

**THE LIVED EXPERIENCES OF EMERGENCY CARE GRADUATES AS THEY
TRANSITION FROM COLLEGE TO PROFESSIONAL WORKPLACE**

By

ARTHUR MBUYISELO MALGAS

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**SUPERVISOR: Prof. A. Adefuye
CO-SUPERVISER: Prof C. Vincent-Lambert**

DECLARATION

I hereby declare that the compilation of this mini dissertation is the result of my own, independent investigation. I have endeavoured to use the research sources cited in the text in a responsible way and to give credit to the authors and compilers of the references for the information provided, as necessary. I furthermore declare that this work is submitted for the first time at this university and faculty for the purpose of obtaining a Master's degree in Health Professions Education and that it has not previously been submitted to any other university or faculty for the purpose of obtaining a degree. I also declare that all confidential information provided by study participants will be treated as such.



28.11.2021

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DEDICATION

To my wonderful wife and kids, this work is dedicated to you in appreciation of your motivation, inspiration, sacrifices and love that always seek to make me a better professional.

And to my late mother, Gugu, this milestone you spoke into my life, and the journey continues.

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LIST OF ABBREVIATIONS AND ACRONYMS

ALS	Advanced life support
CHE	Council for Higher Education
ECT	Emergency care technician
EMS	Emergency medical services
HEQSF	Higher Education Qualifications Sub Framework
HPCSA	Health Professions Council of South Africa
NQF	National Qualifications Framework
NECET	National Emergency Care Education and Training
PBEC	Professional Board for Emergency Care
SAQA	South African Qualifications Authority

SELECTED DEFINITIONS AND TERMS

Emergency care technician: A mid-level health worker equivalent for the emergency care profession, who has successfully completed a two-year, 240-credit National Qualifications Framework (NQF) Level 5 National Certificate in Emergency Care Technician qualification (RSA NDoH 2017a:3).

Emergency medical service: An organisation or body that is dedicated, staffed, and equipped to operate an ambulance, medical rescue vehicle or medical response vehicle in order to offer emergency care (RSA NDoH 2017a:1).

Paramedic: A person registered as such, in terms of the Health Professions Act, 1974, Act No. 56 of 1974 (RSA NDoH 2017b:21).

Transition: Passage or movement of individuals from one state, condition, or place to another, which can result in profound alterations in their lives and for significant others and has important implications for well-being and health (Duchscher 2008:442).

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SUMMARY

Keywords: advanced life support, clinical skills, emergency care technician, knowledge, graduate, paramedic

Central to every formal education qualification offered by any education and training institution is the aim to produce well-rounded graduates who have gained new knowledge, skills and professional attributes. Emergency medical care education and training programmes are no exception to this desire to produce highly skilled and well-trained graduates. Emergency Medical Services (EMS) workers are generally referred to as paramedics by members of the public; however, there are different levels in which they are categorised, depending on the level of training obtained and professional registration with the regulatory body.

Currently, emergency care education and training in South Africa have finalised alignment with higher education after the National Emergency Care Education and Training (NECET) policy was promulgated by the minister of health. The need to review and realign EMS education and training was necessitated by the South African Qualifications Authority (SAQA) and the Higher Education Act. This review resulted in the development of a two-year, 240-credit National Certificate in Emergency Care Technician (ECT). The previous qualification, at National Qualifications Framework (NQF) Level 5, was phased out as per the revised Higher Education Qualifications Sub-framework (HEQSF) and was replaced by a Diploma NQF Level 6 qualification. The NQF Level 5 qualification produced graduates who were eligible to register in the professional category of advanced life support (ALS) with the Health Professions Council of South Africa (HPCSA).

Graduates from the ECT programme reported being confronted by negative attitudes from experienced members of the profession and did not feel that they were being accepted during clinical practice shifts at EMS stations, especially in areas where other ALS paramedics were working. Some paramedics who had progressed to the ALS category through short courses expressed their lack of trust and confidence in ECT graduates and their capabilities. The ECT scope of practice was released by the Professional Board for Emergency Care (PBEC) and was also heavily criticised. The scope of practice allows ECTs to perform several advanced and invasive, life-saving procedures, including the administration of potent medication.

Most of the resistance and criticism seemed to be based on opinions and emanated from a lack of understanding of what the training programme entailed and how it was delivered. To date, no research has been conducted to investigate the perceptions and lived experiences of ECTs trained paramedics in South Africa. This study investigated the lived experiences of ECT graduates in the North West Department of Health at the time that they made the transition into practice and their ability to practise their scope of expertise. In addition, this study formulated implementable recommendations that can be used to support graduate paramedics as they transition to the workplace.

This mini-dissertation sets out the research study, which was done through focus group interviews with ECTs who were trained at the North West EMS College. A review of literature available on EMS education and ECT training, and an analysis of the clinical competencies attributed to ECTs, assisted the researcher in designing an interview schedule that was followed when conducting the semi-structured interviews. The findings of this investigation contribute to the current body of knowledge depicting how the ECTs trained in the North West Department of Health experienced their transition into practice.

THE LIVED EXPERIENCES OF EMERGENCY CARE GRADUATES AS THEY TRANSITION FROM COLLEGE TO PROFESSIONAL WORKPLACE

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The education and training of EMS workers in South Africa, as with many other countries, has for many years been based on attending vocational short courses as well as post-employment and an on-the-job training model, rather than through formalised university education. To introduce formal university training and professionalise the profession in South Africa, the National Department of Health, together with the Health Profession Council of South Africa (HPCSA), developed the Emergency Care Technician (ECT) training programme in 2006. Provincial Emergency Medical Services (EMS) colleges and the military offered training. Graduates of the ECT programmes were eligible to register in the professional category of advanced life support (ALS) with the HPCSA (RSA DoH 2017a:3). At present, approximately 1,124 ECT graduates are registered with the HPCSA (Sobuwa & Christopher 2019:3). The ECT scope of practice allows ECTs to perform invasive, life-saving procedures and administration of scheduled medication.

Over the years, graduates of the ECT programme have reported that they faced resistance and criticism during their transition to the EMS workplace. Graduates reported being confronted by negative attitudes from members of the profession, especially in areas where other categories of ALS paramedics were working. Some ALS paramedics who trained and progressed through short courses expressed their lack of confidence in ECT graduates and their capabilities. The resistance and criticism seemed to be based on anecdotal views and opinions and may have emanated from a lack of understanding of what the training programme entails. To date, no known study has been conducted to gain deep and meaningful insights into own experiences of ECTs to validate or negate this report. Hence, in this research project, an in-depth study was done by the researcher with a view to gain insight into the lived experiences of advanced life support (ALS) paramedics as they transition into the workplace environment. A series of four (4) focus group discussions were conducted with graduates of the Emergency Care Technician (ECT) programme, employed by the North-West Department of Health. This study aimed to investigate the lived experiences

of graduate paramedics as they transition into practice and to identify the support that may be required to facilitate the successful transition of new graduate paramedics that are entering the EMS workplace in South Africa.

It is envisaged that the findings of this study will contribute to the existing body of knowledge on the experience of South African graduate paramedics as they transition into the workplace environment to practise. Until the experience had been researched, it was difficult to make recommendations for change. Hence, this study aims at making recommendations on strategies that can be implemented by the EMS management, education, and training institutions to facilitate the successful transition of new graduate paramedics entering the EMS workplace in South Africa.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Over the last two decades, pre-hospital emergency care training and education in many parts of the world experienced a shift from the short-course training model to higher education qualifications. In Australia, this evolution of paramedic education progressed for more than a decade and resulted in the undergraduate university qualification that is currently in force (Kennedy, Kenny & O'Meara 2015:1038).

The EMS (Emergency Medical Service) profession in South Africa owes its existence, prior to 2004, to the short courses (vocational qualification courses), such as the:

- i. two weeks Basic Ambulance Assistant (BAA);
- ii. 12-week intermediate life support Ambulance Emergency Assistant (AEA); and a
- iii. four-month Advanced Life Support Critical Care Assistant (CCA), that paved the way for the current structured profession (RSA DoH 2017a:3).

Between 2004 and 2006, the Health Professions Council of South Africa (HPCSA), as a Standard Generating Body (SGB), introduced a two-year 240-credit Emergency Care Technician (ECT) qualification, following a review of the learning outcomes of the then existing short courses and higher education qualifications in Emergency Care Profession (RSA DoH 2017a:3; Sobuwa & Christopher 2019:3). The ECT was considered a "mid-level qualification (i.e. mid-level worker)" equivalent for the emergency care profession and the first intake of students occurred in 2007 at Provincial Ambulance Training Colleges as well as selected Universities of Technology (Lambert 2011:3). The rationale for an ECT

qualification is to produce “technicians” who can provide emergency care to ill and injured patients following approved practice guidelines and management protocols (Lambert 2011:3). At present, the 240-credit Diploma in Emergency Medical Care has replaced the mid-level qualification, according to the three-tiered Emergency Care Qualification Framework (ECQF), newly adopted by the National Department of Health and aligned to the South African National Qualifications Sub-Framework (RSA DoH 2017a:3; Lambert 2015:175). Between 2007 and 2018, various colleges produced ECT graduates (approximately 1,124), who are currently practising as independent ALS pre-hospital emergency care providers, together with thousands of short course graduates (approximately 60, 000) that form the bulk of HPCSA registered emergency care personnel (RSA DoH 2017a:3; Sobuwa & Christopher 2019:3).

It has been reported that students experience multiple transitions as they move from school to university and then into the professional workforce (Wood, Psaros, French & Lai 2015:2). While the challenges that arise with a move from secondary to tertiary education has been well described in the literature (Briggs, Clark & Hall 2012:4; Knox 2005:103), little is known about the transition from the academic discourse of university study to the professional discourse specific to their discipline (Wendler, Bridgeman, Markle, Cline, Bell, McAllister & Kent 2012:1). Unpublished reports of the challenges encountered by graduates of the ECT programme when they transition to the professional workplace have emerged, among which, issues related to workplace readiness and resistance and negative attitudes experienced during the transition period. Some ALS paramedics who trained and progressed through short courses expressed a lack of confidence in ECT graduates and their capabilities. However, no known study has been conducted to validate or negate these attitudes or gain meaningful insights into the transition experiences of new graduate paramedics, or the forms of support they require in South Africa. This study aims to gain insight into paramedics’ experiences of transition from college to the professional workplace environment and identify the support that may be required to facilitate the successful transition of new graduate paramedics entering the workplace. In addition, the recommendations the study propose can inform current plans related to education, training, and transition support for new graduate paramedics.

1.3 PROBLEM STATEMENT

Since the introduction of the ECT qualification, limited evidence has been gathered on how these highly trained and skilled ALS providers integrate into the service and what their

opinions are regarding practising their clinical competencies. The problem that will be addressed is the lack of scientific knowledge on the lived experiences of paramedic graduates as they transition into the EMS work environment and the support they may require during this period for a successful transition.

1.4 RESEARCH QUESTION

In order to address the stated problem, the following research question was addressed:

- i. What are the lived experiences of ECT graduates (ALS paramedics) as they transition into the EMS workplace environment? (Focus group discussion)*

1.5 OBJECTIVES OF THE STUDY

To achieve the overall goal and aim of this study, the above research question was answered by pursuing the following objectives:

- i. To explore the lived experiences of ECT graduates as they transition to the EMS workplace to begin their work as paramedics. To achieve this objective, a thorough insight into the perceptions of ECTs was sought by gathering and analysing empirical data during focus group interviews.*
- ii. To formulate strategies that can be implemented to support graduate paramedics when transitioning to the professional workplace environment.*

1.6 RATIONALE AND OVERALL GOAL OF THE STUDY

The overall goal of this study was to obtain empirical data on South African paramedics' lived experiences as they transition to the EMS work environment and identify the support that may be required to facilitate the successful transition of new graduate paramedics entering the EMS workplace in South Africa.

1.7 AIM OF THE STUDY

This study aims to obtain empirical data on the lived experiences of ECT graduates during their transition into the professional workplace environment.

1.8 RESEARCH DESIGN AND METHODOLOGY

Research designs or study designs are models that are used for the collection, analysis,

interpretation and reporting of data in research studies. The main terms quantitative and qualitative are often used to describe the different approaches and methods used in the research process. Due to the nature of the objectives, this study was a pure qualitative research study. Historically, qualitative methods were employed only in social sciences research and were unfamiliar to researchers in the health care profession. However, in their book on qualitative methods, Pope and Mays (2006) report that, at that time, there was a growing interest in using qualitative methods for health research, and that it was increasingly acceptable in clinical and biomedical fields.

In qualitative research, non-statistical methods are used, and a small, purposively selected sample is usually involved. According to Aldous, Rheeder and Esterhuizen (2011:24), "an optimal study design is best for the study purposes in terms of achieving the objectives while being both time and cost-efficient and within the scope of the research". It is with reference to this explanation that an exploratory, descriptive, cross-sectional design was utilised for this study. Factors that were taken into consideration when choosing this design included the research objectives, the amount of time available to conduct the research, potential costs involved, as well as the number of potential study participants. Other important aspects considered were factors that may influence the reliability, validity, and trustworthiness of the research.

To answer the research question and achieve the objectives, one method was employed in this study to gather data. A review of the literature assisted to conceptualise the problem being investigated and the local situation. The information gathered from a literature review, document analysis and the researcher's insight were used to formulate an interview schedule for the research method used, which was focus group discussions. Focus group discussions are simply defined as guided, monitored, and recorded group discussions on a particular topic organised for research purposes. (Gill, Stewart, Treasure & Chadwick 2008:293). As suggested by Gill *et al.* (2008), an agenda, sometimes referred to as an interview guide, was prepared to facilitate the focus group discussion. Qualitative methods, such as focus group interviews, provide a deeper understanding of social phenomena; therefore, according to Gill *et al.* (2008), these methods are the most appropriate when little information is available or detailed insights are required from individual participants.

De Vos *et al.* (2011:316) quote Schram to explain phenomenology as an approach that aims to describe what a person's conscious experience of everyday life and social actions consist of, or what concepts and structures of experience give form and meaning to the

experience. They also quote Creswell, who describes a phenomenological study as one that describes the meaning of the lived experiences of a phenomenon or concept for several individuals. The intention to understand the phenomenon being studied on its own terms is central to this research approach; therefore, a description of human experience as it is experienced by the participants is provided. This study followed a phenomenological design, as one of the qualitative designs identified by Creswell in De Vos *et al.* (2011:316), as being suitable for a variety of disciplines, and which has proven to be popular and frequently used to provide valuable insights.

1.9 DESCRIPTION OF THE METHOD

1.9.1 Focus group discussions

1.9.1.1 Theoretical background

A focus group interview is a group discussion organised to gather information on a specific topic that is being researched (Gill *et al.*, 2008:293). The focus group discussion is one of the most common data collection methods in qualitative research. Focus group discussions share similarities with less structured interviews; however, Gill *et al.* (2008) suggest that there is more to focus group discussions than just the mere collection of similar data at the same time from many participants. De Vos *et al.* (2011:360-361) describe focus groups as a means of improving understanding of how people feel or think about a particular issue; they quote Krueger, who defines focus group discussions as carefully planned discussions that have been designed to obtain perceptions on a defined area of interest in a permissive environment.

Focus group discussions were first used as a method in market research, and, over time, its use evolved until it was introduced in academic research. The exponential growth of this method in the 21st century, specifically in medical education, following the acceptance of qualitative methods in health professions research, is described by Stalmeijer, McNaughton and Van Mook (2014:2). Vincent-Lambert (2011:86) states that the focus group technique is most suitable for instances where the topic has not been explored yet, and to generate new and rich data. According to Stalmeijer *et al.* (2014:2), the insights, perspectives, and opinions of a group of participants can be gathered through the use of a focus group discussion and therefore position focus groups under a methodological umbrella for the researcher who is interested in participants' ideas, interpretations, feelings, actions and circumstances, and is concerned about how individuals form meaning from their

experiences in the world.

In their contribution to the World Bank's Social Development paper, Krueger and Casey (2001:5) emphasise that the first step while planning a focus group study is to decide whether this method is appropriate for answering key questions that the researcher needs answered. They state that this method works well when the researcher wants to understand how people think or feel about an issue, idea, behaviour, product, or service. This method was chosen by the researcher to investigate the research question this study aims to answer, as this phenomenon has not yet been explored, and to gain a deeper and more meaningful understanding of the participants' own perceptions, perspectives, opinions, and beliefs on the subject matter under investigation.

Literature consulted on focus group research (Gill *et al.*, 2008:293-295; Krueger & Casey 2001:5-8; Kruger, 2014; Stalmeijer *et al.* 2014:2) indicates some common characteristics of this method, which include the following: participation of role players, a comfortable environment, sampling and number of focus groups, using a facilitator and an interview guide to collect the data, systematic analysis and reporting of data.

1.9.1.2 Role players

Key role players involved in the focus group method are, namely, the participants, a group facilitator, and an observer. According to Rabiee (2004:655), participants in this type of research are selected according to the following criteria:

- i. that they would have something to say on the topic;
- ii. are within the required age range;
- iii. have similar social characteristics; and
- iv. would be comfortable talking to the interviewer and each other.

Participants taking part in a focus group commonly share specific characteristics, experiences/feelings or knowledge about a phenomenon, and this commonality creates space for them in which to share their perceptions freely, thereby, providing rich information on the topic (Krueger & Casey 2001:4). The participants included in this study are ECT graduate paramedics who have been through the transition process and have undergone the experience of assuming the ALS paramedic role. Furthermore, they were classmates either during their training or, at some point, were

colleagues in the workplace. Therefore, they had valuable contributions to make, share common characteristics, and were able to communicate freely in the group discussions.

Rabiee (2004:656) cautions that, when exploring sensitive and personal issues, it may be advantageous to involve acquaintances who have established a level of trust amongst themselves, which would encourage free expression of views. She refers to Krueger's suggestion to constitute a homogenous group. Doing so is particularly important where little is known about the topic under investigation. Contrary to what the literature suggests, because of the personal and sensitive nature of the information investigated, the researcher performed the role of facilitator for gathering data in this study. The researcher's previous relationship with participants as the manager responsible for their training and presently as a colleague in the EMS profession created a safe space for sharing rich information on the topic. In most cases, it is more appropriate if the facilitator, also referred to as a moderator in other literature, is an individual not known to the participants. Using a stranger as a facilitator avoids the possibility that the facilitator influences participants, preventing them from sharing freely. Furthermore, the underlying theories in the researcher's mind could affect the way they facilitate the discussion (Stalmeijer *et al.* 2014:10). However, in this study, the researcher fulfilled the role of the facilitator without creating any of the aforementioned. The researcher, as the manager responsible for training EMS personnel, had numerous discussions with the graduates during their training about real work situations that they may encounter once they assume the role of the ALS provider.

Rabiee (2004:656) also emphasises the importance of the role played by the facilitator regarding whether the group of participants is newly formed or pre-existing acquaintances. She states that the facilitator should have adequate knowledge of the topic and be skilful enough to manage the existing relationships or to create an environment conducive to making participants who do not know each other feel free to engage and share views, feelings, and ideas. The participants in this study were comfortable sharing their experiences with the researcher, as the researcher served as their mentor and role model during their years of training or, for some, as a medical and professional advisor.

1.9.1.3 Target population

The study population, stated simply, refers to all subjects that a researcher can gain access to. Aldous *et al.* (2011:34), explain that when a researcher is unable to study the entire study population, a sample of the population may be taken. However, the sample must be representative of the whole study population and sufficient size. The authors explain

furthermore, to ensure representativeness of the sample, probability sampling can be used to limit bias. However, Rabiee (2004:655) quotes Lederman, who explains that, for a focus group discussion, "participants are selected as a purposive, although not necessarily representative, sampling of a specific population".

In this qualitative study, the target population for the focus groups were ECT graduates who were employed in the Department of Health. Participants who did not meet the inclusion criteria, as set out in the following, were excluded from the target population. The sample was constituted by participants:

- Who were qualified ECTs
- Employed by the North West Department of Health on any of the following post levels: ECT, ECT shift leader, ECT station manager, ECT district coordinator,
- Who were employed permanently and
- Who have completed the NQF Level 5 ECT course

1.9.1.4 Description of sample and sample size

Stalmeijer *et al.* (2014:5), quote Barbour, who describes the purpose of qualitative sampling as: "to reflect the diversity within the group or population under study rather than aspiring to recruit a representative sample". Stalmeijer *et al.* (2014), emphasise that, in addition to obtaining answers to questions, the researcher is also interested in group dynamics, as it could provide rich data. It is in this respect that qualitative researchers consider sampling to be purposeful. Purposive sampling was used to select the sample for this study.

This sampling method is explained by Khoza (2018), as a type of non-probability sampling, where decisions on individuals to be included in a study are taken by the researcher. When using purposive sampling, the qualitative researcher has to identify the population that is a possible source of data that is significant for the purposes of the study. To achieve the involvement of participants that will provide valuable data, the eligibility requirements of the study population, as detailed in Section 1.8.1.3 as the inclusion criteria, were applied.

ECTs employed by the NWDOH are stationed in all four districts of the province, namely, Bojanala, Dr Kenneth Kaunda, Ngaka Modiri Molema, and Dr Ruth Segomotsi Mompati districts. A letter inviting all ECTs to participate was sent to each of the four districts. Those interested in participating were required to complete a participant sign-up form and return

it to the researcher. The information supplied on the form was assessed against eligibility requirements, which enabled the researcher to purposefully select participants who are employed per district, whereafter they were contacted directly when scheduling the focus groups. The survey population consisted of individuals who voluntarily agreed to participate in the study after reading and signing the informed consent forms.

In the respective districts, ten (10) ECTs were purposively selected to compile the final sample of participants. In selecting the 10 participants, the researcher balanced the participants by selecting ECTs who were employed in EMS before undergoing the training, with others who were recruited for the training post-matric. The sample consisted of 26 participants out of the 32 ECTs who returned the signed participant forms and were invited.

Another point that had to be considered was the number of focus group discussions to be conducted. Rabiee (2004:656) quotes Krueger, who suggested to continue with conducting focus group discussions until a clear pattern emerges and subsequent groups are producing no new information. According to Rabiee (2004:656), at the point when no new information is generated through focus group discussions, a phenomenon known as theoretical saturation has been reached. In this study, saturation was reached during the fourth focus group discussion as no new information was emerging.

1.9.1.5 Exploratory interview

A pilot study was done using an exploratory interview to ensure that the questions are unambiguous, well-structured, and solicit answers that will assist in addressing the research question. The pilot study was also used to determine the amount of time needed for the completion of one focus group discussion.

The exploratory interview was arranged with ECTs who were available in the Dr Kenneth Kaunda district, including those employed at the EMS College. An invitation was sent out to all ECTs in the district, estimated to be around 30 in number, to over-sample in order to achieve a desirable number of six to eight participants. Only three participants availed themselves at the venue and participated in the exploratory interview. No adjustments were made to the interview guide, as the participants did not request any changes to be made. The ECTs who participated in the exploratory interview were also selected in the cluster and were included in the focus group discussion. The data collected during the exploratory interview were therefore not included in the final data of this study.

1.9.1.6 Data gathering

Four focus group discussions were conducted, one in each of the four districts of the North West province during May 2021. This was after the initial plan for collecting data between April 2020, and June 2020 was disrupted by the COVID-19 pandemic and its associated restrictions. The researcher's own professional work requirements demanded his undivided attention as part of the provincial department's preparation and response to the pandemic; thus the study was put on hold and granted an extension by the University.

ECTs that consented to participate were invited to the focus group discussions. Arrangements on the date, time and venue were communicated to the participants via e-mail and cell phone messages. For each district, one focus group was conducted at the department's boardroom or training facilities with participants that work within that cluster. At the beginning of each focus group discussion, participants received a short introduction on the purpose of the study and were assured that there is no right or wrong answer and that all contributions are valued and will remain confidential. The researcher facilitated the focus group discussions using a pre-determined interview guide whilst taking field notes of important information and observations.

A voice recorder was used to record the discussions; participants were informed that the discussions would be recorded, and they consented. Focus group discussions 1 and 2 comprised of five participants each and lasted 38 and 51 minutes, respectively. Focus group discussion three comprised of seven participants and lasted 68 minutes; while focus group discussion four comprised of nine participants and lasted 66 minutes. All voice recordings were downloaded on a computer, which was password-protected to ensure the safekeeping of the data.

1.9.1.7 Data analysis

The voice recorded data collected from the discussions were transcribed verbatim by an independent transcriber. Doing so provided a permanent record of what was said in the discussions as recommended by Gill *et al.* (2008). The transcript of each focus group discussion was read and re-read by the researcher while going through field notes to familiarise himself with the data. A qualitative analysis was subsequently done using Atlas.ti 8.3 software (Scientific Software Development, Germany). With the assistance of a co-coder, iterative inductive coding was used, and attention was paid to any emerging patterns and themes from participants' responses on key issues pertaining to this study. A thematic

analysis was done in order to categorise the data into themes, categories, and sub-categories. The perspectives provided by these ECT graduates provided a deeper understanding of the research problem.

1.10 TRUSTWORTHINESS

A great deal of attention needs to be paid to ensuring the validity and reliability of any research method applied. Research without rigour is considered to be fiction and is, therefore, worthless. Challenges to rigour in qualitative inquiry paralleled the blossoming of statistical packages and the development of computing systems in quantitative research. Morse, Barrett, Mayan, Olson and Spiers (2002:14) refer to the seminal work done in the 1980s by Lincoln and Guba, in which they substituted reliability and validity with the concept of trustworthiness in qualitative research. The concept of trustworthiness contains four aspects, namely, credibility, transferability, dependability, and confirmability.

1.10.1 Credibility

Credibility addresses the issue of internal validity and ensures that the study measures what it is intended to measure. To ensure credibility, the researcher used the following techniques suggested by Lincoln and Guba and adapted by Khoza (2018:22-23):

- i. Adopted a qualitative, exploratory, and descriptive research design that is an appropriate and well-recognised research method;
- ii. Was familiar with the culture of the participating organisation as an employee of the Department, within the same directorate;
- iii. Employed purposive random sampling of participants to eliminate researcher bias;
- iv. Ensured triangulation of data by including participants working in all four districts of the North West province. This ensured that the researcher obtained different perspectives representing a broad view of the reality in question, thereby ensuring the credibility of the study; and
- v. Established rapport with the participants as a mentor and manager responsible for training, ensuring honesty throughout the research process.

