their units by being available, approachable, orientating, coaching, guiding, role modelling, supervising and mentoring NQRNs. To create an environment conducive for newly-qualified nurses to learn, grow and develop, UNMs should be knowledgeable and skillful to mentor, guide, direct, support and involve NQRNs in performing unit management skills. These skills should be

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developed during their training while placed in clinical settings, however, within their initial months of entry to the new role NQRNs should be supervised while performing these skills.

7.4.4 The Dynamics

Dynamics are chemical, physical, biological, or psychological power sources driving an activity or person towards goal attainment (Dickoff *et al*., 1968:431). In order for NQRNs (R.683) to be supported by UNMs or experienced RNs, certain dynamics should occur. The dynamics may be barriers or enhancers of model implementation (Ntshingila, Temane, Poggenpoel & Myburgh, 2021:5). In this study, dynamics refers to displeasing conditions of workplace environment. Participants indicated negative aspects that retard NQRNs' professional growth and development in their new role.

The dynamics in this study were NQRNs' challenges that impede them to be supported in their new RN role. These challenges impaired their ability to perform unit management activities independently, namely, shortage of staff, negative staff attitude and relationship, increased responsibility and accountability, deprived practice opportunity and lack of UNM support. The power drives needed for the UNMs to achieve the goal of the activity should be goal-focused and motivated, and possession of appropriate knowledge and skills to perform the activity. There should be mutual trust and respect, interpersonal relationship, professional maturity, and knowledge and skills in order to empower NQRNs to be able to run the unit independently.

The UNMs should provide a supportive environment for NQRNs to learn, grow and develop. According to Meyer, Naudé, Shangase & van Niekerk (2009:100), there are aspects to be considered in order to create a psychological environment conducive for learning as follows: mutual trust, mutual respect, collaboration, support, openness and authenticity, pleasure and humaneness. In this study, the dynamics were: change of

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attitude, trust, respect, interpersonal relationship, emotional intelligence (EI) or professional maturity and professional knowledge and skills.

7.4.4.1 Change of Attitude

The negative attitude from the people involved in supporting NQRNs (R.683) in the nursing unit can affect how support is conducted. The UNMs as people with experience and being in a position of authority might impose what is expected of NQRNs without allowing them to participate in decision-making of whatever affects them. This might leave the NQRNs with fear and they might not take part in the performance of unit activities. It is important that both UNMs and NQRNs have positive attitudes towards each other to ensure that support is successful. NQRNs (R.683) should be treated equally as professionals like other nursing staff members in the unit to allay anxiety and reduce stress because the environment will be positive and healthy to work in.

7.4.4.2 Trust

The UNMs as people with experience and being in position of authority must create a conducive non-threatening climate where NQRNs should be at liberty to ask questions and participate in unit management activities. Therefore, it is important that both UNMs and NQRNs have positive attitudes towards each other to establish mutual trust and ensure that support is successful. When NQRNs trust UNMs, they will be free to actively participate within the unit without any doubt. Where there is trust, NQRNs (R.683) should be treated equally as professionals like other nursing staff members in the unit to allay anxiety and reduce stress because the environment will be positive and healthy to work in.

Trust appears to relate to honesty, integrity and benevolence in communication, and affirms positive relationships between communicating parties (Hofhuis, van der Rijt & Vlug, 2016:4). NQRNs (R.683) as recipients should acknowledge that support in their

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new RN role is of paramount importance to their performance. However, UNMs cannot adequately support NQRNs without full understanding of the challenges and stresses they experience in their entry to the new role (Oermann & Garvin, 2002:225). Hence, NQRNs (R.683) should trust UNMs or experienced RNs and openly share barriers that affect their personal and professional development. NQRNs (R.683) should be guided, coached and directed to function independently in a context within which it is possible for support to take place.

Newly Qualified Registered Nurses (R.683) expressed that some factors impede creation of a conducive environment to receive their support, i.e., needs such as inadequate staffing ratio where there is a mismatch between patient acuity and skills mix, heavy workload, expanded responsibility and accountability due to RN's wider scope of practice, increased unreasonable expectations, and poor UNM-NQRN relationships (Brown *et al.*, 2015:199; Sönmez & Yildirim, 2016:108; Hussein *et al.*, 2017:7; Kamphinda & Chilemba, 2019:7). By creating a supportive atmosphere in the unit, UNMs should honour NQRNs' developmental ability and being passionate to support by ensuring NQRNs feel free to ask questions when uncertain or want to discuss problems with unit managers (Naudé *et al.*, 2009:100). Hence, UNMs are regarded as trusted advisers and supportive guides, teachers, mentors and supporters (Naudé *et al.*, 2009:160). Therefore, it is imperative that there is a relationship of mutual trust and respect between UNMs and NQRNs.

7.4.4.3 Respect

It is the UNMs' role to create a supportive workplace environment. Therefore, there must be respect between UNMs and NQRNs. Without respect between the two parties they would not be able to treat each other humanely and professionally. While communicating with newly-qualified nurses in the unit, unit managers should make them feel welcomed and respected by avoiding shouting or scolding them and passing

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negative remarks in front of patients or colleagues. The findings of this study revealed that participants were shouted, scolded and corrected in front of patients and other nurses. If this is not addressed well it might impede the support process within the nursing unit and thus hinder quality and safe patient care.

Although newly qualified registered nurses are inexperienced and uncertain while performing some activities of unit management, unit managers should continue to respect them while guiding, supervising and mentoring them to enhance learning, growth and development. As role models, unit managers should conduct themselves in a professional manner in their speech and conduct to be emulated by new graduate nurses. It is imperative to create and maintain a healthy supportive environment where there is respect between UNMs and NQRNs. The nursing culture of respect if practiced by unit nurse managers in the nursing unit, newly qualified registered nurses will learn to treat their colleagues and patients with respect as they were treated respectfully by UNMs.

7.4.4.4 Interpersonal Relationship

There should be a good interpersonal relationship of mutual trust between UNMs and NQRNs (R.683), because when people trust each other it is easy to share information, concerns, knowledge and skills without any doubt or fear. Health professionals mostly reported that poor communication and interpersonal relationships among fellow health workers, managers and patients resulted in negative attitudes, lack of motivation or morale (Nangombe & Amukugo, 2016:50). NQRNs (R.683) who trust UNMs can openly and freely communicate in case they want to ask questions or request to be supported without fear. Similarly, UNMs who feel trusted can easily lend a helping hand when needs arise. Pennbrant *et al.* (2013:744) revealed that nurses experiencing supportive personal relationships find it less stressful to master their new professional roles. If the UNM and NQRNs have a good relationship that supports and nurtures, the

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new graduate nurse will feel supported (Asiem, 2020:11).

7.4.4.5 Professional Maturity/Emotional Intelligence

Nursing is a stressful and challenging profession which is physically and emotionally demanding. NQRNs working in this complex workplace environment face various stressors during their initial period of entry to the new role (Vishavdeep, Sharma, Das, Prahbhjot & Ghai, 2016:203). Therefore, for NQRNs to deal with workplace stressors they need to possess personal attributes such as emotional intelligence (EI) in order to understand the emotional ambience of the nursing unit (Heydari, Kareshki & Armat, 2016:122). According to Kinkanloo, Jalali, Asadi, Shokrpour, Amiri & Bazrafkan (2019:138), EI refers to a social skill that controls stress and affects a person's ability to cope with the demands and environmental pressures. When NQRNs have ability to effectively manage their own emotions they will have increased confidence and professional competence while providing patient care that enhances resilience in the work place (Fong-Hong, 2019:4).

Resilience refers to one's capacity to handle environmental strains, demands and increased pressure without being discouraged (Imoto, Yoshioka & Kaneko, 2020:1027). Brennan (2017:43) affirmed that a person with EI is able to effectively cope with and positively adapt to complex workplace with adversity. NQRNs with EI display professional maturity by being able to monitor their own emotions and those of others. Hence, Aradilla-Herreo, Tomas-Sabado & Gomez-Benito (2013:1) indicated that being able to manage one's emotions in nursing enables a person to perform nursing activities with confidence and competence. Libbtecht, Lievens, Carette & Côté (2015:112) maintain that NQRNs with increased EI have good interpersonal relations and communicate well with others.

UNMs should educate NQRNs EI in order to enhance their mental health as is related

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to sensitivity to interactions, anxiety, and aggression (Kinkanloo *et al*., 2019:139). Empowered NQRNs with high EI overcome fear in their nursing units, have increased positive attitudes and great control over their emotions resulting in an increased therapeutic nurse-patient relationship (Fong-Hong, 2019:5). When NQRNs developed EI, it enhances their resilience that benefits the organization by retaining personnel, improving productivity and patients' satisfaction (Fong-Hong, 2019:6).

7.4.4.6 Professional Knowledge and Skills

As nursing advances continuously in technology and other skills, UNMs need to acquire new skills and knowledge regarding various roles they should play in the nursing unit and thus they should have positive attitude towards lifelong learning to keep their knowledge abreast (Naudé *et al*., 2009:124). UNMs earn respect of newly-qualified nurses if they are lifelong learners who are passionate with the professional development of their subordinates (Naudé *et al*., 2009:107). Both parties involved in support should be willing and committed to share professional knowledge and skills they have acquired to render quality care in the unit. UNMs and NQRNs' (R.683) should acknowledge their weaknesses (lack of adequate knowledge and skills) and accept constructive criticism in order to be able to understand the support needs to be met.

7.4.5 The Procedure

The procedure highlights the path, steps, or pattern according to which the activity is performed to attain the goal (Dickoff *et al*., 1968:426). A procedure describes the sequence of steps, and specifies for each step what needs to be done, often including when the procedure should be executed and by whom. The procedure in this study refers to the creation of a supportive workplace environment.

UNMs should initiate participative management in order to involve NQRNs in

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addressing the identified challenges. UNMs should employ their range of unit management skills and knowledge to effectively enhance the implementation of the model to address the dynamics of the nursing unit context. Once the nursing unit dynamics are addressed, the outcome should be a conducive supportive environment to enhance support for NQRNs in the nursing unit context.

Dickoff *et al*. emphasized on the procedure by basing on principles, sets of rules, routine or protocols that constitute a series of actions aimed at the goal that benefits the recipient (Bodrick, 2011:203). However, Bodrick (2011:204) agreed that the procedure does not determine the activities in detail, but offers to direct steps on how the activity should be performed.

The procedures associated with the model to enhance support for NQRNs (R.683) involves the following phases: building rapport phase, facilitation or execution phase and monitoring and evaluation phase. Figure 7.6 depicts the procedure.

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PROCEDURE

PHASE 1: BUILDING RAPPORT

- Create a positive workplace environment

PHASE 2: FACILITATION OR EXECUTION

- Identification of learning needs
- Mutual goal setting
- Mentoring
- Precept by example/role modelling
- Clinical meetings

PHASE 3: MONITORING AND EVALUATION

- Checklist or questionnaires
- Reflection
- Quarterly assessment
- Performance management
- Feedback

Figure 7.6: Procedure

7.4.5.1 Phase 1: Building Rapport

This is the initial phase in which the UNM establishes a relationship with NQRNs to create a positive workplace environment to support the NQRN within their initial period of entry to the new role. Creating a positive workplace environment needs the UNM to possess skills of creating rapport, trust and respect in the nursing unit. A positive working environment is a workplace that promotes employee safety, growth and goal attainment. These environments are most conducive to a successful workforce as they

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encourage employees to perform to their highest ability. Health care institutions can achieve a positive working environment by focusing on their overall culture, supporting employee growth and making employees feel safe and comfortable. When the UNM creates a positive workplace environment, the outcomes of the nursing unit (both for patients and nursing staff alike) improves (Aiken, Sermeus, Van den Heede, Sloane, Busse, McKee *et al.*, 2012:4). NQRNs who trust and respect UNMs will be free to actively participate within the unit without any doubt. This interpersonal relationship between these two parties allays anxiety and reduce stress because the environment will be positive and healthy to work in. UNMs as persons in charge of the unit are the appropriate individulas to utilize their skills to create rapport which will make NQRNs feel that they are in a safe and supportive space and can proceed to the facilitation or execution phase.

7.4.5.2 Phase 2: Facilitation or Execution

In this phase, the UNM jointly works with NQRNs to assist them actively journey to self-awareness. NQRNs feel secure and safe to share activities with UNM for capacity development. And when the NQRNs are capacitated, they will be able to cope with challenges of the new role. In this phase, cooperativity by both parties will enable UNMs to identify the NQRN's learning needs. The UNMs assist NQRNs to take control of their professional development through learning to take responsibility and identify their own learning needs by acknowledging that there are some gaps to be closed through capacity development. This is performed through a process where UNMs assist NQRNS to understand what goals to set for capacity development. This leads to mutual goal setting which makes NQRNs and UNMs to be goal-orientated and that enhances NQRNs' confidence. Joint planning and decision-making are necessary in mapping the process, and allocation of roles and responsibilities for both parties to achieve the goals of the support strategy (Ramathuba & Makhado, 2021:5). In this phase of facilitation or execution, the UNM is the facilitator of capacity development.

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To ensure that the NQRN develops his/her capacity in the new role, the UNM act as mentor who drives the process to empower the NQRN towards competency and independency through capacity development. In this study, it was identified that NQRNs (R.683) were not mentored during their entry in the new role with the assumption that it is long they were working as nurses despite the extended scope of the RN. Mentoring is vital in clinical practice because it supports NQRNs' (R.683) need to feel satisfied and successful as RNs.

During mentoring, there is sharing of advice and/or experience, role development where both UNMs and NQRNs have an opportunity for professional growth and career satisfaction (Mariani, 2012:1). Therefore, NQRNs (R.683) need support, mentoring, coaching, and guidance to attain the basic skills required to be successful in their new role. Mentoring is a collegial, developmental, empowering and nurturing relationship requiring commitment and self-confidence, mutual sharing, learning and growth that happens in a conducive respectful and friendly atmosphere (Mariani, 2012:3).

Mentoring is described as a strong and powerful tool for effective support during transition period, as it provides an opportunity for graduates to learn and therefore effectively implement the knowledge and skills they have gained under the umbrella of an experienced professional (Simane-Netshisaulu, Maputle, Netshikweta & Shilubane, 2018:143). It is through mentoring whereby graduates also master effective communication skills between professionals as well as with the patients (Simane-Netshisaulu *et al*., 2018:143). The UNMs should keep their knowledge up-to-date in order to model the role for NQRNs to emulate them. A role model is a person whose behaviour is admired and emulated by others (Mirhaghi, Moonaghi, Sharafi & Zeydi, 2015:32). In nursing, role models influence others' behaviours by exemplifying personal, professional and practical traits expected in the profession (Felstaed & Springett, 2015:66). In this study, NQRNs (R.683) perceived senior experienced

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nurses as key learning resources who can play a crucial role in their professional development. However, some experienced nurses preferred to complete tasks themselves rather than involving NQRNs which made them felt unsupported.

Though role modelling is regarded as an outstanding way of transmitting positive values, attitudes and patterns of behaviour (Jack, Harmshire & Chambers, 2017:22), NQRNs (R.683) were excluded in unit management activities, as they reported that: "*they don't call us you just go there so that you must know work. You will go there and you sit. But they won't involve you they will be doing it themselves and you will be just seeing that ok, they do it like that."* According to Kenny, Mann & MacLeod (2003:1208), vicarious learning helps the observer to watch the behaviour of others without the need to experience direct feedback. However, this 'silent modelling' is regarded unacceptable teaching method because it has multiple interpretations, based on the observer's point of view (Kenny, Mann & MacLeod, 2003:1206).

Therefore, UNMs should be positive role models to NQRNs (R.683) during their initial months of entry in the new role in order to transfer professional values and attitudes which can be emulated and develop NQRNs to competent independent professionals who perform their unit activities with confidence. Another participant suggested that: "*The senior must do the procedure first and allow the newly-qualified registered nurse to do it under her watch and do on the spot teaching in case there are some corrections to be done."*

Except being a precept by example, the UNM can plan a monthly workshop or in-service training to facilitate capacity development for NQRNs for the first twelve months in their new RN role. During the first six months of practice, NQRNs concentrate mainly on learning their new roles, and the policies and procedures of the nursing unit (Ferguson & Day 2007:107). In-service training is the training received by nurse

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practitioners within the working environment that is directly related to their work, to improve their professional knowledge, skills, values and attitudes based on the institution or nursing unit demands (Muller, 2009:350-351). With the latest developments in health care system, the knowledge and skills newly-qualified nurses acquired during their academic preparation become insufficient to deal with new health-related problems. Although some institutions may have some programmes running to keep their personnel's knowledge and skills abreast, NQRNs' knowledge and skills insufficiency calls for in-service training. According to Magagula (2017:1), in-service training is a systematic professional learning experience intended to expand the knowledge, skills, and attitudes of nurses and consequently enhance their contributions to quality health care.

Hence, UNMs as being in charges and supervisors in the nursing units should play a significant role in the support and planning of the in-service training programmes. Mlambo, Silén & McGrath (2021:2) affirmed that on-site learning happens at the direction and the willingness of managers to facilitate by providing time and space for learning to take place within the clinical settings (Mlambo *et al*., 2021:2). For the in-service training to be effective, the training programme should be designed, implemented and assessed based on principles applicable for an education programme (Muller, 2009:351). Furthermore, regular clinical meetings can be held to facilitate or execute NQRNs' capacity development. Clinical meetings also, serve as learning platforms where doctors are also, part of and patients' conditions are also, discussed (Bruce, Klopper & Mellish, 2011:270).

7.4.5.3 Phase 3: Monitoring and Evaluation

In this phase, to confirm if ever the NQRN's professional capacity have been developed to be a proficient nurse practitioner, monitoring and evaluation is required. Monitoring and evaluation is a critical aspect of support. To determine the effectiveness

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of support, both UNMs and NQRNs should evaluate the activities entailed and give feedback. NQRNs should evaluate the UNMs' performance in their facilitation of capacity development. UNMs should monitor the process throughout and give feedback to NQRNs on their performance of unit management activities. Feedback provides information on strength and weakens of the process which is necessary for improvement of the support process.

