Strategies to improve the work environment of professional nurses working at a private hospital in Bloemfontein.

by

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DECLARATION

I, Jacoba Christina Ruder, hereby declare that this research is my own independent work. I further declare that this work is submitted for the first time at the University of the Free State, Faculty of Health Sciences, towards a Masters Degree in Social Sciences (Nursing) and it has never been submitted to any other university or faculty for the purpose of obtaining a degree and all the sources that were used and quoted have been indicated and acknowledged as complete references.

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1 July 2013

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I dedicate this study to all the true professional nurses who still take pride in their work and care for their patients tirelessly, without much recognition.

ABSTRACT

Nursing as a profession is currently facing a multitude of difficulties and adversaries. Some of the difficulties and adversaries are poor planning within the managerial top structure of the profession, general negative opinion of the nursing profession, managed patient care by medical schemes, privatisation of hospital care and an ever changing patient profile. These factors lead to the professional nurses of today feeling overwhelmed and frustrated, who will easily leave the profession causing high rate of turnover and a loss of talent and expertise.

During the course of this study the current situation within a specific private hospital was evaluated by using the Nominal Group Technique. Characteristics of a negative and a positive work environment were specified and the advantages of creating and maintaining a positive work environment were emphasised. The recommendations gathered during the nominal group sessions were categorised and prioritised to ascertain the most important and critical factors that could improve the work environment of the professional nurses.

Strategies were formulated based on the recommendations generated by the professional nurses themselves to improve their work environment. These strategies could be used by the management of the hospital to improve the work environment of the professional nurses to be able to retain the existing staff and recruit interested candidates to fill the vacant positions.
The hierarchical needs theory of Maslow was used during the study to indicate the importance of creating and sustaining a positive work environment for the professional nurse by first concentrating on the attainment of the lower order needs. Once the lower order needs are met, the higher order needs will become priority and once that is met, self-actualisation and fulfilment of the professional nurses will follow. Fulfilled staff working in a motivating, positive work environment will not think of leaving the profession and will deliver good quality nursing care leaving the patients feeling satisfied and well cared for.

Key terms: Positive and negative work environment, Maslow's hierarchical needs theory, work environment; strategies for the improvement of the work environment, rate of turnover, nursing management, professional nurses, nominal group technique, private hospital.

OPSOMMING

Daar word tans baie probleme ondervind binne die verpleegberoep waarvan die oorsaak toegeskryf kan word aan swak beplanning binne die top bestuur, ‘n algemene negatiewe persepsie van die beroep, beperkinge op die gebruik van mediese sorg deur mediese fondse, privaat hospitaalsorg en ‘n voortdurend veranderende pasiëntprofiel. Genoemde faktore het tot gevolg dat die geregistreerde verpleegkundige van vandag oorweldig en gefrustreerd voel en nie sal skroom om die beroep te verlaat nie, wat lei tot ‘n hoë personeelomset en verlies aan talent en vaardighede.

Die huidige werksomgewing vir die geregistreerde verpleegkundige binne ‘n sekere privaat hospitaal is ondersoek deur gebruik te maak van die nominalegroeptegniek. Die positiewe en negatiewe karaktertrekke van ‘n werksomgewing is gespesifiseer en die belang van die skepping en instandhouding van ‘n positiewe werksomgewing is onderstreep. Die aanbevelings wat gedurende die groepsessies gegenereer is, is gekategoriseer en geprioritiseer om die vernaamste probleemareas binne die werksomgewing van die geregistreerde verpleegkundige te verbeter.

Strategieë ter verbetering van die werksomgewing van die geregistreerde verpleegkundige is saamgestel op grond van die voorstelle wat gemaak is deur die geregistreerde verpleegkundiges gedurende die groepsessies. Hierdie strategieë kan deur die bestuur van die hospitaal aangewend word om die werksomgewing vir die geregistreerde verpleegkundige te verbeter, wat kan lei tot minder personeelomset en nuwe aanstellings om vakante poste te vul. Maslow se behoeftehïerargieteorie is gebruik om die belang te onderstreep om eerstens aandag te gee aan die vervulling van laerordebehoeftes voordat hoërordebehoeftes in aanmerking geneem kan word. Alvorens laerordebehoeftes nie vervul is nie, kan die vervulling van hoërordebehoeftes nie plaasvind nie. Self vervulling en optimalisasie kan slegs gebeur indien die laerordebehoeftes vervul is en die geregistreerde verpleegkundige werksaam is binne ‘n positiewe, opbouende werksomgewing. Die vervulde geregistreerde verpleegkundige sal hoë kwaliteit verpleegsorg lewer wat pasiënte geborge en goed versorg sal laat voel.

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Sleutelterme: Positiewe en negatiewe werksomgewings, Maslow se hiërargiese behoefte teorie, werksomgewing, strategieë vir die verbetering van die werksomgewing, personeelomset, verpleegbestuur, professionele verpleegkundige, nominalgroepstegniek, privaat hospitaal.

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CHAPTER 1:

THEORETICAL BACKGROUND, PROBLEM STATEMENT AND LAYOUT

"Nursing is an art, and if it is to be made an art, it requires as exclusive devotion, as hard a preparation, as any painter's or sculptor's work."

Florence Nightingale (Roussel, 2009:102).

1.1 INTRODUCTION

Nursing care within South Africa leaves a lot to be desired, which could be attributed to a high degree of centralisation of the decision making and control as well as inadequate planning within nursing (Booyens, 2008:3). However, poor decision making, lack of control and inadequate planning are not the only difficulties: staff management is not done with the necessary planning and interdepartmental collaboration between nursing and Human Resource departments, thus leading to an unnecessary high level of staff turnover and loss of potential (Booyens, 2008:3). A high level of staff turnover and loss of nursing potential lead to a negative and unproductive work environment causing more negative effects such as staff that feel hopeless and unhappy and patients receiving nursing care of a low standard (Ehlers & Oosthuizen, 2011:Online).

