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Role transition experiences of professional nurses to primary healthcare nursing

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ROLE TRANSITION EXPERIENCES OF PROFESSIONAL NURSES TO PRIMARY HEALTHCARE NURSING

Zaakirah Rasdien

A Dissertation submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg,
In fulfilment of the requirements for the degree of Master of Science in Nursing.

Johannesburg, 2023.

DECLARATION

I, Zaakirah Rasdien, declare that this Research Report is my own, unaided work. It is being submitted for the Degree of Master of Science in Nursing at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.



_____

Signature of candidate

14th day of June 2023 in Johannesburg

DEDICATION

I dedicate this work to my late mother, my father, and most importantly, my husband and children, who were my pillars of strength and support system during this time.

ACKNOWLEDGEMENTS

I acknowledge with sincere gratitude the persons who have supported and guided me to the result of this research report.

Mrs J Gassiep, for encouraging me to do my Master's degree.

All the participants in this research. The interest you have demonstrated made this research possible.

The District Research Committee, for allowing me to conduct the research in Johannesburg,

My mentors and supervisors, Dr Amme Mardulate Tshabalala and Co-supervisor Dr Lizelle Crous, whose steadfast guidance kept me focused. Your support has been invaluable.

ABSTRACT

Background: The transition process into specialist nursing can be challenging for any professional nurse. There is a general expectation that once a professional nurse has completed an additional specialised qualification, they should be ready for practice on the first day. Lack of preparation and role transition structure can ultimately influence the care of patients.

Aim: The purpose of the study was to explore the experiences of professional nurses in the city of Johannesburg as they transitioned to Primary Healthcare nursing.

Design: An explanatory sequential mixed methods study design, consisting of two phases, was used in this study. A quantitative research study was conducted first using a self-administered Nurse Practitioner Role Transition Scale (NPRTS) developed by Cusson et al. (2015). Followed by individual semi-structured interviews.

Results: PHCNs need to work in an environment that is comfortable, and enables them to be competent and have confidence, enabling them to be effective in their roles. The results showed that “Navigating challenges” included those challenges by self, colleagues, doctors, and the institution. Participants suffered a lack of support from management and colleagues, a shortage of staff, inadequate medications and equipment, a lack of orientation, and a lack of mentorship

Conclusion: The study findings brought to light the challenges faced by newly qualified PHC nurses. The two phases of this study highlighted factors that can contribute to an acceptable transition process from being a registered nurse to a PHC nurse.

Keywords: Primary Healthcare nurses, role transition, experience, professional nurses

LIST OF ABBREVIATIONS

COJ	City of Jo'burg/Johannesburg
NPRTS	Nurse Practitioner Role Transition Scale
PHC	Primary Healthcare
PHCN	Primary Healthcare Nurse
PN	Professional nurse
SANC	South African Nursing Council

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CHAPTER 1- OVERVIEW OF THE STUDY

1.1 Introduction

This chapter presents the overview of the study. Included in this chapter is the orientation to the study, the problem statement, a summary of how the objectives of the study were going to be achieved and the importance thereof. Additional aspects presented in this study include the clarification of concepts pertaining to the study and a synopsis of ethical considerations applicable in this study.

1.2 Orientation to the Study

Generally, a transition is described as a process or a period of shifting from one situation or state to another (Oxford dictionary, 2013). In the context of this study, transition relates to the process of role shift from professional nurse to a qualified Primary Healthcare Nurse (PHCN). Meleis et al. (2010) described transition as a process triggered by change, resulting in the movement from one stable state to another stable state. Clark (2013) added that, in the context of career transition, the change in role also includes change in orientation to a role already held.

In an attempt to describe role transition in nursing, Benner (1984) used the Dreyfus model of skill acquisition (Dreyfus and Dreyfus, 1980), and linked the complexity of the role transition process to the acquisition of associated skills and level of clinical judgment. Benner (1984) identified five (5) levels of transition proficiency, namely: 1) novice, 2) advanced beginner, 3) competent, 4) proficient and 5) expert.

At Level 1, the novice is a person who mechanistically approaches a task with incomplete understanding. Level 2 is an advanced beginner who can complete a task without supervision and uses steps to complete actions. At Level 3, a competent person completes work independently to an acceptable standard. At Level 4, the proficient person has a deeper understanding and develops a holistic approach with a high standard. At Level 5, the expert is intuitive, with an understanding that is deep and holistic and works beyond interpretation; excellence is achieved with ease (Dreyfus and Dreyfus, 1981).

Sellman (2018) indicated that each time a person moves from one situation or state to another, they leave behind their comfort zone, where one had a wealth of experience and competence—resulting in a sense of confidence and control—and find it replaced with uncertainty, unfamiliarity, and unease. In the context of nursing, the first transition begins once a person enters the nursing profession as a nursing student. They gradually move through the levels of proficiency until they are registered professional nurses; they enter the workforce and may become experts with years of service. Sellman (2018) explained that a transition could result from entering a new environment or enrolling in a new specialty postgraduate program.

Change can be stressful, and it evokes feelings of denial and anger as the person searches for familiarity, comfort, and direction (Spoelstra and Robbins, 2010; Barnes, 2015; Sellman, 2018). A professional nurse considered an expert at work may feel like a novice as a postgraduate student. Sellman (2018) describes this as transitional shock, which has the potential to influence the person negatively with regard to their self-esteem, sense of self-confidence, and level of control.

In South Africa, a Primary Healthcare nurse (PHCN) is a professional nurse with an additional qualification, registered as such by the South African Nursing Council (SANC) (Nursing Act, 2005). A PHCN is trained under the SANC Government Notice No. R. 48 (Nursing Act 2005) and is a competent PHCN who can function independently as well as interdependently to render appropriate primary care services. The R. 48 programme concluded with the last intake in 2019. Note that in 2020, the Nursing Act 2005 was amended, leading to a change in the curriculum for Nurse Specialists. The Nurse Specialist programme is numbered R. 635 and is now at a National Qualifications Framework (NQF) level 8, whereas the R. 48 was at NQF level 7. The change in the NQF level will improve the PHCNs' skill acquisition, increasing their competence as well as confidence.

PHCNs play an increasingly central role in meeting the needs of the community through comprehensive disease prevention and promoting health services as well as providing curative, rehabilitative, and palliative care (WHO, 2019). Services range from managing acute illnesses to chronic diseases, as well as mother and child health care. Some of the PHCNs work as program managers.

One of the key role expectations of PHCNs is clinical decision making. According to Gillespie and Peterson (2009), acquiring clinical decision-making skills involves a process where the novice nurse is expected to progress from being depending on abstract principles to applying concrete experience and viewing a clinical situation within its context and as a whole. Gillespie and Peterson (2009) and Faraz (2019) alluded to the possible barriers related to the transition process. Lack of guidance or support, such as during a consultation with a patient with multiple conditions or difficult personalities that demand skilled decision-making, is a barrier to successful role transition in nursing. Azimian et al. (2014) identified other barriers including inadequate preparation for transition and the inability to manage patients (and other work-related situations) during the process of induction into the new role. Such barriers could result in staff shortage.

Despite these barriers to successful role transition, a PHC nurse needs to adapt to the new role and take on additional responsibility. Barnes (2015) referred to the importance of being aware of the factors affecting the role transitioning process for nurses, which highlights the need to explore this process of PHCNs in the South African context.

Professional nurses in the process of transitioning to primary healthcare nursing also need to adapt and adjust themselves to the primary healthcare setting, which includes becoming part of the team, and adapting to the culture of the clinic and the various kinds of patients seen in the clinic.

Transitioning from an experienced professional nurse to a PHCN can lead to anxiety, insecurities, and long adjustment periods (Thompson, 2018).

1.3 Problem Statement and Research Question

The transition process into specialist nursing can be challenging for any professional nurse. In general, it is known that change brings about stress. Brykczynski (2009) stated that transition from one role to another in patient care could predispose one to feelings of self-doubt, leading to uneasiness and lack of confidence in clinical skills, and feelings of inability to effectively manage the patients. In addition, Spoelstra and Robbins (2010) stated that although role changing and learning new skills is a

noticeable process, there is limited information in the literature about the PHCN's experience of the transition process from a registered nurse's role. Once a professional nurse has completed an additional specialised qualification, they might be expected to be ready for practice on their first day in a new role. Strange (2015) stated that lack of preparation and role transition structure could ultimately affect the care of patients. Currently, there exists a gap in the knowledge of professional nurses' experiences of their role transition to PHCN. Hence, the research question is, "What are the PHCN's experiences of role transitioning to primary healthcare nursing?"

1.4 Purpose of the Study

The purpose of the study was to explore and describe the professional nurse's experiences of role transition to Primary Healthcare nursing.

1.5 Research Objectives

The objectives of the study were implemented in two phases.
In Phase 1, the objectives were to:

- Describe factors that influence professional nurses' experiences of transition to Primary Healthcare nursing role.
- Determine the association between demographics and factors that influenced role transition.

In Phase 2, the objectives were to:

- Explore professional nurses' experiences of role transition to Primary Healthcare nursing.
- Integrate the results of Phase 1 and 2 to develop recommendations to improve the PHCNs working environment post-training.

1.6 Significance of the Study

No studies were found describing the professional nurse's transition to the PHC nurse's role in the South African context. Therefore, the result of the study may firstly contribute to the body of knowledge related to the PHC nurse's transition. Secondly, the findings can potentially produce information that assist managers and other PHC nurses to understand contextual factors related to the PHC nurse transition process. Lastly, as transitioning can be a challenging process, the results could be used to

make recommendations on how to provide support and facilitate a smooth transitioning process for PHCNs.

1.7 Operational Definitions

1.7.1 Primary Healthcare nurse

A PHC nurse is a professional nurse with an additional qualification in clinical nursing science, health assessment, diagnosis, treatment, and care and registered with the South African Nursing Council (Nursing Act, 2005).

1.7.2 Role transition

According to the Oxford dictionary (2013), transition relates to a process or period of changing from one state or condition to another. In the context of this study, transition refers to the process of role shift from a professional nurse to a qualified PHC nurse.

1.7.3 Career progression

Career progression can be defined simply as the act of “moving forward in your career” (Unitemps, 2022). Career progression can take many forms, such as receiving more responsibilities or taking on new challenges using a different skill set.

1.8 Summary of the Research Methodology

An explanatory sequential mixed methods study design, which consisted of two phases, was used for this study. Phase 1 consisted of quantitative data collection process using a self-administered Nurse Practitioner Role Transition Scale (NPRTS) developed by Cusson and Strange. (2015). The study was conducted on a sample size of (n = 80) trained PHC nurses from the seven regions within the City of Johannesburg.

In Phase 1, convenience sampling was used to recruit participants via an online platform. After experiencing challenges getting sufficient responses, a snowballing recruitment process was applied and face-to-face interviews were conducted.

The IBM Statistical Package for Social Sciences (SPSS, 2021) software was used for data analysis.

In Phase 2, individual semi-structured interviews were conducted with participants from Phase 1 who agreed to be part of the qualitative component of the study. Interviews were conducted using a semi structured interview guide until data saturation was reached at twelve participants.

Qualitative data was analysed using the coding reliability thematic approach. All measures to ensure trustworthiness of the study, as well as adherence to ethical requirements, were followed and are presented in detail in Chapter 3.

1.9 Chapter Overview

Chapter	Description
Chapter 1	An overview of the study
Chapter 2	Literature review
Chapter 3	Research Methodology
Chapter 4	Phase 1 Quantitative Data results and discussion
Chapter 5	Phase 2 Qualitative Data results and discussion
Chapter 6	Summary; Limitations and Recommendations

1.10 Summary

An overview of the study was presented in Chapter One. Chapter Two presents a literature review, conducted to gain greater knowledge of the key concepts related to PHC nurses' transitions.

CHAPTER TWO- LITERATURE REVIEW

2.1. Introduction

The previous chapter discussed the overview and introduction to the study. This chapter presents a review of the literature related to the focus of the study. PubMed, SCOPUS, CINAHL, ProQuest, and Google Scholar among other search engines used to access journal articles to identify relevant articles. Accessed journal articles were reviewed to identify current knowledge as well as gaps in existing knowledge.

2.2 Role Transition

Kralik et al. (2005) indicated that as newly qualified nurse practitioners transition into their new roles, they must incorporate this change into their lives and adapt to new situations as their circumstances have changed from being a Professional Nurse (PN) to PHCN.

Meleis et al. (2010) described a transition as a process triggered by change, resulting from moving from one fairly stable state to another state. Clark (2013) defined career progression as transitions related to changes in a role or changing orientations to a role already held. Twedell et al. (2016) explained role transition as one's professional identity being transformed from one profession to another.

A new graduate nurse faces the first of several professional transitions: the transition from the student role to the nurse role. Whereas the expectations of students are specified in the course and clinical objectives, expectations for a new nurse as an employee may not be so clear. This may cause a poor transition experience as a new graduate (Barnes, 2015; Brown & Olshansky, 1997; Cusson & Strange, 2008; Faraz, 2019; Kelly & Mathews, 2001). Work roles cannot be supported without the understanding of work role transitions (Bridges, 1995; Meleis, 2010).

Change brings about stress. The transition into specialist nursing can be challenging for any professional. Brykczynski (2009) stated that moving from one role to another could predispose one to feelings of self-doubt, leading to uneasiness, lack of confidence in clinical skills, and feelings of inability to effectively manage patients. In addition, Spoelstra and Robbins (2010) stated that although role changing and learning new skills is often a noticeably rapid process, there is limited information in the

literature about the registered nurse's experience of transition to the role of Primary Healthcare nurse. This transition has been described as stressful, frustrating, and overwhelming, and two decades of research have found that being a newly qualified PHCN is not easy (Barnes et al., 2021). During these role transitions, there is a decrease in job satisfaction and in confidence.

Situational transitions that have health-care implications are typified by experiences and responses to situational changes. According to Chang and Daly (2019), the transition between student nurse and graduate nurse is a period described as intense belief of socializing into a clinical network. Chang and Daly (2019) also stated that during this time, the student learns about the type of attitudes, values, knowledge, and skills needed to cope in the nursing environment. There remains a gap between what students are taught and what they experience in the clinical workplace, known as reality shock (Clipper and Cherry, 2015; Sellman, 2018).

2.3 Primary Healthcare Nurses

In countries such as America, the United Kingdom and Australia, a PHCN is known as a Nurse Practitioner, Family Nurse Practitioner or an Advanced Practice Nurse. These nurses have received the necessary university education to treat, diagnose and educate patients. This is very similar to the South African context. Reebals et al. (2022), Hussein et al. (2017) and Lalonde and Hall (2016) identified a lack of support for the transitioning of novice nurses. The researcher could not find articles related to lack of support of PHCNs in South Africa. In Australia, Henderson et al. (2013) mentioned that the role of Primary Healthcare has grown tremendously in trying to manage the burden of chronic disease and prevent hospitalization.

In South Africa, a Primary Healthcare nurse (PHCN) is a professional nurse with an additional qualification, registered as such by the South African Nursing Council (SANC) (Nursing Act, 2005). A PHCN is trained under the SANC Government Notice No. R. 48 (Nursing Act, 2005) and is a competent PHCN who can function independently as well as interdependently to render appropriate primary care services.

2.4 Factors That Have an Impact on Primary Healthcare Nursing In South Africa

In South Africa, many social and demographic variables, as well as a range of systemic and structural challenges, influence the provision of primary healthcare. De

Villiers (2021) mentions that these include widespread staff shortages and inconsistency in skill sets between rural and urban areas. This has resulted in an inferior management of patient care levels. The National Department of Health (NDOH) has identified six priority areas, which are infection prevention, positivity, patient safety, shorter waiting times, cleanliness, and the availability of medication and supplies. Even with the six priorities in place, there is still a lack of medication and resources in the clinics.

In efforts to establish equality so that everyone in the country has access to efficient, high quality health services, the National Health Insurance (NHI) system was established. The NDOH also designed the Ideal Clinic (IC) programme to assist in the assessment of clinics in South Africa. This was to improve the standards of clinic structure, finance, human resources, and waiting times. In a study by Matlala et al (2021), only 322 clinics out of 3 477 clinics achieved a score of above 70%, showing that even with the Ideal Clinic programme, facilities are struggling to achieve a better status and face serious challenges.

2.5 Adult skill Acquisition

The Dreyfus model of adult skill acquisition (Dreyfus and Dreyfus, 1980) is a developmental model, based on a situation, performance, and experiential learning. It provides for five levels of skill development from novice to expert (Sweeney, 2006). The levels are novice, advanced beginner, competent, proficient, and expert. The model describes the changes in the characteristics of performance as skill develops.

One of the key role expectations of PHCNs is clinical decision-making. According to Gillespie and Peterson (2009), acquiring clinical decision-making skills involves a process whereby the novice nurse is expected to progress from depending on abstract principles to applying concrete experience to view a clinical situation within its context and as a whole. Gillespie and Peterson (2009) and Faraz (2019) identified possible barriers in the transition process. Lack of guidance or support during a consultation with a patient, especially one with multiple conditions or difficult personalities that demand skilled decision-making, has been stated as one of the barriers to successful role transition in nursing. Azimian, Negarandeh, and Fakhr-Movahedi (2014) also stated that inadequate preparation for the transition is a barrier to successful role

transition, and that the inability to manage patients and other work-related situations during the process of induction into the new role could result in staff shortage.