Empirical evidence revealed that feedback to NQRNs by UNMs was not common, and yet very crucial to determine the effectiveness of support. The initial phase is building rapport, followed by facilitation or execution phase. After workshops or in-service training, NQRNs are placed to run the unit independently while being monitored and evaluated. Monitoring and evaluation of capacity development is ongoing to determine the outcome of support the ultimate purpose of the model.

An evaluation form or questionnaire is prepared to evaluate the presenter after an in-service. The environment, time, content, teaching method and media, the manner of presentation such as speed, tone and mannerism can be rated to assist for future preparation and to rectify shortfalls identified. The checklist or questionnaire can be used as a tool to monitor and evaluate the progress of capacity development process. Quarterly assessments can be done in order to identify some shortcomings that should be addressed.

A system of performance management can also be utilized to monitor the NQRN's competency and ability to manage the unit independently. The UNM should regularly monitor the NQRN's performance, either formally as scheduled in the performance agreement or informally to identify areas that need to be addressed before the formal performance assessment. To maintain this support process, it requires continuous feedback and reflection from NQRNs as the recipient of support in the new role.

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7.4.6 The Terminus

The terminus is the outcome or endpoint or an achieved goal of an activity (Dickoff *et al.*, 1968:422). It is the intended end results after the implementation of the model. The UNMs as agents should bring about change by facilitating the support process by involving and guiding NQRNs towards the goal of the procedure. The expected outcome post model implementation encompasses: availability and sufficient interaction between UNMs and NQRNs through unit visits, rounds and climate meetings, NQRNs are recognized, accepted, welcomed and treated as team members in the unit. NQRNs are orientated about all activities in the unit, continuous mentoring and regular in-service training are provided. It is anticipated that adequate provision of human resources to ensure proper skills mix, mentoring and supervision of NQRNs would result in a supportive and safe environment in nursing units. In this study, the purpose of developing a model is to enhance support for NQRNs (R.683) within their initial eighteen months in the new role so that they develop confidence to be able to perform unit management activities competently and independently, resulting in provision of quality care to patients. Figure 7.7 shows the terminus of the model to enhance support foe NQRNs (R.683) in their new role.

Figure 7.7: The Terminus: Empowered, competent, confident and independent registered nurse

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7.5 Model Development

The model was developed based on the concepts explained following the conceptual framework as proposed by Dickoff, *et al.* (1968:426). The model to enhance support for NQRNs (R.683) is discussed following Chinn & Kramer's (2018:190-201) components which are: an overview of the model, the purpose of the model, the structure of the model composed of the assumptions of the model, the definition of the concept, relational statement and the nature of structure. The description of the model process is followed by evaluation of the model.

7.5.1 An Overview of the Model

A model is a schematic representation how support for NQRNs (R.683) by UNMs will be enhanced. This model is based on the premise that capacity development is necessary for effective support for NQRNs in their new roles. The empirical data from NQRNs and UNMs in the convergent of mixed method show the need for a support model.

Furthermore, legal and professional statutes regulating nursing expect competent nurse practitioners who are capable of functioning independently in a responsible and accountable manner. This model to enhance support for NQRNs will be a point of reference for UNMs to effectively support NQRNs in entry to their new roles to develop their professional capacity.

7.5.2 The Purpose of the Model

According to Chinn & Kramer (2018:190), the best way of describing the purpose of a model is to consider who will implement it under which conditions or circumstances. The purpose of this model was to provide a frame of reference to UNMs to enhance support for NQRNs (R.683) in selected hospitals during their initial eighteen months in the new role and guide them on the operationalization of the proposed model.

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7.5.3 The Structure of the Model

According to Chinn & Kramer (2018:197), the structure of the model depicts the overall form of conceptual relationships within it. The structure of the model assists in understanding the relationships between concepts, their order of occurrence and how they relate to each other. The structure of the model is discussed based on the following sub-headings as described by Chinn & Kramer (2018:190-202) which are: assumptions of the model, concept definition, relational statements and the nature of the structure.

7.5.3.1 Assumptions of the Model

Assumptions are fundamental acceptable truths on which the model is based (Chinn & Kramer, 2018:199). Assumptions are related to the relationship statement and reflect the values underlying the model. The model was based on the following assumptions:

7.5.3.1.1 Assumptions Associated with the Agents

UNMs as being in charge of the nursing units are in a prime position to direct policy, systems, procedures and unit management (Parand, Dopson, Renz & Vicent, 2014:1). Therefore, they are legally and ethically compelled to ensure that there is rendering of high-quality patient care in nursing units. Patient safety and care is regarded as their first priority. However, in this study, participants indicated that UNMs should support them in the unit during their initial period of entry to the new role.

Feather & Ebright (2013:65) revealed that, as leaders, UNMs have two broad independent functions in which one dimension is task-oriented, and the other is employe-oriented, concentrating on building rapport, teamwork as well as employee identification within the organization. UNMs form a mutual trusting and respectful interpersonal relationship with NQRNs during their initial period in the new role to ensure a supportive workplace environment.

7.5.3.1.2 Assumptions Associated with the Recipients

Recipient are NQRNs who have been employed recently in the new role as RNs. NQRNs, as recipients, are in interaction with their environment, both internal and external. The assumption is that NQRNs are inseparable with their environment. NQRNs as holistic beings with body, mind and spirit, are totally perceived within internal and external environments.

As inexperienced recipients who still need to develop skills to cope with challenges encountered in the workplace environment, it is assumed that effective support for NQRNs within their early period of employment is vital. NQRNs need to be welcomed, orientated, mentored and continuously supported to develop capacity to function independently as nurse practitioners.

In addition, there is an interactive process between UNMs and NQRNs where they both establish an interactive relationship, agreeing and committed to share responsibilities in the support process. NQRNs voice their support or learning needs and are mutually involved in the relationship. To maintain this relationship, UNMs should exhibit attributes of emotional, psychological and social support that are significant for the sustenance of the established relationship with NQRNs. UNMs should precept by example to be emulated by NQRNs.

They should be mentors, guiders and supporters. This will ensure NQRNs feel safe and unthreatened to communicate with UNMs and pour their heart without fear of being ridiculed or judged. UNMs should be available, accessible and approachable to NQRNs. This will enhance support as NQRNs will be able to perform their unit management activities under with the support process getting from UNMs. UNMs and NQRNs as key individuals in the support process, should work jointly in the nursing unit to accomplish the objectives of support.

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7.5.3.1.3 Assumptions Associated with the Context

Support for NQRNs takes place in a context which is interactive in nature. NQRNs operate in a complex context where they are faced with various legal, ethical and professional frameworks that put demands on the nursing units, and NQRNs who are expected to be competent and render high quality and safe patient care. The context is complex because in the nursing unit as a core context, NQRNs are expected to function according to their job description and performance agreement. The context has both physical and psychological dimensions, in relation to which NQRNs require to be supported. UNMs' address to the NQRNs identified support need is through the process of support.

Pennebrant, Nilsson, Öhlén & Rudman (2012:744) indicated that many nurses work in complex situations, where they depend on assistance from co-workers and nurse managers in order to successfully transition from school to work (Pennebrant *et al*., 2012:744). Therefore, the UNMs should not only be acquainted with the nursing regulatory and ethical framework, but must be familiar with the scope of practice of various health care practitioners within the nursing unit (Muller, 2009:100) to assist them with their professional capacity development. The nursing unit as the main context where support activities take place should provide a non-threatening and supportive space for NQRNs to develop their professional capacity.

7.5.3.1.4 Assumptions Associated with the Dynamics

The effectiveness of the support process requires mutual trust, respect and interpersonal relationship through communication between UNMs and NQRNs. The components of the model depend on each other because the support process is interactive in nature, thus the elements are inseparable. The dynamics that exist within the nursing units, i.e., agents and recipients, have an impact on the effectiveness of the support process.

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The nursing unit climate and attitude of both UNMs and NQRNs can influence the support process (Ramathuba & Makhado, 2021:3). Effective communication and active listening are driving forces of the support that NQRNs are getting from UNMs. When NQRNs are empowered, competent and confident in performing unit management activities independently it benefits the unit at large as they will be capable of rendering quality and safe patient care.

7.5.3.1.5 Assumptions Associated with the Procedure or Process of Support for NQRNs

As a dynamic profession, nursing grows and develops as there are cutting-edge and contemporary developments. Due to these latest developments, rendering support for NQRNs should occur in a physical and psychological context. Support is a process of developing professional capacity and empowering NQRNs. Through this support process, UNMs should keep their knowledge and skills abreast. UNMs will be harnessed with professional attributes to support and empower NQRNs with new knowledge and skills. The established supportive interpersonal relationship between the NQRNs and UNMs enables UNMs to mentor NQRNs through the challenges encountered in the nursing unit.

7.5.3.1.6 Assumptions Associated with the Outcome of Support

Support through professional capacity development for NQRNs in the nursing unit is a determined process. The purpose of support is empowering and capacitating NQRNs in their new role. This includes development of guidelines for support in order to direct NQRNs to perform effectively in their practice workplace environment. The outcome of support is accomplished in the practice area of NQRNs where there is interaction between UNMs and NQRNs. In the interaction, NQRNs are able to verbalize their support or learning needs and mutually participate in the supportive relationship established with UNMs. UNMs should ensure that NQRNs are engaged to build this

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relationship to have ownership and sustain the relationship. Supportive interpersonal relationship between UNMs and NQRNs (R.683) is assumed to be a foundation for the support process.

7.5.3.2 Concept Definition

The concepts of this model were identified through the empirical study, literature review and are clarified through the six survey activities or elements conceptualized by Dickoff *et al.* (1968), namely; agents, recipients, context, procedure, dynamics, and terminus.

This model has the following central concepts: Nursing unit context; UNMs or experienced RNs as agents; NQRNs (R.683) as recipients; Interactive support process between the two parties; Appropriate support which was the end result of support; and Dynamics of support which were changes of attitudes towards treatment of NQRNs (R.683) in the nursing unit, good interpersonal relationship of mutual trust and respect, willingness and committed to share knowledge and skills.

7.5.3.2.1 Context

The context is composed of the nursing units' cultural context, attitudes, values, legal frameworks, policies and protocols in the work environment. The units' culture influences the nature and outcome of performances as well as the provision of support.

7.5.3.2.2 Agents

The agents were UNMs or experienced RNs because they had knowledge, skills and experience as they were once NQRNs who were supported or who had support needs in their new role before they were experienced and competent nurse practitioners. In this context, the agents were UNMs or experienced RNs who were entrusted with NQRNs (R.683) in their units.

7.5.3.2.3 Recipients

These were NQRNs (R.683) who were supposed to be supported to be confident in managing their units competently and independently without any fear or stress.

7.5.3.2.4 Interactive Process

There must be interaction between experienced nurses and less experienced ones because support occurs where there is a supporter and the supported. Active participation is imperative for both parties. They should be willing to share acquired knowledge and skills, and opportunity to freely vent their feelings and concerns. This happens if there is mutual interaction, cooperation and collaboration. It was identified that the units' cultural context, values and beliefs influenced how UNMs support NQRNs (R.683) within their initial months of entry in the new role.

7.5.3.2.5 End Results/Outcome of Appropriate Support

This was the ultimate outcome of support where agents and recipients could interact with each other to attain appropriate support.

7.5.3.2.6 Dynamics

The dynamics were the underlying powers that may affect how support occurs, which were change of attitude towards treatment of NQRNs (R.683) in the nursing unit, good interpersonal relationship of mutual trust and respect, willingness and committed to share knowledge and skills, appraisal and feedback skills from nurse managers, reward and praise from UNMs.

7.5.3.3 Relational Statement of the Model

Relational statement of the model provided linkages among and between the concepts of the model (Chinn & Kramer, 2018:195). The following relational statements were formulated for the model to enhance support for NQRNs (R.683):

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- Effective support for NQRNs (R.683) is influenced by the context (nursing units) within which it occurred.
- UNMs and NQRNs are initiators and sustainers of effective support.
- NQRNs are the main recipients of the support process.
- Dynamics that propel the support process between NQRNs (R.683) and UNMs are changes of attitudes towards treatment of NQRNs (R.683) in the nursing unit, good interpersonal relationship of mutual trust and respect, willingness and commitment to share knowledge and skills, appraisal and feedback skills from nurse managers, reward and praise from UNMs.
- Support as a procedure or process influences the attainment of the terminus which is effective support. The support process includes building rapport, facilitation or execution, and monitoring and evaluation.
- Effective support relies on the interactions of the UNMs as agents and NQRNs as recipients.
- Change of attitude, mutual trust, respect and interpersonal relationship between NQRNs intend to influence effective support to facilitate professional capacity building.

7.6 The Nature of the Structure

The schematic presentation of the model to enhance support in Figure 7.8 attempts to explain the relation between the identified concepts. The model composes of different shapes and colours which all have a significant meaning. The explanation of each will be included in the description. There are three phases in the model: the rapport building phase, the facilitation or execution phase and the monitoring and evaluation phase.

LEGAL FRAMEWORKS

NURSING UNIT: CONTEXT 2

Empowered, Competent, Confident & Independent RN

PROCESS

Monitoring and Evaluation Phase

Performance Management
Quarterly assessment & Feedback
Reflection
Checklist or questionnaires

Facilitation/Execution Phase

Clinical meetings
Workshop/In-service
Precept by example/ role modelling
Mentoring
Mutual goal setting
Identification of learning needs

Building Rapport Phase

Create a positive workplace environment

FACILITATOR OF CAPACITY DEVELOPMENT

FACILITATION OF CAPACITY DEVELOPMENT

CAPACITY DEVELOPMENT

Agents: Unit Nurse

Trust, respect, interpersonal relations

Recipients: NQRNs (R.683)

Hospital Policies and Procedures

SANC: CONTEXT 1

Labour Relation Act 66 of 1995, Skills Development Act 97 of 1998

National Health Act 61 of 2003, Batho-Pele Principles, Human Rights Charter

Nursing Act 33 of 2005, Scope of Practice (R.2598), Acts & Omissions (R.387)

Figure 7.8: A model to enhance support for newly qualified registered nurses (R.683)

The outer orange border around the model depicts that the context is constituted by statutory legislation that regulates nursing activities. The inner green frame shows that

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nursing units operate within the legal frameworks, policies and procedures for support to take place. The two green imaged circles on the lower right-hand side and lower left-hand side signify the key role players in the support process, the agents and recipients. The doubled sided blue arrow between the agents and recipients represent the mutual relationship between them. The blue arrow pointing upward projecting from the double arrow between the agents and recipients shows the influence both elements can exert to ensure that the process of facilitation of professional capacity development is conducted. The phases of the process are interconnected and contiguous. The yellow colour inside of the model demonstrates the relationship that develops between the UNMs as the process facilitator, and NQRNs throughout the three phases of the model. The broad blue upward-facing arrow at the right-hand side from the recipients depicts the progression through the phases that NQRNs will go through. This arrow also shows the skills NQRNs are acquiring as they are able to cope with challenges of the workplace environment. The broadness of the arrow signifies NQRNs' self-capacity development. The broad blue downward-facing arrow to the agents demonstrate the dedication and commitment of UNMs of descending to the level of NQRNs with the aim of empowering and capacitating them with new knowledge and skills. The broadness of the arrow shows the expertise possessed by UNMs. The process ends with a blue arrow facing towards the terminus, which is the empowered, competent, confident and independent RN.

7.7 Conclusion

This chapter described conceptual framework for model development, description of concepts and their application to model development, components of model development, development of the model and model description. The next chapter focuses on formulation of guidelines to operationalize the developed model and validation of the model following Chinn & Kramer (2018:208).

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CHAPTER 8

GUIDELINES TO OPERATIONALIZE THE MODEL AND MODEL VALIDATION

8.1 Introduction

Chapter 7 focused on model development and description of the model to enhance support for NQRNs (R.683) in selected hospitals of Limpopo Province with special emphasis on Mopani and Vhembe districts.

8.2 The Purpose

The purpose of this chapter is to describe the guidelines to operationalize the developed model and validate the model.

8.3 Guidelines to Operationalize the Model

Model development ends with application. Chinn & Kramer (1995:101) pointed out that the application of the model is the final step of model development. The application warrants the description of guidelines on how the model is to be operationalized.

In this study, the guidelines are applied and explained following the six elements of practice theory, namely, guidelines pertaining to agents, recipients, context, dynamics, procedure and terminus or outcome (Dickoff *et al.*, 1968:423).

The guidelines for the model to enhance support for NQRNs (R.683) will be described in accordance with the practice model as presented in the previous chapter of this study.

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The following are six elements of the practice model:

1. Guidelines pertaining to the supportive context
2. Guidelines for agents
3. Guidelines for recipients
4. Guidelines pertaining to the dynamics of support
5. Guidelines pertaining the supportive process
6. Guidelines for the terminus

8.3.1 Guidelines for the Supportive Context

The following guidelines emanated from data analysis and conceptualization of the context where support was expected to occur in public hospitals of Mopani and Vhembe districts in Limpopo Province. The context where support was expected to happen were nursing units in selected hospitals.

8.3.1.1 Guidelines for Nursing Units

Nursing practice is regulated by legal and professional statutes, policies and procedures. Carvalho, Reeves & Orford (2017:15) indicated that the public sees the nurse in full bloom, yet nurses have their clinical practice firmly rooted to the legal, ethical and professional foundations of their education and training. It is therefore contemplated that nursing units conform to the requirements of supporting NQRNs based on these statutes.

8.3.1.2 Legal Framework

- **National Health Act 61 of 2003**
    - The Act stipulates the regulation of human resource planning.

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- UNMs provide guidance in the planning of staff allocation to ensure provision of adequate nursing coverage in the unit based on stipulated directives.
- Daily monitoring of duty roster or time register to minimize shortage of staff.
- Continuous monitoring and adjustment of allocated staff should be done for adequate staffing in both shifts.