An overburdened health system gets bombarded with change on the political, socio-economical, demographic, technological and epidemiological front which weakens the health system further. The work environment of the nursing staff is affected by these changes contributing to nurses experiencing the work environment as unfavourable and negative (Booyens, 2008:3; Breier, Wildschut & Mgqolozana, 2009: Online). It is therefore no surprise that nurses in general and especially professional nurses are leaving the profession seeking more satisfying and lucrative opportunities (De Villiers, 2005:Online; Mdindela, 2009:17).

The importance of the work environment on staff morale and lower patient mortality is well documented through research on the Magnet hospitals (Aiken, Clarke, Sloane, Lake & Cheney, 2008; Lake, 2002). The reports of these research highlighted the importance of

decentralized decision making; effective and visible leadership, acknowledgement of professional nurses' autonomy, having enough staff on the establishment and utilizing a flexible scheduling system (Lake, 2002:177).

In the history the importance of the environment on human beings was already recognized as early as the 1800s where the teachings of Florence Nightingale (1860) emphasised the fact that persons are in relationship with the environment. She stated that a positive physical environment with sufficient fresh air, light, warmth and cleanliness has healing properties which can only benefit patients and staff alike (Jooste, 2010:16).

1.2 THEORETICAL BACKGROUND

The importance of the environment on the human race was captured by Maslow in his hierarchy of needs theory (see figure 1.1). This theory states that for a person to be able to attain the highest level of fulfilment which is named "self-actualisation" in the model, the lower levels (specifically the physical and emotional needs) first must be fulfilled (McLeod, 2007: Online; Oosthuizen & Ehlers, 2011: Online; Stacey & DeMartino, 1958:26).

Figure 1.1 shows the five hierarchical levels within a pyramid.

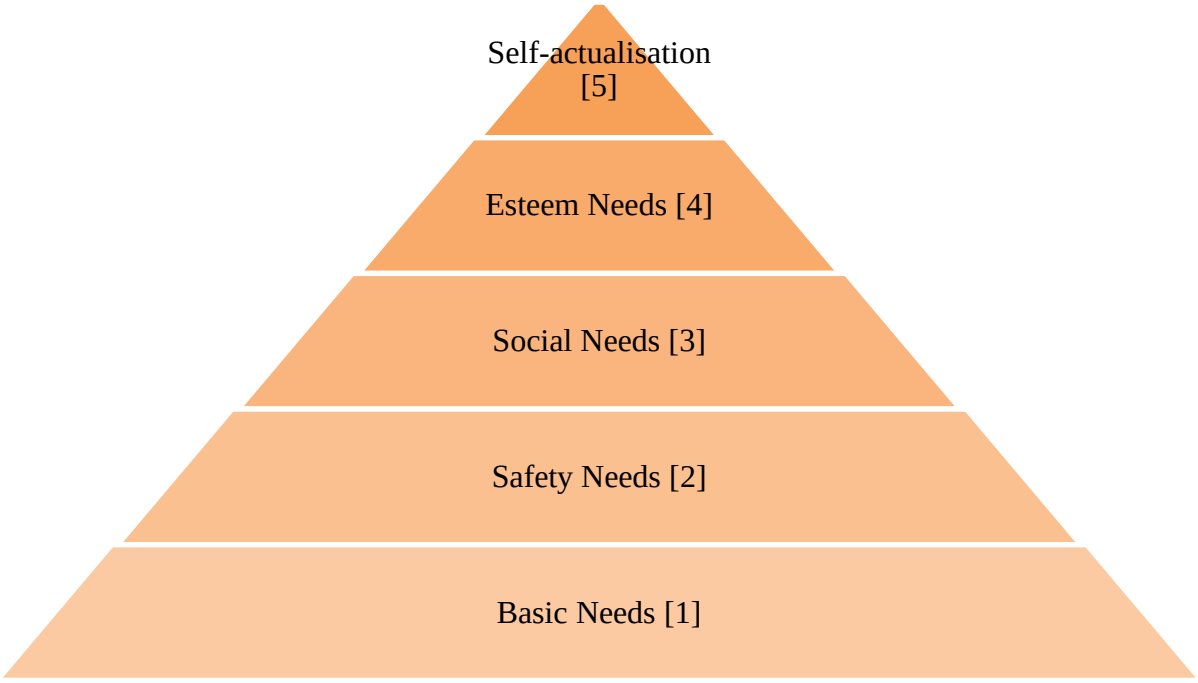


Figure 1.1 Maslow's original hierarchy of needs

Maslow's theory (figure 1.1) clearly indicates that, to reach self-actualisation, the lower-order needs first have to be addressed. Basic needs [1] include biological and physiological needs such as air, food, drink, shelter, warmth, sex and sleep. The second level [2] includes needs of safety such as protection from the elements, security, order, law, limits and stability. The third level [3] deals with social needs where belongingness and love are important such as work group, family, affection and relationships. The esteem needs [4] are the fourth level which includes self-esteem, achievement, mastery, independence, status, dominance and managerial responsibility. The top level [5] includes the needs for self-actualisation such as realising personal potential, self-fulfilment, seeking personal growth and peak experiences. Once that self-actualisation is reached new needs develop and the cycle repeats (Benson & Dundis, 2003:315-320; Stacey & DeMartino, 1958:26).

Against the background of Maslow's theory, staffs' needs regarding the work environment has to be fulfilled in order for them to feel valued (self-esteem needs) and to reach their full potential (self-actualisation) (Huber, 2000:147; Pietersen 2005:19-25). Fulfilment and self-actualisation of nursing staff contributes to rendering of quality nursing care (Hinno, Partanen, Vehvilainin-Julkunen, & Aaviksoo, 2009:966). Nurses whom reported to be working in a supportive work environment experienced a higher level of satisfaction and were more productive. They were less likely to have burnout and stress, experienced lower intentions to quit, which led to a lower rate of turnover (Booyens, 2008:372; Leiter & Laschinger, 2006:137; Verhaeghe, Vlerick, Gemmel, Van Maele, De Backer, 2006:646-654).