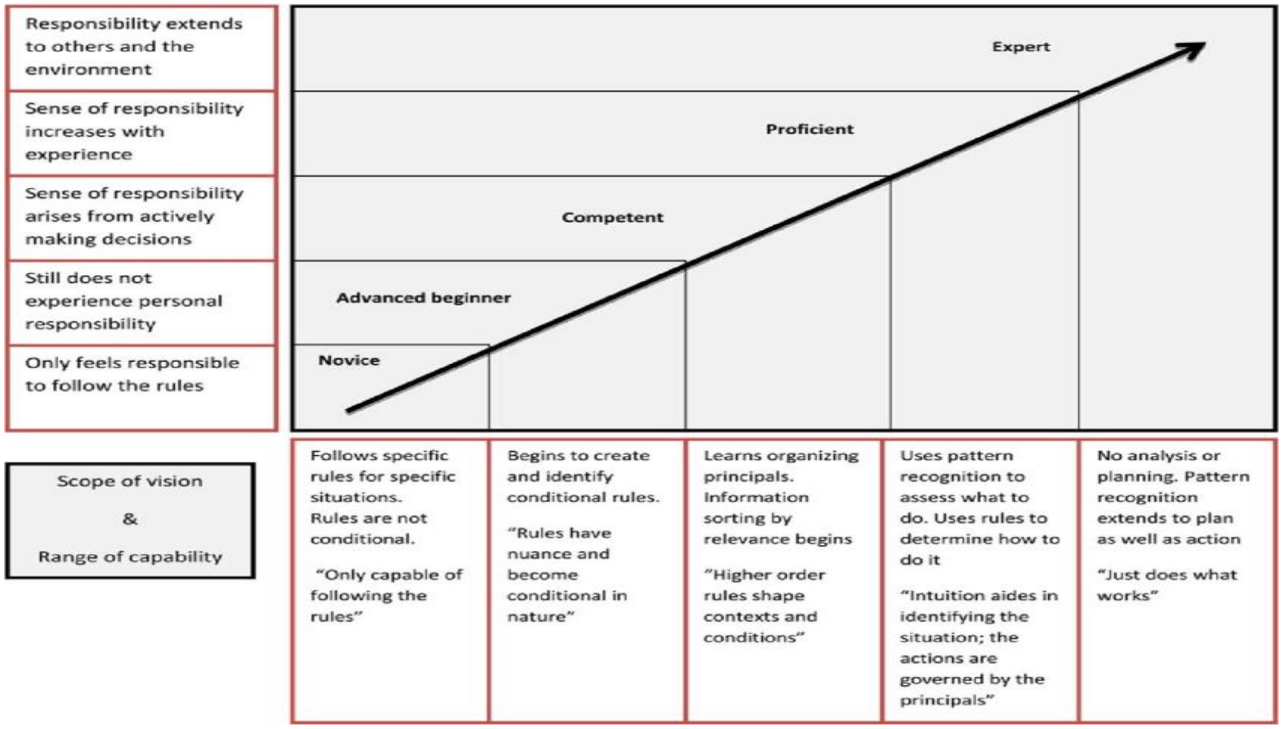


Figure 2.1: Dreyfus, Dreyfus 1980

2.6 Benner's Application of the Dreyfus Model

Benner (1982) describes the Dreyfus model as "a situational model, rather than a trait or a talent model". In the early 1980s, Benner (1984) described role transitioning in the nursing profession by drawing on the Dreyfus model of skill acquisition, which found the complexity of the role transitioning process to be closely linked to the acquisition of associated skills and level of clinical judgment.

Benner identified five (5) levels of transition proficiency, namely: 1) novice, 2) advanced beginner, 3) competent, 4) proficient, and 5) expert. At Level 1, the novice is a person who mechanistically approaches a task with incomplete understanding. Level 2 is an advanced beginner who can complete a task without supervision and uses steps to complete actions. Level 3 describes the competency role in which work can be completed independently to an acceptable standard. At Level 4, the proficient person has a deeper understanding and develops a holistic approach with a high standard. At Level 5, the expert is intuitive with an understanding that is deep and

holistic and works beyond interpretation, and excellence is achieved with ease (Dreyfus and Dreyfus, 1981).

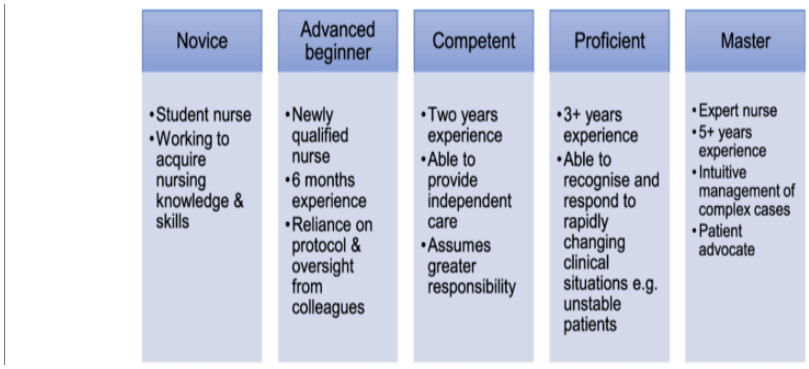


Figure 2.2: Benner 1984

2.7 Facilitators and Barriers of the Transition

Self-confidence, interaction with colleagues, and a positive work environment all overlap to gain experience as you grow into competency and beyond (Kim and Shin, 2020). Fears, workload, excessive role expectations, and emotional difficulty are some of the barriers explained by Kim and Shin (2020). Strange (2015) pointed out that a lack of preparation and role transition structure can ultimately affect the care of patients and has not been explored in the public healthcare context of South Africa. Lack of transition process knowledge, role preparation, and role transition structure can ultimately affect the care of patients. Barnes (2015) alluded to the importance of developing knowledge of the factors involved in the transition to a nurse practitioner. Hence, the need for a study focused on Primary Healthcare nurses' role transition.

2.8 Career Progression

Movement within a profession means changing roles, moving from a point of comfort where a person has acquired the needed skills and competencies for that particular role, into an unfamiliar space where new skills and competencies are needed to fulfil the new role (Sellman, 2018). In the context of nursing, the transition begins once a person enters the nursing profession as a nursing student. They gradually move through the levels of proficiency until they are registered professional nurses, enter the workforce, and may become experts with years of service. However, change can be stressful and evokes feelings of denial and anger as the person searches for familiarity, comfort, and direction (Spoelstra and Robbins, 2010; Barnes, 2015; Sellman, 2018). A professional nurse considered an expert at work may feel like a

novice as a postgraduate student. Sellman (2018) describes this as transitional shock and has the potential to influence the person negatively in terms of their self-esteem, sense of self-confidence, and level of control.

2.9 Conclusion

This chapter reviewed the literature relevant to the study, covering role transition, Primary Healthcare and career progression. The next chapter will discuss the research methodology for the study.

CHAPTER 3 - RESEARCH METHODOLOGY

3.1 Introduction

The purpose of this chapter was to present the overall strategy used to explore the experiences of professional nurses transitioning to Primary Healthcare Nurses. An explanatory sequential mixed methods study design was found to be the most suitable research design to achieve the objectives of the study.

3.2 Research Setting

A location in the context of research is the physical place where the study is conducted (Gray & Grove, 2021). In this study, data were collected from a cohort of PHC nurses who completed training in any of the nursing colleges in Gauteng Province in the years 2018 to 2020. The prospective participants had to be working in one of the PHC clinics situated within the seven regions of the City of Johannesburg municipality—either municipality clinics or provincial clinics. This was to enable the researcher to collect more data across the COJ region and increase the population size for the study (see Figure 3.1).

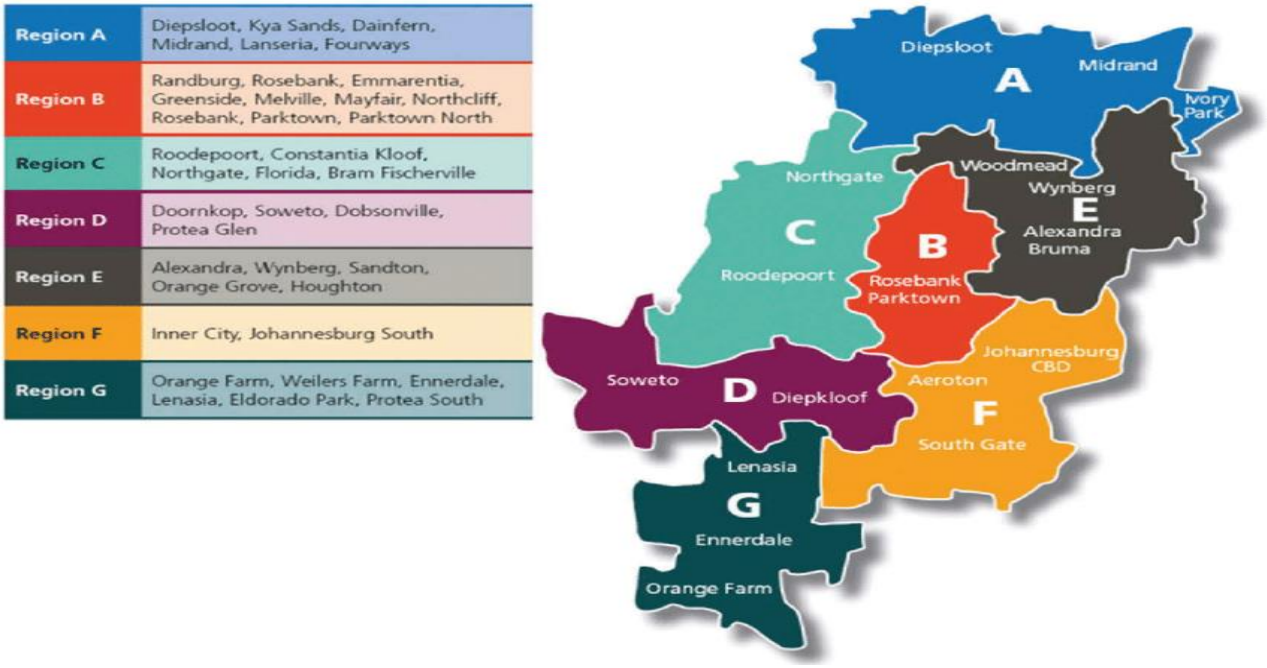


Figure 3.1: COJ Region breakdown

3.3 Research Design

Gray and Grove (2021) describe a research design as an all-encompassing strategy of the process that will be adopted to investigate the research problem. This study used

an explanatory sequential mixed method design consisting of quantitative and qualitative components.

A quantitative study is done by collecting and analysing numerical data, whereas a qualitative study is referred to as a study of the nature of the phenomenon (Gray and Grove, 2021). The current study is described as an explanatory study as the quantitative component was implemented first, followed by the qualitative component. The research design was sequential as the quantitative data was collected and analysed first in Phase 1, and the results were used to inform Phase 2, the qualitative component (Tashakkori & Creswell, 2007). Explanatory research is a method used to explore how or why something occurs and to increase the understanding of the topic, as limited information was available on the role transition of PHCNs.

3.4 PHASE 1: Quantitative Component

A quantitative and cross-sectional design research approach was conducted in the first phase of the study (Polit & Beck, 2017), which consisted of a self-administered questionnaire titled “Nurse Practitioner Role Transition Scale” or NPRTS developed by Cusson et al. (2015).

3.4.1 Quantitative and cross-sectional design

Quantitative design

Levy (2017) described quantitative design as collecting data to achieve objectivity and control. In this study, newly qualified PHCNs gave data about their demographic factors as well as factors that influenced their role transition.

Cross-sectional design

Cummings (2017) described a cross-sectional design as data collected at a single point in time. In this study, data were collected once from the newly qualified PHCNs to identify the factors that influenced their role transition.

3.4.2 Study population

In this study, population refers to all PHC nurses included in the study of interest (Polit & Beck, 2017). The anticipated population was all the registered nurses who had been working as a PHCN for a period of 3–24 months prior to the data collection period in

2021, in one of the clinics in the seven regions within the City of Johannesburg. These would have been the 2019 and 2020 graduates. The estimated total population number was (N = 140) based on the nursing college annual recruitment target over a period of two years. However, less than a hundred students were recruited for the PHC course due to the anticipated phasing out of the R. 48 course.

3.4.3 Sample, sample size and sampling

Sample

A sample refers to a section of the target population selected for inclusion in the research undertaken (Gray and Grove, 2021).

Sample size

The researcher in this study opted for a total sample method, which considers the total population, as the total population of PHC nurses was small (Polit and Beck, 2017). The sample size for this study was therefore (n = 80).

Sampling

Sampling is a description of the process used to select people for the study (Gray and Grove, 2021).

The researcher initially used a college student register for 2019 and 2020 at a nursing college as the first step of implementing the non-probability convenience sampling strategy (Gray and Grove, 2021). The potential participants were identified and contacted. There were not enough respondents on the REDCap application, therefore snowballing was used to acquire more respondents. The researcher later took an opportunity to collect responses from potential respondents, using printed questionnaires, while they were at Rahima Moosa Campus for their graduation preparation. Gray and Grove (2021) describe a snowball sampling technique as a strategy whereby different social networks are used as an aid to find people who hold similar characteristics.

Inclusion and exclusion criteria

All participants were included if they were PHCNs with a minimum of three months' and maximum of two years' experience as PHCNs, employed within the City of

Johannesburg region, and willing to participate and reflect on their experiences of transitioning into the PHCN role in practice settings. Participants who qualified more than two years ago were excluded, as they might not be able to remember and reflect on their transition process (Gray and Grove, 2021).

3.4.4 Data collection

3.4.4.1. ***Data collection instrument***

Data were collected using a self-administered questionnaire that consists of three parts, sections A, B, and C.

Section A	Entailed the demographic-related aspects such as age, gender, educational qualifications, number of years practising, and area of allocation.
Section B	In this section, the PHCNs were requested to indicate their perception of their level of skills acquired based on the Dreyfus skills acquisition model (Dreyfus, 1980).
Section C	Consisted of 31 items of the self-report Nurse Practitioner Role Transition Scale (NPRTS) developed by Cusson et al. (2015). (See Appendix F.)

Permission was sought and granted for the use of the 31-items measuring scale (see Appendix E), consisting of four dimensions:

- Developing Comfort and building Competence
- Understanding of the Role of Others
- Collegial Support
- Communication and Relationships.

The response options were according to a five-point Likert scale ranging from 1 = Strongly disagree to 5 = Strongly agree.

3.4.4.2 Reliability and validity of the instrument

Before starting to collect main data from respondents, an NPRT Content Validity Index (CVI) was done. Five expert PHCNs were given the NPRT Content Validity Index (CVI) Questionnaire to fill in. They used the following rating:
1 = not relevant;
2 = unable to assess relevance without item revision or the item requires such revision that it would no longer be relevant;
3 = relevant but needs minor alteration;
4 = very relevant and succinct.

The purpose of this process was to assess the soundness of the NPRTS scale to measure what is supposed to be measured (Gray and Grove, 2021) as well as to assess suitability for the South African context, particularly within primary healthcare, as well as to ensure the study's feasibility and to identify any ambiguity or flaws in the NPRTS scale.

The questionnaire was pretested in a pilot study to make sure that the questions were clear. No need for changes was identified, suggesting that the study constructs were reliable. The findings emerging from the trial run were not incorporated in the main study results.

The NPRTS scale (developed by Cusson et al., 2015) consists of 16 and 31 items scales and was previously validated in two studies. A sample of (n = 182) was used in the first study, and thereafter (n = 427) participants took part in the revision and validation process (Cusson et al., 2015). The samples represented nurse practitioners and a range of specialties and practices. The internal consistency for most of the items was reported to be good and stable in both studies and ranged between 80 and 88 (Grove and Gray, 2021).

The internal consistency was determined through a Cronbach's alpha coefficient on the instrument's items in the six subscales in Table 3.1.

Factors	**No. of Items**	**Valid Cases(N)**	**Cronbach's Alpha**

Comfort, Competence, and Confidence	9	80	0.672
Understanding	6	80	0.450
Support	10	80	0.611
Communication Relations	6	80	0.543

Table 3.1: Outcome of the Cronbach's Alpha test

Table 3.1 shows the interrelationship of the three key concepts of the NPRTS scale, determined using Cronbach's alpha test. The statistical significance was used to test reliability and objectivity of each factor. The similarity of responses to the same questions was measured using Cronbach's alpha test.

Cronbach's alpha reliability coefficient normally ranges between zero and one. A value of above 0.6 is considered highly reliable and an acceptable index (Nunnally, 1994). As shown in Table 3.1, the Cronbach's alpha coefficient values range from 0.450 to 0.672, which were not significant.

3.4.4.3 Data collection process

Phase 1 consisted of a quantitative research study conducted using a self-administered Nurse Practitioner Role Transition Scale (NPRTS) developed by Cusson et al. (2015).