1.10.2 Transferability

Transferability addresses the issue of external validity. In the context of this study,

transferability was defined as the degree to which the research findings of this study can be applied in a different context (Polit & Beck 2006:82). The transferability of the findings of this study is limited, as the study was done in a particular context. However, the purpose of using focus group discussions in this study was to generate data in order to obtain perceptions on a defined area of interest and was therefore not meant to be generalised across other domains.

1.10.3 Dependability

Dependability refers to the reliability and aims to verify whether, if the research study was to be repeated using the same methodology in the same context with the same participants, similar results would be obtained (Polit & Beck 2006:86). Furthermore, Lincoln and Guba (1985:42), state that dependability may be described as the steadiness of the data acquired over time and circumstances.

In order to ensure dependability, the research methodology employed, its implementation in this study, as well as the data gathering process are distinctly detailed. This research report also provides an introspective evaluation of the research project in order to enable the reader to develop a meticulous understanding of the methodology used and the efficacy thereof in the research study.

1.10.4 Confirmability

Confirmability in the context of this study refers to the researcher's objectivity in the study and his aim to ensure that the steps taken to guarantee that the findings of the research are based on the participants' experiences and not as a result of researcher bias. To ensure confirmability, the following strategies were applied:

- i. The researcher acknowledged the methods that were used in the study, as detailed in Section 1.9, and explained the choice of the research method used (Lincoln & Guba 1985:43);
- ii. Triangulation was used to minimise the effects of researcher bias by obtaining data from different participants in different venues at different times, and
- iii. A thorough methodological description allowed the reliability of results to be scrutinised and enabled the readers of this research to establish the degree to which the data and constructs that emerged from the study may be accepted (Lincoln & Guba, 1985:43).

1.11 ETHICAL CONSIDERATIONS

1.11.1 Approval

Approval for the research project was obtained from the Ethics Committee of the Faculty of Health Sciences at the University of the Free State, No. UFS-HSD2019/1552/2611 (Annexure F). Given the fact that there are no patients involved in this study, but rather participants who are employees of the Department of Health, approval was also granted by the North West Department of Health Research Committee.

1.11.2 Informed consent

In this study, informed consent was obtained from all participants, and they were requested to sign a purposefully designed form. A short overview of the study and its purpose were provided to the participants, with an explanation of what will be required of them. Permission was also sought from participants to voice record the focus group discussions before they commenced. Participants who were not willing to provide consent were allowed to withdraw their participation at any time; however, no participants in this study refused to provide consent.

1.11.3 Right to privacy and confidentiality

No names or personal identifiers of participants appear on any data sheet that was sent for transcribing or used for analysis. Number coding was used to ensure the confidentiality of the participants' responses. In this study, all information was managed in a strictly professional and confidential manner.

1.12 SCOPE OF THE STUDY

The study is interdisciplinary, as it reaches between Health Professions Education and Emergency Medical Care.

1.13 VALUE, SIGNIFICANCE AND CONTRIBUTION OF THE STUDY

1.13.1 Value

The value of this research study is to inform stakeholders in the EMC professions of the needs of graduate paramedics as they transition to the EMS workplace and strategies that can be implemented to ensure a successful transition.

1.13.2 Significance

This study documents the experience of graduate paramedics in South Africa regarding their experiences as they transition from college to workplace environment and identify support that may be required by this group. The study contributes significantly to the body of knowledge about the transition experiences of paramedics graduating in South Africa.

1.13.3 Contribution

This study formulates recommendations on strategies that can be implemented by the EMS management, education, and training institutions to facilitate the successful transition of newly graduated paramedics entering the EMS workplace in South Africa.

1.14 LAYOUT OF MINI DISSERTATION

The arrangement of this mini dissertation is as follows:

- Title page
- Declaration
- Acknowledgements
- Table of contents
- List of abbreviations and acronyms
- Selected definitions and terms
- List of tables
- List of figures
- Summary
- Chapter 1: Orientation to study
- Chapter 2: Literature review
- Chapter 3: Manuscript
- Chapter 4: Conclusions and limitations of the study
- References
- Appendices

1.15 CONCLUSION

Chapter 1 provides an orientation to the study: The background to the problem, objective, rationale, and overall goal was discussed together with the aim of this study. The qualitative research approach, as well as the method used, were explained. The significance and value of this study were also discussed, and the chapter concludes by providing an outline of the mini dissertation and the chapters to follow.

The next chapter will describe the relevant published literature. It will focus on describing the history and current status of EMS training, the ECT programme and the concept of transitioning into practice as it applies to the EMC and work environment.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter discusses the review of relevant literature that was conducted during this study. From the introduction and the background provided in Chapter 1, it is clear that limited literature exists on graduate paramedics' transition experiences in South Africa.

The literature review for this study aimed to conceptualise the research problem and locate it in a body of theory. A literature review also "serves to put the researcher's efforts into perspective, situating the topic in a larger knowledge pool" (Grinnell & Unrau quoted by De Vos 2011:134-135), thereby creating a foundation based on existing, related knowledge. A researcher should learn from other scholars: how they have conceptualised and contextualised issues, what research instruments they have used and to what effect. Definitions of the concepts, various hypotheses in the field of study, existing data and findings that have been produced, and tools that have been developed by relevant previous research can be ascertained through a literature review. The literature review provides the necessary background and context for the stated problem. It also forms the basis of and rationale for the research method chosen in a study.

In this study, the literature review has the specific aim of describing the history and current status of EMS training, the ECT programme and the concept of transition into practice, as it applies to the EMC and work environment. Due to limited literature available for the local context, the researcher endeavoured to critically appraise available literature and reference other relevant and valid studies.

2.2 LITERATURE SEARCH

A search was conducted by consulting EBSCO webhost to find literature on similar studies and topics in EMC and other health professions. Databases that were used to conduct the search include Academic Search Ultimate, Africa Wide Information, CINAHL with Full Text, eBook Collection, Medline with Full Text, PsycARTICLES and MEDLINE. The following search phrases were used to search for relevant literature: Medical graduate and transition to the workplace; experiences of emergency medical care graduates during the transition to the workplace; paramedics transition to the professional workplace; and EMC training in RSA.

In preparation for this study, the researcher found that there are limited articles relevant to the topic. Most of the literature that is available appears to refer to Australian paramedic education and clinical contexts, with one specific study done as a scoping review of research already undertaken into the experiences of paramedics during the transitioning from student to novice practitioner (Kennedy *et al.* 2015:1037).

A secondary web-based search was conducted with the search engine Google Scholar, which contributed additional scholarly articles, using the terms: "Transition experiences of paramedic graduates", "paramedic graduate transition into the workplace", and "ALS transition into emergency medical services". However, the studies that were identified focused on the transition of graduates into the nursing field, such as the qualitative research that presents a theory of transition into acute care practice by a graduate nurse (Duchscher, 2008). Limited literature, which could provide knowledge of the problem investigated by this study, is available in the local South African EMS context.

2.3 GRADUATE TRANSITION FROM STUDENT LIFE TO THE PROFESSIONAL ENVIRONMENT

According to Wood, *et al.* (2015:1), students experience multiple transitions as they move from school to university and then into the professional workforce, wherein they go through a major phase of development within the first few months of their careers. The authors further highlight the transition from student life to the world of professional work as the next big challenge for teachers involved in undergraduate teaching and learning. This is due to a significant gap in understanding challenges students face while transitioning from the academic discourse of the university to the professional discourse specific to their discipline, as they are only documented by a few studies (Wendler *et al.* 2012:1). Duchscher (2008:442) defines transitions as "passages or movements from one state, condition, or place to another, which can produce profound alterations in the lives of individuals and their significant others, and have important implications for well-being and health". However, Hout (2013:20), in her definition, emphasises the psychological effects and explains transition as an internal reorientation that people have to go through before the external change (end of student role) can work.

According to Hout (2013:11), support for graduates going through the transition into the workplace is a relevant topic for every newly hired professional to enable them to function in a safe, competent, and ethical manner. Some organisations put in place initiatives to

provide support for the new graduates to lower staff turnover, creating positive work environments and, to some extent, generating a culture shift through supportive programmes developed in collaboration with operational managers (Hout 2013:11). This is particularly important due to the human resource management crisis seen in fields, such as the healthcare industry, where there is growing attrition of competent and experienced practitioners that are replaced with new graduates who do not possess the required expertise and confidence to deal with the increased burden of disease and clinical workload (Duchscher 2008:441).

This human resource crisis is further compounded by the growing evidence of a psychologically disorienting, discouraging, and exhausting initial work experience among young professionals, as pointed out by Duchscher (2008:441), which results in high levels of burnout within the first 18 months of professional practice. Such stress-induced environments render graduates feeling unprepared for their new roles, and as a result, they become uncertain of their relevance and impact, leading to poor performance in the execution of their duties (Ndaba 2013:2). Many studies' findings, consistent with studies of more experienced practitioners, showed that such work environments were associated with graduates' intentions to leave the workplace (Ndaba 2013:2; Agllias 2010:347). These challenges and the desire to know the necessary resources to support graduates entering the workplace are encouraging organisations to explore what constitutes a quality work environment.

More than a century ago, several studies were conducted, which investigated how health professionals were trained and what improvements were necessary to ensure that the training is responsive to the changing needs of society. The Flexner report published in 1910, as well as subsequent commentaries, produced ground-breaking reforms in health professions training. The reforms, which emanated from the implementation of the recommendations, equipped health professionals with the knowledge that contributed to the doubling of life expectancy during the 20th century (Frenk, Chen, Bhutta, Cohen, Crisp, Evans, Fineberg, Garcia, Ke, Kelley, Kistnasamy, Meleis, Naylor, Pablos-Mendez, Reddy, Scrimshaw, Sepulveda, Serwadda & Zurayk 2010:1923). The commission on education of health professionals for the 21st century that ultimately published the Lancet report adopted a global perspective, seeking to advance health by recommending instructional and institutional innovations to produce a new generation of health professionals that would be best empowered to address present and future health challenges. It is therefore imperative that educators concern themselves with graduate transition experiences to continue

preparing health profession graduates who are competent in the evolving context while remaining committed to the ideals of their profession (Agllias 2010:346).

2.4 HEALTH PROFESSIONS' GRADUATE AND TRANSITION TO WORKPLACE

The transitional experience of health professional graduates has been studied widely in nursing and other allied health fields. Duchscher (2008:441), studied and wrote extensively on the newly graduated nurse's transition experience, and her work over ten years culminated in the stages of transition theory. This theory describes the first 12 months of work experience as a process of becoming, in which graduates evolved through the stages of doing, being, and knowing. Duchscher (2008:442), describes these 12 months as a "complex but relatively predictable variety of emotional, intellectual, physical, sociocultural, and developmental issues that in turn feed a progressive and sequential pattern of personal and professional evolution". The theory suggests that, in the initial phase of transition, a nursing graduate be allocated a reduced workload, an experienced clinical colleague dedicated to the preceptor role, a prolonged orientation period handling low acuity cases in a dedicated unit and only after about six months be exposed to more complex duties and high acuity cases.

In her qualitative study on lived experiences of newly qualified professional nurses doing community service in midwifery, Ndaba (2013:64), found that participants shared similar negative experiences during interviews. The clinical areas exposed them to conditions that gave them the reality shock experience, stress and feelings of being overwhelmed by the levels of responsibility and accountability, and this had the potential to affect the quality of mothers and childcare. The human resource crisis created a lack of support for graduates, which may have compromised patient care and safety (Ndaba 2013:64). Shortage and poor conditions of equipment also resulted in participants feeling frustrated and demoralised, thereby further rendering them unable to deliver quality patient care.

The transition from medical student to junior doctor is also reported in the literature as very stressful due to inadequate preparation during medical school and poor support for newly qualified doctors as they enter clinical practice (Brennan, Corrigan, Allard, Archer, Barnes, Bleakley, Collett & Regan de Bere 2010:450). Previous research found the first six months very stressful for medical and social work graduates due to high personal expectations, anxiety about their personal capabilities as well as ignorance of routine clinical practice procedures (Brennan *et al.*, 2010:450; Agllias 2010:346). In addition to the new

sense of responsibility, graduates also experienced challenges in relation to role clarification and uncertainty of not knowing what is expected of them. However, some studies indicate that prior clinical placements during the training years help to ease the transition period and prepare junior doctors for their role, as a result of the hands-on clinical experience gained during well-structured, early and meaningful contact made with patients (Brennan *et al.*, 2010:456).

2.5 PARAMEDIC GRADUATE AND TRANSITION TO WORKPLACE

Kennedy *et al.* (2015:1037), highlighted the primary roles of paramedics within the emergency care field as responsible for the assessment, treatment, and safe transportation of patients to the hospital. They further indicated that the nature of pre-hospital work exposes paramedics to a wide range of experiences, from low acuity inter-hospital transfers to potentially distressing multiple casualty incidents or violent patients. This, therefore clearly calls not only for paramedic education and training to be on par with other allied health and emergency medicine professional education standards but also that the transition experience and its impact on new paramedic graduates be understood to identify the support required (Kennedy *et al.*, 2015:1037; Hout 2013:10). The limited amount of literature produced on the lived experiences of new paramedics entering the working environment reported in this study is confirmed by Hout (2013:1) and Kennedy *et al.* (2015:1041). Similarly, no known study exists that documents the transitional experiences of newly qualified paramedics in South Africa or the support that they may require during the process. Hence, this study will add to the limited existing body of knowledge on the topic.

2.6 EMC EDUCATION AND TRAINING IN SOUTH AFRICA

In South Africa, prior to 1970, the local municipalities were responsible for the provision of ambulance services. The training and level of care offered was mostly basic first aid only, with a few larger cities having access to doctors and nurses to treat and care for the critically ill and injured. Prior to 1994, ambulance services were racially segregated, and resources were unequally distributed in favour of the white population. Organisations such as St John, The Red Cross and The South African First Aid League played an important role at the time by filling the gaps in other areas of the country with ambulances predominantly staffed with volunteers. The training received, and the level of care rendered by the volunteers was mostly basic first aid, with only a few larger cities having access to doctors and nurses to

treat and care for the critically ill and injured (RSA NDoH 2017:3).

The training of ambulance personnel evolved during the 1970s, from a one-week course that years later resulted in three different levels of training (RSA NDoH 2017:3). Firstly, the mid-late 1970s saw the introduction of a one-week basic ambulance course and a rescue medic course for staff working in ambulances. Subsequently, the then Pre-hospital Emergency Care Committee, under the auspices of the South African College of Medicine, introduced an Emergency Medical Assistant Course 1 for non-ambulance personnel. Ambulance departments started a similar Ambulance Medical Assistant Course 1, and later, an Ambulance Medical Assistant Course 2 was introduced. This course formed the basis for the Critical Care Assistant (CCA) Course. Emergency care training during this period was fragmented and varied from province to province. However, these courses produced skills-based personnel that would function under the direction of a medical doctor. In 1985 a four-week Basic Ambulance Assistant (BAA), twelve-week Ambulance Emergency Assistant (AEA) and a four-month CCA short course were introduced. These courses remained relatively unchanged, apart from the CCA course, which was extended by an additional five months of clinical practice component (RSA NDoH 2017:3; Lambert 2011:2-3).

It became evident that, in order to professionalise the industry and align emergency care to other health professions, professional qualifications, which would be recognised and regulated by the HPCSA, were required. The first qualification introduced was a three-year National Diploma in Emergency Medical Care (EMC), which since 1987 being offered at the then technikons, which are now known as universities of technology. It was envisaged that the three-year qualification would replace short course training and would empower graduates not only to provide an appropriate standard of clinical care but also through instilling an appreciation for research and professional academic development. This was followed by the introduction of a one to two-year part-time Bachelor of Technology in EMC qualification, necessitated by the need for a higher level of training that would enable emergency care personnel to independently deliver higher levels of emergency medical care (RSA NDoH 2017:3; Lambert 2011:3). However, it is worth noting that these formal education programmes continued parallel to the historic short courses. This was attributed to the acknowledgement that the few HE institutions offering the three-year qualification produced a limited number of tertiary graduates. This meant that output from the HE programmes could not rapidly address the immediate needs of the public (Lambert 2011:3). Following hereafter is a diagrammatic representation (cf. Figure 2.1) of the historic EMS education courses that were offered parallel to the new higher education offerings.

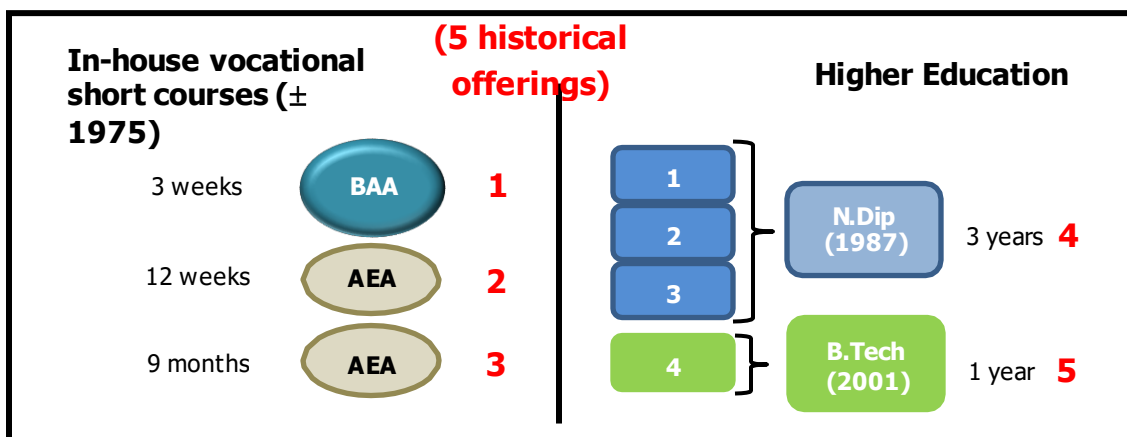


Figure 2.1: Historical system for South African EMS education and training

2.7 THE EMERGENCY CARE TECHNICIAN – MIDDLE LEVEL WORKER PROGRAMME

Following a review of the learning outcomes of the short courses and higher education qualifications, as described in the aforementioned Figure 1, the HPCSA introduced a two-year full time, 240-credit ECT qualification between the period 2004 and 2006 (RSA NDoH 2017:3; Sobuwa & Christopher 2019:3). Successful completion of this NQF level 5 mid-level worker programme allowed graduates for professional registration as an ECT with the HPCSA in the ALS category. The ECT curriculum offered broader and deeper foundational and emergency care knowledge over short courses and also offered Medical Rescue, Specialised Transport of Patients, and Communication Centre elective modules (Cermak 2016:14).

At the respective higher education institutions, in line with the Higher Education Act, the National Diploma and BTech degree were reviewed and resulted in the creation of a four-year NQF level 8 professional bachelor's degree in EMC in 2005. A master's and a doctorate programme were also introduced. The rationale for an ECT qualification was to produce technicians who can attend to a majority of cases and provide emergency care to ill and injured patients following approved practice guidelines and patient management protocols (Lambert 2011:58). Various provincial colleges between 2007 and 2018 produced approximately 1,124 ECT graduates who are currently registered with the HPCSA and practising as independent mid-level pre-hospital emergency care providers, alongside thousands of short course graduates (Sobuwa & Christopher 2019:3)

The National Emergency Care Education and Training (NECET) policy, which was signed

into law by the National Minister of Health in 2017, now provides for a three-tiered Emergency Care Qualifications Framework (ECQF), which is aligned with all the changes that recently took place in the higher education environment. The policy provides for the entry-level Higher Certificate in EMC (NQF5), Diploma in EMC (NQF6) and bachelor's degree in EMC (NQF8). The NDOH has adopted the ECQF to meet the emergency care service level needs of South Africa (RSA NDoH 2017:7).

As illustrated in Figure 2.2, the NECET policy and the ECQF it brought about have served to replace the historic short course vocational training system that has been in place since the evolution of EMS.

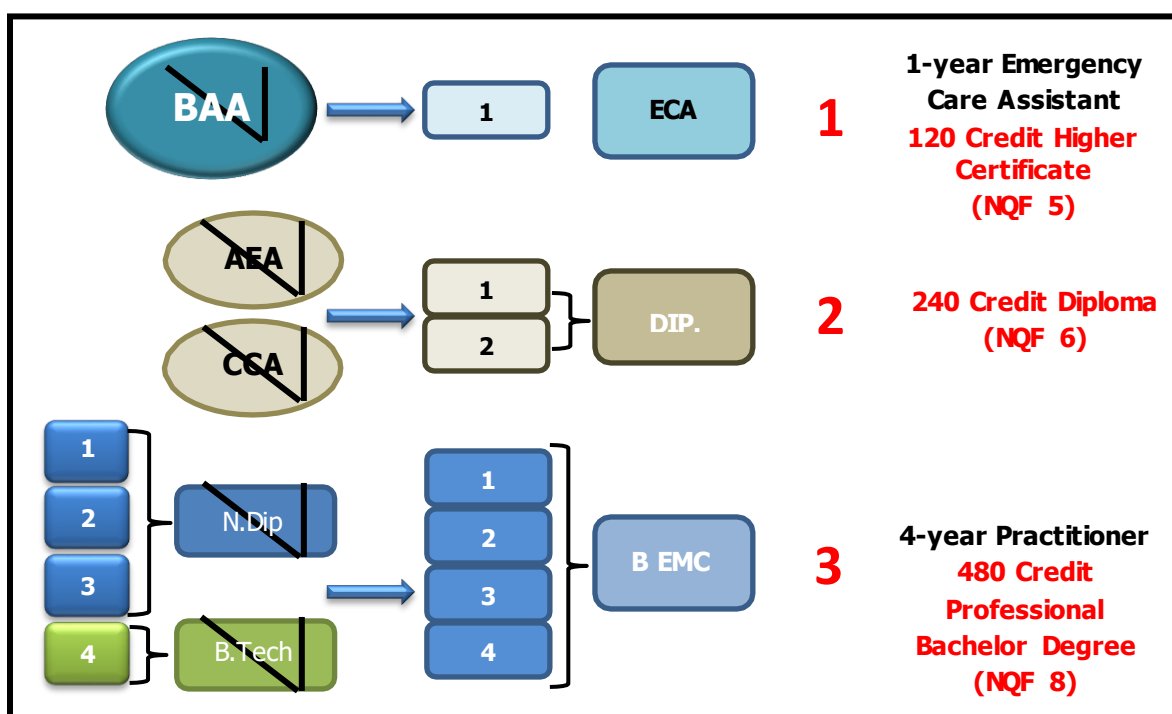


Figure 2.2: New EMS Education System – Necet Policy

At present, the 240-credit Diploma in Emergency Medical Care has replaced the ECT programme as the mid-level qualification, according to the three-tiered ECQF adopted by the NDOH and aligned to the South African National Qualifications Sub-Framework (RSA NDoH 2017:3). However, to date, no known study has investigated the lived experiences of these mid-level pre-hospital emergency care providers during their transition into the professional work environment.

2.8 CONCLUSION

The concept of healthcare service delivery with mid-level workers/technicians and practitioners is neither unique nor foreign to the healthcare professions; in the local emergency medical care context, the rationale to produce ECTs as mid-level workers is linked to a critical shortage of ALS care providers (Lambert, 2011).

In summary, this chapter presented the concept of graduate transition into the workplace, why it concerns educators and educational institutions as well as how it affects graduates. Specifically, literature that documented experiences of graduates in other health professions was consulted due to the limited research on paramedic graduates' transition. Furthermore, it presented the evolution of emergency medical care education and training in South Africa over the years and the dire need to professionalise in order to align with relevant legislative prescripts and for holistic patient care benefits. The literature reviewed focused primarily on reforms and the development of NQF aligned emergency medical care programmes, which among others, being the mid-level ECT programme. Although the ECT programme was replaced by the new two-year diploma to produce mid-level workers in EMS, no studies are focusing specifically on the experiences of South African ECT graduates as they transition into the work environment. The following chapter is a manuscript that focuses on the research methodology employed by the researcher, as well as the findings, discussion, and recommendations of this study.

CHAPTER 3

PUBLISHABLE ARTICLE 1: TRANSITION FROM COLLEGE TO PROFESSIONAL WORKPLACE: LIVED EXPERIENCES OF MID-LEVEL EMERGENCY CARE GRADUATES WORKING IN A PROVINCIAL DEPARTMENT OF HEALTH IN SOUTH AFRICA

The manuscript was prepared according to the journal submission guidelines for the *Australasian Journal of Paramedicine* (cf. Appendix I). The manuscript has since been submitted to the journal and is presently in review for publication.

Transition from College to Professional Workplace: Lived Experiences of Mid-level Emergency Care Graduates Working in a Provincial Department of Health in South Africa

Arthur Malgas¹, Antonio Oladele Adefuye^{2*}, Chantel Witten²

¹North West Province (NWP) Emergency Medical Rescue Services (EMRS) College, Orkney, South Africa

²Division Health Sciences Education, Office of the Dean, Faculty of Health Sciences, University of the Free State, Bloemfontein, South Africa

***Corresponding author:**

Professor Antonio Adefuye,

AdefuyeAO@ufs.ac.za

ABSTRACT

Introduction: It has been reported that the transitional experiences of health professions graduates in work placements can be complex. While some experience a supportive and welcoming environment, others may be exposed to negative workplace cultures with negative outcomes. In this study, we explored the lived experiences of emergency care technician (ECT) graduates (mid-level paramedics) when transitioning to the emergency medical service (EMS) work environment.

Methods: This research is designed as a qualitative study that made use of focus group discussions held with 26 ECT graduates to obtain verbal statements describing their lived experiences when transiting from college to pre-hospital workplace environments.

Results: The three dominant emerging themes were Workplace readiness and reception; Professional confidence; and Resistance in the workplace. The experiences reported regarding workplace readiness and reception were largely negative. The majority of the participants shared that the EMS station they were deployed to had not been ready to receive and optimally utilize their skills. In addition, participants stated that their integration into the workplace had been unpleasant, as they experienced a great deal of exclusion and resistance from colleagues. Furthermore, participants described how peer support, positive feedback from patients and co-workers and the new skills and knowledge acquired during training had enhanced their professional confidence.

Conclusion: By describing the lived experiences of ECT graduates during their college-to-workplace transition, this study explains some of the challenges that mid-level graduate paramedics may encounter when transitioning into the EMS workplace environment in the South African context. These findings suggest that more needs to be done by stakeholders in emergency care education and practice in South Africa to ensure that transition of graduate paramedics to the workplace environment is a positive and less stressful experience.

