EXPERIENCES OF NEWLY QUALIFIED PROFESSIONAL NURSES IN A PUBLIC HOSPITAL IN THE GAUTENG PROVINCE

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DECLARATION

I, Nelisiwe Ngwenya, declare that this research report submitted for the partial fulfilment of the degree; Master of Science in nursing, at the University of the Witwatersrand, Johannesburg, is my own work and has not been submitted before for any other degree at any other institution.

…….

Signature of candidate

14th day of May 2021 in The Faculty of Health Sciences.

Protocol Number: M170920

DEDICATION

This research report is dedicated to:

My Mom Boniswa Pauline Ngubane Scina, for her unfailing love.

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- Firstly, I would like to thank God through whom all things are possible.
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LIST OF ABBREVIATIONS

CINAHL	Cumulative Index to Nursing and Allied Health Literature
DENOSA	Democratic Nurses Association of South Africa
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
NHI	National Health Insurance
NIMART	Nurse Initiated Management of Antiretroviral Therapy
SANC	South African Nursing Council
USA	United States of America

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CHAPTER ONE:
OVERVIEW OF THE STUDY

1.1. Introduction

Several research studies (Abodium et al,2019; Govender, 2015; & Nkoane,2015), have reported on the experiences of newly qualified professional nurses in public health care institutions. These experiences are said to influence the decision of newly qualified professional nurses to stay on in the public health care institutions or to leave the public health care institutions.

Evidence in literature also suggests a close link between the experiences of newly qualified professional nurses and attrition rate (Al Awaisi, Cooke & Pryjmachuk, 2015). Understanding how newly qualified professional nurses experience their new role can help to develop a plan of action to guide the process of socialisation of newly qualified professional nurses into the profession. According to the South African Nursing Council (SANC) statistics for 2015/2016, fewer than 1000 professional nurses enter the healthcare service in Gauteng annually, making this resource a scarce commodity. With the high staff turnover and increase in professional nurses exiting the profession, it is vital for newly qualified professional nurses to be retained in the profession.

According to Armstrong, Geyer, and Bell, (2019), "the private sector delivers healthcare services to approximately 28.8% of households in South Africa, with 71.25% of households seeking public sector services"), (Statistics South Africa, 2018). Although 71% of households use public health services, only 47.5% of professional nurses on the SANC register work in the public sector (Statistics South Africa, 2016a; Statistics South Africa 2016b). When these statistics are considered, the nurse-to-population ratio for people using public sector health services is 3.41 professional nurses per 1000 people, whereas in the private sector it is 9.63 professional nurses per 1000 people (Statistics South Africa, 2018). The World Health Organisation (WHO), minimum ratio for nurses to population is 500 people per nurse, maximum. The official ratio of people per registered nurse in South Africa in 1998 was 1: 463, (Solidarity Research Institute, 2009). This ratio has not been revised over the years. This evidence suggests that there is a shortage of professional nurses in the

public healthcare system. This is mainly because most nurses leave the system in pursuit of better conditions of service as offered by the private healthcare sector.

This shortage of professional nurses can also be attributed to changes in policy in South Africa, which included the re-engineering of the district healthcare system. The system is nurse-driven and has placed a demand on the number of professional nurses/midwives required (Department of Health, 2011). The demand for professional nurses is further influenced by the National Health Insurance (NHI) (Department of Health, 2018); human immunodeficiency virus (HIV) testing and counselling campaign (Department of Health, 2015); and task shifting. Which is defined by as "the rational re-distribution of tasks among health workforce teams. It includes moving specific tasks from highly qualified health workers to health workers who have fewer qualifications. This is to make efficient use of the available human resources" (WHO, 2019). In South African public health care service, tasks are shifted to professional nurses and midwives for the Nurse Initiated Management of Antiretroviral Therapy (NIMART) (George et al., 2012); and the HIV prevention care and treatment targets as outlined in the 90-90-90 strategy of the Joint United Nations Programme on AIDS together with the sustainable development goals (United Nations, 2015). The demand for professional nurses increased because NHI and the HIV treatment campaign services are free to all, and user fees were abolished for access to the services. This means that more people are attending health care services because the services are affordable.

The HIV testing and counselling campaign and the NIMART programme were introduced to make up and to address inequalities in the South African health care system. The NIMART programme addressed inequalities by improving access to health care services for all people, especially the previously disadvantaged rural communities. It also improved access to safe and affordable drugs and medicine to all. HIV testing and the NIMART programme has increased the demand for professional nurses/midwives. This is because staffing numbers were not necessarily adjusted appropriately, the shortage of registered nurses in the public healthcare system has a negative impact on the South African healthcare system: a healthcare system affected by the quadruple burden of diseases consisting of HIV/AIDS and tuberculosis, which exacerbate the shortage of human resources (Coovedia et al., 2009).

This chapter analyses the background of the study, problem statement, research question, purpose of the study, its significance, research objectives, and operational definitions.

1.2 Background of the Study

In a study of a nationally representative sample of professional nurses conducted in the United States of America (USA), on the turnover rate of newly licensed professional nurses, (Kovner et al., 2014) indicated that 17.5% of professional nurses leave their first nursing job within their first year of employment and one in three (33.5%) leave within their first two years.

According to Bateman (2011), the South African attrition rate of health professionals is estimated to be 25%. Working conditions, management issues and human resource are cited as the biggest contributory factors, which include the risk of contracting HIV/AIDS and tuberculosis, workload, and personal safety. This high attrition rate has been described as "the revolving door in the nursing profession" (Kovner et al., 2014).

South Africa has approximately 93 000 professional nurses. Out of this pool, 20% are either non-practising or are in non-related employment as stated by (Greyling and Stanz, 2010), in a study on the turnover of nursing employees in a Gauteng hospital group. The study aimed to investigate individual determinants of voluntary turnover to identify a risk group profile.

(Labonte, et al., 2015), suggests evidence of a link between migration of professional nurses and midwives to other countries, internal migration from the public sector to the private sector and their experiences. This migration is in pursuit of better working conditions. A decline in this migration has been noted because of policy changes in South Africa, that is the introduction of Occupation Specific Dispensation (OSD). (Mahlathi and Dlamini, 2017), conducted a case study in South Africa to understand the movement patterns of professional nurses, including immigration, emigration, and movement between the public and private sectors better. Data analysis revealed that professional nurses and registered midwives employed by the DOH form 34.45% (138 335) of 401 543 professional nurses appearing on the 2016 SANC register. The remaining 65% of professional nurses are unaccounted for.

It has been difficult to obtain empirical evidence of the widespread migration of South African nurses despite several previous research studies. Over a five-year period, only 2158 registered nurses requested verification letters from SANC. This is either directly or through

recruitment agencies. SANC keeps records of professional nurses but cannot differentiate professional nurses in active practice from professional nurses working overseas and professional nurses who have left nursing altogether.

Several studies have been carried out globally regarding the experiences of newly qualified professional nurses. In the South African context, the roles and responsibilities of professional nurses are stipulated in The Scope of practice of Registered Nurses, Regulation 2598, (SANC 1991). The core duty of nurses is to render all-inclusive care to health care users. This duty comes with a responsibility and accountability of overseeing safe and competent nursing to unstable and complex health problems (Regulation 2598 of 15 February 1991 as amended). These responsibilities can only be performed by a qualified competent professional nurse who has received adequate education, both in theoretical and clinical training.

With the high attrition in the nursing profession, it is vital to retain newly qualified professional nurses in the profession. There is also evidence indicating that the experiences of first-year professional nurses are also influenced by the support that nurses receive from their colleagues and management in the work environment, (Feng & Tsai, 2012).

According to (Al Awaisi, Cooke and Pryjmachuk, 2015) newly qualified professional nurses experience a transition period during their first year of practice. This transition period is described as the experience of moving from the known role of being a student to the relatively less familiar role of being a professionally practising nurse. It involves discovery, acquiring and assimilation of new roles, (Duchscher, 2009). The transition period is associated with overwhelming emotions, resulting from a theory-practice gap. Student nurses have a high level of theoretical knowledge that they cannot apply to practical situations yet. The newly qualified registered nurses have preconceived ideas that they are prepared to practise only to discover the contrary at their first employment opportunity; this unexpected workload is described as reality shock (Roy & Robichaud, 2016). Newly qualified nurses experience limitations and a sense of frustration in their new practice (Dinmohammadi, Peyrovi, & Mehrdad, 2013).

Several studies have reported the first year of newly qualified professional nurses as characterised of positive experiences:

Newly qualified professional nurses felt confident and prepared for their new role as registered nurses (Roziers, Kyriacos & Ramugondo, 2014). (Roy & Robichaud, 2016), described this as the initial period, the "honeymoon phase", which is characterized by a feeling of delight, enjoyment, and pride.

Newly qualified professional nurses developed confidence and gained rich experiences from being exposed to the working environment. Al Awaisi, Cooke & Pryjmachuk, 2015). They acquired new skills and they grew professionally from the rotation system which allows them to be placed in different units (Govender, Brysiewicz & Bhengu, 2017). According to (Roziers, 2014), when newly qualified professional nurses are prepared adequately, when they receive positive feedback and when they receive constructive feedback about their clinical performance from unit managers, they develop a sense of achievement.

(Pasila & Elo, 2017) reported that newly qualified professional nurses received orientation during their first year of practise and this experience increased their confidence levels because of the vast skills that they acquired.

In a study conducted by (Phillips, Esterman and Kenny, 2015), newly qualified professional nurses who are exposed to a formal orientation programme on the initial performance of their duties as newly qualified professional nurses, feel prepared for their new role. The orientation program equips newly qualified professional nurses before commencement of their duties with rich experiences and they develop confidence to practice their new role. Rotation patterns and schedules triggers professional growth and provides nurse with an opportunity to extend their skills set (Govender, Brysiewicz & Bhengu, 2017).

Several studies have also reported the first year of newly qualified professional nurses as characterised of negative experiences:

The study on new nurse transitions by Leong and Crossman (2015) identified that nurses had to fit into the nursing profession and organisation by observing the behaviour of other nurses. Newly qualified nurses noticed other nurses performing sub-standard care and experienced criticism from senior nurses if they did not conform to this practice, (Horsburgh & Ross, 2013). This results in newly qualified professional nurses being frustrated as they must be part of providing inappropriate healthcare practices to fit into their new role.

Evidence shows that organisational factors such as staff support and working environment influence the experiences of newly qualified professional nurses to a large extent (Valencia, Kotzé & Van Rooyen, 2005). Working environment is not conducive to good experiences by newly qualified nurses. Such working environment comprises of the following: high turnover rates, inadequate staffing levels, increased workloads safety issues and the impact of the manager's behaviour on staff morale. These factors can negatively affect the experiences of newly qualified professional nurses. However, other newly qualified professional nurses experienced disappointment regarding the expectations they had related to the new working environment. experienced the working environment as being unsafe, lacked security and had insufficient human and material resources. The working environment was experienced as threatening amongst staff and externally from the community who insulted nurses and were aggressive at times. Professional nurses raised their concern regarding the lack of both human and material resources and the impact this has on the provision of quality nursing care.

Newly qualified professional nurses demonstrated a willingness to further their studies. Those who were allowed this opportunity had no intentions of leaving the institution. The few who were not allowed the opportunity to further their studies had no intentions of staying on in the institution. Professional nurses who received support from their colleagues and other members of the multidisciplinary team, developed a sense of belonging in the team.

The South African Minister of Health, Dr A Motsoaledi, emphasised the necessity of developing and managing healthcare professionals in ways that will motivate them to provide quality care, and to make them feel valued and needed (Human Resources Strategy for the Health Care Sector 2012/13–2016/2017). Section 51 and section 52 of the National Health Act of 2003 states that the Minister must prescribe strategies for staff retention. It has also been identified that health professional graduates in the public health sector are being retained due to various 'push' factors, which undermine the government's efforts of training healthcare professionals. This results in wasteful expenditure as R7 billion a year is spent on health sciences education and training in health education institutions and provincial departments of health (National Treasury, 2011).

The new title "sister" also came with a lot of stress and frustration for newly qualified nurses, as they felt that this title came with expectations that they know everything (Roziers

2014). Newly qualified professional nurses experienced shock in their new role when they realise that their high expectations were not met. This is what Roy & Robichaud, (2016: 8) explains as “Reality shock”. This shock was also experienced when the nurses observed and experienced unprofessional behaviours from their senior colleagues. Nurses expresses shock when their colleagues demonstrated hostility towards them (Roziers, 2014).

The purpose of this study will be investigated in the paragraph below.

1.3 Problem Statement

Experiences of newly qualified registered nurses have been documented as being both positive and negative. Literature has shown that the intention to leave as well as the high attrition of newly qualified professional nurses which is of great concern, is largely influenced by first year experiences in the work environment. Similar studies have been conducted in South Africa, but a few studies have been conducted in regional hospitals in the Gauteng Province.

The purpose of this study was to describe the experiences of newly qualified professional nurses employed in a public hospital in Gauteng Province. This study aims to explore the real-life experiences of newly qualified nurses and the support they receive as they transition from a role of being student nurses to a professional role. According to the researchers own personal experience, the support that newly qualified professional nurses receive in their transitioning from the student nurse’s role to a role of being a qualified professional nurse plays a huge role in their future in the nursing profession.

This study aims to answer the following research questions:

- What are the experiences of newly qualified professional nurses?
- What level of support is given to newly qualified professional nurses in their first year of employment?

1.4 Purpose of the Study

To describe the experiences of newly qualified professional nurses in a regional hospital in the Gauteng Province during their first year of practice.

1.5 Significance of the Study

International literature is available on the experiences of newly qualified professional nurses. It is uncertain if there are similarities in how qualified professional nurses in regional hospitals in Gauteng also describe their experiences. This research will probe into the experiences of newly qualified nurses in a public hospital in Gauteng. Knowledge of experiences of newly qualified professional nurses will assist health care institutions in improving first year experiences of newly qualified nurses and will also assist institutions to improve the support they give to these nurses.

Research findings/outcomes will give more insight regarding the direct experiences of these nurses in their first year of practice.

1.6 Research Objectives

The objectives of the study were to:

- To describe the experiences of newly qualified professional nurses in a public hospital in Gauteng.
- To describe the support given to newly qualified professional nurses in their first year of practice in a hospital in Gauteng.

1.7 Operational Definitions

Newly qualified professional nurses

For this study, newly qualified nurses are professional nurses who have completed the prescribed education requirements according to the South African Nursing Act, Regulation 425 of 22 February 1985 for the education and training of a nurse (General, Psychiatric and Community) and Midwife, who have completed one year of community service, and who have been employed at the institution for the period from January 2016 to December 2017.

Experiences

An experience is an event or occurrence that leaves an impression on someone, (Oxford Dictionary of English 20150). In this study, context experiences refer to positive and negative experiences, such as organisational, job, empowerment factors, and relationships with co-worker and supervisors).

Regional hospital

A hospital that receives referrals from and provides specialist support to a district hospital and where healthcare users require the expertise of teams led by resident specialists.

Attrition rate is defined as “exits from the workforce, which can be due to emigration, voluntary exits, (e.g., to other sectors of employment) illness, death or retirement”, (Lopes, Guerra-Arias, Buchan, et al., 2017:21).

1.8 Summary

This chapter provided an overview of the research study, which included the background and the problem statement of the study. The significance of the study, research question and the purpose of the research were highlighted. Operational definitions were also explained.

CHAPTER TWO:
LITERATURE REVIEW

2.1 Introduction

The previous chapter outlined the research plan. This chapter presents literature on the experiences of newly qualified professional nurses. The context for the research study is provided, important aspects and concepts highlighted in literature which informed the narrative of the problem are presented. The important aspects and concepts covered are the following: attrition rate, transition period, reality shock, role stress, orientation, organisational factors, staff support and the work environment.

According to Burns and Grove (2013), a literature review is a detailed, edited presentation by academics. It aims to communicate what is presently recognised about the topic of interest. The researcher pursues an objective description of the phenomenon under study from peer reviewed publications within the field (Polit & Beck, 2012). In the case of this research, the phenomenon is specifically the lived experiences of newly qualified professional nurses to generate in-depth understanding.

The literature review was conducted using the library database of journals and books in combination with the Cumulative Index to Nursing, the Allied Health Literature Index, and PubMed as resources.

According to a study by Armstrong et al., (2019), South Africa increased the use of existing antenatal services from 1994 by providing free maternal health for all which was followed by the introduction of free primary healthcare services for all. This increased use of services exacerbated nursing shortages, as provision was not made for additional human, financial resources, and additional patient loads. The additional burden of HIV and AIDS further led to the introduction of Nurse Initiated Management of Antiretroviral Therapy (NIMART) programme (Pardarath, Ntuli & Berthiaume, 2004). This programme was implemented “as a response to lower the HIV prevalence rate in the South African communities” (Mabelane,

Marincowitz, Ogunbanjo & Govendar, 2015). It is a programme that initiates Antiretroviral treatment and provision of an HIV package of care to individuals. The programme aims to increase accessibility to HIVE care through the provision of antiretroviral treatment at Primary Health Care level early without compromising NIMART further intensified nurses' shortages as staffing numbers were not adjusted appropriately after its implementation.

Through the literature review, it was found that the general issues with the newly qualified professional nurses can be discussed under three important concepts, namely:

2.2 Attrition Rate

Attrition rate is "the gradual reduction of a workforce by employees leaving and not being replaced rather than by redundancy", (Oxford Dictionary, 2013). Evidence in literature suggests a close link between the first-year experiences of newly qualified nurses and attrition rate (Al Awaisi, Cooke & Pryjmachuk, 2015). Kovner et al.
(2015) referred to the high attrition rate as the "revolving door syndrome in the nursing profession". In this research study, the researcher identified that there is indeed a relationship between the first-year experiences of newly qualified registered nurses and attrition rate.

Vulindlela (2017), a public service management information system, provided the following attrition figures of registered nurses in the Gauteng Province:

- 2012 = twenty-four thousand, seven hundred and eighty-four (24 784)
- 2013 = twenty-four thousand, nine hundred and nine (24 909)
- 2014= twenty-five thousand and seventeen (25 017)
- 2015= twenty-six thousand, one hundred and three (26 173)
- 2016 = twenty-seven thousand, two hundred and forty-five (27 245)

A survey conducted in a Gauteng hospital found that the professional nurses' decision to leave their jobs is influenced by organisational causes, nursing practices, work environment and employment opportunities after resignation. It is also influenced by the limited scope for further training, a lack of respect and acknowledgement from other medical professionals, as well as poor working conditions in hospitals (Thom, 2003). Newman, Maylor and Chansarkar (2002) conducted a study on the satisfaction of professional nurses, service quality and nurse retention chain and the implications for management of recruitment and retention. This study was done in four London Trust Hospitals and over a hundred and thirty professional nurses and

midwives were interviewed. The following were quoted as factors leading to high attrition in nursing, long working hours, heavy workloads, employee shortages, and inability to finish shifts on time.

The attrition rate is higher amongst professional nurses who did not choose nursing as their preferred profession of choice during training. Participants who chose nursing as their first preferred profession intend to stay in the profession, regardless of their first-year experiences. According to a study by Chauke,Van Der Wal & Botha (2015), which was conducted to explore the potential of appreciative inquiry as an intervention teaching strategy to transform students nurses image in nursing, by selecting students studying towards the programme of education and training leading to registration as a (General, Psychiatric and Community) and Midwife, from nursing colleges and nursing departments of two selected Universities in the City of Tshwane, Gauteng Province, South Africa. It was identified that there is a relationship between attrition rate of newly qualified nurses and the reason why they chose nursing as a career. High attrition rate was observed in nurses who entered the profession because of a salary earned whilst studying.