The study participants were selected using a population sampling strategy that resulted in a sample size of (n = 80) out of the total population of (N = 140) trained PHC nurses working within the seven regions in the City of Johannesburg.

The potential participants were identified from one nursing college register of PHC nurses trained between 2019 and 2020. The available contact details were used to forward the study details as well as a request to participate in the online research study. On recognizing difficulties of reaching potential participants (as some contact details had changed, some had passed on and some were hospitalised), the researcher opted for a snowball purposive sample identification process. When this process did not yield a satisfactory sample size, the last option was to recruit participants at one college on the day that the 2019 and 2020 graduates would be there preparing for the planned graduations in 2021. Questionnaires were distributed

face to face, in envelopes, and completed questionnaires were placed in a box provided in the hall.

The IBM Statistical Package for Social Sciences (SPSS, 2021) software was used to analyse data in Phase 1.

The process of gathering information related to the study's objectives commenced after permission was granted by the Postgraduate Assessment committee (Appendix A) and the Human Research Ethics Committee (Appendix B), and it was added to the National Health Research Database (Appendix C).

The researcher maintained the security and confidentiality of the participant's information while collecting data. The researcher contacted the City of Johannesburg District Manager, who has acted as the operator in collecting the contact details of all practising PHC nurses who meet the inclusion criteria. Not all contact details could be gathered as some had resigned.

- The researcher initially wanted to go to clinics to collect data, physically, but due to COVID-19, opted for an online survey.
- The researcher added the questionnaire to the REDCap website for participants to fill in the questionnaire online via a link.
- An information and link was emailed and texted to PHCNs in Gauteng working for the City of Johannesburg using snowballing. Completion of the questionnaire was taken as consent.
- The REDCap platform sent out reminders weekly for a period of four weeks to those who had not completed the survey, and then the survey was closed. This ensured the anonymity of the participants.
- When the researcher found out that potential respondents would be at the Rahima Moosa Campus for graduation preparation, the opportunity arose to collect data physically, using printed questionnaires.
- The Rahima Moosa Campus Head gave permission to hand out the questionnaires in envelopes to willing participants. Once completed, each respondent put their questionnaire back in the envelope, sealed it, and put it in a box left by the researcher. Fifty participants responded on this day.
- The researcher abided by the Protection of Personal Information Act (POPI) Act, collecting personal information for a specific purpose, as well as maintaining the

confidentiality and anonymity of the participant and their contact details. The PHCNs that met the inclusion criteria were individually approached via online communication or in person to tell them about the intended study and ask them to participate. Participation was voluntary.

- Thereafter the researcher used snowballing to collect more participants and reverted to REDCap using contact details obtained from snowballing to send the link to potential respondents.

3.4.5 Data Analysis

Data analysis is the process of categorising, ordering, manipulating, summarising, and describing data in meaningful terms (Brink et al., 2018). The quantitative analysis was based on a sample of 80 respondents. The IBM Statistical Package for Social Sciences (SPSS, 2021) software was used. Descriptive statistics, cross-tabulations, and item response analysis were used to analyse the data. The one-sample t-test was used to determine whether each item differed significantly from the average score. In addition, the exploratory factor was conducted to assess the validity of the constructs, while Cronbach's Alpha was used to assess the reliability of the constructs. The Kaiser-Meyer Olkin Measure of Sampling Adequacy (KMO) and Bartlett's Test of Sphericity were used to assess the data's factorability. The results are discussed in Chapter 4.

3.5 Phase 2: Qualitative and Contextual Component

Qualitative methods are used to study the human experience from the viewpoint of the research participant (Gray and Grove, 2021). In the context of this study, the researcher collected in-depth interviews to explore the experiences of the PHCN's role transition.

The study examined a cohort of PHC nurses who completed training at the same nursing college in Gauteng Province and transitioned to working in one of the PHC clinics situated within the seven regions of the City of Johannesburg municipality.

3.5.1 Population and Sampling

Based on Grove, Burns, and Gray (2017), all the PHC nurses who meet the eligibility criteria fulfil the purposive sampling selection criteria. Firstly, they are in a position to

give detailed information about the transition process. Secondly, a study on PHC nurses' transitions is a complex and new area of study in South Africa. At the end of the questionnaire from the first phase of the study, the researcher added an invitation for participants to take part in the second phase. All of the participants who accepted the invitation to the second phase of the study were included in the qualitative phase of the study. A total of (n = 12) participants were interviewed.

3.5.2 Data collection

3.5.2.1 Interview guide

The researcher held individual interviews with each participant using the interview guide (see Appendix K). Interviews were held via Microsoft Teams, which worked well during COVID-19 restrictions. The interview guide included a demographic section, asking for gender and age, and a predetermined main question:

"Can you please tell me how you experienced the transition from being a Professional Nurse to a Primary Healthcare Nurse?"

The researcher also asked probing questions, which included:

- What experiences have helped you, and what experiences were barriers for you during your transition?
- What has made the transition easier for you?
- What would make the transition easier for you?
- What have your experiences been thus far as a new PHCN?

3.5.2.2 Data collection process

Individual semi-structured interviews were conducted on purposively selected samples until data saturation was reached at (n = 12).

Respondents who participated in Phase 1 were asked to indicate if they would be willing to participate in Phase 2 of the study, by ticking a box and filling in their contact information.

Consenting participants for Phase 2 were contacted via telephone or email. Individual interviews were conducted and recorded via the Microsoft Teams application.

During the interviews, pseudo names were used; however, during the analysis process, the transcript of each participant was numbered accordingly and coded respectively.

Depending on the participants' responses, probing questions were asked to guide the interview and elicit detailed descriptions of their experiences, but also to clarify and summarise their contributions. Follow-up questions explored the PHC nurse's transition process, experiences of transition and collegial relationships, as well as how they mastered the role's responsibilities (Strange, 2015). Interviews were conducted until data saturation was reached, which meant no new information emerged (Polit and Beck, 2017). Twelve (12) interviews were conducted, with each taking about 30 to 45 minutes. Most participants opted for an after-work or off-duty time slot, as PHC services are very busy during the day and it would have been difficult to find a quiet place in the facility with an internet connection for the online interview.

3.5.3 Data analysis

In this study, qualitative data analysis of verbatim-recorded data was used to elicit meaning through an iterative process of thematic analysis. Braun and Clarke's (2006) thematic analysis method consisting of six steps were applied to identify similar information and patterns that emerged from collected data.

Each of the interviews was transcribed verbatim from the audio recordings and then read repeatedly. This process allowed the researcher to obtain a sense and an impression of the content and noted patterns from the actual words used by the participants. Similarities in the words used were identified.

Data was reviewed again, and frequently used words and omissions were identified. A specific descriptive code label was assigned to facilitate easy retrieval of concepts for comparison and analysis. This process resulted in a list of frequent terms identified, and no overlapping units. The process of coding aims to prioritize "reliable" data coding – in other words, identification of "accurate" codes/themes within data.

Data were then coded; compared to other data; assigned codes and clustered into categories; and arranged into columns. The list of themes was re-analysed in comparison to the original data, and supportive statements were identified. In the final stage, the data were categorised into two themes, five categories and eight sub-categories, as demonstrated in Table 4.1 in Chapter 4.

3.5.4 Measures of Trustworthiness

Lincoln and Guba (1985) suggested four criteria for developing the trustworthiness of a study: credibility, dependability, conformability, and transferability (Polit and Beck, 2017).

Credibility refers to the interpretation of data being truthfully relayed during the analysis (Polit & Beck, 2017). Early communication and introductions helped to establish credibility and a good rapport with the participants so the data received would be rich in information (Shenton, 2004).

Dependability refers to the reliability of the data studied over time (Polit & Beck, 2017). A detailed report on the design and methods is provided to help with investigations for future studies, as this is the first South African study for PHCNs.

Confirmability refers to the resemblance of the potential data between independent people ensuring the accuracy of the data, its relevance, and its significance (Polit and Beck, 2017). The research supervisor, who independently implemented the thematic analysis process to endorse the primary researcher's findings, checked authenticity of results emerging from the data of the analysis process. An independent qualitative co-coder further confirmed the findings.

Transferability refers to the potential of the study being replicated in other settings (Polit & Beck, 2017). Clear and detailed descriptions of the designs and methods used in this study are provided to ensure transferability (Shenton, 2004).

3.6 Ethical Considerations

The following ethical considerations process was implemented in this study:

Institutional permission

- The research proposal was submitted to the University Postgraduate Committee and permission to conduct the study was granted (Appendix A).
- Ethical approval was sought and granted by the Human Research Ethics Committee (HREC) of the University of the Witwatersrand (Appendix B).
- Ethical clearance was also sought from the Research Committee of the Johannesburg Health District (Appendix C).

Participants

- Prospective participants were reached through online communication for awareness about the study and consent to participate. Appendix (G) was used for the quantitative component and Appendix (I) for the qualitative component. Participants' privacy, confidentiality, and anonymity were ensured by using code numbers during the data collection and reporting process.
- Beneficence refers to ensuring participants' well-being, and non-maleficence refers to ensuring that no harm or discomfort is imposed (Brink et al., 2018). The researcher ensured that participants were not exposed to emotional or physical discomfort. The participants were not coerced to participate and were made aware that they could withdraw at any time during the course of the interview. Additionally, they were reassured that the information collected would be protected and that it would be accessible to the researcher and supervisor only.

3.7 Summary

This chapter presented the Phase 1 and Phase 2 research methodology of the study. In Chapter 4, the quantitative study results and discussion will be presented.

CHAPTER FOUR - QUANTITATIVE STUDY RESULTS AND DISCUSSION

4.1 Introduction

In the previous chapter, the quantitative and qualitative methodology of the study was discussed. This chapter will present the results and discussion of Phase 1 of the study. Phase 1 aimed to determine the association between demographics and other factors that influenced role transition, as well as describing the factors that influence professional nurses' experiences of transition to PHCN roles. This chapter discusses the results of the self-administered NPRTS, as answered by 80 participants.

4.2 Response Rate

The anticipated total population was (N = 140) newly qualified PHCNs from different clinics in the City of Johannesburg who had graduated from the same nursing college. However, at the time, the SANC had embarked on a new curriculum for the R. 48 Clinical Nursing Science Health Assessment Treatment and Care (CNSHAT&C) Postgraduate Diploma, under R. 635. Based on this process of phasing out the CNSHAT&C, fewer than 100 PHC nursing trainees were recruited.

One hundred and three (103) questionnaires were sent as a link via the online platform REDCap as part of the convenience sampling process. Not enough responses were received, so the researcher adopted the snowballing process to access participants, and face-to-face convenience sampling was applied. A total of (n = 80) PHCNs completed the questionnaires. This is considered a 100% response rate in view of the fact that this was the accessible population at that time.

4.3 Demographic Data

4.3.1 Characteristics of the respondents

Table 4.1 summarizes the respondent's demographic characteristics. The characteristics include gender, age, the highest level of education, year of completion, and number of years practising as a PHC nurse, and place of employment as well as the Benners novice to expert criterion. The sample size for the study was n = 80.

Table 4.1: Characteristics of Respondents (n = 80)

Variables	Categories	n	Percentage	Cum. Percentage
Gender	Male	6	7.5	7.5
	Female	74	92.5	100
Age	< 25 years	0	0	0
	25-30 years	6	7.5	7.5
	31-40 years	42	52.5	60
	41-50 years	25	31.3	91.3
	51-60 years	7	8.8	100
	61-65 years	0	0	100
	>65 years	0	0	100
Highest Level of Education	Postgraduate Diploma	65	81.3	81.3
	Bachelor's Nursing Degree	15	18.8	100
	Master's Nursing Degree	0	0	100
	PhD	0	0	100
Year of Completion	2016	1	1.3	1.3
	2017	0	0	1.3
	2018	4	5	6.3
	2019	56	70	76.3
	2020	19	23.8	100
Number of Years of practising as a PHC nurse	1	26	32.5	32.5
	2	53	66.3	98.8
	3	1	1.3	100
Place of Employment	COJ	29	36.3	36.3
	Province	51	63.7	100
Benner's novice to expert	Novice	12	15.00	15
	Advanced Beginner	28	35.00	50
	Competent	40	50.00	100
	Proficient	0	0.00	100
	Expert	0	0.00	100

Source: Field Data (2022)

4.3.2 Gender

The gender distribution of the respondents is shown in Figure 4.1 based on a sample size of 80. The majority of respondents were female, representing (n = 74; 92.5%) of the total sample, while (n = 6; 7.5%) were male.

The gender response seen below:

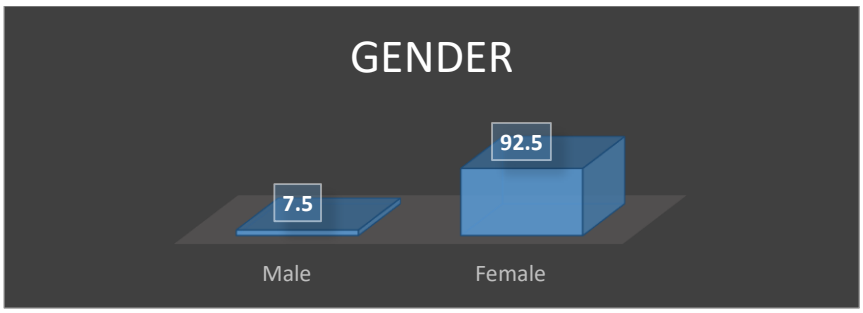


Figure 4.1

4.3.3 Age

Figure 4.2 shows respondents' ages. The majority (n = 42; 52.5%) were within the age bracket of 31 to 40. The second-largest group of respondents were between the ages of 41 and 50, representing (n = 25; 31.3%) of the total sample. The fewest respondents were between 25 and 30 (n = 6; 7.5%). None of the respondents was below 25 or above 60. Thus, respondents are mature enough to have some level of experience as a PHC nurse, which is required for this study. The age response rate shows:

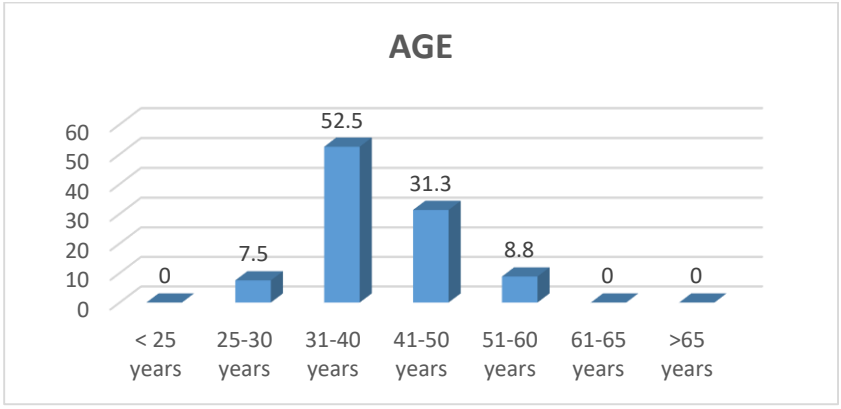


Figure 4.2: Age

4.3.4 Highest level of education

More than half (n = 65; 81.3%) of the respondents have a postgraduate diploma. About (n = 15; 18.8%) have a bachelor's degree in nursing. None of the respondents had a Master's degree or PhD. Most PHCNs have achieved at least a professional nurse education required for this study, indicating that respondents could comprehend questions and provide relevant answers relating to safety attitudes in the workplace. Figure 4.3 indicates respondents' highest levels of education.