Keywords: paramedics, workplace transition, emergency care technician graduates

Introduction

It has been reported that students experience multiple transitions as they move from school to university, and then into the professional workforce (1). While the challenges that arise with a move from secondary to tertiary education has been well described in the literature (2, 3), few studies have documented the challenges they face while transitioning from the academic discourse of the university to the professional discourse specific to their discipline (4). Wood et al. (2015) report that the transition from student life to the world of professional work is often thought of as the next big challenge for undergraduate students. Similarly, it has been reported that the transition experience was challenging and caused stress and anxiety for new graduate paramedics (5).

Before 1980, emergency care education and training in South Africa were fragmented, as training models and patterns varied across the provinces. However, over the past two decades, the profession has undergone continuous reviews and reforms, which started with the introduction of standardized, non-credit-bearing short courses in 1985, and continued to the emergence of the recently approved three-tiered Emergency Care Qualification Framework (ECQF), which was adopted by the national Department of Health and which is aligned with the South African National Qualifications Framework (NQF) (6-8). Central to these reviews and educational reforms were important issues of non-articulation between short courses and existing academic qualifications, compliance to the NQF Act, academic progression, career-pathing and placement, as well as professional development in the emergency medical care (EMC) profession (8). Notable educational reforms include the discontinuation of all non-credit-bearing short courses, the introduction of a two-year 240-credit NQF 5 Emergency Care Technician (ECT) and a four-year 480-credit NQF 8 Bachelor's degree in Emergency Medical Care (B EMC) qualification in 2006 (6).

The ECT is considered a "Mid-Level Qualification (i.e. Mid-Level Worker)" equivalent for the emergency care profession, and graduates are eligible to register in the professional category of advanced life support (ALS) paramedics with the Health Professions Council of South Africa (HPCSA) (8). The ECT programme was designed using outcome-based education principles; an important exit-level outcome of the programme is the ability to provide clinical emergency care independently within an EMS environment. Teaching, learning and assessment practices involve the use of face-to-face lecturing and instruction on theory, tutorial sessions, case study presentations, clinical portfolios, classroom practical sessions and laboratory simulations, assignments and work-integrated learning in the pre-

hospital and clinical environments (8). The ECT qualification allows direct articulation into B EMC, while B EMC allows direct articulation into Master's and Doctoral Programmes (8). ECTs provide emergency care by following approved practice guidelines and management protocols. Their scope of practice means ECT graduates may perform invasive, life-saving procedures, and they may administer scheduled medication (8). Between 2007 and 2018, a number of colleges produced approximately 1,124 ECT graduates, who are currently practising as independent, mid-level, pre-hospital emergency care providers, together with thousands of short-course graduates who constitute the majority (98%) of all EMC professionals registered with the HPCSA (6, 9).

Unpublished reports of the challenges encountered by graduates of the ECT programme when they transition to the professional workplace have emerged, among which issues related to workplace readiness, and resistance and negative attitudes experienced during the transition period. Some ALS paramedics who trained and progressed through short courses expressed a lack of confidence in ECT graduates and their capabilities. However, no known study has been conducted to validate or negate these attitudes or gain meaningful insights into the transition experiences of new graduate paramedics, or the forms of support they require in South Africa. Hence, this study aimed to obtain empirical data on the lived experiences of ECT graduates during their transition into the professional workplace environment. We envisaged that the findings of this study would give insight into paramedics' experiences of transition from college to the professional workplace environment and identify the support that may be required to facilitate the successful transition of new graduate paramedics entering the workplace. In addition, the recommendations the study propose can inform current plans related to education, training and transition support for new graduate paramedics.

Methods

This research was designed as a qualitative study that gathered data through focus group discussions (FGDs). The decision to use FGDs is justified by Stalmeijer, who found FGDs particularly appropriate for research on poorly understood or ill-defined topics, and when the researcher is interested in the depth and richness of the information collected (10).

Study population

The target population included all ECT graduates working as mid-level paramedics for the North West Department of Health (NWDoH). Purposive non-probability sampling was used,

as all ECT graduates (2009–2018) in the employment of the NWDoH were invited to participate in the study – 32 in total. All participants received an invitation letter via e-mail, in which the aim of the study was explained. The survey population comprised individuals who agreed to participate in the study voluntarily after reading and signing the informed consent forms – 26 participants made up the sample. Follow-up telephone calls were made to remind participants who had consented to participate, in the FGD.

Data collection

For the purpose of this study, four separate FGDs were conducted, and a pre-determined interview guide was used. Arrangements relating to the date, time and venue of the FGDs were communicated to the participants via e-mail and mobile phone messages. The four FGDs were conducted in May 2021. FGD 1 and 2 comprised five participants each and lasted 38 minutes and 51 minutes, respectively. FGD 3 involved seven ECT graduates and lasted 68 minutes, and FGI 4 comprised nine graduates and lasted 66 minutes. One of the researchers (AM), who is a paramedic, fulfilled the role of the facilitator.

At the start of each FGD, participants received a short introduction on the purpose of the study, and they were assured that there are no right or wrong answers and that all contributions would be valued. All FGDs were conducted in a conference room at the NWDoH. All activities during the FGDs were audio-recorded, after prior consent had been obtained from the participants. The audio recordings were downloaded on a computer, which was password-protected to ensure the safekeeping of the data.

The focus group interview guide

An interview guide developed for this study comprised one open-ended question: *What was your experience of the transition from ECT training into the workplace environment?*

Exploratory interview

An exploratory interview was conducted with three participants, using the interview guide, prior to the official start of data collection. This was done to establish the feasibility of the chosen data collection method and congruity of the interview guide and to estimate the duration of the FGDs. No adjustments were made to the interview guide, as the participants of the exploratory interview did not recommend any changes. The data generated in the exploratory interview was not included in the final data of the study.

Data analysis

An independent transcriber transcribed the recordings of the FGDs verbatim. The complete transcript was read and reread by the researchers to familiarise themselves with the content. We were assisted by a co-coder to apply iterative inductive coding; we paid attention to emerging patterns and themes. Qualitative analysis was done using Atlas.ti 8.3 software (Scientific Software Development, Germany). The views of the participants of each focus group were considered on their own and then compared to those of the other groups, to identify similar themes and to ensure that all codes are accounted for. All the investigators confirmed the identified themes and codes.

Ethical considerations

Approval for the study was obtained from the Ethics Committee of the Faculty of Health Sciences at the University of the Free State (No. UFS-HSD2019/1552/2611). Approval was also sought from the NWDoH research committee. To ensure participants' right to privacy and confidentiality were upheld, the independent facilitator indicated that no names should be used during the FGDs. If a participant mentioned another's name, the researcher removed the name from the transcription and replaced it with the code allocated to the participant.

Results

Based on frequency counts, the top three emerging themes were Workplace readiness and reception (39%); Professional confidence (38%); and Resistance in the workplace (26%).

Workplace Readiness and Reception

Participants reported that the workplace had not been ready for them when they reported for duty. The participants indicated that their stations were not ready, to the extent that they still do not, to date, have the resources they need to execute their duties. Participants described their transition as not being smooth, and the welcome they received as unpleasant. This was evident from the first group of graduates, as one participant explained:

#1 "There was a lot of resistance and especially for us, it was for us as the first group of ECT, people did not know what the meaning of ECT was."

Many of the participants described how they found the EMS stations they were deployed to unprepared to receive and utilise them. The graduates had to consult with the college

management to intervene and advise their managers on the type of equipment and tools they required to execute their duties effectively (cf. Quote #2).

#2 "there was a negative reception, especially when coming to the workplace readiness, it was not there because as participant 1 was highlighting her points that the stations were not ready like the station I was working at. They were not ready when we requested some of the stuff; there was some tension or resistance from the manager saying we are asking a lot and then why the college did not notify them first on the stuff that they were supposed to buy. So, things were not procured in time and we were struggling a lot. So, the workplace readiness, it was not conducive by then."

Participants attributed poor workplace readiness to the fact that their qualifications had only recently been instituted, as exemplified by Quote #3.

#3 "as a new qualification I think that is what is happening in most cases where you come in and they do not understand why you need this and why you want things – they think that you are being impossible – You are just trying to show off."

In contrast, some participants indicated that they found their workplace ready, as their managers and predecessors had made an effort to prepare their station by procuring the required equipment (cf. Quotes #4 & #5).

#4 "I will say my station was ready for an ALS, an ECT, because we did not struggle to have medication, dry dispensary, equipment and all that. At our station, there was nothing that we lacked...The station was well prepared for me to do my skills and to perform all the duties well. It was not a challenge as such. It was good from the management side. Everything was fine."

#5 "I had already people that were in the first group and the second group of the ECTs that qualified as emergency care technicians. And those people had already prepared a lot of things, you know, like the medications which is at the level of the qualification, the equipment."

Most EMS stations did not have vacant positions to which ECT graduates could be appointed, which also illustrated poor workplace readiness. This situation resulted in salary disparities, as some ECT graduates were employed at lower-level positions, compared to their counterparts who were employed at the correct salary levels. In addition, due to salary notches, some stations placed ECTs at a level equivalent to AEAs (intermediate life support paramedics), instead of ALS paramedics, despite the ECTs possessing higher-level clinical skills and capabilities for patient management. Participants reported that this made them feel discouraged, and it negatively impacted their transition to the workplace (cf. Quotes #6 & #7).

#6 "ECT and ILS – there is no difference. It is the same thing. There is no difference; we do not feel like anything above them. Remuneration-wise levels, recognition at HR [Human Resources], even they don't even understand why you would want to be a bit different or better than ILS."

#7 "people ended up not going for training for ECT – we tend to be discouraged, we're going to go

there for two years, we come back. The person that I was with on the salary scale is going to be getting more than me when I come back. So it's no use for us going there."

ECT graduates observed that workplace unpreparedness indicated a lack of clinical governance. While the scope of practice and functioning of short-course graduates were linked to rigidly defined clinical protocols, with clinical governance being provided by medical doctors, ECT graduates, on the other hand, are allowed to practice independently, without directives regarding who provides clinical governance. This posed a challenge for ECTs, since some of the skills and medication required consultation before they could be administered (cf. Quote #8).

#8 "I think the system did not create an environment to be easy for us in a way, because even if I attend a case where I administer morphine, I don't have anybody in mind who I can call in the whole district or the sub-district where I'm working."

Regarding their reception at the new workplace, the majority of the participants stated that their transitional experience was not as smooth as they had expected it to be (cf. Quotes #9–#12).

#9 "The welcoming at the workplace, it was not as smooth as we expected. There was a lot of resistance."

#10 "In essence, true that there was a negative reception."

#11 "So I would say the transition was not that smooth. But it was something that I was willing to accept."

#12 "It was not a nice welcome."

Professional confidence

A key exit-level outcome of the ECT programme is that graduates should be able to provide clinical emergency care independently within an EMS environment. This suggests that ECTs must possess some level of professional confidence when transitioning to the new workplace if they are to be deemed workplace ready. Moving to the workplace environment with a new and/or advanced set of skills and knowledge enhanced graduates' confidence and made them feel adequately prepared for clinical practice (cf. Quotes #13 and #14).

#13 "After college, confidence was there, and it is still here, it lives here. And we are usually not even afraid to take resuscitation from the doctors and send them away. The confidence comes from the fact that I know where I am coming from; I know what I must do. If you know what you are doing, you gain confidence."

#14 "The College grown our confidence, in a sense of responsibility to the patient. Remember, I've mentioned that our responsibilities tend to be grown – tend to be more than before. So I will say, the confidence as well, it was a matter of self-esteem, it has just grown to get a sense of believing

unto ourselves."

Similarly, experiencing positive patient outcomes after applying their newly acquired skills and knowledge boosted participants' confidence regarding clinical practice further. Their confidence earned them the respect and trust of colleagues and members of the public. For example, in outlying rural areas, medical doctors relied on ECTs to transfer high-priority patients to next level facilities for definitive care, and nursing staff in these areas depended on ECTs to perform live-saving invasive procedures on patients (cf. Quotes #15–#17).

#15 "I was really overconfident. I did attend to a certain patient, it was a diabetic. I went there and the patient had collapsed. So when I went and check the HGT...the reading was 1.0 mmol/L. What was this...the indication was 50% dextrose. All of a sudden, the patient was awake and laughing. So all of the people who were there was very impressed. It boosted my confidence."

#16 "The thing that most boosted my confidence, more often is that, when I arrive with a patient at the hospital, they would tell me no, I am referring this patient and you are the one who will escort the patient. So, that boosted my confidence. The appreciation from the doctors as well."

#17 "When it pertains to the new-borns, most of the nurses have a problem putting in a line for the new-born babies, but they will say the doctor request me to put on a line – and I did not mind...they say because all the people from the college, all of them, can put in a line. For me, it gave our college a name – to be honest – when I got there; they would have already written my name on the book and say, we know you would be able to do it."

Building relationships with colleagues at their workplace also boosted participants' confidence levels. They would mostly achieve this through debriefing interesting and challenging cases they had encountered with their former classmates or more experienced ECTs (cf. Quotes #18).

#18 "we had this thing of, when I come back from a call, we would discuss the call, I will tell him what I did wrong or what I did, and he would tell me 'no, you could have done this or that' – that is how we groomed each other and bring back self-confidence."

In contrast, some participants indicated that the disconnect between simulated training and real-life practice had a negative impact on their professional confidence, and they sometimes felt unprepared for real-life practice (cf. Quote #19).

#19 "So what I knew was what we did, in the worst case, in the simulations, apart from when we had to do our practicals at the college, so now reality hit, I can say I was lied to...Coming to the actual work, like I said, we couldn't take from dummies to real patients; it was more of a shock."

Some participants suggested creating a formal mentorship or internship programme for newly qualified ECTs, as it would enhance their confidence, speed up their preparation for the EMS workplace, and improve it (cf. Quotes #20 & #21).

#20 *"I think a structured, a mentorship for newly qualified especially for new qualifications like we, it was for us, it will assist a lot in bringing a lot of support to newly-qualified people and confidence will build up quicker and benefit to the patient."*

#21 *"Just like what they do with doctors...not just ECTs. To have like interns, to have supervisors overseeing what you are doing with patients, so that you develop more confidence having a backup, knowing that someone is behind you."*

Resistance in the workplace

Resistance was the third-most-dominant theme that emerged from the participants' responses. Almost all the participants in this study used the word resistance to describe their experiences in relation to the reception at the new workplace. Most of the resistance participants described originated from EMS managers and shift supervisors, who felt threatened by the ECT graduates. One of the most common misconceptions observed by participants was that managers and shift supervisors thought ECTs were going to take over their work and replace them in management positions. This fear may be attributed to the reality that, prior to the introduction of ECT training in the North West province, many station managers and shift supervisors were in possession of the Ambulance Emergency Assistant (AEA) qualification obtained via a 12-week short course, and they were registered as ILS EMC providers with the HPCSA. Shift supervisors may have feared that, should a manager position become vacant, ECTs would be preferred over them for an appointment, based on ECTs' qualifications. This is evident in some of the participants' statements, as expressed in Quotes #22–#24.

#22 *"There was this thing of resistance from management. For the mere reason that most if not all management were ILS."*

#23 *"some in management level thought that we were going to take over their work and there was also resistance on that level."*

#24 *"it was not a good reaction from the colleagues that were not trained, they were scared of us that we're going to take everything in front of them, the opportunities that are coming. And if maybe there's a post for manager, they were not thinking that they will be able to participate in the interview to get the manager's post, just because there's an ECT."*

In addition, participants described the resistance they experienced from their colleagues at the operational level. Colleagues with AEA certification believed that ECT graduates were being given preferential treatment by management, that is, that management listened more to the ECTs. Furthermore, in terms of best practices and evidence-based patient management, the older generation of AEAs did not appreciate it when ECTs corrected some of their obsolete methods. Older AEAs found it difficult to take instruction from new graduates who had no prior experience in EMS, but who were entering service as senior

medically qualified officers. Participants also referred to age and generational gaps. Most new graduates were relatively young, and older colleagues refused to take instruction from them (cf. Quotes #25–#27).

#25 "Most of the workforce was intermediate life support practitioners [AEAs], so there was a lot of resistance because they felt like management listened to me more often because I was regarded as an advanced life support practitioner."

#26 "Most resistance was on operational level – people, they would feel like you want to change them from what they used to do in a day and they were not really accommodative...but it was a challenge for them to adapt to us in that we ALS that are from nowhere without having any prior operational background."

#27 "I am also an ECT school leaver. One of the challenges as a school leaver, it was that it was a lot of intimidation in the beginning. People were thinking we are still young, and it was challenging, as young as you are, and then you come work with an older person, and you are there for the benefit of the patient, but the person will say that you are young and that they I will not take instructions from you. That was one of the challenging things."

Some EMS staff did not understand the concept of professionalizing the EMS profession and, therefore, questioned why a four-month course, which could produce new AEAs every four months, needed to be phased out and be replaced by a two-year programme (cf. Quote #28). Some EMS staff in the workplace questioned the professional status of ECTs, and asked whether they even belonged to the category of ALS. According to the participants, these attitudes contributed to their experience of resistance while they transitioned to the workplace.

#28 "do not understand why you will discontinue a four months course that would produce so much with this course that is going to bring less."

The resistance also seemed to be caused by a lack of clarity on the roles and responsibilities of ECTs. Many participants reported that junior colleagues would not call them for backup to assist with patients in critical conditions that required ALS intervention. The perception of special treatment of ECTs, when they were issued with certain medical equipment and tools, was also due to this lack of clarity about their capabilities. For the same reason, management did not always utilize the ECTs correctly (cf. Quotes #29–#31).

#29 "Nobody will call ECT for a backup, even if they see a need that this patient needs somebody of higher qualification."

#30 "They judge us, you have a drug bag but I don't have a drug bag."

#31 "I think there was not enough information relayed to the stations about this ECT, where you need them to be used...The utilisation of the ECT was not correct at some stages."

Discussion

It has been reported that the transitional experiences of medical graduates vary, and can be complex and often a source of great anxiety for new practitioners (11, 12). While some graduates experience a supportive and welcoming environment, others may be exposed to stressors associated with negative workplace cultures that have negative outcomes (13). In this study, we explored the lived experiences of ECT graduates (mid-level paramedics), with a particular focus on the period when they transitioned into the EMS work environment. While prior studies have made considerable effort to discuss all aspects of ensuring that graduates, including graduate paramedics, are workplace ready (14-17), the literature is largely silent regarding the organizational or workplace readiness for graduates. This study found that workplace readiness and reception was the most dominant theme that emerged from participants' responses. The theme of workplace readiness as identified in this research highlights the role of employers in preparing the workplace for ECT graduates. Though there were some positive comments (cf. Quotes #4 & #5), the experiences and perceptions reported regarding workplace readiness and reception were largely negative. Poor workplace readiness was experienced as the unavailability of the requisite tools to work, the absence of an appointable post for ECT graduates, salary disparities, and poor clinical governance.

A key aspect of preparing the workplace for employees is providing the appropriate tools for them to do their work. Equipment requirements of paramedics often depend on their certification or licensure levels, local medical direction and jurisdiction, population densities, and the geographic and economic conditions of the region (18). Participants of this study reported that the EMS stations they were deployed to did not provide the requisite equipment for their level of practice, which meant they could not do their work effectively (cf. Quotes #1-#3). This shortcoming can be attributed to a lack of clarity about the roles of an ECT graduate and the relative newness of the qualification. Delivering a successful and good quality pre-hospital emergency care requires having the right tools, in the right place, at the right time (18). It is, therefore, plausible that lack of readiness of these EMS stations, as exemplified by the lack of equipment to work effectively, can negatively affect the quality of services rendered by these graduates.

Gunawan and Amalia (2015), report that education, job placement and work environment are some of the important factors that can influence an employee's performance (as measured by the quantity of work, quality of work and timeliness) (19). This implies that

shortcomings in job placement, salary disparities and negative attitude experienced by these graduates during the transition period may negatively affect their performance. Organizational readiness has been reported to significantly correlate with outcomes such as success in the implementation of health service programmes (20), implementation of quality improvements (21), and adoption of evidence-based treatment practices (22). Furthermore, organizational or workplace readiness has been suggested as a key concept in the dissemination and implementation of frameworks (23). Hence, it is imperative that the HPCSA and the national Department of Health address issues of workplace preparedness when implementing the newly adopted three-tiered EQF, if it is to meet emergency care service level needs in South Africa.

Professional confidence refers to confidence in a professional setting relating to roles and demands of the occupation (24). It is essential for new medical graduates to develop professional confidence so that they can provide quality patient care (25). Ortiz (2016) reports that developing professional confidence is a dynamic process that occurs throughout the first year of practice (26). Participants of this study reported that new knowledge and skills they had acquired during their training to be ECT paramedics enhanced their professional confidence (cf. Quotes #13–#14). This finding confirms prior studies, which reported on the development of professional confidence post formal clinical training (27). Positive feedback from preceptors, colleagues and/or patients has been reported to enhance professional confidence in new medical graduates (26). Similarly, participants reported that positive feedback from their patients and colleagues (doctors and nurses) boosted their confidence (cf. Quotes #15–#17). Relationship building and establishing working relationships with colleagues at the workplace have been identified as major elements of the development of professional confidence (24, 26). In this study, participants reported that establishing a peer learning and support system strengthened their confidence and enhanced their adaptation to the EMS workplace (cf. Quote #18). In addition, participants suggested that creating a formal mentorship or internship programme for newly qualified paramedics would aid early attainment of professional confidence (cf. Quotes #20 & #21). It has been reported that attaining professional confidence underpins clinical competency (27, 28). It is probable that enhanced professional confidence, as reported by this study's participants, contributed to the early attainment of competency during their transition period.

It has been reported that a disconnect between clinical knowledge acquired during training and the way it needs to be applied in actual real-life practice could undermine professional

confidence (29). This suggests that the ability of a graduate paramedic to effectively bridge the gap between knowledge and practical application is vital for attaining competency, and that is likely to contribute to a successful transition from student to novice professional (30, 31). Training colleges utilize clinical placements to foster “on the job” skills acquisition (31). However, systemic constraints, such as limited funding for training, staff shortages, patient unavailability, competition for placements between health care disciplines, and an increasing number of students, have led to a shortage of clinical placement or “on-the-road” experience during undergraduate training (31, 32). Using simulation and simulators could bridge this gap and prepare paramedics for the pre-hospital environment (33). A major disadvantage of medical simulation is its incomplete mimicking of human systems and real-life situations and complexity (34). Some participants of this study stated that the perceived disconnect between simulated-based education and the real-life situation created a “theory-real-life-practice” gap, which had a negative effect on their professional confidence (cf. Quote #19). We, therefore, advocate that all training platforms, when they implement the newly adopted three-tiered ECQF, design their programmes so that they provide early and sufficient exposure to real-life emergencies, rather than relying solely on simulation-based education.

Filstad and McManus (2011) report that it is imperative for colleagues to accept newly qualified paramedics, so that novice paramedics can gain experience in the crucial transitional period. Doing so will, in turn, reduce stress, and affirm paramedics’ confidence in their clinical practice (11). In this study, graduate paramedics reported that they had experienced a negative reception. In addition, participants stated that they had experienced a great deal of resistance from some colleagues, as well as managers with lower qualifications (AEA), who felt threatened by their presence in the workplace (cf. Quotes #22–#24). This reaction was attributed, in part, to inadequate clarity about the roles of an ECT graduate, as reported by some participants (cf. Quotes #29–#31). Experiencing hostile behaviours, such as being ignored or made to feel unwelcome in the workplace, may impact negatively on the transitional experience, thus, making transition difficult and stressful. The concept of the “other” – those who are perceived as different or marginal – has been identified as the cause of resistance within organizations (35, 36). Othering, in the context of this study, resulted because graduates of short courses perceived ECT graduates as being different from them. Canales (2000) suggests that exclusionary othering employs power in relationships to dominate and oppress. It is, therefore, plausible that new graduates are dominated and oppressed during their transitional period. It has been reported that the inability of an organization or its members to facilitate social integration may negatively

impact on new paramedic and their sense of belonging (39, 40). Kelly and McAllister (2013) argue that the ability to engage and integrate is an essential component of a healthy, positive workplace, and a lack of such support may precipitate the erosion of trust, productivity and health of members within the organization (41). It is, therefore, imperative that management at EMS stations take the issues of integration seriously and make a conscious effort to facilitate the integration of newly qualified paramedics, in order to make their transition less stressful.

Limitations of the study

The main limitation of this study is that it was conducted on only ECT graduates employed by the NWDoH, thus, limiting the generalizability of the findings of the study. Investigating the lived experiences of mid-level paramedics working in other provinces should be the focus of future studies. A second limitation was that the ECT programme was phased out during this study (last offering 2019). At present, the Diploma in Emergency Medical Care has replaced the mid-level qualification, according to the three-tiered ECQF newly adopted by the national Department of Health, aligned to the South African National Qualifications Sub-Framework (6, 7). However, the findings and recommendations of this study may serve as a valuable guide for stakeholders in emergency care education and practice during the implementation of the newly adopted three-tiered ECQF promulgated by the National Emergency Care Education and Training (NECET) Policy.

Conclusion

By describing the lived experiences of ECT graduates during their workplace transition, this study highlights some of the challenges that mid-level and/or new graduate paramedics may encounter when they transition into an EMS workplace environment in the South African context. Workplace unpreparedness, hostile behaviours in the workplace and disconnect between simulated-based education and the real-life situation are some of the factors that may contribute to a high level of stress and anxiety among new graduate paramedics as they transition from student to practitioner. Taken together, these findings suggest that more needs to be done by stakeholders in emergency care education and practice to ensure that the transition of graduate paramedics to the workplace environment is a positive experience for them.

Recommendations

Based on the findings of the study, we propose the following recommendations to the HPCSA, national Department of Health, and EMC curriculum planners for the support required for new graduate paramedics to integrate into their new role:

- a) Building a healthy and productive peer and collegial relationship should be encouraged, as it is an important component of a successful transition.
- b) EMS managers should ensure that the required equipment is available for all levels of emergency care providers to ensure the delivery of successful and good quality pre-hospital emergency care. A standardized list of equipment for all levels of emergency care providers should be formulated. Proper job placement should also be ensured.
- c) Undergraduate EMC curriculum planners should devise strategies to enhance the clinical experience that promotes more realistic learning – clinical placement (“on-the-road” experience) can be used to enhance the skills and knowledge gained during simulation-based education. Allocating more time for work-integrated learning will be a good step forward in this regard.
- d) The HPCSA should implement frameworks for clinical governance procedures and activities in accordance with different registration categories and scopes of practice.
- e) The HPCSA and the National Department of Health should engage EMS operations teams and managers to develop and sustain a healthy and supportive working environment for new graduate paramedics. Programmes that ensure early and smooth integration of newly qualified paramedics into the workplace should be initiated.
- f) The HPCSA, National Department of Health and EMS operations should develop and implement a formal mentorship programme, by partnering new graduates with supportive experienced paramedics for a clearly defined period (12 months), to smooth the continuum from student to practitioner and provide the ideal support to facilitate a successful transition for new graduate paramedics (5).

