

The experience and perceptions of nurses working in a public hospital, regarding the services they offer to patients

BY

NTANDO SEGNON

A thesis submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in partial fulfillment of the requirements for the degree of Masters in Occupational Social Work.

Student Number: 0303296P

Johannesburg, 03 February 2014

DECLARATION OF ORIGINALITY

I, the undersigned, hereby declare that this is my own original work and that all fieldwork was undertaken by me. Any part of this study that does not reflect my own ideas has been fully acknowledged in the form of citations. No part of this research report has been submitted in the past, or is being submitted, or is to be submitted for a degree at any other university.

Ntando Segnon: 0303296P

Signature

ACKNOWLEDGEMENTS

Firstly, I would like to thank my God who gave me strength, wisdom and patience throughout my studies.

I would like to give my most sincere gratitude to my supervisor Dr Linda Smith for her patience, hard work, enormous knowledge, support and guidance she has given me during this research study and since the time of doing my undergraduate social work degree.

To all my children, Xoli, Pretty, Emmanuel and Joshua, you have always been my source of inspiration.

My appreciation extends to all the participants who agreed to participate in the study and who gave of their precious time.

ABSTRACT

Nurses comprise the majority of health care service providers and function as an integral part of the services rendered by the health care system in South Africa. There are however, frequent expressions of concern about their working conditions and circumstances. The health care system in South Africa faces difficulties in terms of resources and service provision, with nurses themselves sometimes being criticised for rendering less than adequate services (Khoza, Du Toit & Roos, 2010). Healthcare sector strikes have also been a feature of recent times, influenced by poor salaries, deterioration of academic facilities, poor working conditions in the public sector and the unfortunate conditions facing patients at public health facilities (Dhai, Etheredge, Voster & Veriava, 2011).

The nursing care-relationship, however, requires qualities of empathy, compassion, ethical practice and commitment and these demands and contradictions may lead to burnout, compassion fatigue and secondary trauma (Holdt, 2006). The study therefore explored the perceptions of nurses about their role, the quality of the health care services which they provide, their perceptions on nurse/patient relationships; and their perceptions of both problems and strengths or protective factors in their nursing role. Using a qualitative approach, the study included twenty nurses working in a large public hospital in Gauteng. Purposive sampling was used to select participants from various wards.

Data was collected through semi-structured, face-to-face interviews, in order to enable participants to reflect on the meanings of their experiences and the perceptions they attach to these experiences. Thematic content analysis was used to analyze data. The main findings were that nurses perceive their occupational stress arising from shortage of staff and limited and inadequate equipment. This resulted in fatigue, and a high rate of absenteeism. Nurses in this hospital reported that they experience trauma due to the nature of their work with little visible and accessible formal debriefings, trauma counseling and Employee Wellness Programmes in place to assist them with stress management for traumatic experiences and other work related problems. Working conditions are perceived as unfavorable and unsafe,

exposing them to health hazards, while simultaneously having to deal with frustrated patients and relatives.

TABLE OF CONTENTS	Pages
Declaration of originality	i
Acknowledgements	ii
Abstract	iii
Table of content	iv

CHAPTER ONE: INTRODUCTION

1.1	Statement of the problem and rationale for the study	01
1.2	Purpose of the study	03
1.3	Brief description of research and data collection methods	03
1.4	Overview of the study	04

CHAPTER TWO: LITERATURE REVIEW

2.1	Introduction	06
2.2	Health care in South Africa	06
2.2.1	The South African care system	06
2.2.2	Nursing care in South Africa	08
2.3	Health care policy framework	11
2.3.1	Introduction	11
2.3.2	Batho - Pele principles in relation to health care	12
2.3.3	Ethical and professional rules	17
2.3.4	The rights and responsibilities of patients	21
2.3.5	The rights and responsibilities of nurses	24
2.4	The nurse patient relationship	29
2.4.1	The caring nursing relationship	29
2.4.2	Professional socialization	31
2.4.3	Confidentiality in patient care	33
2.4.4	Religion and spirituality	36
2.5	Occupational challenges	39
2.5.1	Trauma	39
2.5.2	Compassion fatigue	40

2.5.3	The role of empathy	41
2.5.4	Burn out	42
2.6	The role of the Occupational Social Worker	44
2.7	Employee Wellness Programmes	47
2.8	Conclusion	49

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1	Research design	51
3.2	Aims and objectives of the study	52
3.3	Research methodology	53
3.3.1	Sampling procedures	53
3.3.2	Research instrument	54
3.3.3	Data collection	54
3.3.4	Data analysis	55
3.3.5	Limitations	56
3.4	Ethical considerations	56
3.4.1	Introduction	56
3.4.2	Avoidance of harm and none-maleficence	57
3.4.3	Informed consent	57
3.4.4	Coercion and perverse incentives	58
3.4.5	Confidentiality	58
3.4.6	Actions and competence of researcher	58
3.4.7	Release or publications of the findings	59

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.1	Demographic profile of participants	60
4.2	Summary of categories and themes	60
4.3	Nurses' perceptions of the nature of their roles	62
4.4	Relationship with patients	64
4.4.1	Patients attitudes	64
4.4.2	Nurse patient relationship	66

4.4.3	Confidentiality	68
4.4.4	Empathy	69
4.5	Perceptions about strengths in nursing care	69
4.5.1	Introduction	69
4.5.2	Personal development	70
4.5.3	Patient recovering from their illnesses	70
4.5.4	Positive feedback from patients and relatives	71
4.5.5	Positive feedback from colleagues and management	72
4.6	Perceptions about challenges relating to nurses professional role and practice	72
4.6.1	Introduction	72
4.6.2	Shortage of staff	73
4.6.3	Language barrier between patients and nurses	74
4.6.4	Shortage of equipment's and resources	74
4.6.5	Working space	75
4.6.6	Conflicts amongst staff	76
4.6.7	Role clarifications and duties performed	78
4.7	Perceptions and experiences regarding stress, trauma, burn out and compassion fatigue	78
4.7.1	Stress	78
4.7.2	Factors leading to stress	79
4.7.3	Trauma	81
4.7.4	Burnout	82
4.8	Coping strategies in dealing with challenges in the Workplace	83
4.8.1	Negative coping mechanisms	83
4.8.2	Positive coping mechanisms	84
4.8.3	Debriefings	85
4.8.4	Employee Wellness Programmes	85
4.8.5	Religion and spirituality	86
4.8.6	Improvement of service delivery and nursing care	86

CHAPTER FIVE: SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1	Summary of main findings	89
5.1.1	Introduction	89
5.1.2	Perceptions of nurses about their experiences of the care and roles they offer	89
5.1.3	To explore the quality of the relationships between nurses and their patients in public hospital	90
5.1.4	To explore perceptions of nurses about their experiences of the care and roles they offer in public hospital	90
5.1.5	To explore nurses perceptions of stress, compassion fatigue and burnout and their coping strategies	91
5.2	Conclusions	92
5.3	Recommendations	94
	Bibliography	96

APPENDICES

Appendix A : Letter requesting permission to conduct the study

Appendix B : Participants' information sheet

Appendix C : Consent forms

Appendix D : Framework of questions

Appendix E : Letter of permission from the agency

Appendix F : Letter of clearance from ethics

Appendix G: Table 1: Demographic profile of participants

Table 2: Summary of categories and themes identified

Table 3: Nurses' perceptions of roles

Table 4: Nurses' perceptions of patients' attitudes

Table 5: Factors leading to stress

Table 6: Nurses' perceptions on how service delivery can be improved

CHAPTER ONE: INTRODUCTION

1.1 Statement of the problem and rationale for the study

The nursing profession is generally perceived as being characterized by care and compassion. However, there are also negative perceptions around the mistreatment and negligence of patients, fuelled by media discourse around rudeness and arrogance towards patients (Khoza et al., 2010). Less attention seems to be paid to the difficult conditions and circumstances under which nurses' work, except when attention is paid to labor disputes and strikes relating to salaries and working conditions. According to Mulaudzi, Libster & Phiri (2009), the context of the South African health care system is complex and fraught with resource and service delivery difficulties. The unique characteristics, working conditions and stressors of the nursing profession, within this health care system, may furthermore produce stress, burnout and compassion fatigue among nursing profession (Mulaudzi et al., 2009). In this contradictory and complex environment, nurses are required to exercise care ethically, compassionately and with empathy. However, these conditions are not always favorable to the maintenance of such principles of care giving (Pillay, 2009). It has been shown that many doctors and nurses in South African public hospitals believe that public hospitals are highly stressed institutions due to shortage of staff, unmanageable workloads and management failures which places their function in a general crisis (Vawda & Variawa, 2012). There are pressures of work overload, physical and psychological stress, inefficiency and clinical failure caused by understaffing and consequently a reduction in the quality of care and avoidable morbidity, mortality and compromised patient care. It may be argued that the prevalence and emergence of cases and allegations of cases of misconduct relating to poor nursing care (South African Nursing Council, 2008) may be a consequence of and related to the context of such stressors and under-resourced environments. According to Buchan (2006) nursing shortage is not just an organisational challenge or a topic for economic analysis; it has a major negative impact on health care (Buchan, 2006).

Failure to deal with a nursing shortage whether it is local, regional, national or global will lead to failure to maintain or improve health care.

Various studies have been conducted among health professionals relating to stress, burnout and compassion fatigue (Jewkes, 1998, Jenero, 2007, & Kravits, 2010) tend to focus on causal factors and recommendations on how to correct the psychological effects of these factors. However, they seemed to ignore explorations of the reciprocal relationship between professional nurses, patients and the hospital setting as the organization or institution where interactions take place (Kruger & Van Breda, 2001). The specific perceptions of nurses themselves, regarding working conditions, stressors, strengths and coping strategies, remain relatively unexplored, especially in the South African context. It is in this regard that a study exploring these issues from nurses perspectives, would contribute to the understanding and knowledge around the care relationship between nurses and their patients and general nursing care provision in South Africa.

Furthermore, occupational social work has an important contribution to make in such health care settings through services that may be offered at various levels of intervention, directly to nursing professional, the employer and the organizational framework. A practice model within occupational social work as proposed by Kruger & Van Breda (2001) enables occupational social workers to view both the employee and the organization simultaneously. Consequently, the locus of change shifts from employees only, to the reciprocal nature of both the employee and the workplace, with its structures, management staff, communication channels, and organizational culture, policies and procedures and people management practices and their mutual impact. This study may contribute to further understanding of the specific health care environment that would benefit from such an occupational social work practice approach.

1.2 Purpose of the study

The purpose of the study was to establish what difficulties and strengths nurses experience in their working settings impacting on service delivery. This study hoped to reveal the quality of the relationship between nurses and patients and their daily interacting and how they impact on one another. This study hoped to reveal the need for Department of Health to look into employing and incorporating Occupational Social Workers to conduct Employee Wellness Programs for employees, in particular, nurses.

1.3 Brief description of research design and data collection methods

The study adopted a qualitative approach as it aimed to explore nurses' perceptions and the meaning they attach to their experiences around the services they render. The research was qualitative, using an exploratory/descriptive design with elements of a phenomenological approach. According to Creswell (1998) cited in De Vos (2005, p. 268), this approach describes the meaning of experiences of a phenomenon or topic for various individuals. Purposive sampling was used to select twenty nurses working in the identified public hospital in Gauteng. They were interviewed during their lunch break in order not to interfere with their working schedule. Purposive sampling was used as it targets individuals who are particularly knowledgeable about the issue under investigation (Grinnel & Unrau, 2010). Maxwell (2013) states that when using purposive sampling the researcher appropriately selects the sample on the basis of his or her own knowledge of the population, its elements and the nature of the research aims. After the permission to conduct the study was obtained from the identified public hospital, the researcher approached the nursing sisters in charge of the three units and requested permission to meet with the nurses in those units. The first twenty participants who agreed to participate were included in the study. These participants were selected randomly. The unstructured in-depth interview schedule with both closed and open-ended questions was used as a tool for data collection to allow for greater exploration of

the participants perceptions. The interviews were recorded and participants were requested to sign consent forms to participate and to allow the researcher to record the interviews. Data was analysed using the adapted Tesch version as described in De Vos (2005) & Creswell (2003). As the researcher collected data using the tape recording and descriptive method, transcriptions of the interviews were done regularly and accurately. Similar topics were clustered together using different highlighters to identify topics with similar meanings enabling the researcher to come up with themes, categories and subcategories. Each topic, theme, categories and subcategories were represented with a quote of the exact words from the transcript. Both the researcher and the supervisor discussed and agreed on the categories, sub-categories and themes to be included in the analysis. Direct quotations were used to support every category and sub-category as themes. Both the supervisor and the researcher met face to face and through e-mailing correspondence supervision to discuss the findings and agreed on categories, sub-categories and themes identified.

1.4 Overview of the study

Chapter one provides the introduction to the report and includes a problem statement and rationale for the study, describes the purpose of the study, gives a brief description of the research design and data collection methods and provides an overall outline of the report. Chapter two gives an overview of relevant literature, providing a description of the health care system in South Africa generally and policy frameworks for health and nursing services in South African hospitals. The health care provision and working conditions of nurses in South Africa were looked into, in greater detail. The interconnectedness between the ethical and professional rules of the Profession Council of South Africa, the rights and responsibilities of patients as well as the rights of nurses' and the nurse-patient care relationship are highlighted. The researcher explored the link and relationship between professional socialization, empathy, confidentiality, religion and spirituality as vital in nursing and patient care. The negative impact in

nursing and patient care such as trauma, burnout and compassion fatigue is discussed and the impact it has on service delivery. Finally the role of occupational social workers in the workplace is defined and its importance and role clarified in the workplace. Chapter three describes the research approach and design, being qualitative, exploratory and descriptive in nature and making use of the phenomenological approach. The aims and specific objectives of the study are also outlined. The research methodology, outlining sampling procedures, research instrument, and data collection methods and data analysis are discussed. Lastly limitations and ethical considerations are discussed. Chapter four consists of the presentation and analysis of data whereby while chapter five gives a summary of the main findings, conclusions and recommendations.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The literature review begins by examining health care in South Africa generally and policy frameworks for health and nursing services in South African Hospitals. It further examines the state of the health care provision and working conditions of nurses in South Africa. Policy frameworks serve as a frame of reference to guide nurses in rendering services. However, when the policies are not implemented service delivery is hampered. It is therefore crucial that these policies are implemented and that nurses working conditions are conducive for them to perform their tasks and core responsibilities without interference. The ethical and professional rules of the Health Profession Council of South Africa, the rights and responsibilities of patients as well as the rights of nurses were explored. These are crucial in forming harmonious and interpersonal working relationships between the hospital, the nurse and the patients. Therefore, the employer, the nurses and patients are protected. However, challenges arise when, for example; nurses rights are violated by either hospitals or patients. The hospital can violate nurses rights for instance by not providing nurses with safe working environment exposing them to health hazards and patients can violate nurses rights to respect. This chapter further examines issues around professional socialization, empathy, trauma, burnout, and compassion fatigue in the workplace, the role of occupational social workers in the workplace and policy developments in respect of the national health care system.

2.2 Health care in South Africa

2.2.1 The South African health care system

According to Ataguba & Akazilli (2010), South Africa has a pluralistic transitional health care system with separate public and private sectors. The two-tiered health care system

has separate public and private streams. “Inequalities between private and public healthcare expenditure persists whereby the private sector consumes R43-billion and services seven million people, while the public sector spends R33,2-billion and services 38-million people” (Karim, 2009, p.1). This is supported by Rowe & Moodley (2013), that the private sector enjoys a much more favourable health care provider to patient ratio. Moreover, 16% of citizens can afford private medical scheme cover and are able to access private health care exclusively, yet this portion of the population accounts for up to 45% of the total national health expenditure (Rowe & Moodley, 2013). According to Ataguba & Akazilli (2010, p.9), “the public sector is funded by general tax and is based on a district health system approach with its emphasis on primary health care. Although some are able to self-fund primary health care in the private sector, but also rely on the state for secondary and tertiary care, with 68% of the population depend entirely on the public health sector”. However, Karim (2009) reported in 2007, 88% of South Africans were dependent on public healthcare services with the poor making up the majority of this figure. This means in 2010 there was a decrease of 20% of the population entirely dependent on public health sector.

Pillay (2009) describes South Africa's health system as consisting of a large public sector and a smaller but fast-growing private sector. Health care varies from the most basic primary health care, offered free by the state, while the private hospitals offer highly specialized health services for those who can afford it. Karim (2009), states that lack of resources has led to overcrowding in public health facilities, lack of space and privacy, and inadequate pharmaceutical services. Some clinics lack basic communication tools such as telephones, faxes and computers, which prevent staff from fulfilling their duties efficiently (Karim, 2009). In addition, Pillay (2009, p.82) concurs and states that “the public sector is under-resourced and over-used, while the mushrooming private sector, run largely on commercial lines, caters to middle- and high-income earners who tend to be members of medical schemes (18% of the population). Whilst foreigners looking for top-quality surgical procedures at relatively

affordable prices". Therefore, in 2013 there was a decrease of 2% in the number of members affording private medical scheme when comparing to 2009 whereby there were only 16% of members affording private medical scheme, a study conducted by Rowe & Moodley (2013). Monyakane (2007) argues, despite numerous research studies and interventions by the state to address such challenges, public hospitals remains under-resourced. A study conducted by the International Marketing Council of South Africa states that "although the state contributes approximately 40% of all expenditure on health, the public health sector is under pressure to deliver services to about 80% of the population. Public health consumes around 11% of the government's total budget, which is allocated and spent by the nine provinces" (International Marketing Council of South Africa, 2010, p.3). According to Rowe & Moodley (2013), the introduction of National Health Insurance (NHI) may help to achieve greater equity and bring about changes in the health care system in South Africa, however, further argues, with the introduction of National Health Insurance, the health care system in South Africa may be moving towards a socialist model.

2.2.2 Nursing care in South Africa

According to Smit (2005), care, together with compassion, forms the foundation of morality in nursing care. Nursing ethics is taught along the lines of Kohlberg's theory of morality, with its emphasis on rules, rights, duties and general obligations. According to Mafunisa (2003), South Africans need public servants that are skilled, effective and loyal in their work. This means public servants are expected to act in an acceptable, effective, efficient and accountable, fair and equitable manner in the execution of their official duties (Mafunisa and Kuye, 2003). However, nurses find themselves in the dilemma of caring for the sick and needing care themselves. According to Smit (2005) the exacting and demanding nature of the care provided by health care workers leads to many nurses experiencing occupational stress, fatigue and symptoms of occupational burnout.

When focusing on experiences of nurses in South Africa, the nature of the public health sector in this country needs to be taken into consideration (Smit, 2005). Nurses experience a sense of both physical and mental fatigue. This sector has been affected by Apartheid policies resulting in a fragmented system characterized by deteriorating capital infrastructure and insufficient medical equipment (Rowe & Moodley, 2013). Despite transformation that took place in November 1996, whereby the South African Nursing Association dissolved and transferred its assets to the Democratic Nursing Organization of South Africa (DENOSA), to form a unitary, non-racial nursing professional association, Jewkes et al., (1998) assert that nurses in the public sector still work in very difficult conditions. Hospitals remain overcrowded with staff shortages and most nurses still have to juggle a complex double burden of long work hours and home lives (Jewkes et al., 1998).

Richardson & Thomson (1999) state the USA which has a nurse population ratio of almost 10 nurses to 1000 of the population, is reporting nursing shortages. So too are countries in Africa and Asia with a reported nurse population ratio of less than 0.5 nurses per 1000 population. Moreover, “the issue of defining, measuring and addressing nursing shortages has to take account of the extreme disparity in the current availability of nursing skills in different countries, sectors and regions. One important issue to note is that there is no single ‘magic bullet’ policy that will solve nursing shortages” (Richardson & Thomson, 1999, p.11). Low wages and heavy workloads have also typified the occupational milieu of nurses. In many situations nurses in the public sector work in harsh and often squalid conditions (Pillay, 2009). Nurses are concerned with their occupational environment as a whole. These concerns included the deterioration of the hospital’s infrastructure, inadequate availability of medical equipment, shortage of nursing staff, and an increasing workload (Mafunisa, 2003). In order for nurses to provide quality care, health care facilities must provide a working environment where sufficient medical supplies are at hand (Smit, 2005). According to Buchan (2006, p9), “there is no single universal definition or measure of nursing

shortages, but clear evidence of inadequate nursing resources in many countries, and evidence of inadequate use of available nursing resources in many more". Furthermore, policies that can make a difference are well known, and may be inadequately tested in their implementation. In examining the context in which nursing shortages exist and persist, Buchan has noted, nursing shortages are a health system problem, which undermines health system effectiveness and requires health system (Buchan, 2006).