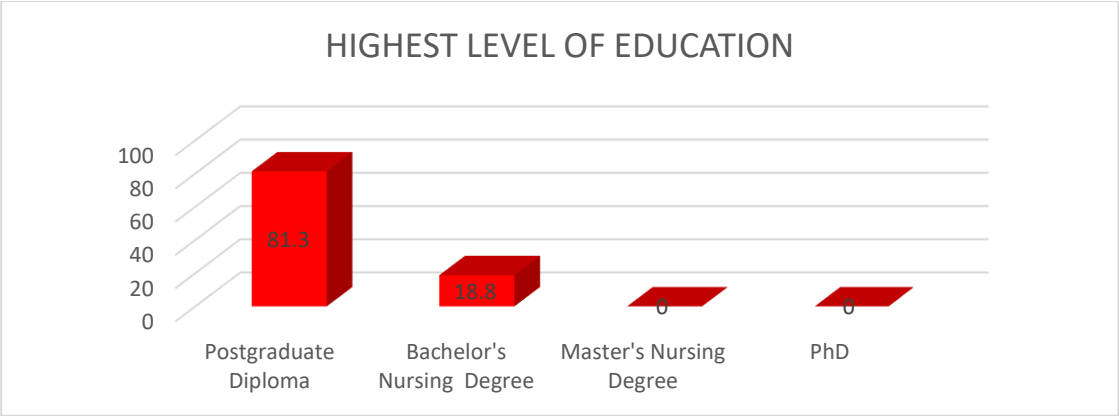


Figure 4.3: Level of education

4.3.5 Year of completion of Primary Healthcare nursing

The findings in Figure 4.4 below reveal that (n = 56; 70%) of the total respondents completed their studies in 2019, followed by (n = 19; 23.8%) in 2020. Only (n = 4; 5%) completed their studies in 2018, while only one nurse graduated in 2016 (n = 1; 1.3%). The year of completion graph shows:

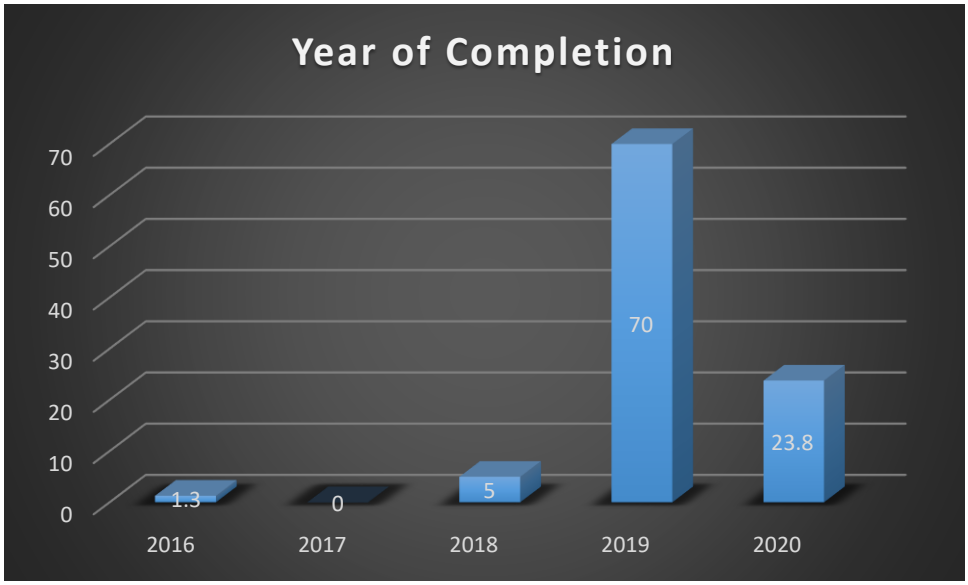


Figure 4.4: Year of completion

4.3.6 Number of years practising as a PHC nurse

Respondents' total years of practising as a PHC nurse is illustrated in Figure 4.5. The results highlight that about (n = 53; 66%) of the respondents have been practising for two years. About (n = 26; 32.5%) have one year of experience. Only (n = 1; 1.3%) had practised for three years. The result implies that respondents have obtained some

level of experience as PHC nurses, having the basic knowledge to understand the research instrument. The years of practising as a PHCN shows:

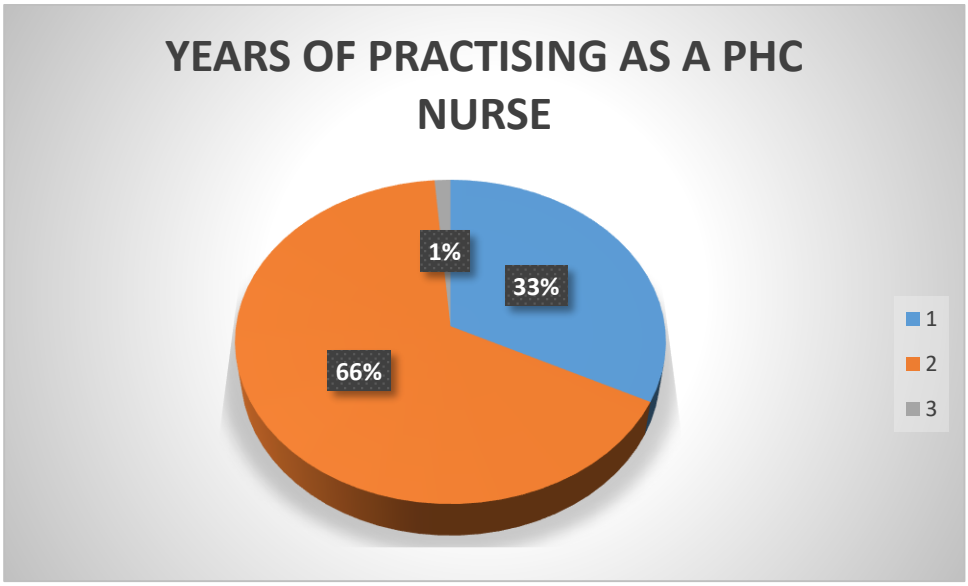


Figure 4.5: Years of practice

4.3.7 Place of Employment

Figure 4.6 below shows that (n = 51; 63.7%) of the respondents were working at the provincial level, while (n = 29; 36.9%) were located at the COJ.

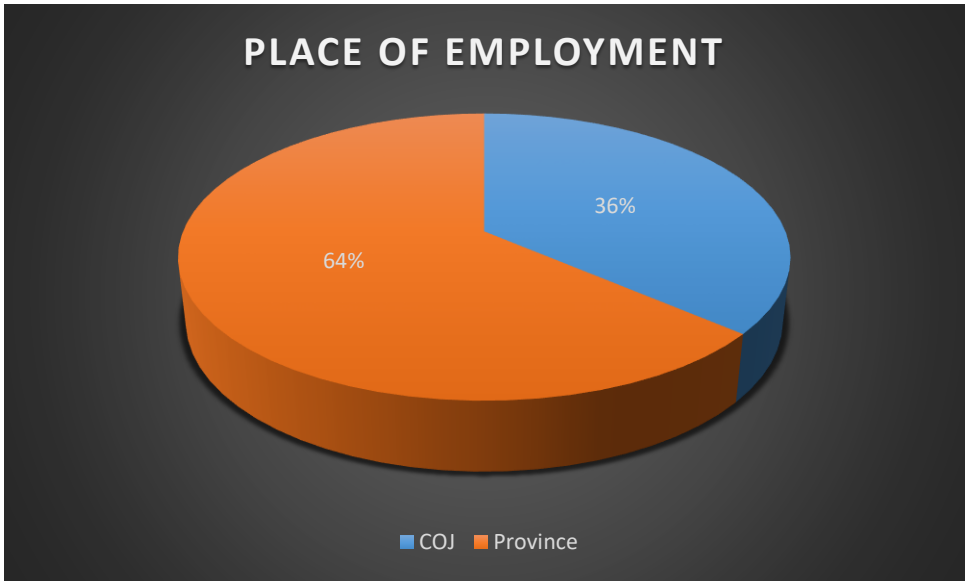


Figure 4.6: Place of employment

4.3.8 Opinions of respondent's level of expertise in the transition process

Respondents indicated the expertise they felt they had during their transition process. The results indicate that (n = 40; 50%) of the respondents felt competent. This means they have a good working and background understanding, see actions at least partly in context, and can complete work independently to a standard that is acceptable though it may lack refinement. These groups had more awareness and preparation for their transition. About (n = 28;35%) put themselves at the advanced beginner level, which implies that they have a working understanding, tend to see actions as a series of steps, and can complete simpler tasks without supervision. Finally, (n = 12; 15%) classed themselves as novices, which means they have an incomplete understanding, approach tasks mechanistically, and need supervision to complete them. Transition for this group of respondents might be difficult, as they need time to learn and to gain more experience. (None of the respondents selected proficient or expert.)



Figure 4.7: Level of expertise in the transition process

Table 4.2 looks at the relationship between Benner's levels of novice to expert and the number of years of practising as a PHC nurse. The results show that of the nurses who have practised for one year, (n = 5; 19.23%) are novices, while (n = 9; 34.62%) are at the advanced beginner level, and the majority (n = 12; 46.15%) felt they were competent. For those practising for two years, more than half (n = 28; 52.82%) felt competent in their roles, whereas (n = 19; 35.84%) were at the advanced beginner

level, and the rest stated that they were novices. The chi-square p-value (0.157) is statistically insignificant, implying that nurses' expertise and years of practice are independent of each other.

Table 4.2: Relationship between the Level of expertise and Years practising as a PHC nurse

		Level of Expertise			Total
		Novice	Advanced Beginner	Competent	
	Years	(n)(%)	(n)(%)	(n)(%)	(n) (%)
Number of years you have been practising as a PHC nurse	1	(n = 5) (19.23%)	(n = 9) (34.62%)	(n = 12) (46.15%)	n = 26
	2	(n = 6) (11.32%)	(n = 19) (35.84%)	(n = 28) (52.82%)	n = 53
	3	(n = 1) (100.00%)	0 (0.00%)	0 (0.00%)	n = 1
Total		n = 12	n = 28	n = 40	n = 80
Pearson Chi-Square Tests:		6.629 (0.157)			

4.4 Nurse Practitioner Role Transition Scale (NPRTS)

4.4.1 Measurements used for the study

This section describes respondents' opinions on the four main domains of the nurse practitioner role transition scale (NPRTS). The first domain refers to the 3Cs—comfort, competence, and confidence. The second domain is understanding; the third is support; and the fourth is communication relations.

The questions were assessed using a 5-point Likert scale, where 1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree nor Disagree, 4 = Agree, and 5 = Strongly Agree. The mean value measures the average response for each question collectively. A mean value above the average score of 3 shows high acceptance/agreement with the survey questions, and vice-versa. The one-sample t-test was used to determine whether the mean for each item differs significantly from the average mean score of 3.

4.4.2 Comfort, Competence, and Confidence (3C)

Table 4.3: Comfort, Competence, and Confidence

Comfort, Competence, and Confidence	Responses as Frequency (%)										N	Mean	P-Values
	Strongly Disagree		Disagree		Neither Agree nor Disagree		Agree		Strongly Agree				
	1		2		3		4		5				
	n	%	n	%	n	%	n	%	n	%			
I was comfortable in my role	19	23.8%	5	6.3%	16	20.0%	9	11.3%	31	38.6%	80	3.35	0.055
I was treated as a professional by my colleagues	3	3.8%	4	5.0%	7	8.8%	1	13.8%	55	68.6%	80	4.39	0.000
My PHCN role was very well understood by my physician colleagues	2	2.5%	6	7.5%	13	16.2%	9	11.3%	50	62.5%	80	4.24	0.000
I was very comfortable managing my patients	3	3.8%	7	8.8%	18	22.5%	5	6.3%	47	58.6%	80	4.08	0.000
My PHCN role was very well understood by my nurse colleagues	2	2.5%	2	2.5%	14	17.5%	3	3.8%	59	73.7%	80	4.44	0.000
My PHCN role was very well understood by the public	7	8.8%	5	6.3%	30	37.5%	6	7.5%	32	40.0%	80	3.64	0.000
I felt less confident than I did before becoming a PHCN	33	41.3%	12	15.0%	11	13.8%	3	3.8%	21	26.3%	80	2.59	0.029
I felt very competent in managing my patient caseload	5	6.3%	10	12.5%	12	15.0%	6	7.5%	47	58.8%	80	4.00	0.000
My PHCN role was very well understood by my patients/families	7	8.8%	9	11.3%	19	23.8%	5	6.3%	40	50.0%	80	3.78	0.000

Source: Field Data (2022)

Nine items define respondents' opinions on competence in their role, as presented in Table 4.3. This also reflects the attainment of comfort in managing the patient caseload, the ability to transition into the nursing practitioner role, and the development of confidence. This is an important factor because increased confidence in one's ability and performance would foster forward movement through the process of transition. Respondents were asked to rate their level of agreement concerning each of the nine items outlined in Table 4.3.

Nine respondents (n = 9; 11.3%) agreed they were comfortable in their role, while (n = 31; 38.6%) strongly agreed. On the contrary, (n = 24; 30.1%) of the respondents disagreed that input is well received in their facility, whereas (n = 16; 20.0%) remained neutral. Also, (n = 56; 82.4%) of the respondents agreed that they were treated as professionals by their colleagues. The majority (n = 50; 62.5%) strongly agreed with the assertion that their PHCN role was very well understood by their physician colleagues, while (n = 9; 11.3%) agreed. All the items under this factor have high levels of agreement by respondents, except the statement relating to confidence. According to the survey, the majority (n = 33; 41.3%) strongly disagreed that they felt less confident than they did before becoming a PHCN. About (n = 12; 15.0%) also disagreed. Only (n = 24; 30.1%) were in agreement (both agree and strongly agree).

The mean collectively measures the average response for each role. An average score above 3 indicates above-average comfort, competence, confidence, and vice-versa. The one-sample t-test was used to determine whether the items identifying this construct differ significantly from the average score of 3. The highest mean value was 4.44, for the statement "My PHCN role was very well understood by my nurse colleagues." All the other items recorded mean values above the standard average of 3.0, except for "I felt less confident than I did before becoming a PHCN," which showed average values of 2.59. Generally, the respondents indicate a strong agreement on the level of comfort, competence, and confidence (3Cs) in their roles. The p-values are statistically significant at 95%, affirming the importance of this construct.

4.4.3 Understanding

Table 4.4

Understanding	Responses as Frequency (%)										N	Mean	P-Values
	Strongly Disagree		Disagree		Neither Agree nor Disagree		Agree		Strongly Agree				
	1		2		3		4		5				
	n	%	n	%	n	%	n	%	n	%			
I felt that I was isolated	41	51.2%	8	10.0%	13	16.3%	5	6.3%	13	16.3%	80	2.26	0.000
I felt that I got very little support	27	33.8%	8	10.0%	14	17.5%	5	6.3%	26	32.5%	80	2.94	0.041
I felt it was easy to transition from nurse to PHCN	13	16.3%	11	13.8%	18	22.5%	8	10.0%	30	37.5%	80	3.39	0.024
I felt I had the skills to deal with the role transition	2	2.5%	7	8.8%	12	15.0%	8	10.0%	51	63.7%	80	4.24	0.000
I felt that I needed extra time to complete my responsibilities	17	21.3%	14	17.5%	13	16.3%	8	10.0%	28	35.0%	80	3.20	0.063
My PHCN role was very well understood by management	5	6.3%	5	6.3%	8	10.0%	8	10.0%	54	67.5%	80	4.26	0.000

Source: Field Data (2022)

The second construct reveals the understanding of the role of PHCN. It also identifies the understanding of the role of others as perceived by PHC nurses. Six items were considered in Table 4.4. Respondents were asked to rate their level of agreement concerning the questions outlined in the table. More than (n = 40; 50%) of the respondents agreed with each of the questions, except for the first two items. The table shows that (n = 41; 51.2%) strongly disagreed that “I felt that I was isolated.” This was supported by (n = 8; 10.0%) who also disagreed. Also, (n = 35; 43.8%) disagreed and strongly disagreed that “I felt that I got very little support.” This shows that most of the respondents had a lot of support and never felt isolated.

The highest mean was 4.26, for the statement “My PHCN role was very well understood by management.” Further, about (n = 54; 67.5%) strongly agreed that management understood their PHCN role well, while (n = 8; 10.0%) agreed with this statement. Only a total of (n = 10; 12.6%) disagreed, while (n = 8; 10.0%) remained neutral. The lowest mean was 3.76, for the statement “Morale in this facility area is high.” This represented (n = 26; 32.4%) who agreed, and (n = 25; 31.2%) who strongly agreed with this statement.

The mean score for the questions in Table 4.4 was above the average value of 3, except for the first two items, which had means of 2.26 and 2.94 respectively. The results strongly agree with the various questions indicating that PHC nurses had an improved understanding of the roles. The statistically significant p-values confirmed this. It also suggests that as others understand, and accept, the new PHC nurses, the ease of transition is expected to increase.

4.4.4. Support

Table 4.5: Support

Support	Responses as Frequency (%)										N	Mean	P-Values
	Strongly Disagree		Disagree		Neither Agree nor Disagree		Agree		Strongly Agree				
	1		2		3		4		5				
	n	%	n	%	n	%	N	%	n	%			
My PHCN program prepared me for a smooth role transition	1	1.3%	15	18.8%	1	15.0%	7	8.8%	45	56.3%	80	4.00	0.000
I felt anxious about the integration of theory into my practice	16	20.0%	22	27.5%	17	21.3%	7	8.8%	18	22.%	80	2.86	0.395
My workday was just how I imagined it would be when I was a student	22	27.5%	19	23.8%	12	15.0%	7	8.8%	20	25.0%	80	2.80	0.253
My education prepared me to effectively manage my patients	1	1.3%	4	5.0%	3	3.8%	8	10.0%	64	80.0%	80	4.63	0.000
My supervisor was very available/approachable	9	11.3%	9	11.3%	18	22.5%	4	5.0%	40	50.0%	80	3.71	0.000
My mentor was very available/approachable	21	26.3%	5	6.3%	22	27.5%	4	5.0%	28	35.0%	80	3.16	0.367
I felt that my PHCN role was seen as a substitute for a Doctor	10	12.5%	6	7.5%	10	12.5%	12	15.0%	42	52.5%	80	3.88	0.000
I had trouble applying the theory to practice when I was under stress	27	33.8%	21	26.3%	14	17.5%	4	5.0%	14	17.5%	80	2.46	0.001
I felt that I was doing more than one person’s work.	13	16.3%	3	3.8	12	15.0%	3	3.8%	49	61.3%	80	3.90	0.000
I felt I developed my PHCN role within a nursing framework	4	5.0%	1	1.3%	11	13.8%	7	8.8%	57	71.3%	80	4.40	0.000

Source: Field Data (2022)

Respondents' opinions regarding understanding the role were described in this sub-section. Ten questions were asked under this domain. Most of the questions recorded an above-average value, showing that more than 50% of the respondents agreed to each of the questions outlined under support. The question, which states, "My education prepared me to effectively manage my patients," recorded the highest mean of 4.63, comprising an agreement level of (n = 8; 10.0%) = Agree; (n = 64; 80.0%) = Strongly Agree), while about (n = 3; 3.8%) were neutral to this question. In addition, the majority of the respondents (n = 28; 60.1%) disagreed that "I had trouble applying the theory to practice when I was under stress" (n = 27; 33.8%) = strongly disagree; (n = 21; 26.3%) = Disagree). About (n = 4; 5.0%) agreed they had trouble applying the theory to practice under stress. This is supported by (n = 14; 17.5%) of the respondents who strongly agreed with it. Again, the majority of the respondents disagreed (n = 20.0% = Strongly Disagree; (n = 22; 27.5%) = Agree with the statement "I felt anxious about the integration of theory into my practice", and about (n = 28; 29.1%), neither agree nor disagree (n = 17; 21.3%), (n = 7; 8.8%) = Strongly Agree agreed to the assertion.