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Competing interests

There is no competing interest.

Author contribution

AM conceptualised the study, developed the protocol, collected data and prepared the manuscript under the supervision of AOA. CW assisted in data analysis and interpretation.

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CHAPTER 4

CONCLUSIONS AND LIMITATIONS OF THE STUDY

4.1 INTRODUCTION

In this final chapter the researcher summarises and concludes the study. A discussion of the study findings from the focus group discussions forms the main body of the manuscript in Chapter 3, which led to the main conclusions, as will be discussed in this Chapter. The contribution of the study is discussed together with possible limitations and, concluding remarks.

4.2 SUMMARY OF CONCLUSIONS

This is the first study to explore and describe the lived experiences of graduate paramedics as they transition into the professional EMS work environment in South Africa. Thus, this study contributed to the existing body of knowledge on emergency medical care education and training as well EMS operations research in South Africa.

In order to achieve the aim of the research study, the researcher posed the question: What are the lived experiences of ECT graduates (ALS paramedics) as they transition into the EMS workplace environment?

In its endeavour to answer the research question, the study was required to realise the objective of describing the lived experiences of ECT graduates during daily operations as they integrated into the EMS work environment. To achieve this objective, insights into the experiences of ECTs were sought through the use of focus group discussions to gather and analyse empirical data. The study described the subsequent experiences of graduate paramedics (ECTs) working at a provincial Department of Health in South Africa.

During the data analysis, several dominant codes converged to form relevant themes, which comprised workplace readiness and reception, confidence to practise, and resistance in the workplace. This study described the experiences of ECTs to have been mainly very negative, whilst some aspects of their confidence to practise and training programmes provided positive experiences. The findings of this study highlights some of the challenges that mid-level graduate paramedics may encounter when transitioning into the EMS workplace

environment in the South African context.

Workplace readiness and reception was the most dominant theme that emerged from the majority of participants' responses. The participants reported that they experienced a hostile and unwelcoming reception from managers and their colleagues. In addition to stations not being prepared for them to function optimally, they received a lot of resistance from threatened management and colleagues. It is plausible that the deficiency in the readiness of EMS stations, as exemplified by the lack of equipment and resources, could be a result of such resistance, which ultimately hampered graduates to work efficiently and deliver quality patient care. Organisational readiness is a concept that has been reported to have a significant correlation with outcomes such as success in the implementation of quality improvement and health service programmes.

The transition experience of ECT graduates was difficult and stressful, consistent with the findings by Hout (2013:51), who stated that new paramedics commonly experience stress and anxiety, and feel unsupported by management. The stressful experience is also common among other healthcare graduates, including the transition from medical student to a junior doctor (Brennan *et al.* 2010:450; Hout 2013:51). However, some of the participants reported that they found the stations better prepared and that this was attributed to the efforts made by their predecessors and some of the supportive managers.

Confidence to practise emerged as the second most dominant theme from participants' responses as they described their transition into the workplace. In addition to entering the workplace with advanced skills and knowledge for better patient outcomes, the participants reported the role played by their peers to build their confidence. Establishing a peer support system assisted most participants in strengthening their confidence. It was also the preparation provided by the ECT training programme for the operational role of ALS that boosted the confidence of graduates to practise. This theme represented positive aspects of the transition period, as experienced by the graduates.

Another dominant theme that emerged and overlapped across other codes, was resistance. The word was used by almost all participants in this study to describe their negative experiences regarding reception at the workplace. The participants reported experiencing resistance from EMS managers who may have felt threatened by the ECT graduates. A common perception by participants was that some managers thought ECTs were going to take over their work and replace them in management positions. This may be attributed to

the fact that during ECT training inception, the majority of station managers and shift supervisors held only an AEA qualification. Most of the resistance participants experienced was from their colleagues at an operational level, again particularly those who were AEA qualified and had been regarded as the highest qualified EMS officers in the province.

Participants reported a lack of clarity regarding their roles and responsibilities and found that they had to often explain their role and scope of practice to various stakeholders. They attributed this to their qualification being relatively new and that EMS managers possessed a lower AEA qualification. This resulted in graduates not being equipped with the required tools and being underutilised in operational deployments. The participants also indicated that in some respect, they were not recognised as ALS but rather treated as lower AEA officials. Participants indicated that junior colleagues would not call them for backup to assist with patients in critical conditions that require advanced life support interventions. These findings suggest that the transition period fractured the solid professional identity developed by ECTs after their training years. This poses a high level of risk to graduates of being exposed as incompetent and subsequently, reducing their credibility; thereby negatively affecting the quality of care provided to the communities they serve.

As resistance emerged as a dominant theme in this study, it is also worth noting that various measures had been implemented to counter this negative experience. The college had implemented activities to create awareness amongst staff and management regarding the need to professionalise the industry. The in-service training offered by ECTs to colleagues during their shifts contributed to overcoming the resistance. This assisted in clarifying the roles and responsibilities and winning over the trust and confidence of junior staff members. It is through in-service training that advocacy to professionalise the EMS service gained momentum and that other categories of staff started accepting ECTs in the interest of patient care and service delivery.

4.3 LIMITATIONS OF THE STUDY

The main limitation of this study is that this research was conducted involving ECTs trained and employed by the Department of Health in the North-West province only. Accordingly, the findings of this study reveal only the experiences of North-West ECTs, thus limiting the generalisability of the findings of this study. The lived experiences of ECT graduates in other provinces or the military were not investigated, thereby offering opportunities for other future research studies to share similar experiences to corroborate or test the findings of

this study.

A second limitation was that the ECT programme was phased out during this study, with the last offering ending in 2019. However, the findings and recommendations presented herein may serve as a valuable guide for stakeholders in emergency care education and practice during the implementation of the newly adopted three-tiered ECQF, promulgated by the National Emergency Care Education and Training (NECET) Policy.

4.4 CONCLUDING REMARKS

The introduction of a mid-level worker programme as part of the pedagogy in formal emergency medical care education and training has revolutionised the delivery of the service within operations. The ECT programme became the vehicle through which more graduates with broader and deeper foundational and emergency care knowledge were produced, registrable with HPCSA as independent ALS providers. These graduates were intended to man the majority of EMS ambulances and attend to most emergency cases, where other higher categories of ALS skills considered to be scarce are not available. The content of the programme and registered scope of practice rendered ECTs to be ideal for rural areas, such as the North-West province where it seems difficult to retain scarce and specialised healthcare workers.

The main objective of this study was to explore the lived experiences of mid-level worker ECT graduates as they integrate into EMS operations. Although the NQF 5 ECT programme has been phased out and replaced by an NQF 6 Diploma in Emergency Medical Care, the findings and recommendations of this study remain relevant to provide insight to all relevant stakeholders within emergency medical education and operations regarding graduates' transition experiences. This also creates further research opportunities as the newly adopted 3-tiered ECQF is implemented to broaden the body of knowledge on this topic.

In conclusion, the lived experiences of ECT graduates during their transition into the EMS workplace environment, as described in this study, highlights the fact that poor workplace readiness, oppression and hostile behaviours are some of the challenges mid-level graduate paramedics may encounter in the South African context. Therefore, it suggests that more needs to be done by stakeholders in emergency care education and operations to enhance the transition of new generation graduate paramedics into the workplace environment and change this into a positive experience. Finally, this highlights the need for a structured

mentorship programme to support newly graduated paramedics as they assume the role of ALS in the workplace.

"Looking at the past must only be a means of understanding more clearly what and who they are so that they can more wisely build the future."

(Paulo Freire, Pedagogy of the Oppressed)

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APPENDICES

- Appendix A: Letter to departmental research committee to request permission to execute the study.
- Appendix B: Letter requesting participants to take part in the focus group.
- Appendix C: Letter to obtain consent from participants.
- Appendix D: Participants' signup forms.
- Appendix E: Signed informed consent forms.
- Appendix F: Ethics approval extension.
- Appendix G: Focus group discussion transcripts.
- Appendix H: Atlas.ti 8.3 codes.
- Appendix I: Australasian Journal of Paramedicine – Journal submission guidelines.
- Appendix J: Originality (Turnitin) report

Letter to departmental research committee to request permission to execute the study

04 STEGMAN CRESCENT

NESERHOF

KLERKSDORP

2571

24 JUNE 2019

Research Committee Coordinator

Private Bag X2068

C/O Sekano & 1st Street

North West Department of Health

Mahikeng

2735

Dear Mrs. N. Mangonyane,

PROJECT TITLE: THE LIVED EXPERIENCES OF EMERGENCY CARE TECHNICIAN GRADUATES IN THE NORTH WEST DEPARTMENT OF HEALTH.

I am a registered student with the University of Free State (UFS), Division of Health Sciences Education for a Masters' Degree in Health Professions Education (HPE). I am in the process of conducting a research study as part of my course requirements.

The study involves collection of data through the use of focus group interviews with Emergency Care Technicians (ECTs) that were trained by the Department of Health and were appointed in the employ of Emergency Medical Services within the Districts. The research study will be approved by the UFS' Health Science Research Ethics Committee. The aim of the study is to explore the lived experiences of ECT graduates in the Department of Health. The results of this study will be made available to yourself as well as senior management of your organisation.

This letter serves to obtain permission to conduct this study.

Please do not hesitate to contact me for further information regarding this matter.

Yours faithfully,



Arthur Malgas

dallito911@gmail.com

083 756 4424

Letter requesting participants to take part in the focus group

24 JUNE 2019

TO: ALL EMERGENCY CARE TECHNICIANS

North West Department of Health

Mahikeng

2735

Dear Sir/Madam,

PROJECT TITLE: THE LIVED EXPERIENCES OF EMERGENCY CARE TECHNICIAN GRADUATES IN THE NORTH WEST DEPARTMENT OF HEALTH.

I am a registered student with the University of Free State (UFS), Division of Health Sciences Education for a Masters' Degree in Health Professions Education (HPE). I am in the process of conducting a research study as part of my course requirements.

The study involves collection of data through the use of focus group interviews with Emergency Care Technicians (ECTs) that were trained by the Department of Health and were appointed in the employ of Emergency Medical Services within the Districts. The research study will be approved by the UFS' Health Science Research Ethics Committee. The aim of the study is to explore the lived experiences of ECT graduates in the Department of Health. The results of this study will be made available to yourself as well as senior management of your organisation.

This letter serves to invite you to participate in the research study. Your participation will be on voluntary basis. Names will not be used and confidentiality is guaranteed as you will be assigned a participant number. You will be allowed to withdraw at any point if you do not want to continue with the study. **The discussion will last for an hour and half (90minutes) at most.** Should you wish to participate, kindly fill in the Participant Sign-up Form attached herewith and return it to the email address/fax provided below.

Please do not hesitate to contact me for further information regarding this matter.

Yours faithfully,



Arthur Malgas

Email: dallito911@gmail.com

Cell: 083 756 4424

Fax: 018 473 0319

PARTICIPANT SIGN UP FORM

If you wish to take part in the research conducted by Arthur Malgas, entitled "The lived experiences of Emergency Care Technician graduates in the North West Department of Health."

Please complete the section below with your personal details and send it back to the researcher by email or fax:

FULL NAMES: _____
HIGHEST EMS QUALIFICATION: _____
YEAR OBTAINED: _____
TRAINING INSTITUTION: _____
EMPLOYER POST GRADUATING: _____
CURRENT POSITION HELD: _____
PERMANENT OR CONTRACT? _____
CONTACT NUMBER/S: _____ / _____
EMAIL ADDRESS: _____

Signature: _____

Date: _____

Kindly return this form via email to dallito911@gmail.com or by fax to (018) 473 0319.

Thank you.

Letter to obtain consent from participants**APPENDIX C****PARTICIPANT INFORMATION AND CONSENT FORM**

I, Arthur Malgas am currently registered with the University of Free State for a Masters' Degree in Health Professions Education. I am currently conducting a study about the lived experiences of Emergency Care Technician graduates in the North West Department of Health. The researcher is asking for your assistance to participate in focus group interviews. Your participation will be on voluntary basis.

The focus group interviews will not be used as an assessment tool; it will neither be graded, nor will it be used in any performance appraisals. Names will not be used in the final research report, and confidentiality is guaranteed as you will be assigned a participant number. You will be allowed to withdraw at any point if you do not want to continue with the study without any form of penalties. The discussion will last for an hour and half (90minutes) at most.

The researcher would kindly appreciate your participation in this study as the outcomes may assist in informing programme design, curriculum development and implementation of future programmes offered. Please note that you will not be remunerated for participating in this study.

For further information please feel free to contact the researcher or the supervisor on the following contacts:

A. Malgas: 083 756 4424
dallito911@gmail.com

Dr J. Bezuidenhout: (Supervisor): (051) 401 7772
BezuidJ@ufs.ac.za

CONSENT FORM

If you wish to take part in the research conducted by Arthur Malgas, entitled “**The lived experiences of Emergency Care Technician graduates in the North West Department of Health.**”

Please complete the form below.

I..... (Name) voluntarily agree to take part in the focus group interview for this study entitled “The lived experiences of Emergency Care Technician graduates in the North West Department of Health.” The study has been explained to me and I have had the opportunity to ask questions related to the study. I acknowledged that I will not be remunerated for participating in this study.

Signature.....

Date.....

For further information please feel free to contact any of the researchers or the supervisor on the following contacts:


A. Malgas: 083 756 4424
dallito911@gmail.com

Dr J. Bezuidenhout: (Supervisor): (051) 401 7772
BezuidJ@ufs.ac.za

Participants' signup forms

Signed informed consent forms

Ethics approval extension

<p>UNIVERSITY OF THE FREE STATE UNIVERSITEIT VAN DIE VRYSTAAT YUNIVESITHI YA FREISTATA</p>		<p>UFS·UV HEALTH SCIENCES GESONDHEIDSWETENSKAPPE</p>
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Health Sciences Research Ethics Committee

12-Nov-2019

Dear Mr Arthur Malgas

Ethics Clearance: **THE LIVED EXPERIENCES OF EMERGENCY CARE TECHNICIAN GRADUATES IN THE NORTH WEST DEPARTMENT OF HEALTH**

Principal Investigator: **Mr Arthur Malgas**

Department: **Office of the Dean: Health Sciences Department (Bloemfontein Campus)**

APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is: **UFS-HSD2019/1552/2611**

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.


A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.



Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely



Dr. SM Le Grange
Chair : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za
IRB 00006240; REC 230408-011; IORG0005187; FWA00012784
Block D, Dean's Division, Room D104 | P.O. Box/Posbus 339 (Internal Post Box G40) | Bloemfontein 9300 | South Africa

Focus group discussion transcripts

FOCUS GROUP 1

***Introduction of the researcher – Mr. Malgas
Welcoming and briefing******What is your experience with regard to the transition from ECT training into the workplace?*****Participant no 05:**

When I finished my studies as an ECT, I started at the station. Most of the workforce was intermediate life support practitioners (AEAs), so there was a lot of resistance because they felt like management listened to me more often because I was regarded as an advanced life support practitioner. So everything was hard, they had a lot of resistance against me – some did not even want to work with me because they felt like I was exposing them by doing patient care, but they did not realize that I was just helping them to strengthen their practice as intermediate life support practitioners?

Participant no 01:

As a student, especially if you come to do advanced courses, as a BAA, it was not easy – it was challenging – but we adapted with time. The lecturers were really accommodating – I think it's because we were guinea pigs. The welcoming at the workplace, It was not as smooth as we expected. There was a lot of resistance and especially for us it

was for us as the first group of ECT, people did not know what the meaning of ECT was – where it was coming from or where it was going – some in management level thought that we were going to take over their work and there was also were resistance on that level, but most resistance was on operational level – people, they would feel like you want to change them from what they used to do in a day and they were not really accommodative until they started understanding where the profession is going and why there must be other qualifications.

Participant no 02:

We as a first group of the ECT as the school leavers, it was very challenging for me being at the college again because I did not know any of the courses (I had no BAA course) and I was part of the 1st group being called "the school leavers". At first I thought it's going to be a thing that I would not be able to do, but the College, at least the instructors, the principal, the management – they were there for us. So we had to cope and at the end of the day we qualified.

Then the challenge again came at the station. It was like – there was those "old guys" who did the old courses and still maybe adapting to the situation as a BAA or ILS (AEA) – me, I come as a school leaver, but at the end of the day, they did understand. You can have a qualification without having an information of BAA or AEA, because at the end of the day we did it as 'school leavers' but it was a

challenge for them to adapt to us in that we ALS that are from nowhere without having any background because we are from nowhere, not knowing anything without any EMS background. But it was merely 2-3 months as a challenge, meaning that people don't accept you by people who were there for a long time, but they came back. They came to us and then we had those classes – maybe the in-service training and then they accepted that we are here to help them and that's what we did when they came back and that's how we engaged with them to show them what we've learned and we can have more information to improve our patient treatment and all that. The in-service training was really helpful for us, because the BAA and ILS's, they have more experiences on the road outside and how to treat the patient and all that, and we did not have that. We have the theory from school but we did not have much practical work, but that's where we came together, do all those in-service training, it helped us a lot. Till today, at least it does show that we do good and that and BLS and ILS can come and ask for that and if we work together, at least we can have better patient care for both of us.

What is the "school leavers" that you told us about?**Participant no 02:**

The school leaver programme, it's like we were the 1st group of the ECTs not having BLS or ILS background. We did not have any EMS background.

I did not have any BAAwe were regarded as if just from school, then we went to do the ECT for the 1st time. Like not the in-service guys that were from the station and they had the qualification, like the BAA and ILSs – so we were like we were from school, even at that time we were not from school from Gr 12 or what, just because we did not have any EMS background

So how did that affect, because as a ECT you qualify as an advanced life support – were there specific problems with the fact that you come out as a clinical snr person, with colleagues that are more experienced or did it not have a relation to the fact that you are actually advanced life support

Participant no 02:

Ja, we had challenges like we are school leavers – we know nothing about EMS – really we did not have that much information – but at the College they told us about BLS and ILS – what it is and how to go about it working with the patient and all that. But when coming to the station, the other ones ILS were the ones who were most advanced at that time. I am coming as a school leaver telling them what to do, they didn't take it right at first. But those in-service trainees, they were the ones that helped us to overcome our challenges. Because resistance was too much, it doesn't mean we are ECT we can do it. But with the in-service training and the support from manager at the time it helped us a lot. We adapted fast knowing that it is not for us but for the new course of treatment for the patient.

Participant no 03:

I am also an ECT school leaver. One of the challenges as a school leaver, it was that it was a lot of intimidation in the beginning. People were thinking we are still young , and it was challenging, as young as you are, and then you come work with an older person, and you are there for the benefit of the patient, but the person will say that you are young and that they "I will not take instructions from you". That was one of the challenging things. Another challenging thing was whereby you as an ECT were expected to do all the calls, all emergency calls, now whenever there is a call, they would say – no, the ECT's are there, they will do it – so that was one of the challenges in the beginning.

So let me just try and understand what you were saying. You said that for all the calls, the expectation would be that the ECT would be the one at all times with the patient – irrespective of the priority or condition of the patient.

Participant no 03:

I will be specific at my shift. In my shift we had only one ECT by then. Due to certain circumstances, the ECT when I arrived at the station was in the office....and at a shift level there were only AEAS... I was the only ECT at that level... so each challenging call that was given to the shift, it was given to the ECT. So it was mostly challenging yes.

Participant no 02:

So I wanted to add onto this issue of participant no

3. It was about the types of call – it was a challenge – like each and every call i.e. like there would be a primary call and secondary calls, and maybe there was convulsion, collapse, even if they don't ask – what kind of call, they did not prioritise as such – just because you are an ECT you are and ALS, you would do that call. If they say that there is a convulsions, you go – collapse, you go – they did not ask – they just say it's your call. You have the qualification, you can do it.

Participant no 04:

Initially when we started to go back to the stations, it was tense – even to our managers – like participant 5 made it clear that most of the workforce in the system is the ILS by then. Also the managers would find that they are an ILS and they were starting to have that fear, maybe, that we are here to take their positions. But in my station, by then, we were two who were qualified ECTs and who were on the trend setters, it was the first group to qualify. And then we bring them to the point that we are here to assist them for the benefit of the patient that is why we equipped ourselves medically, clinically so. And then also the in-service training was having a good impact because they end up tolerating that there is a change in the system, that the ALS is there and the ECT, they are there to improve the service delivery and the patient care. And then we end up having good relations, but like me and my colleague by then, we differ because he was having more passion on rescue as where I am having more passion on medical side. So, even though we qualified on ECT and we have done rescue, both, but also my passion was on medical

side. We progressed a lot and then there was a serious impact that was done.

How would you describe the preparation that the training gave you compared to what the role of the ECT in the operational environment required? How would you describe how the training prepared you?

Participant no 01:

I think the training did prepare us well for the road, for operational, especially that the training prepared us broadly so – looking at the fundamentals modules that the ECT is having. After ECT we could assist a lot in different aspect, including things like communication in the station self, in the management, things like treating patients that are not emergency patient, to safe a patient like an HIV related patient. The training did prepare us broadly because in the past in the previous courses, we were taught only about the patient only. Nothing about how we communicate to the community – how to communicate with the patient – how to conduct yourself, but ECT training was brought to prepare us for each and every situation we come across. Including the advanced clinical skills that we learned from ECT, it was really worth it and brought a difference into our province.

Participant no 03:

It taught us more about self-discipline and with that self-discipline, we looked at the fundamentals that they have done whereby you respect the next culture, the ethics, the beliefs of the next individual

and yet again coming to the implementation at the station, it was not rocket-science to deal with it because you know the fundamentals. You know you have been groomed in self-discipline. And also your respect towards the work that you do. So for me it was more of a self-discipline.

Participant no 04:

The training took the mentality of being upskilled. You end up thinking laterally because you were taught many things like participant 1 mentioned. Those fundamentals and modules, HIV and the EMS structure modules– the EMS structure end up putting people from the school leaver point of view, putting them on-board – to have those hierarchy, how it works and it end up training them to see where they fit and also giving our colleagues a thorough training that they are in the system - they are also helping a lot.

Participant no 02:

I would say the ECT – it prepared me a lot as we did lots of fundamentals and as was said, we were the first group of school leavers - we learned a lot, like the ethics, the EMS structure, all that and the patient skills in most of the modules that they gave us. They prepared me for when I come back to the station, it was like it was something that I know. I didn't have any struggle – how to treat a patient – how to have confidence and all that and maybe how to deal with community and a patient who is difficult and all of that prepared me a lot. Even if there was more challenges of how to handle the situation if you come across a situation like you have a difficult

patient. But you will go back, knowing how did they train you – how you need to present yourself in front of the patient and in front of your colleague and how to take care of such situations. It helped a lot.

The next question on reception by colleagues when you return or allocated to a new station....couple of the participants did cover this in question 1 already.

How was your confidence on how to go out on a call, especially now with those cases where you were saying that you were sent out mostly on challenging cases of higher priority calls. How was your confidence to treat and attend to all those calls?

Participant no 02:

It was challenging because, yes you know what you were taught at school, but then to meet a live patient, especially when they say it was a collapse, sho! You will have that thing of how am I going to treat a patient, but knowing you know what you are going to do there. But you have that fear of thinking "I am going to do something wrong" or "I am not going to do things right" or something, it was challenging to go to those calls. Like maybe how to treat a patient – you can do that and coming to drugs again, you going to ask – you are going to ask yourself "how am I going to give it" – you are still remembering it but when you are on-route to that call of a collapse, you have that fear and there is so many questions coming and you don't want to go wrong and you want to do the right thing, But as time goes on, you do the collapse today and

tomorrow, the convulsions on the other day and maybe when you come back from a call, I had one of my colleagues – we were both school leavers – we were on the same crew / shift – we had this thing of, when I come back from a call, we would discuss the call, I will tell him what I did wrong or what I did, and he would tell me “no, you could have done this or that” – that is how we groomed each other and bring back self-confidence. We have that session after each and every call. Debriefing calls. That maybe it was challenging or maybe I did not have much confidence in it.

Participant 01:

Confident, it was not easy. Especially for me, because I didn't have a lot of exposure on the road. I was mostly in the control room before I came for ECT. But I had a colleague who made it easy for me who was working as a station manager and also in passion for patient that will always after hours go on calls for me and show me how to do, sometimes to go there and just watch me do things and then he would correct me - he says “No, man, what do you think?” “How can you do it better” and we are calling each other, mentoring each other, like when he goes for transfer, you will always tell me that I'm going for transfer. They see this and this. And me I'll be in the comfort zone. And he is with a patient, ask me keep your phone on standby for me. And we will consult each other and view the patient and says, “Ah, I'm seeing this” “I'm not sure where to start” “What do you think? Because I'm thinking this way”. So it was much easier to work hand in hand with their colleague because we could share the ideas and after the call, we would still meet and talk about that call or “How did it went” and “where do

you think you did good” “Where do you think you did bad” and “what was the result from the doctor” and we still do follow ups with the patient and learn more about it. And that at least helped me to build my confidence when it comes to treatment.

Participant 04:

Firstly, it started as the fear of the unknown because there will be some additional skills, capabilities on your scope by then. But, like, by the time when I started as an ECT, I was an intermediate so it boosted my confidence somehow, somehow, even though we, who qualified as the first group, we used to communicate or to contact each other if I had a challenging call I would contact one of my colleague and talk about the call that I had and I did 123 and it was so challenging and then he will give me his opinion or his feedback on that what maybe I've done wrong or I've done right so that it was boosting also my self-esteem and my confidence was growing gradually like so and then like I said, that fear of unknown it was now cut off, it was breaking down so we ended up having that confidence instead.

Message I'm getting – similar system of peer consultation or mentor. Would it have helped if it was a structured programme from employer? Allocated a senior person for mentoring?

Participant 01:

Yeah, I think when we qualified by then we were told that we need to most of our drugs we use and skills we had to consult. But unfortunately we didn't

have a lot of people to consult with and most of it with one person that we had to consult with will not always be available. But I think if this was a structured thing from the department that says as a newly qualified like other careers, when you qualify, you get internships, you get those programs, I think it will make things much easier. Your road will be much easier to run on when you're having somebody who is always watching over your shoulder to see whether you're doing the right thing and guiding you and assist you on that and knowing that I can rely on this person, not just relying on a random everyone on your same level to assist you with other things. I think a structured, a mentorship for newly qualified especially for new qualifications like we, it was for us, it will assist a lot in bringing a lot of support to newly-qualified people and confidence will build up quicker and benefit to the patient.