Labour Relations Act 66 of 1995

- The Act stipulates that employees should work normal hours and are entitled for leave days.
- UNMs must be familiar with the content of this Act and comply.
- To orientate and familiarize NQRNs about this Act and the imperative of adherence on entry to new role.

Skills Development Act 97 of 1998

- UNMs to analyze skills gap to support NQRNs through capacity development.

Human Rights Charter

- The right to work in an environment that is safe and well-equipped.
- Right to participate in problem-solving and decision-making.
- Right to practice according to the legal scope of practice.
- Right to be orientated, workshopped and trained in-service.
- Right to written guidelines pertaining to the management of the working

environment.

- Right to working environment that is fee from threats or intimidation.

Batho Pele Principles

- UNMs to orientate NQRNs on Batho Pele Principles and ensure compliance.
- To design a strategy to ensure compliance to Batho Pele Principles to create a conducive workplace environment to enhance support.

Professional Body

- The practice of nursing is regulated by the Nursing Act 33 of 2005, and its rules and regulations. These statutes provide the legal and professional framework for nursing practice. The Nursing Act should be accessible in the nursing unit and adhered to by both UNMs and NQRNs during support.
- Provision of best practice evidence-based capacity development whereby NQRNs work alongside UNMs as mentors in all shifts to observe and perform unit management activities under their direct supervision.
- Guidelines concentrating on the vision, mission, values, beliefs and attitudes of the nursing unit to ensure a supportive workplace environment.
- Internal unit in-service training should be conducted to update NQRNs (R.683) on new developments.
- Attitudinal change awareness to all unit staff.
- NQRNs should be able to verbalize their concerns on negative attitudes and behaviours of unit staff.

- Climate meeting to be conducted and doctors should also be involved for learning purposes.
- UNMs and NQRNs should be able to enhance value clarification regarding personal and professional beliefs.
- NQRNs' active involvement enables them to be co-determinants in decision-making and problem-solving in the unit.
- NQRNs should trust UNMs to an extent that they are free to communicate openly and express their feelings and concerns about being supported in the unit.
- Both parties should ensure that their relationship is based on empathy, trust and respect.

8.3.2 Guidelines for the Agents

- UNMs or experienced RNs as agents should create a positive atmosphere where NQRNs will feel accommodated as members of the nursing unit.
- UNMs should provide a conducive environment in which harmonious interaction amongst members of the health care team is promoted for enhancement of support to take place without any barriers.
- As a UNM, the agent should be innovative in planning orientation, staff development sessions and acting as a mentor.
- The agents should strengthen coordination between all unit nursing staff responsible for enhancing support for NQRNs (R.683) and ensure that there is appropriate support.
- It is the agents' responsibility to keep themselves up to date with new

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developments and recent information, which will enable them to equip NQRNs.

- Involvement of NQRNs during performance of management roles within their initial months of entry to the new role should be a norm. This will boost NQRNs' competence and confidence levels, resulting in improved performance.

- The agents (UNMs) should be willing to learn from the recipients (NQRNs) as they have a wealth of information that could be beneficial to them.

- UNMs should demonstrate EI and maturity as well as relating well with NQRNs to improve joint cooperation.

8.3.3 Guidelines for the Recipients

- Establishment of harmonious relationships with UNMs enables NQRNs to gain a sense of belonging which facilitates effective support.

- Positivity and active participation towards support form the basis for adjustment with responsibilities of a new role.

- Involvement in performance of management roles promotes competence and confidence, resulting in performance improvement.

- NQRNs should be able to identify their own learning or support needs and communicate them to UNMs. Both parties should jointly plan for newly-qualified nurses' capacity development processes.

- NQRNs should be conversant with routine, unit policies and SOPs that regulate nursing activities in the unit.

- NQRNs have right to work, learn and professionally develop in a non-

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threatening workplace environment which is well staffed to receive support from mentors (UNMs).

- To work according to their scope of practice and reasonable performance expectations.
- NQRNs should clarify their own norms and values related to support to be enhanced during their initial months of entry on the new role so that it is easier for them to engage UNMs in their support.
- NQRNs should be clarified of their expected role to be played to ensure support during their first eighteen months of entry to the new role is enhanced.
- UNMs and NQRNs should have culture of self-directed lifelong learning by updating themselves with latest developments.

8.3.4 Guidelines Pertaining the Dynamics of Support

The dynamics in the nursing unit can either be hindrances or enhancers of effective support. The guidelines to operationalize the dynamics of support are described as follows:

8.3.4.1 Change in Attitude

Negative staff attitudes have been highlighted as one of the most powerful barriers of graduate nurse support (Freeling & Parker, 2015:e42). Therefore, for appropriate support to occur the following should be done:

- UNMs or experienced RNs should be ready to change their negative attitudes which cause poor support that also puts patients at risk.
- UNMs should set good examples by establishing a positive workplace

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culture to be emulated by the entire unit staff.

- UNMs should communicate with nursing staff who have negative attitude and behaviours toward NQRNs, and give them chance to improve their attitude and behaviour.
- UNMs should establish a system of rewarding positive attitude by frequently praising and encouraging success in attitudinal change.
- NQRNs should be welcomed, orientated, and supported to feel part of the unit staff.
- UNMs should establish an open-door policy to encourage staff with problem to discuss with UNMs.
- UNMs should plan and conduct workshops to raise awareness regarding negative attitude and unacceptable behaviour.
- UNMs should establish zero tolerance to negative attitude and behaviour and ensure compliance.
- UNMs should practice authentic leadership practices to establish a culture of trust where unit staff may feel comfortable to report any negative workplace attitude and behaviour.
- UNMs should continuously monitor and manage these attitudes and behaviours.

8.3.4.2 Trust

- UNMs and NQRNs should establish mutual trust in order for NQRNs to feel free to ask questions when they are uncertain or want to discuss their concerns with UNMs.

- UNMs should establish an atmosphere of trust by being honest and truthful as well as encouraging NQRNs to follow suit.
- UNMs should continuously keep their knowledge up to date and maintain their competence while performing their activities in the unit to stimulate NQRNs' trust toward them.
- UNMs should adhere and fulfil their promises to enable NQRNs to trust them.
- UNMs should display positive behaviour and conduct that strengthens the atmosphere of trust.
- UNMs should allocate NQRNs duties according to their scope of practice and capabilities to enhance trust.

8.3.4.3 Respect

- UNMs should create a non-threatening workplace atmosphere that engenders acceptance, mutual respect, trust and support.
- UNMs should exercise respect for individual NQRNs for them to feel accepted and accommodated to participate in facilitation of their capacity development activities.
- UNMs should increase their knowledge and skills to gain respect from NQRNs.
- UNMs should create a respecting working environment through provision of required human resources and opportunity to practice unit management activities.
- NQRNs should be treated with respect and dignity.

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- UNMs should establish good rapport with NQRNs, create an atmosphere of mutual respect to motivate NQRNs' active participation in the support process.

8.3.4.4 Interpersonal Relationship

- UNMs should form good interpersonal relations with NQRNS so that they can respect and trust them for support to be positively enhanced.
- UNMs should create a workplace environment conducive for capacity development where reflective thinking of NQRNs should be facilitated through interaction.
- UNMs should encourage NQRNs to build good working relationship with them and other unit staff to enhance a sense of belonging.
- UNMs should encourage interpersonal relationship to support NQRNs as they adjust to their new role.

8.3.4.5 Professional Maturity/Emotional Intelligence

- NQRNs should possess EI so that they can understand the emotional ambience of the nursing unit and improve their resilience.
- UNMs should be actively involved in the empowerment and professional capacity development of the NQRNs who are just entering their new role, to promote their potential, talent and achievement.
- An emotionally intelligent UNM is able to assess NQRNs' emotions by observing non-verbal cues to address identified challenges in the workplace before they escalate.
- UNMs and NQRNs must do accurate self-assessment to be self-aware of

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their strengths and weaknesses, as this will assist to ensure self-confidence and capabilities.

- Both parties should be flexible for adapting to change and accommodating new developments with the latest information.
- UNMs and NQRNs should be able to monitor and manage own and others' emotions.
- EI to be infused into workplace policies, procedures, as well as conducting EI training for NQRNs.
- UNMs should improve unit climate, quality service and enhance NQRNs and UNMs' decision-making and problem-solving capacity through EI.

8.3.4.6 Professional Knowledge and Skills

- Effective supportive process requires UNMs' passion for lifelong learning and professional capacity development of their subordinates.
- UNMs and NQRNs should acknowledge their inadequate knowledge and skills, and accept constructive criticism to identify the support needs to be met.
- Both parties should be eager to share acquired knowledge and skills with each other.
- UNMs should strive for keeping their knowledge up to date and inspire NQRNs to do the same.
- UNMs' knowledge and skills can be maintained through in-service education and workshops in order to transfer them to NQRNs.

8.3.5 Guidelines Pertaining the Supportive Process

8.3.5.1 Phase 1: Guidelines for Building Rapport

This phase focuses on the building of rapport between UNMs and NQRNs, in order to ensure a supportive workplace environment for effective facilitation of professional capacity development.

Create a Positive Workplace Environment

- UNMs should welcome and orientate NQRNs to allay fear and anxiety of the new position.
- UNMs as facilitators of support process should have regular open and honest communication in order to be trusted by NQRNs in their early employment period.
- UNMs should listen actively to NQRNs and encourage them to speak their mind.

8.3.5.2 Phase 2: Guidelines for Facilitation or Execution of Support

Identification of Learning Needs

- Involvement of NQRNs in self-assessment process to enhance self-awareness.
- NQRNs’ inputs should be utilized to identify knowledge and skills gap for personal and professional capacity development purposes.
- Assessments tools can be used to determine newly-qualified nurses’ current capabilities, skills and learning needs, for example, NQRNs can be assigned a task to perform while UNMs observe if capable.
- NQRNs should be allowed to identify what is working well and what they

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think should be done.

- Cooperative identification of NQRNs' learning needs.
- Acknowledgement of identified gaps to be addressed through professional capacity development.

Mutual Goal Setting

- When learning needs have been identified, mutual goal setting commences.
- Ensure interactive planning by both UNMs and NQRNs to meet identified learning needs.
- Devise a realistic plan of action with concurred activities and expected outcomes.
- Arrangement of planned time, meetings and required resources to execute the activities.
- An agenda should be drawn by UNM as a facilitator with NQRNs so that they both know what will happen and when to enhance compliance.
- Consistent feedback should be given for any advancement to ascertain if the process goes as planned.

Mentoring

- UNMs must act as mentors who drive the facilitation of capacity development processes.
- They should possess requisite knowledge and skills such as good interpersonal relations and managerial skills.

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- UNMs should be willing and committed to mentor NQRNs in their new role.
- Both parties should be eager to share acquired knowledge and skills to enhance professional growth and career satisfaction.
- Mentoring and coaching should be provided by UNMs as experienced and knowledgeable nurse practitioners in unit management.

Precept by Example or Role Modelling

- UNMs must maintain professional competence and keep their knowledge and skills up to date in order to model the role.
- As role models, UNMs assist NQRNs in professional development, competence and confidence in the workplace by portraying resilience and healthy coping mechanisms when faced with difficult situations.
- Model best practice of new knowledge and skills for NQRNs in the clinical practice environment.
- Demonstrate clinical competence, effective teaching, good interpersonal relations, approachability and enthusiasm to be emulated by NQRNs.
- Show respect and non-judgemental attitude toward NQRNs and inspire them to follow suit.
- Effective role model inspires, motivates and encourages NQRNs to strive to be confident and competent like them.

Workshop or In-Service Training

- NQRNs should be provided with continuous professional development opportunities, which include attending seminars, conferences, workshops

and in-service training.

- UNMs as facilitators should schedule and conduct workshops and in-service training sessions. To empower NQRNs with confidence and competence to perform unit management activities independently.
- Workshops and in-service training should be conducted within the institution monthly to enhance attendance.
- NQRNs should be provided an opportunity to discuss with UNMs who are knowledgeable about unit management activities.

Clinical Meetings

- Except workshops and in-service training unit management activities can also be taught during unit visits and rounds with NQRNs.
- Clinical meetings with doctors where patients' conditions are discussed can be utilized as a means of support to NQRNs as they will be learning during the discussions by asking questions.
- Unit visit support should be provided to NQRNs who experience negative staff attitudes and behaviours, unreasonable expectations from senior colleagues, unmanageable assigned responsibility, and lack of support within their first months of employment as these retard their capacity to thrive.

8.3.5.3 Phase 3: Guidelines for Monitoring and Evaluation

Checklists or Questionnaires

- Actively monitor whether NQRNs' learning needs are being met.

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- Regular monitoring and evaluation of the support processes should be conducted to identify gaps in the effectiveness of support to develop strategies for improvement.
- Both UNMs and NQRNs should review whether the planned goals for NQRNs support through facilitation of capacity development have been accomplished.
- An assessment tool such as checklist or questionnaire can be utilized to evaluate the progress of the process.
- Evaluation can be done at the end of an in-service or workshop session using a questionnaire.
- A checklist can be used to monitor the progress of capacity development weekly to enhance support.

Reflection

- UNMs and NQRNs should reflect to analyze how the capacity development process unfolded.

Quarterly Assessments

- Quarterly assessments of NQRNs' performance should be done to identify gaps that should be addressed.

Performance Management

- A system of performance management can also be utilized to monitor and evaluate NQRNs' competence and ability to manage the unit independently.

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Feedback

- Provision of regular feedback is essential in NQRNs' professional growth and development as well as reduction of stress and anxiety.
- Regular feedback should be given by both UNMs and NQRNs.
- Reinforcement and praises for positive behaviour motivate NQRNs to strive for the best, resulting in increased productivity.

8.3.6 Guidelines Related to the Outcome of the Model

The model's purpose is the expected outcome to be attained after the implementation of the model. The purpose of the model enhances support for NQRNs from UNMs during their initial months of entry to the new role and promotes understanding of the meaning of appropriate support by both parties. The evaluation of having attained appropriate support will be determined as follows:

- UNMs and NQRNs are able to initiate support within early months of entry to the new role.
- Both parties are able to conduct climate meetings and are openly and freely share feelings and concerns without fear or anxiety.
- UNMs and NQRNs are able to establish a good supportive interpersonal relationship to enhance support.
- Both parties are willing and committed to share acquired knowledge and skills to enhance support in the nursing unit.
- NQRNs are no longer afraid or anxious of managing the unit alone.
- NQRNs demonstrate confidence, competence and independence while

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performing their unit management activities.

- NQRNs demonstrate active participation in unit management.
- There is change of UNMs’ attitude towards NQRNs support in the nursing unit.
- There is visibility and approachability of UNMs by NQRNs in the nursing unit.
- NQRNs’ work performance and self-confidence are appraised to ascertain whether NQRNs are able to assume responsibility to meet their support needs.
- NQRNs who subjectively report feeling supported by UNMs may be considered positive as they may assume responsibility for meeting their support needs.
- The outcomes seek to develop capacity among NQRNs, which entails empowerment, mentoring, coaching, professional development, guidance and support.

8.4 Validation of the Model

Validation refers to the act of appraising the appropriateness comparatively with what is known about the model system and sufficient results that serve as a solid basis for decision-making (Vemer, Ramos, Van Voorn & Feenstra, 2016:350). According to Chinn & Kramer (2018:202), after the description of the model, the researcher should critically scrutinize how the model might serve the intended purpose. Furthermore, the researcher should understand how the model will be operationalized and how it might be reviewed and updated.

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However, in this study, the model was not validated by experts as it has not yet been implemented. Although the model was not validated by experts, critical reflection of the model was done based on guidelines by Chinn & Kramer (2018:208). The researcher adopted Chinn & Kramer (2018:203) to validate the model by posing the following questions as displayed in Figure 8.1.

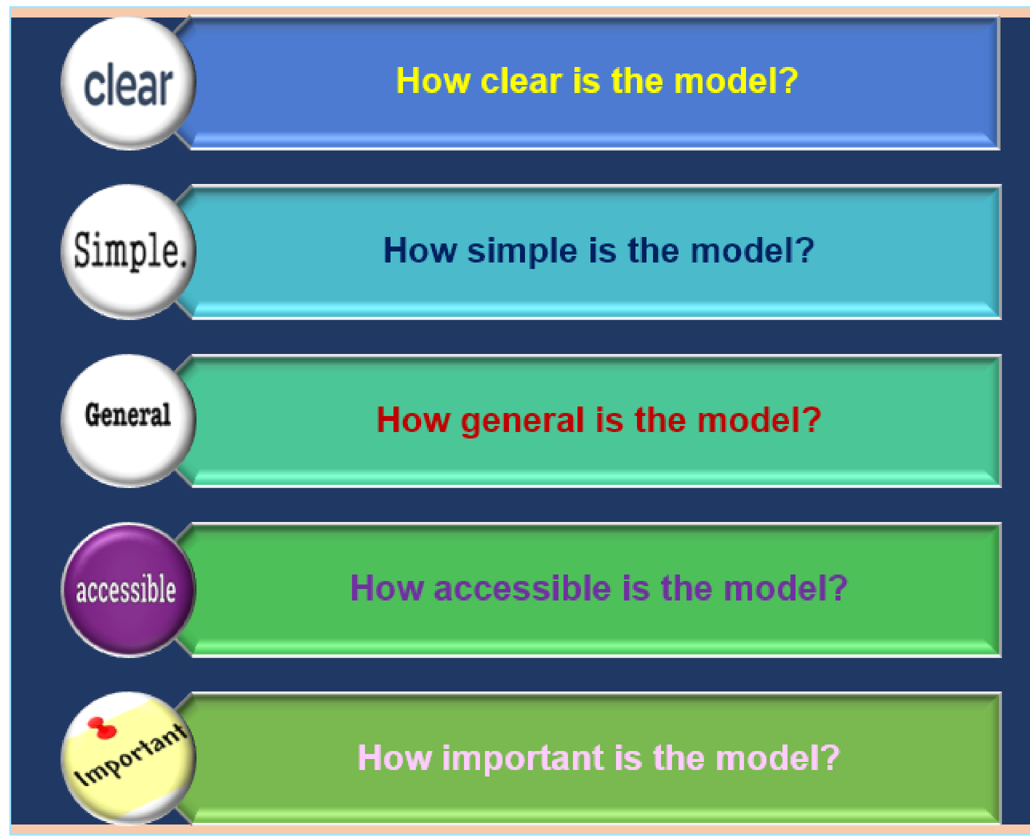

Figure 8.1: Critical reflection questions of theory

Furthermore, the researcher responded by describing the critical reflection of the process that contributes to critical insight and brings direction for model development (Chinn & Kramer, 2018:203).