A longitudinal study was conducted by Flinkman, Isopahkala-Bouret & Salantera (2013), on professional nurses plans to exit nursing and the rate at which nurse's leave and are replaced in Finland, and all three participants in the study did not choose nursing as their first career of choice. They all turned to nursing as career after failed attempts to apply for admission at universities.

Janiere (2010) conducted a study of the experiences of first-year nursing students at the University of the Western Cape during their first clinical placements in a hospital. It was found that most participants did not choose nursing as their first career choice; they were rejected at other universities where they had applied for other programmes, and then "settled" for nursing. Other participants entered nursing because they were forced by their parents. This shows that the intention rate to leave nursing is higher in professional nurses who did not choose nursing as their first career of choice.

2.3 Transition Period

The transition from student nurse to newly qualified registered nurse can be a daunting process, full of unfamiliar experiences and anxiety-provoking situations. Despite hours of

clinical experience in a variety of settings as well as classroom education, new graduates often find themselves unprepared for their first jobs (Rush et al., 2012). According to Al Awaisi, Cooke and Pryjmachuk (2015), newly qualified professional nurse's experience a transition period during their first year of practice. This is when student nurses have graduated into professional nurses and when they enter the health care environment. This is when they are socialized into the new role.

This period is often accompanied by overwhelming emotions, resulting from the theory practice gap (Duchscher, 2009). The theory-practice gap refers to having a high level of theoretical knowledge that cannot be applied to practical situations. This gap can also arise due to preconceived ideas about the work experience, only to discover the contrary during their first employment opportunity (Duchscher, 2009).

The lack of an effective transition for newly qualified professional nurses has implications for patient care, which is marked by high turnover rates during their first year of employment (Spector & Echternacht, 2010). Implications for patient care include ineffective practice readiness, medication errors, failure to recognise complications, compromised patient safety, and mistakes or omissions or harm to patients due to limited knowledge and experience (Al Awaisi, Cooke & Pryjmachuk, and 2015).

The transition period may further differ as professional nurses are trained to qualify as professional nurses under Regulation 425 and Regulation R683. They can enter the system through two different programmes – either via diploma or via the university degree programme. This could affect the transition from student to professional as nurses receive education from different institutions of learning. At the time of this study, nursing education in South Africa required that diploma nurses receive their theoretical learning at nursing colleges, which are currently identified as institutions that exist outside mainstream education, and degree nurses receive their training at universities, which are recognised as higher education institutions of learning (Armstrong et al., 2017). Universities are registered as private higher education institutions and received accreditation from both the South African Nursing Council and Council on Higher Education, whilst Public colleges are only accredited with SANC and are not registered as institutions of higher learning. In the South African Health care context, enrolled nurses can access the professional nurse qualification through the bridging programme. According to the South African Nursing Council (2006b, South African Nursing Council 2016b, South African Nursing Council 20018b), there was

an increase in the numbers of professional nurses produced through the bridging programme. Although this category of professional nurses contributes to the pool of professional nurses, there is great concern because "of the average age of entry into the work force which is thirty-five years old, they lack scientific background of the comprehensively trained professional nurse and are not as productive and as flexible as nurses trained in the four-year comprehensive program", (Armstrong et al., 2019).

The healthcare system, its challenges, and the environment can also be large contributors to difficulties during the transition period.

2.4 Reality Shock

The shock that many newly graduated professional nurse's experiences upon their first employment opportunity is referred to as 'reality shock'. Roy & Robichaud, (2016) defined reality shock as: "the reactions of new workers when they find themselves in a work situation for which they have spent several years preparing, for which they thought they were going to be prepared, and then suddenly find they are not". Duchscher (2009) also described the unexpected workload experienced by nurses in their first year of practice as reality shock.

Literature shows that newly qualified professional nurses experience limitations and a sense of frustration in their new practice (Dinmohammadi, Peyrovi & Mehrdad, and 2013). The difficulties of reconciling the disparity between "idealised role conceptions" and "actualised role conceptions", which is reported as reality shock, give rise to nursing role conflicts (Duchscher, 2009; Feng & Tsai, 2012). Reality shock refers to the disturbances between what graduates understood about nursing from their education and what they experienced in the 'real' world of healthcare services (Caliskan, A., & Ergun, Y.K., 2012).

Roy & Robichaud, (2016) described the idealised role conceptions as what newly qualified professional nurses thought their new role would encompass. They envisaged that they would have adequate time to advocate for their patients and to provide health education and counsel to patients and their families, only to experience actualised role conceptions.

Newly qualified professional nurses claim that they have never been prepared to take on roles of supervising, delegating, and providing direction to other nurses – most of whom are senior both in practice, experience, and age. This resulted in newly qualified professional nurses experiencing stress (Caliskan, A. & Ergun, Y.K., 2012).

Training must equip nurses for practise by empowering them with independency. Reality shock influences assimilation to the workforce. Reality shock also affects professional nurse retention, which in turn affects patient safety and quality of care. Reality shock can be measured in several aspects with each aspect reinforcing another. These aspects will be discussed below in the concept that follows.

2.5 Role Stress

Role stress is the discontinuity between a person's awareness of his/her role and the execution of the task at hand. (Hoffart, Waddell & Young, 2011). It is regarded as an element of reality shock which is evident in the initial year of practice for nurses.

Kumar &Kaur (2015:) conducted a study among staff nurses working in Scri Guru Ram Das Institute of Medical Sciences and Research Centre, in Vallah, Amritsar (Punjap). An Institute providing training and education for medical, dental, paramedic and nursing courses. The aim of this study was to establish if there is a relationship between job satisfaction and organisational role stress. Findings were that staff nurses who experience work related stress present with poor morale, poor performance, high turnover, and low job satisfaction. In this study organisational stress is defined as "the experience of negative emotional states such as frustration, worry, anxiety and depression attributed to work – related factors.

A study conducted by Ruzungunde, Murugan and Hlatshwayo (2016), to investigate whether organisational commitment of employees within a health care institution influenced by job stress, in Public health care institutions within the Nkonkobe Municipality Region, in the Eastern Cape found that work related stress has a negative effect on commitment of nurses who have been in the nursing profession for at least a year and more.

Literature identifies five categories of stressors; namely, excessive competition, hazardous working conditions, job insecurities, task demands, and long unusual working hours (Robbins & Judge, 2007). A study conducted in the UK investigating the transition of newly qualified nurses during their first year twelve months post qualifying, found that newly qualified nurses encounter several work-related stressors. These stressors were due to heavy workloads and shortage of staff (Halpin, Terry & Curzio, 2017). These stressors result in a high attrition rate, more sick leave, and low job satisfaction (Kumar, Kaur & Dhillon, 2015).

2.6 Orientation

Jill, Scott, and Hayes (2007) indicated that comprehensive orientation programmes reduce newly qualified staff turnover by 17–23%. This was also evident in a study conducted by Chadher (2012), who reported that graduate nurses who are given a great deal of support stayed in the profession. In a study conducted by Phillips, Esterman and Kenny (2015), an adaptation model of organisational socialisation was applied to the process of transition for newly qualified graduate .This adaptation was informed by a larger 2012 Australian study with four hundred and fifty nine newly qualified graduate nurses reporting their transition experiences during their first year of practise, findings were that for newly qualified registered nurses , socialisation was regarded as a positive experience and was effective during the transition period if there was also a comprehensive orientation programme through their first year of practise and in instances where an orientation programme was not implemented for graduate nurses, the transition experience was regarded as a negative experience.

Govender, Brysiewicz and Bhengu (2015) conducted a study to establish the perceptions of newly qualified nurses carrying out compulsory community service in Kwa Zulu Natal. The authors argued that there are no formal structures in place in South Africa for integrating newly qualified nurses into institutions once they are employed.

Professional socialisation is defined as "the process by which people who enter a profession internalize or take in new knowledge, skills, attitudes, behaviours, values and ethical standards and make these a part of their professional identity" (Mariet, 2016). Professional socialisation for health care professionals has two aspects, which are organizational socialization, which is fitting into the structure of the organization, and maintaining relationships with colleagues and learning the organizational culture, which is learning formal and informal rules of the practise environment (Mariet, 2016).

In a study on new nurse transitions by Leong and Crossman (2015), a study exploring the perceptions of new nurse's experiences or role transition in Singapore, newly qualified nurses reported that they had to fit into the organisation by observing sub-standard care from senior nurses already in practice as there were no formal orientation programmes in place for them.

2.7 Organisational Factors

Evidence shows that organisational factors such as staff support and working environment influence the experiences of newly qualified professional nurses to a large extent (Govender, Brysiewics & Bhengu 2015). These factors are largely influenced by the relationship between the newly qualified registered nurses and nurse managers. Registered nurses felt they were not given the support they expected by nurse managers, which resulted in feeling demotivated, experiencing anger, and being frustrated (Valencia, Kotzé & Van Rooyen, 2005).

2.6.1 Staff support

Mmamma, Mothiba & Nancy (2015) conducted a study to explore and describe the experiences of nursing unit managers with regards to the turnover of professional nurses who were under their supervision in a hospital in Limpopo, South Africa. They described a lack of support by senior members of the staff, insensitivity of management to staff needs, inadequate staffing, and staff shortages as factors that influence the experiences of newly qualified registered nurses negatively. This study relates to the context of Mmamma et.al (2015) research study as it explores the experiences of South African nurses in the public healthcare environment.

Leong and Crossman (2015) conducted a study on new nurse transitions in Singapore to explore the perceptions of new nurses. They identified that nurses had to conform into the nursing profession and organisation by copying the behaviour of other nurses.

Horsburgh & Ross, (2013), observed that the nurses delivered sub-standard care and experienced criticism from senior nurses if they did not conform to this practice This results in frustration for newly qualified nurses as they must be part of delivering inappropriate healthcare practices to fit in their new role.

2.6.2 Working environment.

Evidence shows that the working environment influences a newly qualified professional nurse's experiences to a large extent (Valencia, Kotzé & Van Rooyen, 2005). Among others, factors related to working environments mentioned by literature include better living and working conditions. However, a lack of facilities or resources, lack of promotion, heavy

workloads and unsafe working environments contribute to nurses' decisions to leave South Africa (Oosthuizen, 2005; Mmamma et al., 2015).

The safety of nurses is compromised, and little is done to protect them from harm (Geyer, 2004). According to Mmamma et.al (2015), issues relating to safety and lack of security are amongst factors that contribute to nurses leaving nursing in South Africa. Violence is another factor that contributes to nurses leaving nursing in South Africa. Incidences where employees are abused, assaulted, and harassed at work are known as workplace violence, in these incidences the safety, well-being and health of employees is challenged, (Steinman, 2003).

Workplace violence is a serious problem in healthcare services worldwide (Arnetz & Arnetz, 2001). Between 35% and 80% of hospital staff in Bulgaria have been physically assaulted at least once, while up to 82% of nursing staff have experienced verbal abuse from patients and their family members (Rippon, 2000); 67% in Australia, while physical assault has been reported for 33% of nursing staff in Turkey.

In South Africa, the Medical Research Council conducted a study on workplace violence in the healthcare industry. The Council reported that most respondents had experienced violence in different forms: verbal abuse was reported by 92.3% of respondents, while 36.4% of interviewees had occasionally been threatened with physical assault (Khali, 2009: 210). Health facilities, emergency departments and psychiatric setting constitute more incidents of violence (Gates, Riss & McQueen, 2006).

2.7 Summary

This chapter examined relevant research reports, articles, and literature in relation to this study. Studies relevant to the topic were reviewed. The main themes identified with the experiences of newly qualified professional nurses according to literature review, are orientation, how they experience the transition period, preparedness to practise, organisational factors, which include factors such as support of professional nurses, the working environment, and high attrition rate in the nursing profession amongst newly qualified professional nurses. The research methodology will be examined in the next chapter.

CHAPTER THREE:
RESEARCH METHODOLOGY

3.1 Introduction

Given the nature of the problem being investigated by this research, the data acquired is by qualitative methods. The following chapter seeks to explain the exact research methodology employed and the reasons for the specific choices made.

3.2 Research Approach

The following qualities of a qualitative research described by Creswell (2013), are met in this study.
Each section will be investigated in detail.

3.2.1 Researcher as key instrument

Qualitative researchers collect information by looking into documents, monitoring behaviour, or having interviews with participants (Creswell, 2013). A semi-structured interview schedule was used to collect information.

3.2.2 Inductive and deductive data analysis

Patterns, categories, and themes are arranged from the bottom up by organising the data into abstract units of information (Hatch, 2002). Specific themes were observed and identified, and generalisations were made. General themes were also identified and observed, and these were applied into specific themes until the researcher established an all-inclusive set of themes. (Creswell, 2013). Adequate information was collected until no similar themes were identified.

All the interviews were transcribed into text before iterative reading was used to formulate categories and themes.

3.2.3 Participants' meanings

Throughout the entire process the researcher-maintained objectivity, (Creswell, 2013). A voice recorder was used to record information accurately. Open-ended questions were asked, and participants could express themselves freely. This technique allows for

categories and themes to emerge, that may not have been part of the original literature review. The initial plan must be flexible. The question may change, and the site may be modified. The site used varied between participants; some were interviewed in the institution as planned and some were interviewed elsewhere for their convenience**.**

3.2.5 Reflexivity

The researcher investigated the influence that her presence, her role, and background had on the interpretations. This is critical to the process as all qualitative data must be interpreted, which means that the base assumptions of the enquirer may skew the interpretation if care is not taken (Creswell, 2013).

The researcher has a similar background to the participants. She has been a qualified nurse since 2000 after completing the four-year course diploma at a nursing college in KwaZulu-Natal. It was the researcher's first-year experience as a newly qualified nurse that stirred interest to find out about what other nurses think about their first year of practice.

3.2.6 Holistic account

Qualitative researchers try to develop a comprehensive picture of the problem under study. This involves reporting several perspectives, identifying many factors involved in a situation, and generally sketching the larger picture that emerges (Creswell, 2013).

In this study, the researcher used several enquiries to gain the necessary details in the information collected. The researcher attempted to gain a full understanding of the experiences of the participants. This was amplified by the usage of open-ended question schemes instead of closed response data.

3.3 Research Design

Burns and Grove (2013:253) defined research design as "the blueprint for conducting a study that maximises control over factors that can interfere with the validity of the study findings". The aim of the study was to describe the experiences of newly qualified professional nurses. A qualitative research study was deemed appropriate to achieve the objectives of this study.

3.3.1 Qualitative research

This study took place in a public hospital in the Gauteng province. The study was performed to promote understanding of human experiences and situations, and to develop theories that describe these experiences and situations. Furthermore, it was conducted to understand how newly qualified professional nurses and their first-year experiences.

The researcher conducted the study to explore and describe the experiences of newly qualified professional nurses.

3.3.2 Descriptive research

Burns and Grove (2013) purported that descriptive research explores new areas of research and describes situations as they exist in the world. The descriptive study offers a way of designating new meaning; explaining what exists; discovering the prevalence with which something occurs; and grouping information. The researcher in this study has described the lived experiences of newly qualified registered nurses employed in a Public Hospital in Gauteng, who were employed in January 2016/2017 period.

3.4 Population and Sampling

"A population is the entire aggregate of cases in which a researcher is interested", (Polit and Beck 2014). The population under study for this research consisted of newly qualified nurses who met the minimum requirements prescribed for the education and training of a nurse (general, psychiatric and community) and midwife. For this study, the population was n = 50 registered nurses who qualified from universities and nursing colleges and who were employed at the institution under studying Gauteng at the time this research was conducted.

Using purposive sampling, the researcher consciously chooses the participants, elements, events, or incidents to be included in the study (Burns & Grove, 2009). According to Polit and Beck (2012), purposive sampling includes choosing cases that are most beneficial to the study. A purposive sample was chosen based on the research participants' characteristics.

The researcher obtained a list from hospital administration that included all new professional nurses employed during 2016–2017 at the study site and who were eligible to participate in the study. The research study's purpose and overall details were explained to

the professional nurses. Upon consenting, they were given an information sheet, a consent form as well as a demographic data sheet. Availability and preparedness of professional nurses to participate in the study guided the researcher.

A sample of a study may include either inclusion or exclusion criteria, or even both depending on the research conducted (Burns & Grove, 2013). In terms of inclusion criteria, researchers must, when identifying contexts and participants for their studies, consider whether participants can provide rich narratives guided by their understanding and interests or the participant possesses characteristics that are needed for that study's purpose (Burns & Grove, 2013; Wiklund-Gustin, 2010).

For this study, participants were required to meet the following inclusion criteria:

- Participant must have qualified for a degree or diploma within 2 to 3 years of the interview date.
- Participant must have completed the SANC Regulation 425 Programme and thus be registered as a nurse (general, psychiatric and community) and midwife. Participants must have been employed during the period from January 2016 to January 2017.
- Participants must have completed at least 1 year but no more than 3 years of service in a public academic hospital in Gauteng.

The exclusion criterion was all registered nurses who have completed the Bridging Programme and who were employed for their first year after training at any site other than the regional hospital in Gauteng selected as the research site were excluded from this study.

3.5 Research Setting

The research setting is the physical location where and the conditions in which data collection takes place in the study (Polit & Beck, 2012). The selection of a setting in qualitative research is based on the purpose of the study, the accessibility of the setting or site, as well as the number and type of participants or subjects available in the setting (Burns & Grove, 2013). The contextual setting for this study was a regional public hospital where participants worked and were familiar with the specific processes and practices of the institution. The setting was chosen because it is the natural setting where participants work and have developed their experiences of the topic under question. Data is gathered in the

area where participants experience the problem under study (Creswell, 2013). Specifically, for this thesis, the research study was carried out in a public hospital in Gauteng.

3.6 Data Collection

Data collection is the gathering of information to address the research problem (Polit & Beck, 2012). The research tool, research questions and process of data collection are detailed in the following sub-sections.

3.6.1 Data collection tool

Data was collected by using ten (10) semi-structured interviews, which were recorded using audiotapes in addition to interviewer notes. The recordings were subsequently transcribed. These transcripts are provided in Appendix H.

3.6.2 Research questions

Open-ended, semi-structured questions were asked to participants. The overarching question was: “Please tell me about your experience as a newly qualified professional nurse?” Probes and prompts were used to allow participants to clarify and/or elaborate on their responses. All interviews were recorded using an audiotape recorder with permission from the participants (Polit & Beck, 2012). See Appendix H for interview transcripts.

3.6.3 The process of data collection

Potential participants were approached individually and invited to participate during their own time. They were issued with an information sheet relating to the purpose and proceedings of the study. Considering the nature of work-related activities of this category of nurses in this hospital, the participants could select a convenient meeting time and place, in keeping with the view of a natural setting as described by (Tuckman 1994).

The meeting was held after working hours at the institution under study with all the participants. The researcher emphasised the confidentiality of the research process to the participants. Each participant was given a consent form to sign. Their signature taken as agreement to participate in the study, and separate consent was obtained for audio recording of interviews. At this stage, each participant was given general instructions and guidelines on how the interview would be conducted. A total of n = 10 participants was interviewed.

3.7 Data Analysis

Data analysis was conducted concurrently with data collection using qualitative content analysis. Qualitative content analysis is a broad, general set of methods for analysing the content of qualitative data to support an argument with the aim of identifying important aspects of the content. It also allows one to present these aspects clearly and effectively to support the argument and persuade the reader to contribute to research (Hsieh & Shannon, 2005).

Interviews were first transcribed and then validated against the recorded interviews. Ideas and concepts were identified according to frequently used words or phrases, which were then coded and categorised. Categories are patterns or themes that are expressed directly in the text or derived through analysis (Hsieh & Shannon, 2005).