A high turnover rate leads to staff shortages that negatively affect the quality of patient care, social environment , staff morale and it adds to the financial burden of the company (Mdindela, 2009:17; Meyer, Naude & Van Niekerk, 2004:162; Roussel, 2009:370-375).

In the USA the Agency for Healthcare Research and Quality in 2007 found that hospitals performing poorly in nurse retention spend on average $300,000 per year on turnover cost (Roussel, 2009:272; Booyens, 2008:372; Nel, Werner, Haasbroek, Poisat, Sono & Schultz, 2010:583).

According to the English Dictionary (Longman, 2009:566) environment in general refers to *"the air, water, and land on Earth, which is affected by man's activities, setting, situation,*

atmosphere, milieu and location or surroundings of a person". Environment also refers to *"the people and things that are around you in your life, for example the building you use, the people you live or work with and the general situation you are in"* (Longman, 2009:566).

The responsibility of ensuring a positive work environment lies with the executive nurse or top management (Matron) and the nurse manager or second level management (line manager). The executive nurse fulfils the overall management of nursing practice throughout the hospital. This includes provision of nursing education and professional development, enhancing quality nursing care for all the patients and conducting nursing research. These responsibilities could be delegated to lower management but the ultimate accountability lies with the executive nurse (Booyens 2008:196).

To be able to create a safe and positive work environment for the professional nurse it is important to continuously evaluate the work environment and implement the strategies for improvement by the nurse manager and nurse executive. The result of ignoring the cognisance of a positive or negative state of the work environment for the professional nurse could be a costly oversight causing a high rate of turnover amongst professional nurses and other categories. The latter was proven by research in the Magnet hospitals: these hospitals demonstrated that a good work environment led to higher staff retention and improved patients' outcomes (Aiken, Clarke, Sloane, Lake & Cheney, 2008:223).

1.3 PROBLEM STATEMENT

The work environment of professional nurses in the health sector should be a very important consideration to nursing managers. Sixty – seventy percent of a health system budget gets allocated to staff salaries, and nurses contribute the biggest part of the work force within a health system. (Booyens, 2008:116). Jack Needleman in Kelly (2008:297) stated: *"A higher proportion of nursing care provided by registered nurses (professional nurses) and a greater number of hours of care by registered nurses per day are associated with better care for hospitalized patients."* Also taking Maslow's theory into consideration, the work environment is of utmost importance.

A large private hospital network in South Africa had 6 683 full time professional nurses employed during 2010. The turnover of professional nurses of this total hospital network was

18.04% from January up to September 2010 ([redacted] Limited, 2010). In comparison with this, the specific hospital under study had 90 employees (20 registered nurses, 6 Unit Managers and one Nursing Manager and the rest comprised of complementary staff). The turnover amongst the professional nurses of this hospital was 23.33% ([redacted] HRSSC, 2011). The higher turnover amongst the professional nurses working at these particular local private hospitals elicited interest by the researcher as to find reasons why this occurred.

An acceptable or optimum rate of turnover is between 5 and 10% (Booyens, 2008:370). A zero present turnover is also not feasible as it could lead to a stagnant organisation with no new ideas or innovations that newcomers can add to the organisation. In comparison with Booyens, (2008:370) suggesting 5-10% acceptable turnover rate, 23.33% turnover of the hospital under study is detrimental and unfavourably high.

One of the factors contributing to a high turnover rate is, as mentioned, a poor work-environment. This specific hospital's work environment of professional nurses was not yet evaluated for being positive or negative up to date so, to be able to identify whether the work environment contributes to the high turnover or not, inputs of professional nurses are sought.

1.4 PURPOSE OF THE STUDY

The purpose of this study is to describe strategies to improve the work environment of professional nurses working at a private hospital in Bloemfontein.

1.5 RESEARCH QUESTION

The research questions to be answered are:

"What are the views of professional nurses' employed by a private hospital company regarding their work environment?"

"What actions can management implement to improve the work environment?"

1.6 CONCEPT CLARIFICATION

The concepts will be described in alphabetical order.

1.6.1 Nursing environment

The nursing environment consists of the environment in which the **actions of nursing care** of the patient are taking place. Brunner and Suddarth (1980:20) defined nursing care as: *"... a*

service-oriented health profession that is directed toward ***meeting the health and illness needs of the individual*** *relative to all aspects of his or her functioning capacity."*

1.6.2 Strategies

Strategies are **plans of action**, methods or series of movements which are implemented to accomplish a certain goal (Encyclopedia Britannica 2011).

The Longmans Dictionary of Contemporary English define strategies as: *"...****planned series of actions*** *for achieving something..."* (Longman, 2009:1743).

Ehlers and Lazenby (2010:3-4) emphasised the fact that the general view of a strategy changed within the last decade or two due to the fast pace of development and fierce rivalry amongst companies. They defined strategy as a deliberate action or intention to achieve something to be one step ahead of the competition. In the past, strategy was seen as an analytical, extrapolating exercise from the past mainly implemented by the top-management. The emerging view is that a strategy is not only an analytical, but also **organisational exercise creating the future and implemented as a total and continuous process** by the organisation as a whole (Ehlers & Lazenby 2010:3-4).

The strategies that will be discussed in this study will be **operational strategies (plans or methods)** to improve the work environment of the professional nurses working at this specific private hospital.