8.4.1 How Clear is the Model?

According to Chinn & Kramer (2018:203), the question to be asked is 'how clear is this theory?' The question basically asks how well the theory can be understood and how

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consistently concepts can be conceptualized. The critical reflection question posed led the researcher to perceive that the model was clear. Concept analysis conducted on the concept support with the empirical findings from participants assisted in making the model clear. The theoretical definition assisted the researcher to form relational statements that made the model clear. Attributes and connotations of the concept support were identified through literature review and this assisted in describing a conceptual framework. Consistency was maintained throughout the study in the use of major concepts.

A concept map was also derived from concept analysis and this provided meaning on how support could be provided to NQRNs (R.683) during their initial months of employment in the new role in the nursing unit context. Dickoff *et al.*'s (1968:434-435) six elements of practice model, which are context, agents, recipients, dynamic, procedure and terminus were used as basis for describing the model. The major and related concepts formed the structure of the model for enhancing support for NQRNs (R.683) by UNMs and therefore the structural clarity was met.

According to Chinn & Kramer (2018:203), clarity of the model is determined by semantics and structural aspects of the model. The semantic clarity of the model was achieved through the use of only core concepts of support, no new concepts were introduced. Structural clarity has been achieved using Dickoff *et al.*'s (1968:434-435) survey list of activities as the basis for describing the structure of the model. In this study, the researcher regarded semantic clarity, semantic consistency, structural clarity and structural consistency to ascertain how clear the model is (Chinn & Kramer, 2018:203).

Semantic Clarity

The researcher defined concepts using terms that have common meaning within the

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nursing profession (Chinn & Kramer, 2018:205).

Semantic Consistency

The researcher used concepts in a way that is consistent with the definition of concepts (Chinn & Kramer, 2018:206). In addition, the researcher used basic assumptions to clarify the meaning of other components of the model (Chinn & Kramer, 2018:206).

Structural Clarity

The researcher described elements of structures in the model and their relationships to provide a clear understanding of how the structures integrate with each other (Chinn & Kramer, 2018:207).

Structural Consistency

The structure served as a conceptual map that improves clarity of the model (Chinn & Kramer, 2018:207). The researcher consistently used different structures in the model to guide discussion of issues.

8.4.2 How Simple is the Model?

Simplicity refers to the minimum number of elements within the descriptive category, particularly concepts and their interrelationships (Chinn & Kramer, 2018:208). Simplicity was reached by using the major concepts in the model. The process of support was described using major and related concepts. The model is relatively simple and intricated to understand as the structural components and their relationships are clearly indicated and explained.

The arrows in the structure indicated the direction of activities to avoid confusion. The procedure of how the model will facilitate capacity development and the dynamic drives that exist within the contexts of clinical settings and their effects on the effectiveness

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of support in clinical practice area are clearly stated in simple terms. The model is intended to be operationalized in nursing units in selected hospitals, therefore, it should be reasonably easy to operationalize and simple enough to be clear.

8.4.3 How General is the Model?

Chinn & Kramer (2018:208) referred to model generality as its breadth of scope, purpose, its applicability and broad array of situations. The model was described as a response to the support needed for NQRNs (R.683) by UNMs during their initial months of entry in the new role. Based on empirical findings, NQRNs (R.683) were not supported in the nursing units.

The model was therefore developed to assist UNMs to enhance support for NQRNs (R.683) within eighteen months of entry in the new role in selected hospitals. However, the model can be applied in other hospitals within the province where NQRNs are employed. Although the model was specifically for NQRNs (R.683), it can be used for any category of NQRNs during their initial period of employment.

8.4.4 How Accessible is the Model?

Accessibility addresses the extent to which the concept indicators can be identified and to what extent the purpose can be accomplished (Chinn & Kramer, 2018:209). The model will be made accessible to the hospitals where data were collected through in-service training and workshops that would be conducted by the researcher where the model would be implemented and evaluated.

In-service training or workshops would be conducted with UNMs at hospitals where the study was conducted. The model could also be accessed through library search, publications in accredited journals, attendance of seminars, and national and international conference presentations.

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8.4.5 How Important is the Model?

The importance of the model is attached to its significance or practical value (Chinn & Kramer, 2018:210). Therefore, the importance of this model is its value and applicability to support NQRNs (R.683) in their early employment period. The model is purposed to enhance support for NQRNs (R.683) in selected hospitals by addressing identified challenges in nursing units' contexts such as negative staff attitudes and behaviours, shortage of staff, lack of support and increased level of responsibility and accountability.

Chinn & Kramer (2018:210) proposed that an important theory is future-focussed and forward-looking, is usable in practice, education and research. NQRNs (R.683), if supported in the workplace environment during their initial period of employment by experienced, knowledgeable and skilled UNMs, will be motivated and encouraged to run units independently with confidence and competence. They will be empowered to deal with challenges of workplace environment with resilience.

8.5 Conclusion

Chapter 8 discussed the operationalization and validation of the model. The guidelines to operationalize the model were described in accordance with the elements of the practice model as described by Dickoff *et al.* (1968:423). The following elements of the practice model were discussed: agents, recipients, dynamics, procedure and outcome (Dickoff *et al.*, 1968:423). Validation of the model was described based on Chinn & Kramer's (2018:203) critical reflection questions as displayed in Figure 8.1. Chapter 9 focuses on justifications, contributions, recommendations, limitations, and conclusions.

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CHAPTER 9

JUSTIFICATIONS, CONTRIBUTIONS, RECOMMENDATIONS, LIMITATIONS, AND CONCLUSIONS

9.1 Introduction

In the previous chapter, the guidelines to operationalize the model and model validation were described. This chapter focuses on the justifications, contributions, recommendations, limitations, and conclusions of the study.

9.2 Purpose

The overall purpose of the study was to develop a model to enhance support for NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.

9.3 Objectives of the Study

The study objectives were categorized according to the phases of the study, namely, the empirical phase, conceptualization of concepts phase, model development and validation of model phase. The following objectives were applied to attain the purpose of the study:

Phase 1A: Qualitative Research Approach

- To explore and describe the challenges encountered by NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.
- To identify the challenges encountered by NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.

Phase 1B: Quantitative Research Approach

- To identify support structures available for NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa.

9.4 Themes

Table 9.1 summarizes the themes from qualitative and quantitative strands.

Phase 2: Contextualization of Concepts

- To analyze concepts emerging from the data.

Phase 3: Development of Model

- To develop a model to enhance the support for NQRNs (R.683) in selected hospitals by UNMs.

- To validate a developed model to enhance support for NQRNs (R.683) in selected hospitals by UNMs.

Phase 1A: Qualitative Approach

- **Objective 1:** This objective was aimed at exploring and describing the challenges encountered by NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa

This objective was attained by obtaining data from 51 NQRNs (R.683) through seven FGIs. The data obtained were thus transcribed verbatim using Braun & Clark's six steps of Thematic Analysis. The researcher familiarized herself with the data by transcribing interviews and getting a sense of the whole. Through repeated checking of the identified themes, the researcher found appropriated descriptive wording for the themes.

Table 9.1: Summary of themes from qualitative and quantitative strands

Themes	Qualitative Data	Quantitative Data	Interpretation
Shortage of staff	Unavailability of UNMs or experienced registered nurses to support NQRNs (R.683) due to shortage of staff.	74% of respondents indicated that sometimes there is enough staff compared with number of patients, while 52.8% stated that always there is adequate personnel per shift.	Quantitative findings are supported by participants' quotations in Sub-Theme 1.1.4: Shortage of Staff; wherein participants verbalized sometimes being left by themselves due to shortage of experienced registered nurses to follow up and provide coaching, guidance, mentoring and support to NQRNs (R.683). This denotes that staff ratios in nursing units can be problematic at times.
Negative attitudes and behaviours in workplace	Unfriendly and unwelcoming workplace	45.7% of respondents indicated that NQRNs (R.683) are sometimes included as part of SOPs. And 65.3% stated that sometimes praise is provided to outstanding performers.	Quantitative findings are supported by participants' quotations in Sub-Theme 1.1.1: Negative Attitudes and Behaviour in the Workplace; wherein participants lamented about appalling staff attitudes and professional jealousy by some unit staff members. This suggests that the relations are not at the best levels.
	Increased level of responsibility and accountability		The findings support the issue of denied to practice according to NQRNs' newly acquired status, as supported by Sub-Theme 3.1.1: Mentoring and Sub-Theme 3.1.2: In-Service Training. Findings reveal that lack of designated mentor leads to NQRNs assume managerial positions of being unit leaders prematurely.
Emotional resilience	Negative working relationship with senior colleagues	56.9% (n=151) of respondents indicated that NQRNs are placed being in-charge of the unit prematurely to counteract shortage of staff. 58.87% responded that sometimes new employees are delegated based on their scope of practice, competencies, personal and professional development needs.	Findings were supported by Sub-Theme 3.1.1: Mentoring wherein participants verbalized sometimes being supported by senior RNs, and also, expressed their plea to have role models and mentors, as well as in-service training. This implies that NQRNs are not receiving sufficient support from senior members as intended.

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Continued/…

Table 9.1: Summary of themes from qualitative and quantitative strands (continued)

Themes	Qualitative Data	Quantitative Data	Interpretation
Insufficient support		52% (n=138) responded that sometimes senior members mentor, coach, guide and support NQRNs in the unit. 62.64% (n=166) indicated that sometimes NQRNs are allocated a mentor to support and guide them. 78.9% (n=204) indicated that there is never mentoring and peer support in which NQRNs are made to understand their roles and responsibilities. And 53.21% (n=114) indicated that sometimes there is assessment and development of competency as part of control, checking standards of patient care. 60% (n=159) indicated that there is no staff satisfaction questionnaire to be completed by NQRNs monthly to evaluate their views. 56.98% (n=151) indicated that sometimes constructive feedback is provided to encourage and motivate them to improve their performance. 55% (n=146) indicated that sometimes supervision, direction, and correction are done on personnel focusing on motivation and empowerment not punitive. This denotes that there is no sufficient assessment of performance, feedback and reward provided to NQRNs.	These findings reveal that lack of designated mentor leads to NQRNs assume managerial positions of being unit leaders prematurely. As it is difficult for NQRNs to have mentors to serve as role models, guiders, coaches, supervisors, directors, assessors, correctors and supporters who will regularly assess their performance and offer feedback and praise for outstanding performance. Thus, NQRNs feel demotivated, uncertainty about their capabilities regarding the requirements of their new role which impede their competency and ability to function independently. The findings reveal lack of assessment and feedback denoting that errors and mistakes remain unchanged and good performance will not be reinforced hindering empowerment, motivation and professional competency development.

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Themes emerged from the findings that NQRNs (R.683) who were within their eighteen months of employment in the new role experienced negative attitude and behaviour such as bullying and insubordination from unit staff.

These negative workplace environments led NQRNs (R.683) to feel uncertain, fear, anxious and frustration. NQRNs (R.683) felt overwhelmed with responsibilities and accountability. Those emotions and feelings led NQRNs (R.683) to feel unwelcomed as they were not even orientated or supported in their new role. They were left to run units and lead shifts by themselves as there was shortage of staff. NQRNs (R.683) felt they were being 'set up to fail' and deflated by lack of clinical support, since NQRNs (R.683) were expected to 'hit the floor running', and many decided to persevere and accept the difficult situation and adapt to hard circumstances.

Some of NQRNs (R.683) complained to UNMs as a result of fear to take sole responsibility for the care of many patients and run the unit without the support of the senior experienced UNM. There were some factors that contributed to leaving NQRNs (R.683) running units and leading shifts by themselves, namely shortage of staff and the fact that NQRNs (R.683) had previous nursing experience. The findings revealed that both senior and junior unit staff had negative attitude and behaviour towards NQRNs (R.683).

Some NQRNs (R.683) experienced fear of failure when left alone to run the unit, and expressed that they did not know whom to ask for help if uncertain for fear of being ridiculed as there was interpersonal relationship gap between NQRNs (R.683) and other unit staff members. The majority of NQRNs (R.683) felt that there was a need for them to be supported during their initial period in the new role until they are able to stand on their own. It is also emerged that NQRNs (R.683) in their early months of employment felt that there was a need to be orientated, mentored and in-serviced

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regarding unit management.

- **Objective 2:** This objective was aimed at identifying the challenges encountered by NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa

This objective was attained through utilization of Braun & Clark's six steps for Thematic Analysis. During the analysis of the data obtained from focus groups interviews with NQRNs (R.683) employed in selected hospital of Limpopo Province in Mopani and Vhembe districts, four themes were identified (i.e., Table 6.2: Analysis of the concept support for NQRNs within their initial months of entry into the new role).

Phase 1B: Quantitative Approach

- **Objective 3:** This objective was aimed at identifying support structures available for NQRNs (R.683) in selected hospitals of Limpopo Province, South Africa

This objective was reached through collection of data from 265 UNMs using self-administered questionnaires. The findings revealed that 74% of respondents indicated that sometimes there is enough staff compared with number of patients, while 52.8% stated that there is always adequate personnel per shift. Quantitative findings are supported by participants' quotations in Sub-Theme 1.1.4: Shortage of Staff wherein participants verbalized sometimes being left by themselves due to shortage of experienced RNs to follow up and provide coaching, guidance, mentoring and support to NQRNs (R.683). This denotes that staff ratios in nursing units can be problematic at times. Also, 45.7% of respondents indicated that NQRNs (R.683) are sometimes included as part of SOPs, and 65.3% stated that sometimes praise is provided to outstanding performers. Quantitative findings are supported by participants' quotations in Sub-Theme 1.1.1: Negative Attitudes and Behaviour in the Workplace; wherein

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participants lamented about appalling staff attitudes and professional jealousy by some unit staff members. This suggests that the relations are not at the best levels. This is affirmed by NQRNs (R.683) indicating that the relationship was pretentious.

Of the respondents 56.9% (n=151) indicated that NQRNs are placed being in-charge of the unit prematurely to counteract shortage of staff. This was supported by NQRNs' (R.683) lamentation of overwhelming responsibility and accountability, while 58.87% responded that sometimes new employees are delegated based on their scope of practice, competencies, personal and professional development needs. The findings support the issue of denied to practice according to NQRNs' newly acquired status, as supported by Sub-Theme 1.3.2: Denied Opportunity to Practice as a Registered Nurse.

Of the respondents, 52% (n=138) indicated that sometimes senior members mentor, coach, guide and support NQRNs in the unit. 62.64% (n=166) indicated that sometimes NQRNs are allocated a mentor to support and guide them, while 78.9% (n=204) indicated that there is never mentoring and peer support in which NQRNs are made to understand their roles and responsibilities. Findings were supported by Sub-Theme 3.1.1: Mentoring wherein participants verbalized sometimes being supported by senior RNs, and also, expressed their plea to have role models and mentors, as well as in-service training. This implies that NQRNs are not receiving sufficient support from senior members as intended.

Of the respondents, 53.21% (n=114) indicated that sometimes there is assessment and development of competency as part of control, checking standards of patient care. 60% (n=159) indicated that there is no staff satisfaction questionnaire to be completed by NQRNs monthly to evaluate their views. 56.98% (n=151) indicated that sometimes constructive feedback is provided to encourage and motivate them to improve their performance. 55% (n=146) indicated that sometimes supervision, direction, and

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correction are done on personnel focusing on motivation and empowerment not punitive. This denotes that there is no sufficient assessment of performance, feedback and reward provided to NQRNs. These findings reveal that lack of designated mentor leads to NQRNs assume managerial positions of being unit leaders prematurely. As it is difficult for NQRNs to have mentors to serve as role models, guiders, coaches, supervisors, directors, assessors, correctors and supporters who will regularly assess their performance and offer feedback and praise for outstanding performance. Thus, NQRNs feel demotivated, uncertainty about their capabilities regarding the requirements of their new role which impede their competency and ability to function independently. The findings reveal lack of assessment and feedback denoting that errors and mistakes remain unchanged and good performance will not be reinforced hindering empowerment, motivation and professional competency development.

Phase 2: Contextualization of Concepts

- **Objective 4**: This objective was aimed at analysing the concepts emerging from the data

This objective was achieved following Rodgers & Knafl's (1993:83) six steps which guided the researcher to have insight of the meaning of 'support' for NQRNs in the clinical setting. During the process of concept analysis, theoretical definition, antecedents and consequences of the concept 'support' emerged. Based on the identified uses, defining attributes and model case of the concept 'support', the theoretical definition of support refers to a friendly and non-judgemental professional assistance, guidance and coaching in the form of emotional, instrumental and informational aspects from an understanding, committed, empathetic, knowledgeable and skillful role model to a less experienced vulnerable NQRN who is willing to receive and accept feedback to elevate self-confidence and thus functions independently as a competent nurse practitioner.

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According to Rodger & Knafl (1993:83), antecedents are those aspects that normally precede the word, they should occur prior to the occurrence of the concept of interest. In the present study antecedents are those factors facilitating support for NQRNs (R.683) in their new RN role. In this study, for support to take place both parties (front-line nurse managers and NQRNs) must be self-aware of the knowledge and skills which they possess or lack to be open and honest to each other so that they can share the information resulting in development of good interpersonal relationship with mutual trust and respect. Both parties should be empathetic and sympathetic to accept and treat each other in a professional way and thus enhance personal and professional growth and development. Therefore, good communication skills and team cohesion is imperative to cement the interpersonal relationships required for support to take place.