Smit (2005), states there are various factors which contribute to nurses experiences of occupational stress. This includes for example working with patients that are infected with HIV and AIDS. Nurses at times experience feelings of helplessness or powerlessness because of the fact that no cure is yet available. For many, dealing with the manner in which their patients responded to their own suffering and the process of dying as a result of HIV/AIDS was extremely emotionally draining (Smit, 2005). The deterioration of the hospital infrastructure, insufficient medical equipment and under staffing, are a major problem and of great concern. This has created a situation where nurses were not only expected to provide care for increasing numbers of patients in overcrowded wards, but were also expected to perform duties outside their scope of job description, such as cleaning floors and collecting linen from the hospital laundry. A further concern contributing to occupational stress was receiving little or no support from nursing managers and hospital administrators (Smit, 2005). Mafunisa (2003) maintains that senior public servants should provide empathic communication, teamwork, joint efforts, nurturing leadership, determination and achievement of common objective (Mafunisa, 2003). Whilst dealing with challenges within the hospital infrastructure, patient's illness and poor working conditions, nurses find themselves angered, having to deal with negative attitude of patients and outraged against members of society that treat them with contempt. A study conducted by Smit (2005) revealed that nurses felt angered by disrespectful and unappreciative patients. For instance, nurses gave account on how they were spat on, cursed and verbally abused by patients. However, the study also revealed that despite the nurses negative experiences there were also

positive experiences, which gave them self-fulfillment. This included patients appreciating care that they received, by making patients feel comfortable and being emotionally supportive to patients (Smit, 2005).

2.3 Health care policy framework

2.3.1 Introduction

The transition to democracy and transformation of society in South Africa after 1994 was accompanied by many policy and legislative changes. This was also true within the health care system generally and in the nursing profession in South Africa (Jewkes, Abrahams, & Mvo, 1998). According to the South Africa Year Book of 2009/2010 (2009), the South African health care system is regulated by the National Health Act (2003), which provides a framework for a single health system for South Africa. It highlights the rights and responsibilities of health providers and healthcare users, and ensures broader community participation in healthcare delivery from a health facility level up to national level. Furthermore it establishes provincial health services and outlines the general functions of provincial health departments (South African Year Book, 2009). Rowe & Moodley (2013) state, the South African legislative environment has changed recently with the promulgation of the Consumer Protection Act and proposed amendments to the National Health Act. The National Health Act indicates patients can now be viewed as consumers from a legal perspective. This may have serious implications for health care systems, health care providers and the doctor-patient relationship such as contributing to increased medical litigation (Moodley & Rowe, 2013).

In October 1997, the South African government introduced eight Batho Pele Principles (BPP) to serve as acceptable policy framework and to improve the standard of public service delivery (South African Department of Public Service and Administration, 1997).

Despite this policy framework, hospitals and clinics has been criticized by the media for their pathetic service delivery and portrayed as overburdened and under productive. Rowe & Moodley (2013), argue that fourteen years after the implementation of the BPP policy many major government sectors, especially hospitals, are still plagued by poor service delivery. Moreover, multiple efforts by the government to rescue the situation have not been successful (Rowe & Moodley, 2013). These principles therefore provide a standard and expectation for service delivery which protects and ensures citizens are served properly and all public servants work to their full capacity and treat state resources with respect (Ngidi & Dorasamy, 2013). According to the Department of Social Development (2013), BPP is all about giving good customer service to the users of government services and upholds a strong belief that a good service delivery leads to happy customers and employee satisfaction for a job well done. The White Paper on Transformation Act (1997) requires of departments to regularly and systematically inform the public on current and new service provision in order to keep abreast of the new developments and challenges. Furthermore, consultation between the government and the public is the essential aspect of BPP, with the ability to transform the manner in which civil servants communicate with the public (Rowe & Moodley, 2013). For the purpose of the study the eight BPP will be discussed in relation to health care i.e. consultation, service standards, access, courtesy, information, openness and transparency, redress and value for money.

2.3.2 The eight Batho-Pele Principles in relation to health care

The first principle which is consultation is interlinked with all remaining principles and recommends that the public be consulted on all public service developments (Matoti, 2011). According to Ngidi & Dorasamy (2013, p.38), “Consultation put emphasis on continuous consultation of service users about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered”. Health professionals should explain the different methods of

treating medical conditions to patients and patients should be given a choice about the methods they prefer. The advantages and disadvantages of each method of treatment should also be explained to them. While government departments continually try to improve the services rendered, it should also take cognizance of promises made to deliver services on time (South African Department of Public Service and Administration, 1997). In terms of the White Paper on Transforming Public Service Delivery (1997), the first step would be to identify needs for service users through consultation, then formulate realistic service standards depending on the resources available. Thereafter measure these standards so that everyone can see if they are being met (Ngidi & Dorasamy, 2013). According to the White Paper on Transforming Public Service Delivery (1997, p.15), implementing the principle of “service standards” entails that “citizens should be told what level and quality of public services they will receive so that they are aware of what to expect”. Patients should be informed about the different levels of service standards and health care e.g. there are primary health care centres; district health care centres etc. and these centres provide different level of care. Therefore patients should be informed about the different services provided at these different levels of health care (Ngidi & Dorasamy, 2013). Furthermore, Khoza et al. 2010 states that for instance within a public hospital, certain service standards pertaining to the functioning of the ward are to be displayed on the wall in the units so that they can be visible to patients and their families. These include: a shift roster for the nursing staff, ward rounds, schedule for serving of meals to patients, schedule for nurses tea breaks and lunch times and schedule for visiting times

Karim (2009) state that poverty is a major barrier to accessing healthcare services in South Africa, furthermore, access to these services is severely constrained by transport costs especially in rural and remote areas and unacceptably long waiting times at clinics or hospitals. Her article on Mail & Guardian also revealed that inefficient management, lack of infrastructure and human resources, and poor staff attitudes were infringing on citizens’ constitutional right to access healthcare (Karim, 2009). According to the White

Paper on Transforming Public Service Delivery (1997, p.15), “citizens should have equal “access” to the services to which they are entitled to”. Monyakane (2007) adds that this includes access of health services to patients who were previously disadvantaged as a result of poor infrastructure by setting up mobile units and redeploying facilities and resources to those in greatest need. In addition “special provision should be made to accommodate patients with disabilities, for example proper toilets and passages suitable to accommodate their disability and entrances for wheel chairs to gain access” (National Department of Health 2010, p.15).

Every citizen has the right to be treated with respect and dignity, irrespective of gender, race, status etc. For this reasons the BPP states “patients should be treated with “courtesy” and consideration” (White Paper on Transforming Public Service Delivery (1997, p.15). According to Rowe & Moodley (2013), patients are to be treated as individuals, with fairness, in an unhurried manner, with empathy and understanding as well as with consideration and respect. Furthermore, all managers should ensure they receive first-hand feedback from front line staff and should personally visit front line staff at regular intervals to see for themselves what is happening (Mafunisa et al., 2003). It is highly recommended that the Departmental National and Provincial Department’s Code of Conduct specify the standards for the way in which patients should be treated. These include: greeting and addressing patients, the identification of staff by name when dealing with patients whether in person, telephone or in writing, the style and tone of written communications, simplification and customer friendliness of forms, the conduct of interviews, how complaints should be dealt with, dealing with people with special needs, gender and language (Rowe & Moodley, 2013).

The White Paper on Transforming Public Service Delivery (1997, p.15) state “citizens should be given full, accurate “information” about the public services they are entitled to receive”. Implementing Batho Pele will require a complete transformation of

communication with the public (Department of Social Development, 2013). Information must be provided in a variety of media and languages to meet the differing needs of different customer's. This is essential to ensure the inclusion of those who are, or have previously been disadvantaged by physical disability, language, race, gender, geographical distance or in any other way (Khoza, 2007). Rowe & Moodley (2013), states written information should be free of jargons and supported by graphical material where this will make it easier to understand and where information is to be communicated verbally, it should done with simplicity allowing questions, understanding and clarity (Rowe & Moodley, 2013). According to Khoza (2007), provision of information aims to empower patients to understand the health services they are entitled to receive and should have certain medical procedures that they are about to undergo explained to them, e.g. signing informed consent forms before undergoing surgery (National Department of Health, 2010). Health care professionals should explain the procedures, risks and benefits.

“Openness and transparency” entails patients informed on how national and provincial departments are run, how the hospitals are run, how much it costs to access medical care, how well they perform and who is in charge (White Paper on Transforming Public Service Delivery, 1997, p.15). This Batho Pele principle encourages government departments to be open and honest about every aspect of their work. According to the Department of Social Development (2013) annual reports should be compiled and citizens informed on how resources were used and how much everything cost, including costs for staff, equipment, services and so on. It should also include how well departments performed, and if promises were kept and delivered on time. If standards were not met for whatever reasons, those reasons should be listed and provide strategies and solutions to improve on them. Open day programmes be held and service users invited for feedback on how departments are run (Department of Social Development, 2013).

In “redress”, if the promised standard of service is not delivered, patients should be offered an apology, a full explanation and a speedy and effective remedy and when the complaints are made, patients should receive a sympathetic, positive response and apology” (White Paper on Transforming Public Service Delivery (1997, p.15). According to Monyakane (2007) when service provision falls below the minimum promised standard there should be procedures in place to remedy the situation. Therefore, each department is required to review and improve their complaints systems. According to Rowe & Moodley (2013) systems should be well publicised and easy to use and excessive formality should be avoided. Complaints should not only be done in writing but also allows other ways such as face to face and telephone. The complainant should be given feedback on the progress of the case timeously and outcome can be expected. Complaints should be treated with fairness, confidentiality and responsiveness (Moodley & Rowe, 2013). The principle of getting the best possible “value for money” put emphasis on providing public services economically and efficiently in order to give patients the best possible value for money resulting in patient satisfaction on receiving medical services paid for (Department of Social Development, 2013). Khoza (2007) notes that this is an important principle especially for unit managers to plan, organise and control all resources in such a way that cost effective patient care is rendered. Furthermore, nursing units must control their resources in order to prevent unnecessary shortages for example, shortage of linen (Khoza, 2007).

2.3.3 Ethical and professional rules

A healthcare workforce that is responsive and fair in its treatment of patients is one of the central pillars of a modern health system. It is for this reason, among others, that healthcare workers are bound by ethical codes of practice to treat patients according to their needs, and not according to their gender, religious beliefs, sexual orientation, skin color or other socially devalued attributes (Ahmad, Reidaph, Alletely, & Hassil, 2013). Gildenys (2004, p13) defines ethics as “principles or standards of human conduct”

which is sometimes referred to as morals and it essentially deals with what is right and wrong, good and bad and acceptable and unacceptable (Rossouw, Prozansky, Burger, Du Plessis and Van Zyl, 2006). Hence ethical behavior is behavior which is not only good for one-self but also good for others.

According to Relf, Laverriere, and Devlin (2009), the ethical principles of health care includes amongst others, autonomy, beneficence, non-maleficence and justice including the requirements of informed consent and protecting patient confidentiality. These principles are supported by the South African Nursing Council and reflected in the nursing codes of ethics of the international Council of Nursing as well as its member associations including the Democratic Nursing Organization of South Africa (DENOSA) and the American Nurses Association (ANA), (Relf et al., 2009). The Health Professions Council of South Africa (HPCSA, 2008) states autonomy refers to health care practitioners honouring the right of patients to self-determination and to make their own informed choices. Rowe & Moodley (2013) stated that although autonomy applies to both patients and doctors, the health care provider's autonomy is limited by factors such as the control of authorities. Rowe & Moodley (2013) argue that patients instead of doctors are now the ultimate decision-makers with regards to their own bodies and health taking away the concept of the doctor as an expert in knowing what is best for the patient and making medical decisions on behalf of the patient (Rowe & Moodley 2013). As much as autonomy and what is referred to as "client self-determination" in the field of social work, plays an important role in patient decision making, it can be argued that it can also be detrimental causing more harm than the good intended. The classical example is the patients right to refuse treatment. According to Kaufert & Putsch (1997), the patient's current choice to refuse treatment might not even represent what the patient truly wants due to the effects of the patient illness, or of the treatment itself. Despite these ethical dilemmas the health care provider still has obligations to society including all other patients, as well as to third parties, regulatory authorities and the law to provide health care at his optimal level and saves lives (Rowe & Moodley, 2013). In

addition, Kaufert & Putsch (1997) acknowledge patient autonomy as an important ethical principle in medicine. However, it should neither be conceived as a value that necessarily overrides all others nor as a simplistic directive always to comply with the expressed wishes of patients.

According to Hugman (2005), respect for life is the most basic ethical principle in professional care and each service user should be respected as a unique person who is equally morally valuable as all other persons. Even when the patient is faced with death, the objective is to keep the person comfortable, appreciating their individual wishes and quality of life (Benatar, 1997). Respect for each patient as a unique individual requires an appreciation of differences in age, religion, attitudes, culture, background and response to illness. This encompasses everyone involved in patient care to promote health and to save lives as its primary goal (Booyesen, Erasmus and Van Zyl, 2003). Furthermore, learning to accept and work with patients differences, nurses will appreciate what makes each patient special, and overcome any difficulties in relating to them (Booyesen et al., 2003). In theory, the answer is simple argues Ahmad, Reidpath and Allotey (2013), treat the patient in front of you according to their healthcare need. However, the challenge for the health system is that practice does not necessarily mirror professional intent, and personal prejudices and fear of contagion interfere in decisions for care (Ahmad et al., 2013).

In an attempt to address ethical dilemmas, Richardson and Thomson (1999) propose a universal unified ethical code that applies to all those in health care. According to Richardson & Thomson (1999), the universal unified ethical code must be unifying in the sense that all who shape the experience of patients can use it as a point of reference for their own difficult decisions in cases where they are faced with dilemmas. It is argued such a code to be helpful must cut across disciplinary, professional, organisational, and political boundaries. Furthermore, it should be a code that applies to systems, their

leaders, and their participants, no matter what their degree or job description, binding and guiding equally doctors, nurses, other health professionals, healthcare managers and executives, regulators of care, and private and public payers. The fate of patients and the public's health depends now on interactions so complex that no single profession can credibly declare that its own code of ethics is enough (Richardson & Thomson, 1999).

The Health Professions Council of South Africa (HPCSA, 2008), clearly states that the practice of a health care professional is based on a relationship of mutual trust between patients and health care practitioners. The term "profession" means a dedication, promise or commitment publicly made. To be a good health care practitioner requires a life-long commitment to sound professional and ethical practices and an overriding dedication to the interests of one's fellow human beings and society. In the course of their professional work, nurses are required to subscribe to certain rules of conduct and ethical codes (HPCSA, 2008). While nurses have their own value systems, they should also comply with the values required in nursing and not allow their own culture to override these. Consequently, it is important for nursing students and health professionals to critically reflect on their attitudes and beliefs as well as societal perceptions in order not to allow these to interfere and work against their ethical professional code of conduct (Relf et al., 2009). Nurses need to be encouraged to sincerely examine personal values and reflect on personal bias that might conflict with professional responsibilities (Richardson & Thomson (1999).

According to South African Nursing Council (2008) a nurse "must" not participate in unethical or incompetent practice (SANC, 2008). However, the literature is replete with examples of patients who are accorded different and worse treatment because of some perceived moral taints. The HIV epidemic provides a classic case in point. Healthcare workers have reported not wanting to treat people living with HIV/AIDS (PLWHA) for a

range of reasons and this has led to a reduction in access to treatment and care for those with undesirable attributes (Relf et al., 2009). In fact, although nurses are in the forefront of care provision for persons with HIV/AIDS, they often experience anxiety and fear about caring for these individuals (Siminoff, Erlen, & Lidz, 1991). This situation has, in many instances, created a tiered health system making it difficult for nurses to adequately assume the role of patient advocate (Vance & Denham, 2008). The South African Nursing Council HIV/AIDS Policy (SANC, 2008) emphasizes the patient's right to confidentiality, effective, non-judgmental nursing care, and empathy for the social dilemma of AIDS and HIV-infected patients. Further, this policy condemns discrimination against persons living with HIV or AIDS and violations of confidentiality.

When caring for persons with HIV and AIDS, it was discovered that nurses, including nursing students, do not always support the ethical principles of autonomy, informed decision-making and confidentiality (Relf et al., 2009). The Code of Ethics for Nurses with interpretative statements requires nurses to provide respect for human dignity, to acknowledge the right to self-determination and protect patient privacy and confidentiality (Heagert, 2000). Similarly, the South African Nursing Council (SANC) has established ethical guidelines indicating that all nurses "must" respect patients' rights to confidentiality. Thus, ethically nurses "must" maintain confidentiality and may only give information to third parties when the patient consents to this or when the law requires disclosure of information (Booyesen et al., 2003). It is evident the BPP put citizens at the forefront and set the tone for how citizens are to be treated on entering health care facilities and institutions by the public servants rendering services. However, it is also important to consider the rights of public servants as well. Both nurses and patients have rights and as these rights are respected and practiced by both parties, harmonious working environments and relationships are possible.

2.3.4 The rights and responsibilities of patients

For many decades the vast majority of the South African population has experienced either denial or violation of fundamental human rights, including rights to health care services (Herbst, 2013). To ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa, 1996, the Department of Health committed itself to uphold, promote and protect this right and, therefore, proclaims this Patients' Rights Charter as a common standard for achieving the realisation of this right (Swanepoel, 2011). According to the Patients' Rights Charter of the Department of Health (2010), every patient has the right to a healthy and safe environment, confidentiality and privacy which includes respect by those to whom they entrust such information, as well as other health care workers and intermediaries who deal with their health care information (SAMA, 2012).

According to Herbst (2013) information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or any order of court. When a healthcare provider breaches confidentiality, patients are likely to feel betrayed resulting in distrust of the health care system. In order for the health care system to be effective, the public must trust the health care system, including healthcare providers, and believe that their personal information will be kept confidential (South African National Department of Health, 2010). Patients should also respect the privacy and family life of the health care professionals (SAMA, 2012). Furthermore, patients has the right to an environment that is not harmful to their health or wellbeing, including a setting that is conducive for recovery with the duty to create an environment that is not detrimental to the health and wellbeing of others, by ensuring medicines are stored and used correctly as indicated by the health practitioner and to comply with the prescribed treatment or rehabilitation procedures (Herbst, 2013).

Patients have the right to express themselves freely and to have their freedom of expression respected especially where their health care is concerned. This includes the right of patients to complain about health care services and to have such complaints investigated and to receive a full response on such investigation. Patients have the responsibility to follow the advice given by their practitioners and to regularly and openly communicate with their doctors on matters affecting their health care and the duty to provide health care providers with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes (Swanepoel, 2011), moreover, to take care of the health records in their possession (Herbst, 2013). Everyone has the right to access to health care services and the responsibility to care for and protect the hospital environment, to utilise the health care system properly and not to abuse it. To take the responsibility to know the local health services in their area, what they offer and enquire about the costs of treatment and/or rehabilitation and to pay for service rendered (South African National Department of Health, 2010).

Patients have the right to language and culture which includes the right to converse in the language of one's choice, where practicable (Swanepoel, 2011). According to Paasche-Orlow, Green, Schillinger, & Wagner (2006), patients with limited literacy, when compared with those with adequate literacy, more often report that their doctors use words they do not understand, speak too fast, do not provide enough information about medical conditions, and fail to make certain that they understand their health problems. Similarly, limited literacy has been associated with more distrust of providers, pessimism about treatment and lower satisfaction. Rowlands (2012) states that providers tend to be unaware of their patients but nothing much is done to facilitate successful communication. To do so, Paasche-Orlow et al., (2006) suggests health providers need to learn a set of communication skills, including how to convey empathy, promote trust, and encourage dialogue and how to elicit patient questions. However, Swanepoel (2011) argues that due to an extremely high patient burden in the public health sector, most health care professionals are not able to dedicate adequate time to

ensure that poorly educated patients are properly informed in order to make their own decisions. It then becomes a challenge in trying to empower the patient with knowledge and information through clear communication. Moreover, SAMA (2012) assert that South Africa is one of the countries where a multicultural society exists, with an influx of foreign nationals, the resources (e.g. health care educators, interpreters, doctor with training in an additional indigenous local language) are often not available to ensure that a patient is truly informed and able to exercise proper autonomy (SAMA, 2012). According to the Department of Health (2010), it is also the responsibility of the patient to respect linguistic and cultural diversity and to speak out when these constitute barriers to good health care and to ensure their cultural practices are not detrimental to others (South African National Department of Health, 2010).