1.6.3 Work environment

The Oxford Dictionary defines the environment as the **physical surroundings of a person**. That includes the people, psychosocial aspects and physical space around a person (Oxford Dictionary, Online: 2011). According to Lake and Friese (2006:176-188) the core dimensions of an environment are **leadership or management style, decision making, collaboration and cohesion.**

Work environment in this study refers to the physical surroundings of professional nurses in the place where they are working and it comprises of nursing care environment, personnel environment, psychological environment, equipment and stock environment, physical and financial environment.

1.7 RESEARCH PARADIGM

The research paradigm is the framework of thought which a researcher applies where different questions need answering (Polit & Beck, 2008:20). The **ontological** question to be answered is "what is the nature of knowledge", the **epistemological** question is "what is the

relationship between researcher and knowledge" and the **methodological** question is "how to acquire the knowledge" (De Vos, Strydom, Fouché & Delport, 2009:39).

In this study the ontology (nature of reality) is that there are multiple mental constructions of work environment possible (Guba, 1990:19; Bailey, 1997:18-22; Hansen-Kechum & Myrick, 2008:205-213).

The nature of knowledge is the interactions of participants in the research technique, while the "how to acquire knowledge" will be answered through analysing the data gathered through the Nominal Group Technique.

1.8 RESEARCH DESIGN

A research design is a plan of action to be used to conduct a study and is designed to maximise control over the factors that could interfere with the desired outcome of the study (Burns & Grove, 2009:696). Polit and Beck (2008:765) defined research design as *"the overall plan for addressing a research question, including specifications for enhancing the study's integrity"*. Moule and Goodman (2009:168) describe it as a map leading the way in which the researcher will be involved with the participants to be able to report on the research aims and objectives.

Different research designs exist, for example qualitative, quantitative, traditional, non-traditional and mixed method designs. No design is superior to the other and the best design is the one that is most applicable to address the research project at hand (Brink, 2008:119).

For this research to be able to draft strategies to improve the work environment of the professional nurses in this particular hospital, a qualitative, explorative and descriptive design was chosen.

1.8.1 Qualitative design

A qualitative design was chosen, since the data to be collected will be the recommendations from participants, and not figures or completed questionnaires. According to Burns and Grove (2009:746) a qualitative design involves a systematic approach, data gathering is through interactive processes and it can be subjective. Denzin and Lincoln (2005:21) stressed the fact that qualitative research data is generated through interactions and communication of

individuals or groups of people. The needs/ideas/experiences of people (Klopper, 2008:68) in this case the professional nurses themselves, will be captured.

1.8.2 Explorative design

The research is explorative because the strategies to improve the work environment as recommended by the professional nurses themselves will be studied and not only portions thereof.

The exploratory design used in the analysis of data is a step within the research process during which the researcher is committed to familiarise oneself with the research data (Polit & Beck, 2008:463). Brink (208:120) describes an exploratory design as an examination or investigation into the research problem as a whole. Results that are generated from the Nominal Group sessions are exploratory in nature as investigation and exploration of the working environment of the professional nurse are done in its fullest context (Potter, Gordon & Hamer, 2004:127).

1.8.3 Descriptive

The descriptive nature of the study entails that the phenomenon of the work environment is studied (explored) in order to obtain better insight into the complete/whole thereof. The realities and viewpoints of a certain set of professional nurses will be obtained to provide insight in the different aspects of the work environment in order to develop strategies improving it (Brink, 2008:201; Schram, 2006:30).

1.9 RESEARCH TECHNIQUE

The Nominal Group Technique (NGT) will be used to gather data. The NGT is a consensus seeking method which consists of structured meeting/s. An orderly procedure is followed during the meetings to obtain the research data and the data is analysed in both a qualitative and qualitative manner to obtain solutions from the required data (Botma, Greeff, Mulaudzi & Wright, 2010:251; Gibson & Soanes, 2000:459).

1.9.1 Advantages of the Nominal Group Technique

The advantages of this method are that the participants can voice their opinion in a non-threatening, depersonalised manner without the fear of retribution from management as the recommendations of the participants will not be traceable (Carney & McIntosh, 1996:1024; Van de Ven & Delbecq, 1972:338). The second advantage is the fact that the validity of the data is enhanced as the participants and facilitator are present during the generating,

controlling and verifying of the data (Allen, Dyas & Jones, 2004:110). The third advantage is that a large amount of expert opinions and information can be gathered during a short period of time (Moule & Goodman, 2009:230), the results are immediately available and limited extra time is needed to analyse the data. The fourth advantage is the fact that this technique can be used for multi-disciplinary groups and groups from different backgrounds. The fifth advantage is that the nature of the Nominal Group Technique is relatively cost effective, (Gibson & Soanes, 2000:461) which makes the NGT suitable for this study as minimal financial support was received.

Further advantages include that all the participants take part on an equal basis and all the inputs are treated equal (written down, clarified and voted for). Domination by outspoken or articulate participants over quiet and introverted participants is limited as it is a technique where a free and democratic exchange of opinions and generation of ideas takes place (De Vos *et al.*, 2009:408-423).

1.9.2 Disadvantages of the Nominal Group Technique

No disadvantages could be found in the literature regarding the Nominal Group Technique. Possible disadvantages could be the difficulty in finding a suitably qualified and skilled facilitator which could be problematic due to the availability of a facilitator in coordination with the researcher and participants. The second possible disadvantage could be the amount of preparation necessary to be able to conduct the group session such as preparation of the venue, participants' stationary, and drawing of the control card.

1.10 POPULATION

Population refers to the entire number of participants that might be of interest to the researcher and have the same characteristics (Brink, 2008:206; Burns & Grove, 2009:42; De Vos, *et al.*, 2009:193).

The population for this study will be all the professional nurses working at this particular private hospital. There are 27 professional nurses of which one is the Nursing Services Manager, 6 are Unit Managers and 20 are professional nurses directly involved with nursing care (Van der Merwe, 2010:personal interview).