This may be the last question and can you just reflect on how ready was the workplace in terms of allowing to practise your scope fully with confidence..

Participant 02:

I will say when I come to the station, I will say my station was ready for an ALS, an ECT, because we didn't struggle to have medication, dry dispensary, equipment and all that. At our station there was nothing that we lacked, so it made our patient treatment easy and for yourself to have self-confidence because by that time we have even electrical equipment, was good. By then even if when I go to a call maybe a cardiac patient, they

don't have a problem of I don't have an ECG or I don't have drugs and all that. The station was well prepared for me to do my skills and to perform all the duties well. It was not a challenge as such. It was good from the management side. Everything was fine.

Participant 01:

Unfortunately, in our case, it was different. Because I think we were the first group of ECT, nothing was prepared for us. We had to, every now and then, refer back to the college and say that we're struggling with 123 and then they have to intervene and advise management on what we need, what needs to be bought – why this. All the managers that were there were most of them were ILSs, maybe few if not one, were advanced life support, where they will understand what is needed, what equipment is needed for advanced life support. But we did struggle, I think for the six months if not more than that. Where we had to, every now and then, ask even the other services like hospitals, they won't understand - Okay, why this person will want morphine. When we as doctors, we can only give Voltaren? Why do you want this? Why do you want ECG? Why do you want the response vehicle? It was really challenging for us because we had to explain every day why I need this; why I need a drug bag; why I must carry this bag; So for most of the ECTs that we studied with, we're talking the same language except for few maybe some district where you have a manager that is also coming from ECT, who will understand and push things for you to for the service to be rendered. But as a new qualification I think that is what is happening in

most cases where you come in and do not understand why you need this and why you want things - they think that you are being impossible – “You are just trying to show off” all those things.

if you don't mind participant number one do you do you think or are you aware of any information or awareness and that was shared with station management and other departmental staff before maybe the first graduates were released into the system

There was some consultations done even before the course can start where we told what is this course, what is its intentions and why but most of us, we didn't know why, we do not understand why you will discontinue a four months course that would produce so much with this course that is going to bring less, and some of us who went to just to going see whether it's going to work, when as I say you're wasting your time, why are you going in there, but in the process I know that college kept on trying to make awareness in the stations with management to make them aware that this qualification, this is what is needed of them, start preparing for them but I think most of the people they were just being negative and reluctant to say, no, this will not work. You don't see it working. We are used to – you know, change is difficult - it's not easy just to change. So people always tell us to the short courses and they didn't see it working and they felt like the waste of time, is a waste of money to invest in something that you don't think that it will work, but I think management, they've tried to educate people though you can take a horse to the water, you cannot force it to drink.

Participant 04:

In essence, through that there was a negative receptions, especially when coming to the workplace readiness, it was not there because as participant 01 was highlighting her points that the stations were not ready like the station I was working at. They were not ready when we requested some of the stuff, there was some tension or resistance from the manager saying we're asking a lot and then why the college didn't notify them first on the stuff that they were supposed to buy. So, things were not procured in time and we were struggling a lot. So, the work place readiness, it was not conducive by then.

Any last thought something you're thinking about that you want to add?

Nothing.

The end

FOCUS GROUP 2

Good afternoon, colleagues, thank you for your time for attending this focus group interview. My name is Arthur Malgas and I am a student registered with UFS, am conducting research on the lived experiences of ECT Graduates in the North West Department of Health. Thanks for your time. And please note in front of you, there's a participant number when it's your turn to speak, and you will just identify yourself with your participant number. And also note that with the informed consent that I explained earlier at anytime you are more than welcome to withdraw, if you want to withdraw from this research, and from this focus group, so colleagues, I will, immediately start, I'm going to ask you some few questions. We'll go through them one by one, it's not a lot. It's five questions. And please feel free to share and respond to the questions. And you will just indicate if you want to speak

For the first question, can you just share with me your experience of that transition period from the ECT training, starting into the operational environment working as an ECT.

Participant 05:

When I finished my studies, I'm currently assisting with the provincial office. We do the duties of the operational manager, but I'm actually if I'm correct on the substantive station manager, where I'm from, and the other thing is that so, when I got back from my..., when I finished my studies, my two year studies, I had where I come from, where I was

working, I had already people that were in the first group and the second group of the ECTs that qualified as emergency care technicians. And those people I had, we had already through them prepared a lot of things, you know, like we the medications which is at the level of the qualification, the equipment. And also we had already prepared the ground for them to be accepted as the advanced life support practitioners because at that time, there was a confusion that they were not at the level of advanced life support.

So, when I finished myself, that the ground was already ripe, it was just that one was excited. And we have a new qualification. So one used to instead of concentrating on that mistake, the first one would want to work with a qualified already qualified ECT at that time. So I was kind of excited. And also is that you know, when you are from the training like especially in the emergency care setting, we're excited to have new skill set of skills, you are excited that you will be carrying medication that never carried by most of the people in the EMS industry. So So and one felt very special at that particular time. So yeah, so So yeah, I was I was I really felt very proud. And actually, for me, it was easy because we had already ripen the environment for those for the ECT intending to operate in that setting.

Thanks, colleagues, its fine. We do not have to identify yourself even with your current responsibilities. But can I just check the participant 5? You saying at the time you went back to the station, were already went into administrative management office?

Yes.

Okay. So yeah, so I was I was already a manager at that time, I think not I think I know I was a manager. So, but because of the excitement one was most of the time working on the road, so sort of to practise and to see if one knew the skills that he had learned from the training institution.

Okay, thanks. Thanks. Any other participant?

Participant 03:

After qualifying was absorbed by EMS. And it is much of what - it had such impact because remember, we train at Klerksdorp, which is more urban. And now I had to switch to Zeerust, which is more rural. And one of the other things that I can mention is that I was one of those who were the so called school leavers. So I had no medical background. So what I knew was what we did, in the worst case, in the simulations, apart from when we had to do our practicals at the college, so now reality hit, I can say I was lied to because despite the fact that some of the colleagues had attitude against the school leavers, you know, they were ready for us and all that, because they had believed that we came to take the opportunities and that we had a manager there was somehow prepared to welcome us to a point of getting uniform, I remember I got in, by the time they said, the budget for uniform was exhausted and things like that. So he went out of his way to make sure that we get proper uniform. Coming to the actual work, like I said, we couldn't take from dummies to real patients, it was more of a shock.

You had to go in 100%. And there would be times where I would say I had to question myself, is this the right thing, that's when me and some of my classmates at the college, we had a group 'call a maaitjie' in case you were not that sure of what to do. And then you would refer and as I said, with Zeerust – it's a rural case - it was not most of the time that we would get priority one patient, most of the time it would be, from clinic to hospital, from hospital to hospital, it was very rare that you'd get a patient that you would initiate treatment, manage and transport to the hospital. So when you had such patient, it would be after a very long while. So I would say the transition was not that smooth. But it was something that I was willing to accept. Actually, I can say I accepted because this is what I had to do. So that's, that's all I can say, you participate.

Okay, thank you for that. But I wanted to just ask on that concept of school leavers. Can you briefly explain what does school leavers mean?

Okay, um, when I when I got to the college, when was it 2010. I had learned that the group 1, group 2, group 3, they were actually the students that were already employed by the Department of Health, our BAAs and AEAs, and then they went there to train for ECT. Now with group 4, I don't know what was the story, but it ended there in a way that they had to select recruit people from in a lack of a better word, with different walks of life, like you get your people who are working at Jet and some were taxi drivers and so forth. So It's basically people who had no background as a paramedic, and then I was in group 6. I was one of their so called

school leavers.

Participant 01

I'm actually going to add more on what participant 3 said. Not only was I her class mate, but we were employed at the same time, but I got directly employed or let me say, absorbed into Mafikeng.

So basically, my town is still a bit older, if you will notice much, it's not a big town, we cannot compare it to where we started. And when we did our practicals so I'm adding on what she has already said. I would say our predecessors did not plough enough like participant 5 said he found already the ground prepared for ECT and he was just flowing when he got there and his successors has also received that kind of thing. With Mafikeng it was a bit different whereby you get that as ECTs we are called by AEA or ILS, did not like ECTs.

They would call us for vital signs, they would call us names. So like I was also a school leaver. It was a shock to me, why do we look different? Why were we treated different to these colleagues, until we understand that these two qualifications are actually at loggerheads since. Well, this has been the highest qualification. Now, ECT is

And then it was, again because like participant number 5 says, we're using incredibly high schedule medication or should I say pharmaceutical agents - Doctors could not believe their eyes and he just did not believe our PRFs when we submit - nurses did not even believe that we can go around carrying morphine when their morphine is locked by 2-3

keys. And then I can carry them in a drug bag, in my ambulance and in my car. So it was it was not 100% full welcome. It was difficult to manage with these institutions – I think the first three, four years was not really easy. And participant number 5, I liked what he said that most of the predecessors went into being supervisors, went into the managers and they did not represent the qualification fully at the ground level. So when it came to us at a later stage, we found that it struck me we needed to, to lift the banner - to lift the name of ECT. At current, I would say the support for ECT has dropped a lot.

The name ECTs weight that it had when I started has depreciated a lot, we are still fully 100% at competition with AEA - not that I'm undermining them. But you must remember they've only done a four-month course and we've been to this very long technician course for two years. But there is no recognition. There is no - we don't feel anything above them. We don't feel like anything above them. Remuneration-wise levels, recognition at HR, even they don't even understand why would you want to be a bit different or better than ILS and you should explain to them that the treatment that you give, the management that you give, the drugs that you will give will mean nothing to them. So basically. It is, how shall I say, this is going grey to disappear, unless something is really done about it. I really love ECT. I really love being a medical official, paramedic and motivation wise, it is dying. It is dying and we need resuscitation. We need CPR very fast, ECT CPR as soon as possible.

Thanks. Ah, maybe before can I just check on the

issue of remuneration and recognition.

ECT and ILS – there is no difference. It is the same thing. There's no difference.

Everything is the same. Okay, despite the job now, the work what you do.

Participant 02

I was fortunate enough when I went to the college, I was already employed by the department as a shift leader. So I went there for my two years, I came back in 2010. On that group that went that graduated 2010, for Mafikeng there was the manager and two supervisors. So the people that are working on the ground, there was limited numbers like the previous participant said, we came back. Yeah, it was a struggle. Money wise, equipment. The treatment that we getting, everything, it was like we are aliens, we don't belong with the others. And whenever there's something positive that needs to be said about the ECTs, it was never said. Always they would, they would want to say bad things.

To us ECT, it is as if we were painted in a different colour than the others. But eish, Mafikeng, it's a very, very difficult place to work. Things are not changing instead of becoming better, they becoming worse. Yeah, people ended up not going for training for ECTs - we tend to be discouraged, we're gonna go there for two years, we come back. The person that I was with on the salary scale, is going to be more than getting more than me when I come back. So it's no use for us going there. So

that's the thing that was happening and that it's still happening. So we need something to show that you were trained, you do more skills than the others. You can do better. So the remuneration is the big thing. On the ECTs. That's putting them down.

Participant 4

Is pitiful. Okay. I don't know it is that.

But I was the first ECT from the 1st group – it was not easy for me. Because all the personnel at the station were looking at us. They were expecting so much of us. But I was not afraid because I did know what I'm taught. And I'm going to do what I'm taught from my college. I worked so hard, but there was no equipment, enough equipment, especially the drugs, but at least within two to three months, demands to give out the drugs. Then I started to work. And I used to work fine. Because I do the things that I was taught and but only the doctors at Casualty. They are the only one who realize that we can do distance from ALS as ECT and they were amazed. What are we doing? They think maybe its not the transfer ECT, how I manage a patient and even the control center. Most of the difficult calls, they gave to me because everything they say –she is from school, let her go to their call after call, even children and people were sleeping – it was not easy for me. Renumeration. They were so 3 or 4 ILSs, getting more than I was under the salary. But for so many years I hear is that after maybe after about 10 years, they just does better for me. But it's only because I like to treat the patient even though my supervisor can.

no thanks for that. So was it all calls or high priority

calls? Or any calls....

Whenever I am available - they used to call me, - even when I were at another call, then I said, no control, I am from the call, from the call three calls - where are the other ambulances - they say, I'm from school, and I can manage the patient. So I have to go there - I didn't sleep when I knock off - it was bad.

Can we move to question number 2?

Question number three – most of it was actually already addressed, but question number 2, How will you describe the preparation, that the training at the college gave you, compared to the role of a ECT that you had to do when you are now employed at operations? How would you describe it.

Participant number 5,

I think the training includes everything, whether you are going to operate in an urban area, or you're going to operate in a rural area, or you are going to operate under poor or rich area. So, the training was once was in such a manner that it would do to be able to operate in that under those circumstances, but naturally, your EMS training has got a composition of academic and physical training, so especially the ECT, because we, you know, we will do even the physical exercises and all those things. So we were in a way, the college was actually the scope of training was actually relevant to whatever you would come across outside there.

Yeah. So that's, physically mentally and emotionally.

As a participant, participant 01

yeah, I think it was fully and well researched, in terms of what they want to produce, in terms of coverage of Northwest, or should we say, South Africa, population and geographical locations. It covered almost everything. I think that question goes back a little bit to me, and participant 3 in terms of what we meant when we said, when we got deployed to rural areas, it says that the excitement and the challenge of using those incredible drugs on those MVAs, accidents and critical patients, here in rural areas - you just get maybe psyche one or two, you get one diabetes once a month and you kinda like have this urge of when can I get patients but usually put in a skill like that CPR. The challenges that you used to get at, what did you call it? Training or clinical practise - is what it was it was it was young, but in terms of preparation, ECT was well structured, was well researched and it covered everything, environmental had everything to do with the rural areas. Disaster had everything to do with mass reaction from us - so we can respond to anything in a job site when we are ECT and we can go to matches at the stadium. We can go to any kind of gathering festivals - we know how to manage any type of situation. So it was very well researched. I think. I haven't, because I didn't went for the B.Tech or anything up to this one, ECT is the best one in EMS as far as I'm concerned.

Participant 3,

In agreement with participant 05, he was right, the training at our college, - it covered everything. The

only thing as I said, referring to me being considered a school leaver. Now having to go back to the station and actually find your supervisor is less qualified than you, you'll find that your manager is less qualified than you. When you request some other equipment or medication, there's always those questions and with where I was absorbed, we had to order medication from the hospital. So both before you could actually get your resources, there will have to be these questions this and that and all that. But despite all that, the training, it was good.

So for question number 4. And like I said, most of you are registered that we've made your inputs mostly. But I wanted to ask you, how can you describe the reception by colleagues within EMS when you started practicing as an ECT. So if you have something to add, I know we've touched on it. But if anyone has anything to add, they can just say something to add.

Participant 02:

But the reaction that we got when we came back, it was not a good reaction from the colleagues that were not trained, they were scared of us that we're going to take everything in front of them, the opportunities that are coming. And if maybe there's a post for manager, they were not thinking that they will be able to participate in the interview to get the manager's post, just because there's an ECT they think automatically they are the manager, but as time went on, they kinda accepted it, okay, we are just AEAs and they are ECTs, so we'll compete. If we don't win, we'll go the other way to try to fight them.

It was not a nice welcome.

Participant 03,

When I started, I typically only had one ECT from group 01. Because those who were there to be absorbed from group 04, apparently they refused, saying Mafikeng is a very bad area.

So like I said before, the colleagues had expectations to a point like participant 04 said, every time you have a priority one patient, they expected us to go there, despite the distance because there's this other village from our base, it's 130 kilometers driving there and 130 kms driving back. You go there for priority one patient, you get to the base, you have to transport another one to MPH, the distance, you get tired. So we just had to sit down, strategize with them. We said how about now for each ambulance there is a BAC and ECT because even then there were way lesser AEAs. Then came the acting post when the supervisor had to go on leave. According to the qualifications, the ECT had to act - they had a problem and saying ECTs cannot act in supervisory positions because they are more qualified - they should be on the streets - them as BACs have to be in the office, help with admin and audit. And a very serious problem that I encountered because I was one of the college champions whereby we were required to do in-service training, you know, you're not even as a college champion but within that KPIs and all that, we had to offer in-service trainings, they would refuse point blank - "I'm going for lunch" " I don't have time for this"...blah, blah, blah, so you see, it was it was much of a challenge. Now I have to do

this with Mike I have to share this information but they refusing and do you write that on your own document to complain that my colleagues refused this or that? And they will be telling you, "you are just a little kid. You just got here. You cannot force me to do things that I don't want to do"

But with time they warmed up to this, and they started considering going to school and the environment changed – it's just that I am no longer with my initial sub district and I moved to Mafikeng. That's all I'm saying.

Participant 05:

With my, my experience as well. Like I indicated that I'm actually on the management level.

So, I had a lot of queries from my colleagues at that time saying that "how can we help them to get to some of the things", "how can we influence you know, this particular thing to help them". It was difficult because my experience is that and that's one thing that we are still experiencing even today and it was also a vision of the province at that time that encouraged all the supervisory team members and the managers to attend this type of training. So that it could help in transition and also it could, at the end, benefit the patient more. Because they felt that, you know, because they basically shared the information that was shared with me at that time when they required some medication and equipment, they would be ignored and they would not accept the experience. You know, in a way we tried to put some pressure and influence on this but it is really difficult to change a human being to

whatever it's actually of importance to the patient and the industry. But I think and I believe that with time, things will change. We just have to increase the numbers of those people that can influence.

Participant number 04:

As participant number 03 said, the in-service training - was a problem in our station. They say we think we are better. I was talking to them, they say "Who am I" and even in sports – and I like sports - I advise them to exercise so that you cannot have more of the gaining, because to carry the weight of the patient , I tried to attract them to sport so that these can be physically fit enough to deserve but they do refuses and now I'm the only one that is participating in sports. I even tried they said we are cooler, even this year.

Was it because, these things that you were introducing, feel they were rejected because you were ECTs or for any other reason? I think some of you who said similar things but for you just your opinions do you think it was because you are coming with them as an ECT or do you think there was any other reason?

I think sobecause like our colleagues said. While she was still at ILS or BLS everything was okay. Now he goes there and comes "now things change". Again, imagine with us as the new ones, it was one so basically, this qualification was the problem. It just needed strong ambassadors, which it maybe half of us managed to be and still going strong and like participant 03 says, some are starting to warm up to it. warm up to it. So as they are warming up

to it, they just needs us to raise the bar getting higher.

Yeah. And I also think that in it happens also in a lot of industries, except if it's done for profit purposes, when it's done for profit purpose, it gets done as quick as possible. I think because we are service delivery based, or I think it's a question of you are a manager, you are used to doing 123. Now, this person has got a lot on the scope of practice, then they bring all this type of discipline of work on you again to reorganize and, get this and that which we never did before. And also things of that you do not understand because you even you never came across. I think that's why that resistance also came from that you are adding a job on me by adding work on me. And some naturally, I think it happens with many people.

It's the question of, you know, that natural jealousy, I think it's also that element of jealousy. It's also I think that it's like you are giving some, some instruction and, it's like you are imposing things that are not supposed to be happening here. So I think it's that kind of thing.

I think if we if we can. And in every industry, and in every person's life, if we get rid of such things, life would be better, it would be lived better. Because then everyone will just say that so you achieve a lot.

Participant 03:

okay. Remember with EC T, there's three basic rescue modules. So with where I was initially absorbed, I don't know if the rejection was because

we are school leavers. We know nothing. Or people just hate the qualification. Was it because we are women, because I got to learn that more of the ECT's that side with females. One incident, I had to be very personal with a male colleague who's older than me, because we got dispatched to an MVA and he firstly he got there late. And then he wanted to give me orders. I didn't want to be rude, telling him that he is more qualified than other people. But he pushed me and I ended up saying words, you understand? We left it at that. And then we went back to the station. A whole lot of things were said and he also said "he won't be taking orders from me as a woman." So I was left confused. And this is one person with whatever chances that came from the college I would inform - there's refresher. There's more to it than to, as he was one of the people that I would open the invite at to every time – so I don't know is this gender based.... This course, is it because it was very confusing, but we just had to move on.

Okay, now, thanks, colleagues. So we are left with two questions. So maybe we can move to question 4 before we run out of time. And question 4 question 4 question 4. I just wanted to check. Based on this, we're talking about what how do you feel as your confidence was like going now to work independently and start practicing a new scope of practice without anyone supervising?

Participant 05:

I think it's just natural and it's not an easy thing, just to you, you might have learned the skills, but and you know most of the things you know you do

it in theory and then you do practical and clinical practice but also time limitations. You want to do your practicals and have to finish them. So, when you finish, now you've got the skills and they are new skills and you've got this medication so even that is natural, I think it's natural that you, you, you suffer that kind of doubt to say "Am I doing the right thing" and all of this. I am lucky when I went off the training, then I went to the people I was already used to working with, and they already had the skills and practises for 2 years – so it was easy for me – I had already practised independently. I had an increase on my set of skills. So I had a jacked-up rate of confidence. Like my colleague was saying here, participant 3, that with a person who just came from school, it is difficult because they never practised anywhere, but with me because I was in the industry for a few years, it was kind of easy. One just had to get used to the skills and practise the skills and mastering the skills.

Participant 03:

I remember I had templates, and written everything there. I had the protocol written nicely – like we said before, we had a "call-a-maaitjie" group because you always second-guess your decision and you just want to be sure because there would be the council should anything go wrong. And it became more – it damped one's confidence – we did not have equipment, now came a time where you had to go toyou would be having a family telling you that machinethere's nothingand you had to tell the family that that person is no more...you keep on asking yourself, "what if I get a call and they tell me that the person was alive So that confidence

started with years and skills and finding my way around things – how to do things – not like from the College, the book, you know like you have your own tactics. I started gaining more confidence. And when this or that happens, this is how I go about it, but not doing nothing – ensuring that my patients gets what is rightful.

Interesting....Last question....Share....it is also partly covered....How ready was your place of employment in terms of allowing you to fully practise your scope and handle cases?

Participant 02:

Mafikeng was never ready. And still now, we are not ready. We don't have equipment. We don't have the resources that we need to perform our skills. It's a big challenge in Mafikeng.

Participant 01:

When I arrived, there were a couple of ECTs. Previous groups. But the equipment was ordered. The person who did the ordering, was a BLS. I approached my manager and then I explained to her that this person does not have an idea what these things are and how serious they are. They were handling them, mostly they were lying around and people without knowledge will even get R5000 – R10 000. My manager told me to take over there, for ordering for the ECTs. I took over. I really want to believe that I struck a good look...I think it was till end of late 2019. It's not easy to get them, but I was pushing it very hard. And yes, at the present moment, now that I'm not doing that, I am aware

that they are getting a really serious challenge because no one would stand up to the plate and take over that and they are basically working around it. So, like I said, ECTs – if we want us to be on the platform, just claim the platform. Let us not wait for anyone to pull us onto that platform – let us force ourselves into this. Remember, it is not for any ILS or BLS or BTech – we are ECTs. We have what we do for the patient. So if you can put it in your mind as the first thing that comes to you, you just find yourself flowing, you don't even know how you found yourself.... So if we let loose of the ropes, the building will collapse. But basically, I think if we as ECTs stand strong, we will make it.

Participant 05:

Lastly, my experience also as a manager, we have a lot of discrepancies. There are different standards. Others are doing 1-2-3, and others are doing 1-2-3-4-5-6. My experience is that we need – there is a need to standardise – everyone – we are different people – feelings will always not be the same. But at least some things must be common everywhere. We are not the same in the provinces. To make our lives easy as ECT practitioners, so that we are able to do the work – we need to bring some, the same standards in place. We are not.

Participant 03:

The sub-district was not ready for us. Remember I said, there was only one ECT – now when I got there, 4 of us were absorbed. But we had a manager that was very accommodating. Like he would go out of this way to ensure that whatever we needed to

practise with, he gets it for us. In a sense that, I remember he made me responsible for the ordering of drugs and some equipment, and that's when again I fought with the one ECT we had, bringing in the gender and age into it – but, as it went on, things started changing – like I said – the manager was very welcoming. And then we got to Mafikeng and then I understood that I had to buy my own HGT machine and now I had to buy saturation monitor – things that I did not have to use my own money to buy. So I can say Zeerust was not good, but the manager was okay. He was not an ECT, but he made sure that whatever the ECTs needed, he pushes for that with the sub-district.

The end.

FOCUS GROUP 3

Good morning, colleagues. Welcome to this focus group interview. My name is Arthur Malgas, a student registered with the University of the Free State, HPE. And thank you for coming to this group interview. The topic of my study is the LIVED EXPERIENCES OF EMERGENCY CARE TECHNICIAN GRADUATES IN THE NORTHWEST DEPARTMENT OF HEALTH.

Briefing by facilitator

Can you just tell us about your experience of the transition from ECT training into the workplace or the operational workplace that you were appointed or return to, your experience of that transition period from the ECT training into the workplace?

Participant 06:

I think I qualified in 2011 with too much expectation after qualifying as an ECT. I was so excited that after getting trained as an ECT, FIRST thing was what was in my mind was money - too much MONEY, my salary will be very good for an ECT, at operational level. I qualified that way and prior that 2010, it was too much for me as a student, especially when World Cup 2010 came. Especially that it comes in wintertime. And we were used so much in the world cup in North west, especially when the games at the Royal Bafokeng stadium. And during that time, I felt that this is too much for me. I even wanted to quit because we spent too much hours in the stadium and the problem actually, the world cup program took a lot of our

time and we even talked about the hours that the college will give us back or they will even pay us. they will pay us after World Cup but you didn't get anything like that. You will put in so many hours that some hours will be used for us to compete our ECT program then with ECT program itself after qualifying, then there were a lot of things in terms of the skill. There are some SKILLS that it seems as if whether are we on the same level with the CCA at operations.

There are some skills that were said, they will be added after we qualified in ECT. We expected a lot of added skills as an ECT, till to date.

So another thing one other things the advanced life support with ECT, CCA and ECP, I was confused whether I am falling under advanced life support, all of us CCA and ECPS. So we were just practicing the field – with some tension between our skills at operational level, especially between ECT and CCA, in terms of intubation, intubated patient, how the ECT has to behave in that situation and where should the CCA is also getting in there.

So, there was there was that tension with regard to the patient care and skill with regard to the level with CCA is deployed and that also. So, to date as an ECT, I feel like ECT are the greatest when coming to clinical experience, skills experience, just that we are still waiting to be updated with other required skills. So, that is dead currently. And also the other thing, there was the saying that it says ECTS will not be office based, they will only be operational level at the ambulances.