Coding is "finding patterns and producing explanations using both inductive and deductive reasoning to categories data into segments", (Brink, Van der Walt, and Van Rensburg 2016). Overarching themes in the data were then built as developed by O'Connor and Gibson (2012). Different types of codes were used to categorise data manually. manually (Brink, Van der Walt & Van Rensburg, 2016).

3.8 Trustworthiness

Trustworthiness was accomplished using Lincoln and Guba's (1985) strategies. Trustworthiness is a method of achieving rigour in qualitative research without sacrificing relevance (Lincoln & Guba, 1985). Rigour is reflected in qualitative research as openness, adherence to the philosophical perspective, thoroughness in collecting data, and the researcher's self-understanding, (Burns and Grove 2009).

In this study, the researcher used Lincoln and Guba's (1985) four strategies of establishing trustworthiness of qualitative data, namely: credibility, transferability, dependability, and confirmability. These strategies are described in the sub-sections that follow.

3.8.1 Credibility

Credibility refers to confidence in the truth of the data and the interpretation thereof (Brink, Van der Walt & Van Rensburg, 2012). It resolves the question of whether the research has demonstrated the conviction in the truth and the genuiness of the findings. Credibility

determines the honesty and authenticity of what newly employed registered nurses stated as their first-year experiences in a public hospital in Gauteng. Credibility questions how the research findings match reality in the context in which they were presented. Credibility was achieved through establishing rapport with participants. Participants were also assured of confidentiality in the beginning of the study.

3.8.1.1 Prolonged engagement

Prolonged engagement was established by building rapport and trust with the participants. Before the interviews were conducted, the researcher contacted participants and established rapport with them. This resulted in participants being comfortable to share their experiences.

Participants were also assured of confidentiality in the beginning of the study. There was enough time for data collection until data saturation occurred. The researcher had enough time to collect data and to take field notes to enrich the data collected. Field notes were kept as part of data collection. The researcher immersed herself in the data by repeatedly listening to tape recordings and internalising and familiarising herself with the data.

3.8.1.2 Triangulation

Triangulation was ensured by using different literature sources to conceptualise the findings for the purpose of making recommendations to assist newly qualified professional nurses to function effectively in a public hospital in Gauteng.

3.8.1.3 Member checking

Member checking was done informally throughout the interviews. The researcher frequently analysed participants responses and asked for comments to ascertain if the conclusion drawn reflect their perspectives.

3.8.1.4 Iterative questioning

Data quality was assured using probes, rephrasing questions and by going back to previously discussed information to obtain more detailed information.

3.8.1.5 Researchers credentials

The researcher completed a module in research methodology and qualitative analysis. She is, therefore, knowledgeable on the processes of this research approach. The research

supervisor is also knowledgeable in qualitative research processes. The supervisor constantly monitored the entire research process to ensure adherence to research principles.

3.8.1.6 Debriefing sessions between the researcher and the research supervisor

There were frequent meetings between the researcher and the research supervisor. In these meetings, the supervisor monitored data analysis process. Constructive feedback was given on how to achieve accuracy of data.

3.8.2 Dependability

Dependability is a strategy for assessing the quality of information in a qualitative study, it refers to the consistency of results over time and across conditions (Polit & Beck, 2012). It is attained through rich and comprehensive explanations that are rooted in and developed out of contextual association. This was achieved by the research supervisor adhering to the following:

- providing guidance and ensured that the researcher adhered to the research plan.
- Providing constructive feedback regarding data analysis
- Evaluating the content of the interviews for quality
- Assessing and confirming results of the study.

3.8.3 Transferability

Transferability refers to the extent to which the outcomes of the specific study can be applied to other situations. According to Lincoln and Guba (1985), qualitative research data is collected until saturation is reached. Transferability is assumed from the sample to the target population only, and the findings can be transferred to similar contexts by describing the context in detail.

Findings may not be transferable to other nursing institutions because of the limitations of this study.

3.8.4 Confirmability

Confirmability refers to the lack of prejudice/bias in the data findings. The findings should produce the same results when applied by other researchers using the same research participants in a similar context (De Vos et al., 2011). Neutrality promotes others accepting the research findings as worthy and authentic. The following measures were ensured:

- Interviews were digitally recorder to capture all information from participants.
- Interviews were transcribed verbatim.
- All raw data would keep for two years after publication and for six years if they are not published.

3.9 Ethical Considerations

The following ethical principles were observed in this study, informed consent, privacy and confidentiality, protection of participants from harm, avoidance of conflict of interest, transparency, and access to information, (Berg, 2017; Henning et al., 2004). Ethical clearance and permission to conduct this research were obtained from the Helen Joseph Provincial Hospital (Appendix D), the Human Research Ethics Committee of the University of Witwatersrand (Appendix F), and the University of Witwatersrand's Postgraduate Committee (Appendix G).

Participants were not coerced or forced to take part in the study. They were informed of their right to participate and to withdraw at any time during the study. A code number was assigned or allocated to the transcript and to the data collection sheet in case it would be necessary to trace the data back to an individual. Pseudonyms were used to protect the privacy of all participants (Burns & Groove, 2013).

Participants did not benefit in any way from taking part in this study (Burns & Grove,

2011). Participant's lives were not endangered in any manner in this study. Consent obtained from participants included a detailed explanation of the research topic, the purpose of the research, the aim of the research, the title and position of the researcher, as well as the data collection methodology that was be used. Copies of the provided documents are displayed in Appendix A and Appendix B. The use of audiotapes was explained to participants and a separate consent form for audio-recording was provided (Appendix B).

3.10 Summary

The theoretical foundations selected by the researcher were explained in relation to the research design used in this study. The researcher attempted to justify the reason for the choices regarding research methods and design. The specific details around various aspects of the methodology employed, such as data collection, analysis, trustworthiness, and ethical

considerations, were outlined. This foundation of the methodology gives context to the data obtained from the research.

CHAPTER FOUR:
PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents the findings of the data analysis and discussion thereof. The themes and sub-themes derived from the raw data are presented, discussed, and integrated with literature. Data was collected at a Public Hospital in Gauteng Province. Semi-structured interviews were conducted with ten registered nurses. The selection criteria included nurses employed during 2015/2016 in the institution. From the analysis, four clear themes with four sub themes emerged from the data.

4.2 Description of the Data

A date was assigned to each recording and the written text. Recordings were then coded alphabetically in the order of the interviews. Recordings were converted into written text and the researcher is the only one who may retrieve this information, for ethical reasons.
The demographic data of participants and its significance will be explained.

4.3 Presentation of Research Findings

The data is separated into two main parts, the demographics of the participant population and the actual qualitative analysis of the data. Two participants were males, and eight participants were females. Two participants hold a nursing degree qualification, and eight participants hold diploma certificates. Both qualifications are regulated by Regulation 425 therefore, they are registered in the same category with the South African Nursing Council.

In the year 2016, a total number of five nurses who took part in this study were appointed and five were appointed for the first time as registered nurses in the year 2017.

4.3.1 Participants characteristics

The mean age as observed from the participants is the true reflection of the age of nurses in South Africa. Eight participants were female and two were males, mainly because the nursing profession is still dominated by females to a larger extent. As of 31 December 2016, Gauteng Province had 34 024 female registered nurses and 2579 male registered nurses

(SANC, 2017). Two participants completed the Regulation 425-degree programme at a university and eight completed the Regulation 425 programme as a diploma in public nursing colleges, which reflects nurse training in the Gauteng Province. Public colleges produce a larger number of registered nurses than universities. Gauteng province has seven universities that train registered nurses and five public colleges that train registered nurses (SANC, 2018).

This data is confirmed by the SANC statistics for the four-year programme output (Gauteng Province) which is shown in Table 4.1:

Table 4.1: SANC statistics for the four-year programme output in the Gauteng Province (SANC, 2018)

Year	**2015**	**2016**	**2017**
Universities	136	93	144
Public colleges	670	681	654

Table 4.1 shows that Gauteng universities produced 136 registered nurses in 2015, 93 registered nurses in 2016, and 144 registered nurses in 2017. Gauteng public nursing colleges produced 670 registered nurses in 2015, 681 registered nurses in 2016, and 654 registered nurses in 2017 (SANC, 2018). The Regulation 425 programme produce fewer registered nurses in Gauteng universities than public nursing colleges.

Five of the participants commenced their employment as registered nurses at the institution in 2016. The other five commenced their employment in 2017. Both groups of nurses, those who obtained a degree qualification and those who obtained a diploma qualification, were trained under the same SANC Regulation 425, and they were all exposed to similar clinical facilities. Their training programmes carry the same number of theoretical learning hours and clinical training hours. Many similarities were found in the views of both types of participants in terms of age, gender, qualification type and year of commencement of employment in the identified institution. This correlates with the findings of Duchscher (2013:1720), whose study concluded that nurses who obtained a degree in nursing expected that their role and status would be different than diploma nurses'. In this study, the nurses with degrees and nurses with diplomas had similar experiences.

4.3.2 Research findings and significance

Table 4.2 *The themes and sub-themes that emerged from the data.*

Themes	Sub-themes
1. Readiness to practise care	Formal preparation Induction and adaptation
2. Organisational factors	Human Resources issues Policies and management issues
3. Bullying (by managers)	
4. Intention to stay in the institution	

4.4 Discussion of Themes and Sub-themes

Theme 1: READINESS TO PRACTISE

Two sub-themes will be discussed under this theme. Formal preparation, as well as induction, and adaptation. The two sub-themes are discussed below:

4.4.1. Formal preparation

In the South African context, registered nurse training is regulated by the Regulation 425 programme, which is the regulation relating to the approval of and minimum requirements for the education and training of nurses (General, Psychiatric and Community) and Midwives leading to registration for nurse colleges and universities. The duration of the nurse training course is four academic years (SANC, 2008). The Gauteng nursing college's curriculum stipulates that clinical placement of learners should consist of 1000 hours per year, with a total of 4000 hours. During training, nursing professionals would be assisted with integrating theory into practice.

Despite the total period allocated for clinical training and the number of hours in the clinical setting, newly qualified nurses indicated their unpreparedness to practise in the clinical environment. They indicated that curricula concentrated more on theoretical learning than on clinical proficiency.

Newly qualified nurses were challenged during their first two years after graduation when they realised that their reality was not what they expected. They experienced reality shock when entering the workplace. The following are direct quotations of reality shock that participants encountered: In this study, participants experienced the challenge of not feeling confident to perform their new responsibilities. They felt that they did not have the leadership experience required to delegate and supervise staff.

(OO):

"I felt like my training had prepared me for the theoretical part, but not really for the clinical part."

(KK):

"They tend to think you come fully prepared for clinical practice, in all units, from college, you are a graduate and then you must perform, some don't have patience to teach you."

Participants in this study were stunned by the amount of responsibility that came with their new roles. They now had to supervise and manage staff, which they were not used to. This supports literature evidence that nurses experience shock when they realise that their new roles come with accountability. The formal preparation of the participants did not result in their ability to cope with the requirements of their new role.

(AA):

"When we got to the ward, I had forgotten most of the things, like I went to ICU during my second year of training, I had forgotten almost everything about ICU." (PP):

"I was thrown into the deep end, working in the medical ward for less than a month, I was left alone with the ward and I did not know what to do and how to handle certain situations."

4.4.2 Induction and adaptation

According to the participants, the institution under study has a well-planned and organised induction programme, which is organised by the human resources department for new staff members. They indicated that they were exposed to a one-month formal orientation programme in the institution. During orientation, they learned about the physical layout of the institution and were orientated to the different departments. Participants in the institution also attended the junior management course for a period of two weeks. They were also taken through a back-to-basics course, which they regarded as useful as it reminded them of the basics in nursing care. The participants agreed that the formal orientation made them feel ready and prepared to practise. It reminded them of nursing care practices which they had forgotten. It was only at unit level in the institution where most participants were not orientated.

In some wards, orientation was not provided; this was attributed to increased workloads and staff shortages. The participants were forced to learn the particulars of their units on their own. For the participants to be functional, they had to ask for help from experienced nurses, this wasted time and discouraged nurses. These nurses felt frustrated and lacked confidence.

Those participants who were exposed to unit orientation were confident to practise as independent practitioners, whereas those who were not taken through unit orientation did not feel competent.

(VV): "We had a full month's orientation, two weeks was from human resources department, labour relations, different sections of management and then we had two weeks' orientation from the nursing section where different matrons from different departments /units came to present their departments to us."

(PP):

"For the first month we had four weeks orientation. Two weeks were for the Human Resources Department, Labour Relations, and all sections of management. We were taught how the hospital is ran, how to lodge complaints and about all the processes in the institution. All allied staff presented their Departments. Another two weeks was for the Nursing Orientation. Different Matrons from different units addresses us".

(GG):

“We were given a month’s orientation, we had two weeks of orientation and two weeks of what is called junior management course, and then for the rest of the month we were orientated on different aspects like regulations, back to basics”.

Newly qualified professional nurses in this study had a challenge adapting to their new environment. The new role came with a new responsibility of managing and supervising staff.

The following are direct quotation of the challenges that participants encountered:

(KK):

“I was not really confident and sometimes I really felt like people were taking advantage because I was new and I did not know the wards and I did not have the authority, and at times I did not know how to speak up and tell people like to delegate certain tasks, like to sort of have that leadership I felt like too new and shy to have that authority especially when having to, like manage and supervise subcategories I found that really difficult, it’s not really in my nature to tell people what to do.”

(NN):

“It has been hard trying to adjust, cause now the responsibilities fall on you and you have to obviously now you are the one responsible for everything and being in a new institution it is hard because you are not used to the way that they do things.” (OO):

(XX):

“Things like that they just throw you under the bus, like you just don’t want to come to work, you don’t look forward to coming to work every day, every day, you have your own personal issues, you come here you meet such people, they are bitter and they are angry I don’t know for what, but you come to work and you expect to be productive and people give you negative energies.”

Participants verbalised that there was mentoring in some units in the institution and in other units they were left on their own, showing an inconsistency within the institution.

Evidence suggests that mentoring and providing guidance and support to newly qualified nurses are effective for reducing stress. Nurses who were supported in the form of being mentored in the new units felt prepared and confident to assume their new roles.

(GG):

“There was always someone to mentor us, they showed you what to do and how to do it.”

(LL):

“You are left alone with the ward and you do not necessarily know what to do, and how to handle the situation.”

Adaptation refers to the ability to learn new skills, knowledge, and behaviours in changing environments. It also refers to unlearning old behaviours. Newly qualified professional nurses enter the practice environment with enthusiasm and preparedness. They want to implement new up to-date practices in the wards, improve the quality of care, and work smart, only to be received with great negativity from nurses who do not want to change their old practices. Participants mentioned how they were excited to introduce updates in the nursing practise, from the evidence-based knowledge they received in training and how their excitement was shunned upon by nurses already in the units. Nurses in the units were not receptive to learning new ways methods of working effectively.

(LL):

“You try to improve things, but people are very reluctant to change, they do not want change actually, you want to come up with things like maybe this can work, let’s try this system, no, they do not even give it a chance, they reject it immediately.”

(XX):

“We were taught about evidence-based practice and you come here, you see that ooh they are still using that, this is outdated, this is the new one, you introduce to them no this is the new one who says this and this or this is the policy that the government released and then you get things like who are you or they question even your training, where did you train?, here we do not do this, here we do this and this and it has been working perfectly”, but who says this, they are like no, here we do this and you end up seeing that you know, you end up being demotivated, what is the use of me being here you try to improve things but people are very reluctant to change, they do not want change actually, you want to come up with things like maybe this can work, let’s try this system, no, they do not even give it a chance, they reject it

immediately when you say it. What is the use of me being here you try to improve things, but people are very reluctant to change, they do not want change?"

Support from colleagues in the workplace also allows adaptation into the new environment. In this research study, participants felt that they were supported by other professional nurses, lower categories of nurses, however, they raised concerns about managerial support, and support from some medical practitioners, which they felt was lacking.

(OO):

"The staff in general is actually supportive, but in other wards then, people are different, in other wards support is good from managers to lower categories, even the porters, you get, everybody teaches you here at Helen Joseph, it's very different in the way which they do things, some support was even from the doctors."

(NN):

"The support is great in the ward that I am in, ward nine high care, the operational manager, professional nurses and other categories, the support is great".

Participants felt that they are not recognised as professionals by some practitioners and as members of the multidisciplinary team. By virtue of their education and training, and the fact that nurses are recognised by a professional body as competent professionals, registered nurses expected to be respected. However, they felt that they were only expected to carry out doctors' orders without question. This demotivated most nurses who felt that they also have a role to play in the treatment of their patients. These nurses were disappointed with the nurse-doctor hierarchical relationship, which made them feel subordinate, unable to make clinical decisions, and only expected to execute doctors' orders.

(LL):

"They give you that attitude that you as a member of the team you must be the quiet member, you must just accept everything that the team agrees on and you have no opinions whatsoever. You get an attitude as the nurse that your opinion is not relevant".

"I did not see you in my class, I did not even see you in the corridors of the institution where I trained".

In this study, participants who received support from their colleagues, nurses and managers indicated that support increased confidence to practise as independent practitioners. However, some respondents expressed dismay with some of the doctors who did not regard nurses as members of the multi-disciplinary team. In units where support was given, relations amongst staff improved.

Theme 2: ORGANISATIONAL FACTORS

It emerged from the interviews that there are organisational factors that have an influence on the experiences of newly qualified professional nurses in their work environment. The organisational factors quoted included two subthemes: human resources issues and policy and management issues.

Two sub-themes will be discussed under this theme, human resources issues, policy, and management issues.

4.4.3 Human Resources Issues

Physical and psychological safety of newly qualified nurses in the institution was also mentioned as an area of concern in the interviews**.** The institution has a responsibility of providing a safe working environment for its employees. Participants felt that they are not safe in the healthcare institution, particularly in the casualty section of the institution where they felt that they are exposed to community members who threaten them and are violent towards nurses. Here they are exposed to the community, who sometimes become aggressive towards professional nurses. Professional nurses feel unsafe and fear for their lives when they are placed in these units. According to the participants, the institution is not doing enough to protect the safety of the staff in such units. Furthermore, the security personnel deployed to such units are not equipped or trained to handle violence and professional nurses fear for their lives.

(VV):

“Casualty a high-risk area, it is surrounded by gang rival, first and fore most the security is not tight, there are instances where gang members come to see a patient, they come drunk and become violent when you have to defend yourself, security is far away from where you are, and you cannot defend yourself.”

(XX):

“Sometimes security is not well trained to fight off that violent behaviour, when you call for backup, they call other security members in other words, looking out for other departments, so when they come to assist, they neglect their posts.”

Staff psychological issues were not attended to in the institution; this is evident in situations in which staff members felt that they needed counselling after traumatic incidences, which were not prioritised by management. The need for counselling and debriefing was noted by participants where traumatic incidences occurred. Participants felt that they did not receive timeously emotional and psychological support. Nurses are frequently exposed to dying patients and death during their work. They need skills and experience to manage emotional issues posed by the reality of deaths.

(KK):

“There was a traumatic incidence in casualty, a child passed away and the staff asked if the staff wellness sister will come and do debriefing in November, and she said she is booked up until February and by then it really would not be relevant.”

One of the participants shared an incident where one of the patients under her care committed suicide. They expected to receive counselling, and this never happened. It is also a reality in the institution that everyone who experienced trauma did not receive counselling.

(SS):

“In ward two, one of the patients committed suicide, we were told we were going to receive counselling we never got counselling and as I go along, I realise it is not just us a lot of nurses who experienced trauma in the hospital don’t get counselling.”