Consequences were described by Rodgers (1989) as the phenomena that result from the use of the concept. In this study, the following outcomes were identified as consequences of the concept of support: competence, confidence, independence, accountable for acts and omissions, job satisfaction. These consequences are appropriate because when NQRNs are supported when they enter their new RN role, they will display job satisfaction through provision of quality and safe patient care with confidence as competent independent nurse practitioners who are accountable for their acts and omissions.

Phase 3: Development of the Model

- **Objective 5:** The development of a model to enhance the support for NQRNs (R.683) in selected hospitals by nurse managers

This objective was attained through formulation of conceptual framework based on the survey list outlined by Dickoff *et al.* (1968:422). The Dickoff *et al.*'s (1968) survey list encompasses the agent, recipient, context, dynamic, procedure and terminus. The

conceptual framework formed the basis of the development of a model to enhance support for NQRNs (R.683). According to Dickoff *et al.* (1968) a conceptual framework aimed at creating situations intending to attain the desired and preferred outcomes. In this study, the model was successfully developed based on the study findings for Phase 1, empirical phase in Chapters 4 and 5 and Phase 2, Concept analysis in Chapter 6. The concepts on the Dickoff *et al.*'s (1968) survey list served as the basis for the model development and increased the possibility of developing a model to enhance support for NQRNs (R.683). The following questions were utilized to direct the process of model development:

- Who performs the activity?
- Who is the recipient of the activity?
- In what context is the activity performed?
- What is the energy source of the activity?
- What is the guiding procedure, technique or protocol of the activity?
- What is the intended outcome or endpoint of the activity?

The model was intended to effectively support NQRNs (R.683) within their initial period of employment to empower them with decision-making and problem-solving skills, thus, improving their competence and building confidence that would enable them to function independently. The purpose of the developed model was to enhance support for NQRNs who had less than eighteen months of employment and enable them to be successfully empowered in their new RN role. The model was also described following Chinn & Kramer's (2018:190) approach.

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9.5 Model Description

9.5.1 Purpose of the Model

The purpose of this model was to provide a frame of reference to UNMs to enhance support for NQRNs (R.683) in selected hospitals during their initial eighteen months in the new role and guide them on the guidelines for operationalizing the proposed model.

9.5.2 Structure of the Model

The structure of the model was discussed based on the following sub-headings as described by Chinn & Kramer (2018:190-202) which are: assumptions of the model, concept definition, relational statements and the nature of the structure as outlined in Relational Statement of the Model (Section 7.5.3.3).

Phase 4: Validation of the Developed Model

- **Objective 6:** The validation of a developed model to enhance support for NQRNs (R.683) in selected hospitals by nurse managers

Although the model was not validated by experts, this objective was realized by validating the model following Chinn & Kramer's (2018:203) five critical reflection questions. The following critical reflection questions guided the validation of the model:

- How clear is the model?
- How simple is the model?
- How general is the model?
- How accessible is the model?
- How important is the model?

9.6 Justification and Contributions

This study is an original contribution to the body of knowledge in nursing practice for the following reasons:

- The support for NQRNs has been implemented for those who were placed on Compulsory Community Services (CCS), but it had never been done for NQRNs (R.683) with previous EN experience.
- The identified challenges faced by NQRNs (R.683) contributed to the development of a conceptual framework based on the Dickoff *et al.*'s (1968) survey list that comprises the agent, recipient, context, dynamics, procedure and terminus.
- The collected data revealed new matters relevant to NQRNs (R.683) through FGIs. The findings of the study were based on the identified themes post data analysis and interpretation.
- The developed model to enhance support for NQRNs (R.683) is a contribution to the body of knowledge in nursing practice, research and policy making to enhance the effectiveness of support in the clinical practice setting.
- This study attained its core purpose by developing a model to enhance support for NQRNs (R.683).
- Although the R.683 legacy programme declared ending by 2023 by SANC, the model can be piloted to those who are currently on training as well as those who have just qualified as RNs.
- The model can also, be modified or improved further to suit the NQRNs who will undergo new programmes.

9.7 Contributions to Future Research

The model acts as a challenge for nursing practice to test the applicability of the model guidelines, to refine the study even further, if necessary. It challenges UNMs to reflect on their support skills for NQRNs.

9.8 Piloting

The applicability, relevance and effectiveness of this model should be achieved through piloting the model to selected hospitals where data were collected for awareness and appreciation.

9.9 Limitations

As stated by Grove & Gray (2019:46), limitations are challenges or restrictions in a study that may decrease the credibility and generalizability of the study findings. The limitations of this study are:

- The approval from Mopani district office was delayed and slowed down the progress of the study.
- The findings of the study are not generalized to all hospitals in South Africa. The study was only conducted in Mopani and Vhembe districts of Limpopo Province, which is not representative of the entire population of NQRNs (R.683).
- The vast distance between Mopani and Vhembe districts also slowed down the progress of the study as the researcher had to visit one hospital per week because the agreement was to visit on Wednesdays which was suitable for FGIs.
- Access to NQRNs (R.693) was a challenge in two selected hospitals, in

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one hospital participants were allocated on night shift and could not manage to attend the FGI due to strain of night shift. In another hospital, the number of NQRNs (R.683) who availed themselves were only two, despite the fact that ten participants agreed to participate in the FGIs. This meant that only two NQRNs (R.683) could participate in the FGI due to difficulties of gathering a group of NQRNs (R. 683) as agreed. On follow-up it was indicated that five took owed hours while three were off sick.

- The study had financial constraints for the researcher as she was not funded, hence, it was difficult to recruit and train assistant researchers to help with data collection.

- The study was only conducted in public hospitals, thus limiting the findings to public hospitals. However, it is foreseen that this model would be transferable to either private or public hospitals where NQRNs 9R.683) are employed. Despite the limitations of this study, its purpose to develop a model to enhance support for NQRNs (R.683) was attained.

9.10 Recommendations

According to Grove & Gray (2019:481), the researcher provides suggestions for future research based on the study findings.

9.10.1 Recommendations for Nursing Practice

Literature affirmed that transition from classroom to clinical practice setting is challenging and stressful for NQRNs. As inexperienced in unit management, NQRNs during their initial period of employment need support of experienced RNs. Hence, the following recommendations are made for Nursing Practice:

- The model to enhance support for NQRNs (R.683) should be disseminated

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to NQRNs and UNMs through in-service training, workshops and scheduled clinical meetings for acceptance and support.

- UNMs in the unit should provide orientation and offer mentoring, guidance and support to NQRNs.
- Both UNMs and NQRNs should work jointly in the nursing unit to attain the objective of support.
- UNMs should create a non-threatening supportive environment for NQRNs to develop their professional capacity.
- Clear policies and guidelines to support NQRNs need to be developed jointly by both agents and recipients.
- The workload of UNMs should be reduced to permit mentoring, support and guidance for NQRNs, which might require adequate staffing ratio.

9.10.2 Recommendations for Nursing Research

It is recommended that the focus of future research should be:

- To explore the experiences of how UNMs need to be encouraged to address the problem of bullying in the nursing unit.
- The implementation and evaluation of the model to enhance support for NQRNs be done for applicability, relevance and effectiveness.
- An evaluation instrument to test the model within the selected hospitals' nursing units' contexts needs to be developed.
- A follow-up study on the effectiveness of the model in the clinical practice setting should be conducted.

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- The application of the support model for other categories of NQRNs can be further researched.

9.10.3 Recommendations for Policymakers

To ensure effective support for NQRNs (R.683), provincial, district or institutional professional development committees could incorporate the model as part of clinical nursing practice frameworks. The model should be presented to provincial, district and institutional nursing practice stakeholders who are directly contributing to nursing services for awareness and appreciation of the value of the support model and the guidelines for operationalizing the model.

9.11 Conclusions

The purpose of the study was accomplished through the development of a model to enhance support for NQRNs (R.683). The study was evaluated in terms of the purpose and objectives to determine whether intended aims have been attained. The study was conducted in four phases which were clearly outlined. There were some limitations for this study which were described. Recommendations were made for nursing practice, future research and policymakers. It is also realized through this study that NQRNs (R.683) during their initial period of employment were inexperienced leading them to be uncertain when it comes to decision-making and problem-solving in the nursing unit.

The study revealed that NQRNs (R.683) needed to be empowered with necessary knowledge and skills, attitudes and values to enable them to be independently functional in the nursing unit. The researcher is of the opinion that situations encountered by NQRNs (R.683) should be considered challenging, as some indicated being overwhelmed with responsibility and accountability; they felt alone and vulnerable, fearful and stressed without support of UNMs, since they were uncertain

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of what to do and whom to ask for help. Therefore, support of UNMs is of utmost importance. NQRNs (R.683) had previous nursing experience, however, they had never been given an opportunity to practice activities of unit management which is quite daunting, especially being left alone to manage the unit without support, therefore support can never be overemphasized.

This chapter has described the justification and contributions, piloting, limitations and recommendations of the study. Through this research, a model to enhance support for NQRNs (R.683) was developed. It is vital that each hospital should assess the support needs of NQRNs to contextualize a support programme. The support needs for NQRNs (R.683) in different nursing units might not be the same. The supportive model should be formalized and recognized by UNMs for it to be effective. It is hoped and believed that the developed model in this study can become an effective tool through which change of supporting NQRNs (R.683) can be initiated.

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ANNEXURE A

Ethical Clearance Certificate from the University of Venda Research Ethics Committee

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Mrs TS Sadike

Student No:
18012563

PROJECT TITLE: **A model to enhance support for newly-qualified registered nurses(R.683) in selected hospitals of Limpopo Province, South Africa.**

PROJECT NO: **SHS/19/PDC/05/0104**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof DU Ramathuba	University of Venda	Promoter
Prof ML Netshikweta	University of Venda	Co - Promoter
Dr KG Netshisaulu	University of Venda	Co - Promoter
Mrs TS Sadike	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: April 2019
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: ....
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2019 -04- 10
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
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ANNEXURE B1

LETTER TO LIMPOPO PROVINCE DEPARTMENT OF HEALTH REQUESTING PERMISSION TO CONDUCT RESEARCH

University of Venda
Private Bag x5050
Thohoyandou
0950
Date: ……………..

The Research Ethics Committee
Limpopo Province Department of Health
POLOKWANE
0700

RE: PERMISSION TO CONDUCT A RESEARCH PROJECT AT YOUR INSTITUTIONS

TOPIC: A MODEL TO ENHANCE SUPPORT FOR NEWLY-QUALIFIED REGISTERED NURSES (R.683) IN SELECTED HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA

Dear Sir/Madam

I am a registered nurse, presently studying for a Doctorate Degree with the University of Venda, majoring in Advanced Nursing Education. My student number is 18012563. I hereby request permission to conduct a study at your province at the following districts: Mopani and Vhembe. The purpose of the study is to develop a model that will enhance support for newly-qualified registered nurses (R.683) in selected hospitals of Limpopo Province, South Africa.

The study will benefit the province at large; it will contribute to the achievement of management and supervisory skills by newly-qualified registered nurses who will be empowered to manage nursing units independently with confidence and competence, and thus enhance safe quality patient care and minimize lawsuits. A letter of invitation will be issued to all potential participants along with a consent form. All participants maintain the right to withdraw from the study at any

time without penalty. Enclosed you will also, find a copy of my research proposal and the ethical clearance copy from the Research Ethics Committee.

Thank you for taking time to read this letter. Should you have any queries please feel free to contact me at 082 409 9261 or email baloyits@live at any stage. I look forward to hearing from you.

Yours faithfully

Tinyiko Sophie Sadike (082 409 9261)

Signature: ……………………………………….. Date: …………………………………………

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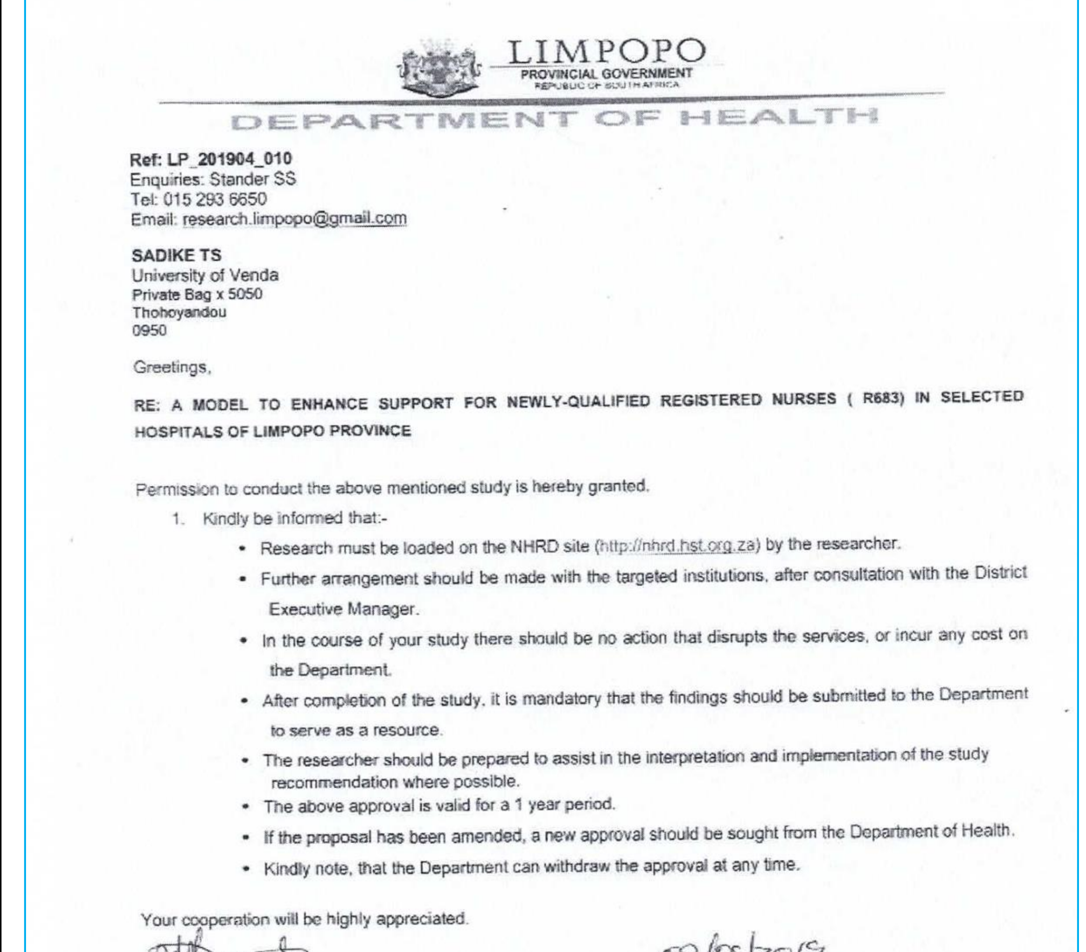
ANNEXURE B2

PERMISSION FROM LIMPOPO PROVINCE DEPARTMENT OF HEALTH TO CONDUCT RESEARCH



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Ref: LP_201904_010
Enquiries: Stander SS
Tel: 015 293 6650
Email: research.limpopo@gmail.com

SADIKE TS
University of Venda
Private Bag x 5050
Thohoyandou
0950

Greetings,

RE: A MODEL TO ENHANCE SUPPORT FOR NEWLY-QUALIFIED REGISTERED NURSES (R683) IN SELECTED HOSPITALS OF LIMPOPO PROVINCE

Permission to conduct the above mentioned study is hereby granted.

1. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
   - In the course of your study there should be no action that disrupts the services, or incur any cost on the Department.
   - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 1 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.
   - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

Head of Department

02/05/2019
Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House. 18 College Street. Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.

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ANNEXURE C1

LETTER TO MOPANI AND VHEMBE DISTRICTS REQUESTING PERMISSION TO CONDUCT RESEARCH

University of Venda
Private Bag x5050
Thohoyandou
0950
Date: …………….

To: The Executive District Manager

RE: PERMISSION TO CONDUCT A RESEARCH PROJECT AT YOUR INSTITUTIONS

TOPIC: A MODEL TO ENHANCE SUPPORT FOR NEWLY-QUALIFIED REGISTERED NURSES (R.683) IN SELECTED HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA

Dear Sir/Madam

I hereby apply for permission to conduct a research study at your hospitals. I am a registered nurse, presently studying for a Doctorate Degree with the University of Venda, majoring in Advanced Nursing Education. My student number is 18012563. The purpose of the study is to develop a model that will enhance support for newly-qualified registered nurses (R.683) in selected hospitals of Limpopo Province, South Africa, and thus reduces medico-legal hazards.

The study will benefit the district at large; it will contribute to the achievement of management and supervisory skills by newly-qualified registered nurses who will be empowered to manage nursing units independently with confidence and competence, and thus enhance safe quality patient care and minimize lawsuits. A letter of invitation will be issued to all potential participants along with a consent form. All participants maintain the right to withdraw from the study at any time without penalty. Enclosed you will also, find a copy of approval letter from the Provincial Department of Health.

Thank you for taking time to read this letter. Should you have any queries please feel free to contact me at 082 409 9261 or email baloyits@live at any stage. I look forward to hearing from you.