1.11 UNIT OF ANALYSIS, SAMPLING AND RECRUITMENT

Polit and Beck (2008:768) describe the unit of analysis as *"the basic unit or focus of a researcher's analysis-typically individual study participants"*. According to Welman, Kruger

and Mitchell (2005:53) are the unit of analysis the elements within the population that the study is about. Mouton and Marais, (1990:40) stipulated that the "**who** and **what"** questions of the prospective participants of the study should be answered during/through the unit of analysis.

Within this study the unit of analysis was all the professional nurses working at the two particular private hospitals (within the same hospital group) and who complied with the inclusion criteria.

Since there are only 20 professional nurses available to participate in the Nominal Groups, no sampling will be done and all 20 will be approached for participation if they meet the inclusion criteria.

The inclusion criteria will be registration with the South African Nursing Council as a professional nurse, full-time employment at this particular hospital and willingly consent to participate.

1.12 CHARACTERISTICS OF THE PHYSICAL WORK ENVIRONMENT OF THE TWO HOSPITALS

The physical work environment of the two hospitals are discussed in Chapter 2 regarding physical lay-out, buildings, patient profile and services of both hospitals are explained.

1.13 DATA COLLECTION

The Nominal Group Technique is a very structured method and strict adherence to the protocol of the Technique is important for the success of the study. The conducting of the group sessions is discussed in Chapter 2 in four steps. The sessions would be started with step 1 which is the silent generation of recommendations. Step 2 is the Round-Robin reporting of recommendations followed by the discussion phase in step 3. Step 4 is the last step during which the recommendations are ranked.

According to Brink (2008:166), Burns and Grove (2009:746), Polit and Beck (2008:213-214), an exploration session should be done prior to the real research to test the suitability of

the data collection. This is done on a small scale to be able to make adjustments if necessary before the actual start of the research process.

An explorative session will be conducted to determine if the research question elicit appropriate responses.

The explorative session will be held with the five unit managers. The data gathered from the explorative session will not be used in the actual research because the participants of the explorative sessions are part of the management team who might have different ideas as to what aspects should be present within a work environment.
The research question that will be tested is:
"*What recommendations can you make to improve the work environment of professional nurses working at the ……Private Hospital"*

An appropriate facilitator will be contracted to guide and steer the group sessions. The facilitator will have to be well experienced in the handling of group sessions. Strict adherence to the steps of the Nominal Group Technique is necessary to be able to get the most recommendations from the participants (Denscombe, 2010:353).

1.13.1 Saturation

Saturation of data should be achieved when no new ideas are generated within a group session during the Round-Robin phase of the session (Potter, Gordon & Hamer, 2004:127).

1.14 DATA ANALYSIS

Data analysis is the organised, systematic synthesis of research data to be able to compare, reduce and give meaning to data (Polit & Beck, 2008:768). Data will be analysed by using both quantitative and qualitative methods. The quantitative methods occur during the Nominal Group process when the responses are prioritised and ranked. The qualitative analysis of the data will be done according to the principles of Tesch (1990:95-97).

1.15 TRUSTWORTHINESS

Trustworthiness is a term that was used by Lincoln and Guba, (1985:290) and depicts the amount of trust the reader of a study can have in the research findings. Trustworthiness is maintained through enhancement of Credibility (truth value), dependability (consistency), confirmability (neutrality) and transferability (applicability) (Botma, Greeff, Mulaudzi & Wright, 2010:233).

1.15.1 Truth value

Truth value refers to whether the real, lived experience or perceived reality by the participants is captured. This is obtained through amongst others implementing strategies such as member checking, triangulation of methods, sources theories or investigators and prolonged engagement (Botma, *et al.,* 2010:233). Speziale, Streubert, Carpenter and Rinaldi, (2007:49) also emphasises member checking to indicate that data is a true reflection of the discussions. In the NGT member checking as well as clarification of inputs is applied to enhance truth value.

1.15.2 Consistency

To enhance consistency means the research process (methodology, data presentation and analytical processes) must have been done in such a way that it will be able to withstand an external audit on an acceptable level (Brink, 2008:119; Moule & Goodman, 2009:189).

In this study a co-coder will be used in the analysis of the data and the research process will be thoroughly described.

1.15.3 Neutrality

The of reductionism or bracketing will be used to eliminate the researcher's conceptualisations, prejudices and theories (Green & Thorogood, 2009:14). That means that the researcher will be able to suspend her own judgment and beliefs to be able to objectively deal with the data gathering as well as data analysis (Laverty, 2003:6).

1.15.4 Applicability

The applicability of research results is not the responsibility of the researcher, but the researcher must ensure that a detailed data trail of all the different steps within the research process is outlined so that other persons would be able to identify whether the findings could be applied in different or their specific situations (Polit & Beck, 2008:768). This is enhanced by a detailed description of the processes followed during data gathering, data analysis and

conclusions reached. The researcher will describe the research steps and processes comprehensively and in detail to enhance applicability.

1.16 ETHICAL CONSIDERATIONS

Ethical considerations are a system of moral values that guides the researcher and protects the participants (Polit & Beck, 2008:753). Potential risks of interaction might develop due to the nature of qualitative research like misunderstandings, embarrassment, conflict of opinion and value. Therefore, the researcher will consider issues like respect for persons, beneficence and justice which are expressed in the Belmont report (Brink, 2008:33; Burns & Grove, 2009:735). The researcher will explain the purpose and extent of the study to possible participants. The participants will therefore have sufficient time to decide whether they want to participate or not. The participants will be requested to give informed consent in writing.

Permission to perform the study should be obtained from the relative institutions and committees such as the Expert and Evaluation committee of the School of Nursing, Ethics Committee of the Faculty of Health Sciences and the two hospitals.

1.17 VALUE OF THE STUDY

The value of the study lies in the implementation of the identified strategies to improve the work environment of professional nurses in the specific hospital. When professional nurses experience their work environment as positive, they will deliver patient care of a high standard which will lead to the attainment of the higher needs according to Maslow's hierarchy of needs.