4.4.4 Policies and Management Issues

All health care institutions are expected to have clear policies regarding nurse-to-patient ratios, addressing the challenge of staff shortages in the units. Managers are at the forefront in implementing these policies and in ensuring that these policies are available and accessible to all. In this study, registered nurses experienced staff shortages, nurse-to-patient ratio issues and resistance to change from their colleagues. The registered nurses were exposed to staff shortages and had to perform more tasks to cover for these shortages in the workplace. Newly

qualified professional nurses were overwhelmed by staff shortages in the units where they were placed. They were overwhelmed because they still had to perform their duties of supervising staff, performing administrative tasks, and paying attention to nursing care. This resulted in exhaustion and burnout.

(KK):

"The hardest thing for me was all the wards I was working in were very short-staffed."

(OO):

Staff shortage affected me a lot, I felt drained because I had to work extra to cover the shortages nothing you know that nothing is going to be done about it."

(XX):

"We are understaffed sometimes you are the only PN on duty and you have to do all these other things you have to make sure that people do what they are supposed to do, all those things they are on you and it becomes overwhelming, it becomes emotionally, physically like everything exhausting."

Participants raised a concern that there were no stipulated nurse-to-patient ratios in the units where they were allocated; hence, they found themselves overwhelmed with the workload. Nurse-to-patient ratios display the total patients cared for by one nurse. Furthermore, they were exposed to inappropriate skill mixes.

(OO):

"The nurse patient ratio does not correspond, like there is a discrepancy".

(PP):

"The ward quota will be three registered nurses per shift and the ward will only have one registered nurse in a shift. This becomes a challenge, as you come on duty, through the gate, you already know that it's going to be a hectic day, and this is demotivating, sometimes you also absent yourself because of burnout."

According to participants, white patients received preferential treatment when it comes to triaging in casualty department. They were also favoured when it came to the allocation of beds in the institution. Race-related health outcomes in the health industry are still firmly in

place and will remain a decisive force in the South African health and healthcare for many years, even generations to come. This is because of the legacy of apartheid in South Africa. Policies must be in place to address eradication of preferential treatment in nursing units. Policies must also clearly stipulate measures of dealing with this discrepancy in the institution. This is to ensure that all patients are treated as equal, and they all receive the same level of treatment by the health care staff. Two of the ten participants in the institution observed staff giving preferential treatment to white patients over black patients. These participants raised a concern that the institution is still holding on to old practices, which are a product of the apartheid regime. Post-apartheid democracy is closely linked with issues of transformation and governance.

(VV):

"In case where a patient is supposed to be triaged to go to orange, if there is a black person and there is no space there, they will gladly write, maybe we will do an ECH test, if maybe they come complaining of a chest pain, they will do an ECG test and write everything is normal and they will step them down to yellow". And when … it is a white patient coming in with the same condition, orange being full, they would rather look around to see who they can take out of orange and step them down to yellow and they will give them first preference for them to enter the orange room."

From the experiences of the participants there still seems to be some practices that show that the institution provides preferential treatment to white patients. This demotivates newly qualified nurses who believe that in this era, these issues should no longer be a challenge and should be addressed. This is mainly because the institution under study used to be a white-only institution that only served the white community. The institution is in a white-dominated residential area, which is mostly frequented by white healthcare users. The community residing around the institution is still in the process of transformation and, hence, getting used to diverse healthcare practitioners in the institution.

This is what some of the participants had to say about the notion of white supremacy:

(NN):

“They are still scared of white people, they still have that ‘white supremacy’ thing, like when you see a white person you have to be scared, you have to treat them much better than you are treating a black person.”

(GG):

“You can tell by the way patients speak to you that they know that in this institution if I am white, I am going to be treated much better than the other patients and also doctors, they have that thing that you will not tell me anything, the colour of my skin dictates that I get respect regardless of whatever is happening.”

The leadership style displayed by most managers in the institution discouraged nurses who reported that they were not free to be active participants in work issues because they feared victimised by management. Newly qualified nurses also expressed their disappointment when they observed the behaviour of management, whom they regarded as role models and whom they expected to uphold ethical behaviour.

(LL):

“I was excited to be chosen to be the mouthpiece of registered nurses in one committee, only to discover that whenever you raise issues, management does not take you seriously, they ignore your input and nothing changes, only management can make changes in the institution and no input is received from young nurses.”

(GG):

Managers did not allow newly qualified nurses to take initiative in decision making. The manager made all the decisions themselves without including nurses. Nurses felt that this discouraged their creativity. You cannot take or make independent decisions regarding the ward, every decision that you make must always go to the matron, this is limiting.

Theme 3: BULLYING (by managers)

Bullying is defined by the Oxford dictionary (2021), as the use of power to frighten or hurt weaker people. Literature suggests a close relationship between leadership and bullying. Bullying of professional nurse by nurse managers, was also identified by newly qualified professional nurses. This bullying negatively affected experiences of nurses into their work area. Newly qualified professional nurses did not expect this type of behaviour from their seniors.

The participants expected nurse managers to be professional and to demonstrate role modelling behaviour. however, they experienced the behaviour of nurse managers as unprofessional. This unprofessional behaviour of nurse managers made newly qualified professional nurses felt undermined. Newly qualified professional nurses experienced verbal abuse from their managers, as they would be shouted at and humiliated in front of patients.

(XX):

"These people are supposed to be your mentors you are looking up to them to be you role model, but when you look at them they are not painting the picture that you want or the picture that you think should be, they will tell you about professionalism yet the things that they tell us not to do are the things that they do, the things they will say, no but the hospital says this, they will come and make noise for you in front of your patients, they will come and address you like you are a child, like you are not a nurse."

(LL):

"Matron will shout at a nurse in front of a patient, I think there is a more appropriate approach to that, I think they should try maybe and look at how different hospital are doing things, some matrons are always yelling, the thing is people here have accepted the situation, even though its wrong."

(SS):

"You do not see seniors displaying professional behaviour towards us, they shout at nurses in front of patients."

Theme 4: INTENTION TO STAY IN THE INSTITUTION

The experiences of newly qualified professional nurses in their work environments have an influence on whether they choose to stay with the new institution, or whether they choose to leave the institution. The experience can even lead to newly qualified professional nurses choosing to leave nursing as a career. From the ten participants interviewed in this study, only three verbalised an intention to stay in the institution. This is mainly because they acknowledge

that the institution offers a good learning opportunity to them, and they are also staying because the institution has offered them an opportunity to go to school to further their studies.

(VV):

“I intend to stay in the institution because they have offered me an opportunity to go to school. I am also working in the Department I am enjoying., the Trauma Department.”

(SS):

“For this year I am staying. I have realised that I am exposed to more learning opportunities, in this institution compared to what my colleagues have learned and are exposed to in their institutions.”

(KK):

“The only reason why I would consider leaving the institution would be to further my studies. I am really happy where I am, and I am learning a lot from my experiences here”.

Seven participants have plans to leave the institution. One of the participants intends to leave because of the stress of commuting from his /her residential place to work. Three participants intend to leave nursing as a profession altogether, one intends to leave because nursing was not his /her first career choice, the second one feels the system is unfair to nurses and the third one is studying Public Health, once she is finished with her studies, she is leaving nursing. The fifth participant is leaving because the institution does not offer her chosen field of advancement. The sixth participant feels there is too much oppression in the institution. The seventh participant feels that the unit she has been placed in is not challenging her. She has made numerous requests to move to another unit but has been denied the opportunity.

(AA):

“I cannot see myself staying in this institution for long. I am not happy in the Department where I am in. I need a challenging environment”.

(PP):

“The only reason why I am leaving the institution, is because I am commuting from my residential area to workplace, and it is strenuous. I wish I could take the Department I am working in with me.”

(XX):

“I really did not want to do nursing in the first place. I am not staying in this profession.”

4.5 Summary

Four themes emerged from interview findings, readiness to practice, organisational factors, bullying by managers and intention to stay. Themes and subthemes that emerged from the data collected were discussed in this chapter. The findings will be compared to literature review in the next chapter.

CHAPTER FIVE:

DISCUSSION OF FINDINGS

5.1 INTRODUCTION

In this chapter, the findings of the research study will be compared with the findings of the literature review.

5.2 COMPARISON OF THE FINDINGS OF THE STUDY WITH LITERATURE

5.2.1 Readiness to practice.

- **Formal preparation**

Participants in this study raised a concern, that they felt their training did not adequately prepare them for their professional roles. They agreed that the academic programme prepared them more for theoretical knowledge. It failed to focus on the realities of the clinical environment. These findings concur with findings in literature. According to Pennbrant, Nilsson and Öhlén (2013), newly qualified nurses felt that their training did not equip them adequately for their working life. They felt that their training should have prepared them by affording them more opportunities to enhance their skills and practical knowledge. Al Awaisi, Cooke and Pryjmachuk (2015) also confirmed this finding. They concluded that newly qualified nurses felt unprepared to practise in the clinical area because of the curricula that concentrated more on theoretical learning than on clinical proficiency. Horsburgh and Ross (2013) also concluded that newly qualified nurses had considered themselves prepared for their new role after graduation, but they discovered that they were not prepared for practice. Rush et al. (2013) further found that newly qualified nurses felt that the academic programme did not prepare them adequately for specific areas of practice.

In the South African context, registered nurse training is regulated by the Regulation 425 programme, which is the regulation relating to the approval of and minimum requirements for the education and training of nurses (General, Psychiatric and Community) and Midwives

leading to registration for nurse colleges and universities. The duration of the nurse training course is four academic years (SANC, 2008).

The Gauteng nursing college's curriculum stipulates that clinical placement of learners should consist of 1000 hours per year, with a total of 4000 hours. During training, nursing professionals would be assisted with integrating theory into practice.

Evidence produced between 2004 and 2006 indicates that clinical teaching of nursing students is not adequate (Armstrong, Bhengu & Kotzé, 2015). Clinical teaching refers to nurse educators, registered nurses and clinical managers who teach nursing students in a clinical area (Sezers, 2018:15). Clinical teaching is aimed at producing competent professionals capable with critical thinking skills, (Bruce, Klopper & Mellish, 2016). This evidence is supported by a study conducted by Cassimjee and Bhengu (2006), regarding the perception of the time spent with facilitators during clinical exposure. The study concluded that students get very little clinical teaching. Participants in this study felt overwhelmed with the amount of responsibility in the units they were placed in. From the supervision of the staff to delegation of tasks. Most also raised a concern that they were not familiar with certain procedures in the units they were placed in.

- **Induction and adaptation**

Orientation is defined as the training or preparation for a new job or activity. According to Babar et al. (2016), one of the primary reasons for nursing orientation is to ensure that new employees understand and retain the policies and procedures for patient safety. Orientation of new personnel has two parts: induction training, which should be presented by the human resources department within an institution, and an orientation programme, which is the responsibility of the department where the individual employee will be working (Armstrong et al., 2017).

Induction is a formal introduction to a new job or position (Oxford English Dictionary: 2013). Induction takes place during the first 2–3 days of orientation of new employees and it aims to reduce anxiety; create a positive attitude towards the institution; assist the new employee to become productive; assist in creating realistic work expectations; and saves time of fellow workers (Armstrong et al., 2017).

According to the participants, the institution under study has a well-planned and organised induction programme, which is organised by the human resources department for new staff

members. Participants in the institution attended the junior management course for a period of two weeks. They were also taken through a back-to-basics course, which they regarded as useful as it reminded them of the basics in nursing care. The participants agreed that it made them feel ready and prepared to practise as it reminded them of nursing care practices which they had forgotten. This concurs with literature findings, as participants indicated that they were exposed to a one-month formal orientation programme in the institution. During orientation, they learned about the physical layout of the institution and were orientated to the different departments. However, nurses expected to also receive a structured orientation in their units to perform their duties well. Three nurses indicated that they received orientation in their specific units, which assisted them to perform their duties. These nurses stated that orientation made them feel confident and motivated to practise. In the medical ward, ward orientation was not provided; this was attributed to increased workloads and staff shortages. The participants were forced to learn the particulars of their areas while under all the demands and responsibility of the unit. For the participants to be functional, they had to ask for help from experienced nurses, this wasted time and discouraged nurses. These nurses felt frustrated and lacked confidence.

Those participants who were exposed to unit orientation were confident to practise as independent practitioners, whereas those who were not taken through unit orientation did not feel competent. Participants in the study felt confident after receiving orientation and they became familiar with the work environment. This correlates with study findings by Dlamini et al. (2014), which confirmed that orientation is important for new nurses. Those who receive orientation are confident to practise. Established nurses were found willing to offer their support in the form of orientation but they were overwhelmed with work and had insufficient time for orientation.

5.2.2 Organisational Factors

According to Maslow's (1970) hierarchy of needs, human beings have a need to feel safe from harm. Their needs include shelter, job security, health, and safe environments. If a person does not feel safe in an environment, they will seek safety before they attempt to meet any higher-level needs. These needs are critical to physical and psychological wellbeing (Bruce, Klopper & Mellish, & 2016).

Some participants felt that they are not safe in the healthcare institution, particularly in the casualty section of the institution where they felt that they are exposed to community members who threaten them and are violent towards nurses.

Their findings concur with literature review which reports that unsafe working environments contribute to nurses' decisions to leave the public health care institution. (Oosthuizen, 2005; Mmamma et al., 2015). The safety of nurses is compromised, and little is done to protect them from harm (Geyer, 2004). According to Mmamma et.al (2015), issues relating to safety and lack of security are amongst factors that contribute to nurses leaving nursing in South Africa. Violence is another factor that contributes to nurses leaving nursing in South Africa. Incidences where employees are abused, assaulted, and harassed at work are known as workplace violence, in these incidences the safety, well-being and health of employees is challenged, (Steinman, 2003).

Workplace violence is a serious problem in healthcare services worldwide (Arnetz & Arnetz, 2001). Between 35% and 80% of hospital staff in Bulgaria have been physically assaulted at least once, while up to 82% of nursing staff have experienced verbal abuse from patients and their family members (Rippon, 2000 :452); 67% in Australia, while physical assault has been reported for 33% of nursing staff in Turkey. This is in accordance with the results of this study. The need for counselling and debriefing was noted by participants where traumatic incidences occurred. Participants felt that they did not receive timeously emotional and psychological support. Participants in this study have indicated that counselling and debriefing services in the institution are not efficient. According to Uys & Middleton (2014), debriefing is a consultation where an individual who has experienced a traumatic experience is assisted and supported to identify and verbalise her feelings, to this occurrence. It is aimed at reducing psychological trauma to victims and it also equips them with coping mechanisms. Nurses in the public health care sector need counselling and debriefing services as they are faced with overwhelming incidences, (DENOSA, 2017). "Nurses who do not receive support are at risk of becoming either hardened to the plight of those in their care, or else overly involved in the challenges of their patients", (DENOSA, 2017).

In this study, registered nurses experienced staff shortages, nurse-to-patient ratio issues and resistance to change from their colleagues. The registered nurses were exposed to staff shortages and had to perform more tasks to cover for these shortages in the workplace. According to Armstrong et al. (2017), the nursing shortage has become a crisis in Africa

regarding the safety of care provided to the public. Different categories of nurses, providing differing levels of care according to their expertise, make up what is termed “skill mix”, (Hall, 2009). This skill mix is not the same across countries and it depends also on the severity of the patient’s illness, (Jacob, Mckenna & D’Amore, 2015). There is a strong relationship between a disproportionate skill mix and the rate of nurses who exit in health institutions, (Jacob, Mckenna & D’Amore, and 2015). According to Ganz and Toren (2014), an improper skill mix leads to understaffed units. This increases the workload and results to burn out amongst nurses.

Research findings agree with literature review as newly qualified nurses raised a concern that there were no stipulated nurse-to-patient ratios in the units where they were allocated; hence, they found themselves overwhelmed with the workload. Nurse-to-patient ratios display the total patients cared for by one nurse. California, USA, is the only state internationally that has legally defined that units always maintain the required minimum nurse-to-patient ratios. The nurse-to-patient ratio must be 1:2 in intensive care units (ICUs) and 1:4 in emergency departments (Lippincott, 2009).

According to 2010 statistics of the SANC, South Africa had a ratio of 3:3:1:4 for enrolled nursing assistants: registered nurses/midwives: specialist registered nurses/midwives: patients in 2006. The recommended staff ratio in each unit per shift is: three enrolled nursing assistants, three registered nurses/midwives, and one registered specialist nurse per four patients (Uys & Klopper, 2013). However, in the South African public healthcare sector, nurse-to-patient ratios range from as low as 1 nurse: 18 patients to as high as 1 nurse: 44 patients, with anecdotal evidence from the Eastern Cape suggesting that ratios have reached 1 nurse: 50 patients in some general wards and 1 nurse: 10 patients in some postnatal wards.

Participants had trouble and were overwhelmed with staff shortages in the units, which was evident during their interviews.

Transformation is a marked change in form, nature, or appearance (English Oxford Dictionary 2018). According to Van Rensburg and Benatar (1993), apartheid is one of the most decisive forces that moulded the South African healthcare system and the health of the population. It has led to grave race-related disparities, inequalities, fragmentation, and discrimination. Participants in this study felt that they are not recognised as professionals by some practitioners and as members of the multidisciplinary team. By virtue of their education and training, and the fact that nurses are recognised by a professional body as competent professionals, registered

nurses expected to be respected. However, they felt that they were only expected to carry out doctors' orders without question. This demotivated most nurses who felt that they also have a role to play in the treatment of their patients. This concurs with findings by Al Awaisi, Cooke and Pryjmachuk (2015) that nurses feel as if doctors in the institutions treated them as subordinates and not as professionals.

Race-related health outcomes in the health industry are still firmly in place and will remain a decisive force in the South African health and healthcare for many years, even generations to come. Two of the ten participants in the institution observed staff giving preferential treatment to white patients over black patients. Participants raised a concern that the institution is still holding on to old practices, which are a product of the apartheid regime. Post-apartheid democracy is closely linked with issues of transformation and governance. Generally, transformation speaks to new relations between the state and civil society that facilitate working towards mutually beneficial societal goals (Armstrong et al., 2017).

White supremacy is defined as a belief that white people are more deserving than other races, (McIntosh, 1988). The notions of white supremacy, racial segregation, and the ideologies of apartheid government continue to hinder the South African government's attempts to restructure its healthcare system.

From the experiences of the participants there still seems to be some practices that show that the institution provides preferential treatment to patients of colour, which demotivates newly qualified nurses who believe that in this era, these issues should no longer be a challenge and should be addressed. This is mainly because the institution under study used to be a white-only institution that only served the white community. The institution is in a white-dominated residential area, which is mostly frequented by white healthcare users. The community residing around the institution is still in the process of transformation and, hence, getting used to diverse healthcare practitioners in the institution. If nurses are respected and acknowledged as members of the multidisciplinary team, they will be more productive in the institutions as they will feel like valuable members of the healthcare team. Participants in this study belong to the fees must fall generation. They have never experienced apartheid directly. They are a generation which is passionate about equity issues and fair distribution of resources.

In South Africa, access to medication, healthcare facilities and trained personnel must be given on a non-discriminatory basis without making any distinction of any kind based on race, ethnic group, colour, sex, language, religion, political or another opinion, national or social origin, property, birth, or other status. Discrimination on any of the above is a violation of the Promotion of Equality and the Prevention of Unfair Discrimination Act 9 (No. 4 of 2000) and is a criminal offence (Armstrong et al., 2017). The Patients' Rights Charter introduced by the Department of Health also emphasises the rights of healthcare users; access to healthcare is one of the rights mentioned in this charter (Department of Health, 2002).