Yours faithfully

Tinyiko Sophie Sadike (082 409 9261)

Signature: ……………………………………….. Date: …………………………………………

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ANNEXURE C2

PERMISSION FROM MOPANI DISTRCICT TO CONDUCT RESEARCH

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
MOPANI DISTRICT

Ref: S4/2/2
Enq: Mohatli IE
Tel: 015 811 6543

To Sadike T.S
University of Venda

Re: PERMISSION TO CONDUCT RESEARCH IN MOPANI HEALTH FACILITIES: YOURSELF

1. The matter cited above bears reference
2. This serves to respond to the request submitted to research on the topic: **"A model to enhance support for Newly Qualified Registered Nurses in selected hospitals of Limpopo Province."**
3. It is with pleasure to inform you about the decision to permit you to conduct research at Letaba, Nkhensani and DR CN Phatudi hospitals within Mopani District.
4. You will be required to furnish hospital authorities with this letter for purposes of access and assistance.
5. You are further advised to observe ethical standards necessary to keep the integrity of the facilities.
6. The Mopani District wishes you well in your endeavour to generate knowledge.

Director: Corporate Services
Date: 24.06.2019

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ANNEXURE C3

PERMISSION FROM VHEMBE DISTRICT TO CONDUCT RESEARCH

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OFHEALTH
VHEMBE DISTRICT

Ref: S5/6
Enq: Muvari MME
Date: 29 May 2019

Dear Sir/Madam..SADIKE T.S...

Permission to conduct a research on the
"A MODEL TO ENHANCE SUPORT FOR (R 633)".

1. The above matter refers.

2. Your letter received on the 29 May 2019 requesting for permission to conduct an investigation is hereby acknowledged.

3. The District has no objection to your request.

4. Permission is therefore granted for the study to be conducted within Vhembe District. You are expected to submit the results to the District.

5. You are however advised to make the necessary arrangements with the facilities concerned.

Wishing you success in your endeavors.

....pp. [signature]..........................
CHIEF DIRECTOR: DISTRICT HEALTH

2019/05/29.........
DATE

Private Bag X5009 THOHOYANDOU 0950
OLD parliamentary Building Tel (015) 962 1000 (Health) (015) 962 4958 (Social Dev) Fax (015) 962 2274/4623
Old Parliamentary Building Tel: (015) 962 1848, (015) 962 1852, (015) 962 1754, (015) 962 1001/2/3/4/5/6 Fax (015) 962 2373, (015) 962 227

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ANNEXURE D1

LETTER REQUESTING PERMISSION TO CONDUCT RESEARCH AT SELECTED HOSPITALS

University of Venda
Private Bag x5050
Thohoyandou
0950

Date: …………….

To: The Chief Executive Officer

RE: PERMISSION TO CONDUCT A RESEARCH STUDY AT YOUR INSTITUTION

TOPIC: A MODEL TO ENHANCE SUPPORT FOR NEWLY-QUALIFIED REGISTERED NURSES IN SELECTED HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA

Dear Sir/Madam

I hereby apply for permission to conduct a research study at your hospital. I am a registered nurse, presently studying for a Doctorate Degree with the University of Venda, majoring in Advanced Nursing Education. My student number is 18012563. The purpose of the study is to develop a model that will enhance support for newly-qualified registered nurses in selected hospitals of Limpopo Province, South Africa.

The study will benefit the hospital at large; it will contribute to the achievement of management and supervisory skills by newly-qualified registered nurses who will be empowered to manage nursing units independently with confidence and competence, and thus enhance safe quality patient care and minimize lawsuits. A letter of invitation will be issued to all potential participants along with a consent form. All participants maintain the right to withdraw from the study at any time without penalty. Enclosed you will also, find a copy of approval letter from the Provincial Department of Health.

Thank you for taking time to read this letter. Should you have any queries please feel free to contact me at 082 409 9261 or email baloyits@live at any stage.

I look forward to hearing from you.

Yours faithfully

Tinyiko Sophie Sadike (082 409 9261)

Signature: ……………………………………….. Date: …………………………………………

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ANNEXURE D2

PERMISSION FROM DR CN PHATUDI HOSPITAL TO CONDUCT RESEARCH

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DR CN PHATUDI HOSPITAL
PRIVATE BAG X 4056
TZANEEN
0850

To: Sadike T.S
School of health & sciences
University of Venda
P/Bag X5050
Thohoyandou
0950

Re: Permission to conduct a Research Study

1. The above matter bears reference
2. The hospital hereby acknowledge receipt of your letter dated 20/05/2019.
3. The letter is regarding the permission to conduct a Research study in the institution.
4. This letter refers to confirm that the hospital is granting you to come and conduct such a study, after you have consulted with the District Executive Manager (Mopani District).
5. You are therefore requested to indicate the date and period of the research study, so that the Hospital do proper planning for you.

NB! May you kindly provide the institution with an approval letter from the District Executive Manager on the day of the research study.

Thanking you in anticipation

Yours Truly

Acting CEO
Sape W.M

11/06/2019
Date

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ANNEXURE D3

PERMISSION FROM ELIM HOSPITAL TO CONDUCT RESEARCH

PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
ELIM HOSPITAL

Ref: S5/3/2
Enq: Raluthaga.T
Date: 2019. 05. 23

To: Ms. Sadike T.S
Management College of South Africa

Cc: Deputy Manager: Nursing Services: Mrs. Mabunda K.G

Cc: Acting Deputy Director: Risk Management Service Mr. Matsheka N.J

From: Human Resource Organizational Strategy and Planning

SUBJECT: A MODEL TO ENHANCE SUPPORT FOR NEWLY-QUALIFIED REGISTERED NURSES (R.683) IN SELECTED HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA: Yourself

1. The above matter bears reference.
2. Receipt of your dated letter 20. 05. 2019 together with the approval from the Provincial Office is hereby acknowledged with thanks.
3. You are hereby granted permission to access the hospital to conduct the research as requested.
4. When collecting the data, you are kindly advised to liaise with Mrs. Mabunda K.G: Deputy Manager: Nursing Services and Mr. Matsheka: Acting Deputy Director: Risk Management Service regarding issues of information security and the patient's rights.
5. Your urgent attention is always appreciated.

CHIEF EXECUTIVE OFFICER

23.05.19
DATE

P/Bag X312, Elim Hospital, 0960
Tel (015)556 3201/2/3/4/5, Fax (015)556 3160,
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ANNEXURE D4

PERMISSION FROM FROM LETABA HOSPITAL TO CONDUCT RESEACH

Letaba Regional Hospital
Private Bag X 1430
Letaba
0870

Ref: S5/4/2/3
Enq: Malatji E.M
Date: 22/05/2019

ATT: SADIKE TS
Private Bag X5050
THOHOYANDOU
0950

RE: OFFER FOR APPLICATION TO CONDUCT RESEARCH STUDY TO ENHANCE SUPPORT FOR NEWLY-QUALIFIED REGISTERED NURSES

1. The above matter refers

2.It is a great pleasure to inform you that the Chief Executive Officer has approved your application to conduct research study to enhance support for newly-qualified registered nurses It has been approved for a period of a year as per our department`s approval. And you will placed under nursing services management.

Starting Time: 07h30
Lunch Time: 13h00 to 14h00
Knock off Time: 16h30

3. You will be expected to work from Monday to Friday.

4. NB.Please note that you will not get remuneration/ Compensation during your Research study.

Hoping that you will enjoy your stay in the hospital.

ACTING CHIEF EXECUTIVE OFFICER .... 22/05/2019 ......
DATE

Private Bag X 1430, LETABA, 0870
Cnr. Tarentaal and Lydenburg Road, Tel: (015) 303 8200, Fax no: 015 303 8421

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ANNEXURE D5

PERMISSION FROM LOUIS TRICHARDT MEMORIAL HOSPITAL TO CONDUCT RESEARCH

CONFIDENTIAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

LOUIS TRICHARDT HOSPITAL

Ref: 4/2/2
Enq: Masindi L.P
Email: londani.masindi@dhsd.limpopo.gov.za
Date: 06/06/2019

TO: MANAGER NURSING SERVICES
TO: CLINICAL MANAGER

CC: CHIEF EXECUTIVE OFFICER

SUBJECT: APPROVALTO CONDUCT RESEARCH AT LOUIS TRICHARDT HOSPITAL: SADIKE T.S

1. Your letter dated 20 May 2019 is hereby acknowledged.
2. Kindly note that Miss Sadike T.S from University of Venda has been granted permission to conduct on the following research topic **"A MODEL TO ENHANCE SUPPORT FOR NEWLY-QUALIFIED REGISTERED NURSE (R.683) IN SELECTED HOSPITAL OF LIMPOPO PROVINCE, SOUTH AFRICA "**.
3. The above permission is subject to the conditions as set down in both permission letters from Provincial Health Department dated 02/05/2019 and Vhembe District Office dated 29/05/2019. Copies are attached for easy reference.
4. Kindly assist her accordingly.

Thank you.

ACTING CHIEF EXECUTIVE OFFICER

07/06/2019
DATE

P/BAG X 2417 LOUIS TRICHARDT 0920
TEL: 015 516 0148 Crn. Hospital & Snyman Street Fax: 015 516 3252/ 4658
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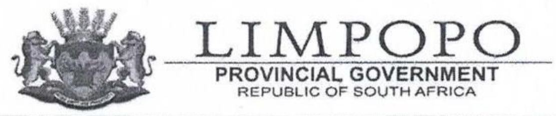
ANNEXURE D6

PERMISSION FROM MALAMULELE HOSPITAL TO CONDUCT RESEARCH



DEPARTMENT OF HEALTH
MALAMULELE HOSPITAL

18 JUN 2019
REGISTRY

REF : S 4/5
ENQ : Siwela T.S
DATE : 14/06/2019

TO WHOM IT MAY CONCERN

SUBJECT: PERMISSION TO CONDUCT A RESEARCH: SADIKE T.S

1. This serves to acknowledge the receipt your application to conduct a research study at Malamulele hospital and the research topic is **"A model to enhance support for newly-qualified registered nurses (R.683) in selected hospitals of Limpopo Province, South Africa"**
2. The permission to conduct the study in question is recommended since has all the requirements such as : the application letter, research proposal, Training institutions Ethical clearance certificate, Provincial and District offices approvals as prescribed by departmental circular no 24 of 2015.
3. Hopping for an effective cooperation between the participants of this research

Thank you

....
CHIEF EXECUTIVE OFFICER
MALAMULELE HOSPITAL

DEPARTMENT OF HEALTH
MALAMULELE HOSPITAL P BAG X9245
MALAMULELE 0982
20 JUN 2019
REGISTRY

18/06/19
DATE

CONFIDENTIAL

Malamulele Hospital Private Bag x9245 Malamulele 0982
Tel: (015) 851 0026/1020/1017/1019 Fax: (015) 851 0620

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ANNEXURE D7

PERMISSION FROM NKHENSANI HOSPITAL TO CONDUCT RESEARCH

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
NKHENSANI DISTRICT HOSPITAL
Private Bag X9581
Giyani, 0826
Tel: (015) 811 7300
Fax: (015) 812 2461

Ref: S5/1/6/2
Enq: Mathebula K.D
Date: 14 June 2019

TO: Sadike Tinyiko Sophie
University of Venda

RE: APPLICATION FOR PERMISSION TO CONDUCT THE RESEARCH STUDY

1. It is with pleasure to inform you that your application for the aforementioned study has been approved at Nkhensani District Hospital.
2. The approval of your research study is subject to the following conditions:
   - 2.1 During the course of your research study, hospital services should not be disrupted..
   - 2.2 Upon completion of your study you should be prepared to assist in the interpretation of the study findings/recommendations.
   - 2.3 After completion of the study a copy should be submitted to the Department of Health to serve as a resource.
3. You should liaise with the Office of the Chief Executive Officer (CEO) as and when you intend to start research study.
4. Your cooperation is always appreciated

CHIEF EXECUTIVE OFFICER

14/06/2019
DATE:

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ANNEXURE D8

PERMISSION FROM SILOAM HOSPITAL TO CONDUCT RESEARCH

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
SILOAM HOSPITAL
Confidential

Ref : S4/2/1/1/3
Enq : Tshilimandila S: HRM
Date : 24 May 2019

...TMENT OF HEALTH
SILOAM HOSPITAL
HUM... RESOURCE
2019 -05- 28
P/BAG X 2432,
MAKHADO, 0920
LIMPOPO PROVINCE

To: Sadiki T.S

RE: PERMISSION TO CONDUCT RESEARCH: YOURSELF.

1. The above matter refers.
2. The Hospital highly acknowledges the receipt of your letter dated 20/05/ 2019 regarding the above matter.
3. Kindly note that the institution is granting you permission to come and conduct research in A Model to enhance support for Newly-Qualified registered Nurses (R.683) in selected Hospitals of Limpopo, South Africa.
4. You are kindly requested to adhere to the conditions as set out in your approval from the Provincial Office.
5. Hoping you will find the above in order

Chief Executive Officer

27/05/2019
Date

Private Bag X2432. Makhado, 0920
Tel (015) 973 0004/5/6, 015 973 1447/8, 015 973 1977, 015 973 1892/4/9 Fax (015) 973 0607.

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ANNEXURE E

NQRNS (R.683) FOCUS GROUP INTERVIEW TRANSCRIPT

TRANSCRIPTION 8: INSTITUTION NO. 6 DATE: 14.08.2019

VENUE: BOARDROOM TIME: 09H00

INTERVIWER: I

PARTICIPANT: P

COLOUR CODES: NO CERTIFICATES ETC., LEFT ALONE, STAFF SHORTAGE, WORKLOAD, TIRED, FRUSTRATION, NO ORIENTATION, ATTITUDE, NO RECOGNITION, FEAR, NO CONFIDENCE, INSUBORDINATION, NO TRUST, NO KNOWLEDGE

INTRODUCTION

I: Good morning colleagues.

P(ALL): Good morning.

I: How are you?

P (ALL): Fine and you?

I: I am fine.

I: As I have already explained to you I am Tinyiko Sadike, I am a PhD student at the University of Venda. Today I'm coming to collect data as I have explained to you. Can I, let me just remind of the topic is a model to enhance support for newly-qualified registered nurses R.683 in selected hospitals Limpopo Province, South Africa. I think you know that when I talk about R.683 I'm talking about the regulation which is guiding the training of bridging students. I'm not going to call anyone of you using your real names. So, for today I'm here to collect data where I'm going to ask you some questions as I have given you those cards what is going to happen is that we are not going to use our real names, we are just going to use the numbers that are written in those cards. Everybody is holding a card which is written participant number so and so, participant number so and so. So, in case you want to answer the question or maybe you want to support your colleague. Please do not say I want to support what so and so say have said just say I want to support what participant number so and so have said that is why I gave

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you those cards that when you are answering the question you raise up the hand and then you show us your card so that we can be able to call you according to that card, don't forget do not mention any name of the hospital, do not mention any name of your colleague or any name of your supervisor the discussion is anonymous as we have already agreed. And then I have already said that our discussion is going to last for 30 to 45 minutes if ever now that one 45 minutes will be the maximum. So, now we are going to start with our discussion. So, what I'm going to do is that when you are answering the question we are going to use this mic you are going to hold it and share among yourself so that it can be able to catch the voices when we are busy discussing. Are you comfortable and are you ready?

P (ALL): Yes (*softly*).

I: Ok, if you are ready we are going to start communicating or maybe discussing as colleagues. Ok, what I want to know is about the challenges, isn't that now you were once enrolled nurses and then now you are registered nurses isn't so.

P (ALL): Yes (*softly*).

I: So, as registered nurses there are challenges that you might be encountering or you are encountering immediately when entering your new role. So, I just want you to share with me those challenges that you are encountering or you have encountered when you enter your new role as a registered nurse. So, anybody who want to answer it just raise up your hand. Participant number 9 I see you raising the hand just share with us.

P9: Ok, me as a new professional nurse I have encountered problems such as **being mastering a lot of things in a very short time because when you come back from bridging when you are a newly-qualified you don't have another time to learn**, is the time that the ward or **your supervisor will just give you a job to do and want to see doing it properly whereas maybe you are starting to accommodate yourself** and to get used to this professional thing. So, that is what I have encountered at my time.

I: Ok, participant number 2 I see you raising your hand you can share with us.

P2: Ok, Thank you! Ooh Ok, *'min…'* sorry, myself I have encountered this in my unit: *eeh* when you are coming from bridging course you suppose to have like support from supervisors, the place where I was working at the first place it was medical. So, I was so comfortable and I was ready *eish* to maintain the skills. So, there was a time there we have to change from unit where we were working to another unit. So, then when we move to another unit you find that in that unit all the staff that were used to work there or those who have skills from the other unit they have changed to another unit. So, you suppose to remain alone or with a new qualified registered nurse there. So, you find that there is a lot of challenges maybe patients are many let say we is casualty is casualty *neh* you have to see let's say 80 patients with new qualified registered nurse you knock off at nineteen (19) you find that there is no other staff the shortage is killing you and then **you end up doing some mistakes**, when you are about to be *charg*…to tell the supervisors that you have faced so many challenges which is what and what they only

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come to give you *eish* to give you the written *statemen*…the written warning they forgot that they were they was the one who supposed to give you time to learn or to show you whatever it is there as the unit is very busy. They don't support but when things go wrong is then that they show up and then **they want to blame you but they forgot that you just new there**, you need to be supported or to be shown things in a good way. So, we are facing challenges everyday which I don't think it will be solved. Thank you!

I: Thank you so much, any colleague who want to…ok participant number P1.

P1: In my ward as a newly-qualified professional nurse what I have encountered is that they leave you alone and do run the ward as a newly-qualified professional nurse and then the problem is that we are getting very tired because we have a shortage of professional nurses there, we are supposed to knock off at nineteen hour (19) everyday when Wednesday come you are very-very tired that is the challenge that we are having. Thank you!

I: Thank you so much for sharing with us, participant number P6 I see you raising the hand.

P6: Thank you so much, I want to support the-the participant P1 what she was saying, even myself I encountered that they will left you alone running the medical ward and that ward is so heavy you cannot manage while you are still new, you need somebody who will be there maybe some years so you find yourself nursing 44 patients 45 alone as a professional nurse and which is not good because **they need to support us at least three months or six months showing us how to do things and then leave you when they can see that now you are ready to run the ward.** Thank you!

I: Ok, Thank you! I there anybody who want to share something except what our colleagues have said, participant number 3 and then from there you will hand over to participant number 39/[P4]I saw her raising the hand again.