The further benefit for the professional nurses will be that their voices will be heard, their ideas for improvement in their situation will be evaluated, and their viewpoints be listened to. This could make positive change take place.

The benefit for the hospital is that the management of the hospital will receive already prioritised strategies for the improvement of the work environment of professional nurses. It could be implemented to be able to ensure a positive working environment which might lead to a drop in staff turnover and financial savings due to a more stable workforce.

1.18 STRUCTURE OF THE REST OF THE STUDY

Chapter 1: Introduction, theoretical background, problem statement and layout of the study

Chapter 2: Research design and methodology

Chapter 3: Analysis and discussion of the research findings

Chapter 4: Recommended strategies of the group, shortcomings and closure of the study

1.19 SUMMARY

The outline of the study is described in this chapter, followed by a detailed description of the methodology in the next chapter.

CHAPTER 2:

RESEARCH DESIGN AND METHODOLOGY

"The scientist must, for example be concerned to understand the world and to extend the precision and scope with which it had been ordered. That commitment must, in turn lead him to scrutinize …. some aspect of nature in great empirical detail" **(Kuhn, 1970:41).**

2.1 INTRODUCTION

In this chapter the research design and methodology whereby the study was done will be discussed in detail. Design and methodology have different meanings and are used within different stages of the research process (Henning, Van Rensburg & Smith, 2004:36; Mouton, 2001:55-57). According to Burns and Grove (2009:696) a research design is a plan of action (blueprint) implemented when a study is conducted to be able to have control over the factors that might influence the outcome of the study. Methodology on the other hand describes the specific steps or method used during the research process that starts with the identification of the research problem to the final plans of data collection (Henning *et al.,* 2004:36; Mouton 2001:75). For the purpose of this study, the terminology, **research design** will be used.

2.2 RESEARCH PARADIGM

According to Polit and Beck (2008:76) a paradigm is the way in which people see and interpret the world around them. In research, the researchers' framework that is used to describe and/or base their argument on is their research paradigm. Within the natural sciences a few historical paradigms are Newton's mechanics, Einstein's relativism and Darwin's evolutionary theory (Babbie, 2011:32). De Vos, Strydom, Fouché and Delport (2009:39-40) stated that: "…all scientific research is done within a certain paradigm, which is the way in which researchers interpret or valuate their research..." Table 2.1 depicts paradigms associated with different research approaches.

Table 2.1 Paradigms of qualitative research

	Ontological	**Epistemology**	**Methodology**
Paradigm	What is the nature of reality	What is the nature of knowledge	How to acquire knowledge
Quantitative / Positivist paradigm	Realist	Objective	Empirical experimentalism or numerically
Qualitative paradigm	Multiple mental constructions	Creation of interaction between researcher and researched	Analysis of descriptions or discourse
Application of the paradigm	The work environment can be studied from multiple different angles	Various participants took part in the study all bringing their own viewpoint, enriching the research data	A consensus seeking method namely the Nominal Group Technique

(Guba, 1990:19; Bailey, 1997:18-22; Hansen-Kechum & Myrick, 2008:205-213.)

According to table 2.1 can be seen that each research paradigm is constructed of three philosophical assumptions, an ontological; epistemological and methodological aspect. The ontological aspect relates to the nature of reality, epistemology refers to the nature of knowledge and methodology addresses the methods of how or procedures to follow by the researcher to get to the answer of a particular research question (Bothma, Greeff, Mulaudzi & Wright, 2010:40).

Machmillan and Schumacher (2010:6) alluded that **interpretative or constructivist epistemology** is usually followed in qualitative research. The use of systematic methods to gather data, for example with the Nominal Group Technique which is a **structured consensus seeking method,** forms part of the constructivist epistemology.

The researcher further accepts the fact that there are multiple social realities applicable to the specific phenomenon of the work environment of professional nurses, which highlights the

constructivist epistemology that is applied (Macmilan and Schumacher 2010:5-6) in this study.

The paradigm of the researcher will guide and steer the research process according to philosophical concepts. The researcher sees a professional nurse as a person primarily involved in the nursing care of a patient. That involves accurately assessing, planning, conducting and documenting of the necessary care for a patient whether healthy or sick from new-born to the process of dying. This process takes place in a specific work environment that could be either conducive to quality nursing care or negative and destructive for both the patient and nurse.

The methodological aspect of the research is expressed in a qualitative, explorative and descriptive research design.

2.3 RESEARCH DESIGN

Research design within the qualitative realm is determined around the research choices made by the researcher during the process of the research. Qualitative research design is not as clear-cut and prescriptive as quantitative research and can evolve within the research process (De Vos, *et al.,* 2009:269). To find the answers to the question of what can be done to enhance the work environment of professional nurses in a specific setting, a qualitative, explorative and descriptive design was chosen.

2.3.1 Qualitative design

Systematic, interactive and subjective methods are used in qualitative research to gather the data (Burns & Grove, 2009:746). The data are gathered systematically because it follows a certain prescribed process or pattern. In this research the data will be gathered by systematically following the steps of the Nominal Group Technique.

In qualitative research there is interactivity such as interactions and communication of individuals or groups of people through which data are generated (Denzin & Lincoln, 2005:21; Gay & Airasian, 2003:163). The communication or interactivity of the different group members, who are employees of the specific private hospitals, will provide much more

and richer data on how management can improve the work environment than would completion of questionnaires.

The subjective nature of the qualitative methods used in qualitative research enables the researcher to capture and analyse the ideas, beliefs and opinions of the participants. By following a qualitative approach in this study it would be possible to generate and **explore** strategies that could be implemented to improve the environment of the specific group of professional nurses.