5.2.3 Bullying

According to Armstrong et al. (2017), autocratic leadership discourages creativity from newly qualified registered nurses. It is demotivating because autocratic leadership promotes adherence to structure, rules, procedures, and a high level of dependency. This agrees with what was reported by participants in this study. Participants reported that they were not free to be active participants in work related issues because they feared management. Newly qualified nurses also expressed their disappointment when they observed the behaviour of management, whom they regarded as role models and whom they expected to uphold ethical behaviour. They quote incidences where matrons and nurse managers will shout at them, in front of their patients and in front of their colleagues.

With all the reported experiences of newly qualified professional nurse. Research findings indicate that only three participants in this study want to leave the institution. One participant stated that the only reason why he wishes to leave the institution, is because he stays far away from the institution. Commuting from where he stays to the institution, and vice versa is the only reason why he would leave the institution. Another participant stated that she did not want to study nursing in the first place. She stated that nursing was not her first career of choice, she was not accepted for her preferred choice and she came to nursing. The third participant indicated that once she is studying public health, as soon as she is finished with her studies. She is leaving the health care institution. All other participants stated that they are staying on in the institution, because of the opportunity to study and because of the experience and knowledge they have acquired from the institution. According to literature findings, attrition rate is higher amongst professional nurses who did not choose nursing as their preferred profession of choice during training. Participants who chose nursing as their first preferred profession intend to stay in the profession, regardless of their first-year experiences. According

to a study by Chauke, Van Der Wal & Botha (2015:), which was conducted to explore the potential of appreciative inquiry as an intervention teaching strategy to transform students' nurses' image in nursing. This was done by selecting students studying towards the programme of education and training leading to registration as a (general, psychiatric and community) and midwife, from nursing colleges and nursing departments of two selected Universities in the City of Tshwane, Gauteng Province, South Africa. It was identified that there is a relationship between attrition rate of newly qualified nurses and the reason why they chose nursing as a career. High attrition rate was observed in nurses who entered the profession because of a salary earned whilst studying.

5.3 Summary

In this chapter, the findings of the research study were compared to literature review. Similarities were identified in the experiences of newly qualified nurses with what is documented in literature. All the findings revealed that newly qualified nurses felt that their training did not adequately prepare them for their professional roles. They agreed that the academic programme prepared them more for theoretical knowledge. The curriculum failed to focus on the realities of the environment, which include staff shortages, work overload and adherence to a strict routine. Newly qualified nurses raised a concern that there were no stipulated nurse-to-patient ratios in the units where they were allocated; hence, they found themselves overwhelmed with the workload. According to the participants, the institution under study has a well-planned and organised induction programme, which is organised by the human resources department for new staff members. However, nurses expected to also receive a structured orientation in their units to perform their duties well. There was mentoring in some units in the institution and in other units they were left on their own, showing an inconsistency within the institution. Newly qualified registered nurses were excited that they would implement current, up-to date knowledge in their clinical practice, only to be met with resistance from staff in the nursing units. Participants who received support from their colleagues, nurses and managers indicated that support increased confidence to practise as independent practitioners however, they raised concerns about managerial support, which they felt was lacking. The need for counselling and debriefing was noted by participants where traumatic incidences occurred. Participants felt that they did not receive timeously emotional and psychological support. All ten participants viewed the overall management style as threatening and autocratic. Some participants agreed that

the institution is not safe for registered nurses, especially in units such as the casualty department. Here they are exposed to the community. Preferential treatment to white patients over black patients was also observed by some participants in some units of the institution. Participants raised a concern that the institution is still holding on to old practices, which are a product of the apartheid regime practices.

CHAPTER SIX:

MAIN FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

6.1 INTRODUCTION

In this Chapter, the main findings of the research study, the limitations of the study and recommendations will be presented will be presented.

6.2 MAIN FINDINGS

Nurses experienced their first year of employment as challenging. They experienced frustrations with their new environment as they were not used to it. They were not familiar with the processes and procedures in different units where they were placed. They came into the new environment with high expectations and with a lot of excitement in assuming their new role. They felt they were ready to implement new up to date changes in the workplace.

Their expectations were not met, they felt that their training did not equip them for the realities of the clinical environment. They experienced a lot of resistance from nurses who were already in the institution for a longer period. Who felt that their way is the only way of doing things? They found themselves faced with responsibility and accountability as professional nurses, which was new to them as they had been student nurses and responsibility had always rested on their seniors.

The institution under study provided a planned induction and orientation programme to newly qualified professional nurses. This orientation programme lasted for four weeks, of which the first two weeks were for the geographical layout of the institution. Different departments of the institution gave a detailed orientation of their departments and what their role is in the institution. The other two weeks was for the Junior management course and the bac to basic course where the newly qualified nurses were prepared for their new role.

Newly qualified professional nurses who were exposed to a planned induction and orientation program felt prepared to practise in their new role. They felt ready to practise as professional nurses and to manage and supervise staff in their new units. However, even though they went through a month’s induction programme, some felt that it was not enough for them to manage wards by themselves. The participants who were mentored and who could shadow their

colleagues appreciated this and they verbalised that this gave them a feeling of belonging and made them feel prepared for their new role.

Participants also indicated resistance to change from nurses who have a longer period in the institution. Newly qualified nurses enter their new workplace with excitement of introducing new methods of working smart. This is because they were taught about evidence-based practice during their training. They become demotivated and frustrated when their colleagues refuse to accept changes.

The newly qualified professional nurses experienced the work environment as unsafe to them. In the casualty department, a concern was raised of gangsters who become aggressive and violent towards professional nurses.

Some participants reported incidences of preference given to white patients in the institution. Patients of colour were also reported to have an attitude of white supremacy. The management style of managers also was a challenge to most participants. Participants felt frustrated when managers shout at them in front of their patients. This affected the relationship of newly qualified professional nurses with their patients. They developed an attitude of doing routine and not caring for their patients.

Seven participants indicated that they are not planning to leave the institution. They stated that the institution has provided them with knowledge that their colleagues in other institutions have not been exposed to. They all agreed that the rotational system exposes them to new units and new conditions. The institution also provides an opportunity for professional nurses to further their studies. Three participants indicated that they are living the institution entered the nursing profession because she was not accepted for her preferred course, the other participant is staying far away from the institution, and the third participant is studying public health.

6.3 LIMITATIONS OF THE STUDY

The findings of this study must be seen considering the following limitations: methodological limitations and common limitations of the researcher.

6.3.1 Methodological Limitations

- The research setting of this study comprised a single setting that only investigated the experiences of registered nurses who were employed in the period of 2016/2017. This

limited the view of the experiences of registered nurses, and it might also restrict the population to which findings can be generalised to.

- The sample of ten participants also limit the generalisation of the findings to the community of professional nurses in the Gauteng Province.
- Data was collected in the participants work environment. This might have influenced their responses as they shad to return to work after the interview.

6.3.2 Common Limitations of the Researcher

- The presence of the researcher in the interviews may have influenced the responses of the participants, who might have responded in what they taught the researcher wanted to hear.

6. 4 RECOMMENDATIONS

Clear themes regarding the issues facing newly qualified working nurses emerged from the analysis and discussion of the results. From the qualitative analysis, one can now make recommendations as to how to address these issues and thus improve these experiences. Implementation of these recommendations should reduce, if not a reverse, the current attrition within the industry.

There is no single solution that will address all the themes that were found. There are, however, several systems and programmes that if implemented could assist in addressing multiple issues simultaneously. If these recommendations are implemented correctly and cohesively, they might address most of the concerns discussed in the previous chapter.

6.5.1 Recommendations for nursing practise

Increase and improve safety in the workplace.

- Safety and security measures for nurses and health care workers in public healthcare institutions should be instituted and strengthened to increase job satisfaction.

Introduce Effective counselling and debriefing programmes for professional nurses.

- Counselling and debriefing services for professional nurses to be ensured in the public health care institutions. This will ensure psychological safety of nurses and it will result to increased productivity.

Instituting support programmes for newly qualified professional nurses

- Experienced nurse leaders must be provided to mentor newly qualified nurses to their new role to improve job satisfaction.
- Development of mentorship workshops and training for seasoned nurses to provide emotional support to newly qualified professional nurses.
- Peer support programmes to be developed to help newly qualified professional nurses share their experiences.

Implementing monitoring and evaluation systems in the health care institutions

- Institutions should implement a form of managerial/supervisory evaluation system, which would allow subordinates to evaluate the management skills of their superiors.
- Nurse managers to hold institutional workshops on effective management practices to update their management skills.

Developing institutional policies

- Nurses to develop policies to ensure adequate and enough staffing.
- Nurses to develop policies that will eradicate and address the imbalances of the past era of apartheid in public health care institutions.
- Public healthcare institutions should implement adequate staff-to-patient ratios to prevent burnout in nurses.

6.5.2 Recommendations for nursing education

- Placement of students in the clinical area during training must be prioritised. This will prepare graduate nurses to be competent, skilled, and responsive to the challenges, needs and demands of health care services.
- Academic Institutions, nurse managers and the Department of Health must jointly develop guidelines to help prepare and support student nurses in their transitioning period to professional nurses.

6.5.3 Recommendations for research

- Development of mentoring programmes for newly qualified professional nurses. These programmes must also be monitored and evaluated for effectiveness.

6.6 Conclusion

This chapter suggested ways to better the experiences of newly qualified registered nurses. This includes collaboration with training institutions, in designing curricula that will prepare the professional nurses for the clinical environment. Ensuring and strengthening the safety of newly qualified registered nurses functioning in public institutions. Strengthening the psychological well-being of professional nurses by ensuring that counselling and debriefing services are accessible to professional nurses. Ensuring that team-building activities in institutions are implemented to strengthen teamwork and team spirit amongst healthcare workers. Updating managers with management and leadership skills for this new era. Addressing issues of transformation in public health care institutions.

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APPENDIX A

THE CONSENT FORM

I agree that the study on the Experiences of Newly Qualified Professional Nurses in a Regional Hospital in Gauteng Province has been explained to me by Nelisiwe Ngwenya and I understand what it entails.

I understand that the study is about newly qualified professional nurses sharing their experiences of practice. I understand that the findings of the study will be added to the field of nursing and that I will benefit from the study by being exposed to the research processes and by contributing to the field of nursing research.

I agree to be interviewed by the researcher in the premises of Institution.

Signature……

Date…….

APPENDIX B

CONSENT TO AUDIO-RECORDING AND TRANSCRIPTION

This study involves the audio recording of the interview with the researcher. Neither your name nor any other identifying information will be associated with the audio recording or the transcript. Only the research team will be able to listen to the recordings.

The tapes will be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of the interview may be produced in whole or part for use in presentations or written products that results from this study. Neither your name nor any other identifying information will be used in presentations or in written products resulting from the study.

By signing this form, I give my permission to be audio-taped, under the terms outlined. I also understand that this consent for recording is effective for two years after the study. After which the tapes will be destroyed.

Signature…….

Date…….

APPENDIX C

INFORMATION SHEET

Title of Study: Experiences of Newly Qualified Professional Nurses in a Regional Hospital in Gauteng Province

Introduction

Good day, my name is Mrs Nelisiwe Ngwenya. I would like to invite you to take part in this study. I am required to conduct research as part of my studies in Master of Nursing Science Degree (MSc). at the University of the Witwatersrand, Faculty of Health Sciences, and Department of Nursing Education.

What is the purpose of this Research Study and why have I been chosen?

I am inviting you and other 49 newly qualified professional nurses to take part in this study as you meet the characteristics for this study. This study is targeting professional nurses who have completed the South African Nursing Council R425 Programme, which leads to registration as a Nurse (General, Psychiatric and Community) Midwife and who have completed one-year community service in a Public Hospital in Gauteng, employed from the period 2016-2017.

In this study I would like to collect information about your experiences as a newly qualified nurse.

What will happen to me if I take part in this study and what do I have to do?

If you agree to take part in the study, you will be required to avail yourself for an interview which will take no longer than thirty (30) minutes and which will be conducted in the premises of Institution. An audio recording will be used during the interview.

What are the side effects or risks of taking part?

This study has minimal risks for you, as you may only suffer temporal discomforts like what you would experience in daily life and will come to an end when the study is completed.

What are the benefits for participating in the study?

Taking part in this study will be of benefit if you as you will get to contribute to the general field of nursing, and you will also be exposed to the processes of the research study.

Is there reimbursement for study participation?

You will not be paid to participate in the study. There will be no costs to you for any of the procedures in participating in the study.

Do I have to take part?

Your participation in this study is entirely voluntary. It is up to you to decide whether to take part. If you do decide to take part you will be given this Information Sheet to keep and will be asked to sign an informed consent form/ should you wish to discontinue participation, you may do so freely at any time and without giving a reason. If you choose not to participate or to withdraw from the study, this will not affect your employment in any way.

Will my taking part in this study be kept confidential?

All information obtained during this study will be kept confidential. All your information will remain anonymous and only authorised personnel (research committee) will have access to this information. Data may be reported in scientific journals and will not include any information that identifies you as a participant in this study. Data will be kept for two years if published or six years if not published, after this period they will be destroyed. In the event of data sharing with other researchers for academic purposes written permission will be sought from HREC (Medical).

Who is organising and funding the research?

I have/not organised the study, as stated above this study is for degree purposes. This study is not funded, nor will it be used for commercial gain.

Whom do I call if I have questions or problems?

If you would like more information, have any problems, concerns or questions about the study or please contact my Supervisor Mrs Meghan Botes at tel. 011 4883317 or e mail Meghan.Botes@wits.ac.za

or

Human Research Ethics Committee (Medical), University of the Witwatersrand

HREC (Medical) contact details: Prof P Cleaton Jones, Tel 011 717 2301, email peter.cleaton-jones1@wits.ac.za

Ms Z Ndlovu/ Mr Rhulani Mkansi/ Mr Lebo Moeng Administrative Officers 011 717 2700/2656/1234/1252 zanele.ndlovu@wits.ac.za; Rhulani.mkansi@wits.ac.za; and Lebo.moeng@wits.ac.za

APPENDIX D

PERMISSION FROM HELEN JOSEPH

68 Sunningdale Drive
Kibler Park
2091
10 June 2017

The Hospital Manager
Institution
No. 1 Perth Road
Westdene
Johannesburg
2092

Dear Mrs Dikgale

Re: PERMISSION TO CONDUCT ACADEMIC RESEARCH

I am a master's student at the University of Witwatersrand, Department of Health Sciences in the Faculty of Nursing Education. I am conducting a research study with the topic: The Experiences of Newly Qualified Professional Nurses in a Regional Hospital in Gauteng Province.

I would like to request permission to conduct the qualitative study at Institution. Employees who have been with the organisation for one year will be sampled and data will be collected using individual in-depth interviews.

I undertake to ensure that collected, information furnished, and views expressed will be properly acknowledged in the research study and treated with strict confidentiality. A copy of the research will be made available to the hospital on completion of the study.

At the end of the study, researcher also aims to give feedback and make recommendations that can possibly enhance experiences of newly qualified professional nurses.

Thank You.

Yours sincerely,
Mrs N. Ngwenya
Student number 757029

APPENDIX E
INTERVIEW GUIDE

Please tell me about your experience as a newly qualified professional nurse.

PROBE: Can you give me an example of a positive experience?

PROBE: Can you give me an example of a negative experience?

PROBE: How did that (negative experience) make you feel?

Describe the support you received from this period?

Will you stay in your current employment?

PROBE: Why are you considering staying?

Is there anything we have not discussed you feel is important for the topic?

APPENDIX F

ETHICS APPROVALS

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Gauteng Department of Health
Helen Joseph Hospital
Enquiries: Dr. M. Mukansi
Research Committee: Chairperson
Tel :(011) 489-0306/1087
Fax :(011) 489 1038
E mail:murimisi.mukansi@wits.ac.za

22 November 2017

To whom it may concern

Subject: HELEN JOSEPH HOSPITAL RESEARCH COMMITTEE APPLICATION

PROTOCOL TITLE: Experiences of newly qualified professional nurses in regional hospital in Gauteng Province.
Protocol Ref No: Nelisiwe Ngwenya
Ethic Clearance: Pending
Principal investigator: Nelisiwe Ngwenya

Department: Nursing

Committee Recommendations
Conditional access approval is given while waiting the final ethical clearance certificate from the University of Witwatersrand HREC.

As this is all independent research project it remains the responsibility of the researcher to recruit participants from the relevant department within the hospital and acquire their individual voluntary consent to participate in your study.

Dr. Murimisi Mukansi
Chairperson of the HJH Ethic and Research Committee

APPENDIX G

UNIVERSITY RESEARCH APPROVAL

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

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

16 May 2018
Person No: 757029
PAG

Mrs N Ngwenya
68 Sunningdale Drive
Kibler Park
2091
South Africa

Dear Mrs Ngwenya

Master of Science in Nursing: Approval of Title

We have pleasure in advising that your proposal entitled ***Experiences of newly qualified professional nurses in a regional hospital in the Gauteng Province*** 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 H

CLEARANCE CERTIFICATE

R14/49 Mrs Nelisiwe Ngwenya

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M170920

NAME: (Principal Investigator)	Mrs Nelisiwe Ngwenya
DEPARTMENT:	Nursing Education Helen Joseph Hospital
PROJECT TITLE:	Experiences of Newly Qualified Professional Nurses in a Regional Hospital in the Gauteng Province
DATE CONSIDERED:	29/09/2017
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Mrs Meghan Botes
APPROVED BY:	Professor P. Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	13/12/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. in this case, the study was initially review September and will therefore be due in the month of September each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX I

INTERVIEW TRANSCRIPTS

Note that any grammatical errors are as transcribed from the audio tapes and were not corrected for authenticity.

INTERVIEW 1

INTERVIEWER: Can you please tell me about your experience as a newly qualified professional nurse?

AA: It was a huge change of environment for me. As a student you can get away with anything and just blame it on everyone else, when we came here, we were professional nurses. So that was it and we came to the ward and we were expected to just be on point and be there knowing everything. Another problem was that I had forgotten most procedures, like when I went to ICU. ICU took me back to my second year of study. I felt so dumb, I felt like my training was a waste of time. Sometimes it was intimidating, you Did not know where to start when it comes to disciplinary measures and things like that. You are young, you get people who are older than you and you are supposed to delegate the. I remember when I was in ward eight, there was this enrolled nurse who always questioned my delegation to a point where I just asked her if she wants to write down her own delegation and do her own thing in the ward when other people are working. I told her 'You are not going to question me every time". That is when I think I learned to be assertive and firm because if you are not, everyone just takes advantage of you, and "Aynamadoja mo, you have to knock off late". At seven, you must give report. I must say for the first few months it was challenging having to do things that you were avoiding during training. The staff in the first ward where I was placed was very supportive, I got the best support there. I got to be comfortable in my second ward, like I got to say, I can do this.

INTERVIEWER: You are saying your first experience was a huge change it was challenging; it was challenging both positively and negatively because you had forgotten

most of the things especially in clinical and you are saying it was also intimidating for example when it came to implementing disciplinary measures to your seniors

INTERVIEWER: But you also learned to be assertive, and you learned to be firm. In the first unit where you were placed the staff was very supporting?

INTERVIEWER: So, you mean the staff was supportive?

AA. Yes, everyone from enrolled nursing assistants, professional nurse to operational managers.

INTERVIEWER: How did it make you feel that now you in that position that you had to implement disciplinary measures to your juniors and to your seniors as well?

AA: I avoided it at first because, if you are not used to it, you feel bad,

AA: I felt I was going to be a bad person and I did not want that; you know when you are seeking acceptance in a new place you want people to accept you and love you and you want a positive working environment. It does not mean you do not have to discipline them when you want them to accept you, they must just accept you for the right reasons.