SAMA (2012) states that patients have the right not to be unfairly discriminated against directly or indirectly on the basis of their race, origin, gender, or any other ground and have the right to be free from harassment. However, they have the duty and a responsibility not to discriminate and harass any health care worker or the employees (Herbst, 2013). Patients have the right to freedom of religion, belief and opinion respected by doctors. This includes indigenous belief systems, religious dress and rules in relation to modesty, as well as certain medical procedures, such as blood transfusions. They also have the responsibility to respect the religion, belief and opinion of health care providers and not to force any doctor or other person to act according to a certain set of beliefs (SAMA, 2012). According to the same policy document, the responsibilities of the patient are to take care of their health and to respect the rights of other patients and health providers, to utilize the health care system properly and not to abuse it. According to the South African National Department of Health (2010), patients has the right to access medical care, they also have the responsibility to protect the environment and the duty not to misinform health care professionals by giving incorrect information about their health but to provide with relevant and accurate information for diagnostic, treatment, rehabilitation or counseling purposes.

2.3.5 The rights and responsibilities of nurses

Being registered under the Health Professions Act, 1974 (Act No. 56 of 1974), gives health care practitioners certain rights and privileges. In return, they have the duty to meet the standards of competence, care and conduct set by the Health Professions Council of South Africa and its Professional Boards. Health care practitioners hold information about patients that is private and sensitive (HPCSA, 2008). According to the South African Nursing Council (2008), established under the Nursing Act (2005) in carrying out his/her duty to patients, the nurse operates within the ethical rules governing the profession and his/her career scope of practice, ensuring improved service to patients. Nurses need to be aware of their scope of practice as they perform their duties in providing health care to patients' (Charisma Healthcare Solutions, 2007). The nursing staff should advocate for and protect patients for whom he/she has accepted responsibility and ensure that the working environment is safe which is compatible with efficient patient care. This means to refuse to implement a prescription or to participate in activities which, according to his/her professional knowledge and judgment, are not in the interest of the patient and to refuse to carry out a task reasonably regarded as outside the scope of his/her practice and for which he/she has insufficient training or for which he/she has insufficient knowledge or skill (SANC, 2008).

Nurses have the right to be equipped with physical, material and personnel requirements relevant to their working situation to make it possible for them to provide optimal health care to patients (Charisma Healthcare Solutions, 2007). The lack of adequate facilities and other resources results to nurses' being drained, exhausted and struggling to cope with the overwhelming workload. The end result is a mentality where nurses' are forced to "treat the numbers, not the patient" and ultimately, patient care is compromised. The health, morale and emotional well-being of the nurses' also suffer (Haegert, 2000).

According to the Nursing Act, (2005), health care professionals should conduct themselves professionally, promoting the vision of acceptable nursing care. According to Mafunisa (2003, p.63) “professionalism refers to being competent, effective, efficient, ethical and qualified for performing assigned and accepted duties. It is most effective when it begins at the top and proceeds downward throughout the departmental structures. The nursing staff should always strive to follow written policy guidelines and prescriptions concerning the management of his/her working environment. The Characteristics of a Professional Person in the Nursing Profession indicates that the nurse is responsible to know and understand current legislation relating to practice, communicate with others in a way that demonstrates respect and sensitivity uphold the ethical code, philosophy, values and norms of the profession; and conduct oneself in a professional and refined manner. This will ensure consistency and improved health care service provided. Moreover, public servants are responsible for setting an example, not only in terms of methods and use of public resources, but also for sound judgement and respect for the provision of the Constitution of the Republic of South Africa, 1996 (Act 108 of 1996), Code of Conduct for Public Servants, Public Service Act, 1994 (Proclamation 103 of 1994) and societal values (Mafunisa, 2003, p. 63).

It is true to say that South African health clinics are underfinanced. There are chronic staff shortages and a poor transport system. However this does not justify or take away the nurse’s responsibility to offer quality, nursing care to patients and treating patients with respect and dignity (Haegert, 2000). A nurse should know the diagnosis of patients for whom he/she accepts responsibility in ensuring that she/he identifies any mistakes such as wrong medications that would have been prescribed by mistake or doses of medications (SANC, 2008). In their work environment, the nursing staff should have a good medical support and referral system to handle emergency situations to optimise health care provided and refuse to implement a prescription or to participate in activities which, according to his/her professional knowledge and judgement, are not in the

interest of the patient (2004 - 2013 South African Nursing Council, Under the provisions of the Nursing Act, 2005).

Russell & Stone (2002) states nursing staffs have the right to education, growth and development provided by the employer. It is also his/her responsibility to keep themselves with new development and information pertaining their profession through furthering their education at the personal level and conducting research in their scope of practice to keep up with new development. According to Vawda & Variawa (2012), in order to give quality care and improved service delivery, nurses need support, development and empowerment. Furthermore, Russell & Stone (2007) state that certain aspects, such as empowerment, compassion, role modelling and the building of a reciprocal relationship based on trust, are all functional characteristics of a servant leader (Russell & Stone, 2007). According to Butler (2002), the best places to work are places where nurses are provided with training and opportunities to develop. Improving professional practice and enhancing nurses' clinical competence through ongoing education may increase retention and job satisfaction and help ensure a stable workforce (Mokoka, Oosthuizen & Ehlers, 2010). Therefore, the primary health care nurse manager in charge of the clinic has the ultimate educational accountability to ensure continuous teaching and learning in practice. They need to devote themselves to serving the needs of their staff members; focusing on meeting the learning needs of those they lead; coaching and encouraging self-expression and becoming role models to assist staff members reach their full potential (Mokoka et.al 2010). Servant leaders lead through their visible attitudes and actions, seeking to involve others in decision making and planning (Gersh, 2006). Mafunisa (2003) adds that nurses must keep up with the state of art i.e. continuing education.

Healthcare professionals are challenged to broaden their understanding of health, disease, suffering, and of their role in society (Benatar, 1997). Section 24 of the

Constitution states that, “everyone has the right to an environment that is not harmful to their health or well-being”. This includes the right to a safe working environment, necessary to prevent accidents and workers from contracting occupational diseases, freedom from abuse and violence, threats or intimidation and interference (SANC, 2006). The study conducted by the Industrial Health Research Group and the South African Municipal Workers Union (2004) identified safety hazards experienced by primary health care workers amongst others as violence, assault, rape, aggressive and angry health care users, carrying heavy equipment, broken chairs, inadequate security, inadequate procedures for disposing of sharps, poor medical waste management, slippery floors, un-serviced machinery and broken equipment and health hazards classified into chemical, physical, biological, ergonomic and psycho-social hazards. Lundstrom, Pugliese, Bartley, Cox and Guther (2002) states the presence and risk of exposure to viruses, bacteria and parasites transmitted through the air or body fluids (such as TB, Hepatitis B and HIV) are prone to health care workers. The reason being health care workers are exposed to working conditions such as overcrowding, bad ventilation, inadequate supply and use of personal protective equipment (PPE), negligent waste disposal methods and staff shortages (Lundstrom et al, 2002). These conditions cause burn-out, stress and depression amongst health care workers, which in turn increases the risk of occupational injuries and exacerbates staff shortages (Vawda & Variawa, 2012).

Oosthuizen (2005), states that the physical safety of nurses in their workplace is of great concern and one of the biggest challenges faced by hospitals in the public sector. Lack of safety in both the working environment is one of the other contributing factors affecting retention. Lundstrom at al. (2002) argue budget cuts, frozen posts and decreased funding in the health care sector have a direct impact on the health and safety of health care workers, whose occupational health and safety rights are often neglected. A study conducted by Mokoka et al. (2010) revealed hospital security was not vigilant, with incidents of violence being perpetrated in front of security. Nurses’

personal possessions were not safe, with instances of possessions and valuables being stolen at nurses' stations, duty rooms and even from inside nurses' lockers (Mokoka et al, 2010). According to Oosthuizen (2005) it is the responsibility of hospital management to ensure nurses have the resources to enable them to practice in a safe and efficient way. General unacceptable conditions in hospitals and a shortage of personnel put patients and nurses at risk and influence turnover rates (Oosthuizen, 2005). Lundstrom et al. (2002) state that it is the responsibility of the worker to report unsafe conditions and incidents of occupational exposure to their employer or health and safety representative.

According to International Council of Nurses, Nurses and Human Rights (1998), nurses deal with human rights issues daily, in all aspects of their professional role. At times, they may be pressured to apply their knowledge and skills in ways that are detrimental to patients and others. There is a need for increased vigilance, and a requirement to be well informed, about how new technology and experimentation can violate human rights. Furthermore nurses are increasingly facing complex human rights issues, arising from conflict situations within jurisdictions and political upheaval (International Council of Nurses, Nurses and Human Rights (1998). It is therefore important for nurses to experience a sense of protection regarding their rights, especially in the light of the sometimes difficult and stressful nature of their professional duties. Despite the above mentioned challenges, nurses have the right and the responsibility not to participate in unethical or incompetent practice and to refuse to carry out a task reasonably regarded as outside the scope of their practice and for which they have insufficient training and knowledge or skill (SANC, 2008).

According to SANC (2008), nurses have the right to fair compensation for their work, consistent with their knowledge, experience and professional responsibilities. In the health care industry, the challenge to retain professional nurses is ongoing because of

the global nursing shortage and factors that are related to the health care environment; these include working hours, increased workload, poor salaries and working conditions, which make retention efforts more challenging than in other industries (Oosthuizen, 2005). Health authorities are faced with a challenge to come up with strategies, policies and legislation that will direct the recruitment and retention of nurses (Kaestner, 2005).

2.4 The nurse-patient relationship

2.4.1 The caring nursing relationship

According to Mulaudzi, Libster, & Phiri (2009) a philosophy for nursing must declare that its professionals and students are engaged in unquestionable, ethical patient care and that they should be accountable for human lives as part of their ethical obligations. Moreover, the ability to care however is something that requires nurturing. Haegert, (2000) states that learning to exercise ethical care needs to be nurtured like a seedling. However, the person needs to be willing to give this gift and having a positive view about other people or human persons (Haegert, 2000). According to Watson (2000) human caring is based on human values such as kindness, concern, and love of self and others which Haerget (2000) refers to as "Ubuntu". "Ubuntu" is derived from an African idiom that states "Umuntu ngumuntu ngabantu", translated as "I am because you are and you are because I am" (Mafunisa & Kuye, 2003 p.13). The principle of "Ubuntu" embodies qualities of compassionate caring that is ethical. Moreover states that devaluing a person is a contradiction of the traditional concept of "Ubuntu" (Haerget, 2000). Each nurse and patient is linked with others in the community. This strong sense of self in relation within community is a foundation to holistic nursing and emphasizes the promotion of unity, shared vision and inclusiveness (Mulaudzi et al., 2009). According to Haegert (2000), this stability will be created between the climate of the persons' work environment and the public caring ethic of its personnel. Therefore care for others becomes ethical when it seeks to develop a person as a person and

such care must not be assumed or taken for granted (Haegert, 2000). Mafunisa & Kuye (2003) state nurses should display care by giving ethical attention and treating patients with gentleness.

According to Harrison & Zohhadi (2005), knowledge, skills and attitude are required to enter into a relationship with a patient. Not only do nurses and care workers lack training in establishing relationships, but they also experience inadequate knowledge, support and supervision. It is suggested that facilitation of a therapeutic nurse-patient relationship has always been the cornerstone of nursing and includes self-knowledge and knowledge about the essential components of therapeutic communication (Van den Heever, Poggenpoel, & Myburgh, 2013). These components include unconditional acceptance of the patient, the ability to listen and to hear, constructive non-verbal skills and verbal communication techniques. The use of rapport and alliance enables this process to happen by providing support, consistency and reliability in patient care (Mafunisa & Kuye, 2003). Furthermore, nurses are expected to show empathy, positive regard and respect to all patients, but the bureaucratic environment in hospitals driven by technology and a mainly medical model of care, makes this therapeutic relationship between nurses and their patients difficult (Van den Heever et al., 2013). Therefore a nursing manager has the duty to establish a trusting relationship through providing support to nurses, displaying honesty, transparency in organizational problems and involvement in nurses' participation in decision making and problem solving, setting attainable goals and keeping her word (Van den Heever et al., 2013).

It is therefore imperative that nurses are conscientised with regard to the importance of caring even during their learning years of becoming professional nurses (Haegert, 2000). According to Watson (2000) during this process of learning and preparation, sensitivity to self is important in the preparation of the nurse to care, to be sensitive to others and clients and is critical to the caring relationship. This process allows for the

nurse to be changed through the caring relationship and is fundamental to the facilitation of authentic communication (Harrison & Zohhadi, 2005). Influenced by the work of Carl Rogers, Watson (2000) asserts that when an individual is sensitive to one's self he/she develop empathy towards others. This is through one's self ability to reflect on thoughts, feelings and experiences and development of one's own potential. This allows the nurse to be fully present to the client and not hidden behind professional detachment (Watson, 2000). This requires that the nurse encourages patient active participation and willingness to be involved in improving his / her health. The nurse facilitates patient self-determination through sharing their knowledge, expertise and professional judgment in making health decisions enabling the patient to gain and regain some control over his/her lives (Mafunisa & Kuye, 2003).

2.4.2 Professional socialization

Professional socialization is an important aspect of professional practice. Merton (1975) cited in Bausch & Rohan (2009, p. 115), defines socialization as “the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge and culture in the groups of which they are or seek to become a member”. For example, medical students are taught to internalize and actualize the values of detachment, distance and emotional control. They learn that they are expected to adopt a posture of detached concern consistent with the profession's claim of affective neutrality. Furthermore, medical training emphasizes the technological, rather than the interpersonal; aspects of patients care and seem to emphasize detachment more than concern (Rohan & Bausch, 2009).

This form of socialization may be problematic as it seems to place an emphasis on treating the patient as an object of medical interest rather than a human being, which tends to depersonalize the patient. However, Mulaudzi et al, (2009) takes a different

view by incorporating the spirit of “Ubuntu” as defined earlier. She argues that “Ubuntu” and nursing are complimentary. They both emphasize caring, which is the most important aspect of the nursing profession. Moreover, senior nurses would implement caring, “ubuntu” philosophy by welcoming, nurturing and affirming young nurses to the profession and striving to help them feel part of the nursing community (Mulaudzi et al., 2009). She further argues that this is emphasized by an idiom, “vhathu ndi mapfula vha a dolwa” (Tshivenda language), which simply mean: “people are like body lotion”. They are applied when one applies body lotion the skin is nurtured and nourished becoming smooth. The purpose of lotion is to avoid skin damage and cracks. Likewise if the person is not supported and surrounded by others, the person will crack. The lotion idiom is similar to English “idiom” which says, “No man is an island” (Mulaudzi et al., 2009). Therefore both patients’ and nurses have a need to be nurtured and given support to avoid any cracks. When nurses are nurtured and supported during their socialization processes, they will transfer the nurturing and support to patients during their practice. This links to the maxim “I am because you are and you are because I am”. A further concern that contributed to their experience of occupational stress was the perception that they received little or no support from nursing managers and hospital administrators (Mokoka, et al., 2010). According to Meyer, Naude & Van Niekerk (cited in Naude & McCabe 2005:4), support in the workplace develops when positive relationships are built, where there is mutual respect, trust and integrity. The work environment needs to be friendly and supportive and the workplace must have a welcoming atmosphere. According to Upenieks (2003), nurses want to be appreciated and respected by management and doctors. They want their expertise to be recognized and to participate in decision-making processes pertaining to patient care. Relationships in the workplace could influence nurses decision to stay or leave, including friendship and support between colleagues and peers (Meyer, Naude & Van Niekerk (cited in Naude and McCabe 2005),

Social workers are also guided by values and ethics in their field of practice. These principles and ethics guide and inform the social worker's practice and profession. For example, social work practice focuses on the person in an environment which means a client is seen or viewed as a person within a particular context, rather than a person with a physical or emotional problem. In addition social workers are taught skills in conveying empathy, warmth and caring and non-emotional involvement (Hepworth, Rooney, Strom-Gottfried & Larsen, 2010). Rohan & Bausch (2009) state that the socialization of nurses lie somewhere between that of physicians and social workers. Furthermore, oncology nursing literature implies a balance of technical and interpersonal skills in professional socialization e.g. nurses who care for those with cancer are expected to deal with the physical aspects as well as to address some of the psychosocial aspects of the cancer experience. They learn that their role is not only to help keep patients alive but also to participate in the personal lives and experiences of patients' and their families. "The literature clearly states that for example, empathy is an essential component of the helping relationship" (Rohan & Bausch, 2009, p.87).

2.4.3 Confidentiality in patient care

Practice as a health care profession is based upon a relationship of mutual trust between patients and health care practitioners. To be a good health care practitioner, requires a life-long commitment to sound professional and ethical practices and an overriding dedication to the interests of one's fellow human beings and society (Khoza et al, 2010). The National Health Act (Act No. 61 of 2003) makes it an offence to disclose patients' information without their consent, except in certain circumstances. It provides that the patient information must not be given to others, unless the patient consents or the health care practitioner can justify the disclosure (Gillespie, 2012). Moreover, practitioners are responsible for ensuring that clerks, receptionists and other staff respect confidentiality in their performance of their duties (HPCSA, 2008). Similarly, the South African Nursing Council (SANC), a statutory body established to

control training, registration and practice of all nurses, has established ethical guidelines indicating that all nurses must respect a patient's right to confidentiality. The South African Nursing Council HIV/AIDS Policy (SANC, 2006) emphasizes the patient's right to confidentiality; effective non-judgmental nursing care; and empathy for the social dilemma (Relf et al, 2009).

According to the HPCSA (2008), the health care provider can only disclose the patient information provided he/she is satisfied that the information can be released. This is often essential to protect the best interests of the patient, or to safeguard the well-being of others. Gillespie (2012) adds that, the risk of harm must be serious enough to outweigh the patient's right to confidentiality. The health care practitioner should always try to obtain the consent of the patient first, and disclose such information provided consent is not forthcoming and the disclosure of the information must be documented (Gillespie, 2012). The National Health Act (Act No. 61 of 2003), states that all patients have the right to confidentiality which is consistent with the right to privacy in the South African Constitution (Act No. 108 of 1996). According to Gillespie (2012), the guidelines on confidentiality are the result of extensive discussion and debate with professional and patient groups and the provisions of the National Health Act. They place new responsibilities on health care practitioners regarding the obtaining of consent for and keeping patients informed about the disclosure of information concerning them (HPCSA, 2008). The guidelines set out a framework for respecting patients' rights, while ensuring that information needed to maintain and improve health care for individual patients and society is disclosed to those who need it for such purposes. These guidelines ensure privacy, friendly relationships between patients and practitioners, and assist health care practitioners to comply with their ethical and legal obligations (HPCSA, 2008). These guidelines are based upon international ethical codes, the South African Constitution (Act No. 108 of 1996) and the National Health Act (Act No. 61 of 2003). Disclosures in the public interest would include but not be limited to situations

where the patient or other persons would be prone to harm as a result of risk related contact.

The National Health Act 2003 requires that health care providers (which include health care practitioners) and health care establishments are responsible for personal information about their patients and must make sure that such information is effectively protected against improper disclosure at all times. For example, this means that employees such as clerks and receptionists must also be trained to respect the confidentiality of patients when dealing with personal information (Van Rensburg, 2004). Many improper disclosures are unintentional. Health care practitioners should not discuss information about patients where they can be overheard or leave patients records where they are vulnerable to disclosure, either on paper or electronically, where they can be seen by other patients, unauthorized health care personnel or the public. Health care practitioners should endeavor to ensure that their consultations with patients are private (Van Rensburg, 2004). When a healthcare provider breaches confidentiality, patients are likely to feel betrayed resulting in distrust of the health care system. In order for the health care system to be effective, the public must trust the health care system, including healthcare providers, and believe that their personal information will be kept confidential (Surlis & Hyde, 2001). Additionally, given the stigma associated with HIV and AIDS, a major concern for many people who are HIV-positive is the respect for privacy and confidentiality on the part of the healthcare providers (Ahmadi et al., 2013). According to Gillespie (2012) record-keeping systems should have a way of limiting access to information regarding the status of HIV-positive patients. The HPCSA says such information should be treated as highly confidential and specific consideration should be given to sharing this information with other professionals involved.