So, so for now, I can see that ECTs are attached to most of the position at the offices, that is one part more or less, and for me to agree with for an ECT to be in an ambulance, I will say we actually went there as there was an expectation to say we will be earning more, especially when coming to notch, ECT notch will be more than the station managers notch, especially that we will deliver more at operational levels. Thank you.

Okay, thank you for that input. Can I just clarify one thing you mentioned?

On upgraded or expected additional skills? What are you referring to? There was? Well, there will be some new skills will have to be introduced to the ECT capabilities? What are you referring too?

Yeah, there was a module we were expecting from the college. They will call it a transport module. I don't know what was included in that module? Yeah.

I don't know what is in that module, the transportation module? I don't know what was included in there. But we expecting those tools to be implemented, but we have been waiting for three years. Expecting that. Thank you.

Participant number 05:

Before I can say whatever they want to say some of us I just wanted add on to one thing that he said to me about upgrading the scope of practice of the ECT. I had a discussion this morning with my manager asking him if he's aware about the new

CPGS - fortunately enough, like I said I was in the FS and the guys that I met, it was proposed by the HPCSA – 2 years ago – the skills for ECT ECPs etc. So. It looks like a lot of people are not aware of that here at all. I don't know why. And I myself went through the three I was trained on skills like surgical cric, and some obstetrics skills. And a few drugs like..... I think it was 5 drugs.

And the article came out from HPCSA recently that those, they were not yet signed off. And the HPCSA said they will sign them off at a later stage and then I saw that correspondence from HPCSA recently, and it said the skills and drugs are signed off - the healthcare workers can use those drugs and the skills. So it looks like we are left behind, so far behind because our course is not running there. So i'm not sure maybe what you would answer on that as to when are we going to receive the training based on the new CPGS?

Can I just remind you of the topic of this research, just share our experiences of transition from training into the workplace.

Now with my experience is quite different. I also had expectations because when we started, we knew that after completing with the qualification, we will be deployed preferably to near the towns where we coming from. And with us, it was different. Because you graduated, and the department never deployed us. We had to run around and go into private and stuff and some of us are still working for private sectors. And some of us got lucky and we got employment in the department of other provinces. So the wanting to come back home, Myself, I

applied for a transfer and fortunately, I got approved and I came back home. So it's my experience when I got back home is that I think the department trained people and now doesn't know how to use them. We were trained on certain skills that we cannot even practice because we do not have equipment and we are not being utilized well. The control centre - particularly our control centre, we are being dispatched in such a way that if there are four ambulances rostered, we are being dispatched from ambulance one to four. Calls are not being prioritised according to qualifications or capabilities. Also, they are just been dispatched like ambulance number one went and then now ambulance number two goes, it's number three. Number four goes it's never about a what type of a call. And what personnel or what qualifications attendees are in the call. I think I'm the only ECT who is operational in that station. But I can be told in the morning when you know we clock in, "please go take a doctor to the rural clinics today". And then I'm leaving everybody behind with the ambulances. Or I can be told to take a patient to Orthopaedics in Klerksdorp. You'd like to think I could be utilized better to say those are P3 patients that can be driven to the different towns, leave the ECT behind, so that he can concentrate on other serious calls around the community. So I think that's one thing we were trained, but we are not being utilized according to our expectations. Thank you.

Any other participant that want to contribute to the first question?

Participant number 04:

ECT training, to be honest, came as a very

interesting and appealing journey for us as EMS personnel. It was presented and marketed as something that will really rebrand and position EMS among other healthcare professions, in a way that they will be recognitions of the services that is being rendered. So, I qualified in 2013 as an ECT and came back operational, but "with a lot of confusion", not only with myself, but also among other staff. Whether I'm advanced life support, or what I want to be regarded as in terms of my practice. And this created, I think it's some of the things that may have been said by the other participants.

So, this "created a bit of resistance in the system" of acknowledging the ECT capabilities, and the impact that the skills that they acquired, can make in the community or in the service that are given to the community.

And it also had other challenges with regards to how will in terms of recruitment, an ECT be categorized? Because even on the department's PERSAL system at the time, there were no post where people could be placed. So, some of us remained for a number of years with the previous qualification on the PERSAL while we practiced or registered as ECTs.

So, it was a gap that when the course was formulated, or was created, was left out that now when these people come how do we absorb them – "does the human resource have a post for them to translate ECTs". So obviously, that created also in terms of monetary rewards or salaries, it created confusions that some were higher than the others, some remain the way they were with the previous qualifications while others became translated to

new salaries. While we were at the same levels.

So the experience is that ECT was actually a good qualification and had good intention. But there is the areas that for instance, that I mention of human resource, recruitment and retention, keeping those ECTs system is as the course was meant for the benefit of the community to improve the EMS service, especially in rural areas whereby the highest skills cannot be retained.

So it's those challenges. The other thing is, even after that, "there was no redress that anybody could look that we have produced graduates, and now how do we make use of them into the system?" How do we create an environment that will actually make an impact in the service and as a result, now, it "has actually rendered this qualification useless in the system, even though they are not, but the system is actually rendering them with that qualification useless because they have not been allocated or being acknowledged to practice up to the level of their skills".

And beyond that, there are some skills within ECT where there is consultations and with other drugs where the consultation have to be made, there is also a resistance because if somebody is like for instance, the protocol will say a medical officer or an ECP somewhere, there is a resistance whereby in terms of consultation, you will not get the joy of getting the proper advice and being acknowledged that you are capable of doing something so when you do that consultation there is a bit resistance. And it is just that there's a lot of things I'll stop here for now.

I just wanted to raise points for clarity like you said. The issue of confusion and resistance... Is there a specific group of people that are resisting and not acknowledging or was this just a general EMS comment.

It's the entire system, it's the colleagues at the operational level of, those who are either in the same or let me say at operational level who are juniors. For example, "nobody will call ECT for a backup, even if they see a need that this patient needs somebody of higher qualification". So, the feeling is no ECTs.

So, this is because of the confusion, everybody's not clear, what the ECTs are about or what will they do, should they be called, but I somehow at some point, I will say, I have taken an initiative of presenting to colleagues that this is, should you have this particular case, these are the abilities that comes within the ECT qualification.

So, when you encounter a case of some sort, then I'll be available to come out, but I think for about two years, I used to be on standby. I was working. I was put on a straight shift - to work Monday to Friday. So I will hardly actually get cases.

So it was just standby on paper and practically, so that is some sort of resistance that you will get. But again, it was also the system that was in the health system itself.

Even though we put you on standby, you will have no access of a vehicle that you are on standby - so the vehicle is at a station and but you are on

standby at home. So it's either you, you will drive yourself to a station then to respond to the scene, or somebody will come and then fetch you from home and then that is when you attend to the case.

So it's those things that I said the system was not acknowledging the ECT with its capabilities.

So also with other colleagues in the higher level, with like, they were having no confidence in ECTs to be able to carry out their duties at the level of their training. I'll pause, colleagues will add.

Participant 07:

I don't want to repeat what my colleagues said. But on my side, will start with expectation, was expecting a better salary. Anyway, I was the first one in the province get the better one (salary). The only challenge that I had after qualifying and even today, I was never given an opportunity to practise the skills. Like this year, I've been working 10 years as an ECT, I qualified in 2011.

Was there any specific reason why you're not given opportunities to practice?

I actually wrote a letter because no one responded so I made some follow-ups, then they would just ignore you.

Okay, is it because you appointed in administrative office position? You are not appointed as a operational ECT?

Before I qualified as an ECT, at first I was appointed

in the call centre, and I attended the course and came back to the call centre. But I didn't see it as a disadvantage.

Because for me to write that letter, I saw an opportunity because for the mere reason that there was no ECT within the station that will be on operational – I could have been given a chance to practise those skills. Actually, it is just a resistance and maybe they were feeling that maybe I would be making more money.

Is it the same as the issue of taking over? Like the ECTs to take over.

Yes, it is the fear of the unknown.

Would you like to come in on this question, participant number?

Participant no 2:

My colleagues here said everything. Because "I also expected a high salary, but the shocking news that I did receive the starting salary is at R105000". That was my starting salary as an ECT. So I was kind of demoralized. But anyway, the "other things were good for me because immediately on my arrival at the station, they did give me the response vehicle, and the equipment was there and I was working from Monday to Friday". Only responding to the calls and assisting the crews.

So, there's nothing much more that I can say. So you only attended to high priority cases? Yes, and back up to other crews having difficult

patients

Okay, colleagues, thanks. I think we can go to question two.

And the second question in general also share: How would you describe the preparation that the training has given you compared to what is expected to practise the operational role of ECT to treat patients according to your scope of practise.

Participant no 07:

The preparation was well-done, intensive. Is just that there were those challenges, like somewhere that challenge with shortage of equipment, shortage of resources.

Participant no 02:

The preparation was not so much well because we were the first group, so everything was not prepared... Everything was cut and paste - I don't know how to explain it. Once we have to do some of the things ourselves, like, researches, stuff like that. As you know, the computers, we have to go to the town running around looking for computers for researches, go to the library, and stuff like that.

So you were the first group trained by the province, are you referring to the preparation to run the course? Because the question is, how you would describe the preparation the whole training, after the two years, How would you describe how it prepared you for this role of operational ECT....

After the training there was no preparation, like other participants have said. It was that resistance for management because there was no equipment.

Participant 05:

Yeah, I think I think the training was more intense. We were overly prepared, in a way that when we exited or completed, we came out with our sleeves rolled, only to find out that the environment is very relaxed, that I think that is the reason why we are disappointed.

Because you are being prepared, you know, like when you get on the road and it will be almost the same as the training. When you look at the ambulances, they are empty. From the college during the course, the ambulances there has equipment, but when we get here, there is no equipment in the ambulances.

Participant 01:

The preparation on College side was well, I really enjoyed... I was eager to see myself at home, servicing my community. But coming back home, operationally it was not well prepared,

there was a lot of changes and you know, and understand when this change it is very painful.

So there was a lot of rebellious people who had resistance, there was a lot of tensions, there were a lot of challenges.

Our colleagues and management, they were like,

we were in-between, so they were fighting us.

They were - I don't know how to put it, they were like, "we are treated special".

And then this is where most of our colleagues, their morals are down nowadays, more especially the first group, they didn't get a lot of things like other groups that are coming after them, so treatment was not like....100%.

Now, under general, management didn't support the programme like 100%, I think that if they had a supported the programme and research, we would have seen a lot of changes. So there's a lot of things that I can say but I'm pausing...

Participant 03:

Preparation from the training was I can say was fine but not 100%. But when coming to the workplace. The problem was that it was not what we expected it to be like, You are prepared that today I'm going to break an ampoule but you're only to find that you're going to take like he said, we're going to take the P3 from here to there.

So you will be the only ECT maybe on the station that has to run for the day or for the whole shift. So when I did go to take the P3's from a certain place to another place, there'll be maybe convulsions in the village and I will be nowhere to be found.

And this is also compared to like, how are we treated as staff members.

So even our staff members, We are prepared to tackle those problems but we are not used in our stations, like our colleagues said. They judge us, "you have a drug bad but I don't have a drug bag". So if they go to attend to the patient that maybe is convulsing, since yesterday the patient is continually convulsing, but he or she (colleagues) does not have that gut to call you. You are there at the station, the problem is see at the control centre because if they know that this ECT available, or maybe is working or is on standby, you'll sit there with your Diazepam drug. But they will just call anyone junior in the station to go to the call – to the convulsing patient. And what our colleagues do is that they will come with this convulsing patient to the clinic. They don't just give us the chance to practice, so to speak.

So but I don't want to say much, nowadays things are much better because our station manager managed to address those problems. And to be honest, I've seen several times I've been called and the people started to see, the community started to see the changes that we have in our service. Because I remember one time I was called to a convulsing patient. So they called me for backup. So when I get there, I just managed to treat the patient and the family was saying "do you have doctors in your ambulances?". So I was feeling great, that makes me feeling like a hero – make me proud. The people see the changes in the treatment that we render.

Participant no 06:

The preparation after the training of the ECT

programme, the preparation was good because they instilled the discipline to the ECTs and also instilled the professionalism. After preparation of that programme, there was no support from the station managers because they were expecting ECTs...so there was that negative attitude already – so there was not enough support from the station managers at the station level. We struggled too much when we came from the college as an ECT at the operation.

Question 3, already covered a lot. How was the reception by colleagues when you arrived at the workplace?

Participant no 5:

I think "sometimes it's not like the people don't like us or the qualification or the profession – orjealous the way we are thinking about it". I think there is this gap where they do not understand the scope of practise, our scope of practise. One person will attend a call where a patient is convulsing, but the particular person does not know if there is anything beneficial that you can do to that patient. You understand? "Maybe that person think, no, there is nothing that an ECT on the scope of practise can do to this patient, let me just rather transport the patient to the hospital". So I don't know how to close that gap, but one person suggested that we could maybe run the in-service training within the stations, but now again there is negativity that is running around if you go to the boardroom for a bit of training, people will not pitch. So I don't know how we can close that bit of a gap.

Participant no 07:

I just want to say something. "There was this thing of resistance from management". For the mere reason that "most if not all management were ILS". When the ECT came in, they were having all, they wanted somewhere to submitary?? then it is where you experience something like allocation of resources.... "The utilisation of the ECT was not correct at some stages".

Question 4. Tell us about your confidence levels to work independently without supervision.

Participant no 02:

I was really overconfident. I did attend to a certain patient, it was a diabetic. I went there and the patient had collapsed. So when I went and check the HGT... the reading was 1.0mmol/L. What was this...the indication was 50% Dextrose. All of a sudden, the patient was awake and laughing. So all of the people who were there was very impressed. It boosted my confidence.

Participant 01:

I was more than confident. When I started to work, I was working with ...I don't know if I should use that...the "white guy", he was treating me like he was testing me or what...so I do my level best so that they can recognise our qualification. So, I was confident.

Was this your partner you were working with?

Ja. It was my senior before I went to ECT training.

So when I came back, he wanted to test me. So I showed him.

Participant no 04:

The confidence was there. "Because we knew we would make a difference in our service and image of EMS and the community there will receive a better service. Before we went to college, there was no-one who could do what we were taught to do, so obviously we knew we are bringing something that we learned and make a difference". So, also the confidence was on the basis that we anticipated that we would be able to progress better with the studies of a higher qualification. ECT was put to us as something that will create a career path in the EMS setting in education, so we were actually motivated to become the best ECTs so that we can go to the next level in terms of training in EMS.

Participant no 05:

I also had enough confidence as an ECT. I remember just after qualifying, I was working in the FS and I was attending to call in the hospital. It was a small hospital like a clinic there was only one doctor there and it was a new-born baby and the baby was born with a relatively low blood glucose and I knew that umbilical vein cannulation was indicated. So I went and spoke to the doctor, the other boy had a very big laceration on the hand, the doctor asked me if I am competent to do the skill, but the sister, who was supposed to prepare for the skill, it's a sterile procedurebut she was not sure ... but I had the confidence, but she prepared and I went on instinct. The only time that sister realised

that I could do it, was when we test when the blood comes out (back flow)...

There was appreciation with all the colleagues that was working there – I felt so proud of myself that I could do it...

Participant no 06:

On the question of my confidence... I was confident enough after attending all different kinds of conditions of the patients and using the medication that I had. One other thing is, in my area with the experience that I have, with the environment that I was working in, I've seen that at the hospitals we were the onesactually it was the ECTs that were transporting the P1 patients to hospital – the intubated patients – but there was a lot of stories behind that for ECTs to escort those patient, but in our area, doctors they know that we as ECTs in our area, those people would be the one transporting these patients to hospital. Since then the confidence remains high, but there were a lot talking behind that about the ECT transporting a P1 patient – it's just that I don't know when the patient is intubated, if the patient is in an emergency or not. I've never seen that. That is when I used my confidence to transport the patient, and that's when I grew my confidence to manage all conditions according to my ECT protocol.

Participant no 03:

The confidence that I had when I reached the college was that even today, the sisters in most of the clinics that I attended, they would say that

maybe the patient is, when coming to the new-borns, most of the nurses has a problem to put in a line for the new-born babies, but they will say the doctor told me to put on a line – that I didn't mind – they would say I was just asking who would be coming And I did not mind... they say because all the people from the college, all of them, can put in a line. For me, it gave our college a name – to be honest – when I got there, they would already written my name in the book and said "we know you would be able to do it". They were saying every day at the college we were taught to put up a line.

Participant no 02:

The thing that most boosted my confidence, more often is that, when I arrive with a patient at the hospital, they would tell me "No, I am referring this patient and you are the one who will escort the patient". So, that boosted my confidence. "The appreciation from the doctors as well".

Question 5: how ready was your place of employment when you arrived to allow you to practise already covered in many angles. After having this conversation, including the last question...any other information to add....

Something that was said, that was very important about the consultation. I think the system did not create an environment to be easy for us in a way, because even if I attend a case where I administer Morphine, I don't have anybody in mind who I can call in the whole district or the sub-district where I'm working. I don't have anybody who I know is available for me to consult to say, "I'm having a

patient here..." and I think morphine is indicated and "I need you to give me advice". I'm sorry to compare our situation to the private sector, when you get to a certain company in a private sector, they give you, before you even start working, "here's your MO...." Blah blah blah...."You should be calling this one or that one..." and "This is what you should be doing"....

With them, you cannot administer any drug before consulting if that drug needs consultation, so I think with our environment ECT has been taken light which means I can administer morphine without consultation which is wrong according to our scope of practise. I think that is one of the things that need to be fixed.

Participant 06:

In our area, I think, they were ready because they were saying there is an ECT who would come from the college. They were ready, waiting for that ECT. The manager at that time, was preparing the office for him. That is how welcomed he was.

How are we going to close the gap of our Juniors to call the back-up of us as ECTs and how can we sort it out. Last time I was saying, if you send someone to a call, and he sees that the patient need advanced life support – if he or she don't call that person, it means that he was undertreating the patient and that person need to be disciplined and be reported because he was actually undertreating the patient. He was supposed to call someone to give a good care to the patient. The standard of care should be at the same level since we have all the

same skills at the station.

Participant no 06:

When the shift start, but currently now we have ECPs at the station – you can consult with them, the medical officer, get a good relationship with the medical officer. He should give all the ECTs the contact number of the medical officer. But for now, we should utilise the ECPs that we have.

What about retrospective consultation?...coming back from a call, giving retrospection of what you had

Participant no 04:

The time I was operational, I did have sort of a relationship with the doctors, at that time because when you get an order for a schedule 05 or 06, they need to sign on the order, they would sign it and then you will get the schedule 05 or 06 medication. But after, when I come with a patient that has been given a schedule 05 or 06 – especially morphine – on the OP there was a part that has to be authorised and I would request the doctor to sign there, because we have agreed that this drugs as I am going to give them, I have to do a consultation and on deliberation there was a delay treatment for the patient. So, it's fine, when you see that you need to give and you can give but the timeline must be agreed. He has to sign. So he asks, "why must I sign and if I sign I authorise you to give morphine" and "how was this thing put together that I must authorise you to give morphine" – "I cant do that when I am not there and tell you to do that but

when you are back, I can't see the patient" so he don't want to sign and authorise something when he is not there.

I think it is more important to give the vital signs to whoever is there, so to give a picture of the patient.

The end.

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QUOTATION MANAGER

	Document	Reference	Quotation Content	Codes	Your suggested sub-category
1	Focus Group 1	264 - 494	Most of the workforce was intermediate life support practitioners (AEAs), so there was a lot of resistance because they felt like management listened to me more often because I was regarded as an advanced life support practitioner.	Resistance	Management support
2	Focus Group 1	1299 - 1704	some in management level thought that we were going to take over their work and there was also were resistance on that level, but most resistance was on operational level – people, they would feel like you want to change them from what they used to do in a day and they were not really accommodative until they started understanding where the profession is going and why there must be other qualifications.	No clarity on roles and responsibility Professional hierachy Resistance Workplace experience	Threatened/ Intimidated Management Proffesionalizing the industry Overcoming resistance
3	Focus Group 1	2209 - 2791	Then the challenge again came at the station. It was like – there was those “old guys” who did the old courses and still maybe adapting to the situation as a BAA or ILS (AEA) – me, I come as a school leaver, but at the end of the day, they did understand. You can have a qualification without having an information of BAA or AEA, because at the end of the day we did it as ‘school leavers’ but it was a challenge for them to adapt to us in that we ALS that are from nowhere without having any background because we are from nowhere, not knowing anything without any EMS background	Experimental group Professional hierachy Resistance Workplace experience	Proffesionalizatio n the industry Overcoming resistance
4	Focus Group 1	2794 - 3797	But it was merely 2-3 months as a challenge, meaning that people don’t accept you by people who were there for a long time, but they came back. They came to us and then we had those classes – maybe the in-service training and then they accepted that we are here to help them and that’s what we did when they came back and that’s	Professional hierachy Theory vs practical experience Workplace experience Resistance	Overcoming resistance

			<p>how we engaged with them to show them what we've learned and we can have more information to improve our patient treatment and all that. The in-service training was really helpful for us, because the BAA and ILS's, they have more experiences on the road outside and how to treat the patient and all that, and we did not have that. We have the theory from school but we did not have much practical work, but that's where we came together, do all those in-service training, it helped us a lot. Till today, at least it does show that we do good and that and BLS and ILS can come and ask for that and if we work together, at least we can have better patient care for both of us.</p>		
5	Focus Group 1	3878 - 4389	<p>The school leaver programme, it's like we were the 1st group of the ECTs not having BLS or ILS background. We did not have any EMS background. I did not have any BAA ...we were regarded as if just from school, then we went to do the ECT for the 1st time. Like not the in-service guys that were from the station and they had the qualification, like the BAA and ILSs – so we were like we were from school, even at that time we were not from school from Gr 12 or what, just because we did not have any EMS background</p>	<p>Experimental group Professional hierarchy School Leavers Theory vs practical experience Resistance</p>	<p>Professionalizing the industry</p>
6	Focus Group 1	4715 - 5518	<p>Ja, we had challenges like we are school leavers – we know nothing about EMS – really we did not have that much information – but at the College they told us about BLS and ILS – what it is and how to go about it working with the patient and all that. But when coming to the station, the other ones ILS were the ones who were most advanced at that time. I am coming as a school leaver telling them what to do, they didn't take it right at first. But those in-service trainees, they were the ones that helped us to overcome our challenges. Because resistance was too much, it doesn't mean we are ECT we can do it. But with the in-service training and the support from manager at the time it helped us a lot. We adapted fast knowing that it is not for us but for the new course of treatment for the patient.</p>	<p>Experimental group Professional hierarchy Resistance School Leavers Theory vs practical experience Workplace experience Preparation by training ??</p>	<p>Components of ECT training Threatened/ Intimidated Management Overcoming resistance</p>
7	Focus	5542 -	<p>I am also an ECT school leaver. One of the challenges as</p>	<p>Experimental group</p>	<p>Generational gap/</p>

	Group 1	6242	a school leaver, it was that it was a lot of intimidation in the beginning. People were thinking we are still young , and it was challenging, as young as you are, and then you come work with an older person, and you are there for the benefit of the patient, but the person will say that you are young and that they "I will not take instructions from you". That was one of the challenging things. Another challenging thing was whereby you as an ECT were expected to do all the calls, all emergency calls, now whenever there is a call, they would say – no, the ECT's are there, they will do it – so that was one of the challenges in the beginning	Professional hierarchy Resistance School Leavers Workplace experience?	Age difference No clarity on roles and responsibility ?
8	Focus Group 1	6543 - 6860	In my shift we had only one ECT by then. Due to certain circumstances, the ECT when I arrived at the station was in the office....and at a shift level there were only AEAS... I was the only ECT at that level... so each challenging call that was given to the shift, it was given to the ECT. So it was mostly challenging yes.	ECT call allocation Professional hierarchy Workplace experience	No clarity on roles and responsibility?
9	Focus Group 1	7457 - 7782	Initially when we started to go back to the stations, it was tense – even to our managers – like participant 5 made it clear that most of the workforce in the system is the ILS by then. Also the managers would find that they are an ILS and they were starting to have that fear, maybe, that we are here to take their positions.	Professional hierarchy Resistance Workplace experience	Threatened/ Intimidated Management
10	Focus Group 1	10326 - 10841	The training took the mentality of being upskilled. You end up thinking laterally because you were taught many things like participant 1 mentioned. Those fundamentals and modules, HIV and the EMS structure modules– the EMS structure end up putting people from the school leaver point of view, putting them on-board – to have those hierarchy, how it works and it end up training them to see where they fit and also giving our colleagues a thorough training that they are in the system - they are also helping a lot.	ECT Training for the operational environment Professional hierarchy Work relationships Preparation by training ??	Components of ECT training
11	Focus Group 1	19275 - 19529	But as a new qualification I think that is what is happening in most cases where you come in and do not understand why you need this and why you want things - they think that you are being impossible – "You are just	Experimental group No clarity on roles and responsibility Peer support Professional hierarchy	No clarity on roles and responsibility ?