INTERVIEWER: You mentioned that you got support especially from the first ward you were allocated in. Can you tell me more about the support you received during this time, in terms of whether it was from all categories of staff, from managers, subordinates or was it also from the support staff in that unit?

AA.: It was literally from other subcategories, not necessarily from the area manager. She was not around most of the time. When I first got there, everyone introduced themselves. They were very happy to have me in the admissions ward, it was busy, so you had to literally be on your toes. I did not know where everything was, I could just ask anyone even an enrolled nursing assistant. For basic nursing procedures, I would just go to the ENA's people who are always with the patients because, you know they do all the vitals, they would know which patient is there and how things are done, and the sisters will help me with administration. They helped me with off duties and with monthly reports, things I did not know. The operational manager gave me a chance, she would allocate me to be responsible for tasks in the unit. The person who was doing the monthly report for that month was delegated to assist me. I would shadow the person who was doing the monthly duties, learn how it is done then do it the following month. I will then be given feedback on my

performance. My first encounter with the Aerial manager, was not very nice, me and we were not seeing eye to eye most of the time.

INTERVIEWER: Just to find out if I heard you well, you are saying that phase was a period where you were still no sure of yourself, where you still wanted to be accepted in the new environment, but you did get support from all categories of staff, even from the lower categories as well, even the professional nurses you were within the unit, they assisted you with management duties. They gave you a chance to reflect and they gave you feedback on the tasks that were allocated to you. Your unpleasant experience was with the aerial manager?

INTERVIEWER: Can you just identify one thing you would say was not a pleasant experience with your aerial manager?

AA: She did not give anyone a chance to respond. It was always her word against everyone else's. She will get in the ward and say I found you with headphones on when you dispute that she would say:" Are you saying I am lying"? and I would say no I never had headphones on at work, "No you saying I am lying", she would force the issue to say you are saying this when you are not saying so.

INTERVIEWER: You are still at this institution where you started working in the year 2016, do you see yourself staying next year and in the next years to come?

AA: This institution is full of two-faced people, they smile in your face and act like they are supporting you whereas.it is not that way, like. for an example immediately when I got here, I understood it was my final rotation, but I wanted to be in another Department. I requested that after the four-month rotation I be allowed to go back to this Department because it is where I mostly feel alive, and it is the reason why I wake up and come to work. I was told I could go back, but when the time came, I was told to type a letter, but nothing happened. They kept on saying you will go you will go, but that did not happen. There is also a lot of favouritism going on. You will come in late and suddenly, the aerial manager knows, and you get a warning, another person comes in late, but they would not be even asked questions, you know such things. If you have a personal problem or something, you are reprimanded. You are not even allowed to pay back the hours. I do not know if it is power hunger or what but everything that happens into your life, you must report, which I do not understand how. I ended up developing like a form of depression, like I would literally not want to wake up

and come to work. I would literally do nothing; I would not even take a bath. The day before I come to work, I would have insomnia because I just, did not want to come to work. Daily, I would tell myself, I am not happy here, I do not want to be here. I do not want to be in this place. I do not want to work in this department. I did not want to quit my job; I love nursing with a passion, but can I just leave this Department. I want a challenge, am new, I am fresh that is what I was saying to them. I wanted a ward where I can do more resuscitations. A ward where I will get exposure to sick patients. I do not see myself staying, like there is no room for growth here. I want the type of an environment that makes me ask myself," I wonder what type of patient I'm going to see today? what does the patient have, what is this. I want to challenge myself, even after a twelve-hour shift, I want to reflect.

INTERVIEWER: You want an exciting environment where you can grow, currently you are no longer challenged with what you are doing, you are no longer excited.

INTERVIEWER: Is there anything we have not discussed that you feel is relevant for the topic or what do you think can be done better or can be changed to improve the stay of registered nurses especially during their first year of employment in this institution?

AA: I feel like, constant rotation is what should be done. I love nursing and I feel like young nurses should be allowed to have a voice. Rotation is very important, being exposed to different environments will give you a chance to choose where you want to be, rotate enough in the whole hospital. That will decrease most problems like absenteeism. It will also improve one's experience.

INTERVIEWER: Thank You very much …, so your recommendations are that you recommend constant rotation which will lessen the stressors or the burn out of being in one unit

INTERVIEWER: And will improve experience of registered nurses as well, you are also saying you wish that that registered nurses voices could be heard, listened to, cos you are saying if you are placed in an environment which you like, which you prefer, which you chose you will be more productive than being in an environment you do not like

AA: Definitely.

INTERVIEWER: Thank you very much…, we have come to the end of the interview.

INTERVIEW 2

INTERVIEWER: Can you tell me about your first-year experience as a newly qualified professional nurse

SS: It was quite scary at first, but when you get to the orientation you relax. You meet different people from different sectors. The management team, the staff development team, all the other departments. The infection control team, we met the Human Resources team. Matrons who explained the processes of the institution. It was scary at first, because we learned they are review sessions in case there is an incidence in one of the wards, which is what made me scarred initially. I remember telling one of the Matrons," we are not going to work freely here, and she said, as long as you do the right things, you will be fine, so it was scary, but we eventually adjusted to the place.

INTERVIEWER: So, your experience, was scary at first, but once you went through the orientation week you got to meet all the departments that are functioning in the hospital, then you were at ease.

What would you say you enjoyed with your first-year experiences?

SS: The Sisters were very welcoming. The operational managers are very welcoming, educational even. I remember in the first ward I went in, Ward 18, I had two sisters, one of whom is now my operational manager now, she took me in and educated me with every detail of the ward. My experience was within the Soweto Region and West Rand Region so coming here, I found a totally different environment. It was like you are starting afresh, but they would educate from step to step. I have learned a lot, even from the lower categories. Nursing Sisters are usually busy to handle the orientation and the basic things in the ward, but you get that a lot of staff nurses are hands on, and they will teach you how to do things from A to Z.

INTERVIEWER: So, you saying operational managers were welcoming and they educated you in a lot of processes and you also stated that even lower categories, staff nurses were also informative, they were willing to give you information.

So, can you not maybe think of, a negative experience apart from the positives that you have mentioned?

SS: I had, I had one which, it literally almost took me down, I even had to get interventions from the sisters. In the second Ward I was placed in, the operational manager was not in the ward, she was busy, I think it was with her management course. I had not found a proper place, I was almost late every day, which is not an excuse. We had to go for our quarterly reviews, I asked for my report. I think I triggered an angry button. I do not know. I got a shouting of my life, that is the most, I do not know like down experience I ever had from the hospital. Which is I always tell the people that came after me that "make sure that your paperwork is done in time coz if you go back to ask for your report, people always remember the bad things you've done and not the good things.

INTERVIEWER: What are these quarterly reviews?

SS: Before you are permanent, you must have your quarterly reports, so you spent a certain time in a certain ward, I spent six months in that ward. I had to get two quarterly reviews or reports from that particular OM. My late coming was a trigger for her anger, so I never got my quarterly reports from her because she was still angry about me being late.

INTERVIEWER: How did that experience make you feel?

SS: I withdrew so much so that when I got to my permanent ward, they told me that I do not follow through with my requests because I will have things that I am not familiar with, I will ask people and I will never go back to it. I would not bother because I did not want the confrontation that I got with her. It made me withdraw so much and it was seen by my operational manager, my new operational manager who is now telling me., you probe further if you want something, regardless of peoples' attitudes towards you, so it made me withdraw.

INTERVIEWER: What would you recommend maybe for say a group of newly qualified professional nurses? from that incidence,

SS: I would tell them that before you leave a ward, make sure your quarterly report is written at that time, you leave with all your paperwork and all your files.

SS: I would also recommend that orientation must not only focus on patient education, but it must also focus on nurses' responsibilities.

SS: I realise that most of us, most of the newly employed nurses do not even know what a quarterly report is, we know there is a PMDS which is what they usual give us with the rest of the staff, but because they are permanent, we never see their quarterly reports, so we do not know that we must request one until we leave the ward, and you are confused.

INTERVIEWER: Can you also try and think back and tell me about the support that you received during that period,

SS: In ward I was in, two of patients committed suicide. We were told we were going to receive counselling. We never got counselling and as I go along realised it is not just us, but a lot of nurses who experienced trauma in the hospital do not get counselling. You are told you must make follow up yourself, no one comes to you.

INTERVIEWER: Follow up with whom? With the counselling Departments

SS: Yes, with the counsellors, you go to the counsellors and explain that you need to see them and set an appointment, but with our working ours it is not easy. You will receive support from your fellow colleagues, like your subcategories and your sister in charge, they are very helpful. I can say I have received such support, but not in terms of the hospital in general.

INTERVIEWER: From the day that you were employed till today, are you thinking on staying with the institution or are you thinking of pursuing other adventures?

SS: For this year I would like to stay. I have realised that I have learned a lot. My other colleagues or people I have studied with, who are employed in other institutions, have not had the experiences and the exposure I have had. There is a lot that I have learned and a lot that I feel I need to learn. I am getting opportunies. One thing about the hospital is that they do not allow long stays in one unit, they rotate us a lot so that you are exposed to different conditions, different departments, different working conditions of different wards. Of which is a learning curve.

INTERVIEWER: You are saying is that you are still going to stay, cos you have realised that you have learned a lot and you are still going to learn a lot because of the rotation system in the institution.

INTERVIEWER: I think I am done with the questions, but before we close, I would like to find out from you if there is anything that you feel we have not discussed that you feel relates to the topic?

SS: No, I think we have covered everything.

INTERVIEW 3

INTERVIEWER: Can you tell me about your experiences as a Newly Qualified Professional Nurse?

PP: I would say it is up to an individual to decide how they see the experiences; it could be positive and negative experiences. I was thrown in the deep end, working in a medical ward less than a month. I was left alone with the ward and I did not necessarily know what to do and how to handle certain situations. Knowing very well that the following morning when managers come in and take in the report, I will be blamed. They do not take responsibility for not grooming you enough. I guess that is a harsh reality of life, where you get to learn certain things through the experience. If a similar a situation arises soon, you are then able to handle it. From your previous experiences, you will know exactly what will happen and what needs to be done to avoid certain situations It Is a bad experience at first, but in retrospect it teaches one to stand on their own. When you are from College the first ward you are placed in, is the medical ward. Medical wards are usually not as hectic as surgical wards. This is because in surgical wards, there are surgical procedures to be done, preparing patients for theatre.

When I was placed in Casualty, I felt very much protected there. This is because there are about ten professional nurses in each day, in the hierarchy you would be number eight. The professional nurses that are around you cushion you.

In retrospect you get to experience shortage of staff in the wards. In some days you find only two junior professional nurses on duty, and the senior is sick. You must save the ship.

INTERVIEWER: If I hear you well you are saying it is up to an individual how he perceives the experiences. The first ward you were placed in was in a Medical ward and you felt as you were thrown in the deep end because you were expected to perform without adequate grooming?

PP: Yes, you are correct.

INTERVIEWER: You are saying said whilst you are still performing your duties, managers would come the following day for a report, and you took that as a harsh reality of life. You also feel that this experience prepares you for the future and you also said retrospectively, even though it can seem like a bad experience, but it prepared you for the future, you also mentioned the rotation system, meaning you are not allocated in the same unit for the whole year, but you rotate periodically, every four months.

INTERVIEWER: You moved to the surgical ward you found a different management style, all together, even the procedures that you were required to perform were different procedures to the medical ward, but you are saying when you look back you take that as a learning experience.

PP: Yes.

INTERVIEWER: Can I just go back to what you mentioned about feeling protected, what did you mean exactly when you saying here in casualty you feeling protected?

PP: By that I mean I do not get to run the day or a shift alone as a professional nurse. There are always other professional nurses I can always go to for their opinion.

INTERVIEWER: How would you explain the support you received from the hospital as a newly qualified professional nurse, did you receive any support?

PP: We had a four-week orientation, so two weeks was orientation from HR where we had people from Labour Relations, from different sections of management, like stock control, Facility managers, security managers. The Chief executive's office had a representative who taught us how to lodge complaints. We were taught about staff meetings. When do they have their meetings and who is in those? Several Departments came to present. The two weeks that followed was nursing orientation, where Matrons from different units came to present on what to expect and how to go about processes. What we need to know about the Hospital. I feel the hospital did well in this regard. Compared to my colleagues from other hospitals who only received one week of orientation. We also had a Junior management course "back to basics", that ran for four weeks. We had to attend one day, every Thursday for a month. However, I felt that the integration system is where they lack, for example I mentioned that you find yourself in a ward and you are left with a unit in a month. Proper integration has not happened in that regard. What needs to happen is periodic, follow up visits probably from staff development to see if newly employed staff is coping in the ward.

This is because you become so overwhelmed in the ward with no one to talk to you just must:" man up and do the job" so, if I were to rate the support, I would rate it below 50%, There is still a lot that must be done to support newly qualified professional nurses. When it comes to other nurses in the ward, they tend to think you come fully prepared from college, you are a graduate and then you must perform. Others do not have patience to teach you, maybe if they teach you something for the first time, you may grab a few things, if they must repeat, it is now a problem. Doctors respond positively, during the rounds most of the time it is where most of the teaching takes place. It is where you get to learn a lot, but then because they are moving at a fast pace you do not get to engage a lot with them. Other aligned staff in the ward, just come and live. They do not have the time and the patience to teach.

INTERVIEWER: What you are saying is that for the first month you were employed the whole month was for orientation, for the first two weeks was HR, all sections of management who gave you an overview of how the hospital is going to be ran and they also introduced you to the processes in the hospital, you mentioned that all allied staff also came to present for their departments and for the two weeks that followed it was the nursing orientation, and you said that for that two weeks where nursing was presenting you had different matrons from different units presenting to you, you also said that as far as orientation is concerned you feel that the institution actually did well. Compared to your colleagues who are employed in other hospitals. Who only got one week of orientation? You mentioned the junior management course and the back to basic course which was also part of your orientation. However, you feel that the institution is still lacking with the integration system, you are recommending that may be periodical and follow up visits should be done to assess, to check whether you are coping well, because there are instances where you felt that you were being overwhelmed with the happenings of the hospital. You would rate the support below fifty percent. This is other registered nurses think you come fully prepared whilst you still a newly employed. They will not have time to teach you. They become irritated with you. Doctors responded positively, even though during rounds you do not get engage well with them because of the fast pace.

INTERVIEWER: Are you planning to stay in this institution or are you planning to leave for other adventures?

PP: The only reason why I would leave the institution, is for personal reasons, I live in the

East Rand and it is too far to travel. The only reasons why I would live the institution are only related to family responsibilities., as I must travel to come to work.

INTERVIEWER: So, you are saying the only reason that would make you leave Helen Joseph is that you are staying in the East Rand and you must travel a long distance coming to work, so it is family responsibility only other wise if you could take Casualty with you, the department you are working in, you would take it with you.

Meaning that you really enjoy working in Casualty?

PP: Yes, that is correct

INTERVIEWER: What would you recommend to the management to improve the stay of newly employed nurses.

PP: The staffing, because I have never seen a physical draft for wards, for an example the ward quota will be thirty and the ward will have twenty-five nurses, so now it becomes a challenge again, because as you come on duty and as you come through the gate you already know today is going to be a hectic day.

PP: The leadership style, I think it is more threatening. Even though you are doing your job, there is still someone threatening you instead of motivating you. If the leadership style were more motivational than threatening you would enjoy coming to work, even though you are overwhelmed with work and with staff short shortage. You will be encouraged to work if you are motivated and when you feel appreciated.

INTERVIEWER: I hear that you are saying the institution must improve staffing, you are mentioning the nurse patient ratio. From the day you were employed since you have never seen that ratio. What you have seen is the ward quota which is also not adhered to.

INTERVIEWER: You also recommending the leadership style which is more threatening needs to be improved. If staff is motivated, they would enjoy coming to work. An employee who feels appreciated is productive.

INTERVIEWER: We have come to the end of our interview, thank You.

INTERVIEW 4

INTERVIEWER: Can you tell me about your experiences as a newly qualified professional nurse?

XX: I had a different perspective when I started working because it was my first experience coming to this hospital. I have been doing my practical at different hospitals. It was also difficult to adjust to the new environment. Matrons are always present. Policies did not make sense to me. There are Government Policies and there are Hospital Policies, which are always different from the original policies they are adapted from. There is always a fight between myself and the seniors, obviously I would come and confront them and say" but the hospital policy is different from the government policy "and it is always like the hospital must have its own policies, but they must be in line. When you look at the policies that they use, they are not always in line with the general policies. With the uniform policy, the South African Nursing Council says navy blue and white, it does not say it must be a shirt of a particular design, it must be a jersey of this design. When you get here, they tell you a shirt is not supposed to be of this design, it is not supposed to have this and if it is like that it is not uniform. I had five tunics from my institution where I trained. They all have the Gauteng Health emblem, I was told I am not supposed to wear that because I am advertising the institution, to me this did not make sense. I had to get new uniforms and new shirts and get new pants.

XX: The attitude that we get from the seniors is not the attitude we expect from them. We are expected to stand up when a senior staff member enters the ward, of which I do not understand. I feel that is done in the military. Things like that just throw you under the bus. You do not look forward to coming to work. Every day you have your own personal issues, you come here you meet such people, they are bitter, and they are angry. You tell yourself that today I am going to be productive. You get here you find the person who will give you all that negative energy. You feel like you just want to go home and just not come back to work. You wake up every morning already stressed "ooh I am going to see that person; she is going to say this to me.

You look at this person, they are way older than your parents, you look at them and you feel there is a need to obviously respect them. Especially if you are black African like me, you must respect them, but they do not even respect you. They do not even recognise you as a professional. They see you as a child, they even treat you as a child, they treat you like they own you.

"Attitude and Professionalism" go together, some people will tell you how to be professional, demanding you to be professional yet they themselves are not professional.

There is always an issue around leave, a senior will come and tell you cannot have your sick days immediately or before you start your seven-day shift.

No one plans to be sick. One reason why people absent themselves is the type of shifts we work. You work twelve hours for four days you rest one day, you come back for another twelve hours and this is very strenuous. When you work such shifts, there is too much work to do. Looking at our hospital, we are understaffed sometimes you are the only PN on duty and you must do everything. You must make sure that people do what they are supposed to do, it becomes overwhelming, it becomes emotionally exhausting. Matrons always preach about professionalism, yet they will come and address you like you are a child. All these behaviours make one to start developing a negative attitude. You also behave unprofessional. You start coming late and decide not to call. Whether you call or not call that person is still going to make noise for you.

INTERVIEWER: Can I just clarify if I heard you well, you first mentioned that your experience especially your first-year experience was totally different from what you expected mainly because this is a new environment. You found it difficult to adjust and in this new environment, you discovered that there are too many people in control. Matrons in management who are always visible. You mentioned the issue of policies that institutional policies that are supposed to stem from government policies. They are not in line with government policies, and this results in, you not seeing eye to eye with the seniors in the hospital.

INTERVIEWER: You mentioned the attitude of the seniors who do not display a professional positive attitude. This has resulted in you also trying to stand up to the seniors, culturally as a black person, you are expected to respect your seniors, but sometimes you find it questionable when you find that you must respect people who are not modelling professional behaviour, people who are supposed to be your mentors.

INTERVIEWER: You feel you are not treated as professionals nurse. You are treated more like a child.