2.4.4 Religion and spirituality

Emmons' (1999) definition of spirituality encompasses a search for meaning, for unity, connectedness, transcendence, and for the highest of human potential. Religion, on the other hand, is a shared belief and social structure within which spirituality is primarily shaped for most people. Pargament (1997, p.14) defines religion in its broadest sense, as a "multidimensional construct including both institutional religious expressions, such as dogma and ritual, and personal religious expressions, such as feelings of spirituality, beliefs about the sacred, and religious practices". In simple terms, Verghese (2008) states religion is institutionalized spirituality. It involves belief and obedience to an all-powerful force usually called God, who controls the universe and the destiny of man. Furthermore, Hill (2003) states religion involves the ways in which people fulfill what they hold to be the purpose of their lives, a search for the meaning of life and a sense of connectedness to the universe. Fitch (1997) highlighted that spirituality is a very personal part of human nature and no two individuals can share exactly the same spiritual experiences. The expression, meaning and focus of spirituality differ from individual to individual. Spirituality includes experiences of transcendence, good and evil, belonging and connectedness, meaning and purpose (Fitch, 1997). Verghese (2008) argues that religions can lose their spirituality when they become institutions of oppression instead of agents of goodwill, peace and harmony, becoming divisive instead of unifying. Spirituality is reflected in everyday life as well as in disciplines ranging from philosophy, literature, sociology, and health care. According to Dyer (2007) spirituality and religiosity are often believed to have both negative and positive effects on health outcomes. Substantial amount of research has failed to find a connection between spiritual beliefs and health. Although interest in this area has been increasing, definitions of religiosity and spirituality are inconsistent and unclear, making empirical evidence difficult to acquire and evaluate. Similarly, Wagner (2006), suggest that spirituality has the potential to address the ultimate questions that are intrinsic to the experience of being human. McDonald (2000) states, everyone has a spiritual dimension that motivates, energizes, and influences every aspect of life. It can be

considered a basic human quality that transcends gender, race, color, and national origin. According to Puchalski, Ferrell, Virani, Otis-Green, Baid (2009) spirituality is a person's way of being, thinking, choosing, and acting in the world in light of that person's ultimate values.

The idea of discussing spiritual and religious issues with clients presents discomfort for many professional practitioners as religion and spirituality are seen to be inherently conflicting due to the personal "investments" made by the practitioners and the client (Naicker, 2010). For many years religion and spirituality were considered taboo topics especially in psychology (Hill, 2003). According to Naicker (2010) the reason for avoiding religion and spirituality in therapy is that psychologists themselves tend to be considerably less religious in comparison to the general population. It was only towards the end of the 20th century that the idea of incorporating spirituality into psychotherapy emerged and psychologists began to realize that religion and spirituality are integral parts of the psychology of individuals (Naicker, 2010). Despite the rising attention to religion and spirituality in therapy, it was found that most graduate and postgraduate training programmes offer little or no training in this integration, hence the emphasis on the need for training programmes to increase their sensitivity to the topic, provide more opportunities for student growth in the area, and to incorporate these issues into course work (Kelly, 1995). According to Puchalski et al. (2009), in the early 1990s, academic medical centres, medical and nursing schools, residency programs, and hospitals began to recognize the role of spiritual care as a dimension of palliative care and have incorporated into their programs issues of spirituality and holistic health care. Trends that appear to be driving this new interest in spirituality include many studies that demonstrate the connection between spirituality and health improvement. Also there is a high demand from clients or patients that their spiritual needs be addressed along with their physical, mental, and emotional needs (Hickman, 2011).

According to Verghese (2008), the Royal College of Psychiatrists in London has a special group on Psychiatry and Spirituality. The American College of Graduate Medical Education mandates in its special requirements for residency training in Psychiatry, that all programs must provide training in religious and spiritual factors that can influence mental health. Lines (2006), describes specific religious and spiritual techniques that therapists often use in therapy. These include forgiveness, reading scripture, mindfulness, meditation and somatic techniques such as chakras. The reading of religious and spiritual scriptures is viewed as appropriate in religious counseling, but Lines (2006) states that it can also be used in therapy as these scriptures hold stories of spiritual and moral wisdom. According to Puchlaski et al. (2009), when life-threatening illness strikes, it strikes each person in their totality. This totality includes not simply the biologic, psychological, and social aspects of the person, but also the spiritual aspects as well. Therefore, the bio psychosocial-spiritual model states every patient has a spiritual history whereby health care providers can tap into to provide holistic quality care to patients. According to Kahle (2004), in studies relating to mental health, people who are more religious show a greater sense of wellbeing and satisfaction with life. Furthermore actively religious people are less depressed, less anxious and are less likely to commit suicide (Kahle, 2004).

In South Africa, a section in the Bill of Rights states that, “everyone has the right to freedom of conscience, religion, thought, belief and opinion” (Constitution of the Republic of South Africa, 1996, p. 149). This implies that according to the legislation, practitioners are not allowed to avoid or ignore the religious beliefs and opinions of clients. Associated with this is the issue of responsibility on the part of mental health professionals to constantly be aware and respectful of their clients’ religious and spiritual traditions, beliefs, and practices (Kahle, 2004).

Anandarajah & Hight (2001) state that it is important that physicians maintain a balanced, open-minded approach to medical care without sacrificing scientific integrity, to keep an open mind regarding new methods of study and to be aware that there are some things that may never be fully understood. The physician should evaluate whether spirituality is important to a particular patient and whether spiritual factors are helping or hindering the healing process. In addition, elements of general spiritual care should be incorporated into the routine medical encounter. Although not easily measurable, a physician's ability to offer connection, compassion and presence can be a powerful therapeutic intervention (Anandarajah & Hight, 2001).

According to Indian (2008), spirituality in man produces qualities such as love, honesty, patience, tolerance, compassion, a sense of detachment, faith, and hope are essential components in any helping relationship. Moreover, according to Puchalski et al. (2009) spiritual care models offer a framework for health care professionals to connect with their patients; listen to their fears, dreams, and pain; collaborate with their patients as partners in their care; and provide, through the therapeutic relationship, an opportunity for healing. The care is rooted in spirituality using compassion, hopefulness, and the recognition that, although a person's life may be limited or no longer socially productive; it remains full of possibility (Puchalski et al., 2009).

2.5. Occupational challenges

2.5.1 Trauma

Defining the meaning of a traumatic event is important to clarify it from the often confusing terminology of trauma and trauma related phenomena (Geldenys, 2005). According to Hesse (2002) cited in Sabo (2005, p.138) a traumatic event is characterized by a situation that involves the actual or threatened death or injury to

one's self or others. "The DSM-IV-TR (2000) highlights the essential features of posttraumatic stress disorder (PTSD) as the development of characteristic symptoms following by exposure to an extreme traumatic stressor experienced by the individual or a close family member. The characteristic symptoms may include intense fear, helplessness or horror" (Hesse, 2002, cited in Sabo, 2005, p.138).

It is therefore possible but not certain that any trauma counselor or counseling professional may suffer from compassion fatigue, burnout or both (Geldenys, 2005). Furthermore, Geldenys (2005) states that trauma workers and therapists should be aware of the possibility of reoccurrence of traumatic material, if unresolved. This could not only lead to therapeutic relationships being contaminated, but also the personal well-being of the trauma worker may be jeopardized.

2.5.2 Compassion fatigue

According to Sabo (2005, p.52), "compassion fatigue is thought to be a combination of secondary traumatization and burnout precipitated by the care delivery that brings health-care professionals into contact with suffering and has been associated with the cost of caring for others in emotional pain". It results from the natural consequences of caring for people who are suffering rather than a response to the work environment (Sabo, 2005). Moreover it results from knowing about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person. Compassion fatigue differs from post-traumatic stress disorder (PTSD) in that the individual is exposed to the traumatized or suffering person rather than the traumatic event itself (Sabo, 2005). Much debate on who is susceptible to compassion fatigue exists. Figley (1995) cited in Sabo (2005, p.138), states that "the vulnerability is not limited to trauma worker or therapists, but nevertheless these individuals are susceptible. Professionals that may suffer from compassion fatigue,

other than therapists, are medical staff, nurses, paramedics and psychiatric personnel". The vulnerability is attributed to the fact that medical staff and therapists are constantly surrounded by traumatized individuals and trauma-inducing factors (Sabo, 2005). It is further argued that compassion fatigue has emerged as a natural consequence of caring for clients who are in pain, suffering or are traumatized. The study shed light on how nursing work might impact the health of nurses by exploring the concept of compassion fatigue however the study does not elaborate and explore the views of patients with regard to the service rendered to them by health care professionals (Sabo, 2006).

2.5.3 The role of empathy

According to Baird and Jenkins (2002, p.42), "empathy signifies a central focus on the feelings of clients and their world. It involves more than just the ability of the therapist to know what the client means". It is a communication tool that validates the world as perceived by the client and requires that the individual perceive the world as the other, be non-judgmental, understand the other's feelings and communicate this understanding (Jenkins and Baird, 2002). Furthermore, Russel et al. (2007, p.107) cited in Figley (1995), suggests that "empathy and emotional energy are the underlying drivers in the development of compassion fatigue". However, Sabo (2005) argues that little empirical evidence exists to support empathy or over caring as a sole causal factor for compassion fatigue.

Empathy has been shown to be a critical component of the helping relationship. It does not necessarily infer negative consequences for the professional. If, as Figley (1995) purports, empathy increases the risk for compassion fatigue, then it might be hypothesized that all health-care professionals should manifest secondary traumatic stress (STS) or compassion fatigue symptomatology to varying degrees (Figley, 1995).

“Research has shown that only 7% of professionals working with traumatized individuals exhibit emotional reactions typical of the “big bang” trauma experiences such as post-traumatic stress disorder (PTSD)” (Geldenys, 2005, p.43). Geldenys (2005) further argues that despite the risks involved in providing care or assistance to individuals who are in pain are suffering or traumatized, certain qualities seem to afford protection such as resiliency, hardiness and social support. “Perhaps the emphasis within traumatology research should shift from the pathology to what protects human beings engaged in caring work with those experiencing pain, suffering and trauma” (Geldenys, 2005, p.44). The two concepts empathy and confidentiality once practiced jointly can create harmonious working relationship for both the patient and the nurses.

2.5.4 Burnout

Secondary traumatic stress (STS) or compassion fatigue must not be confused with burn out. Burnout refers to a state of feeling emotionally exhausted and disconnected from other people, and lacking a sense of accomplishment from one’s work. “It is not specific to work with traumatized people; however it is related to the work setting variables such as workload, overload of responsibility, lack of control over the quality of services provided and interpersonal problems at the workplace” (Deighton, Gurriss & Traue, 2007, p.68). According to Maslach (1993), burnout is characterized by emotional exhaustion, depersonalisation and a sense of reduced personal accomplishment, accompanied by a decrease in motivation and occurs as a result of chronic occupational stress in 'normal' individuals. According to Geldenys (2005), burnout is a reaction to a stressful work situation and appears to consist of three stages. The first stage involves an imbalance between resources and demand. The second stage is the immediate and short term imbalance. This stage is accompanied by feelings of anxiety, tension, fatigue and exhaustion. The last stage consists of change in attitudes and behavior. Furthermore, burnout may be identified as a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment in individuals in the helping

professions deriving from social interaction between the therapist and the client (Russel et al., 2007). Sources of burnout may include organizational conflict and lack of support from the organization. When the work environment is strained, strain is transferred to individuals in that setting (Geldenuys, 2005). Lundstrom et al. (2002) add that stress and job burnout is also related to specific demands of work, including overload, variations in workload, role conflict, and role ambiguity. Moreover, workers who perceive a high level of stress and job burnout have poor coping responses and lack of job satisfaction, which often erode commitment to the organization and lead to higher turnover. Vawda & Variawa (2012) states that although these emotional challenges are recognised by health care workers themselves, as well as the supervisors of the health facilities, it appears that many health care workers do not have access to facilities to assist them in dealing with these issues.

In support of this, Bown (2012), states that high tension experienced by doctors and health care practitioners without adequate support creates high levels of stress, which can compromise performance. She further articulates that work related tension was on the rise whereby most doctors are working in increasingly challenging environments, their professional conduct and competence brought into question, sued for negligence but limited support. According to Lundstrom et al. (2002) experts have suggested that burnout results from a variety of stresses, including situations in which work demands cannot be met because of a lack of resources such as social support from co-workers and supervisors, job control, participation in decision making, utilization of skills, and reinforcements such as rewards. It is argued that if medical practitioners are to maximise their potential and provide the best service in patient care, support provided should match the level of stress in the job (Bown, 2012). Vawda & Variawa (2012), states that the dire need for emotional support amongst health care workers must be addressed, and appropriate and sustainable counselling mechanisms should be implemented to provide health care workers with tools to cope with such emotions.

Furthermore, counselling and debriefing should mainly focus on the emotional challenges facing health care workers. These include anger (usually resulting from stress), death, loss, grief, and depression. According to Rajin (2012) programmes such as the Employee Assistant Programme are a necessity to address psychological and physical problems, work-related stress, chemical dependency (alcohol and drugs), depression, marital and family problems, financial problems, health, anxiety, and even job boredom. The EAP Handbook (1999) explains that these programmes are initiated by employers as a humanitarian and a moral act to assist employees not only to adhere to legislative prescripts but to assist employees to cope with workplace demands and to overcome the difficulties that are work related.

2.6 The role of Occupational social work

Straussner (1990) cited in Van Breda (2009, p.39) defines occupational social work as “a specialized field of social work practice which addresses the human and social needs of the work community through a variety of interventions which aim to foster optimal adaptation between individuals and their environments”. This definition foregrounds the work community, a term that is inclusive of employees, their families and the workplace itself, as other stakeholders (e.g. clients and shareholders). The definition also emphasizes the person-in-environment principle by stressing the importance of optimal adaptation between different systems within the work community, thereby focusing our attention on the points of interface between systems. It is important to note that the social worker working in industry is not an occupational social worker.

The difference would be that of the social workers working in industries focus of concern would be individual employee and their families. In industrial social work also known as occupational social work, “the focus would be on the person-as-employee and the unit of need may extend to the organization in which systemic and procedural changes may

be indicated” (Du Plessis, 2001, p.89). Kruger & Van Breda (2001) do however recognize there may be tension between the employee and the employer regarding loyalty towards employees and their families and management on the other. To address this tension a metaphor of binocular vision is proposed. Kruger & Van Breda (2001, p.948) defines binocular vision as the “ability to have a “telescopic” and “microscopic” view of the situation at the same time. Just like a microscope views issues close up and a telescope views from the distance. The telescopic lens enables the social worker to see the broader picture. This view focuses on policy and issues that marginalize workers, whereas the microscopic lens focuses on everyday struggles of families and individuals, dissatisfaction of workers. Moreover, the binocular vision encourages social workers to remain at the interface without becoming overly allied with either party (Kruger & Van Breda, 2001). The binocular vision works best when in cooperated with the practice model.

The occupational social work practice model conceptualized by Kruger & Van Breda, (2001) describes four positions of occupational social work practice. The first position is restorative intervention focusing on the employee-as-person and is aimed at resolving personal problems. In this regard the person is viewed as an employee with personal problems that do not necessarily arise from work. The role of the occupational social worker is that of therapist, enabler, facilitator, community worker and problem solver. Du Plessis (2001) states that this approach is concerned with the personal needs of employees as individuals, parents or community members. Secondly, promotional interventions also focus on the employee as a person, but are aimed at prevention, education and development. This is aimed at promoting and enhancing social functioning of clients. The occupational social worker’s role includes that of educator, trainer, facilitator, enabler, coordinator and group worker or community worker (Du Plessis (2001).

Thirdly, the work-person interventions focus on the person as employee and are aimed at assisting employees and their families in adjusting to the demands of the workplace. The concern is with the occupational needs of employees as employees, such as their ability to cope with work-related stress, interpersonal conflict in the workplace and the negative spillover of work stress into the family (Du Plessis, 2001). In this position the role of the occupational social worker includes negotiator, arbitrator, mediator, facilitator etc. Lastly, workplace interventions focus on the organization as client, aimed at assisting organizations to adjust to the needs of the workforce. Du Plessis (2001) further states that the concern is with facilitating a work system or community that is characterized by justice, equity and human dignity.

Here the focus is on policy, hierarchy and bureaucracy. It is aimed at creating a harmonized environment in the workplace. The role of the occupational social worker includes that of policy maker, systems analyst, researcher, organizational developer, social conscience of the organization. Carapinha (1998) cited in Du Plessis (2001), states that another client system, namely the employee-as-citizen would be concerned with facilitating the social well-being of the communities in which employees live and in which organizations operate, through corporate social investment. The occupational social worker must place him/herself in the middle of this model and select a position from which to intervene.

Du Plessis (2001) further articulates the view that a focus on person as employee invites attention to work related problems. The work-related problem directs the focus for interventions in systems and policies. It is therefore imperative that occupational social workers must earn their rights to become part of company policy formulation and organizational change. Other issues that are tackled by occupational social workers include stress and workload management, bullying and harassment at work, alcohol

and or drug abuse, interpersonal conflict, poor teamwork, discrimination and mental health problems (Du Plessis, 2001).

It seems however that occupational social work has been ignored and given scant recognition by public sector departments in South Africa (Mbana, 2005). There are no such vacancies created or advertised by the public sector to alleviate the challenges faced by public officials, despite the demands visible enough to create positions for occupational social workers. According to Mbana (2005) the South African National Defence Force (SANDF), South African Police Service (SAPS), with parastatals such as ESKOM and post office are the only government departments that utilize Occupational social workers' programmes or interventions. Furthermore, there are no records of occupational social workers employed by the government in order to render a comprehensive service to enhance the wellbeing of the department workforce and to improve both individual and organizational performance and moreover, to reduce the risks and costs associated with human behavior.

2.7 Employee Wellness Programmes

Bessinger (2006) states that health and wellness of employees is of strategic importance for any business, which wants to achieve leadership in a global business world. Changes in technology have resulted in a loss of control over working hours, in job losses and in an increasing sense of job insecurity. Rothmann (2003) cited in Bessinger (2006, p.52) states that "many organizations have implemented practices that attempt to reduce costs and increase productivity, which often lead to a mentality that favors' profitability over the welfare of people". According to Bessinger (2006), with these changes more and more of the economically active populations are striving to work smarter, not harder. In response most employers are prompted to revisit their employment proposition. Employee Wellness Programmes have a major role to play in

assisting employees to cope with change and guiding employees through transitional phases to regain feelings of job security and a sense of belonging to the organization (Bessinger, 2006).

According to the International Labour Organization (ILO) and the World Health Organization (WHO), health is defined as aiming to “promote and maintain the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers, in their employment situation, from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological needs and capabilities; and to summarize, the adaptation of work to man and of each man to his job” (Stellman, 1998, p. 28). Although this definition of health includes physical and psychological dimensions, legislation is interpreted to focus on physical health rather than psychological health.

According to Sieberhagen, Rothmann, & Pienaar (2009) South African labor law is not clear on the definition of occupational health and still favors physical health. Moreover, employee wellness is not defined within South African labor law. Els (2005) states that the law is clear in defining health and safety, as well as clear in paying attention to health and safety. While inadequate safety measures usually have an immediate effect, inadequate attention to psychological health may take considerable time before it manifests as an occupational disease (Luthans, 2002). According to Sieberhagen et al. (2009) South African labor relations framework provides a mechanism for employee health interventions. However, there is a lack of guidance in case law and statutes with regard to dealing with psychological stress and little is done in terms of risk analysis and occupational stress interventions (Luthan, 2002). According to Els (2005), South Africa needs a national strategy to deal with physical and psychological risks at work that

influences the health and wellness of employees. Employee health and wellness is defined by Rothmann, Steyn, & Mosterk (2006) as a state in which employees are energetic, motivated, healthy, productive and committed to the organization and its goals.

According to Bessinger (2006), another approach adopting Maslow's hierarchy of needs as a theoretical framework for needs analysis in implementing EAP, theorizes that people are 'wanting' beings whose needs guide their behavior. These needs influence a person's activities until they have been satisfied. Maslow proposed that motivation is a function of five basic needs i.e. physiological, safety, love, esteem and self-actualization.

According to Maslow, lower-level needs must be satisfied, in general, before higher level needs are activated sufficiently to drive behavior. Further, only unsatisfied needs can influence behavior (Deighton et al., 2007). According to Bessinger (2006, p.37), "individuals move up the needs hierarchy through a dynamic cycle of deprivation, domination, gratification and activation. That is, when the individual experiences deprivation at a particular level in the hierarchy, the unsatisfied need will direct the individual's thoughts and action, this process continues until the need for self-actualization is activated". Maslow suggest that we can ask people for their philosophy of the future, what their ideal life or world would be like and get significant information as to what needs have or have not been fulfilled (Bessinger, 2006).