			trying to show off" all those things.	Resistance Theory vs practical experience Workplace experience	
12	Focus Group 1	19781 - 20972	There was some consultations done even before the course can start where we told what is this course, what is its intentions and why but most of us, we didn't know why, we do not understand why you will discontinue a four months course that would produce so much with this course that is going to bring less, and some of us who went to just to going see whether it's going to work, when as I say you're wasting your time, why are you going in there, but in the process I know that college kept on trying to make awareness in the stations with management to make them aware that this qualification, this is what is needed of them, start preparing for them but I think most of the people they were just being negative and reluctant to say, no, this will not work. You don't see it working. We are used to – you know, change is difficult - it's not easy just to change. So people always tell us to the short courses and they didn't see it working and they felt like the waste of time, is a waste of money to invest in something that you don't think that it will work, but I think management, they've tried to educate people though you can take a horse to the water, you cannot force it to drink.	Experimental group No clarity on roles and responsibility Professional hierarchy Resistance Work fears Workplace experience Workplace readiness and support	Professionalising the industry Overcoming resistance
13	Focus Group 1	20996 - 21601	In essence, through that there was a negative reception, especially when coming to the workplace readiness, it was not there because as participant 01 was highlighting her points that the stations were not ready like the station I was working at. They were not ready when we requested some of the stuff, there was some tension or resistance from the manager saying we're asking a lot and then why the college didn't notify them first on the stuff that they were supposed to buy. So, things were not procured in time and we were struggling a lot. So, the work place readiness, it was not conducive by then.	Experimental group No clarity on roles and responsibility Professional hierarchy Resistance Theory vs practical experience Work fears Workplace experience Workplace readiness and support	Non-responsive Management
1	Focus Group 2	1475 - 1986	I had already people that were in the first group and the second group of the ECTs that qualified as emergency	Experimental group Professional hierarchy	Preceding graduates

			care technicians. And those people I had, we had already through them prepared a lot of things, you know, like we the medications which is at the level of the qualification, the equipment. And also we had already prepared the ground for them to be accepted as the advanced life support practitioners because at that time, there was a confusion that they were not at the level of advanced life support.	Workplace experience Workplace readiness and support	
2	Focus Group 2	3099 - 3374	I was I was already a manager at that time, I think not I think I know I was a manager. So, but because of the excitement one was most of the time working on the road, so sort of to practise and to see if one knew the skills that he had learned from the training institution.	Confidence building ECT Training for the operational environment Professional hierarchy Theory vs practical experience Workplace experience	Skills acquired excitement/ exploration
3	Focus Group 2	6597 - 7003	And when we did our practicals so I'm adding on what she has already said. I would say our predecessors did not plough enough like participant 5 said he found already the ground prepared for ECT and he was just flowing when he got there and his successors has also received that kind of thing. With Mafikeng it was a bit different whereby you get that as ECTs we are called by AEA or ILS, did not like ECTs.	Peer support Professional hierarchy Workplace readiness and support	Preceding graduates
4	Focus Group 2	7957 - 8321	I liked what he said that most of the predecessors went into being supervisors, went into the managers and they did not represent the qualification fully at the ground level. So when it came to us at a later stage, we found that it struck me we needed to, to lift the banner - to lift the name of ECT. At current, I would say the support for ECT has dropped a lot.	Professional hierarchy Resistance Work relationships Workplace readiness and support	Preceding graduates
5	Focus Group 2	8325 - 8630	The name ECTs weight that it had when I started has depreciated a lot, we are still fully 100% at competition with AEA - not that I'm undermining them. But you must remember they've only done a four-month course and we've been to this very long technician course for two years. But there is no recognition.	Negative perception of ECT Professional hierarchy Resistance Work fears Workplace experience	Professionalising the industry
6	Focus Group 2	8681 - 9316	We don't feel like anything above them. Remuneration-wise levels, recognition at HR, even they don't even understand why would you want to be a bit different or better than ILS and you should explain to them that the	Components of ECT training ECT Training for the operational environment Negative perception of ECT Professional hierarchy	Occupation Specific Dispensation remuneration and

			treatment that you give, the management that you give, the drugs that you will give will mean nothing to them. So basically. It is, how shall I say, this is going grey to disappear, unless something is really done about it. I really love ECT. I really love being a medical official, paramedic and motivation wise, it is dying. It is dying and we need resuscitation. We need CPR very fast, ECT CPR as soon as possible.	Resistance Workplace experience Workplace readiness and support	recognition
7	Focus Group 2	9411 - 9493	ECT and ILS – there is no difference. It is the same thing. There's no difference.	Workplace readiness and support Professional hierarchy Remuneration and recognition	Occupation Specific Dispensation remuneration and recognition
8	Focus Group 2	10497 - 11029	Yeah, people ended up not going for training for ECTs - we tend to be discouraged, we're gonna go there for two years, we come back. The person that I was with on the salary scale, is going to be more than getting more than me when I come back. So it's no use for us going there. So that's the thing that was happening and that it's still happening. So we need something to show that you were trained, you do more skills than the others. You can do better. So the remuneration is the big thing. On the ECTs. That's putting them down.	Negative perception of ECT Professional hierarchy Remuneration and recognition Work fears Workplace experience Workplace readiness and support	Occupation Specific Dispensation remuneration and recognition
9	Focus Group 2	11368 - 11863	I worked so hard, but there was no equipment, enough equipment, especially the drugs, but at least within two to three months, demands to give out the drugs. Then I started to work. And I used to work fine. Because I do the things that I was taught and but only the doctors at Casualty. They are the only one who realize that we can do distance from ALS as ECT and they were amazed. What are we doing? They think maybe its not the transfer ECT, how I manage a patient and even the control center.	Professional hierarchy Work fears Work relationships Workplace readiness and support Workplace experience	Non-responsive Management Relations with other healthcare professionals
10	Focus Group 2	12062 - 12324	Remuneration. They were so 3 or 4 ILSs, getting more than I was under the salary. But for so many years I hear is that after maybe after about 10 years, they just does better for me. But it's only because I like to treat the patient even though my supervisor can.	Workplace readiness and support Professional hierarchy Remuneration and recognition	Occupation Specific Dispensation remuneration and recognition

11	Focus Group 2	15424 - 15579	Now having to go back to the station and actually find your supervisor is less qualified than you, you'll find that your manager is less qualified than you.	Resistance Professional hierarchy	Professionalising the industry
12	Focus Group 2	16297 - 16913	But the reaction that we got when we came back, it was not a good reaction from the colleagues that were not trained, they were scared of us that we're going to take everything in front of them, the opportunities that are coming. And if maybe there's a post for manager, they were not thinking that they will be able to participate in the interview to get the manager's post, just because there's an ECT they think automatically they are the manager, but as time went on, they kinda accepted it, okay, we are just AEAs and they are ECTs, so we'll compete. If we don't win, we'll go the other way to try to fight them.	ECT Training for the operational environment Negative perception of ECT Professional hierarchy Resistance Work fears Workplace experience	Threatened/ Intimidated Management Overcoming resistance
13	Focus Group 2	17625 - 18056	We said how about now for each ambulance there is a BAC and ECT because even then there were way lesser AEAs. Then came the acting post when the supervisor had to go on leave. According to the qualifications, the ECT had to act - they had a problem and saying ECTs cannot act in supervisory positions because they are more qualified - they should be on the streets - them as BACs have to be in the office, help with admin and audit.	Negative perception of ECT Resistance Professional hierarchy Work fears Workplace experience	Threatened/ Intimidated Management and Colleagues
1	Focus Group 3	907 - 1841	I qualified that way and prior that 2010, it was too much for me as a student, especially when World Cup 2010 came. Especially that it comes in wintertime. And we were used so much in the world cup in North west, especially when the games at the Royal Bafokeng stadium. And during that time, I felt that this is too much for me. I even wanted to quit because we spent too much hours in the stadium and the problem actually, the world cup program took a lot of our time and we even talked about the hours that the college will give us back or they will even pay us. they will pay us after World Cup but you didn't get anything like that. You will put in so many hours that some hours will be used for us to compete our ECT program then with ECT program itself after qualifying,	Difficult working environment Expectations from ECT qualification Negative perception of ECT Professional hierarchy Remuneration and recognition Preparation by training?? Workplace experience	Components of ECT training Professional Status

			then there were a lot of things in terms of the skill. There are some SKILLS that it seems as if whether are we on the same level with the CCA at operations.		
2	Focus Group 3	1843 - 2425	There are some skills that were said, they will be added after we qualified in ECT. We expected a lot of added skills as an ECT, till to date. So another thing one other things the advanced life support with ECT, CCA and ECP, I was confused whether I am falling under advanced life support, all of us CCA and ECPS. So we were just practicing the field – with some tension between our skills at operational level, especially between ECT and CCA, in terms of intubation, intubated patient, how the ECT has to behave in that situation and where should the CCA is also getting in there.	<p>Components of ECT training</p> <p>Difficult working environment</p> <p>ECT Training for the operational environment</p> <p>Expectations from ECT qualification</p> <p>No clarity on roles and responsibility</p> <p>Professional hierarchy</p> <p>Workplace experience</p>	Professional Status
4	Focus Group 3	7769 - 8325	So, I qualified in 2013 as an ECT and came back operational, but “with a lot of confusion”, not only with myself, but also among other staff. Whether I’m advanced life support, or what I want to be regarded as in terms of my practice. And this created, I think it's some of the things that may have been said by the other participants. So, this “created a bit of resistance in the system” of acknowledging the ECT capabilities, and the impact that the skills that they acquired, can make in the community or in the service that are given to the community.	<p>Difficult working environment</p> <p>ECT Training for the operational environment</p> <p>Professional hierarchy</p> <p>Work fears</p> <p>Workplace experience</p> <p>Workplace readiness and support</p> <p>Resistance</p>	<p>Professional Status</p> <p>Occupation Specific</p> <p>Dispensation remuneration and recognition</p> <p>Professionalisation the industry</p>
5	Focus Group 3	10117 - 10618	And beyond that, there are some skills within ECT where there is consultations and with other drugs where the consultation have to be made, there is also a resistance because if somebody is like for instance, the protocol will say a medical officer or an ECP somewhere, there is a resistance whereby in terms of consultation, you will not get the joy of getting the proper advice and being acknowledged that you are capable of doing something so when you do that consultation there is a bit resistance.	<p>ECT Training for the operational environment</p> <p>Professional hierarchy</p> <p>Resistance</p> <p>Work fears</p> <p>Workplace readiness and support</p> <p>Workplace experience</p>	Relations with other healthcare professionals
6	Focus Group 3	10907 - 11566	It's the entire system, it's the colleagues at the operational level of, those who are either in the same or let me say at operational level who are juniors. For example, “nobody will call ECT for a backup, even if they	<p>Components of ECT training</p> <p>Confidence building</p> <p>Difficult working environment</p> <p>ECT Training for the operational environment</p>	<p>No clarity on roles and responsibility?</p> <p>Overcoming</p>

			see a need that this patient needs somebody of higher qualification". So, the feeling is no ECTs. So, this is because of the confusion, everybody's not clear, what the ECTs are about or what will they do, should they be called, but I somehow at some point, I will say, I have taken an initiative of presenting to colleagues that this is, should you have this particular case, these are the abilities that comes within the ECT qualification.	Negative perception of ECT No clarity on roles and responsibility Patient care Professional hierarchy Resistance Workplace experience	resistance
7	Focus Group 3	12345 - 12610	So it's those things that I said the system was not acknowledging the ECT with its capabilities. So also with other colleagues in the higher level, with like, they were having no confidence in ECTs to be able to carry out their duties at the level of their training.	Components of ECT training Difficult working environment Negative perception of ECT Professional hierarchy Resistance Workplace experience Workplace readiness and support	Occupation Specific Dispensation remuneration and recognition
8	Focus Group 3	16966 - 17264	So there was a lot of rebellious people who had resistance, there was a lot of tensions, there were a lot of challenges. Our colleagues and management, they were like, we were in-between, so they were fighting us. They were - I don't know how to put it, they were like, "we are treated special".	Difficult working environment Professional hierarchy Resistance Work fears Workplace experience Workplace readiness and support	Management support
9	Focus Group 3	18410 - 19239	So even our staff members, We are prepared to tackle those problems but we are not used in our stations, like our colleagues said. They judge us, "you have a drug bag but I don't have a drug bag" . So if they go to attend to the patient that maybe is convulsing, since yesterday the patient is continually convulsing, but he or she (colleagues) does not have that gut to call you. You are there at the station, the problem is see at the control centre because if they know that this ECT available, or maybe is working or is on standby, you'll sit there with your Diazepam drug. But they will just call anyone junior in the station to go to the call – to the convulsing patient. And what our colleagues do is that they will come with this convulsing patient to the clinic. They don't just give us the chance to practice, so to speak	Components of ECT training Difficult working environment ECT call allocation ECT Training for the operational environment Negative perception of ECT No clarity on roles and responsibility Professional hierarchy Workplace experience Resistance Workplace readiness and support	Management support No clarity on roles and responsibility ? Professional Sabotage?
10	Focus	19914 -	The preparation after the training of the ECT programme,	Preparation by training??	Components of

	Group 3	20408	the preparation was good because they instilled the discipline to the ECTs and also instilled the professionalism. After preparation of that programme, there was no support from the station managers because they were expecting ECTs...so there was that negative attitude already – so there was not enough support from the station managers at the station level. We struggled too much when we came from the college as an ECT at the operation.	Resistance	ECT training Management Support
11	Focus Group 3	21503 - 21837	"There was this thing of resistance from management". For the mere reason that "most if not all management were ILS". When the ECT came in, they were having all, they wanted somewhere to submitary?? then it is where you experience something like allocation of resources.... "The utilisation of the ECT was not correct at some stages".	Difficult working environment Professional hierarchy Resistance Work fears Workplace experience Workplace readiness and support	Threatened/ Intimidated Management and Colleagues No clarity on roles and responsibility?
12	Focus Group 3	22656 - 22767	Ja. It was my senior before I went to ECT training. So when I came back, he wanted to test me. So I showed him.	Resistance Work relationships	Threatened/ Intimidated Management and Colleagues
13	Focus Group 3	26774 - 27539	Something that was said, that was very important about the consultation. I think the system did not create an environment to be easy for us in a way, because even if I attend a case where I administer Morphine, I don't have anybody in mind who I can call in the whole district or the sub-district where I'm working. I don't have anybody who I know is available for me to consult to say, "I'm having a patient here..." and I think morphine is indicated and "I need you to give me advice". I'm sorry to compare our situation to the private sector, when you get to a certain company in a private sector, they give you, before you even start working, "here's your MO..." Blah blah blah..."You should be calling this one or that one..." and "This is what you should be doing"....	Mentorship programme Peer support Positive work experience Previous work skills Professional hierarchy Use of pharmaceutical agents Work fears Work relationships Workplace experience Workplace readiness and support	Non-existent Clinical Governance
14	Focus Group 3	28123 - 28704	How are we going to close the gap of our Juniors to call the back-up of us as ECTs and how can we sort it out. Last time I was saying, if you send someone to a call, and he sees that the patient need advanced life support – if	Challenging call outs ECT call allocation ECT Training for the operational environment Patient care	Non-existent Clinical Governance

			he or she don't call that person, it means that he was undertreating the patient and that person need to be disciplined and be reported because he was actually undertreating the patient. He was supposed to call someone to give a good care to the patient. The standard of care should be at the same level since we have all the same skills at the station.	Professional hierarchy Scope of practice for ECTs Workplace experience Workplace readiness and support	
15	Focus Group 3	29157 - 29772	The time I was operational, I did have sort of a relationship with the doctors, at that time because when you get an order for a schedule 05 or 06, they need to sign on the order, they would sign it and then you will get the schedule 05 or 06 medication. But after, when I come with a patient that has been given a schedule 05 or 06 – especially morphine – on the OP there was a part that has to be authorised and I would request the doctor to sign there, because we have agreed that this drugs as I am going to give them, I have to do a consultation and on deliberation there was a delay treatment for the patient.	ECT Training for the operational environment ECT work enthusiasm Peer support Positive work experience Professional hierarchy Use of pharmaceutical agents Work relationships Workplace experience Workplace readiness and support	Non-existent Clinical Governance
1	Focus Group 4a	2300 - 2742	And the CCA can intubate – you are useless or something, something like that. So we had to adapt to the situation and try to win everyone else to say, look, treating patients is not about intubating. And this is what made you need to do and this is what we don't need to do, stuff like that. So basically, I know for everyone, "it was difficult", as much as it was difficult for me to adapt to the station and the working environment outside.	Components of ECT training Difficult working environment ECT Training for the operational environment Professional hierarchy Workplace experience Workplace readiness and support	Professional Status
2	Focus Group 4a	3578 - 4093	Transitions of ECT from college and looking at a BAA qualified staff (in-service staff) and AEA qualified staff there was a vast difference. I think the difference that I am talking about is the difference especially at the college - because the BAA's is struggling a bit and for AEA's, at least it was a like a uplifting of skills. Coming back to workplace. Now, I will be "talking maybe from management perspective to say even now, ECTs are more disciplined than those BAAs and AEAs that were appointed year back".	Positive college experience Professional hierarchy Work relationships Workplace readiness and support Preparation by training??	Components of ECT training
3	Focus Group 4a	4097 - 4523	I think it was an advantage to appoint shift leaders and station managers – who are ECT qualified than those who	Components of ECT training Difficult working environment	Overcoming resistance

			are AEA qualified and still on that, "I think there are still station managers that felt threatened. They don't want to accept a higher qualified person in their workplace". So for them to give them support, procure equipment, just in the interest of patient treatment - not in for competition, it is a challenge.	ECT Training for the operational environment Professional hierarchy Work relationships Workplace experience Workplace readiness and support Resistance	Threatened/ Intimidated Management and Colleagues
4	Focus Group 4a	5301 - 6092	When I came back to the station it was a different from that AEA one that was at the college 2 years back, and then not to say maybe I was like away from the people but it was the discipline that I have. even telling people no you shouldn't do this you must do this. It was like "she's feeling she's much better than others" and then the responsibility it wasn't easy to carry that much responsibility. Especially from "I'm coming from the station that we have those old people who are saying I've been there for long" - it was not easy for you to tell these people that I'm now your senior. It was not easy and then in our shifts, like i was one ECT and then they would know it and I was prepared. When coming to work, "everyone was prepared to see me fail or am I capable to do the work".	Components of ECT training Difficult working environment ECT Training for the operational environment Professional hierarchy Work fears Work relationships Workplace experience Workplace readiness and support	Professional Status
5	Focus Group 4a	6663 - 7157	even treating the patient – no we should start treating patients like this. Most in most cases like when the shift starts, prepare something for the shift - let me say I'm with somebody out on a call and then I saw something wrong, I would prepare them and then present to the whole shift somewhere in the beginning it was not easy. "Some would listen and some will be playing with their phones but at the end I managed to win them". So then I was able to maybe present all the shifts everything	Patient care Peer support Positive work experience Professional hierarchy Work relationships Workplace experience Workplace readiness and support Resistance	Overcoming resistance
6	Focus Group 4a	16786 - 17370	I think there was not enough information relayed to the stations about this ECT, where you need them to be used, because there was this misconception that when the ECTs come, because they are the most qualified on the station, and by then they would be taking up all the positions that whoever is having, and I'm telling you it was very difficult, because you will hear from the corner to say, "you cannot be my supervisor. I've been here for too long", they did	Difficult working environment Negative perception of ECT No clarity on roles and responsibility Professional hierarchy Work fears Resistance Workplace experience Workplace readiness and support	No clarity on roles and responsibility? Threatened/ Intimidated Management and Colleagues

			not know that actually ECTs are more meant to be on the road, than to be in office. "So the reception was not very good".		
7	Focus Group 4a	17371 - 18033	I'm telling, not very good, because everyone was expecting - must remember that before the introduction of the ECTs, the most highest qualification was ILS. And there was not so much of ILSs at stations you'd find in a shift and there was about maybe two or three ILSs, if I still remember correctly, two or three in a shift. "So here comes an ECT. More especially from school. And you're the most qualified person and expecting that you should be taking over all the responsibilities so they wouldn't take it nicely" as I'm saying that maybe the relay of information of these ECTs to station so that people should understand what a ECT is and what it meant for.	<p>Difficult working environment</p> <p>ECT Training for the operational environment</p> <p>Professional hierarchy</p> <p>School Leavers</p> <p>Work fears</p> <p>Work relationships</p> <p>Workplace experience</p> <p>Resistance</p>	<p>No clarity on roles and responsibility?</p> <p>Threatened/ Intimidated</p> <p>Management and Colleagues</p>
8	Focus Group 4a	29534 - 29851	Firstly, we will start with equipment for example Intra-osseus needles, LMAs: there were no equipment, including basic equipment. So, when we got there, we had to procure equipment. Luckily, I was the station manager with ECT qualified shift leaders we came together and managed to procure everything that we needed.	<p>ECT Training for the operational environment</p> <p>Professional hierarchy</p> <p>Resources</p> <p>Work relationships</p> <p>Workplace readiness and support</p>	<p>Non-responsive Management</p>

RESISTANCE

0	Document	Reference	Quotation Content	Codes	Your suggested sub-category
1	Focus Group 1	264 - 494	Most of the workforce was intermediate life support practitioners (AEAs), so there was a lot of resistance because they felt like management listened to me more often because I was regarded as an advanced life support practitioner.	Resistance	Management support
2	Focus Group 1	1299 - 1704	some in management level thought that we were going to take over their work and there was also were resistance on that level, but most resistance was on operational level – people, they would feel like you want to change	Resistance	Threatened/ Intimidated Management Professionalising

			them from what they used to do in a day and they were not really accommodative until they started understanding where the profession is going and why there must be other qualifications.		the industry Overcoming resistance
3	Focus Group 1	2209 - 2791	Then the challenge again came at the station. It was like – there was those “old guys” who did the old courses and still maybe adapting to the situation as a BAA or ILS (AEA) – me, I come as a school leaver, but at the end of the day, they did understand. You can have a qualification without having an information of BAA or AEA, because at the end of the day we did it as ‘school leavers’ but it was a challenge for them to adapt to us in that we ALS that are from nowhere without having any background because we are from nowhere, not knowing anything without any EMS background	Resistance	Professionalisation the industry Overcoming resistance
	Focus Group 1	2794 - 3797	But it was merely 2-3 months as a challenge, meaning that people don’t accept you by people who were there for a long time, but they came back. They came to us and then we had those classes – maybe the in-service training and then they accepted that we are here to help them and that’s what we did when they came back and that’s how we engaged with them to show them what we’ve learned and we can have more information to improve our patient treatment and all that. The in-service training was really helpful for us, because the BAA and ILS’s, they have more experiences on the road outside and how to treat the patient and all that, and we did not have that. We have the theory from school but we did not have much practical work, but that’s where we came together, do all those in-service training, it helped us a lot. Till today, at least it does show that we do good and that and BLS and ILS can come and ask for that and if we work together, at least we can have better patient care for both of us.	Resistance	Overcoming resistance
5	Focus Group 1	3878 - 4389	The school leaver programme, it’s like we were the 1st group of the ECTs not having BLS or ILS background. We did not have any EMS background. I did not have any BAAwe were regarded as if just from school, then we	Resistance	Professionalising the industry

			went to do the ECT for the 1st time. Like not the in-service guys that were from the station and they had the qualification, like the BAA and ILSs – so we were like we were from school, even at that time we were not from school from Gr 12 or what, just because we did not have any EMS background		
6	Focus Group 1	4715 - 5518	Ja, we had challenges like we are school leavers – we know nothing about EMS – really we did not have that much information – but at the College they told us about BLS and ILS – what it is and how to go about it working with the patient and all that. But when coming to the station, the other ones ILS were the ones who were most advanced at that time. I am coming as a school leaver telling them what to do, they didn't take it right at first. But those in-service trainees, they were the ones that helped us to overcome our challenges. Because resistance was too much, it doesn't mean we are ECT we can do it. But with the in-service training and the support from manager at the time it helped us a lot. We adapted fast knowing that it is not for us but for the new course of treatment for the patient.	Resistance Preparation by training ??	Components of ECT training Threatened/ Intimidated Management Overcoming resistance
7	Focus Group 1	5542 - 6242	I am also an ECT school leaver. One of the challenges as a school leaver, it was that it was a lot of intimidation in the beginning. People were thinking we are still young , and it was challenging, as young as you are, and then you come work with an older person, and you are there for the benefit of the patient, but the person will say that you are young and that they "I will not take instructions from you". That was one of the challenging things.	Resistance	Generational gap/ Age difference
9	Focus Group 1	7457 - 7782	Initially when we started to go back to the stations, it was tense – even to our managers – like participant 5 made it clear that most of the workforce in the system is the ILS by then. Also the managers would find that they are an ILS and they were starting to have that fear, maybe, that we are here to take their positions.	Professional hierarchy Resistance Workplace experience	Threatened/ Intimidated Management
12	Focus Group 1	19781 - 20972	There was some consultations done even before the course can start where we told what is this course, what is its intentions and why but most of us, we didn't know	Experimental group No clarity on roles and responsibility Professional hierarchy	Professionalising the industry Overcoming

			<p>why, we do not understand why you will discontinue a four months course that would produce so much with this course that is going to bring less, and some of us who went to just to going see whether it's going to work, when as I say you're wasting your time, why are you going in there, but in the process I know that college kept on trying to make awareness in the stations with management to make them aware that this qualification, this is what is needed of them, start preparing for them but I think most of the people they were just being negative and reluctant to say, no, this will not work. You don't see it working. We are used to – you know, change is difficult - it's not easy just to change. So people always tell us to the short courses and they didn't see it working and they felt like the waste of time, is a waste of money to invest in something that you don't think that it will work, but I think management, they've tried to educate people though you can take a horse to the water, you cannot force it to drink.</p>	<p>Resistance Work fears Workplace experience Workplace readiness and support</p>	<p>resistance</p>
5	Focus Group 2	8325 - 8630	<p>The name ECT's weight that it had when I started has depreciated a lot, we are still fully 100% at competition with AEA - not that I'm undermining them. But you must remember they've only done a four-month course and we've been to this very long technician course for two years. But there is no recognition.</p>	<p>Negative perception of ECT Professional hierarchy Resistance Work fears Workplace experience</p>	<p>Professionalising the industry</p>
11	Focus Group 2	15424 - 15579	<p>Now having to go back to the station and actually find your supervisor is less qualified than you, you'll find that your manager is less qualified than you.</p>	<p>Resistance Professional hierarchy</p>	<p>Professionalising the industry</p>
12	Focus Group 2	16297 - 16913	<p>But the reaction that we got when we came back, it was not a good reaction from the colleagues that were not trained, they were scared of us that we're going to take everything in front of them, the opportunities that are coming. And if maybe there's a post for manager, they were not thinking that they will be able to participate in the interview to get the manager's post, just because there's an ECT they think automatically they are the manager, but as time went on, they kinda accepted it, okay, we are just AEAs and they are ECTs, so we'll</p>	<p>ECT Training for the operational environment Negative perception of ECT Professional hierarchy Resistance Work fears Workplace experience</p>	<p>Threatened/ Intimidated Management Overcoming resistance</p>

			compete. If we don't win, we'll go the other way to try to fight them.		
13	Focus Group 2	17625 - 18056	We said how about now for each ambulance there is a BAC and ECT because even then there were way lesser AEs. Then came the acting post when the supervisor had to go on leave. According to the qualifications, the ECT had to act - they had a problem and saying ECTs cannot act in supervisory positions because they are more qualified - they should be on the streets - them as BACs have to be in the office, help with admin and audit.	Negative perception of ECT Resistance Professional hierarchy Work fears Workplace experience	Threatened/ Intimidated Management and Colleagues
4	Focus Group 3	7769 - 8325	So, I qualified in 2013 as an ECT and came back operational, but "with a lot of confusion", not only with myself, but also among other staff. Whether I'm advanced life support, or what I want to be regarded as in terms of my practice. And this created, I think it's some of the things that may have been said by the other participants. So, this "created a bit of resistance in the system" of acknowledging the ECT capabilities, and the impact that the skills that they acquired, can make in the community or in the service that are given to the community.	Difficult working environment ECT Training for the operational environment Professional hierarchy Work fears Workplace experience Workplace readiness and support Resistance	Professional Status Occupation Specific Dispensation remuneration and recognition Professionalisation the industry
6	Focus Group 3	10907 - 11566	It's the entire system, it's the colleagues at the operational level of, those who are either in the same or let me say at operational level who are juniors. For example, "nobody will call ECT for a backup, even if they see a need that this patient needs somebody of higher qualification". So, the feeling is no ECTs. So, this is because of the confusion, everybody's not clear, what the ECTs are about or what will they do, should they be called, but I somehow at some point, I will say, I have taken an initiative of presenting to colleagues that this is, should you have this particular case, these are the abilities that comes within the ECT qualification.	Components of ECT training Confidence building Difficult working environment ECT Training for the operational environment Negative perception of ECT No clarity on roles and responsibility Patient care Professional hierarchy Resistance Workplace experience	No clarity on roles and responsibility? Overcoming resistance
8	Focus Group 3	16966 - 17264	So there was a lot of rebellious people who had resistance, there was a lot of tensions, there were a lot of challenges.	Difficult working environment Professional hierarchy Resistance	Management support