XX: You also question the behaviour of seniors, who always talk about behaving professional but also, they do not see that addressing you as registered nurses in front of patients is not professional behaviour.,

INTERVIEWER: You feel that this has also resulted, or is leading you to display the same unprofessional behaviour that is displayed by the seniors

XX: Yes, also just to add on about the money issue, the salary, last year when I came, I thought maybe I will get paid like early in the year, but it took the whole year, I was still earning a stipend. The whole year until the end of November that was when I got my back pay. We would go to HR to enquire what was happening and we were told Matron has your forms, you go to that Matron she will tell you she is still busy. You are told your forms are not an emergency, yet they want you to come to work. They want you to come in full uniform. Where do I get transport money if I am still getting a stipend, where do I get the money to buy the uniform that I am supposed to wear, that I am expected to wear if I am not getting my salary. At the end of the day, you look at the amount of money you are earning, and you feel like you might as well work like a student, because the money that you are earning is equivalent to a student's salary. You are expected to buy and wear distinguishing devices, with that same salary.

XX: We were taught about evidence-based practice and you come here, you see that they are still using outdated information. You introduce new up to date information, like updated government policies. You get so much resistance from your colleagues. They question where you trained. They tell you how they have always been doing things and how perfectly their ways work. You become demotivated and discouraged. You ask yourself what the use of being here you try to improve things, but people are very reluctant to change. They do not even give you a chance They reject you immediately.

INTERVIEWER: Can you tell me about the support that you received from that initial period when you first started, the support from all categories of the staff in the institution, what can you tell me about the support?

XX: The support from my colleagues, in the ward has always been great. We always look after each other. They are very welcoming. So far, I have had the best support, both emotionally and personally. You can divide the workload among the team.

INTERVIEWER: You were just mentioning the support within the unit, within the unit even with the lower categories that everyone is always willing to help, to assist, you got orientation, people supported you emotionally with your professional and your emotional issues. Can you also mention management support in the whole institution, is there anything

you can say about it and support that involves other departments in the institution like labour relations, HR department, maybe even other members of the multidisciplinary team?

XX: We really do not get much support from management. You talk to them about your issues, and they make you feel worse. Instead of supporting you. it is only a few people in the management that you can rely on. With the Human Resources it is always a struggle. It is like they have a thing against nurses. Other categories like doctors, physiotherapist is attended to immediately when they have challenges, without experiencing any problems. As soon as you a nurse gets there, you are told" we are on lunch" etc., come back after fifteen minutes. When you come back after fifteen minutes," ooh I am busy with this and that".

It is always like when you go there to enquire, you irritate them before they can help you. With the multi-disciplinary team, sometimes you get social workers, psychologists, doctors who are supporting. You also get those who will tell you things like" I did not see you in my class", or "I did not see you in the corridors of the institution where I trained"., Some, do not even greet you. They look at you and they tell you whatever they want to tell you and they go, or you go to them and tell them Doctor I have this issue, I think this is the best way that we can do it, it is always like, not a suggestion from a nurse? They give you that attitude that you as a member of the team you must be the quite member, you must just accept everything that the team agrees on. You have no opinions whatsoever. Some doctors are supportive and will ask for your opinion on patient related issues.

INTERVIEWER: Are you planning on staying with this current employer or you are thinking of exploring other endeavours?

XX: I really did not want to do nursing in the first place, I am not staying in this profession, I am not even looking for a different institution. I am only staying in this institution until I am done with my studies. When I finish with my studies I am resigning, that is the day I am looking forward to, when I resign.

INTERVIEWER: Is there anything we did not touch on, that you feel is important for the interview?

XX: The attitude of us as nurses towards our patients

INTERVIEWER: That is nurses' attitudes towards health care users?

XX: I feel that is also important. I think all the things that we have discussed all the negative things that stem from being overwhelmed, overworked. Being frustrated that you are not getting your money. The bad attitude from the seniors. Thy all affect your relationship towards your patients. You also feel that for you to regain the respect that you lost; you also need to do the same. You also must present yourself with that attitude. You just do your job and get off patients faces. You have no time to support your patient emotionally because you are exhausted emotionally. You cannot afford to hear about their emotional burdens, you want nothing to do with that. You develop the attitude "I will give you your medication and you will go",

XX: The way that you are treated as a professional lead or results in you also lacking that therapeutic relationship with your health care user. You do not see the need of going an extra mile or of doing your work thoroughly because of the way that you are approached or treated as a professional.

INTERVIEWER: Then if you were asked to recommend anything for the hospital to improve the stay of newly qualified professional nurses, what will you recommend:

XX: Number one, I feel like it starts from the top going down, I think our management must go through a yearly training or yearly evaluation. It should be on quartely intervals. Nurses must be equipped with the latest literature, updated policies, every year, every six months if need be. Treatment will not always stay the same because of resistance in the system.

INTERVIEWER: Thank You very much for your contribution.

INTERVIEW 5

INTERVIEWER: Can you tell me about your first experiences as a newly qualified professional nurse?

LL: When I was first employed, obviously I was excited about the new responsibility and having to make use of the skills I had acquired as a student. I was excited and I was looking forward to it, but unfortunately my excitement turned to disappointment very quickly because of the situation I found myself in, in the hospital I was employed in.

The staff shortage, I think that was the main thing that affected me, when there is a shortage of staff, the staff that is on duty, must be the solution to that shortage. This means more work for you and that is draining for you. You do more than you are supposed to do to cover

for that staff shortage. That was the main problem, the staff shortage and nothing was being done about it. Because I remember when I first got there I was, I was selected as a chairperson of the events committee, I thought I would use that as the platform, to interact with the matrons. I thought that maybe on a one-to-one basis I would get to voice such problems and maybe they would do something. That did not help, it was like the staff shortage was not going to change and they were not willing to anything about it.

LL: The other problem is shortage of beds, there is always shortage of beds, they are always having outliers, outliers as in patients from certain wards must be moved to other wards, from the mother ward because that ward is too full. The next day they must be moved back, so patients were being moved around like that because there were not enough beds to cater for all the patients.

LL: One other challenge is of referrals, there were no regulations of referrals, every patient came to the hospital and they would not be referred even when they were stable. According to my understanding, I stand to be corrected, if the hospital is not your catchment area, it is not supposed to cater for you. The institution must refer you to the appropriate institution where you will get the proper treatment if you are stable. It is not like they are turning you away and you if you are not that critical. If you are stable, they can refer you back to the appropriate institution to make space for people within the catchment area. You find out that people who stay in that area, close to the hospital (who are supposed to come to the hospital for medical treatment), are turned away due to people coming from other areas.

INTERVIEWER: Can I just try and sum up what you said to confirm if I got you well?

INTERVIEWER: You are saying that during your first year of employment you were excited because of the new responsibility. You were excited because you felt that you could use the skills that you had acquired and this all turned into a disappointment and this is mainly because of the staff shortages in the institution.

INTERVIEWER: You were still employed you were selected to be the chairperson of the events committee and initially you were hoping that would be the platform where you would be able to voice out the concerns of the nurses because you interacted with the matrons on one-to-one basis, unfortunately it was not like that.

INTERVIEWER: You mention the shortages of beds.

You mentioned the issue of referrals as well, you said there are no regulations which guided the referrals of the patients who came to the hospital.

INTERVIEWER: Apart from these experiences you have mentioned are there any positive experiences you would like to share? That you do remember.

LL: Now I cannot think of any positive experiences,

INTERVIEWER: How did it make you feel that you always had to cover and manage staff shortages?

LL: Exhausted! I was exhausted like in all spheres, emotionally, physically, mentally, I was just drained and that leads to being demotivated, and to some extent your passion for the profession it dies a little every day.

LL: I started asking myself why I am doing nursing. I never thought I would get to a point where I would ask myself that question. When I started doing nursing, I was passionate about it, I loved it and I knew why I wanted to do nursing. The minute I started asking myself that question I knew that something was wrong.

INTERVIEWER: Coming to the support, how would you describe the support you received in the institution, did you receive support? Did you not receive the support, and this refers to the support received from everyone, your colleagues, management, support staff, doctors, and other allied health care workers?

LL: No, there was no support, whatsoever, you know what happened ne, as a professional nurse, you get there and the other like other professional nurses who have been there before you, they undermine you. Other categories ENA's and enrolled nurses also undermine you. They have been there longer than you, because they are older than you, they think they know more than you. I think management is to blame for this. Management was not supportive towards any of the staff, I think that led to the conflicts amongst the nurses, the nurse started not being supportive towards each other, they started hating because they did not receive support from management themselves.

And another thing with support is favouritism among management side, if you are favoured you get support but if you are not favoured unfortunately no one is going to support you. If you lodge a grievance, whether connected to staff or the patients, you are victimised. Your grievance will be known by other managers. The next thing, a random matron you do not

even know asks you, ooh you are Sister “so and so”, they heard about you. The way they are asking you can hear from their tone and their voice, it is a confrontational manner, “ooh so you are the one”! Even though they will not say it directly. That makes you feel intimidated. It is not safe to lodge a grievance, because it will be discussed amongst the nurses or amongst the management staff. That is why most of the staff keep their grievances to themselves because they “fear of victimisation”.

LL: There is what is called “a review”. it is like a mini “South African Nursing Council”, hearing type of setting, whereby they discuss incidences. On Thursdays they would have it for day staff, day duty. They would group themselves to different groups. So different groups were chaired, they were led by different Matrons. For example, group A of Matrons will lead the review for Thursday of the 15th of March for an example, in the review they will discuss an incidence, maybe a patient fell, or the patient was given a wrong medication. They will invite the ward staff to come and sit in for the review and the ward that is in the hearing will be represented by a certain number of staff members. The way they would intimidate the poor staff members, the questions, the manner their approach, the way they would talk, you would not say they are matrons. They would insult the staff or make them feel like they do not know what they are doing, they do not know what they are here for. They fail to understand that some situations are out of your control in the wards and that they did not want to hear the staff side of the story. They would always go with the patient side of the story, forgetting that the patients are not always reliable in terms of information. Patients can be manipulative. I think it was a way of victimising nurses, that is how I took it.

LL: This one time I heard these nurses saying if they would ever be called for a review they would not come to work. They would rather stay at home and further contribute to the shortage in the ward rather than coming to be embarrassed in front of other people. I heard that, and I was still new remember, so it was very disturbing that these nurses fear this. I wanted to experience this for myself first-hand. I went for a sit in to be part of the review. When I saw how the Matrons treated the staff. How they intimidated them; some would laugh. It was disappointing and we started questioning, to question our self, “what do ethical principles even mean”?

INTERVIEWER: What would you recommend to the institution to improve the stay of newly qualified nurses?

LL: To employ more staff because the biggest contribution of nurses living or of whatever problems they are having is shortage of nurses so if they would to start there, that would be another solution.

INTERVIEWER: So, you would recommend that they employ more staff cos the reason you believe there is high staff turnover is the shortage of staff?

LL: I would also recommend that they offer more support to staff as management. I know of about people five who resigned because of being burned out.

INTERVIEWER: Thank You very much … for your contribution. We have come to the end of our interview.

INTERVIEW 6

INTERVIEWER: Can you tell me about your experiences, your first-year experiences as a newly qualified professional nurse?

NN: We were given orientation on the geographic element of the hospital, which was good. We were introduced to different departments. So, we knew who to complain to. We were told about labour laws. We were introduced to staff development and the staff clinic where they took baseline health check. During the first month of your com serve, you are left with the ward and you still need a lot of guidance. You do not know policies, certain procedures. I found myself being overwhelmed with so much, while it was still premature. All in all, I found the institution quite different from Bara like. I was overwhelmed by the Matrons, like by how much I saw them. They were always present which was not something I was used to in Bara. Nurses here fear the Matrons, when you see the Matron you must run, like there is no relationship with the Matrons. I guess it is to improve the quality of care, but I believe it must be done in a way that nurses do not fear the superiors, so that is basically my experiences in short.

INTERVIEWER: I want to ensure that I heard you well, so you said that you were given a thorough orientation of the hospital, you were given a physical layout of the institution. You were introduced to processes like labour relations, labour laws, staff development, staff clinic, so those were the positive side of your first-year experience, then the negative experiences were that you were left to manage the ward by yourself. You felt that you still

needed guidance because even though you had the experience from College, but the environment was still new to you. You felt overwhelmed.

INTERVIEWER: I hear you, so you were saying that experience was sort of new to you, u know what you observed and identified that when a Matron comes everybody panics even if they have done their work, they are doing their work, now how did that make you feel as a registered nurse in a new environment

NN: I felt it was very unnecessary, the etiquette, where I studied it was not practiced, here I was just surprised when everybody just stands up to the Matron, it was a not something I was used you.

INTERVIEWER: Can you describe the support that you received during that period, like support from the staff, support from all members of the staff, from all members of the staff to colleagues as well

NN: The support was good, obviously it will differ from ward to ward. We rotate every four months; my rotation was a bit less so my support would be different from ward to ward. In another ward you will find a manager who was just not visible, who when she saw me, she would want to write a warning for a late coming, when she had never orientated me. The staff in general is good, other wards support is good from managers to lower categories, even the porters. Everybody is willing to teach. it is very different in the way which they do things, some support was even from the doctors.

INTERVIEWER: So, what you are saying is that support is good if you were to rate it and you found that it differed from ward to ward, in other wards you find managers who are visible in other wards you would find managers who would be sort of rigid. In general staff is supportive, everyone is willing to teach you something even. You received support from the medical staff as well.

Now, since you have been employed in this institution, what are your plans? do you aspire to stay or maybe you want to leave?

NN: Yes, I want to leave, as soon as possible. As I said before, the relationship between the nurses in general not just Professional nurses, is just not right, it is not something that I think I can stand for a long time. I feel like there is too much oppression.

INTERVIEWER: If you were to pass on the recommendation to management, what would you recommend?

NN: Maybe the Matrons themselves, they need debriefing. They need to find a different approach in how they do things, at times you will find a Matron who will shout at a nurse in front of a patient. I think there is a more appropriate approach to that, I think they should try look at how different hospital are doing things. Some Matrons are always yelling, the thing is people here have accepted the situation. As soon as the Matrons leave the mood is so low. I think that is not so good for the morale cos they want us to perform well but they are busy breaking down the morale and I think if you have the good professional relationship with your staff then you boost their morale the production levels will be high.

INTERVIEWER: So what you would recommend is that managers, especially the matrons do for debriefing some sort of training, some in-service training and if they would maybe employ a different approach to what they are using, you made an example where one was shouting at a nurse next to the patient and you said that the things that staff have accepted this they are not challenging and you saying that if attitudes change, they will be, if relations are good then there would be production, you will perform, because this would motivate you.

INTERVIEWER: One last question, is there anything that you feel we have not discussed that you feel is relevant to the topic?

NN: No, I feel like I have said it all.

INTERVIEWER: Thank you so much for taking part in the interview

INTERVIEW 7

INTERVIEWER: Can you tell me about your experiences as a newly qualified professional nurse?

MM: So far it has been hard trying to adjust, cause now the responsibilities fall on you. You are the one who is responsible for everything. Being in a new institution was kind of hard They are behind on certain things. They still feel that a young nurse cannot say anything. You cannot show or teach them smarter ways of doing things. That is what I have noticed in this institution,

It is bad to say it, but they are still scared of white people, they still have that “white supremacy” thing, like when you see a white person you must be scared. You must treat

them much better than you are treating a black person, that is what I have noticed in this institution, although I am learning a lot.

MM: Learning is there though there are certain things that are stopping you from flourishing, from growing as a professional nurse

INTERVIEWER: Now when you say they still having “white supremacy “are you referring to staff or are you also including patients as well?

MM: Staff and patients, you can tell by the way patients speak to you that they know in this institution that if they are white, they will be treated much better than the other patients. Doctors also have that bad attitude, that you will not tell me anything, I am, the colour of my skin dictates that I get respect regardless of whatever is happening.

INTERVIEWER: Thank You, can you tell me about the support so far from the day that you were employed, from your colleagues, support staff and allied professional

MM: The support is great in the ward that I am in, ward nine High Care, the OM, Professional nurses and other categories, the support is great, they help a lot, wherever I am working, whenever I need help with anything they even go as far as doing it for me.

INTERVIEWER: Do you think you are going to stay

MM: Not, I want to specialise, and here there is minimal specialties. There is, renal, theatre. I will not be able to specialise in what I want, I love Midwifery a lot and here they do not offer it, I love cardio as well and they do not have a special unit for it, so I am living I am not going to stay.

INTERVIEWER: Going back to the support, I forgot to ask about support by management in the institution.

MM: To be specific with the ward I am working in, the matron and the operational manager are very supportive, if you do not know anything, they escalate it, if you having a problem with a certain Doctor they attend to it immediately, right there, they are very supportive towards us and they encourage learning a lot and they are always there, you can call them at any time they are always willing to help.

INTERVIEW 8

INTERVIEWER: Please tell me about me about you first year experiences as a newly qualified professional nurse?

GG: I started in 2017 April as a Bara Alumni. We started our course mid-year because of what had happened at college. All in all, we were ten in total. When we got there, it was a new environment, I was happy for the fact that I was not placed in Midwifery. We were met by an operational manager and staff development. The institution has what you call personnel development so every new personnel that comes is received by them. They took us for a two-week orientation. We got to meet all different Matrons from different departments who told us about all the different sections of the hospital. They have two weeks of orientation, and two weeks of what is called Junior Management. For that whole month we were orientated on different aspects like the regulations, and we attended the Back-to-Basics course. We were then placed to different units. The environment was cold. I was scared because I was out of clinical. When you are a D4 you are 4 years in practical and theory vice versa and the last two weeks you spent more in psychiatry and community, so the hospital setting was just something totally different.

I started in Medical ward. I was with a colleague of mine. We were in opposite shift, after we started, we were fine. There was always someone to mentor us. They showed us what to do and how to do it, because during clinical we were mostly in clinics, so hospital and clinics setting are different. I was used to having someone shielding me from everything. Within the third week, I think April I had already caught on how the ward functions. I am not someone who is lazy I am a team player, so it became easy.

That is when a patient fell off from his bed. One of the Senior Sisters had taken hours. She left me to oversee the ward, because she trusted me “within a month” to run the ward. That day, it was just total chaos. Another patient signed RHT (refusal of hospital treatment).

GG: The patient fell, and he passed away, but he did not hit his head. We did everything we could for him. He was certified dead and that was that. I had heard in the corridors of what is g called a review. This is where they take everyone who has been negligent basically, to ask them what happened, how did it happen, what could have caused it and how could it have been prevented. Everybody was talking all these negative things about the review that Matrons were being rude. On the day of the review, the Matron of my unit, apparently fell

sick, how convenient. We were left to fend for ourselves. What the issue was, is the fact that the patient fell at night and we only reported at one in the morning. This is because we did not understand the different papers that had to be filled in. They have like ten papers for the same thing, and different forms that go to different people. The procedure is long, like I did not understand why some of these things are very tedious and unnecessary. We went through the review, they did not attach us like I expected, they just told us we could have seen from the patients' blood pressure that there was a problem.

For my clinical trial, in my second year of training the institution I was in, there was no emergency when the patient was gasping for air. In this institution, there is a culture of responding to an emergency. You do not just say the patient is dying, you act accordingly. The Sisters in the institution are given more freedom but they also do not have freedom at the same time, what I mean by that is in the previous institution I was in, we were putting up drips. We were more independent. Here we are not allowed to put up drips. It does not matter what happened especially if you are in a ward setting the only place you can put up a drip is in Casualty. You just call the Doctor. I find that to be limiting, and it makes us more complaisant we do not take things into consideration. We are always waiting for somebody else. The Matrons are always visible, it makes it difficult sometimes to make independent decisions regarding your ward, every decision that you make must always go to the Matron. If you are saying that you are running the ward it is not you who is running the ward it is the Matron.

I am learning a lot in terms of Management and accountability although I feel the system favours the Doctors more than it favours the nurses in this institution.