P3: Ok, Thank you! On my site the challenge that I came across was that participant number 1 has already said and the other one is that the junior nurses when you delegate them they will tell you that you went to school alone. So, you did not come here with the nurse you had to do everything from the scope of the juniors to the from the nursing assistant to nursing the staff nurses and then you also, do your work as a professional nurse which you got tired at the end of the day. Thank you!

I: Ok, thank you colleague participant number P4.

P4: Ok, thank you *eem* I'm really a new newly-newly-qualified I just want to talk about theatre in theatre we see more patients there. So, eish and we are still learning like when we doing procedure **I'm newly-qualified. So, I need to be supported so they do support sometimes but when the old registered nurses are in their theatres, I do have my theatre. So, sometimes they do check on me whether I'm doing well** or not but sometimes I'm just be alone. So, *eish* we have a hectic '*intho*' work there. **So, we need support**. Thank you!

I: Ok, thank you colleague I see participant number 5 when you finish you can handover to 7

because I see her raising the hand.

P5: Ok, thank you very much. So, on my side I can only add on the workload that I have encountered in the unit where I was allocated eem this is specifically for the old registered nurses because it differ from one person to another, some will give you support but some will not. So, we realized that when you are working with the old professional nurses like for example if they are used on how they work in the unit they become more comfortable and they just end up choosing what they to do and what they don't do and the rest of the things are up on your shoulders and when like for example when somebody have done a speciality they will choose to stick to the unit or the cubicle that they are working according to what they are qualified for, and you are left to run the other does not matter how many cubicles are they but as long as you are not specialized you will be running that whole unit and it becomes too heavy and sometime you need support and they said they are busy with their things, and some you can see they don't just want to enter there because they know the challenges in that unit. So, you will be left alone with those challenges. Thank you!

I: Thank you colleague for sharing with us.

P7: Thank you, I want to support the participant number 5 the challenge that I have come across is when I was working in maternity ward, I was a newly-qualified professional nurse, sometimes there was a shortage in the ward while I was supposed to be left alone in the ward while I was not having a midwifery, and I came across a challenge again when I was working in medical ward still there was a shortage some of the sisters are suppose to go to this and then I came across the patients when, there is a lot of patients sometimes you find that they died and then I suppose to write the what we call BI because I was a newly-qualified I was supposed to run around going to some wards to ask for assistance. Thank you!

I: Ok, thank you so much colleagues for sharing with us. I don't know if ever there is somebody who have got something another challenge to share with us. If not let us just continue and then I just want to find out as you have just transited from being enrolled nurses and become registered nurses. *Eeh*, let's just know that when you are registered nurses isn't that you have to work independently and accountable. So, I just want to find out from you. How do you feel about your preparedness for the registered nurse role? How do you feel about the preparedness because you are expected to work independently and accountable. Participant number 9.

P9: Ok, Thank you! In my case I think I was lucky enough because I was working at a specialized unit where you deal with everything in a patient. So, **for preparedness at least it was a little bit it was better when I compared it to general ward because when I go to general ward I find it was very easy for me to work there**. But in a specialized unit also, it was a challenging thing because I work in intensive care unit where we have got specialized trained professional nurses who are like doctors there. **So, for me to reach their scope it means I also, have to pull up my socks. So, that at least I can be like I can reach their**

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height. So, for me I go to general ward it was easy but in a specialized unit it was still a challenge because some of the things I did go out there without even knowing all of them. Thank you!

I: Ok, Thank you! Anyone who wants to share this question? participant number 2.

P2: Ok, Thank you! Ok, for that one **in my case for preparedness in medical ward it was not a problem at all I was ready to work and willing to learn more**. The challenge it came when I arrive in casualty. In casualty we can remember we have eeh many different departments, you have a patient from accident that patient needs a trauma nurse and you'll be alone there without trauma. So, it becomes a challenge when you have to run to rescuci and you have to apply the skills. You find that even the doctor is an intern he needs more from you and you also new. So, that one it becomes a hazard is so straining.

I: Thank you colleagues for sharing this information before we proceed participant number 4 and 8 I will hand it over to you.

P4: Thank you again for giving me time for preparedness I think *eem* for this new allocation I think **in theatre I was welcomed and then they showed me everything and the support. So, I really appreciate** and like for those *'intho'* big cases they sometimes when I-I-I have to go for them they say no there is this old *'intho'* sisters. So, I must *'intho'* wait to see the way they are working. So, **for preparedness I think I'm fine in the theatre**. Thank you!

I: Ok, thank you colleague.

P8: In my case **I was prepared**, I thought I was prepared but then I was thrown into paedriatric care and then there is shortage of staff and you have to do most of the things there is a professional nurse who is specialist paeditrician but when you work in you allocated in your **cubicle you are also, expected to work in that cubicle where the trained professional nurse work you have to leave what you are doing and then you go and also, help in that cubicle**. **But now I became used to it and I'm prepared**.

I: Ok, thank you so much colleague. Ok I see participant number 1 she wants to share something with us?

P1: In my unit, **in my new unit where I'm working now the preparedness was not well for me there was this time we were having a very critical patient. So, we were needing the doctor to come and see the patient and then we call the doctor the doctor was not answering the phone and then we call more than three or four more times. So, we reported that thing we write the statement to file that we have call the doctor to come and then when another nurse which is the is a trained specialist of that unit came and then read those things you write there you have call the doctor and then like she say we are not doing this in this ward like you newly-qualified professional nurses you will have a problem we don't report the doctors** it was like that thing I was it was very disturbing to me because in nursing they say you must report and record everything that we do so the qualified

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specialist who say that we must not record and report what you are doing in the ward that thing disturbed me a lot. Thank you!

I: Ok, colleagues thank you so much for sharing this information and then now let me find out from you since now you are newly-qualified registered nurses. Since when you felt that you are ready to can work safely independently alone. If I say since when isn't that you have got different types of-of-of period being newly-qualified registered nurses. Somebody can say like others they say in my new unit because I used to work there I was already prepared to work safely whatever some they say two months, three months, four months, six months it depends on you because you are coming from different types of units. Is the question clear?

P (ALL): Eem

I: Ok, anybody who want to share with us? participant number 9.

P9: Ok, thank you, **for me it took me like more than three months and then even though I can feel now that I'm not that I can say I'm ready because each case is different. So, I'm still learning also.**

I: How many months are you having for now being a professional nurse?

P9: Now at least I'm above two years, what three years *ee*, **but after three months I was ok**. But for cases that I come across everyday *eish* some are terrible.

I: Meaning that you are now more twelve months? Ok Thank you!

P9: Yes.

I: Ok, anyone who wants to share ok colleague

P2: I can say since last month there was the time where **we had a horrible accident in casualty we received about 44 patients and they were critical traumatic injured. So, from that day I have learned so much. Ja, I can say from that day I become a competent nurse in that unit. So, I feel like I can do anything for now I'm so much ready.**

I: Because of being exposed to that particul… you saw a lot of causalities and now you managed to see how they were being managed and then now you got some skills.

P2: Yes, I then being left alone I can say since like last week I managed casualty (inaudible) I see myself participating and doing work

I: Ok, Thank you! Ok, colleagues let me just find out from you what type exactly. What type of support structure are available in your units, isn't that you are coming from different units? What type of support structures are available there? We are talking about their availability. Participant number P8.

P8: Ok, **in my unit where I'm working the support structures that I got it from the overall supervisor, she is always willing to help where you don't know, she is always available and she likes to teach a lot,** but she only works from Monday to Friday. Yes, and **then we are**

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also, orientated about the ward and some of the things there.

I: Ok, thank you any other one who have something, ok participant 2.

P2: Ok, thank you ja the support structures that I got from my colleague I can say **she is a trauma nurse who is always being there for me, whatever need arise she is always there she never let me down. So, I feel safe around her, even though she went for leave or even though she is not around the skills that have applied in me I can do better and If eel so grateful**. Thank you!

I: Ok, participant 9.

P9: Ok, Thank you! For support structure at my unit also, is **the ward meeting that we with the doctors where the doctors they share their knowledge to us** and then we know much we know what is expected, let me tell you an example of a malnutrition patient because now I'm at paediatric ward, **the doctors will teach you if they are saying when do we need blood glucose they will indicate clearly an teach you everyday please just check blood glucose for the children just check the weight before the children can eat maybe the same time whatever. At least it becomes before because you know '*wuri*' in this cubicle the doctor will need one-two-three.** They do tell us in those kind of meetings and then they are free to help us if we have other questions including **even our operational manager she is very good at even knowing what is being done there she is hands on**. Thank you!

I: Ok, thank you, participant 4.

P4: Thank you! For support structures, really, I want to say this **my matron is my role model in theatre she is always like telling those supervisors that they must like teach me everything there because now I can say that eem my supervisor who I used to work with is my mentor, she teaches me how to scrub for ceaser and how to scrub for laparotomy. So, I'm proud of her for now.**

I: Ok, thank you colleague. I think most of you have already even included what kind of support did you receive but I can still give those who did not answer this one. What kind did you receive when you started your new role as a registered nurse? When you started your new role what kind of support did you receive? Can you share with me colleagues, participant 9.

P9: Ok, Thank you! **Coaching was a very good thing that was done for me because where I started there were nurses they compete about teaching I can teach better than you**. So, and then when you are a stud…**when you are a new professional nurse you just graduated they will pick you up maybe let say is this one she will teach me until I know most of the things or she is quit shore that now I'm quit shore I can left her and go for tea and do whatever she will be doing one-two-three. So, I was lucky because I found the mentor there who taught me**. Thank you!

I: Ok, participant 1 I see you raising the hand.

P1: Thank you! In my ward for a support structure where I was started as a new qualified

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professional nurse **I was very mentored by the trauma specialist there, they really-really teach you how should you manage the trauma patient, and then resuscitation was the best they teach there, everything was perfect.** Thank you!

I: Ok, is there anyone who want to share something with us? Colleagues what type of support did you receive? Ok, participant 8.

P8: **I was supported by my fellow professional nurses, they always make sure whether I was coping with what I was doing and they were helping me. So, that is the kind of support that I got.**

I: Ok, thank you colleagues for sharing with me this information up to so far. Let us just continue and then we find out what can be done to enhance your support. What can be done according to the support that you received so far? What can be done to increase your support? And another thing what can be done. What type of support can be provided for newly-qualified professional nurses in future? Isn't that this one is general for all newly-qualified registered nurses but the other question is about you because you got the support that you have received, but what can be done to enhance that support that you have received. We can start with that one of what type of support can be done to enhance or maybe what can be done to enhance the support that you received. Participant number 5 I saw you raising the card.

P5: Ok, Thank you! For me **I think maybe each institution maybe form a committee or task people who will look specifically to check in the unit if all new qualified professional nurses are well taught or supervised, because some yes they can offer support but there are those people they cannot be there for you.** So, in order to improve sometimes people can keep quiet because you don't know what to do in that unit, like for example the unit managers are not the same also. So, if there are some of **those people who are task to go each and every unit to check what isn't that is going on in the unit I think there will be improvement.**

I: Thank you, anybody who want to add on what our colleague has said? Participant 2 I see you raising your hand.

P2: Ok, thank you I just want to add on that she was saying, **I think even the ward meetings with the doctors can improve or it can also, support us more because when the doctors are more like to talk with us it become easier for us to ask anything if you did not understand or if you don't know something it becomes easy to go and ask** but if you don't work hand on hand with the doctor it becomes more challenging like there are those doctors that tell themselves 'ku' they can't teach a nurse or they cannot give such thing is not their scope is for nurses' scope and whatever. I think **if we have monthly ward meetings with doctors and then we talk about many things in the ward it can improve and it can also, support the nurses, the newly-qualified.**

I: Thank you colleague, do you want to share with us participant number 3 then you will hand over to participant number 6.

P3: Ok, I think what can be done maybe is that I don't know if can say a window period, **they should give a period maybe three to six months seeing that we are working under supervision, they make sure that we work with the old nurses where they guide us, they supervise us. So, that we learn more and avoid making those unnecessary mistakes**. Thank you!

I: Ok, you can hand it over to your colleague.

P6: Ok, Thank you! I just want to add what she said that even **the nurse manager must make sure that he allocates the supervisor to supervise the newly-qualified professional nurse maybe three or six months working with them until they know that now they are fine and then they can do without them**. Thank you!

I: Ok, thank you colleague participant 9 I see you raising your hand.

P9: Ok, Thank you! I just 'wanna' add on participant number 5 I think even the programmes that can be done to each and every new qualified professional nurse because we don't have like programmes like resuscitation as an example, **if each professional nurse can know how to resuscitate you know that is a life saving procedure where if we can have at least a team or not even a team, if one person can be find to at least teach those newly-qualified or maybe certain procedures that we know that these are lifesaving in out units I think at least that can make we can do best or excellent in preserving life.**

I: Thank you, I see participant 7 raising the hand.

P7: Ok, Thank you! **I want to support participant number 38 what she was saying and also, participant number about the resuscitation because some of us we are not exposed to the resuscitation. So, I think maybe on Wednesdays we can ask our supervisors to teach us because you find that sometimes you come across you are with the doctor and then there is a very ill patient and you are the only sister at that time and then when they call for emergency then you just stand and do nothing, and so is very important to ask our supervisors to teach us**. Thank you!

I: Ok, thank you so much colleagues. Let us come to the last question whereby we can say what type of support can be provided to newly-qualified registered nurses in future? What type of support do you think it can be provided to the newly-qualified registered nurses in future? Colleague, participant number 2.

P2: Ok, Thank you! I think **even the emotional support** is needed in the newly-qualified because you find that a person is not having that **self-confidence** about doing something. Sometimes you find that you are not sure about what you are doing. So, even **the self-esteem**. I **think when you are newly-qualified you need more support like emotionally you need to be built you need to be supported**. **So, you build the self-confidence from that emotional support.** Thank you!

I: Thank you so much, maybe for follow-up purpose, participant number 2 if you talk about

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emotional support whereby a person can build the confidence, the self-esteem what exactly can you just try to say it clearly. So, that everybody can understand what are talking about exactly. How support is supposed to be done there? Or maybe what exactly is supposed to be done to ensure that this is emotionally supporting these newly-qualified registered nurses.

P2: Ok, I was trying to say you find that these newly-qualified nurse she made a mistake in a patient. So, there is these old 'gogos' there in the unit which used to say ja we have been preaching this one she can't do it, those things they demoralize us. So, they mustn't do or maybe they must not always judge like exactly what I'm trying to say. So, if they are not being judged in your mistake you-you find eager to learn more. So, if you do something wrong and then you being judged you become, you lose interest in everything that you are doing. Thank you!

I: Thank you so much is there anybody who wants to add something, participant number 9.

P9: Ok, thank you I just '*wanna*' add I think is what she was saying, **the motivation I think is the proper way that can even enhance the self-esteem for a newly-qualified** because you become demoralized if maybe like you have done ah is you even you have sent yourself to school because you didn't want to wait for the line. You-you '*u tsutsumele swilo'* that thing it makes you feel like '*yuu*' it like I'm not gone go further, but **if ever motivation can be given to these newly-qualified I think they can do much better and teach others also**. Thank you!

I: Thank you, anything participant 4.

P4: To add on participant number 2 and participant number 9 to be taken as a human being '*mani*' even waving hands (**frustration**). We are human being it said that we didn't go to school like in that one time. So, that is why we have a lack in somewhere somehow. So, if we have a lack **they have to motivate us and encourage us and trust us**. Thanks!

I: Thank you! Is there anybody who wants to say something before we conclude participant number 8.

P8: The type of support that I think should be provided in the future is **in-service training** because mostly when we go to the ward we don't know most of the things there. So, we need to be trained on what to do and what to expect. So, that we can act accordingly. That is what I think.

I: Ok, thank you, participant number 7.

P7: Ok, Thank you! They also, have to treat us equally because you find that sometimes we are not the same '*neh*', sister so and so she knows better than **me if I have made the mistake she has to correct me in a better manner**, not saying sister '*Name hidden'* she is knows better, **I Know '*wena*' you won't do better thing if you're not sure of your things you better leave that book because '*u hi thyakisela tibuku'* (meaning you spoil our books) you see that thing.** Thank you!

I: Ok, participant number 5.

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P5: Ok, Thank you! Another support I just want to add this on the, I can say or call them the junior nurses if we can all understand that this is not about competition. So, **the lower categories they can learn to support the newly-qualified and try to understand that there were like them and one day it will be their turn to become professional nurses so that they may give that support**, for example if you are delegating somebody to do something so when that person look at you maybe your age or your height or that denial that you were in the same position. So, they take it **like in a competitive way and start to think that maybe you being acting as if you are above are above them.** Nursing, honestly, you cannot do everything on your own. **We delegate each other. So, I think their support also, is much important.**

I: Is there anybody who wants to add something before we conclude colleagues. All in all I just want to say thank you colleagues. We had a wonderful discussion it was just an informative discussion. I thank you so much for your time, and I thank you because I know that you have a lot to do, but you have managed to come and share this information with me and what I know is that it is going to assist a lot. Thank you so, much!

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ANNEXURE F

INFORMATION LEAFLET

Dear research participant, thank you for showing interest in this study.

STUDY TITLE: A model to enhance support for newly-qualified registered nurses (R.683) in selected hospitals of Limpopo Province, South Africa.

PRINCIPAL INVESTIGATOR/S/RESEARCHER: Mrs Tinyiko Sophie Sadike

CO-INVESTIGATOR/S/SUPERVISOR/S: Prof D.U. Ramathuba
Dr K.G. Netshisaulu

1. INTRODUCTION

You are invited to voluntarily participate in a research study titled: **A model to enhance support for newly-qualified registered nurses (R.683) in selected hospitals of Limpopo Province, South Africa.** This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the researcher. You should not agree to take part unless you are completely happy about all the procedures involved.