			Our colleagues and management, they were like, we were in-between, so they were fighting us. They were - I don't know how to put it, they were like, "we are treated special".	Work fears Workplace experience Workplace readiness and support	
9	Focus Group 3	18410 - 19239	So even our staff members, We are prepared to tackle those problems but we are not used in our stations, like our colleagues said. They judge us, "you have a drug bag but I don't have a drug bag" . So if they go to attend to the patient that maybe is convulsing, since yesterday the patient is continually convulsing, but he or she (colleagues) does not have that gut to call you. You are there at the station, the problem is see at the control centre because if they know that this ECT available, or maybe is working or is on standby, you'll sit there with your Diazepam drug. But they will just call anyone junior in the station to go to the call – to the convulsing patient. And what our colleagues do is that they will come with this convulsing patient to the clinic. They don't just give us the chance to practice, so to speak	Components of ECT training Difficult working environment ECT call allocation ECT Training for the operational environment Negative perception of ECT No clarity on roles and responsibility Professional hierarchy Workplace experience Resistance Workplace readiness and support	Management support No clarity on roles and responsibility? Professional Sabotage?
10	Focus Group 3	19914 - 20408	The preparation after the training of the ECT programme, the preparation was good because they instilled the discipline to the ECTs and also instilled the professionalism. After preparation of that programme, there was no support from the station managers because they were expecting ECTs...so there was that negative attitude already – so there was not enough support from the station managers at the station level. We struggled too much when we came from the college as an ECT at the operation.	Preparation by training?? Resistance	Components of ECT training Management Support
11	Focus Group 3	21503 - 21837	"There was this thing of resistance from management". For the mere reason that "most if not all management were ILS" . When the ECT came in, they were having all, they wanted somewhere to submitary?? then it is where you experience something like allocation of resources.... "The utilisation of the ECT was not correct at some stages".	Difficult working environment Professional hierarchy Resistance Work fears Workplace experience Workplace readiness and support	Threatened/ Intimidated Management and Colleagues No clarity on roles and responsibility?
12	Focus	22656 -	Ja. It was my senior before I went to ECT training. So	Professional hierarchy	Threatened/

	Group 3	22767	when I came back, he wanted to test me. So I showed him.	Work relationships	Intimidated Management and Colleagues
3	Focus Group 4a	4097 - 4523	I think it was an advantage to appoint shift leaders and station managers – who are ECT qualified than those who are AEA qualified and still on that, "I think there are still station managers that felt threatened. They don't want to accept a higher qualified person in their workplace". So for them to give them support, procure equipment, just in the interest of patient treatment - not in for competition, it is a challenge.	Resistance	Overcoming resistance Threatened/ Intimidated Management and Colleagues
5	Focus Group 4a	6663 - 7157	even treating the patient – no we should start treating patients like this. Most in most cases like when the shift starts, prepare something for the shift - let me say I'm with somebody out on a call and then I saw something wrong, I would prepare them and then present to the whole shift somewhere in the beginning it was not easy. "Some would listen and some will be playing with their phones but at the end I managed to win them". So then I was able to maybe present all the shifts everything	Resistance	Overcoming resistance
6	Focus Group 4a	16786 - 17370	I think there was not enough information relayed to the stations about this ECT, where you need them to be used, because there was this misconception that when the ECTs come, because they are the most qualified on the station, and by then they would be taking up all the positions that whoever is having, and I'm telling you it was very difficult, because you will hear from the corner to say, "you cannot be my supervisor. I've been here for too long", they did not know that actually ECTs are more meant to be on the road, than to be in office. "So the reception was not very good".	Difficult working environment Negative perception of ECT No clarity on roles and responsibility Professional hierarchy Work fears Resistance Workplace experience Workplace readiness and support	No clarity on roles and responsibility? Threatened/ Intimidated Management and Colleagues
7	Focus Group 4a	17371 - 18033	I'm telling, not very good, because everyone was expecting - must remember that before the introduction of the ECTs, the most highest qualification was ILS. And there was not so much of ILSs at stations you'd find in a shift and there was about maybe two or three ILSs, if I still remember correctly, two or three in a shift. "So here comes an ECT. More especially from school. And you're	Difficult working environment ECT Training for the operational environment Professional hierarchy School Leavers Work fears Work relationships Workplace experience	No clarity on roles and responsibility? Threatened/ Intimidated Management and Colleagues

			the most qualified person and expecting that you should be taking over all the responsibilities so they wouldn't take it nicely" as I'm saying that maybe the relay of information of these ECTs to station so that people should understand what a ECT is and what it meant for.	Resistance	
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WORKPLACE EXPERIENCE

0	Document	Reference	Quotation Content	Codes	Your suggested sub-category
7	Focus Group 1	5542 – 6242	Another challenging thing was whereby you as an ECT were expected to do all the calls, all emergency calls, now whenever there is a call, they would say – no, the ECT's are there, they will do it – so that was one of the challenges in the beginning	Workplace experience?	No clarity on roles and responsibility ?
8	Focus Group 1	6543 – 6860	In my shift we had only one ECT by then. Due to certain circumstances, the ECT when I arrived at the station was in the office....and at a shift level there were only AEAS... I was the only ECT at that level... so each challenging call that was given to the shift, it was given to the ECT. So it was mostly challenging yes.	Workplace experience	No clarity on roles and responsibility ?
11	Focus Group 1	19275 - 19529	But as a new qualification I think that is what is happening in most cases where you come in and do not understand why you need this and why you want things - they think that you are being impossible – "You are just trying to show off" all those things.	Workplace experience	No clarity on roles and responsibility ?
2	Focus Group 2	3099 – 3374	I was I was already a manager at that time, I think not I think I know I was a manager. So, but because of the excitement one was most of the time working on the road, so sort of to practise and to see if one knew the skills that he had learned from the training institution.	Workplace experience	Skills acquired excitement/ exploration
9	Focus Group 2	11368 - 11863	I worked so hard, but there was no equipment, enough equipment, especially the drugs, but at least within two to three months, demands to give out the drugs. Then I started to work. And I used to work fine. Because I do the things that I was taught and but only the doctors at Casualty. They	Workplace readiness and support Workplace experience	Non-responsive Management Relations with other healthcare professionals

			are the only one who realize that we can do distance from ALS as ECT and they were amazed. What are we doing? They think maybe its not the transfer ECT, how I manage a patient and even the control center.		
1	Focus Group 3	907 - 1841	I qualified that way and prior that 2010, it was too much for me as a student, especially when World Cup 2010 came. Especially that it comes in wintertime. And we were used so much in the world cup in North west, especially when the games at the Royal Bafokeng stadium. And during that time, I felt that this is too much for me. I even wanted to quit because we spent too much hours in the stadium and the problem actually, the world cup program took a lot of our time and we even talked about the hours that the college will give us back or they will even pay us. they will pay us after World Cup but you didn't get anything like that. You will put in so many hours that some hours will be used for us to compete our ECT program then with ECT program itself after qualifying, then there were a lot of things in terms of the skill. There are some SKILLS that it seems as if whether are we on the same level with the CCA at operations.	Preparation by training?? Workplace experience	Components of ECT training Professional Status
2	Focus Group 3	1843 - 2425	There are some skills that were said, they will be added after we qualified in ECT. We expected a lot of added skills as an ECT, till to date. So another thing one other things the advanced life support with ECT, CCA and ECP, I was confused whether I am falling under advanced life support, all of us CCA and ECPS. So we were just practicing the field – with some tension between our skills at operational level, especially between ECT and CCA, in terms of intubation, intubated patient, how the ECT has to behave in that situation and where should the CCA is also getting in there.	Workplace experience	Professional Status
4	Focus Group 3	7769 - 8325	So, I qualified in 2013 as an ECT and came back operational, but "with a lot of confusion", not only with myself, but also among other staff. Whether I'm advanced life support, or what I want to be regarded	Workplace experience Workplace readiness and support Resistance	Professional Status Occupation Specific Dispensation

			<p>as in terms of my practice. And this created, I think it's some of the things that may have been said by the other participants.</p> <p>So, this "created a bit of resistance in the system" of acknowledging the ECT capabilities, and the impact that the skills that they acquired, can make in the community or in the service that are given to the community.</p>		<p>remuneration and recognition Professionalisation in the industry</p>
5	Focus Group 3	10117 - 10618	<p>And beyond that, there are some skills within ECT where there is consultations and with other drugs where the consultation have to be made, there is also a resistance because if somebody is like for instance, the protocol will say a medical officer or an ECP somewhere, there is a resistance whereby in terms of consultation, you will not get the joy of getting the proper advice and being acknowledged that you are capable of doing something so when you do that consultation there is a bit resistance.</p>	Workplace experience	<p>Relations with other healthcare professionals</p>
6	Focus Group 3	10907 - 11566	<p>It's the entire system, it's the colleagues at the operational level of, those who are either in the same or let me say at operational level who are juniors. For example, "nobody will call ECT for a backup, even if they see a need that this patient needs somebody of higher qualification". So, the feeling is no ECTs. So, this is because of the confusion, everybody's not clear, what the ECTs are about or what will they do, should they be called, but I somehow at some point, I will say, I have taken an initiative of presenting to colleagues that this is, should you have this particular case, these are the abilities that comes within the ECT qualification.</p>	<p>Resistance Workplace experience</p>	<p>No clarity on roles and responsibility? Overcoming resistance</p>
9	Focus Group 3	18410 - 19239	<p>So even our staff members, We are prepared to tackle those problems but we are not used in our stations, like our colleagues said. They judge us, "you have a drug bag but I don't have a drug bag". So if they go to attend to the patient that maybe is convulsing, since yesterday the patient is continually convulsing, but he or she (colleagues) does not have</p>	<p>Workplace experience Resistance</p>	<p>Management support No clarity on roles and responsibility? Professional Sabotage?</p>

			<p>that gut to call you. You are there at the station, the problem is see at the control centre because if they know that this ECT available, or maybe is working or is on standby, you'll sit there with your Diazepam drug. But they will just call anyone junior in the station to go to the call – to the convulsing patient.</p> <p>And what our colleagues do is that they will come with this convulsing patient to the clinic. They don't just give us the chance to practice, so to speak</p>		
11	Focus Group 3	21503 - 21837	<p>"There was this thing of resistance from management". For the mere reason that "most if not all management were ILS". When the ECT came in, they were having all, they wanted somewhere to submitary?? then it is where you experience something like allocation of resources.... "The utilisation of the ECT was not correct at some stages".</p>	Resistance Workplace experience	<p>Threatened/ Intimidated Management and Colleagues No clarity on roles and responsibility?</p>
1	Focus Group 4a	2300 - 2742	<p>And the CCA can intubate – you are useless or something, something like that. So we had to adapt to the situation and try to win everyone else to say, look, treating patients is not about intubating. And this is what made you need to do and this is what we don't need to do, stuff like that. So basically, I know for everyone, "it was difficult", as much as it was difficult for me to adapt to the station and the working environment outside.</p>	Workplace experience	Professional Status
4	Focus Group 4a	5301 - 6092	<p>When I came back to the station it was a different from that AEA one that was at the college 2 years back, and then not to say maybe I was like away from the people but it was the discipline that I have. even telling people no you shouldn't do this you must do this. It was like "she's feeling she's much better than others" and then the responsibility it wasn't easy to carry that much responsibility. Especially from "I'm coming from the station that we have those old people who are saying I've been there for long" - it was not easy for you to tell these people that I'm now your senior. It was not easy and then in our shifts, like</p>	Workplace experience	Professional Status

			i was one ECT and then they would know it and I was prepared. When coming to work, "everyone was prepared to see me fail or am I capable to do the work".		
6	Focus Group 4a	16786 - 17370	I think there was not enough information relayed to the stations about this ECT, where you need them to be used, because there was this misconception that when the ECTs come, because they are the most qualified on the station, and by then they would be taking up all the positions that whoever is having, and I'm telling you it was very difficult, because you will hear from the corner to say, "you cannot be my supervisor. I've been here for too long", they did not know that actually ECTs are more meant to be on the road, than to be in office. "So the reception was not very good".	Resistance Workplace experience	No clarity on roles and responsibility? Threatened/ Intimidated Management and Colleagues
7	Focus Group 4a	17371 - 18033	I'm telling, not very good, because everyone was expecting - must remember that before the introduction of the ECTs, the most highest qualification was ILS. And there was not so much of ILSs at stations you'd find in a shift and there was about maybe two or three ILSs, if I still remember correctly, two or three in a shift. "So here comes an ECT. More especially from school. And you're the most qualified person and expecting that you should be taking over all the responsibilities so they wouldn't take it nicely" as I'm saying that maybe the relay of information of these ECTs to station so that people should understand what a ECT is and what it meant for.	Workplace experience Resistance	No clarity on roles and responsibility? Threatened/ Intimidated Management and Colleagues

PREPARATION BY TRAINING

0	Document	Reference	Quotation Content	Codes	Your suggested sub-category
6	Focus	4715 -	Ja, we had challenges like we are school leavers – we	Experimental group	Components of

	Group 1	5518	<p>know nothing about EMS – really we did not have that much information – but at the College they told us about BLS and ILS – what it is and how to go about it working with the patient and all that. But when coming to the station, the other ones ILS were the ones who were most advanced at that time. I am coming as a school leaver telling them what to do, they didn't take it right at first. But those in-service trainees, they were the ones that helped us to overcome our challenges. Because resistance was too much, it doesn't mean we are ECT we can do it. But with the in-service training and the support from manager at the time it helped us a lot. We adapted fast knowing that it is not for us but for the new course of treatment for the patient.</p>	<p>Professional hierarchy Resistance School Leavers Theory vs practical experience Workplace experience Preparation by training ??</p>	<p>ECT training Threatened/ Intimidated Management Overcoming resistance</p>
10	Focus Group 1	10326 - 10841	<p>The training took the mentality of being upskilled. You end up thinking laterally because you were taught many things like participant 1 mentioned. Those fundamentals and modules, HIV and the EMS structure modules– the EMS structure end up putting people from the school leaver point of view, putting them on-board – to have those hierarchy, how it works and it end up training them to see where they fit and also giving our colleagues a thorough training that they are in the system - they are also helping a lot.</p>	<p>ECT Training for the operational environment Professional hierarchy Work relationships Preparation by training ??</p>	<p>Components of ECT training</p>
1	Focus Group 3	907 - 1841	<p>I qualified that way and prior that 2010, it was too much for me as a student, especially when World Cup 2010 came. Especially that it comes in wintertime. And we were used so much in the world cup in North west, especially when the games at the Royal Bafokeng stadium. And during that time, I felt that this is too much for me. I even wanted to quit because we spent too much hours in the stadium and the problem actually, the world cup program took a lot of our time and we even talked about the hours that the college will give us back or they will even pay us. they will pay us after World Cup but you didn't get anything like that. You will put in so many hours that some hours will be used for us to compete our ECT program then with ECT</p>	<p>Difficult working environment Expectations from ECT qualification Negative perception of ECT Professional hierarchy Remuneration and recognition Preparation by training?? Workplace experience</p>	<p>Components of ECT training Professional Status</p>

			program itself after qualifying, then there were a lot of things in terms of the skill. There are some SKILLS that it seems as if whether are we on the same level with the CCA at operations.		
10	Focus Group 3	19914 - 20408	The preparation after the training of the ECT programme, the preparation was good because they instilled the discipline to the ECTs and also instilled the professionalism. After preparation of that programme, there was no support from the station managers because they were expecting ECTs...so there was that negative attitude already – so there was not enough support from the station managers at the station level. We struggled too much when we came from the college as an ECT at the operation.	Preparation by training?? Resistance	Components of ECT training Management Support
2	Focus Group 4a	3578 - 4093	Transitions of ECT from college and looking at a BAA qualified staff (in-service staff) and AEA qualified staff there was a vast difference. I think the difference that I am talking about is the difference especially at the college - because the BAA's is struggling a bit and for AEA's, at least it was a like a uplifting of skills. Coming back to workplace. Now, I will be "talking maybe from management perspective to say even now, ECTs are more disciplined than those BAAs and AEAs that were appointed year back".	Positive college experience Professional hierarchy Work relationships Workplace readiness and support Preparation by training??	Components of ECT training

WORKPLACE READINESS AND SUPPORT

0	Document	Reference	Quotation Content	Codes	Your suggested sub-category
13	Focus Group 1	20996 - 21601	In essence, through that there was a negative receptions, especially when coming to the workplace readiness, it was not there because as participant 01 was highlighting her points that the stations were not ready like the station I was working at. They were not ready when we requested some of the stuff, there was some tension or resistance from the manager saying	Workplace readiness and support	Non-responsive Management

			we're asking a lot and then why the college didn't notify them first on the stuff that they were supposed to buy. So, things were not procured in time and we were struggling a lot. So, the work place readiness, it was not conducive by then.		
1	Focus Group 2	1475 - 1986	I had already people that were in the first group and the second group of the ECTs that qualified as emergency care technicians. And those people I had, we had already through them prepared a lot of things, you know, like we the medications which is at the level of the qualification, the equipment. And also we had already prepared the ground for them to be accepted as the advanced life support practitioners because at that time, there was a confusion that they were not at the level of advanced life support.	Workplace readiness and support	Preceding graduates
3	Focus Group 2	6597 - 7003	And when we did our practicals so I'm adding on what she has already said. I would say our predecessors did not plough enough like participant 5 said he found already the ground prepared for ECT and he was just flowing when he got there and his successors has also received that kind of thing. With Mafikeng it was a bit different whereby you get that as ECTs we are called by AEA or ILS, did not like ECTs.	Workplace readiness and support	Preceding graduates
4	Focus Group 2	7957 - 8321	I liked what he said that most of the predecessors went into being supervisors, went into the managers and they did not represent the qualification fully at the ground level. So when it came to us at a later stage, we found that it struck me we needed to, to lift the banner - to lift the name of ECT. At current, I would say the support for ECT has dropped a lot.	Workplace readiness and support	Preceding graduates
6	Focus Group 2	8681 - 9316	We don't feel like anything above them. Remuneration-wise levels, recognition at HR, even they don't even understand why would you want to be a bit different or better than ILS and you should explain to them that the treatment that you give, the management that you give, the drugs that you will give will mean nothing to them. So basically. It is, how shall I say, this is going grey to disappear, unless something is really done about it. I	Workplace readiness and support	Occupation Specific Dispensation remuneration and recognition



			really love ECT. I really love being a medical official, paramedic and motivation wise, it is dying. It is dying and we need resuscitation. We need CPR very fast, ECT CPR as soon as possible.		
7	Focus Group 2	9411 - 9493	ECT and ILS – there is no difference. It is the same thing. There's no difference.	Workplace readiness and support	Occupation Specific Dispensation remuneration and recognition
8	Focus Group 2	10497 - 11029	Yeah, people ended up not going for training for ECTs - we tend to be discouraged, we're gonna go there for two years, we come back. The person that I was with on the salary scale, is going to be more than getting more than me when I come back. So it's no use for us going there. So that's the thing that was happening and that it's still happening. So we need something to show that you were trained, you do more skills than the others. You can do better. So the remuneration is the big thing. On the ECTs. That's putting them down.	Workplace readiness and support	Occupation Specific Dispensation remuneration and recognition
9	Focus Group 2	11368 - 11863	I worked so hard, but there was no equipment, enough equipment, especially the drugs, but at least within two to three months, demands to give out the drugs. Then I started to work. And I used to work fine. Because I do the things that I was taught and but only the doctors at Casualty. They are the only one who realize that we can do distance from ALS as ECT and they were amazed. What are we doing? They think maybe its not the transfer ECT, how I manage a patient and even the control center.	Workplace readiness and support Workplace experience	Non-responsive Management Relations with other healthcare professionals
10	Focus Group 2	12062 - 12324	Remuneration. They were so 3 or 4 ILSs, getting more than I was under the salary. But for so many years I hear is that after maybe after about 10 years, they just does better for me. But it's only because I like to treat the patient even though my supervisor can.	Workplace readiness and support	Occupation Specific Dispensation remuneration and recognition
4	Focus Group 3	7769 - 8325	So, I qualified in 2013 as an ECT and came back operational, but "with a lot of confusion", not only with myself, but also among other staff. Whether I'm advanced life support, or what I want to be regarded as	Difficult working environment ECT Training for the operational environment Professional hierarchy Work fears	Professional Status Occupation Specific

			<p>in terms of my practice. And this created, I think it's some of the things that may have been said by the other participants.</p> <p>So, this "created a bit of resistance in the system" of acknowledging the ECT capabilities, and the impact that the skills that they acquired, can make in the community or in the service that are given to the community.</p>	<p>Workplace experience Workplace readiness and support Resistance</p>	<p>Dispensation remuneration and recognition Profesionalization the industry</p>
7	Focus Group 3	12345 - 12610	<p>So it's those things that I said the system was not acknowledging the ECT with its capabilities. So also with other colleagues in the higher level, with like, they were having no confidence in ECTs to be able to carry out their duties at the level of their training.</p>	<p>Components of ECT training Difficult working environment Negative perception of ECT Professional hierarchy Resistance Workplace experience Workplace readiness and support</p>	<p>Occupation Specific Dispensation remuneration and recognition</p>

13	Focus Group 3	26774 - 27539	<p>Something that was said, that was very important about the consultation. I think the system did not create an environment to be easy for us in a way, because even if I attend a case where I administer Morphine, I don't have anybody in mind who I can call in the whole district or the sub-district where I'm working. I don't have anybody who I know is available for me to consult to say, "I'm having a patient here..." and I think morphine is indicated and "I need you to give me advice". I'm sorry to compare our situation to the private sector, when you get to a certain company in a private sector, they give you, before you even start working, "here's your MO..." Blah blah blah..."You should be calling this one or that one..." and "This is what you should be doing"....</p>	<p>Mentorship programme Peer support Positive work experience Previous work skills Professional hierarchy Use of pharmaceutical agents Work fears Work relationships Workplace experience Workplace readiness and support</p>	<p>Non-existent Clinical Governance</p>
14	Focus Group 3	28123 - 28704	<p>How are we going to close the gap of our Juniors to call the back-up of us as ECTs and how can we sort it out. Last time I was saying, if you send someone to a call, and he sees that the patient need advanced life support – if he or she don't call that person, it means that he was undertreating the patient and that person need to be disciplined and be reported because he was actually undertreating the patient. He was supposed to call someone to give a good care to the patient. The standard of care should be at the same level since we have all the same skills at the station.</p>	<p>Challenging call outs ECT call allocation ECT Training for the operational environment Patient care Professional hierarchy Scope of practice for ECTs Workplace experience Workplace readiness and support</p>	<p>Non-existent Clinical Governance</p>
15	Focus Group 3	29157 - 29772	<p>The time I was operational, I did have sort of a relationship with the doctors, at that time because when you get an order for a schedule 05 or 06, they need to sign on the order, they would sign it and then you will get the schedule 05 or 06 medication. But after, when I come with a patient that has been given a schedule 05 or 06 – especially morphine – on the OP there was a part that has to be authorised and I would request the doctor to sign there, because we have agreed that this drugs as I am going to give them, I have to do a consultation and on deliberation there was a delay treatment for the patient.</p>	<p>ECT Training for the operational environment ECT work enthusiasm Peer support Positive work experience Professional hierarchy Use of pharmaceutical agents Work relationships Workplace experience Workplace readiness and support</p>	<p>Non-existent Clinical Governance</p>

8	Focus Group 4a	29534 - 29851	Firstly, we will start with equipment for example Intra-osseus needles, LMAs: there were no equipment, including basic equipment. So, when we got there, we had to procure equipment. Luckily, I was the station manager with ECT qualified shift leaders we came together and managed to procure everything that we needed.	ECT Training for the operational environment Professional hierarchy Resources Work relationships Workplace readiness and support	Non-responsive Management
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- Abstract: with Manuscript Title, Abstract & Keywords
- Introduction
- Methods
- Results
- Discussion
- Conclusion
- Acknowledgements
- Competing Interests
- References

Abstract

The abstract page should have the manuscript title at the top.

For *quantitative research* the abstract should have the following sub-headings:

- Introduction (the last sentence should be study objective, same as in the main introduction)
- Methods
- Results
- Conclusion

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Introduction

- An overview of the current literature which demonstrates a gap and how this leads to the current study.
- Provides an overview of the problem being studied and the reasons for the study.
- Background information may be presented => historical developments leading to the study.
- The study objective, most important part => the last sentence in the last paragraph.

Methods

- Should describe exactly how the study was conducted.
- Designed to answer the research question
- The most important section of the article, it must be described with sufficient detail and clarity so that another researcher could replicate the study using a different group of participants.
- Used to assess the validity and reliability of the study.

Study Design

- State the study design, eg. a retrospective cohort study.

Setting

- The department/university/ambulance service – number of staff/state and population, reference state population.
- Delete if not applicable.

Participants/Population

- Describe who participated in the study.
- Should include the calculation or method for determining the sample size (if required).
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- Used when using measurement scales, eg. pre-existing surveys.
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Outcome Measures

- Should include the outcomes that will be measured during the study, eg. death, length of hospital stay.
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- Describe what data will be analysed using which stats, tests and statistical program.
- Delete if not applicable.

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- List all ethics committees that approved the study.
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- Demographic results first.
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- Is variability in the results reported?
- Graphical summaries must be accurately presented.
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- Approximately eight to ten paragraphs.
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- The second last paragraph can be one that recommends further research, or changes to current practice.
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Conclusion

- Should summarise the study, no additional information should be added.
- Two to three sentences is normally sufficient to summarise the study.
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