2.3.2 Explorative design

The research design followed is also explorative. According to Polit and Beck (2008:20) an explorative design is a way of investigating a phenomenon in its fullest context. The general questions to be answered are "what is important within this phenomenon?" and "why is it of any importance?" which resembles the explorative nature of this design.

The work environment is the phenomenon that was explored with regard to "what is important for the staff about the environment?" and "how can it be improved?" in order to decrease personnel turnover.

2.3.3 Descriptive design

Polit and Beck (2008:20) are of the opinion that qualitative research is also **descriptive** in nature due to the fact that more and richer data about a specific phenomenon is gathered and described (Polit & Beck, 2008:192; Babbie & Mouton 2001:272; Burns & Grove, 2009:232).

To be able to understand a phenomenon within a descriptive study, it is important to capture and describe data accurately. All steps and procedures followed in this research was described in detail and with accuracy in order to understand which factors in the work environment of professional nurses impact negatively on them and how it can be improved.

2.4 RESEARCH TECHNIQUE

The Nominal Group Technique was applied to gather data with regard to what professional nurses thought could be changed to improve their work environment.

The Nominal Group Technique originated in the late 1960s where it was implemented by Delbecq in various study fields: *"…from social-psychological studies of decision-conferences, studies for program design in the NASA aerospace field, industrial engineering problems of social service and environmental studies by program planners…."* (Van de Ven, & Delbecq, 1972:338). This highlights the diversity of disciplines where the technique was applied with success.

Van de Ven, *et al.,* (1972:338) further stipulated that the Nominal Group Technique could very well be applied within the social sciences. The main difference between this technique and focus groups are that the Nominal Group technique is applied when it is necessary to reach consensus (Botma, *et al.*, 2010:251), such as in the study where consensus is needed regarding how the work environment of professional nurses can be improved. The focus of focus groups is on gathering of data, or to understand different participants' views of a phenomenon (Burns & Grove, 2009:542). The specific needs of the focus group participants does not necessarily receive special attention (Botma, *et al.,* 2010:210). In this study the Nominal Group Technique was applied because the needs of the participants, the professional nurses needed attention.

The choice of applying the Nominal Group Technique in this study relied on the advantages of the technique.

2.4.1 Advantages of the Nominal Group Technique

The first advantage of the Nominal Group Technique is the depersonalised, non-threatening but still structured format of data gathering. The professional nurses could speak freely and voice their opinion openly during the Nominal Groups because management was not present and therefore the environment was non-threatening. All inputs were depersonalised and could not be linked to a specific person who made it acceptable for personnel to voice their thoughts (Carney, McIntosh, & Worth, 1996:1024; Van de Ven & Delbecq, 1972:338).

The second advantage that the Nominal Group Technique holds is the fact that any misinterpretations or misunderstandings are clarified there and then while the process is on-going. The fact that it is clarified in the presence of the facilitator and participants enhances the validity of the data (Van de Ven, & Delbecq, 1971:338; Allen, *et al.*, 2004:110). Any bias or manipulation of the data by the researcher is minimised as controlling and verifying of the data takes place in the presence of the participants (Potter *et al.*, 2004:127).

The facilitator was present for the whole session during which she explained the procedure and guided the session

The fact that the technique does not take up a lot of both the facilitator and participants' time, but still generates data and information rich in content, is a third advantage. This was especially important due to the fact that the only time that the respondents were willing to participate in this research was over their lunch hour (Allen, *et al.,* 2004:110; Dewar, White, Santiago, Posade, & Wilson, 2003:44).

The fourth advantage of the Nominal Group Technique, although not applicable to this study, is the fact that it can be used for multi-disciplinary and multi-generational groups as well as groups from different backgrounds (Allen, *et al.,* 2004:110; Van de Ven, & Delbecq, 1972:332; Gibson, & Soanes, 2000:459). This was an advantage within this study, as the participants were all professional nurses working at two different hospitals but forms part of the same private hospital group but belonged to different racial groups (see Figure 3.4).

The fifth advantage was the fact that applying the technique is not costly with regard to finances and time. By using onsite venues, travelling of participants were limited. The most time-consuming activity was the preparation of the venues, which was done in ordinance with the requirements set by Delbecq, Van de Ven and Gustafson, (1975:41).

All research techniques have some disadvantages and the Nominal Group Technique is no exception to the rule.

2.4.2 Disadvantages of the Nominal Group Technique

An independent facilitator had to facilitate the Nominal Groups in order to prevent the hierarchical relationship of the researcher with the participants to prevent intimidation of the participants. This can be perceived as a disadvantage because an appropriate, knowledgeable facilitator had to be selected, remunerated and the group sessions had to be planned and coordinated with both the facilitator and participants activities.

The second disadvantage was experienced during this research but not mentioned in the literature. Both the hospitals were very short staffed and staff found it difficult to find the time to leave the ward to be able to attend the group sessions although the sessions were held during their lunch hour.

2.5 POPULATION

The population in research is all the subjects that are of interest to the researcher. It could be people meeting the inclusion criteria, research books in a library or any other object that the researcher deems to be of interest (Brink, 2008:123; De Vos, *et al.*, 2009:193; Botma, *et al.*, 2010:200). According to Polit and Beck (2008:761) the entire sum of objects of interest to the researcher can also be called the "universe", but they are not necessarily the participants. In most research it is not possible to involve the universe, therefore sampling usually takes place (Botma, *et al*., 2010:200). In this study the population was all the professional nurses working at this particular private hospital group throughout the country. Since the study was conducted at the hospitals of the group in one city only, the target population were all the professional nurses working at these particular private hospitals and who met the inclusion criteria. The assessable population therefore were all the professional nurses of the particular hospitals, who met the inclusion criteria and who were available to participate (Botma, *et al*., 2010:124; Moule & Goodman, 2009:265). This means those on leave or who were off duty when the Nominal groups took place, could not participate.