Therefore, employee wellness programmes should pro-actively identify emerging or unmet needs throughout the different levels in the organization and align their strategies and devise interventions that would satisfy the emerging needs of employees. Given this, Maslow's theory of hierarchy of needs can be utilized as a theoretical framework

and a tool for a needs analysis prior to and post implementing an Employee Wellness Programme (Bessinger, 2006). Furthermore, South African organizations lack adequate policies to govern employee health and wellness. It is important for organizations to develop employee health and wellness policies in order to regulate employee health and wellness in their organizations. Management standards should promote the use of primary interventions such as job redesign in favor of tertiary interventions that focus on individuals (Bessinger, 2006). According to (Smit, 2005), it is therefore necessary to recognize the importance of more proactive institutional initiatives to support nurses in coping with occupational stress and addressing their emotional concerns. Such strategies may include stress management courses, nurses' support groups, and a more diverse system that allows nurses to receive recognition, both formally and informally, for valuable occupational contributions. In order for nurses to give quality care, health care facilities must provide a working environment where sufficient medical supplies are at hand (Smit, 2005).

2.8 Conclusion

South African health care services are regulated by a policy framework to improve service delivery in public hospitals. Public hospitals seem to be experiencing challenges whereby nurses seem unsatisfied with their working conditions they work under resulting in brain drain, with shortage of staff, unwelcoming salaries, under-resourced and overused and overcrowded hospitals. These policy frameworks seem to be short sighted as it seems to be regulating code of conduct of nurses thereby undermining and ignoring nurses' efforts to render good quality service. The role of Occupational Social Work and its relevance in trying to resolve some of the occupational challenges that the hospital, nurses and patients are faced with was highlighted with an attempt to resolve some of these challenges creating a harmonious working and caring environment for all.

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1 Research design

The study adopted a qualitative approach as it aimed to explore perceptions and develop understanding about the meaning that nurses attach to their experiences around their role and the services that they render. Maxwell (2013) defines qualitative research as research that is intended to better understand the meaning and perspectives of the people one studies, seeing the world from their point of view, rather than one's own, how these perspectives are shaped by and shape their physical, social and cultural context and the specific processes that are involved in maintaining or altering these phenomena and relationships (Maxwell, 2013). According to Shank (2002) qualitative research is planned, ordered and public, following rules agreed upon by members of the research community. The type of inquiry is grounded in the world of experience. Therefore, a qualitative approach was ideal for this study as it allowed the researcher to find meanings and to uncover the nurses' perceptions on their experiences.

The research design was of an exploratory/descriptive nature, utilizing elements of the phenomenological approach. This allowed the researcher to investigate phenomenon of participants in their setting aiming to describe the perceptions and experiences that emerged. A phenomenological approach was used to gather information through in depth interviews. This type of interviewing provides a greater breadth given its qualitative nature (De Vos, 2005). Furthermore, Parker (1998) state that "in depth interviews allow the researcher to understand the complex behavior of members of society without imposing any *a priori* categorization that may limit the field of inquiry" (Parker, 1998. p14).

The researcher was therefore able to gain insight into the nurses' perceptions on their experiences regarding services they offer in the hospital where they are employed. According to Willig (2001), phenomenological methods are particularly effective at bringing to the fore the experiences and perceptions of individuals from their own perspective, challenging structural or normative assumptions. Finally, phenomenological approaches are good at surfacing deep issues, making voices heard and challenging complacency and status quo which might be good for organizational change and transformation (Shank, 2002).

3.2 Aims and objectives of the study

The main aim of the study was to explore the experiences and perceptions of nurses regarding the services they offer in a public hospital in Johannesburg.

The specific objectives of the research study included the following:

- To explore the perceptions of nurses about their experiences of the care that they offer in a public hospital.
- To explore the quality of the relationships between nurses and their patients in public hospitals.
- To explore the perceptions of nurses about the strengths and challenges relating to their professional role and practice.
- To explore nurses' perceptions of stress, compassion fatigue and burnout, and their coping strategies in dealing with these.

3.3 Research methodology

3.3.1 Sampling procedures

In purposively selecting a sample, the researcher identified professional nurses working in three wards of one of the large public hospitals in the Johannesburg area. From this group, a smaller sample of twenty professional nurses were selected at random and volunteered to participate in the study. The twenty participants were selected as this was deemed to be a sufficient number for in-depth data collection. According to Willig (2001), purposive sampling involves selecting a sample according to the criteria of relevance to the research question. The nurses were selected because they were employed at the selected hospital in three different wards and were rendering their services as nurses in the hospital at the time of the study. Purposive sampling was used as it targets individuals who were particularly knowledgeable about the issue under investigation (Grinnel & Unrau, 2010). Babbie (2005) state that when using purposive sampling the researcher appropriately selects the sample on the basis of his or her own knowledge of the population, its elements and the nature of the research aims.

After permission to conduct the study was obtained from the CEO of the public hospital (See the letter requesting permission to conduct a research study at the hospital, Appendix A), the researcher approached the sister in charge of each of the wards and requested permission to meet with the nurses of each of the three particular wards. The first twenty participants that volunteered to participate, from the three wards, were selected. These wards were selected as they are close to each other and therefore easily accessible. Selection criteria included that the participants were registered nurses and working in the Johannesburg hospital.

3.3.2 Research instrument

The semi-structured interview schedule with open- ended questions was used as a tool for data collection to allow for greater exploration of the participants perceptions, (Appendix D: Interview schedule). The researcher attempted to capture the experiences of the participants and the meaning attached to their experiences. This method was used to determine individuals' perceptions, opinions, facts and their reactions to initial findings and potential solutions and was used for research participants who have shared a common experience (Grinnel & Unrau, 2010). The interview schedule was semi-structured and consisted of closed and open- ended questions.

3.3.3 Data collection

Semi-structured face-to-face interviews were used for data collection. According to Babbie (2005), face-to-face interviews offer the highest response rates and also allow for clarifying and probing in order to collect in-depth information. The method encouraged participants to share their thoughts on the study at hand. De Vos et al., (2005) states that researchers use semi-structured interviews in order to gain a detailed picture of participants' beliefs about, or perceptions of a particular topic. As a qualified social worker, the researcher used social work interviewing skills in order to establish rapport and to show sensitivity to participants' responses. To gain in depth information, the researcher maintained enough flexibility to elicit participants' individual stories, while at the same time gathering information with enough consistency to allow for comparison between and among subjects (De Vos et al., 2005). This method was also used to encourage participants to reflect on the meaning of their experiences and what it holds for them. It uncovered and described participants' experiences. It encouraged participants to share their thoughts in the research study.

Although the researcher had pre-arranged with the Social Work Department at the hospital for the use of a social work office for privacy and confidentiality, participants were not willing to leave their units due to shortage of staff and in case of emergencies. Therefore, in one unit the researcher utilized the participants' conference room, and in the other two units the researcher was provided with the unit manager's office where interviews were conducted with privacy and confidentiality.

The participants were requested to fill in the consent forms upon agreeing to participate in the study. The researcher read and gave clarity on the content outlined in the forms. This was done to make sure participants understood they were not under any obligation to participate and participation was voluntarily. The interviews took approximately one hour for each participant. Interviews were audio recorded and later transcribed so that the researcher was able to gather data as accurately as possible and the transcribed data were shown to and discussed with the researcher supervisor.

3.3.4 Data analysis

The researcher used thematic analysis to analyze data. According to Grinnel & Unrau (2010) when analyzing data, the researcher should simply look for patterns and themes that help to capture how the research participants are experiencing the social problem being researched. Furthermore, the ultimate goal was to interpret data in such a way that the true expressions of research participants are revealed. According to Thorne (2000), this strategy involves taking one piece of data in order to develop conceptualizations of the possible relations between various pieces of data. In many qualitative studies, where the purpose is to generate knowledge about common patterns and themes within human experiences, this process continues with the comparison of each new interview or account until all have been compared with each other (Thorne, 2000). The study had not set out to make generalizable findings as it was deemed to be

a qualitative study, seeking to explore in greater depth, the experiences of participants. The emphasis was therefore not on the statistical analysis of percentages and frequencies, but rather on the narrations and meanings attached to perceptions and experiences.

3.3.5 Limitations

Gaining entry to the public hospital was a challenge, requiring time consuming protocols and procedures. Finding adequate numbers of participants was also difficult due to the fact that some participants were not willing to participate in the study due to their busy schedules, shortage of staff and concerns around disclosure of information. However, the qualitative nature of the study did not require a high number of participants and therefore twenty participants were considered to be a sufficient number. It was interesting to note that some unit members rejected the invitation to participate due to lack of interest, while members from some other units were willing to participate, but their unit manager was not in favor of their participation and they could not be included. The participants were assured of brevity of the interviews as well of the undertakings of confidentiality. The study did not generalize its findings due to the small number of the sample. However, it was qualitative in nature and so it was not the intention to generalize. Lewins (2007), states that generalizability is concerned about whether findings or conclusions from the sample are directly applicable to a larger population.

3.4 Ethical considerations

3.4.1 Introduction

Ethics clearance was obtained from the University of the Witwatersrand Medical Ethics Committee (See Appendix F: Ethics clearance letter and protocol number). Ethical

issues taken into account included avoidance of harm or non-maleficence, informed consent, coercion and perverse incentives, confidentiality, actions and competence of researcher, approval of the study by the ethics committee or review board and release or publications of the findings.

3.4.2 Avoidance of harm or non-maleficence

Because the study explored the experiences and perceptions of the participants, it was acknowledged that the questions may be emotionally unsettling for the participants. Participants were informed beforehand that if they should require any supportive counseling, this would be available to them. Free counselling was arranged with Emthonjeni Centre at the University of the Witwatersrand, a multidisciplinary centre for social work and psychology and communication services. The participants were informed that they could withdraw from the study at any given point that they wished without any threats or negative consequences. However, none of the participants withdrew from the study.

3.4.3 Informed consent

Permission to conduct a study was requested and obtained in writing from the identified public hospital. The researcher requested and obtained permission from the hospital superintendent, the Chief Executive Officer and the Head of the Department of all participating departments. All participants were given an information sheet and consent form to sign upon agreeing to participate in the study. Participants were informed that their participation was entirely voluntary. All information on the purpose of the study, the research procedures, duration of participation, and the risks involved if any were communicated to the participants, furthermore no benefits and financial costs were given nor promised to participants. Furthermore, participants were legally and

psychologically competent to give consent to participate in the study. All raw data and tapes will be kept in a locked cabinet and destroyed two years after publication or for six years if no publications emanate from the study.

3.4.4 Coercion and perverse incentives

Participants were not coerced into giving consent and participation in the study. The researcher under no circumstances deceived participants from participating in the study and no incentives were promised nor offered to the participants. Neuman 2003 cited in De Vos et al., (2005, p.59) states that nobody should ever be coerced into participating in a research project, participation must always be voluntary.

3.4.5 Confidentiality

Participants were assured of confidentiality and their identities were not disclosed at all. Their identities were also not able to be linked to any of the responses. Their names and personal details were kept confidential and no identifying information was included on the final research report. The names and other identifying information were replaced with codes. Privacy was provided as interviews were conducted in a secured and closed room.

3.4.6 Actions and competence of researcher

The researcher did not pass judgment and have prejudice against the participants' behavior and attitudes in their setting. Data collected was not manipulated or changed in order to suit the researcher's perceptions and the analysis and findings of the study were reported on accurately. The researcher is a registered social worker and therefore

has experience and competence in the area of interviewing. This contributed further to the sensitivity and general management of the data collection process.

3.4.7 Release or publications of the findings

The findings were reported accurately and objectively. Acknowledgments were given to all sources cited, and shortcomings and errors noted and admitted. The main findings will be presented to the University of the Witwatersrand as well as the Department of Health and feedback will also be given to participants of the study on request

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.1 Demographic profile of participants

The sample comprised of 20 registered nurses. The participants were from three different wards in the hospital. The table below shows the majority of participants were aged 31-35 years, while most participants were below forty years of age. Only one participant was over the age of 45 years. The participants length of service indicates seventeen participants had five years and less and eight participants had one year and less working experience in their respective units, which meant that participants were generally relatively inexperienced as nurses. Only three participants had more than six years of working experience in their units. The table below outlines this demographic profile of participants.

Table1. Demographic Profile of participants

Age		Length of service	
21 – 25	3	0 – 1	8
26 – 30	4	2 – 5	9
31 – 35	5	6 – 10	2
36 – 40	3	10 +	1
41 – 45	4		
46 +	1		
Total	20		20

4.2 Summary of categories and themes

Through an inductive as well as deductive process of data analysis, various themes were identified in accordance with the aims of the study.

Table 2: Summary of categories, themes and sub-themes

Category	Theme	Subtheme
Nurses' perceptions about care and roles	Mentoring and coaching	Educators Role modeling Motivators
	Leadership and supervisory role	Leadership Unsupportive uncaring Organizational functioning Role modeling
	Counseling	Pre and post counseling Support Positive communication patterns, basic physical care,
	Nursing care	Patient care Patient recovery Support
Relationships with patients	Patients' attitudes	Cooperative patients Difficult patients and relatives Empathy Confidentiality
	Nurses' skills and ethics	Trust Courtesy
	Nurse-patient relationship	Frustrated (none-adherence to medication) Friendly Strict Reciprocal relationships
Perceptions about strengths or positive aspects in nursing practice	Personal development and training	Bursary Minimal workshop's and in service trainings
	Positive aspects and strengths	Improved health of patients Positive feedback from patients
	Sense of reward	Positive feedback from colleagues and management

Perceptions about challenges	Shortage of staff	Promotions Abuse of work absences Under resourcing Work overload
	Poor communication	Language barrier Patients feeling disrespected and undermined by nurses
	Lack of resources and shortage of equipment	Broken equipment Limiting working space Poor ventilation Health hazards exposure
	Un-cooperative patients	Patients non adherence to medication and treatment Demanding patients and relatives
	Conflicts	Conflicts between nurses and patients Conflicts between staff
	Employment and labor problems	Unsupportive management Uncaring management Duties not talking to performance agreement and job description Performance of support services duties Poor role clarification
Trauma, stress and burnout	Forms of stress, trauma and burnout	Nature of stress Nature of burnout Nature of trauma Factors leading to stress, burnout and trauma
Coping strategies in dealing with challenges	Negative coping mechanisms	Abuse of leave, Aggression Use of alcohol Taking work frustrations to home Lack of visible and accessible EAP programmes and Employee Wellness programmes
	Positive coping mechanisms	Debriefings, religion and spirituality.

4.3 Nurses' perceptions of the nature of their roles

Nurses perceived their roles as consisting of mentoring and coaching of colleagues, subordinate, patients and patients' families (educators and role modeling); counseling of patients and family members; patient care and nursing care (support); leadership and the supervisory role.

Table 3: Nurses' perceptions of roles

Themes	Subthemes	Quotations
Mentoring, educating and coaching	Educators	<i>"...give them education to continue caring for their babies whilst also at home..."</i> <i>"We educate patients and refer them to local clinics"</i>
	Role modeling towards colleagues	<i>"...like there are colleagues who are looking upon you. It means you should act as a role model to them..."</i>
Counseling	Pre- and post-counseling	<i>"...so I do also counseling".</i> <i>"...by giving them counseling. Cause I am also a counselor".</i> <i>"I conduct pre- and post-counseling with clients"</i>
	Patient care	<i>"...my role, I'm nursing, seeing and making sure the patient is ok..."</i>
Patient care	Patient recovery	<i>"my role in this unit is to make my patient to strive to leave"</i>
	Support	<i>"...and give moral support where needed to my patients",</i>
	Leadership	<i>"...you need to guide them, be assertive; you just need to act as a leader. But it depends..."</i>
Leadership and supervisory role	Organizational functioning	<i>where you are leading, sometimes towards the patient sometimes towards nurses..."</i> <i>"Seeing to it that the unit is fully functioning..."</i>
	Contested roles and tasks	<i>You know when this phone is busy, it can drive you mad...at the same time you have to attend to patients..."</i> <i>"I don't understand why we must clean the patient's vomits if there are cleaners hired to do that job."</i> <i>"Nurses are expected to escort patients to their wards, even when the patient can walk by himself...I don't</i>

understand”.

Participants seemed to perform multiple roles and responsibilities. However, the majority of these roles fall within their scope of work, which is patient care and nursing care while others were out of their scope of work. Participants raised frustrations and dissatisfaction regarding the busy telephones and distractions. They felt their time to offer patient care was often taken by answering telephones and doing routine cleaning work which was supposed to be carried out by other workers. This compromised their ability to adequately nurse patients. According to Mafunisa & Kuye (2003) public servants should be competent, effective, efficient, ethical and qualified for performing assigned and accepted duties. Moreover, public servants should become a model for their colleagues and members of the public, satisfying the need of a system for ethical standards in the quest for the greatest level of client satisfaction and to promote work ethics, acknowledge workplace diversity and act as communicators (Mafunisa & Kuye, 2003). Participants did not appreciate and seemed frustrated about performing roles which were out of their scope of work as these were time consuming and they felt that as a result, their service delivery was hampered.

4.4 Relationships with patients

4.4.1 Patients' attitudes

Table 4: Nurses' perceptions of patients' attitudes

Themes	Quotations
Nurse-patient relationship	<p>“Basically relationship differs from one patient to the other. Other patients are very nice of which they make a relationship to be good between I and them. Other patients are very impossible to deal with. They have issues and so basically they won’t be relationship between I and them.”</p> <p>“Could say it’s good. Cause most of the patients I have contact with, they never gave me problems or attitude like....”</p> <p>“Cause once I lose this patient at the beginning, I won’t be able to have a goal that at the end of treatment the patient will be cured and treatment competent. So first I need to correct my attitude,”</p>
Cooperative patients	<p>“It’s very good. Mm, they are cooperative. I also try to be as comforting as possible and try reassuring them when stressed”.</p> <p>“I can say is good... Sometimes we don’t get along well...especially when they are not cooperative putting their lives and that of the baby in danger...”</p> <p>“I’m very very strict. Cause first thing I explain everything to you. All I need is 100% cooperation from you. Not for me, not for you but the baby...”</p>
Trust	<p>“According to me, your relationship with patient has to be tight ...must be trust between you and patients. Cause once I lose this patient at the beginning, I won’t be able to have a goal that at the end of treatment the patient will be cured and treated... I do feel I have that trusting relationship with patient and that bond”</p> <p>“Is very difficult to have relationship with patients. Because they can trust you or not trust you. ..That’s why relationship is so difficult because they may never trust you with the information they are giving you, maybe you can talk it somewhere.... So for the patient to trust you is very difficult.”</p> <p>“But it’s not easy to build a relationship with our patients. Building that trust is very difficult. But once it built, it stays for a long time.”</p>
Difficult patients and relatives	<p>“...the community sometimes comes and interfere like the relatives, they are the only problem, cause they interfere..., you see, that is what is stressing at the moment. But the relationship with the patient is very good...”</p> <p>“But every day, I get difficult patients. Patients are even better, relatives... They want things to happen fast. Like they arrive now they want to be attended as now...They become impatient, they don’t understand that sometimes we prioritize depending on the emergency of the patient.....even when you try to explain there’s one doctor still they don’t understand...”</p> <p>“...but relatives, it’s a problem. But people who accompany them are our biggest problem. They are too demanding and want things done their way. Otherwise patients are fine.”</p>

There seemed to be a perception that the relationship between the nurses and patients was dependent on their attitudes to form either a positive or negative relationship. Nurses associated cooperative patients as important in defining the good relationship with patients and adherence to medication. In all the participants, it appears relatives of patients were more difficult to deal with than patients. The nurse-patient relationship was tolerable and generally good. Participants mentioned relatives were too 'cheeky, disrespectful, insulting and demanding' compared to patients.

According to the Patients' Rights Charter of the Department of Health (2002) patients responsibilities are to respect the rights of other patients and health providers; to utilize the health care system properly and not to abuse it; to provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counseling purposes; and to comply with the prescribed treatment or rehabilitation procedures. Participants perceived trust as the vital aspect of the working relationship with patients. If trust is not built and maintained the risk of losing patients' and not reaching their objectives was high. Health Professions Council of South Africa (HPCSA, 2008) concurs that trust is the most basic fundamental aspect of a professional relationship between the patient and the health worker, therefore health care profession is based on a relationship of mutual trust between patients and health care practitioners.

4.4.2 Nurse-patient relationship

The majority of participants mentioned they have a good relationship with patients whereby respect for human life and confidentiality are practiced. However there were instances where patients are moody and not cooperative. The majority of participants mentioned they usually experience difficulty and problems from relatives than patients. Participants stated that patients' and relatives' 'difficult behavior' was due to long

queues, having to wait long periods to be seen by the doctor and waiting for files. This creates anger and frustrations amongst patients.