The results indicate a strong agreement with the assertion that PHC nurses received sufficient support in performing their role. This was confirmed by the p-values, which were statistically significant in most of the questions. The study concludes that there must be a high sense of support and professionalism as contributors to the PHC nurse role as this is more likely to lead to a positive role transition.

4.4.5 Communication Relations

Table 4.6: Communication Relations

Communication Relations	Responses as Frequency (%)										N	Mean	P-Values
	Strongly Disagree		Disagree		Neither Agree nor Disagree		Agree		Strongly Agree				
	1		2		3		4		5				
	n	%	n	%	n	%	N	%	n	%			
I felt I developed my PHCN role within a medical framework	2	2.5%	3	3.8%	26	32.5%	6	7.5%	43	53.8%	80	4.06	0.000
I felt that I was an invisible provider on the healthcare team	39	48.8%	11	13.8%	17	21.3%	5	6.3%	8	10.0%	80	2.15	0.000
I felt that I had a poor relationship with the Doctor	34	42.5%	24	30.0%	15	18.8%	3	3.8%	4	5.0%	80	1.99	0.000
I felt anxious in my communications with other healthcare providers	47	58.8%	14	17.5%	8	10.0%	4	5.0%	7	8.8%	80	1.88	0.000
I was able to navigate the healthcare system to develop my new role	3	3.8%	6	7.5%	14	17.5%	8	10.0%	49	61.3%	80	4.18	0.000
I had a clear understanding of third party reimbursement	18	22.5%	7	8.8%	24	30.0%	2	2.5%	29	35.3%	80	3.21	0.028

Source: Field Data (2022)

Table 4.6 presents respondents' opinions on the ability to effectively communicate and develop strong relationships with fellow team members was described by new PHCNs as a positive element in role transition. Specifically, this construct sought to identify the developments of development of communication and relations with team members. To achieve this, six statements were considered. Respondents were asked to rate their level of agreement concerning the questions outlined in the table. The response from the survey showed that (n = 43; 53.8%) of the respondents strongly agreed that they developed their PHCN role within a medical framework, along with (n = 6; 7.5%) who agreed. Again (n = 49; 61.3%) strongly agreed that they were able to navigate the healthcare system to develop their new role; about (n = 8; 10.0%) agreed, whereas (n = 9; 11.3%) disagreed, and the rest were neutral.

Only three of the questions had more respondents who disagreed with the assertion. Firstly, for "I felt that I was an invisible provider on the healthcare team", (n = 39; 48.8%) strongly disagreed; (n = 11; 13.8%) disagreed, and about (n = 17; 21.3%) remained neutral. Thus, most of the respondents felt visible in the healthcare team. This is a good sign because it indicates a sense of belonging.

Secondly, for "I felt anxious in my communications with other health care providers," (n = 47; 58.8%) of the respondents strongly disagreed, while (n = 14; 17.5%) disagreed. Only a total of (n = 11; 13.8%) agreed or strongly agreed with this statement. Hence, the majority affirmed that they had no anxiety issues in their communication with other healthcare providers.

Thirdly, most of the respondents indicated that they had a good relationship with the doctor. This is supported by (n = 34; 42.5%) strongly disagreeing that "I felt that I had a poor relationship with the Doctor."

The mean score for these items affirm the descriptive results. The questions in Table 4.6 were above the average value of 3, except for the last three items discussed. The results indicate that mastering soft skills in collaborating and communicating with team members promotes role transition and the ability to problem-solve complex patient care situations using a team approach. This is also confirmed by the one-sample t-test, which shows significant p-values. It also shows that there was less conflict and more collaboration and communication with the healthcare team.

4.5 Reliability and Correlational Statistics

4.5.1 Exploratory Factor Analysis

	Factor			
	A	**B**	**C**	**D**
I was comfortable in my role	0.683			
I was treated as a professional by my colleagues	0.589			
My PHCN role was very well understood by my physician colleagues	0.538			
I was very comfortable managing my patients	0.217			
My PHCN role was very well understood by my nurse colleagues	0.261			
My PHCN role was very well understood by the public	0.298			
I felt less confident than I did before becoming a PHCN	-0.118			
I felt very competent in managing my patient caseload	0.505			
My PHCN role was very well understood by my patients/families	0.375			
I felt that I was isolated		0.491		
I felt that I got very little support		0.678		
I felt it was easy to transition from nurse to PHCN		0.751		
I felt I had the skills to deal with the role transition		0.442		
I felt that I needed extra time to complete my responsibilities		0.131		
My PHCN role was very well understood by management		0.618		
My PHCN program prepared me for a smooth role transition			0.603	
I felt anxious about the integration of theory into my practice			0.409	
My workday was just how I imagined it would be when I was a student			0.266	
My education prepared me to effectively manage my patients			0.544	
My supervisor was very available/approachable			0.498	
My mentor was very available/approachable			0.445	

I felt that my PHCN role was seen as a substitute for a Doctor			0.417	
I had trouble applying the theory to practice when I was under stress			0.314	
I felt that I was doing more than one person's work			0.196	
I felt I developed my PHCN role within a nursing framework			0.759	
I felt I developed my PHCN role within a medical framework				0.717
I felt that I was an invisible provider on the healthcare team				0.027
I felt that I had a poor relationship with the Doctor				-0.075
I felt anxious in my communications with other healthcare providers				0.360
I was able to navigate the healthcare system to develop my new role				0.069
I had a clear understanding of third party reimbursement				0.375

Table 4.7: Exploratory Factor Analysis

Key: A = Comfort, competence and confidence

B = Understanding

C = Support

D = Communication Relations

4.5.2 KMO and Bartlett's Test

This study conducted exploratory factor analysis (EFA) as a construct validity technique (see Table 4.3 results). Construct validity refers to whether the factor structure of the questionnaire makes intuitive sense (Field, 2013). Before carrying out factor analysis, the Kaiser-Meyer Olkin Measure of Sampling Adequacy (KMO) and Bartlett's Test of Sphericity were used to assess the data's factorability. Specifically, the KMO test was used to check the sampling adequacy of the data, and Bartlett's Test of Sphericity was used to check if correlations between items were sufficiently large for EFA to be carried out. Bartlett's test of Sphericity should reach a statistical significance of more than 0.05 for factor analysis to be suitable (Bartlett, 1954). The KMO index value ranges from 0 to 1, with 0.6 considered the minimum value for exploratory factor analysis to be appropriate (Tabachnick, Fidell, & Ullman, 2007). The KMO and Bartlett's test results are shown in Table 4.8 below.

Table 4.8: KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy		0.649
Bartlett's Test of Sphericity	Approx. Chi-Square	1019.291
	Df	465
	Sig.	0.000

As shown in Table 4.8, the Kaiser-Meyer-Olkin Measure verified the sampling adequacy for the analysis with the KMO value = 0.649, above the minimum value of 0.6 (Tabachnick et al., 2007). Bartlett's Test of Sphericity was statistically significant *(p-value < 0.05),* indicating that correlations between items were sufficiently large for EFA to be conducted.

An exploratory factor analysis assessed the impact of each item on its construct. Four factors were identified. The factor loadings for each of the items under the four domains of the nursing practitioner role are shown in Table 4.7 above. The first factor (A) measures comfort, competence, and confidence and has 9 items. Factors 2-4 measure the other domains. The category of factors is B = Understanding (6 items);

C = Support (10 items); and D = Communication Relations (6 items). Factor loadings of about 0.50 and above indicate the reliability of each item to its domain. The highest factor loading was 0.759, representing the statement, “I felt I developed my PHCN role within a nursing framework”. The lowest factor loading was -0.075, which was “I felt that I had a poor relationship with the Doctor.”

4.5.3 Correlation Analysis

Table 4.9: Correlations

		3Cs	Understanding	Support	Communication Relation
3Cs	Pearson Correlation	1	-0.154	.344**	0.056
	Sig. (2-tailed)		0.171	0.002	0.621
	N	80	80	80	80
Understanding	Pearson Correlation	-0.154	1	0.011	0.190
	Sig. (2-tailed)	0.171		0.924	0.091
	N	80	80	80	80
Support	Pearson Correlation	.344**	0.011	1	.310**
	Sig. (2-tailed)	0.002	0.924		0.005
	N	80	80	80	80
Communication Relation	Pearson Correlation	0.056	0.190	.310**	1
	Sig. (2-tailed)	0.621	0.091	0.005	
	N	80	80	80	80
**. Correlation is significant at the 0.01 level (2-tailed).					

Correlation analysis was employed in this study to measure the relationship between comfort, competence, confidence, understanding, support, and communication relations. Samuel and Okey (2015) describe correlation as a statistical measurement of the relationship between two continuous variables using the correlation coefficient (rho). The correlation coefficient ranges from -1 to +1. A correlation of –1 indicates a perfect negative correlation, meaning that as one variable goes up, the other goes down. A correlation of +1 indicates a perfect positive correlation, meaning that both variables move together in the same direction. A zero correlation indicates that there is no relationship between the variables.

Table 4.9 above shows that there was a statistically significant *(p-value = 0.002)* slight positive correlation *(r = 0.344)* between comfort, competence and confidence, and support. In addition, it can be seen that there was no statistically significant *(p-value = 0.924)* correlation (*r = 0.005)* between support and communications, as indicated by the significance level (p-values > 0.05).

4.6 Discussion of Research Findings

4.6.1 Demographics

The majority of participants were female (n = 74; 92.5%). This is a common trend in nursing. According to the statistics provided by the South African Nursing Council (SANC), in the provincial distribution of nursing workforce, (stat.1/2021) there is a total of 138 681 female registered nurses and 17 711 male registered nurses (https://www.sanc.co.za/wp-content/uploads/2022/01/Stats-2021-1-Provincial-Distribution.pdf). In New Zealand, nurses consisted of 23% males, with females being 77% Nursing Council of New Zealand (The Nursing Cohort report, 2020).

The age ranges of the PHCNs ranged from 25 years to 60 years, indicating that the PHCNs had significant experience as PNs.

The highest level of education was a nursing bachelor’s degree (n = 15; 18.8%) with the second-highest level being a Post Graduate Diploma (n = 65; 81.3%). Therefore, the PHCN qualification was the highest qualification of most participants.

Most respondents were from the 2019 year of completion (n = 56; 70%), making two years of practice the highest rate (n = 53; 66%).

The most common place of employment was within the provincial government (n = 51; 63.7%), followed by the COJ municipality (n = 29; 36.3%), indicating that the provincial government has either more clinics or more staff members to train, or they serve a bigger population.

Forty participants (n = 40; 50%) indicated that they feel competent according to Benner's skill acquisition, followed by advanced beginner (n = 28; 35%) and novice (n = 12; 15%).

4.6.2 NPRTS-related aspects

The discussion will be presented according to the four domains, as follows: Domain 1: Comfort, Competence, and Confidence; Domain 2: Understanding; Domain 3: Communication relations; and Domain 4: Support.

4.6.2.1 Domain 1: Comfort, Competence, and Confidence

Comfort, confidence, and competence in the PHCN's new role measures the understanding of the role by others as perceived by the PHCN (Strange, 2015).

- **Comfort**

Kolcaba (2003) explains comfort in four points:

1. "The need for comfort is basic",
2. "People experience comfort holistically",
3. "Self-comforting measures can be healthy or unhealthy",
4. "Enhanced comfort leads to greater productivity".

It is clear that it takes time to become comfortable. The study provided evidence that the majority (49.9%) of respondents agreed and strongly agreed that they were comfortable in their role, while 30.1% were not. For the item, "I was comfortable managing my patients", 64.9% of respondents agreed and strongly agreed, while 12.4% strongly disagreed and disagreed. This also shows a higher level of competence in respondents.

- **Competence**

Competence is internationally applied to professionals of all kinds, especially in the practice of nursing (Garside and Nhemachena, 2011). According to Benner (1984), competence is a progressive experience, which consists of the five stages mentioned in chapter 2. Pearson (1984) described competence as “mid-point/mid-range.” Nurses at the competent level are those who are able to function safely but may still need to develop holistically, as well as having complete awareness. The study suggests that health workers must ensure an environment that has all the 3Cs of this construct to enable PHC nurses to be effective in their roles and make the transition easier.

- **Confidence**

Lack of confidence makes any transition more difficult (Strange, 2015). The majority of respondents indicated that they felt more confident than they did before becoming a PHCN. This implies good clinical knowledge gained through college. A high level of confidence in PHCNs is not surprising when PHC nurses work in a comfortable and competent environment, where the majority are more likely to be confident about their role.

4.6.2.2 Domain 2: Understanding

An understanding of the role promotes overall education and incorporation (Strange, 2015). It is important to note that the results strongly agree with the various questions indicating that PHC nurses had an improved understanding of the roles. It also suggests that as others understand and optimistically accept the new PHC nurses, the ease of transition is likely to increase.

4.6.2.3 Domain 3: Communication relations

The results agree with the perceptions that mastering soft skills in collaborating and communicating with team members helps promote role transition and the ability to problem-solve complex patient care situations using a team approach (Strange, 2015). This is also confirmed by the one-sample t-test, which shows significant p-values. It also shows that there was less conflict and more collaboration and communication with the healthcare team.

4.6.2.4 Domain 4: Support

Under support, 55% agreed, “my supervisor was approachable” while a total 26.6% of respondents disagreed. Therefore, a significant percentage did not have the required support. On the item, “my mentor was approachable”, 32% disagreed. This indicates that a large number of respondents lacked mentorship and that mentors were not approachable, which is unfortunate, as being nurtured by a mentor or colleague further enhances support and role transition (Cusson and Strange, 2008).

4.7 Summary

In this chapter, the findings from the quantitative phase of the study were discussed. The qualitative phase will be discussed in the next chapter.

CHAPTER 5 - QUALITATIVE RESEARCH FINDINGS AND CONTEXTUALISATION OF LITERATURE

5.1 Introduction

In the previous chapter, the results of the quantitative phase and the related discussion were presented. Chapter 5 presents Phase 2 qualitative interview findings and discusses these in the context of their respective themes, categories and sub-categories.

The findings presented come from data interviews conducted with twelve (n = 12) PHCNs on their transition from professional nurses to PHCNs. The central question asked was **"Can you please tell me how you experienced the transition from being a Professional Nurse to a Primary Healthcare Nurse?"** Data were analysed using qualitative data thematic analysis.

The researcher also asked probing questions, which included:

- What experiences have helped you and what experiences were barriers for you during your transition?
- What has made the transition easier for you?
- What would make the transition easier for you?
- What have your experiences been thus far from being a new PHCN?

5.2 Description of the Sample Profile

The 12 participants (n = 12) consisted of eight females and four males. The ages were as follows:

- Two participants were aged 25 to 35
- Nine participants were aged 35 to 45
- One participant was aged between 45 and 55
- All participants were Registered nurses and had newly qualified as PHCNs between the years 2019 and 2020.

Figure 5.1 depicts the age ranges of participants below:

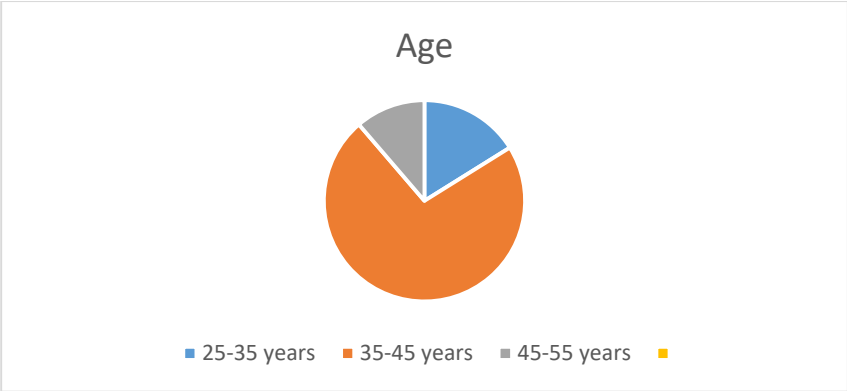


Figure 5.1 Age is a depiction of the age ranges of the respondents

5.3 Themes and Sub-Themes

Following the analysis of the transcripts, two main themes and eight sub-themes emerged that explained the experiences of professional nurses making the transition to qualified PHCNs.