The Medical ward was a nice set up, there was no favouritism. The manager was a team player, and she was involved.

GG: We worked together; the other professional nurses I was with showed me how to do things. We had a good a team spirit.

GG: Then I went out to Orthopaedic Ward, which was the worst ward ever. The manager was always taking sides.

GG: In orthopaedic I got a warning for refusing to put up traction.

That day I was handing over because it was time for me to go, when the sister came, she did not ask why weights were on the floor. I asked the enrolled nurse to attend to this.

Doctors always complain that each time the nurses touch the traction they always worsen the fracture. That is why I did not want to interfere with it. The next thing I know, the photo of the weights on the floor was circulation on social media. The sister whom I was giving a handover, took a photo and placed it on what sup.

I was reprimanded by the Matron on whatsup, instead of her waiting for the next day. She could have called me to her office. She basically sent me a warning via whats-up.

GG: I am now in theatre; I like the ward there are many professional nurses. We are not short staffed. There is a saturation of sisters, you are not as hands on to management as you are when you are in the ward. The operational manager and the staff manage the theatre. It is just that I do not like theatre. Theatre also has its own politics, but I do not like this institution, I hate it is horrible, I hate it honestly.

INTERVIEWER: Can you tell me more about what exactly takes place in the review and the feelings that you experienced in the review?

GG: The review is apparently just like the South African Nursing Council disciplinary hearing, but in a smaller scale.

They check up on accountability and negligence. Before I went in the review, there were already rumours that in the previous hearing the Sister came out crying. Matrons were just unapologetic, there were just basically attacking her as an individual instead of looking into the incidence. That is why I was also expecting that I would be put on the spot.

GG: They give you a pink file with all the patients details. On top there is like five questions that you need to answer. A date is set. I do not know if it is a norm but there were two Matrons who came to us to prepare us. They were basically saying we must say yes to everything. That we must not be defensive, so that things move along swiftly. My colleague is vocal, at least I was there I was a peace maker. When we got there the Senior Matron was not there, so it was these all-other Matrons. The matron of the ward and the staff on duty must be there. Our matron was not there, so when we got there it was us.

All other wards can come and view. The other matrons so the chairperson will open the case they will read the file, what happened, and it will be opened to the floor.

GG: I was asked what I did I mean when I said the patient was ill and stable. I said it meant exactly that. The matron was not satisfied with my response, she wanted me to further explain, I explained, and she still was not satisfied until the chairperson intervened by saying "Mam she has already explained, and I think there is nothing else that she can tell you ".

GG: Then they asked another question who was the shift leader, I was the shift leader that day, and why I did not do cubicle nursing? we did do cubicle nursing. hey, look at the off duties, which were not balancing. The off duties that are signed by them.

INTERVIEWER: Is there anything we have not covered here, that you feel is relevant to this interview?

GG: The institution has what is called post intake, or intake day. In a ward you have beds, I had thirty beds in my ward, so intake is like your admission day.

GG: When your doctors have admitted patients the previous day, it is your duty to find beds for all those patients. It does not matter that the hospital does not have enough beds, that is not their problem. Your duty is to make sure that the patients do have beds.

GG: You job is take patients from admission ward and take them into your ward. There was an incidence where it was a post intake. The hospital was full all the wards said they did not have empty beds. I called the matron of our ward and this one time she said I must decide. I did not know whether I should manufacture the beds and bring them to hospital.

INTERVIEWER: Are there no porters

GG: There is no such in the post intake, you take your patients up and you bring them down.

GG: The only people that use porters in post intake is when the patient has been transferred from casualty to the ward. That is only when porters are available, when they take the patients from the ward to x-ray department.

INTERVIEWER: Now does this mean that even if it is a critically ill patient you as sisters you move him/her to another ward.

GG: We only move mobile patients not critically ill patients.

INTERVIEWER: Can you tell me about the support you received during this period? please be specific with the support from your colleagues, subordinates, and other allied staff?

GG: The medical ward has a lot of support, there was always somebody to ask where to get things. In the orthopaedic ward there was no support. It was one man for himself. There are a lot of politics. I found a way of coping by observing how things were done from colleagues.

The human resources department took a long time with translating us. It took a year before we were translated from community service nurses to professional nurses.

GG: Staff development tried their best, the only problem was that because of the shortage of staff, we could not attend the trainings they had prepared most of the time. Each month, they have a different in-service education for staff. They have back to basics course, they will invite a sister and a sub-category each month to attend, and they have a Junior management, which I like because it addresses different subjects, e.g., regulations, occupational health, and safety it is just broad junior management.

With the matrons, it all depends on the type of a relationship you have with them. If you have a good relationship, they will give you all the support in the world. If you do not have a good relationship with them, unfortunately support will not be as good.

Theatre is a supporting environment because there are a lot of young nurses and they support each other.

INTERVIEWER: What are your plans, do you intend to stay, or do you plan on leaving?

GG: I want to leave the institution, but I cannot do so because I am currently studying Public Health. I feel the system is generally unfair when it comes to nursing in general.

So, if we can find a workable system and do more studies that tell the truth for instance, what happened in Esidimeni was unnecessary, and this is the reason why a lot of people say nurses are dogs.

I f we could take pictures of how patients insult us, pictures of Matrons talking to their own staff and how they treat nurses. The world would know the reality of being a nurse. Last week there was a bomb threat in the institution, all the Matrons left the premises, the same people that will tell you what to do in a disaster situation, left us. That is poor management, and we could have died there. They must practice what they preach.

In theatre you are basically a servant, you give a doctor instruments and you do not even know the instruments, but they went to school. I feel the system is so against nurses.

INTERVIEWER: Is there anything that you feel is applicable to the topic that you feel we have not touched?

GG: I think this study must be given to the institution; they need to know what the feelings of their staff are.

INTERVIEWER: Thank You. We are done.

INTERVIEW 9

INTERVIEWER: Can you tell me about your experiences as a newly qualified professional nurse?

KK: I found it quite challenging, I felt like my training had prepared me for the theoretical part, but not really for the clinical part. I studied at a University and I found that nurses who had studied at a nursing college had more experience with the wards and most of them had trained at this institution. and I had not trained at here, so I was quite unfamiliar with all the policies and all the internal forms that they use in different wards. It took me quite a while to get used to the environment. What I enjoyed is I got nice wards to work in, all the wards I worked in were nice.

INTERVIEWER: So you are saying that you experience was challenging, because you felt that the training that you did, because you trained at a University prepared you for the theoretical part not for the practical part and you also saying that the colleagues that you worked with trained at Helen Joseph and most of them were familiar with the processes in the hospital, but what you are also saying is that the wards that you worked in were actually nice.

INTERVIEWER: So, when you saying that the wards that you worked in were nice wards, what do you mean?

KK: The three wards that I worked in were Psychiatry, Orthopaedics and Casualty, I really enjoy Psychiatry and Emergency Nursing. Those are fields that I am considering specialising in. These are both wards that I really wanted to work in, so I immediately had

interest in them. Orthopaedics was never really something that I enjoyed, but the ward was run so well that I just enjoyed my time there and the Matron was just so good and approachable.

INTERVIEWER: You worked in the three wards, that is the Psych Ward, Orthopaedic Ward and Casualty and you are saying what interested you the most is Psychiatry and Casualty. You are considering furthering your studies in Psychiatry and emergency nursing. Orthopaedic Ward is not actually the ward that you had an interest in but because of how well the ward was run, you have developed an interest.

KK: Exactly

INTERVIEWER: So that is what made the experience pleasant for you?

KK: Yes

INTERVIEWER: So, can you remember any negative experience from the first day you were employed in the institution?

KK: I think the hardest thing for me was all the wards I was working in we were short staffed. I did not really get good orientation because of that. For a long time, I was like I did not know what I was meant to be doing, I did not have direction, but I think it was more like a feeling of not knowing what to do, like the routine how things worked.

INTERVIEWER: You are saying most negative experiences were because of the shortage of staff. You did not get proper orientation in the wards, so you did not have direction. You did not know what it is that is expected from you, as an employed registered nurse in the unit.

KK: Another negative experience, now that I am thinking about it, was I was not confident and sometimes I really felt like people were taking advantage. I was newly employed, and I did not know the wards well. I did not have the authority, and at times I did not know how to speak up and tell people, like to delegate certain tasks. I felt like too new and shy to have that authority especially when having to manage and supervise subcategories I found that difficult. It is not really in my nature to tell people what to do.

INTERVIEWER: I hear you well, can you describe the support during this time, if you received any support, was there any form of support or there was none whatsoever? And if there was support who was it from?

KK: The Matron in orthopaedic ward was very supportive, she had the ward orientation programme. All professional nurses in the ward had to orientate me on certain things, it was a whole check list. For everything that I got orientation on, I got to sign it off till the whole list was finished. This encouraged the other nurses in the ward to go all through the policies in the ward, all the procedures. At the end of it I really felt like I really knew the ward. In Casualty, there is a preceptor, and she always had an open-door policy, like you could go to her at any time, you could ask for help so that was very helpful.

INTERVIEWER, so you are saying that in Orthopaedic you had a very supporting Matron. She had a planned orientation programme with a checklist to tick whatever was done. whatever you did with the registered nurse who was allocated to you. In Casualty they had a preceptor who had an open-door policy, so it was easier for you to adjust, I hear you that is good.

INTERVIEWER: So, tell me, from the experiences that you had as a newly qualified professional nurse in the hospital, are you planning to stay in your current employment or are you planning to explore other ventures?

KK: My priority for now is to go to school, and it looks as if there is quite a resistance regarding allowing people to study in the institution. There is a long waiting list, and it seems they are not flexible to let you go study on your own. They are not flexible with their, schedule like giving you the Tuesday off for study purpose. It seems like they are not willing to do that. If that is the case then I would consider leaving to further my studies but otherwise, other than that I am happy where I am and I feel like I am learning, I am getting pretty good experience.

INTERVIEWER: So, the only reason why you would consider leaving the institution is when they are not flexible enough with study leave that is releasing you to go and attend, all in all you are happy with the experiences because you have learned, you are learning so much?

KK: Yes,

INTERVIEWER: We have come to the end of our interview. I would like to know if there is anything maybe that you feel would be relevant to this interview that you feel we have not mentioned, or you feel we have not touched on.

KK: I think more in terms of the institution, I feel like there is little communication and support between nurses and management, the nursing Director, she never came to see us. To speak to us during our hospital orientation. When we made a request as to where we would like to be placed, she said we must not write letters, she does not want to know where we wanted to be placed. Some of my colleagues I trained with working in other hospitals, when they requested placements, they got them immediately. They all are happy in their institutions. I make a difference to how you see your job, the effort you are willing to put in, when your preference is considered.

KK: Since I have been here, I have never been to any in-service training, I have been to one which conducted in the ward I was placed in.

KK: I was put down for one that ended up being cancelled for Nurses Day Launch. I just feel like sometimes there is not enough coming from higher levels of Management, they always seem to have the opposite of the open-door policy. Every time you go to them it is very hard to get a meeting or they seem like almost rather irritated when you come to them to speak about something.

INTERVIEWER: So, if you were to suggest improvement to better the stay of newly qualified nurses, you would include staff development?

KK: Definitely, I think the institution can look after their staff better, I mean we all have goals to get somewhere. I feel like an organisation should encourage and not stand in the

way of its employees to further their studies. I feel like if you want to keep good nurses in the hospital you want to keep them happy, at least have more dialogue. if it is not possible to place someone in a ward that they prefer at least to explain to them how it is not possible.

KK: In Casualty there was a bit of a traumatic incidence and a child passed away. The staff asked if the staff wellness sister or person will come and do a debriefing. This this was in November and the lady said she could not provide debriefing sessions because she was booked up until the next year February. Which would be irrelevant then for staff. it just seems like that office in staff wellness is more there in terms of for human resource purposes. It is only available for staff's alcohol related problems.

INTERVIEWER: Thank You very much for your participation. We are done.

INTERVIEW 10

INTERVIEWER: Can you tell me about your first-year experiences as a newly qualified professional nurse

VV: The first ward I was in was ward sixteen, it was great. The nurses there had a lot of knowledge. The unit manager there continuously taught us things, took us for in-services. During assembly we would learn something new. Everything was just informative, we talked about problems of the ward and we came up with solutions. My experience there was great. It helped in the basic knowledge of how the surgical unit is supposed to be run if I may say so, so everything went well in that ward.

VV: Then I went to the medical ward, I really had a bad experience form the disorganisation of the ward to their matron to the unit manager. The nurses were so demotivated because from my experience from the surgical ward going to the medical unit there is a huge difference and I think it depends more on the unit manager's role as compared to the level of the nursing care that is supposed to be rendered.

It was just demotivation of the staff. The experience that I took out from the place was just horrible. I did not enjoy. If there was a resuscitation for an example, they would go there dragging their feet. They had the attitude that if a patient is going to die eventually, you

must just let it go. Instead of giving them a chance to perform actual cardiopulmonary resuscitation. I think it is about the actual knowledge of performing resuscitation, then them saying this patient is going to die in any case. I think they were ignorant, or they did not have the proper skills so that is why they had that attitude.

What I noticed is that they did not have a lot of in-service education. In the morning we will talk about hand over, you know from patient to patient, and we would stop there. There was no platform for in-service-education. That ward was just sleepy and dead I just did not enjoy it was bad.

INTERVIEWER: What about the management of the ward, like the operational manager, what was her role?

VV: File management, just files .She was busy walking up and down, you would not be knowing what she person is doing. Even if there was a resuscitation, she would not come and assist. She will go to the office or to another ward.

VV: The staff was very unhappy with the matron. They felt she had certain individuals she favoured. When it came to requesting weekends off, preference would be given to the ones favoured. This resulted in staff shortage because of unhappiness and people took sick leave, they did not come to work.

VV: Then I went to the trauma department that was where now everything is lovely. We have teaching days. We have days where doctors sit in for in-service training and MNM meetings where nurses can also partake. We have spot on teaching. There is an algorithm of what to do in case of an emergency or in case of let me say a situation comes about in terms of how you should handle it. Procedure manuals are available, and we know where they are. Management is also great they are awesome. There are few racisms there and there but because you cannot be the only person thinking that there is racism when the others do not see. The nursing part of it is great is perfect, the experience I enjoy it and the team, everybody is hands on.

INTERVIEWER: Now you mentioned the word “racism”, can you tell me more about this?

VV: You would find that in a case where a patient is supposed to be triaged to go to orange, if it is a black person and there is no space, they will do an ECG test and write everything is normal and they will step them down to yellow.

And when it is a patient of colour, coming in with the same problem, orange being full, they would rather look around to see who they can take out of orange and step them down to yellow. They will give them first preference to enter orange room, and sometimes in the event where you find that this patient's condition does not warrant them to go to orange, they will take them there.

INTERVIEWER: And how did this make you feel, the exposure to this?

VV: I do not know; I think it is more of anger and I would build more resistance. if maybe an instruction comes, they will be that bit of resistance, but I will carry out the task because it is my duty, my scope of practice. I am bound ethically and legally to perform the task, but later I would feel like I will have an issue with that Doctor. I will not go and confront them because I do not want conflict, so I will end up being quite for peace's sake. In my view I felt it was more of racism then total patient care.

INTERVIEWER: Can you tell me about the orientation /induction and support in this period?

VV: Let me start with the induction, we were warmly welcomed by the team that was allocated to welcome us. We took the whole month. Every day we would be given an opportunity to watch how certain things are supposed to be done. They took us around the hospital, you know gave us information into which this department works like this. They showed us the clinics, the emergency exits of the hospital. We were told about everything that entails the hospital. The structural lay out, the operations of the hospital, the organogram of the hospital. The induction was great. It took one month, so if you were not clear on a certain issue, they gave us a day to raise our concerns in what was not covered and what we feel like we still need to know.

VV: And that, so that was the induction programme, and when we were discussing with my colleagues, we felt like it was a great induction programme. Almost everything was covered. When we left to our respective wards, we left with knowledge so that was well covered. Now the problem came when different wards had to orientate you according to where you were placed. In ward sixteen everyone was hands on like the unit manager took time, there was a time whereas newly qualified nurse in that ward they give you one week where you work office hours. The unit manager orientated you daily the first week and she will also give you a pamphlet because you could not grasp everything in one day. She would tell you

for what we did today, the information you will get in page so and so, so that one was excellent, well done.

VV: The following week you were then allocated to shifts, but they will pair you with a professional nurse. Somebody to mentor you if you did not understand a certain thing. They will tell you this is how things are done or you did not understand, you could always refer to the booklet that they gave you and ask questions.

VV: For two shifts they will give you a professional nurse before they allocate you to that shift that you are supposed to work to.

VV: Medical ward, first day of work, there is orientation in the morning and then they expect you to know everything, they did not have any office hours, so you work seven to seven and from then the following day you would rest and come back to work the following day does not like it was the whole week or maybe a couple of days of orientation just to get the grasp of information. We are basically a workforce instead of them accepting us as new staff members. When we got in, we already had to be handed on, a lot of mistakes were obviously done because of that. They did not give us the copy of a procedure manual. They did not explain, they just assumed, for some reason we still remember whatever they told us, so it was not great.

VV: And the Matrons instead of asking us how we are coping, they would only capitalise on the wrongs you did. This is demotivating.

In the trauma department I was orientated by a community service nurse and she was not allocated there, she was also going out of the unit to be placed somewhere else.

VV: I tried raising the point later when I got used to the place, that new people in the ward need orientation. I was told they know and its unfair because this place is always busy, so they will always have excuses as to not to orientate new staff.

You literally give up, and you will maybe ask a senior person to try to explain certain things how they are done and staff. You would find that different shifts were better than other shifts. This is because in other shifts you will find nurses who are understanding and who know how things are supposed to be done. That is the only bad experience I have in terms of not being orientated.

INTERVIEWER: Did you receive any support in this period?

VV: I did receive support, there is support in the hospital from staff members. I only have a concern with the matrons. I do not know what their role is.

INTERVIEWER: Would you; like to tell me more?

VV: Sometimes, like they like to pinpoint all the wrongs that you are doing instead of showing you the right things that are supposed to be done and when they enter the ward, now their weight should be felt by everybody. Sometimes some of them are unapproachable, where when you sometimes have a problem you cannot, but the again it is not every matron.

The support of the multi-disciplinary team is good. The problem comes when the management does not protect workers. I am working in Casualty; it is a high-risk area as it is surrounded by an area with gang rival. First and foremost, the security is not tight. There are incidences where gang members would come into the department and they will want to finish off a person. You would find an incidence whereby those gangsters would become drunk and become violent. When now you must defend yourself, security is far away from where you are. You cannot defend yourself. At the end of the day, you will; be asked by management what did you do to provoke them, not taking into consideration that this person was drunk. You were only trying to instruct them the best way you could.

Sometimes the security is not well trained to fight off that violent behaviour. When you call for back up, they call other security members who are on other wards, looking out for other departments. They come to the emergency department to assist. When they come to assist, they neglect their post. Can you imagine then what would happen if maybe something would happen? so management do not take into consideration the risk that you are put under. They are sitting in their offices and they are not experiencing what we are experiencing.

When it comes to the issue of shortages, they do not give us support, like to give us a word of encouragement. We are not even appreciated for doing a great job. That would motivate teams. We come to work the community is fighting us and management is also fighting us. We feel displaced as nurses, no one understands how hard we are trying.

INTERVIEWER: What are your plans, do you intend to stay? If yes, why?

VV: I intend to stay only because I am in a trauma department, but if I were not there I would have long resigned, and because my goal was to go to school, so they luckily, they have considered me for school. I love the place.

INTERVIEWER: Thank you so much for your contribution. We have come to the end of our interview.