One participant mentioned:

“Other patients they are just impossible to deal with..., we fight with relatives on daily basis. They call us names, swear at us. Every frustration... they...take their frustrations on us. Doctors are not here they take their frustrations on us, swearing at us, calling us names and it’s not nice”.

“Patient can be demanding... We get difficult patient, patients are even better. Relatives are problematic; they want things to happen fast. They arrive now and want to be attended now... So they shout at us”.

“Secondly, patients come here with attitude. They say nurses are very rude. They don’t even wait that you greet them...”

Participants felt that patients do not disclose their conditions of illness and patients take time to build trust with nurses. As a result patients do not receive adequate and accurate treatment. However once the trust is built the working relationship becomes harmonious benefiting the patient and putting the nurse at ease. However, if the relationship is not built the patient might suffer resulting in patient condition deteriorating leaving the nurse with feeling of guilt and not having done enough for the patient. According to the South African National Department of Health (2010), regarding patients’ rights and responsibilities, it is the responsibility of the patient to provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counseling purposes; to advise the health care providers on his or her wishes with regard to his or her health and to comply with the prescribed treatment or rehabilitation procedures in order to receive the best treatment care. For example:

“Patients must be able to trust you and share with you. But first I need to correct my attitude. Because if I lose this patient at the beginning. I won’t reach my goal for the patient to complete his treatment. Patient must be able to trust me, because there will be issues of confidentiality where the patient must disclose his status...”

Another participant responded:

“My relationship with patient is very good. When they have established that rapport with me, they think they don’t want to go to other people, because they feel comfortable with me”.

This concurs with Mafunisa (2003) who argues that a public servant is expected to uphold integrity and trust towards his/her clients or patients and in possession of special case in this case one of building trust with patients or clients. In addition, Khoza (2010) states that practice as a health care professional is based upon a relationship of mutual trust between patients and health care practitioners. To be a good health care practitioner, requires a life-long commitment to sound professional and ethical practices and an overriding dedication to the interests of one’s fellow human beings and society (Khoza, 2010).

4.4.3 Confidentiality

Participants verbalized the importance of adhering to the principle of confidentiality with patient information. They purport that once confidentiality is breached, it is hard to build trust with the patients. Patient information is privileged and must not be shared with others. Ethically, nurses must maintain confidentiality and may only give information to third parties when the patient consents to this or when the law requires disclosure of information (Booyesen et al., 2003).

Participants stated for example:

“..the is confidentiality again where I will ask patient about their status. So it must be bond and be able to trust me.

“When you are here you need to be strict with what you are doing, especially confidentiality. That’s why relationship is so difficult because they may never trust you with the information they are giving you, maybe you can talk it somewhere.... So for the patient to trust you is very difficult.

4.4.4 Empathy

There seemed to be adherence from participants in implementing the principle of empathy when consulting with patients. This was evident in participant’s responses:

“I also try to be as comforting as possible and try to reassure them when stressed. So, so far I have not come across any bad experience”.

“..more especially during pre and post counseling, when we have new patient who don’t understand what they are going through. ...sometimes when counseling the patient you feel what the patient is going through, that also stress us”.

This concurs with Bausch and Rohan (2009) who maintain that empathy is an essential component of the helping relationship. Furthermore, Figley (1995) cited in Russel et al., (2007, p.107), suggests that “empathy and emotional energy are the underlying drivers in the development of compassion fatigue”. However, Sabo (2005) argues that little empirical evidence exists to support empathy or over caring as a sole causal factor for compassion fatigue. Therefore, more studies

need to be conducted to investigate if whether empathy may result in compassion fatigue.

4.5 Perceptions about strengths in nursing practice

4.5.1 Introduction

Participants seemed to appreciate positive experiences and feedback received from patients, relatives and colleagues. The positive experiences included personal development which involved self-development and career development, patients recovering from their illnesses and positive feedback from patients and relatives and from other colleagues and management.

4.5.2 Personal development

Personal development seemed to be valued and regarded as a positive experience by participants. This was evident when respondents mentioned:

“I have learned a lot, lot of positive growth. I did my extra advance; I did a Diploma in trauma in 2010, so those are the positive side”.

“They take us for courses to advance your career and get updated with new developments in your profession, and then you can specialize and become manager or a facilitator. Which I think is good”.

According to the South African Nursing Council (2008), policy documents on nurses rights and responsibilities states that it is the employers' responsibility and the nurses rights to education, growth and development and to keep themselves with new development and information pertaining their profession through furthering their

education at the personal level and conducting research in their scope of practice to keep up with new development in their profession. This concurs with Mafunisa (2003) that a characteristic of a professional is keeping up with the state of art i.e. continuing education is of paramount importance for the professional.

4.5.3 Patients recovering from their illnesses

The majority of participants mentioned seeing patients recovering and getting better was a positive experience for them. Participants responded:

“I get people who are actually thinking they are at the verge of dying and at the end you find they stand up and they strive to leave and really want to leave and they have positive reaction to their treatment”.

“The fact that people come here being sick, on wheelchairs, other not able to walk, talk. But after having started with their treatment, you see them walking, running, you see them talking and laughing. Those are positive experiences”.

“Is like for example, where you progress a patient and you think maybe the patient won't make it in delivering the baby normally and then at the end the patient delivers normally and get a healthy baby or you deliver the baby being flat not breathing, you know very bad, but when you resuscitate the baby with good effect. Those are good experiences”.

Only one participant did not experience any positive experience from the workplace. Participant responded:

“Here, (laughing). I just work because I have to work, there's nothing positive I see. I am always tired...”

4.5.4 Positive feedback from patients and relatives

Participants regarded positive feedback from patients and relatives as positive experience. Respondents mentioned:

“...and coming back to us and say thank you especially relatives, they do come to us that they appreciate the services they received and what not...”

“I got a positive feedback I was working with yesterday, when I hear the patient say she wished she was delivered by me because I was nice to her even if other sisters were rude to her”.

4.5.5 Positive feedback from colleagues and management

There seemed to be a good feeling and a sense of appreciation when participants receive positive feedback from other colleagues and management. One participant mentioned:

“Being appreciated by my colleagues and unit manager by acknowledging the work I do, because sometimes you get the feeling that no one cares...”.

Participants regarded acknowledgement from their colleagues as fulfilling and encouraging. It gave them a sense of belonging and acceptance. This concurs with Upenieks (2003), that nurses want to be appreciated and respected by management and doctors. They want their expertise to be recognized and to participate in decision-making processes pertaining to patient care.

4.6 Perceptions about challenges relating to nurses professional role and practice

4.6.1 Introduction

Challenges experienced varied. Participants outlined challenges experienced from that of shortage of staff and lack of working equipment as the major challenges. Other challenges included interpersonal working relationships between nurse-patient relationships, staff and management working relationship, different roles in duties performed and lastly, language as a form of communication between nurses and patients. According to the South African Nursing Council (2008), established under the Nursing Act (2005) "In carrying out his/her duty to patients, should be equipped with physical, material and personnel requirements relevant to his/her working situation to make it possible for them to provide optimal health care to patients. However, it seems the rights of nurses as stated above are being violated by the employer.

4.6.2 Shortage of staff

All participants in the three participating units mentioned they experience shortage of staff and seeing and seeing large number patient. These results to work overload in having to see many patients beyond their abilities and ratio. Consequently staff becomes tired and majority of staff members take annual leave, sick leave, family responsibility leave and long lunch and tea breaks to in order for them to rest. When there is shortage of staff service delivery is hampered leading to dissatisfaction of patients regarding the care and service received from nurses leading to stress and poor and interpersonal relationships between patients and nurses. They get tired, frustrated and burnout. They felt more staff should be hired. Participants responded:

"Sometimes having to work short staffed in the shifts...that other people are on leave others absent for whatever reason, so it becomes heavy on

us having to take care of so many patients while there's only a few of you.. staffing it's a major problem".

"We end up being very tired and when we are tired sometimes we become cheeky, but then it's upon us to understand that one is tired. It's either you go on leave try and rest and or maybe take a tea break and then come back and carry on with your work".

According to Vawda and Variawa (2012), most doctors and nurses working in public hospitals are highly stressed due to shortage of staff, unmanageable workloads and management failures which places their function in a general crisis. This result in nurses faced with pressure of work overload, physical and psychological stress, inefficiency and clinical failure caused by understaffing and consequently the reduction in the quality of care and avoidable morbidity, mortality and compromised patient care. This concurs with Pillay (2009) that the public sector is under-resourced and over-used.

4.6.3 Language barrier between patients and nurses

Participants verbalized concerns regarding communication barriers emanating from foreign patients who neither speak nor understand English and any of the official languages. This poses as a great challenge as both nurses and patients are unable to communicate. As the results patients feel discriminated against, disrespected and their constitutional and human rights violated which may result to their health compromised. The Constitution of the Republic of South Africa, (no 108 of 1996), Bill of Rights in Chapter 2, states that patients have the right to use a language of their choice and by implication to be addressed in a language they understand. In this regard, participants stated for example:

"..You find that they can't speak a word of English or any of our African languages that we use here. I think that's the challenge, ja".

“..and we struggle when it comes to language and communication. There’s a language barrier. Maybe the hospital must hire midwife who can speak some of these African foreign languages”.

4.6.4 Shortage of equipment and resources

All participants complained of the shortage of equipment, which included shortage of basic equipment such as beds, blood pressure machines, delivery trolleys. They also complained about broken equipment, and not having enough and adequate space to work. Participants responded:

“There’s a patient who’s been here is two days now, she’s waiting for a bed in psychiatric ward, there isn’t...”

“Blood pressure machines are broken. It’s not possible to offer effective care under these conditions even if we are trying our best...”

Another participant from the labor ward mentioned:

“The big challenge we have is delivery trolleys. Here at labor ward we have only two delivery trolleys, it’s a big challenge...”

This concurs with Pillay (2009) that the public sector is under-resourced and over-used. Oosthuizen (2005) adds that, it is the responsibility of hospital managements to ensure nurses have the resources to enable them to practice in a safe and efficient way. General unacceptable conditions in hospitals and a shortage of personnel put patients and nurses at risk and influence turnover rates (Oosthuizen, 2005).

4.6.5 Working space

Participants verbalized concerns regarding the limited working space and hazardous environment not conducive to work under. The space where participants work felt was too limited and not adequate and conducive to perform their duties. This exposes them and patients to health hazards. They felt the environment is not according to the occupational health and safety standards.

Respondents mentioned:

“there’s no space to resuscitate them, like one day we resuscitated a patient on a chair, you see it was serious ,...we resuscitated on a chair and that person could not make it, you see things like that...”

“The space is also too small to work from, so you can’t move around.”

Participants seemed concerned about their health and safety in the workplace. It appeared participant felt their safety and health was not prioritized. They mentioned the place they work in is not well ventilated and does not protect them from infectious diseases that may harm and affect their health. Responded mentioned:

“We are working in highly infectious area and are not protected...Sometimes we are in risk as health workers...there’s a multi-drug resistance TB, mono and normal TB, so patients defaults their treatment...and you as a health worker you were not protected”.

“We need to be protected more”.

According to Charisma Healthcare Solutions (2007), nursing staff have the right to work in an environment that is free of threats, intimidation and/or interference. Moreover, the South African Nursing Council (2008), established under the Nursing Act (2005) states

that, in carrying out his/her duty to patients, the employer has the duty to ensure the working environment is safe which is compatible with efficient patient care.

4.6.6 Conflicts amongst staff

All participants mentioned they have good interpersonal relationships with other colleagues. However like any other relationship there are always conflicts and misunderstandings, but nothing serious. The majority of conflicts are work related rather than personal issues. The participants related that some doctors are impossible to work with. They are at times demeaning and demanding. They are disrespectful and push them around. One responded mentioned:

“This thing of changing doctors keep on changing...So you getting out confused. The doctors can be pushing you around at the end of the day you are so stressed you don’t know actually what you do, because you will be trying to do your best and somebody will be pressurising you and then there’s nothing that you can do. But I don’t take things personally; I just say ok it was work”.

According to Upenieks (2003), nurses want to be appreciated and respected by management and doctors. They want their expertise to be recognized and to participate in decision-making processes pertaining to patient care. Relationships in the workplace could influence nurses decision to stay or leave, including friendship and support between colleagues and peers (Meyer, Naude & Van Niekerk (cited in Naude and McCabe 2005),

The majority of participants mentioned that working relationship amongst staff is fine. There are quarrels and conflicts but nothing serious. No physical fights were reported in all the units. Participants responded:

“We do quarrel but nothing serious we get over it, you move on. Like any other relationships, just that we disagree in certain things, but we find the way forward.”

In some instances participants mentioned they experience resistance from the porters to escort patients to their relevant wards. In wards where patients are to be admitted they have their own ways of working which are not in line with ours.

“They will tell you know we are doing routines at this time ...some of the things is not that practical but otherwise it’s ok...”

According to Meyer, Naude & Van Niekerk (cited in Naude & McCabe 2005:4), support in the workplace develops when positive relationships are built, where there is mutual respect, trust and integrity. The work environment needs to be friendly and supportive and the workplace must have a welcoming atmosphere.

4.6.7 Role clarifications and duties performed

There seemed to be a negative perception of participants around issues of management and the participants’ scope of work. Participants felt there are no clear key role responsibilities on duties performed. Participants felt they are required to perform duties not in their scope of work, such as escorting patients, cleaning the vomits of the patients whereas there are support staffs employed by the hospital to perform such duties. They felt they are forever clashing with management when it comes to problem solving issues. One participant mentioned:

“The example that is nagging me at the moment is they insist that every patient must be escorted by a nurse,.. because from where I’m sitting is not every patient that need to be escorted by the nurse,.. if you can walk in the hospital on your own I don’t see why you should be escorted to the ward by the nurse”.

4.7 Perceptions and experiences of nurses regarding stress, trauma, burn-out and compassion fatigue

4.7.1 Stress

All participants mentioned that they experience stress in their work. The stress experienced was reportedly due to shortage of staff leading to work overload, shortage of beds and equipment's, long hours, fatigue, and uncooperative patients. According to Bown (2012), high level of stress and tension experienced by doctors and health care practitioners from working under challenging conditions without adequate support compromise performance. She therefore, suggests if medical practitioners are to maximise their potential and provide the best service in patient care, support provided should match the level of stress in the job (Bown, 2012).

4.7.2 Factors leading to stress

The table below shows nurses' perceptions about factors leading to stress. This was reported to be shortage of staff, shortage of beds and equipment's, long hours, fatigue and uncooperative patients.

Table 5: Factors leading to stress

Factors	Quotations
Shortage of staff	<p>"It's not nice and sometimes having to work short staffed in a shift, other people are on leave, others are absent for whatever reason"</p> <p>"..shortage of staff. You find we are like five or six staff in a shift and sometimes we have to see more than 100 patients...."</p> <p>"...we expect to give good and effective service, is not possible, because there's only two of you, sometimes it's not possible,".</p>
Shortage of beds and equipment	<p>"..delivery trolleys we have only 2 delivery trolleys.."</p> <p>"Like I can be broad,...shortage of equipment's. No beds...we are full"</p> <p>"Patient spent about four days without beds... you can't sit with one patient, they must go to their wards..."</p>
Long hours	<p>"The hours are long, especially when you are doing nights. Our night duty is seven nights in a row and is twelve hours in a shift",</p> <p>"mmm, only when I'm working night duty. Cause it's like seven nights straight in, it's tiring".</p>
Fatigue	<p>"Now and again, you feel like you wanna quit. But it gets better".</p> <p>"Me personally, I'm burn out, I'm tired, I'm fatigued, yo we are tired most of us in the unit".</p> <p>"ya, at the end of day you feel tired and don't want anything, then you stay home.."</p>
Uncooperative patients	<p>"Patients easily give up. When you tell the person to do this and that, it's like they don't trust what you are telling them will work".</p> <p>"Because some patients even after you have spoken to them, they will still go and think their pastors in their churches can help them without the treatment, you find them bouncing back and getting ill, than what they were before.."</p> <p>"..Patients don't tell the truth about what is happening in their lives. They say they never use anything, whereas they use a whole lot of concussion of medication".</p>

Shortage of staff and shortages of equipment appeared to be a major contributing factor to participants' stress levels. The shortage of staff results in work overload and having to work long hours in overtime replacing absent colleagues. As a result participants are fatigued from their work leading to excessive absenteeism. This is supported by a study conducted Vawda and Variawa (2012), which revealed that most doctors and nurses working in public hospitals believe that public hospitals are highly stressed institutions due to shortage of staff, unmanageable workloads and management failures which place their function in a general crisis.

As a result, nurses experience physical and psychological stress, work overload, inefficiency and clinical failure caused by understaffing and consequently paving the way to the reduction in the quality of care and avoidable morbidity, mortality and compromised patient care. Uncooperative patients pose as a challenge as they put their lives at risk hampering the care provided to them by the nurses thereby the responsibility to patient and nursing care and saving lives is interfered with. However, as stated in BPP, it is the patients responsibility to take care of their health (South African National Department of Health, 2010).

4.7.3 Trauma

Participants indicated that the trauma that they experience was due to work related experiences. Participants are exposed to traumatic experiences that can often not be avoided, while there are some situations where such trauma can be averted. Describing such instances where experiences could not have been avoided included:

“You deliver a baby, the head come, then a hand, a hand then another hand. It’s very very traumatic....”

“The traumatic experience is when the patient comes and just dies in the clinic. Then they just come and die in the clinic, it’s the sad thing. And it

also traumatizes other patients, you see. They just tell themselves it means I'll be next..."

"Mhm, the traumatic experience is that sometimes the patients don't tell the truth about what is happening in their lives. Some of the patients I go there to check on them and I find they have died after a long chat in trying to give them positiveness to life and they just die..."

Geldenys (2005) warns that trauma workers and therapists should be aware of the possibility of reoccurrence of traumatic material, if unresolved. This could not only lead to therapeutic relationships being contaminated, but also the personal well-being of the trauma worker may be jeopardized (Geldenys, 2005). In describing situations where the level of trauma could have been avoided, participants stated that:

"No beds, people will get in sick and we are full and there is no space to resuscitate them. Some welike one day we resuscitated the patient on a chair, you see it was serious, cause that person we could not sent her away and that person could not make it, she died,"

"That first thing, it so bad you can see patient is laborating, experiencing excruciating pain, but now you don't have anything to give her...just to have equipment to work..."

The South African National Department of Health (2010), states that patients have the right to be treated with respect and human dignity when accessing medical care. It seems that when considering situations as these described here, are of great concern and fails to demonstrate respect to human life.

4.7.4 Burnout

Participants seemed to be experiencing burnout due to work related experiences. According Deighton, Gurriss & Traue (2007, p. 68), “burn out is not specific to work with traumatized people; however it is related to the work setting variables such as workload, overload of responsibility, lack of control over the quality of services provided and interpersonal problems at the workplace”. It is then evident that participants are at risk of experiencing burnout because of the variables such as workload and overload of responsibility as described earlier. This was evident in various responses:

“Me personally, I’m burn out, I’m tired, I’m fatigued, yo we are tired most of us in the unit.”

“Sisi, this is a fact, stress, burn out and trauma is our daily basis..”

“Burnout madam, it’s there, it’s too much..”

According to Geldenhuys (2005), it is possible but not certain, that any trauma counselor or counseling professional may suffer from compassion fatigue, burnout or both.

4.8 Coping strategies in dealing with challenges in the workplace

4.8.1 Negative coping mechanisms

There seemed to be a negative sequence of patterns when it comes to participants’ coping mechanisms in dealing with challenges faced at work. These patterns included abuse of leave leading to absenteeism and perpetuating the challenge of shortage of staff, lashing out and intake of alcohol, taking their experiences at home and not having

any coping mechanisms. To illustrate this, some examples of participants' views included:

"Ya, at the end of day you feel tired and don't want anything, then you stay home, which creates absenteeism cause you are tired. For you to recover then come back..."

"Eey, most of us we end up loafing, other people resort being absent at work, taking on leaves, family responsibility leaves, sick leaves and what not. So basically, we just stay away at home...."

Other negative coping mechanisms used by participants were intake of alcohol and lashing out.

"I drink, (laughing), but I don't come to work drunk".

"..eish, sometimes in a negative way, sometimes you shout back..."

Participants responded in order to cope with challenges and stressful experiences at work they take it to their homes. Their responses were:

"So we are coping with our stress. You'll see it at home when asleep".

"You become ok. Cause after that bad experience that you have, you go home to your kids, to your own place and then, you rewind..."

Du Plessis (2001) states that employees and their families should be assisted in adjusting to the demands of the workplace and their ability to cope with work related stress, interpersonal conflict in the workplace and the negative spillover of work stress into the family. Some participants that did not know how to cope responded:

“You just cope yourself. Otherwise you don’t attend any classes for that. You try best yourself”.