The two main themes that emerged from thematic data analysis were '1. Role Change and '2. Navigating challenges associated with the transition', as shown in Table 5.1.

Table 5.1 Themes, Categories and Sub-categories

Theme	Category	Sub-category
1. Role change	1.1 Independent patient care	1.1.1 Increased nurses' competence, confidence in managing patients
	1.2 Taking more responsibilities	1.2.1 Filling the new role
2. Navigating challenges associated with the transition	2.1 Health personnel related	2.1.1 Self: ● Increasing patient consultation speed to fit the clinic's need ● Needing to refer to the manual a lot
		2.1.2 Patients Rushing the queues due to patient complaints
		2.1.3 Doctor Some had fear of approaching the doctor Some were very comfortable with a doctor
		2.1.4 Colleagues ● Inadequate support from colleagues, ● rushing the queues resulting in poor quality of care, ● Resistance to change,

		● High expectations.
	2.2 Institutional	2.2.1 Lack of orientation, lack of mentorship, 2.2.2 thrown in the deep end, shortage of staff, 2.2.3 shortage of equipment, 2.2.4 a massive workload
	2.3 Emotional challenges	2.3.1 Angry, hurt, overwhelmed, stressed, work overload, intimidation, frustrated, anger

5.3.1 Theme 1: Role change

The transition from PN to PHCN entails a change in role from giving patient care to assessing, treating, and prescribing patient care (Forbes and Jessup, 2004). This theme described how participants' roles changed and how they gained trust when they qualified as PHCNs.

5.3.1.1 Role change descriptions

Participants described how their roles changed, from being a professional to being a student PHCN and then to being a qualified PHCN. The theme is discussed under two categories: '1.1 Independent patient care' (with the sub-category '1.1.1 Increased nurses' competence & confidence in managing patients') and '1.2 Taking more responsibilities' (with the sub-category '1.2.1 Filling the new role').

Category 1.1: Independent patient care

After the participants achieved their PHC qualifications, they were able to work on their own with minimal supervision. The kind of education, training, and skills they gained during the Primary Healthcare programme enabled them to provide independent holistic care to their patients in the various clinics. One of the participants who commented on the quality of the training received mentioned that it was adequate, and provided the skills needed to practise without fear.

"I felt like the training was enough because I think it's the training that helped me to be able to manage to work independently in my room. So I didn't have any fear of working alone, hence they gave me that room to work alone because I knew that I can consult with them on those things that I don't understand. But for the college, I think the college that training was more meaningful for me because like I, I able just to work independently, consulting to other people" ***[P8]***

Other participants explained:

“I was more independent. I am able to manage my patient fully without guidance from anyone, you know, and that was the easiest part for me. My main thing was to be able to manage my patient in totality so that going to the PHC made me able to manage my patient better than when I didn't have the PHC” ***[P2]***

“I wouldn't do it before; now I treat patients from a better point of view. And it equipped me with so much information that I was now able to work independently, rarely asking for a doctor's intervention and stuff. So it was a beautiful transition, to be honest” ***[P5]***

Sub-category 1.1.1 Increased nurse competence and confidence in managing patients

The PHC training enabled the participants to gain confidence and competence in managing all kinds of patients that were presented. Competencies and confidence were built as participants finished the Primary Healthcare program. According to Kim and Shin (2020), self-confidence is achieved from small experiences as you grow into competency and beyond.

This is evident as participants stated:

“I feel they did a great job with building my confidence, so it really helped me to get through all that was; that I was faced with during my transition” ***[P10]***

“I found it very, very, very empowering. It was as if I had never been a nurse before. I’m, there was so much improvement in, in my clinical skills” ***[P1]***

“I felt empowered. There was a lot that I have learned. I felt very, very confident in how I apply to the legal ethical framework. Those policies were what was expected of me as a PHC nurse. I felt very, very, very confident about the clinical knowledge that I acquired for me to be actually to, to, to apply it in my workplace. So the key word for me was empowerment. I felt very empowered with the skills that I have left” ***[P11]***

Category 1.2: Taking more responsibilities

Although the PHCNs were led and supervised during their programme, building their capacity to take on more responsibilities as they progress takes more experience to fill the new role of increased difficulty. Participants shared:

“Was a bit nervous because it comes with a lot of responsibilities. You are now directly and indirectly, you are responsible to lead a number of professional NURSES that will be working in a facility on that particular day. In terms of running of services I'm

conducting and supervising other clinicians, in terms of mentoring other clinicians, because we have everybody, comes to you, even including the old people that trained" ***[P1]***

"I would also see that I was in very high demand, high expectations, because of the new role. So, I was fortunate to have a manager that was really supportive and mentored me in the new role, but in regards to Primary Healthcare nurses that were there in the facilities, they were actually looking up to me to lead into actually seeing what's the latest, what has changed? Whereas my manager is very supportive" ***[P1]***

<u>Sub-category 1.2.1. Filling the new role</u>

Participants were not expecting such a high number of responsibilities as they thought they would ease into their new roles. They needed time and experience to practise and to master these new roles, to run these services. Participants shared:

"I assumed more responsibility by being a nurse clinician. I became more senior. So when the manager is not here, I become the acting manager" ***[P2]***

"The transition came with a lot of responsibilities because now as a Primary Healthcare nurse, you have to make a decision. When the doctor per se. For example, in other clinics, there are no doctors, so if you are PHCN, you have to see the patient and, you have to decide here and there on how to treat the patient. And then this came with a huge responsibility" ***[P4]***

5.3.1.2 Role change discussion

This study provided valuable insight into the experiences of participants transitioning to PHCNs, positive or negative. Role transition is difficult (Brown & Olshansky, 1997; Flinter & Hart, 2016; Steiner et al., 2008). Kim and Shin (2020) found that positive and supportive work environments, self-confidence, interaction from colleagues, and a phase transition programme help facilitate transition. The findings in this study showed that the participants who felt empowered and confident and who worked in a positive work environment were those who had a positive transition experience. PHCNs generally felt an increase in their confidence in treating patients compared to before training. They went from being expert professional nurses, who decided to transition to novice PHCNs. These expert PNs had to leave behind their confidence, competence and feeling of control, trading it with doubt and discomfort, which they are not accustomed to (Sellman, 2018).

Forbes and Jessop (2004) indicated that a novice status does not disappear after qualifying as a professional; whether you are a PN or PHCN, you are still expected to work within your scope of practice.

5.3.2 Theme two: Navigating challenges along the transition

As participants made the transition, they had to deal with several challenges. These challenges were grouped into categories: “health-personnel related”, “institutional”, and “emotional” challenges.

Category 2.1: Health-personnel related

This category has subcategories as follows: ‘Self’; ‘Patients’; ‘Doctor’; and ‘Colleagues’. Participants mentioned that navigating themselves together with navigating patients and doctors could be challenging.

Sub-category 2.1.1. Self

- Participants spoke about the “Increasing patient consultation speed to fit the clinic’s need” and “Needing to refer to the manual a lot”.

“It affected me greatly. Because now you have to be fast, and being faster means you might miss other things. You cannot examine properly. Get information from the patient, because now you will be in a hurry to see these other 90 people waiting outside for you. You at times you, you, you knock off 2 hours later.”

“And then when you are fresh from school, come back from school for you to see one person, it might take 15 to 20 minutes and minutes and like them when they see a patient is 5 minutes. I think that also is a problem because you cannot see coming back from school. You cannot see more than 20 patients a day, becomes too much for you because you're not yet used to seeing such a large number of people in a day” [P3]

“I would see the patient and I'll explain to the patient that I just came back from school. I will be a bit slow. I will see the patient and then after I am done, I will go to my mentor with the file inside. The patient is presenting with this and this and this. And I feel this is what the final diagnosis is and then they correct me or advise me otherwise and then I'll go back and then see the patient in totality” [P10]

Sub-category 2.1.2 Patients

Participants had more to say about “Rushing the queues due to patient complaints.” Participants explained:

“It affected me greatly. Because now you have to be fast, and being faster means you might miss other things. You cannot examine properly. Get information from the patient, because now you will be in a hurry to see these other 90 people waiting outside for you. You at times you, you, you knock off 2 hours later” [P11]

“And the other thing. This uh shortage of staff. The lead. Lead us to the patient stays long. In the clinic. Then they start harassing us and insulting us, and sometimes assaulting us. Because they stay long in the clinic, then they become impatient and frustrated” [P4]

“Now you see when we are working, sometimes we just need to push a line. For example, if you have 20 patients at that time, but if you are still new. We are going to fail to do that because we are always consulting and the patient also complaining to you because they do not understand whether you are from school to say this person is very slow to us. Then we came here and this time then we are going back at this time. So it was like very difficult for me just to make my patient happy” [P8]

Sub-category 2.1.3 Doctors

Doctors play a big role in assisting new PHCNs to adjust once qualified, especially when there are no other doctors or more experienced PHCNs in the facility.

“Working with the doctors becomes more difficult” [P4]

“Yes, but others like some of the doctors? Sometimes I feel scared to go to them, but I feel, what can I say? I feel free to discuss with them. Others they are like, they are difficult to be approached. When coming to things like this” [P4]

“Yes, um you know, the ones that I was in school with were my referral system as well. When I was stuck, I call them, or when I am stuck, I do have a doctor that works. I mean it's all the clinics having this problem” [P6]

Sub-category 2.1.4 Challenges from colleagues

The sub-categories for challenges from colleagues were 'Inadequate support from colleagues'; 'rushing the queues resulting in poor quality of care'; 'Resistance to change"; as well as ' High expectations'.

Challenges from colleagues and dealing with the behaviours of a staff member after the course have occurred. Many new and good behaviours were formed during the course and the new PHCNs were excited to implement these changes. This brought about conflict within the workplace. Participants shared:

"There is a resistance to change. In a department like PHC, people are so relaxed. To a point where they feel like they do not want any rotation, they are so comfortable in their rooms to point me, but if there is a shortage elsewhere, it becomes very difficult for a person to move out of the room to go in, assist where they need assistance just because they are too comfortable in their rooms. So people are so resistant when it comes to change" [P3]

"There's a lot of resistance in terms of uh, people, doing the correct things so it was people, my colleagues, basically not all of them, some of them they will not do things according to the book." [P2]

"Very reluctant. Very, very reluctant to follow the newer protocol" [P5]

Participant two mentioned that one of the challenges she had was that colleagues just want to push the queues. This results in poor quality of care.

"*I think it's just that, you know, people want to finish and go. That is it. Work, finish, and go to lunch and it is obviously not all of them. It is just a few. Some of them, they do actually do the right thing; some of it is not that, uh, they want to do the wrong thing. They do not know what to do. They do not open a book, or they just do what they think. Yeah." [P2]*

Category 2.2: Institutional challenges

Institutional challenges had further sub-categories such as lack of support, orientation and mentorship; thrown in the deep end and shortages of staff; shortage of equipment; and a massive workload.

Sub-category 2.2.1 Lack of support, orientation and mentorship

One of the challenges from the institution was inadequate support or lack of support by management.

"It made me feel like I was thrown in the deep end without having any swimming lessons. As for me, returning from college, I did not go to the [same] clinic. I was changed to another clinic. I did not know the people. It was not easy even communicating with them. It was not easy. Talking to the non-PHCNs also. Because they have this attitude towards PHC nurses" [P11]

"Ok, immediately after getting back, as I said many people were sick. The role of acting manager came to me, and when she came back, it was worse. The manager does not solve problems, and when I go to her, she agrees with me. Someone else comes to her; she agrees with them. The manager was also not there and even when she is there, she does not solve problems. There was a lot of bullying from particular individuals" [P11]

"Therefore, we do not see many people, but we have very different types of clients. It is very difficult for the management to give us [more] staff, because they feel that we have a small clinic and the number is not. Umm, kind of. I am making us get staff. Do you understand what I mean? You do not get extra staff. Because of the number that you get in the clinic" [P2]

"When you go to them, they forever busy, but I had very few that they were willing to help and there they will come and check if everything is OK" [P3]

Inadequate supervision and mentorship was another institutional challenge. Some participants had support, and some did not, as indicated below.

Those who had support mentioned:

“OH, what made it easy was that I had few people in the department who were willing to help, including certain doctors. They were also willing to help” [P3]

“The mentoring was perfect. I managed to adapt very easily and quickly, because of the support of the people I found in the field already” [P4]

“But the only thing that we, I myself was doing there, I was trying to consult with them most of the time; I ended up sometimes leaving my patient in my room, going to the other room, to consult with them, if I found any problem with the patient. So that's why I'm saying that there was not enough mentoring” [P8]

“She uh. When I came back, she made sure that I had the right tools for the trade, because that is also important. She made sure, because I am at that time, I remember that time we were struggling to get things like your ENT sets, the right quality stereoscopes in the facilities, and basic tools of the trade. When I came back, she actually made sure that there are tools that are available for me to use instead of using my personal tools. In terms of if I had any ambiguity with regard to a diagnosis of a particular patient, I would actually call her in, just for confirmation or to discuss cases, you know, in my facility” [P1]

Those who did not have support stated:
“There was one mentor, but she was not working on my side. Remember, due to COVID-19, that person was working at the COVID side; so actually, there was no one that was mentoring me” [P12]

“There was nobody specific for mentoring me, but it was some other colleague that I was going to them and consult with them” [P8]

“In terms of the support, I mean it, maybe I see the patient and then I find it difficult to reach the diagnosis of, I mean for the patient, and then I go and consult with my seniors. Then we come up with the relevant diagnoses and the proper treatment for the patient” [P4]

Sub-category 2.2.2 Shortage of equipment

Another institutional challenge was inadequate medication and equipment. There was a mixture of sentiments between those who had sufficient equipment, and those who did not, and when there was a shortage, if the equipment would be brought or supplied.

*"Even now, we still do not have an ENT set. Especially ***. We still do not have an ENT set. We are still using my equipment from PHC, as a student. At the clinic, there is nothing. Even now we are still struggling" [P12]*

"A lot of still shortages from the main pharmacy. There was no medication. Even now, we are still struggling. After three years of being PHC-trained, there we are still struggling. There was a shortage" [P12]

"It affects my work in a negative way because there are certain things that I cannot see. Let me just give an example right now; when you talk of a simple instrument like the one I'm expected to do, perhaps smear; so recently we don't even have any equipment to do Pap smear. Which? Meaning that a person like when we see a patient, a patient will not be nursed holistically because of some equipment that we do not have in the facility" [P3]

"Yeah, equipment. Yes, it is also lacking. It is also lacking some of the tools I remember. It would be your, you know, your simple ENT set. Your simple interest said, whether you come across this patient that is suffering from an earache and then you cannot even see the inside of the ear to see what it's wrong with the ear" [P6]

Sub-category 2.2.3 Shortage of staff

An inability to manage patients and other work-related situations during the process of induction into a new role could be a result of staff shortage (Azimian et al., 2014). Inadequate staffing is another institutional challenge mentioned by the participants:

"The tough side is the clinics are full and we are expected to see all the conditions. It is the first time that we are seeing those conditions that we have seen during our practical side when we were students. Now, when you are alone, it is a little bit tough because you still have to go and refer to your books. Or to consult and the number of

the patient that we are seeing a day is too much for us It was too much for me and it's still too much for me because of the shortage of PHC-trained nurses" [P12]

"A simple example is that in the shortage, there are no EPI nurses, and on the PHC side, we have enough staff. So it becomes very difficult for them to move just because there are fewer clinicians, it becomes very difficult for them to go, and that is why this is a shortage. They feel like, I do not know if they feel like it's too low for them all" [P3]

"It was difficult because of the shortage of staff, which did not get enough mentoring. We were doing other things for ourselves. We did not get people who can orientate us fully on how. Are we going to do things now because of, I think it's a shortage of staff and stuff like that, so we end up learning along the way in that situation" [P8]

Sub-category 2.2.4 A massive workload

Participants felt that there workloads were massive. Massive workloads as a novice PHCN can result is poor quality of patient care, as they do not have experience in working with a massive workload yet. One participant shared:

"The workload load is massive" [P11]

Category 2.3: Emotional challenges

Under the category of emotional challenges, participants expressed different emotions such as being angry, hurt, overwhelmed, stressed, overloaded with work, intimidated, and frustrated. When a registered nurse transitions to a nurse practitioner it is only natural to have feelings of anxiety and insecurity, and this is the natural process of role transition (Thompson, 2018).