2. THE NATURE AND PURPOSE OF THE STUDY

The purpose of the study is to develop a model to enhance support for newly-qualified registered nurses (R683) in selected hospitals of Limpopo Province, South Africa.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

This study involves focus group interviews which will be scheduled at a time that will suit you. You will be asked about challenges encountered by newly-qualified registered nurses who upgraded from enrolled nurses. If you agree to participate, you will be interviewed in a focused group and with your permission be audio recorded for transcribing purposes. The focus group interviews will last for about 30 to 45 minutes. In these focus groups there will be 8 to 15 members participating. The researcher will ask the same question to all members

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simultaneously and each member will be given an opportunity to respond. The interviews will be conducted during the time which will be convenient for you, preferable during your lunch time. Refreshments will be served as it will be your lunch time to prevent inconveniences. The venue will be any authorized area free from distractions such as noise in your institutions. When the agreed time expires during the interview, the research will stop as agreed. Follow-ups will be done to validate if the data is the true words of participants. There will be no placebo or treatment involved in this study. After compiling the report, the audio recordings will be kept for 1 year by the Department of Health Sciences of the University of Venda.

4. RISKS OR DISCOMFORTS TO THE PARTICIPANT

Minimum physical, emotional or social discomfort may be experienced as the study involves the challenges that you have encountered as a newly-qualified registered nurse. Therefore, the researcher will not probe sensitive and personal information except what is relevant to the study. The focus group interview sessions will last for about 30 to 45 minutes. To prevent physical tiredness and economic harm when the agreed time expires, the research will stop as stated. Therefore, there will be no risks or discomforts involved in this study.

5. BENEFITS

Although you will not benefit directly from the study, you will be provided an opportunity to share your challenges that you have encountered as a newly-qualified registered nurse (R.683), and the results will be utilized to develop a model to enhance support for newly-qualified registered nurses (R.683) in selected hospitals of Limpopo Province, South Africa. The published research findings can be used by other researchers in other settings.

6. REASON/S WHY THE PARTICIPANT MAY BE WITHDRAWN FROM THE STUDY

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal from the study will not affect you in any way. There will be no any consequences to you should you choose to withdraw at any stage, even after signing the informed consent.

7. REMUNERATION

Your participation is voluntary. No compensation will be given for your participation. But as the focus group interview will be conducted during lunch time some refreshments will be served after the interview.

8. COSTS OF THE STUDY

Your participation is free, no study costs you are expected to pay.

9. CONFIDENTIALITY

All information that you give will be strictly confidential. The researcher will keep data in a safe place under lock and key where only the researcher will have access to the raw data to ensure confidentiality. The researcher will only share the transcribed recorded material with the co-coder who is an expert for accuracy. Once the information has been analyzed no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or your institution.

10. RESEARCH-RELATED INJURY

The study type does not have any related injury or adverse reaction because participants will be interviewed in a focus group, and the second group of participants will be completing questionnaires.

11. PERSONS TO CONTACT IN THE EVENT OF ANY PROBLEMS OR QUERIES

If you have any questions about this study, please contact Ms Tinyiko Sophie Sadike on cell number 082 409 9261/060 993 5532. Alternatively. you may contact my supervisor Prof D.U. Ramathuba on office number ……………… cell number 072 078 9555, or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof G.E. Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za

Thank you for taking time to read this letter of information.

If you agree to participate, you are kindly requested to sign the attached informed consent form to confirm that you are willing to participate in this study.

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ANNEXURE G

INFORMED CONSENT FOR FOCUS GROUP PARTICIPANTS

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Tinyiko Sophie Sadike, about the nature, conduct, benefits and risks of this study-Research Ethics Clearance Number**: SHS/19/PDC/05/0104**
- I have also, received, read and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and institution will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study even after signing the consent form or during the interview.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant ……………………..………..… Date: ……………. Time: ………………

Signature: ……………………………….

I, Tinyiko Sophie Sadike, herewith confirm that the above participant has been fully Informed about the nature, conduct and risks of the above study.

Full Name of Researcher: ………………………………………… Date: ……………………

Signature: ………………………………….

Full Name of Witness (If applicable): ………………………… Date: ……………………

Signature: ………………………………….

Full Name of Legal Guardian (If applicable): ………………………… Date: ……………………

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ANNEXURE H

FOCUS GROUP INTERVIEW GUIDE

INSTRUCTIONS

1. **Please tick or fill the gaps appropriately**
2. **Do not write your name except the code provided**
3. **Do not discuss your answer with anybody**
4. **Respond to all the questions**

SECTION A: Demographic Information

Participant Code

1. What is your age?

Age distribution	
1. 25-30	
2. 31-35	
3. 36-40	
4. 41-45	
5. 46-50	
6. 51-55	
7. 56-60	
8. 61 and above	

2. Please indicate your gender.

1. Female	
2. Male	

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3. What is your population group?

1. Black/African	
2. Coloured	
3. Indian	
4. White	

4. What is your cultural or ethnic group? Specify...

5. What is your nationality?

1. South African		
2. Other (please specify)		

6. What is your marital status?

1. Single	
2. Married	
3. Divorced	
4. Widowed	
5. Living together	
6. Never married	

7. What is the highest level of education you have achieved?

1. Diploma in Nursing		
2. Other, (please specify)		

8. How many months have you worked as a registered nurse?

1. 0-3 months	
2. 4-6 months	
3. 7-9 months	
4. 10-12 months	
5. 13-15 months	
6. 16-18 months	

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9. How many days do you work per week?

1. 1-5 days	
2. 6-7 days	

10. How many hours do you work per week?

1. 40 hours	
2. More than 40 hours: specify	

11. In which unit do you work? Specify……………………………………………………………

SECTION B: Challenges encountered by newly-qualified registered nurses in selected hospitals of Limpopo Province

The main research question will be supported by the following sub-questions to guide the study:

"What are the challenges encountered by newly-qualified registered nurses in selected hospitals of Limpopo Province, South Africa?"

- Explain the challenges you have encountered in your new role as a registered nurse?
- As you are expected to function independently and accountably as a registered nurse, how do you feel about your preparedness for the registered nurse role?
- Since you have started in this new role, when did you felt that you were ready and safe to practice independently?
- What types of support structures are available in your unit?
- What kind of support did you receive when you started your new role as a registered nurse?
- Who provided such a support?
- What can be done to enhance your support?
- What type of support can be provided to newly-qualified registered nurses in future?

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ANNEXURE I

FOCUS GROUP CONFIDENTIALITY AGREEMENT

During the focus group interview even though your real name will not be used, your identity will be known to other focus group participants, and the researcher cannot guarantee that others in these groups will respect the confidentiality of the group. The researcher will ask you to sign below to indicate that you will keep all comments made during the focus group confidential and not discuss what happened during the focus group outside the meeting.

By my signature below, I hereby agree to maintain the confidentiality of information disclosed during focus group interview sessions. I shall at all times hold in trust, keep confidential and not disclose to any third party or make any use of the identity of any participant involved in the Focus Group.

I hereby certify that I have read the above information and asked questions for clarity and agree to them, and I agree that by appending my signature below, I am bound by the terms and conditions of this agreement.

Name of Focus Group Participant: ………………………………

Signature of Focus Group Participant: ………………………… Date: ……………….

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ANNEXURE J

LETTER TO UNIT NURSE MANAGERS AS RESPONDENTS

Dear Collegues

I am a student of the University of Venda conducting a Doctoral research on”**a model to enhance support for newly-qualified registered nurses (R683) in selected hospitals of Limpopo Province, South Africa”**. I request your participation and feedback. The purpose of this study is to develop a model to enhance support for newly-qualified registered nurses in selected hospitals of Limpopo Province, South Africa. This purpose will be accomplished through the following objectives:

- Explore and describe the challenges encountered by newly-qualified registered nurses (R.683) in selected hospitals of Limpopo Province, South Africa.
- Identify support structures available for newly-qualified registered nurses (R.683) in selected hospitals of Limpopo Province, South Africa.

You will be expected to fill out the attached questionnaire. The completion of the questionnaire will take about 30-45 minutes of your time. Your anonymity is guaranteed, as your name, the name of your nursing unit and the hospital name will not appear on the questionnaire. All the questionnaires will be kept safe for one year after compilation of the final report.

Your participation in this study is voluntary and you may withdraw at any stage, even after signing the informed consent. You will receive no payment for participating in this study. Your participation will be of value as such information will be used for enhancing future newly-qualified registered nurses’ support. Data collected in this study will be disseminated through a research report, presentation at conferences and an article in an accredited nursing journal.

Yours truly

…………………………

T.S. Sadike (082 409 9261) Date: …………………………………

Thank you for taking time to read this letter.

If you agree to participate, you are requested to sign the attached informed consent form to confirm that you understand and willing to participate in this study.

ANNEXURE K

INFORMED CONSENT FORM FOR UNIT NURSE MANAGERS

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Tinyiko Sophie Sadike, about the nature, conduct, benefits and risks of this study-Research Ethics Clearance Number**: SHS/19/PDC/05/0104**
- I have also, received, read and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and institution will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant: ………………………….. Date:……………. Time: …………….

Signature: ………………………….

I, Tinyiko Sophie Sadike, herewith confirm that the above participant has been fully Informed about the nature, conduct and risks of the above study.

Full Name of Researcher: …………………………… Date: ……………. Time: …………….

Signature: ………………………….

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ANNEXURE L

UNIT NURSE MANAGERS QUESTIONNAIRE

INSTRUCTIONS

1. **Please tick or fill the gaps appropriately**
2. **Do not write your name except the code provided**
3. **Do not discuss your answer with anybody**
4. **Respond to all the questions**

Participant Code [ ]

SECTION A: Demographic Information					
Please tell us about yourself.					
1. What is your age?					
Age distribution					
1.1.	25-30				
1.2.	31-35				
1.3.	36-40				
1.4.	41-45				
1.5.	46-50				
1.6.	51-55				
1.7.	56-60				
1.8.	61 and above				
2.	**What is your gender?**	Male		Female	
3.	**What is your population group?**	3.1. Black or African			
		3.2. Coloured			
		3.3. Indian			
		3.4. White			

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4.	**What is your cultural/ethnic group:**	**Specify**...................................	
5.	**What is your nationality?**	5.1. South African	
		5.2. Other (specify)....................	
6.	**Marital status**	6.1. Single	
		6.2. Married	
		6.3. Divorced	
		6.4. Widowed	
		6.5. Living together	
		6.6. Never married	
7.	**How many years have you worked as a registered professional nurse?**	7.1. 0-9 years	
		7.2. 10-15 years	
		7.3. 16-20 years	
		7.4. 21-25 years	
		7.5. 26-30 years	
		7.6. 31-years and above	
8.	**What is your current position in nursing profession?**	8.1. Experienced nurse acting in operational manager position	
		8.2. Operational manager	
		8.3. Assistant manager	
	If other, please specify.	8.4. Other.............................	
9.	**How many years have you worked in this current position?**	Specify: Years............................	
10.	**What is your highest academic qualification?**	10.1. Diploma in Nursing	
		10.2. Diploma in Nursing and Midwifery	
		10.3. Degree in Nursing	
		10.4. Master's degree	
		10.5. Doctoral degree	
	If other please specify	10.6. Other	

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11. How many days do you work per week?		
11.1.	1-5 days	
11.2.	6-7 days	
12. How many hours do you work per week?		
12.1.	40 hours	
12.2.	More than 40 hours? *Specify*………………………………………..	
13. In which unit do you work? Specify……………………………………		

SECTION B: Knowledge of Nurse Managers' Management Role

1.1.	**What kind of support are you providing to newly-qualified registered nurses when managing the unit?**		
	i	Mentorship	
	ii	constructive feedback	
	iii	Preceptorship	
	iv	Coaching	
	v	trial and error	
	vi	none of the above	
	a.	i, ii, iii, iv	
	b.	V	
	c.	i, ii, iii, iv, v	
	d.	Vi	
1.2.	**Management of the unit includes?**		
	a.	Managing patient care, managing personnel and material resources, supervising and teaching	
	b.	Financial only	
	c.	Dictating to subordinates	
	d.	Planning and organizing	
	e.	All of the above	
	f.	None of the above	

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1.3.	**Which management functions will you execute daily for the smooth running of the unit to support newly-qualified registered nurses?**		
	i	Planning	
	ii	organizing	
	iii	Leading	
	iv	controlling	
	v	punishing staff	
	a.	i, ii, iii, iv	
	b.	i, ii, iii, iv, v	
	c.	V	
1.4.	**When newly-qualified registered nurses perform their four-fold functions of patient care, unit management, unit teaching and research, which support should you provide to them?**		
	a.	Use of teachable moment or on the spot teaching.	
	b.	Daily rating newly-qualified registered nurses' performance.	
	c.	Giving newly-qualified registered nurses on-the-job assignments to write.	
1.5.	**When newly-qualified registered nurses draw duty schedule for the unit, as an experienced registered nurse you will?**		
	a.	Oversee their activities and guide them where there is a need.	
	b.	Ask them if applied all principles when drawing duty schedule.	
	c.	Tell them to follow their scope of practice.	
1.6.	**When newly-qualified registered nurses write delegation for the unit, as an experienced registered nurse you will?**		
	a.	Oversee their activities and guide them where there is a need.	
	b.	Ask them if applied all principles when writing delegating.	
	c.	Tell them to follow their scope of practice.	

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SECTION C. Support Measures Provided to Newly-Qualified Registered Nurses by Experienced Nurse Managers

QUESTION	Always	Sometimes	Never
PLANNING			
1. The unit has written vision, mission, philosophy and service standards.			
2. All employees including the new ones have insight of the unit vision, mission, philosophy and service standards.			
3. There is a written teaching programme to guide in achieving quality patient care.			
4. There is a structured written delegation of specific duties to be performed by personnel.			
5. There are enough staff in the unit compared with number of patients.			
6. There are enough supplies and time required to ensure provision of quality patient care and effective unit management.			
7. Newly-qualified registered nurses are allocated and guided to:			
7.1. Write delegation of duties for unit staff.			
7.2. Write duty roster/duty schedule/off-duties.			
7.3. Order and control unit stock/supplies.			
7.4. Conduct nursing audits and write unit improvement plans.			
7.5. Draw and coordinate unit teaching programme.			
8. There are climate meetings organized and conducted in the unit.			
9. During climate meetings all available staff discuss their feelings and concerns.			
10. Staff members are informed about value clarification.			
11. Any identified conflict among staff members is resolved as soon as possible.			
12. Remedial action is provided to counteract any identified negative outcomes.			

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13. There is promotion and encouragement of teamwork and co-determined decision-making and problem-solving in the unit.			
14. There are debriefing sessions arranged for all staff members in case of stressful events like death under their care.			
ORGANIZING			
15. The unit has a well-structured organogram with all unit staff included.			
16. The unit has adequate personnel per shift.			
17. New employees are delegated based on their scope of practice, competencies, personal and professional development needs.			
18. There is consideration of skill mix when delegating new employees or junior nurses with senior staff members.			
19. All new employees are given and explained their job descriptions on arrival by a senior member of the staff.			
20. There is an orientation policy in the unit.			
21. The unit has a structured orientation programme in place.			
22. Senior members of the staff mentor, coach, guide and support newly-qualified registered nurses in the unit.			
23. Newly-qualified registered nurses are part of unit Standard Operating Procedures formulation team.			
DIRECTING OR LEADING			
24. Formal orientation of new employees is done by senior member of the staff.			
25. Newly-qualified registered nurses are orientated on patients' profile, services rendered, protocols, policies and procedures to be followed to in the unit.			
26. As newly-qualified registered nurses have previous nursing experience, they are orientated only if there is something new which they don't know.			

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27. Newly-qualified registered nurses are given and guided to sign performance agreement on arrival in the unit.			
28. Senior staff members are allocated to be on standby to assist newly-qualified registered nurses while on night shift.			
29. Newly-qualified registered nurses are allocated a mentor to support and guide them.			
30. Newly-qualified registered nurses are placed being in-charge of the unit prematurely to counteract shortage of staff.			
31. Senior members of the staff coordinate the teaching programme.			
32. Delegation is done by a senior member of the staff capable to apply the principles.			
CONTROL			
33. There is monitoring of staff's performance according to their job descriptions.			
34. Unit staff are invited on a one-to-one meeting with the aim of reviewing and discussing their performance and key performance areas (KPAs) with the senior member of the staff.			
35. Constructive feedback is provided to encourage and motivate them to improve their performance.			
36. Praise is provided for those who performed outstandingly.			
37. There is mentoring and peer support in which new qualified registered nurses are made to understand their roles and responsibilities.			
38. There is assessment and development of competency as part of control, checking standards of patient care.			
39. The supervision, direction, and correction done on personnel focuses on motivation and empowerment not punitive.			
40. There is staff satisfaction questionnaire to be completed by newly-qualified registered nurses monthly to evaluate their views.			

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ANNEXURE M

CERTIFICATION FROM CO-CODER

Coding Certificate

This is to certify that Prof PR Risenga was responsible for coding the chapter four of the study titled: A MODEL TO ENHANCE SUPPORT FOR NEWLY-QUALIFIED REGISTERED NURSES IN SELECTED HOSPITALS OF LIMPOPO PROVINCE, SOUTH AFRICA for SADIKE TINYIKO SOPHIE

Signed

Date: 25th January 2022

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ANNEXURE N

CONFIRMATION BY LANGUAGE EDITOR

Prof Donavon C. Hiss

Cell: 072 200 1086 | E-mail: hissdc@gmail.com or | dhiss@outlook.com

20 February 2022

To Whom It May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the **Doctor of Philosophy (PhD) in Health Studies** thesis by **Tinyiko Sophie Sadike**, titled: "**A Model to Enhance Support for Newly-Qualified Registered Nurses in Selected Hospitals of Limpopo Province, South Africa**" The manuscript was also professionally typeset by me.

Sincerely Yours

Cert. Freelance Journalism, Dip. Creative Writing, MSc (Medicine), PhD

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