“Don’t have any coping mechanisms...”

4.8.2. Positive coping mechanisms

In order to cope with challenges experienced in their workplace, participants mentioned share experiences to one another as a form of debriefing and ventilation, whilst others depend on their religion and spirituality to cope with their challenges and experiences. There seemed to be very few instances whereby participants’ positive coping mechanisms were experienced in the workplace setting. This can also be linked to the limited availability and accessibility to employee wellness programmes to enable participants cope with challenges experienced in their work place. According to Luthan (2002) little is done in dealing with psychological stress, risk analysis and occupational stress interventions in the workplace.

4.8.3 Debriefing

There seemed to be no formal structured debriefing sessions participants attended to enable them cope with their challenges. However, they utilized their tea breaks and lunch breaks to share their experiences with one another to help them cope and ease anxiety. This was evident in various responses:

“We have our session where we sit, talk and laugh and that eases the stress. But most of the time is talking, sharing and we talk amongst ourselves. This is how we debrief”.

“We talk about things in our shifts. Just talking to your colleagues, we share...”

“You just debrief about talking to your colleagues”.

4.8.4 Employee Wellness Programmes

There seemed to be incongruence in the availability and the usage of Employee Wellness Programmes. Some participants had no knowledge of the availability of Employee Wellness Programme whilst others had the knowledge. However, none of the participants utilized such a programme or had knowledge of someone who used the programme. Participants responded:

“Ja, we’ve got like a wellness programme whereby we get referred to when they notice you got some kind of like absenteeism, a lot of social issues, alcohol related problems, they refer you there and they can assist you”.

“There is no programme like this Employee Assistant Programme. I don’t know of one. Maybe it’s there but I don’t know of it”.

“We know exactly where to go, but it’s so difficult. I don’t know we don’t even think about it., or wellness programmes only when one has break down jait’s difficult”.

According to Rajin (2012), EAP programme addresses psychological and physical problems, work-related stress, chemical dependency (alcohol and drugs), depression, marital and family problems, financial problems, health, anxiety, and even job boredom. These programmes to assist employees to cope with workplace demands and to overcome the difficulties that are work related.

4.8.5 Religion and spirituality

Religion and spirituality seemed to play a vital role in helping participants cope with stress and trauma experienced in their workplace. Participants mentioned:

“That really makes me to cope. I am a religious person, so I go to church, I meditate on the word of God”.

“I pray, read the bible, the word of God...”

According to Kahle (2004), in studies relating to mental health, people who are more religious show a greater sense of wellbeing and satisfaction with life, furthermore actively religious people are less depressed, less anxious and are less likely to commit suicide (Kahle, 2004).

4.8.6 Improvement of service delivery and nursing care

Table 6: Nurses perceptions on how service delivery can be improved

Factors	Quotations
Support to staff	<p>“Hmm, I think support....support staff. We don’t get as much support as we need, as required”.</p> <p>“I think the hospital must have some sort of programmes who will also assist us and give us support. Cause so far we don’t have support. Its work, work, work”.</p> <p>“We do have monthly meetings in our unit with our unit manager to discuss those problems. Even maybe you complain to her that there’s a certain doctor doing this and that and don’t like, she try to confront those doctors”</p>
Employee Wellness Programmes and debriefing	<p>“..then the very staff giving the care should be cared for. For instance debriefings and employee wellness programmes, these are the things that would actually help the staff to cope...”</p> <p>“I think we also need programmes to help us cope with our daily stressors experienced at work. I heard of employee wellness programmes, but I don’t even know how to excess them. So I think we need more awareness on it”.</p>
In service training	<p>“Do thorough, thorough workshops to train people to go back to the basics”.</p> <p>“They have to train. Same to midwives”.</p>

	<p>“What else can be done, even the in service trainings. We should have more in service trainings so that we are also empowered.....”</p>
Employ staff	<p>“More staff must be hired. They must start with the shortage of staff...”</p> <p>“Having more staff...so that patient can get that quality care from nurses”.</p> <p>“There must be enough staff, so that they can reach to those people’.</p>
Salary increment	<p>“..but the problem nurses is the salaries are not attractive, that why people are leaving...”</p> <p>“People will always say, nursing is a calling. It is a calling, but that person needs to eat....when I’m happy, then my job will be excellent”.</p> <p>“...but the salaries are not attractive, that’s why people are leaving in numbers”.</p>
Adequate and efficient equipment	<p>“..even equipment, and stock for us to work”,</p> <p>“To be supplied with more equipment...”</p> <p>“..Enough equipment. Sometimes you find only two monitors are working. Enough equipment and staff, we can cope...”</p>

Participants felt in order to improve service delivery, more nurses and support staff needed to be employed and the provision to adequate and proper working equipment’s and instruments. Participants felt a great need to receive support on work related and private matters impacting on their job performance and productivity.

The programmes such as ‘caring for the carers’ and Employee Wellness Programmes by qualified professionals should be provided, available and accessible. This concurs with the views of Du Plessis (2001, p.89) that in “industrial social work also known as occupational social work, the focus would be on the person-as-employee, employee as a person and the unit of need may extend to the organization in which systemic and

procedural changes may be indicated". The basic skills on primary health care seem to be fading away.

Participants felt a need for in service training to remind them of basics. Lastly, although the Occupation Salary Dispensation (OSD) was implemented to address issues of salaries on public servants, participants felt nurses salaries need to be looked into as more nurses still leave the public hospitals to private hospitals as salaries are more attractive compared to the public hospitals. According to (Dhai et al., 2011), in 2010, healthcare sector striking occurred influenced by poor salaries, deterioration of academic facilities, poor working conditions in the public sector and the unfortunate conditions facing patients at public health facilities. Furthermore, Pillay (2009) states that public sector nurses are mostly dissatisfied with their pay, the workload and the resources available to them.

CHAPTER FIVE: SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of main findings

5.1.1 Introduction

The main aim of the study was to explore the experiences of nurses regarding the services they offer in a public hospital in Johannesburg. By reviewing relevant literature and theory in this field and through analyzing and interpreting the data obtained through the semi-structured interviews with participants from the hospital, the overall aim was achieved. The perceptions of the participants in the course of their work ranged from positive and rewarding experiences through to difficult, unsatisfactory and frustrating experiences. This section will summarise the findings in terms of the overall aim and objectives stated earlier.

5.1.2 Perceptions of nurses about their experiences of the care and roles they offer

The study found that participants felt that they often performed duties in their units, which did not relate to their core functions and performance requirements. They were not sufficiently focused on their key core functioning as per their job description and performance agreement. The roles were both unpleasant and positive. Unpleasant roles included amongst others acting as cleaners, porters, escorting staff and the answering of telephones. Positive roles were educators, role modeling, careers and motivators, giving support, leadership and role modeling. As a result, due to negative roles participants felt frustrated and overwhelmed. However, with regard to positive roles, participants felt good and fulfilled, motivated and a sense of accomplishment.

5.1.3 The quality of relationships between nurses and their patients

The study showed that relationships between patients and nurses differed from one individual to another. The relationships were dependent on the ability to create and allow for positive or negative relationships. Participants linked the bad attitudes of patients towards nurses to patient's frustrations which related for example to long queues, shortage of staff, having to wait for files for a long time and spending long hours waiting in the hospital to be attended to by health professionals.

The study revealed that nurses seemed to empathize with patients' experiences. Participants viewed cooperative patients as having good attitudes to them which set the tone in defining the relationship between the two. The study showed that patients' relatives were the more difficult to deal with compared to dealing with patients' negative attitudes. Patients' relatives were described as often being more demanding, disrespectful, using vulgar language towards nurses and being impatient. Participants perceived trust and confidentiality as the most vital aspect of the working relationship with patients as without such trust a good relationship was not possible.

5.1.4 Perceptions of nurses about the care and the roles they offer in a public hospital.

The study revealed positive feedback from patients, relatives and colleagues about their services. Seeing patients recovering from their illnesses uplifted participants' morale and self-esteem. Moreover, it gave participants a sense of job satisfaction, sense of belonging and achievement. Participants valued personal development and growth in their profession, however felt there was not enough in service training for staff development.

The study revealed challenges experienced by participants varied in various degrees. The challenges experienced by participants were shortage of staff and working equipment's, and unmanageable work load. As a result, participants felt overworked,

fatigued and less productive. This resulted in poor service delivery and created dissatisfaction among patients regarding the care and services received from nurses. Shortage of staff also leads to poor working interpersonal relationships amongst staff as stress levels are high. Nurses do experience conflict amongst one another, albeit only minimally. Conflicts tend to be more work related than personal.

Participants were also frustrated by the language barrier between themselves and patients who could not speak any of the South African official languages. Most of these patients come from other parts of the African continent. Participants are working under hazardous, highly infectious areas and unsafe working environment. The hazardous working environment exposes nurses to health hazards posing a greater risk to their health.

5.1.5 Nurses perceptions of stress, compassion fatigue and burn out and their coping strategies in dealing with these.

The study found that stress experienced by participants was due to shortage of staff, work overload, shortages of equipment, long hours and uncooperative patients who do not adhere to medication putting their lives and those of others in danger. Participants reported a relationship between shortage of staff, work overload, long hours and high rate of absenteeism which resulted in burn out and compassion fatigue. However, the study did not find a clear indication that participants were suffering from compassion fatigue. Participants did however report that they experienced trauma as part of their daily work. In spite of this, it seemed that there were no formal debriefing programs and that generally, nurses did not attend Employee Wellness Programmes from Occupational Social Workers. These programmes were reportedly not visible and accessible. The study further revealed that whilst some nurses had positive coping skills to deal with challenges from work, other nurses resorted to substance abuse whilst others had no idea on how they were coping. This was a concern as it seemed that

participants were unaware of the risks associated with future compassion fatigue and burnout.

5.2 Conclusions

The study found that participants perceived there to be problems with understaffing, overwork unmanageable workloads, long working hours and limited resources. They also reported that they work under stressful conditions due to shortage of equipment and working environments that expose them to health hazards. Nurses perform multiple tasks, roles and responsibilities, in the process neglecting their core functions resulting in poor service delivery. Therefore nurses are overworked, fatigued, less productive and at some point de-motivated. Nurses felt these challenges have been ongoing with no improvement. However, they still hope their working conditions would improve.

Participants felt frustrated by the multiple roles they perform as well as a shortage of staff. The poor nurse-patient and relative relationship was perceived to be the result of poor quality services, beyond the nurse's control as well as difficult working conditions. Most of these challenges points to the shortage of staff.

Both the rights and responsibilities of patients and nurses still need to be upheld and practiced, taking into account that nurses have the responsibility to uphold and adhere to the profession code of conduct. The protection of nurses from angry and frustrated patients and relatives was of concern. Nurses often felt disrespected and disregarded by patients' relatives. However, patients and the relatives' frustrations were acknowledged by nurses and empathize with.

Regarding language barriers between nurses and patients, nurses acknowledged the challenges faced from language barrier when communicating with patients from other African countries. Nurses felt a great need to learn some of the African languages

especially French and Portuguese as these groups had difficulty in speaking South African official languages.

Participants also identified a need for debriefing sessions conducted by professionals and the need to attend Employee Wellness Programmes as the need arises. There is a need for such programmes to be clearly defined and more information disseminated to the nurses. The hospitals also need to begin to utilize Occupational Social Work in conducting Employee Wellness Programmes to all employees. These services should be clearly defined, marketed and accessible.

Despite challenges encountered by participants, participants maintained positive attitude towards the call for their profession. Participants still managed to find fulfillment in their jobs every time a life is saved and seeing patients recovering from their ill health. Participants still maintained the spirit of team work and cohesion pulling together with a vision and mission to save lives and striving to abide by the code of ethics. It is no doubt the government in its efforts to address challenges experienced nationwide in the health care system particularly public hospital, will be fair to note visible outcome. It is therefore envisaged that the ideal transformation in the public health hospital in addressing both the needs of the health care provider and service user may be achieved.

In an attempt to address these challenges the Occupation Specific Dispensation (OSD), a financial incentive strategy, was implemented in 2007, with an intention to attract, motivate, and retain health professionals in the public sector. The policy was fully implemented but failed to produce the intended desired outcomes. In addition, the national health system has a myriad of challenges, among these being the worsening quadruple burden of disease. It is a well-known factor that our health system is inequitable, inherited from the apartheid regime. The public health system in particular, is deteriorating and underperforming with attribute to poor management, underfunding, poor infrastructure and shortage of key human resources. In an attempt to remedy the

situation, the state is in the process of introducing the National Health Insurance, commonly referred to as NHI, to address inequality and to ensure that everyone has access to appropriate, affordable, efficient and quality health care irrespective of their socio-economic status.

5.3 Recommendations

Recommendations for the Department of Health

The Department of Health need to address the significant staff shortages that have a severe impact on nursing staff and their ability to perform their duties adequately.

Occupational Social Workers have an important role to play and should be employed by the Department of Health to offer Employee Wellness Programmes and work on organizational problems within the health care setting. These services must be visible and accessible to the hospital staff.

Nursing staff are exposed to significant challenges and risk of occupational stress and burnout. Their working conditions should be regularly monitored and assessed in order to ensure their ongoing ability to cope and provide quality services

Recommendations for health care facilities

There is an urgent and dire need to address the shortage of working equipment by providing adequate and reliable working equipment for effective and efficient service delivery.

Awareness and educational programmes need to be conducted to educate communities on the rights and responsibilities of patients and nurses through media such as television, radio talk shows and newspapers.

Recommendations for further research

Research investigating challenges faced by the health care system to address shortages of staff and the under resourcing of facilities needs to occur.

More extensive research should be conducted among health care professionals regarding stress, burnout and compassion fatigue and how this impacts on their service delivery.

REFERENCE LIST

Ahmadi, K., Reidpath, D.D., & Allotey, P. (2013). Professionalisation and social attitudes: A protocol for measuring changes in HIV/AIDS-related stigma among healthcare students: *Journal of Advanced Nursing*, 3(5) 7-18, doi: 10.1136/bmjopen-2013-002755.

Anandarajah, G., & Hight, E. (2001). Spirituality and medical practice: Using HOPE questions as a practical tool for spiritual assessment. *Journal of Family Physician*, 63(1), 81-86. Retrieved from <http://www.aafp.org>.

Ataguba, J.E., & Akazilli, J. (2010). Health care financing in South Africa: Moving towards universal coverage. *CME*, 28(2), 74–78.

Baird, S., & Jenkins, S.R. (2002). Secondary traumatic stress and vicarious trauma: A valid study. *Journal of Traumatic Stress*, 15(5), 423-432.

Babbie, E. (2005). *The basics of social research*. Belmont, CA: Thomson Wadsworth.

Batho Pele Principles. (2013). Eight Batho Pele Principles to kick start the transformation of service delivery. Department of Social Development: Limpopo. Retrieved from <http://www.dssl.limpopo.gov.za>

Bausch, J., & Rohan, E. (2009). Climbing Everest: Oncology work as an expedition in caring. *Journal of Psychosocial Oncology*, 27, 84-118.

Benatar S.R. (1997). Health care reform in the new South Africa: *Journal of Medical*, 33(6), 891-95.

Bessinger, M.E. (2006). *The Development of a model for an Employee Wellness Programme for a fast moving consumer goods organization* (Unpublished Master's thesis). University of Pretoria, Pretoria, South Africa.

Booyesen, L., Erasmus, I., & van Zyl, M. (2003). *The Auxiliary nurse*. Pretoria: Juta.

Boeree, R. (1998). Maslow's hierarchy of needs. Retrieved from <http://www.ship.edu/~cgboeree/maslow.html>. 2009.06.13

Bown, S. (2012). The "pressure point": Africa case book. *Medicolegal Journal*, 20 (3). Retrieved from <http://www.medicalprotection.org>

Buchan J. (2006). Evidence of nursing shortages or a shortage of evidence: *Journal of Advanced Nursing*, (5)6, 457–458.

Buchan, J., & Aiken, L. (2008). Solving nursing shortages: A common priority. *Journal for Clinical nursing*, 17(24), 3262-3268. doi:10.1111/j.1365-2702.2008.02636.x.

Butler, I. (2002). A code of Ethics for Social Work and Social Care research: *Journal for Social Work*, 32920, 239-248. doi: 10. 1093/bjsw/32.2.239

Charisma Healthcare Solutions (2007). *Aspiring to attain excellence through serving others*. The Charisma Orientation Workbook (2007). Pretoria.

Creswell, J. W. (2008). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Thousand Oaks, CA: SAGE Publications.

De Vos, A.S., Strydom, H., Fouche', C.B., & Delport, C.S.L. (2005). *Research at Grass Roots for the Social Sciences and Human Service Professions*. (3rd Ed.). Pretoria: Van Schaik.

Deighton, R.M., Gurrus, N., & Traue, H. (2007). Factors affecting burnout and compassion fatigue in Psychotherapists treating torture survivors: Is the therapist's attitude to working through trauma relevant. *Journal of Traumatic Stress*, 20(1), 63-75.

Department of Health. (2013). Nursing Act, 2005 (Act No.33 of 2005)

Du Plessis, A. (2001). *Global perspectives in Occupational Social Work in PR. Maiden (Ed) Global Perspectives of Occupational Social Work*. New York, United States of America: Haworth Press.

Dyer, J. (2007). How does spirituality affect physical health? A conceptual review. *Holistic Nursing Practice*, 21(6), 324-328. Retrieved from <http://globalhealth.washington.edu/docs/bezruchka%201.pdf>

Els, D. (2005). *Wellness: A pig's life. First behaviour-based wellness book*. Pretoria: MC Printers.

Employee Assistance Programme Handbook. (Online). 1999. Consul Research Corporation. Http://www/consad_com/eap/htm. 18 April 2008.

Emmons, R.A. (1999). *The Psychology of ultimate concerns: Motivation and Spirituality in personality*. New York: Gilford Press.

Figley, C.R. (1995). Beyond the victim: Secondary traumatic stress. In R.J. Kleber., C.R, Figley, & B.P.R. Gersons (Eds.), *Beyond trauma: Cultural and societal dynamics* (pp.75-98). New York: Plenum.

Fitch, A. (1997). The relationship among spirituality, religion, ideology and personality. *Journal of Psychology and Theology*, 25(2), 208-213.

Geldenys, E. (2005). *Organizational Responses to compassion fatigue and burnout in trauma counselors: A multi-organizational investigation* (Masters Research report). University of the Witwatersrand, Johannesburg. South Africa.

Gersh, M.R. (2006). Servant leadership: A philosophical foundation for professionalism in physical therapy. *Journal of Physical Therapy Education*, 20(2), 12-16.

Gillespy, G. (2012). Disclosing patient records: Africa casebook. *Medicolegal journal*, 20 (3), 6-7. Retrieved from <http://www.medicalprotection.org>.

Grinnel, R.M & Unrau, Y.A. (2010). *Social Work Research and evaluation: Foundations of Evidence based Practice*. Oxford University Press: USA.

Haegert, S. (2000). An African Ethic for nursing. *Nursing ethics* 7(6) 492-501

Harrison., A. & Zohhadi, S. (2005). Professional influences on the provision of mental health care for older people within a general hospital ward: *Journal of Psychiatric & Mental Health Nursing*, 12 (4), 472-480.

Hepworth, D.H., Rooney, R.H., Rooney., D.G., Strom-Gottfried, K., & Larsen, J. (2010). *Direct Social Work Practice. Theory and Skills*. Brooks/Cole: USA.

Herbst, M.C. (2013). Position statement on patient rights including the rights of caregivers. Retrieved from <http://www.cansa.org.za/position-statement-patient-rights-caregivers-sept-2013.pdf>.

Health Professions Council of South Africa. (2008). Health Professions Act No.56

Hickman, J.S. (2011). Fast facts for the faith community nurse. Implementing FCN/parish nursing in a nutshell. Springer, USA: NY.

Hill, P.C. (2003). Advances in the conceptualization and measurement of religion and spirituality in personality: Implications for physical and mental health research. *American Journal Psychology*, 58(1), 64-74.

Hugman R. (2005). *New approaches in Ethics for the caring Professions*. Palgrave Macmillan: Basingstoke

Industrial Health Research Group and the South African Municipal Workers Union. (2005). Who cares for health care workers? The state of Occupational Health and Safety in municipal health clinics in South Africa: retrieved from <http://www.municipalservicesproject.org/sites/default/file/papersNo8-o.pdf>.