Participants shared:

"I also see my patients, as well. So it tends to be a bit overwhelming, you get frustrated, you do not have help, and then you have to think logically and refer back to whatever that we did at school while we were still training. How you treat certain illnesses. Yeah, that is it. It is overwhelming. You feel stressed, stressful [P6]

“I felt like it was a bit difficult for me because the expectation was too high because of this person. Now it's a clinician and they expect too much from you, yet you don't have any support” [P3]

5.3.3 Navigating challenges: Discussion

The results from Theme 2 showed that “Navigating challenges” included those challenges by self, colleagues, doctors, and the institution. Participants suffered a lack of support from management and colleagues, a shortage of staff, inadequate medications and equipment, a lack of orientation, and a lack of mentorship. It is not difficult to believe that mistakes made by PHCNs could be related to the lack of support during their role transition (Clipper and Cherry, 2015).

Participants went through many emotional challenges. These emotions can be barriers to role transition. Kim and Shin (2020) stated that emotional difficulties, which have resulted in bullying, excessive role expectation, and workload, are barriers to role transition. Brykczynski (2009) found that the transition from an RN into a PHCN role generates conflict, loss of confidence in clinical skills, and anxiety. Cusson and Strange (2015) noted that participants in their study often cited feelings of being overwhelmed. Similar findings were reported in Duchscher (2008), who found that new nurses conceal their emotions from colleagues to hide their inadequacy.

5.4 Summary of Chapter

This chapter discussed the findings from the qualitative phase, which consisted of twelve (n = 12) individual interviews conducted with PHCNs via the Microsoft Teams platform. Thematic data analysis was conducted to identify themes, categories and sub-categories. The final chapter presents the summary of the study, main findings, limitations, recommendations, and the study conclusion.

CHAPTER 6 - SUMMARY OF THE STUDY, MAIN FINDINGS, LIMITATIONS, RECOMMENDATION AND CONCLUSION

6.1 Introduction

The previous chapter presented the qualitative phase of the study, which consisted of the research findings and literature control. This chapter presents the summary of the study, conclusions and limitations of the study. Recommendations for clinical practice, nursing education and research are presented.

6.2 Summary of the Study

6.2.1 Purpose of the study

The purpose of the study was to explore and describe the professional nurse's experiences of role transition to Primary Healthcare nursing.

6.2.2 Objectives

The objectives of the study were implemented in two phases.
In Phase 1, the objectives were to:

- Describe factors that influence professional nurses' experiences of transition to Primary Healthcare nursing role
- Determine the association between demographics and factors that influenced role transition

In Phase 2, the objectives were to:

- Explore professional nurses' experiences of role transition to Primary Healthcare nursing.
- Integrate the results to develop recommendations that may be applied to enhance the PHC nurses working environment post-training.

6.2.3 Summary of the Methodology

An explanatory sequential mixed methods study design was used, consisting of two phases.
Phase 1 consisted of a quantitative research study conducted using a self-administered Nurse Practitioner Role Transition Scale (NPRTS) developed by Cusson

et al. (2015). The study participants were selected using a population sampling strategy that resulted in a sample size of (n = 80) trained PHC nurses from the seven regions within the City of Johannesburg.

The potential participants were identified from the nursing college register of trained PHC nurses between 2019 and 2020. The available contact details were used to forward the study details as well as a request to participate in the online research study. On recognizing difficulties of reaching as many as possible potential participants for the study, the researcher opted for a snowball purposive sample identification process. The challenge was that some potential participant's contact details had changed, some had passed on during the COVID pandemic and some were still hospitalized. This process still did not yield a satisfactory sample size. The last option that the researcher implemented was to recruit participants for the study on the day that the 2019 and 2020 graduates were requested to come to the college for preparation for the planned graduations in 2021. Questionnaires were distributed face to face in an envelope and a request made that once filled in they should be placed in a box provided in the hall.

The IBM Statistical Package for Social Sciences (SPSS, 2021) software was used to analyse data in Phase 1.

In Phase 2, individual semi-structured interviews were conducted with a purposively selected sample until data saturation was reached at (n = 12). Respondents who participated in Phase 1 were asked to indicate if they would be willing to participate in Phase 2 by ticking a box and filling in their contact information. Consenting participants for Phase 2 were contacted via phone or email. Individual interviews were conducted and recorded via the Microsoft Teams application. Qualitative data were analysed using the coding reliability thematic analysis process.

6.3 Summary of the Main Findings

- The findings from Phase 1 indicate that the majority of PHCNS felt increased competence, confidence, and comfort in managing patients after training. However, in Phase 2 they also felt that they had to increase their consultation speed in the clinics due to workload and needing to refer to the manual often, while being newly qualified. Participants also found themselves pushing (rushing to serve) the queue

due to patient complaints about waiting, which often resulted in self-doubt at times and not being thorough.

- Under the domain of understanding in Phase 1, participants strongly agreed that PHCNs had an improved understanding of roles, while in Phase 2 some participants had a fear of approaching doctors or management for consultation or clarity on the diagnosis.
- Under the domain of communication, in Phase 1 the majority of participants felt they had less conflict and more collaboration; however, in Phase 2, the majority had challenges from colleagues, which were described as resistance to change and high expectations after returning from training.
- In Phase 1, participants agreed they had support, whereas the majority of participants in Phase 2 described a lack of support from management and colleagues during their experience of role transition. They also did not have any mentoring after graduation and felt as if they were thrown into the deep end.

6.4 Limitations of the Study

The following is a presentation of the limitations of the study

The researcher had hoped to have access to a large number from the 2019 to 2020 graduates. However, due to Covid-19 pandemic,

- It was very difficult to contact the managers for permission to conduct the study since some were working from home or affected by COVID-19 diseases.
- Difficulties were experienced in accessing the participants since some contact numbers were no longer valid and some were sick at home.
- The initial data collection phase took place during the COVID-19 lockdown restrictions, so it was not possible to make direct contact with the potential participants. Hence, the researcher opted for an online participant survey using REDCap. However, many of the PHC nurses were not technologically perceptive, so this resulted in a low uptake of the REDCap survey.

6.5 Recommendations for Clinical Practice, Nursing Education, and Research

6.5.1 Recommendation for Clinical Practice

Recommendations for clinical practice are aimed at ensuring a conducive clinical practice environment that will contribute toward the health and well-being of the PHC nurses as well as positive patient care.

6.5.1.1 Develop orientation programmes for newly qualified PHCNs to socialize them and offer guidance in their new role, as well as to enhance their confidence is assessing, diagnosing and managing patients' needs.

6.5.1.2 Establish a mentoring programme that has a dedicated person responsible for the novice PHC nurse during their first year of practice to enhance supportive attitudes towards the newly qualified.

6.5.1.3 Newly qualified PHC nurses should be allocated fewer patients than experienced PHC nurses. The novice PHC nurse needs more time to adjust to the new environment and the expectations according to the new qualification.

6.5.1.4 Institutions need to increase the number of training of professional nurses for PHC nursing to mitigate the shortage of staff, work overload and burnout.

6.5.1.5 Ensure that there are adequate resources available to function effectively as a PHC nurse. These include functional equipment and medication. The PHC nurses expressed frustration at trying to prescribe medication that is not available or not in stock.

6.5.1.6 Ensure that trained PHC nurses are adequately remunerated compared to those who are not trained. Several participants raised this issue, and it is the main reason for the high resignation rate. Participants felt that PHC nurses have a greater responsibility for which they are trained; hence they should be paid more.

6.5.1.7 Ensure that the immediate line manager has the same qualification as the PHC nurses. The study findings showed that some PHC service managers were not primary health trained which created conflict in terms of service provision expectations and priorities, understanding the critical points in emergencies, or even how long it takes to assess a patient adequately. This added stress for the newly qualified PHCNs, as they initially take longer to adjust after graduation.

6.5.1.8 Establish a PHCNs’ forum in Johannesburg and form an association whereby all PHCNs can receive updates and guidelines on everything relevant to PHC.

Specialities such as Operating Theatre under the Association of Per-Operative practitioners of South Africa (APPSA) and the Occupational Health Nursing under the South Africa Society of Occupational Health Nursing Practitioners (SASOHN) have regional meetings every month to discuss updates in their specialities. Such an association is critical in the development of PHC and PHCNs, as this will keep PHCNs updated on the latest medications and changes in protocols. Participants stated that PHCNs were not aware of changes in treatment and new protocols for medication until they returned from the course; these were updates made two years prior. It is paramount that PHCNs are up to date, as this is critical for the National Development Plan for 2030 where PHCNs will be at the forefront of health. Thus, PHCNs need to form a Primary Healthcare association for South Africa or in the Gauteng province, where all Primary Healthcare specialists come together, and workshops are held specifically for Primary Healthcare nurses. Members should meet quarterly and create journals and articles for the continuous development of PHCNs.

6.5.1 Recommendations for Nursing Education

During the training programme and while awaiting examination outcomes, opportunities for practice and mentoring should be facilitated. The following is recommended:

- Clinical placement allocation should be intentional during training, and while awaiting results after graduation, to ensure exposure to the practices of assessing, diagnosing and managing patients presenting at the clinic under the guidance of the lecturers and clinical facilitators.
- Primary Healthcare training programme lecturers need to liaise with clinical facilitators in developing a follow-up programme for newly qualified PHC nurses, as in this study, they expressed that there was little to no supervision or mentoring done at the clinics once they were placed post-graduation.

6.5.2 Recommendations for Future Research

Based on the findings of the study and literature reviewed, the following possible research areas are suggested:

- Best practices for mentoring of newly qualified Primary Healthcare nurses
- Nursing colleges not producing PHC qualification in South Africa between 2021 and 2023 and how it affects the National Development Plan for 2030
- The impact of the shortage of staff in clinics in South Africa.

6.6 Concluding Remarks

The purpose of the study, which was to explore and describe the professional nurses' experiences of role transition to Primary Healthcare nursing, has been achieved. The study findings brought to light the challenges faced by newly qualified PHC nurses. The two phases of this study highlighted factors that can contribute to an acceptable transition process from being a registered nurse to a PHC nurse.

Phase 1 of the study portrayed the PHC nurses' sense of increased competence and confidence in managing patients; however, in Phase 2 this was countered by the challenges they experienced within the clinical environment. The increased workload brought about feelings of self-doubt, and together with the limited perceived value of their role and support received from colleagues, doctors and management; this influenced their efficiency, as they could not establish their role as PHC nurse to the fullest.

Implementing the recommendations made for PHC nurses' clinical practice, nursing education, and research may improve the PHC nurses' role transitions and practice and have a positive impact on communities served.

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8. APPENDICES

APPENDIX A: APPROVAL OF TITLE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3 Wits, 2050

Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

12 November 2020
Person No: 2384487
PAG

Ms Z Rasdien
14 lake street
16 shenandoah complex
Florida Lake
1709
South Africa

Dear Ms Zaakirah Rasdien

Master of Science in Nursing: Approval of Title

We have pleasure in advising that your proposal entitled *Role transition experiences of professional nurses to Primary Health Care Nursing* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

APPENDIX B: HREC APPROVAL CERTIFICATE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG	HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

Office of the Deputy Vice-Chancellor (Research and Postgraduate Affairs

TO:	Ms Z Rasdien and Dr L Crous School of Therapeutic Sciences Department of Nursing Education Medical School University E-mail: z.rasdien@yahoo.com
CC:	Supervisor: Dr AM Tshabalala Amme.Tshabalala@wits.ac.za and <HREC-Medical Research Office@wits.ac.za>
FROM:	Mr Iain Burns Human Research Ethics Committee (Medical) Tel: 011 717 1252 E-mail: Iain.Burns@wits.ac.za
DATE:	25 November 2020
REF:	R14/49
PROTOCOL NO:	**M200834** (This is your ethics application reference number. Please quote it in all enquiries, oral or written, relating to this study.)
PROJECT TITLE:	*Role transition experiences of professional nurses to primary health care nursing*

Please find attached the Clearance Certificate for the above project. I hope it goes well and that an article in a recognized publication comes out of it. This will reflect well on your professional standing and contribute to Government funding of the University.

MSWorks2000/Iain0007/Clearscan.wps

APPENDIX C: NHRD APPROVAL LETTER

GAUTENG PROVINCE
REPUBLIC OF SOUTH AFRICA

Research Committee of Johannesburg Health District

Joburg
a world class African city

27th January 2020

14 Lake Street
Florida Lake
Roodepoort
1709

Email: z.t.rasdien@gmail.com

Enquiries: Ms. Busisiwe Sikhosana
Tel: 011 694 3909
Email :Busisiwe.Sikhosana@gauteng.gov.za
Hillbrow CHC: Administration Building,
Cnr Smith Str. & Klein Street
Private Bag X21, Johannesburg,
South Africa. 2017

Dear: Mrs Zaakirah Rasdien

TITLE: *ROLE TRANSITION EXPERIENCES OF PROFESSIONAL NURSES TO PRIMARY HEALTH CARE NURSING*

DRC Ref: 2020-08-019

NHRD Ref no: GP_202008_124

OFFICIAL APPROVAL

The Johannesburg Health District Research Committee (DRC) has reviewed your application. This letter serves as approval to access the Districts Health facilities (mentioned below) for the above research.

The following conditions must be observed:

- The facilities in which the research will be conducted are: City of Johannesburg Offices
- These facilities will be visited from: 27/01/2021 to 27/01/2022
- Participants' rights and confidentiality will be maintained all the time.
- No resources (Financial, material and human resources) from the above facilities will be used for the study. Neither the District nor the facility will incur any additional cost for this study.
- The study will comply with Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit an annual progress report to the District Research Committee.
- Your supervisor and the University Witwatersrand will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.

APPENDIX D: PERMISSION REQUEST TO THE CITY OF JOHANNESBURG

Department of Nursing Education
University of Witwatersrand
7 York Road
Parktown 2193
Johannesburg

Chief Executive officer
City of Johannesburg
158 Civic Boulevard
Metropolitan Centre
Braamfontein.

Dear DR Bismillah

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT THE CITY OF JOHANNESBURG CLINICS

I am currently a registered student at the University of the Witwatersrand in the Department of Nursing Education; I hereby request permission to research the City of Johannesburg clinics. The title of my research is *Role transition experiences of professional nurses to Primary Healthcare nursing. This study shall be conducted as an online survey where participants will answer questions electronically.*

The City of Johannesburg has sent many of its registered nurses to complete an Advanced Diploma for primary health annually on a full-time/part-time basis. Post qualification these employees re-enter your clinics as advanced practitioners.

My study aims to document the transition of Primary Healthcare nurses from novice to expert. Once the research is complete, I would be able to provide recommendations on my findings.

I reassure you that the institution's name as well as the personnel's personal information involved in this study will not be divulged in the research report. I will obtain informed consent from all participants and a copy of my research will be available upon on request. I hope to conduct my research in the Clinics of the City of Johannesburg as the Human Research Ethics Committee has approved my proposed study.

Yours sincerely



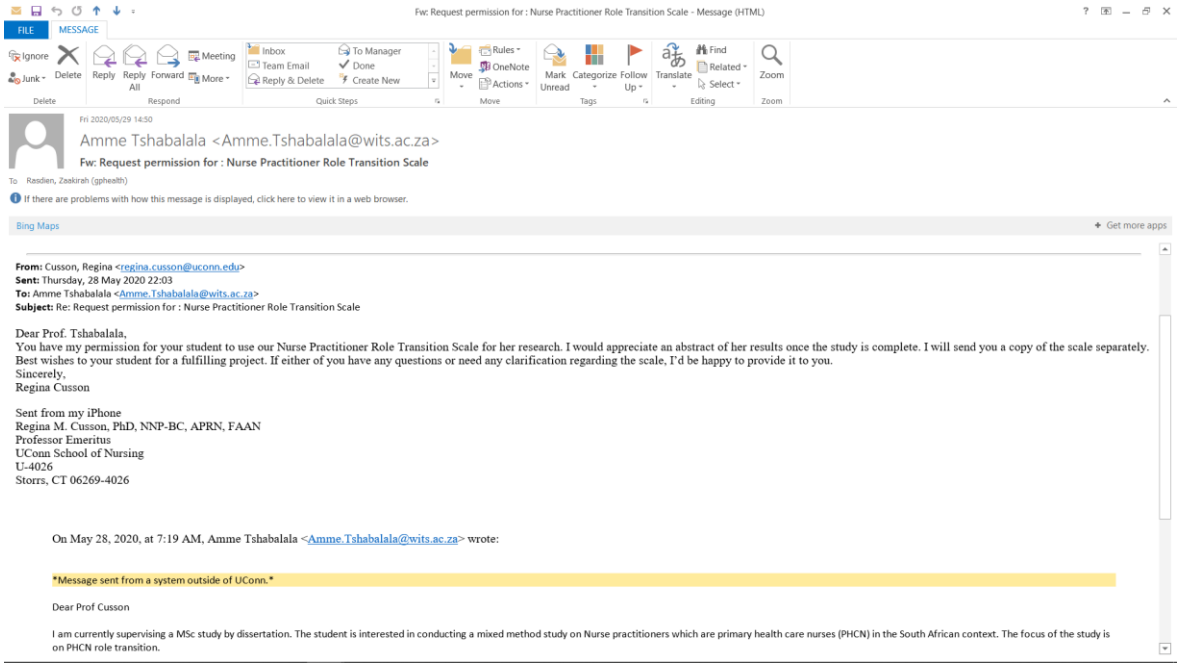
_____

Zaakirah Rasdien
MSc Nursing
0716870690

APPENDIX E: AUTHOR PERMISSION FOR USE OF QUESTIONNAIRE (PHASE 1)

ROLE TRANSITION EXPERIENCES OF PROFESSIONAL NURSES TO PRIMARY HEALTHCARE NURSING

Permission to use the Nurse Practitioner Role Transition Scale (NPRTS) instrument



Fw: Request permission for : Nurse Practitioner Role Transition Scale - Message (HTML)

FILE MESSAGE

Ignore Junk Delete | Reply Reply All Forward Meeting More | Inbox Team Email Reply & Delete To Manager Done Create New | Move Rules OneNote Actions | Mark Unread Categorize Follow Up | Translate | Find Related Select | Zoom

Delete Respond Quick Steps Move Tags Editing Zoom

Fri 2020/05/29 14:50

Amme Tshabalala <Amme.Tshabalala@wits.ac.za>

Fw: Request permission for : Nurse Practitioner Role Transition Scale

To Rasdien, Zaakirah (gphealth)

If there are problems with how this message is displayed, click here to view it in a web browser.