Jewkes, R., Abrahams N., & Mvo, Z. (1998). Why do nurses abuse patients? Reflections from South African Obstetric services. *Soc.Scl Med*, 47(11), 1781-1795

Kaestner, R. (2005). An overview of public policy and the nursing shortage: *Journal of Nursing Administration*, 35(1), 8-9.

Kahle, P.A. (2004). *The power of Spirituality in therapy. Integrating Spiritual and Religious beliefs in mental health practice*. New York, N.Y: Haworth Pastoral Press.

Karim, Q. (2009, April 16). SAHRC: Government failing in health care provision. Mail & Guardian: Africa's best read, p.1. Retrieved from <http://mg.co.za/article>.

Kaufert, J.M., & Putsch, R.W. (1997). Communication through interpreters in healthcare: Ethical dilemmas arising from differences in class, culture, language, and power. *Journal of Clinical Ethics*, 8, 71-87.

Kelly, E. W. (1995). *Spirituality and Religion in Counseling and Psychotherapy. Diversity in Theory and Practice*. Alexandria, V.A: American Counseling Association.

Khoza, V.L., Du Toit, H.S., & Roos, J.H. (2010). Implementation of the "Batho Pele" (people first) principles in one public hospital in South Africa: Patients' experiences. *Africa Journal of Nursing and Midwifery*, 12(2), 58-68.

Kruger, A., & Van Breda, A.D. (2001). "Military Social Work in the South African National Defence Force", 166 (11), 947-951

Lewins, R.J.R. (2007). *Researching Social Life*. University of the Witwatersrand.

Lines, D. (2006). *Spirituality in counseling and Psychotherapy*. London: Sage.

Luthans, F. (2002). The need for and meaning of positive organizational behaviour. *Journal of Organizational behaviour*, 23, 695-706.

Lundstrom, L., Pugliese, G., Bartley, J., Cox, J., & Guther, C. (2002). Organizational and environmental factors that affect worker health and safety and patient outcomes. *Journal of infection control*, 30(2), 93-106, doi: 10:1067

Mafunisa, M.J. (2003). The Professional Public Servant. School of Public Management and Administration. University of Pretoria. *SDR*, 2(2), 62-64.

Mafunisa, M.J., & Kuye. J.O. (2003). *Responsibility, accountability and ethics: The case of public service leadership*. School of Public management and Administration: University of Pretoria.

Maslach, C. (1993). *Burnout: a multidimensional perspective*. Washington, DC. USA: Sage.

Maslow, A.H. (1968). *Toward the psychology of being* (2nd Ed.). Litton Educational, Publication: N.Y.

Matoti, Z. (2011). *Public Service principles of South Africa brought under microscope*. Retrieved from: <http://www.sa-polsci.com>. 2011/11/21.

Maxwell, J.A. (2013). *Qualitative research design* (3rd ed.). Thousand Oaks, CA: Sage.

Mbana, P.J. (2005). *A Social Work Study on the impact of legislation on the practice of Employee Assistance Programmes in the South African Mining industry*: MSD dissertation, University of Pretoria.

Mbana, P. 2005, *A social work study on the impact of legislation on the practice of employee assistance programmes in the South African mining industry*, MSD dissertation, University of Pretoria, Pretoria. Retrieved from <http://upetd.up.ac.za/thesis/available/etd-05062009-153805>.

McDonald, D.A. (2000). Spirituality: *Description, Measurement and Relation to the five factor Model of Personality*, 68(1), 153-197.

Mackay, J., Cousins, R., Kelly, P.J., Lee, S., & McCaig, R.H. (2004). Management standards and work-related stress in the UK: Policy background and science. *Work & Stress*, 18, 91-112.

Meyer, S., Naude, M., & Van Niekerk, S.E. (2004). *The Nursing Unit Manager: A Comprehensive Guide*. Heinemann, Sandton: South Africa.

Mulaudzi, F.M., Libster, M.M., & Phiri, S. (2009). Suggestions for creating a welcoming nursing community: Ubuntu, cultural diplomacy and mentoring. *International Journal Human Caring*, 13(2), 46-52.

Moodley, R., Sutherland, P., & Oulanova, O. (2008). Traditional healing, the body and mind in psychotherapy. *Counselling Psychology Quarterly*, 21(2), 153-165.

Mokoka, E., Oosthuizen, M.J., & Ehlers, V.J. (2010). Retaining professional nurses in South Africa: Nurse managers' perspectives. *Health SA Gesondheid* 15(1), 484-497. doi: 10.4102

Monyakane, M.E. (2007). *An Evaluation of the Transformation of Public Service Delivery through the Development of Administrative Justice in South Africa*. Cape Town: University of Stellenbosch

Naicker, S. (2010). *Perceptions of Psychologist regarding the use of Religion and Spirituality in therapy*. Nelson Mandela Metropolitan University.

National Department of Health. (2010). Patients' Rights Charter. Retrieved from: <http://www.doh.gov.za/docs/legislation/patientsright/charte.html>

National Patients' Rights Charter. (2008). Guidelines for good practice in the Health Care Professions. [Booklet.3]. Health Professions Council of South Africa

Naude, M., & McCabe, R. (2005). "Increasing retention of nursing staff at hospitals: Aspects of Management and Leadership." *Australian Bulletin of Labour*, 31(4), 422-435.

Ngidi, T.L., & Dorasamy, N. (2013). Challenges on application of Batho Pele Principles: A case study of Department of Home Affairs, Durban Regional Office. *Journal of Sociology*, 10 (1).

Oosthuizen, M.J. (2005). *An analysis of the factors contributing to the emigration of South African nurses* (unpublished D Litt et. Phil thesis). University of South Africa, Department of Health Studies

Paasche-Orlow, M.K., Schillinger, D., Greene, S.M., & Wagner, E.H. (2006). *How Health Care Systems can begin to address the challenge of limited literacy: J Gen Intern Med, 21(8), 884–887. doi: 10.1111/j.1525-1497.2006.00544.x*

Patients' Rights Charter of the Department of Health, (2002).

Pargament, K.I. (1997). *The Psychology of Religion and Coping. Theory, research and practice*. New York: Guilford Press.

Parker, M. (1998). *Ethics organizations*. London Publications: New Delhi.

Pillay, R. (2009). *Work satisfaction of professional nurses in South Africa*. Retrieved from <http://www.human-resources-health.com/content/7/1/15>.

Polanski, P.J.L. (2002). Exploring spiritual beliefs in relation to Adlerian Theory: *Counseling and Values*, (46), 127-136.

Puchalski, C., Ferrell, B., Virani, R., Otis-Green, S., Baid, P., Bul, J., Chochinov, H., Handzo, G., Nelson-Becker, H., Prince-Paul, M., Pugliese, K., & Sulmasy, D. (2009). Improving the quality of spiritual care as a dimension of palliative care: The report of the consensus conference. *Journal of palliative medicine*, 12 (10). doi: 10.1089=jpm.2009.0142

Rajin, J. (2012). *Employee Assistance Programme in South African police service: A case study of Moroka police station*. Unpublished Mtech in public administration. University of South Africa. Retrieved from <http://uir.unisa.ac.za>

Relf, M.V., Laverriene, K., Devlin, C., & Salerno, T. (2009). *Ethical beliefs related to HIV and AIDS among nursing students in South Africa and the United States: A cross – sectional analysis*. Duke University, School of Nursing: Durham. USA.

Republic of South Africa. (2003). National Health Act, No.61 of 2003. Pretoria: Government Printers.

Richardson, R., & Thompson, M. (1999). *The Impact of People Management Practices on Business Performance: A Literature Review*. London: Institute of Personnel and Development.

Rossouw, D., Prozansky, M., Burger, M., du Plessis, C., & Van Zyl, M. (2006). *Ethics for accountants and auditors*: Revised edition. Cape Town, South Africa: Oxford University.

Rothmann, S., Steyn, L., & Mosterk, K. (2006). Job stress, sense of coherence and work wellness in an electricity supply organization. *South African Journal of Business Management*, 36 (1), 55-63.

Rothmann, S., & Rothmann J.C. (2006). *The South African Employee Health and Wellness Survey: User manual*. Potchefstroom: Afriforte

Roos, A., Kleingeld, C., & Bisogno, D. (2010). *Integrated trauma, counseling and coaching programme for victim empowerment. Training programme for social workers*: NICDAM.SA.

Rowe, K., & Moodley, K. (2013). Patients as consumers of healthcare in South Africa: The ethical and legal implications. *BMC medical Ethics*, 14:15. doi: 10.1186/1472-6939

Rowlands, G. (2012). Health literacy and public health: a framework for developing skills and empowering citizens. *Perspect Public Health*, 132(1), 23-24.

Russell, R.F., & Stone, A.G. (2007). A review of servant leadership attributes: Developing a practical model. *Journal for Leadership and Organization Development*, 23(3), 45–157.

Sabo, B.M. (2005). Compassion fatigue and nursing work: Can we accurately capture the consequences of caring work? *International Journal of Nursing practice*, (12), 136-142.

Shank, G. (2002). *Qualitative Research. A Personal skills approach*. New Jersey: Merrill Prentice Hall.

Sieberhagen, C., Rothmann,S., & Pienaar, J. (2009). Employee health and wellness in South Africa: The role of legislation and management standards. *SA Journal of Human Resource Management/SA Tydskrif vir Menslikehulpbronbestuur*, 7(1), 144-153. doi: 10.4102/sajhrm.

Smit, R. (2005). HIV/AIDS and the workplace. Perceptions of nurses in a public hospital in South Africa. *Journal of advanced nursing*, 51(1), 22-29.

Siminoff, L.A., Erlen, J.A., & Lidz, C.W. (1991). Stigma, AIDS and quality of nursing care: State of the science. *Journal for Advance Nursing*, 16(3), 262-269.

South African Nursing Council. (2008). Established under the provisions of the Nursing Act, (2005). Retrieved from <http://www.sanc.co.za>

South African Medical Association. (2012). Retrieved from <http://www.samedical.org/health-policies.html>

South Africa. Department of Public Service and Administration. (1997). White Paper on Transforming Public Service Delivery. (Batho Pele White Paper). Gazette No.18340. 1 October. Pretoria: Government Printer.

South Africa Republic (1996). The Constitution of the Republic of South Africa (Act 108 of 1996). Pretoria: Government Printer.

South Africa Yearbook, 2009/2010

Stellman, JM, (1998) "Overview of Chemical Hazards in Health Care," *Encyclopaedia of Occupational Health and Safety*, 4th edition, International Labor Office, Geneva Switzerland, 97.47, 1998.

Surlis, S., & Hyde, A. (2001). HIV-Positive patients' experiences of stigma during hospitalization. *Journal of the Association of Nurses in AIDS Care*, 12(6), 68-77.

Swanepoel, M. (2011). Human Rights that influence the mentally ill patient in South African Medical Law: A Discussion of Sections 9 (2011) PER 48; 27; 30 and 31 of the Constitution (2011) PER 41;

Thorne, S. (2000). Data analysis in qualitative research. *Evidence-based Nursing*, (3), 68-70.

The International Marketing Council of South Africa. Retrieved on 09th July, (2010).

Ethics Human Rights. (2008). Retrieved October 7, 2008, from <http://www.nursingworld.org/>

Upenieks, V. (2003). The interrelationships of organisational characteristics of magnet hospitals: Nursing leadership and nursing job satisfaction. *The health care manager*, 22 (2), 83-99

Van Breda, A. (2009). The Scope of Occupational Social Work Practice in South Africa. *The Social Work Practitioner-Researcher*, 21 (3), 284-297

Van den Heever, A.E., Poggenpoel, M., & Myburgh, C.P.H. (2013). Nurses and care workers' perceptions of their nurse-patient therapeutic relationship in private general hospitals, Gauteng, South Africa, *Health SA Gesondhei*, 18(1), 727-734. <http://dx.doi.org/10.4102>.

Van Rensburg, H.C.J. (2004). *Health and health care in South Africa*. Pretoria: Van Schaik

Vawda, Y.A & Variawa, F. (2012). Challenges confronting health care workers in governments ARV rollout: Rights and responsibilities. *Law Journal*, 15(2). Retrieved from <http://dx.doi.org/10.4314%2Fpelj.v15i2.17>.

Verghese, A. (2008). Spirituality and mental health. *Indian Journal of Psychiatry*, 50, 233-237. Retrieved from <http://www.indianjpsychiatry.org/text.asp>

Wagner, A.R. (2006). *Spiritual and religious pathology in childhood and adolescence. Childhood and adolescence*. Thousand Oaks California: Sage Publications. Inc.

Watson, J. (2000). Philosophy, Science and Theory of Human caring as a conceptual framework for guiding community health nursing practice. *Adv. Nurs*, 23(2), 34-49.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in theory and method*. Burckingham: Open University Press.

<http://www.dpsa.gov.za/batho-pele/principles.asp>. Retrieved on 4th July, (2010).

<http://www.sanc.co.za/policyrights>. The South African Nursing Council, Retrieved on 7th August (2010).

<http://www.southafrica.inf/about/health/health.htm>.

APPENDIX A

RE: REQUESTING PERMISSION TO CONDUCT A RESEARCH STUDY AT YOUR ORGANISATION

Dear Sir or Madam:

My name is Ntando Segnon. I am a Masters Occupational Social Work student doing my final year at the University of the Witwatersrand. As part of the University requirement, I am expected to conduct a research study and I would like to conduct the study at your hospital. My research topic is about the experiences and perceptions of nurses working in a public hospital in Johannesburg regarding the care and treatment they offer to patients. The objectives of the study are to understand the perceptions and experiences of nurses in a public hospital about the care they offer to the patients; to explore the quality of the relationship between nurses and patients in public hospitals; and to explore the perceptions of patients about the working conditions of nurses in public hospitals and how these impact on service delivery.

The researcher will conduct interviews to twenty nursing staff during their lunch break in their wards. These nurses will be selected because they are employed at the identified public hospital and therefore have an experience of working with patients directly in their wards.

I would like to state that participants' information will be treated with respect and confidentiality. The research report of the study with its findings will be made available to you when completed. If requested, the researcher will also present the findings in the nurses' forum held by the health department after the study has been completed. Therefore in order to proceed with the study, I kindly request your written permission to conduct the study at your organisation.

Your cooperation in this regard will be highly appreciated

For any further additional information, I can be contacted on 079 296 8156 my supervisor Mrs. Linda Smith at 011 717-1592 or 082 325 7079.

Yours faithfully

Ntando Segnon

APPENDIX B

THE EXPERIENCES AND PERCEPTIONS OF NURSES WORKING IN A PUBLIC HOSPITAL IN JOHANNESBURG REGARDING THE SERVICES THEY RENDER TO PATIENTS.

PARTICIPANT INFORMATION SHEET

Dear Sir/Madam

My name is Ntando Segnon and I am a Masters student registered for the Master's degree in Occupational Social Work. I would like to invite you to participate in my research study. As part of the requirement of my degree, I am conducting a study on the experiences and perceptions of nurses working in a public hospital in Johannesburg regarding the care and treatment they offer to patients.

Your participation is entirely voluntary and refusal to participate in the study will not disadvantage you in any way. There are also no rewards for participating in the study. If you agree to participate, I will interview you privately in an interviewing room. The interview will last for approximately 45 minutes. You may withdraw from the study at any time and you may also refuse to answer any questions that you feel uncomfortable with answering.

With your permission, the interview may be tape-recorded. No one other than my supervisor and I will have access to the tapes. The tapes and interview schedules will be kept for two years following any publications or for six years if no publications emanate from the study. Please be assured that your name and personal details will be kept confidential and no identifying information will be included in the final research report.

As the interview will include sensitive issues, there is a possibility that you may experience some feelings of emotional distress. Should you therefore feel the need for supportive counselling following the interview, free counselling has been arranged with Emthonjeni Centre at the University of the Witwatersrand, a multidisciplinary centre for social work and psychology and communication services. If you would like to make use of this, you may discuss this with me. Should you wish to ask any questions about the study, I may be contacted on 079 296 8156 or my supervisor, Dr Linda Smith on 082 325 7079. The summary of the results of the study will also be made available on request.

Thank you for taking time to consider participating in the study.

Yours sincerely

Ntando Segnon

APPENDIX C

CONSENT FORM FOR PARTICIPATION IN THE STUDY

I hereby consent to participate in the research project. The purpose and procedures of the study have been explained to me. I understand that my participation is voluntary and that I may refuse to answer any particular question or withdraw from the study at any time without any negative consequences. I understand that my responses will be kept confidential. I also understand that there would be no monetary rewards involved from my participation.

Name of Participant: _____

Date: _____

Signature: _____

CONSENT FORM FOR AUDIO-TAPING OF THE INTERVIEW

I hereby consent to tape-recording of the interview. I understand that my confidentiality will be maintained at all times and that the tape recording is voluntarily. The researcher explained that the tapes will be destroyed two years after publication or six years if the report was not published after completion of the study.

Name of Participant: _____

Date: _____

Signature: _____

APPENDIX D

THE EXPERIENCES AND PERCEPTIONS OF NURSES WORKING IN A PUBLIC HOSPITAL IN JOHANNESBURG REGARDING THE CARE AND TREATMENT THEY OFFER TO PATIENTS.

INTERVIEW SCHEDULE

IDENTIFYING DETAILS

Code Name	
Age	
Gender	
Length of service in the hospital	

1. How would you describe your role in this hospital?
2. How would you describe your relationships with patients?
3. Please describe any positive experiences that you have in relation to nursing care.
4. Please describe any challenges experiences you have in relation to the nursing care.
5. What are your thoughts about stress, trauma, compassion fatigue and burnout?
6. How do you cope with such difficulties?
7. How would you describe the conditions and experiences that lead to such difficulties?
8. What do you think are some of the challenges that nurses face in their work context?
9. What do you think can be done to improve nursing care and service delivery in this hospital?
10. Are there any other comments you would like to make?



**health and
social development**
Department: Health and Social Development
GAUTENG PROVINCE

CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

Office of the CEO
Enquiries: L. Mngomezulu
(011): 488-3793
(011) 488-3753
04th November 2011

Mrs. Ntando Segnon
141 Plum Street
Roodekop Ext 21
Germiston, 1401

Dear Ms. Segnon

RE: "The experience and perception of patients accessing public hospital in Johannesburg regarding the services they receive from Health Care Nursing Professionals"

Permission is granted for you to conduct the above research as described in your request provided:

1. Charlotte Maxeke Johannesburg Academic hospital will not in anyway incur or inherit costs as a result of the said study.
2. Your study shall not disrupt services at the study sites.
3. Strict confidentiality shall be observed at all times.
4. Informed consent shall be solicited from patients participating in your study.

Please liaise with the Head of Department and Unit Manager or Sister in Charge to agree on the dates and time that would suit all parties.

Kindly forward this office with the results of your study on completion of the research.

Yours sincerely

Dr. Barney Selebano
Chief Executive Officer

University of the Witwatersrand, Johannesburg
Faculty of Humanities – Postgraduate Office

Private Bag 3, Wits 2050, South Africa • Tel: +27 11 717 8202 • Fax: +27 11 717 4037



Student Number: 0303296P

MRS NTANDO SEGNON
141 Plum Street
Roodekop Ext 21
Germiston
1401

Dear Mrs Segnon

04 October 2011

APPROVAL OF PROPOSAL FOR THE DEGREE OF MASTER OF ARTS BY COURSEWORK AND RESEARCH REPORT

I am pleased to be able to advise you that the readers of the Graduate Studies Committee have approved your proposal entitled "*The experiences and perceptions of accessing a public hospital in Johannesburg regarding the services they receive from health care nursing professionals.*" I confirm that Mr Joseph Seabi has been appointed as your supervisor in the Psychology department.

The research report is normally submitted to the Faculty Office by 15 February, if you have started the beginning of the year, and for mid-year the deadline is 31 July. All students are required to RE-REGISTER at the beginning of each year.

You are required to submit 2 bound copies and one unbound copy plus 1 CD in pdf (Adobe) format of your research report to the Faculty Office. The 2 bound copies go to the examiners and are retained by them and the unbound copy is retained by the Faculty Office as back up.

Please note that should you miss the deadline of 15 February or 31 July you will be required to submit an application for extension of time and register for the research report extension. Any candidate who misses the deadline of 15 February will be charged fees for the research report extension.

Kindly keep us informed of any changes of address during the year.

Note: All MA and PhD candidates who intend graduating shortly must meet your ETD requirements at least **8 weeks** after your supervisor has received the examiners reports. **A student must remain registered at the Faculty Office until graduation.**

Yours sincerely

H A MODAU

Hale Modau
Postgraduate Division
Faculty of Humanities
Private Bag X3
Wits, 2050
Tel: +27 11 717 4008
Fax: +27 86 553 4699