Bing Maps Get more apps

From: Cusson, Regina <regina.cusson@uconn.edu>
Sent: Thursday, 28 May 2020 22:03
To: Amme Tshabalala <Amme.Tshabalala@wits.ac.za>
Subject: Re: Request permission for : Nurse Practitioner Role Transition Scale

Dear Prof. Tshabalala,
You have my permission for your student to use our Nurse Practitioner Role Transition Scale for her research. I would appreciate an abstract of her results once the study is complete. I will send you a copy of the scale separately.
Best wishes to your student for a fulfilling project. If either of you have any questions or need any clarification regarding the scale, I'd be happy to provide it to you.
Sincerely,
Regina Cusson

Sent from my iPhone
Regina M. Cusson, PhD, NNP-BC, APRN, FAAN
Professor Emeritus
UConn School of Nursing
U-4026
Storrs, CT 06269-4026

On May 28, 2020, at 7:19 AM, Amme Tshabalala <Amme.Tshabalala@wits.ac.za> wrote:

Message sent from a system outside of UConn.

Dear Prof Cusson

I am currently supervising a MSc study by dissertation. The student is interested in conducting a mixed method study on Nurse practitioners which are primary health care nurses (PHCN) in the South African context. The focus of the study is on PHCN role transition.

APPENDIX F: PARTICIPANT INFORMATION SHEET (PHASE 1)

Dear colleague

I am inviting you to participate in a study on *role transition experiences of professional nurses to Primary Healthcare nursing* in the Faculty of Health Sciences, University of the Witwatersrand (Wits). The study is being conducted on Primary Healthcare nurses working in the City of Johannesburg.

This study aims to explore and describe the role transition experiences of professional nurses to Primary Healthcare nursing. The study consists of a confidential, anonymous questionnaire. It will take you no longer than 10-15 minutes to complete.

Your participation in this study is completely voluntary and there will be no negative consequences if you do not want to participate. By undertaking the survey you acknowledge consent to participate in the study.

Ethical approval for this study has been obtained from the University of the Witwatersrand Human Research Ethics Committee (HREC).

I would be happy to answer any questions you have about this study. If you have concerns about your rights as a study participant, or queries about any aspect of the research, you may contact the HREC (Medical): Prof C Penny, Tel 011 717 2301, email Clement.Penny@wits.ac.za; Ms Z Ndlovu and Mr Rhulani, Mkansi Administrative Officers 011 717 1234/1252/2656/2700 zanele.ndlovu@wits.ac.za; Rhulani.mkansi@wits.ac.za

Thank you for participating.

Zaakirah Rasdien

You may open the survey in your web browser by clicking the link below:

https://REDCap.core.wits.ac.za/REDCap/surveys/?s = AJ49Y9FLNX

If the link above does not work, try copying the link below into your web browser:
link to be inserted here
This link is unique to you and should not be forwarded to others.

APPENDIX G: QUESTIONNAIRE

PLEASE NOTE THAT BY COMPLETING THE QUESTIONNAIRE IT MEANS YOU CONSENT TO PARTICIPATE IN THIS STUDY

ROLE TRANSITION EXPERIENCES OF PROFESSIONAL NURSES TO PRIMARY HEALTHCARE NURSING

Section A: demographic data

Please read each item below and place an X at the correct answer or fill in the correct response where required.

1. Indicate your gender.

Male	
Female	

2. Indicate how old you are.

< 25 years	
25-30 years	
31-40 years	
41-50 years	
51-60 years	
61-65 years	
>65 years	

3. Indicate the years you have been practising as a PHCN

<1 year	
1-2 years	
2-3 years	
4-5 years	
6-10 years	
>10 years	

4. In which area of the clinic are you currently placed?

5. Your highest level of education.

Postgraduate Diploma	
Bachelor's Nursing Degree	
Master's Nursing Degree	
PhD	

6. Please indicate the year and month you completed your studies as a PHCN.

_____

Section B:

7. BELOW IS A DESCRIPTION OF NOVICE TO EXPERT. PLEASE INDICATE WITH A TICK IN WHICH CATEGORY YOU THINK YOU FIT WELL. PLEASE CHOOSE one.

Novice Has an incomplete understanding, approaches tasks mechanistically, and needs supervision to complete them	
Advanced Beginner Has a working understanding, tends to see actions as a series of steps, and can complete simpler tasks without supervision.	
Competent Has a good working and background understanding, sees actions at least partly in context, able to complete work independently to a standard that is acceptable though it may lack refinement.	
Proficient Has a deep understanding, sees actions holistically, and can achieve a high standard routinely.	
Expert Has an authoritative or deep holistic understanding, deals with routine matters intuitively, is able to go beyond existing interpretations, achieves excellence with ease	

Section C:

NURSE PRACTITIONER ROLE TRANSITION SCALE

Directions: think about when you just started as a Primary Healthcare nurse. What was your experience? Please read each statement carefully and respond by expressing the extent to which you agree or disagree with it. Please answer **ALL** questions.

Please choose your responses based on the following scale:				
1	**2**	**3**	**4**	**5**
Strongly disagree	**Disagree**	**Neither disagree nor agree**	**Agree**	**Strongly agree**

1	I was comfortable in my role.	**1**	**2**	**3**	**4**	**5**
2	I was treated as a professional by my colleagues.	**1**	**2**	**3**	**4**	**5**
3	My PHCN role was very well understood by my physician colleagues.	**1**	**2**	**3**	**4**	**5**
4	I was very comfortable managing my patients.	**1**	**2**	**3**	**4**	**5**
5	My PHCN role was very well understood by my nurse colleagues.	**1**	**2**	**3**	**4**	**5**
6	My PHCN role was very well understood by the public.	**1**	**2**	**3**	**4**	**5**
7	I felt less confident than I did before becoming a PHCN.	**1**	**2**	**3**	**4**	**5**
8	I felt very competent in managing my patient caseload.	**1**	**2**	**3**	**4**	**5**
9	My PHCN role was very well understood by my patients/families.	**1**	**2**	**3**	**4**	**5**
10	I felt that I was isolated.	**1**	**2**	**3**	**4**	**5**
11	I felt that I got very little support.	**1**	**2**	**3**	**4**	**5**
12	I felt it was easy to transition from nurse to PHCN.	**1**	**2**	**3**	**4**	**5**
13	I felt I had the skills to deal with the role transition.	**1**	**2**	**3**	**4**	**5**
14	I felt that I needed extra time to complete my responsibilities.	**1**	**2**	**3**	**4**	**5**
15	My PHCN role was very well understood by management.	**1**	**2**	**3**	**4**	**5**
16	My PHCN program prepared me for a smooth role transition.	**1**	**2**	**3**	**4**	**5**
17	I felt anxious about the integration of theory into my practice.	**1**	**2**	**3**	**4**	**5**
18	My workday was just how I imagined it would be when I was a student.	**1**	**2**	**3**	**4**	**5**
19	My education prepared me to effectively manage my patients.	**1**	**2**	**3**	**4**	**5**
20	My supervisor was very available/approachable.	**1**	**2**	**3**	**4**	**5**
21	My mentor was very available/approachable.	**1**	**2**	**3**	**4**	**5**
22	I felt that my PHCN role was seen as a substitute for a Doctor.	**1**	**2**	**3**	**4**	**5**
23	I had trouble applying the theory to practice when I was under stress.	**1**	**2**	**3**	**4**	**5**
24	I felt that I was doing more than one person's work.	**1**	**2**	**3**	**4**	**5**
25	I felt I developed my PHCN role within a nursing framework.	**1**	**2**	**3**	**4**	**5**
26	I felt I developed my PHCN role within a medical framework.	**1**	**2**	**3**	**4**	**5**
27	I felt that I was an invisible provider on the healthcare team.	**1**	**2**	**3**	**4**	**5**
28	I felt that I had a poor relationship with the Doctor.	**1**	**2**	**3**	**4**	**5**
29	I felt anxious in my communications with other health care providers	**1**	**2**	**3**	**4**	**5**
30	I was able to navigate the healthcare system to develop my new role	**1**	**2**	**3**	**4**	**5**
31	I had a clear understanding of third party reimbursement.	**1**	**2**	**3**	**4**	**5**

Thank you for completing the questionnaire.

The researcher will be conducting a follow-up study that consists of an online one on one interview.

We would like to invite you to participate in the study.

Please indicate your choice below (Tick in the box)

Yes I would like to participate in the study	
No, I don't want to participate in the study	

If you ticked the yes box, please we would like to have your contact details so that we can communicate the details of the study.

You can write the telephone number and email address if available.

Telephone number	
Email address	

Thank you

APPENDIX H: PARTICIPANT INFORMATION SHEET (PHASE 2)

Title of the study: Role transition experiences of professional nurses to Primary Healthcare nursing

Good Day

My name is Zaakirah Rasdien; I am currently registered as a student at the University of Witwatersrand in the Department of Education in Nursing for the Degree of Master of Science in Nursing (Primary Healthcare). I would like to have the opportunity to explain to you why I am doing research on the role transition experiences of professional nurses to Primary Healthcare nursing and how I will be doing it. In this study, we want to explore and describe the professional nurse's experiences of role transition to Primary Healthcare nursing and will have some answers for you below.

What is the purpose of the research study and why have you been chosen?

The purpose of this study is to explore and describe the factors that influence Primary Healthcare nurses' role transition from Professional Nurse to Primary Healthcare Nurse. You have been chosen because you are a newly qualified Primary Healthcare Nurse.

What will happen to me if I take part in this study and what will I be asked?

Once you agree to take part in the study, you will be asked to sign an informed consent letter as well as a consent letter for the recording. You will be asked questions verbally in a one on one interview online/telephonically.

What are the risks of taking part in the study?

There are no risks involved in participating in this study.

What are the benefits of participating in this study?

The study will contribute to the body of knowledge related to Primary Healthcare nurses' role transitioning and can potentially benefit the managers and Primary Healthcare nurses understand contextual factors related to the PHCN transition process. There are, however, no direct benefits to you as a participant in this study.

Is there reimbursement for taking part in the study?

There is no monetary reimbursement to you for taking part in the study.

Why should you take part?

Your participation in the study is completely voluntary. Should you decide to take part in the study, you will be given a study participation form to sign. Should you wish to discontinue participation you may withdraw freely at any point in the study and without giving a reason. Your participation or not or withdrawal from participating will not alter any working relationship with the management and colleagues.

Will confidentiality be maintained?

All the information obtained in the study will be kept confidential. Your name will not appear on any of the forms that I may use for the study. A code will be allocated for each of the forms as well as recordings that will be used to respond to Primary Healthcare nurses transition from novice to expert roles. No one else except the supervisor and myself will access this information. The box with consent forms as well as recordings will be kept safe in a locked cabinet in the supervisor's office. At the end of the study, the results will be published in a scientific journal. Information that identifies you as a participant in the study will not be in the journal. Data will be kept for two years if

published and six years if not published; after this period, it will be destroyed/recordings will be erased. Permission will be requested from the HREC (Medical) in the event of data sharing with other researchers for academic purposes. Should you wish to view my study results you can do so by contacting me.

Who is funding the research study?

This is a self-funded study as it is part of the fulfilment of my Master's degree. Therefore, the results will not be used for commercial gain.

How will the researcher collect the data?

In this phase of the study, arrangements will be made for an individual interview via video call and data will be sent to those participants who consent to participate in this study. One main question and several probe areas and related questions that the researcher might use to further enhance the interview. I would also like to request your permission to record our interview.

How long will the interview take?

This all depends on the participants and how they answer, but should not take longer than 45 minutes.

Whom can I call for enquiries?

Should you have a concern about the study you can contact me on the following Number:

Principle investigator: Cell [redacted] or email z.rasdien@yahoo.com

Supervisor: Dr A.M Tshabalala Tell: 0114884269 or email

Amme.Tshabalala@wits .ac.za or Dr L Crous (Lizelle.crous@wits.ac.za)

The Human Research Ethics Committee (Medical) of the University of the Witwatersrand has approved the study. The principal function of this committee is to safeguard the rights and dignity of all human subjects who agree to take part in the research project.

If you have any concerns over the way the study is being conducted, the Chairperson of the committee is Professor Clement Penny Tell: 0117172301 or email Clement.Penny@wits.ac.za. Secretary: Zanele Ndlovu Tell 011-717-2700/1234 or email Zanele.Ndlovu@wits.ac.za and Rhulani.Munkansi@wits.ac.za

Thank you for taking the time to go through this information sheet.

Principal investigator: Z. Rasdien

Supervisor: Dr A.M Tshabalala

Co-Supervisor: Dr L Crous (Lizelle.crous@wits.ac.za)

APPENDIX I: PARTICIPANT CONSENT SHEET (PHASE 2)

Title: Role transition experiences of professional nurses to Primary Healthcare nursing

I confirm that I have been informed by the researcher about the nature of the study. I have read/it was read to me and I understood the information sheet and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my medical care and legal rights being affected.

I understand that the researcher and their supervisor may look at sections of my work history. I am aware that questions on the **Role transition experiences of professional nurses to Primary Healthcare nursing** will be asked. The findings will be anonymously processed into a computerized system. Data will be reserved for two years if published or six years if not published, after this period the data will be destroyed.

Should you wish to contact me at any stage regarding consent you can contact me on the following:

Principle investigator: Cell: [redacted] email: z.rasdien@yahoo.com

Supervisor: Dr A.M Tshabalala Tell: 0114884269 or email Amme.Tshabalala@wits .ac.za or

Dr L Crous (email): Lizelle.crous@wits.ac.za

I agree to take part in the above-mentioned study. I hereby give consent for my work history to be used as per the above-mentioned conditions.

---------- **----------** **----------**

Name and Surname of participant Signature Date

Translator/Person explaining Consent

---------- ---------- ----------

Name and Surname Signature Date

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za. Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

APPENDIX J: PARTICIPANT CONSENT SHEET: AUDIO TAPE RECORDING (PHASE 2)

Title: Role transition experiences of professional nurses to Primary Healthcare nursing

I confirm that I have been informed by the researcher about the nature of the study. I have read / it was read to me and I understood the information sheet and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care and legal rights being affected. I understand that as the interview is being done and an audio recording of it will be taken. I agree to be audio-recorded.

I understand that sections of my work history may be looked at by the researcher and her supervisors. I am aware that questions on the **Role transition experiences of professional nurses to Primary Healthcare nursing** will be asked. The findings will be anonymously processed into a computerized system. Data will be reserved for two years if published or six years if not published, after this period the data will be destroyed.

Should you wish to contact me at any stage regarding consent you can contact me as the **Principle investigator:** Cell: [redacted] email: z.rasdien@yahoo.com or my supervisors: **Supervisor:** Dr A.M Tshabalala Tell: 0114884269 or email Amme.Tshabalala@wits.ac.za or Dr L Crous (email): Lizelle.crous@wits.ac.za

I agree to take part in the above-mentioned study. I hereby give consent for my work history to be used as per the above-mentioned conditions.

---------- ---------- ----------

Name and Surname

of participant Signature Date

Translator/Person explaining Consent

---------- ---------- ----------

Name and Surname Signature Date

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za. Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

APPENDIX K: INTERVIEW GUIDE

ROLE TRANSITION EXPERIENCES OF PROFESSIONAL NURSES TO PRIMARY HEALTHCARE NURSING

Research study: Introduction

Before we start this meeting today, I would like to thank you for meeting me. In the information sheet that you have read, I have indicated what my research is about. As discussed, I will be recording and transcribing this interview. I will not be using your real name, to protect your identity. You will receive an opportunity to review the manuscripts at a later date to make sure that I have clearly and accurately described your views.
Do you have any questions before we get started?

Opening prompt

The main question asked will be:

"Can you please tell me how you experienced the transition from being a Professional Nurse to a Primary Healthcare Nurse?"

Please tell me what it was like for you to change from PN to PHCN.

Follow up questions

Interview questions to be asked during the interview:

Expert

- What experiences have helped you and what experiences were barriers for you during your transition?
- What has made the transition easier for you?

Novice

- What would make the transition easier for you?
- What have your experiences been thus far from being a new PHCN?