2.6 UNIT OF ANALYSIS

The unit of analysis is the "who and what" questions about the research (Mouton & Marais, 1990:40). According to Polit and Beck (2008:768) is the unit of analysis the basic focus of the researchers' analysis.

Within this study the unit of analysis was all the professional nurses working at the two particular private hospitals (within the same hospital group) and who complied with the inclusion criteria.

2.6.1 Inclusion criteria

The inclusion criteria should be stipulated carefully, because if participants differ extensively, skewed results could be obtained, for instance an assistant nurse would have different needs and frustrations than a professional nurse (Botma *et al*., 2010:124; Brink, 2008:124; Burns & Grove, 2009:345).

The inclusion criteria was set that the participants had to be full-time employees as professional nurses of the particular private hospitals and they had to be registered as professional nurses with the South African Nursing Council. Whether they obtained registration through a basic degree or diploma in Nursing was not set as a criterion.

2.6.2 Exclusion criteria

Staff that held managerial posts was not included as well as staff that met the inclusion criteria but was not available on the days when the Nominal groups took place. Staff who did not give voluntary consent to participate was also excluded

2.6.3 Sampling

"The sample is a subset of the population that is selected for a particular study" (Klopper, 2008:69). Convenience sampling was done. Although it is the weakest form of sampling, it can still generate a rich and representative sample (Klopper, 2008:69). Originally only one session was planned at one hospital and one session at the other hospital within the company. This would provide richer data. The hospital where the two sessions were held had more personnel who met the inclusion criteria than the second hospital.

According to Moule and Goodman (2009:233) the number of participants in a Nominal group should be minimum five to maximum nine participants. At the one hospital nine professional nurses met the inclusion criteria and at the other hospital six met the criteria. Due to the small numbers of the accessible population, no sampling was done.

2.6.4 Recruitment of participants

The professional nurses who complied with the inclusion criteria were identified by the researcher and an information brochure (see Addendum B) was handed to them. The brochure contained information about the purpose of the research, the research technique and the right of the participant to freely decide whether to participate or not. The date and time when the group session was going to take place was also stipulated in the information brochure.

2.7 THE CHARACTERISTICS OF THE PHYSICAL WORK ENVIRONMENT OF THE TWO HOSPITALS

The physical lay-out, buildings, patient profile and services of both hospitals are slightly different.

2.7.1 Hospital A

Hospital A is about thirty-five years old and was the hospital where the first two group sessions took place.

2.7.1.1 Work environment

The first three group sessions were held in a hospital situated in a previously "white neighbourhood". The hospital is a tall ten-storey building equipped with elevators, air-conditioning, cold and warm water supplies.

2.7.1.2 Patient profile

The patient profile of hospital A are more white patients who are having medical aid cover. Although a number of patients from other races also make use of the private hospital facilities.

2.7.1.3 Services

This hospital provides mostly medical, orthopaedic and general surgical facilities.

2.7.2 Hospital B

Hospital B is the second hospital where the research was done, but it belongs to the same private hospital group.

2.7.2.1 Work environment

Hospital B is situated in a previously "coloured area. It was recently built and is therefore a new building. It is positioned on the ground level only and is equipped with air-conditioning, cold and warm water supplies.

2.7.2.2 Patient profile

The patient profile within this hospital is more coloured and black patients who have medical aid cover.

2.7.2.3 Services

This hospital has maternity services, gynaecological and a fully operating paediatric ward and paediatric intensive care unit.

2.8 DATA COLLECTION

To be able to answer the research question the researcher must make use of certain methods and ways of obtaining or collecting the data (Moule & Goodman, 2009:288). Qualitative data is, according to Berg (2007:34), a rich wealth of information that could be in the form of audio tapes, field notes of interviews, photographs or video recordings. The essence is in thorough collecting and accurate capturing of the data in such a way to prevent confusion, losses or inaccuracies. Creswell (2003:110) sees the data collection as a circular process of locating the site, making rapport, sampling, collecting data, recording information, resolving field issues and storing of the data, after which the process can start all over again.

2.8.1 Nominal Groups

Van de Ven and Delbecq (1972:338) stipulated that the Nominal Group process is characterised by structured meetings, providing an orderly, systematic procedure for obtaining qualitative data closely associated with a problem area. Data of a higher quantity, quality and better representation of the critical and problematic area is generated. It consists of five steps namely: A silent generation of recommendations starts the group session followed by a Round Robin reporting of the recommendations. During the third phase the recommendations are discussed and ranked during the fourth phase. The session is finished by entering the ranked recommendations on a control card.

2.8.2 Explorative group session

Brink (2008:166) stresses the importance of conducting an explorative group session before commencement of the actual research is done. The explorative interview is an opportunity to

test the feasibility of the data collection method, duration of data collection and clarity of the research question(s) on a small scale. After the exploratory session, changes and adjustments can be made to improve the reliability and validity of the data gathering process (Moule & Goodman, 2009:296).

Welman, *et al.,* (2005:148) summarise the value of conducting an exploratory group session as follow:

"*To detect possible mistakes, flaws or defects in the measuring procedure such as ambiguous instructions or a research request that is misleading.*"

The actual question or request is presented to the group who specifies how they interpreted the question, was it clear and concise. This will enable the researcher to determine whether the question will generate the answers to the actual problem. Non-verbal behaviour of the participants can be observed which indicates their level of discomfort or embarrassment about the formulated question (Welman, *et al.*, 2005:148).

Within this research the original plan according to the proposal was to use the group of unit managers for the exploratory study. This was not done as expert opinion advised against it. The reason for this was the opinion that unit managers may perceive the work environment in a different way than the professional nurses and since the population of professional nurses were small, another way of testing the question had to be found.

The decision then was made to use the first planned Nominal Group session as the exploratory session and if any changes had to be made, this session's information would not be included in the real study. This decision was made after the question were scrutinised by experts in the field of Nursing Management and research.

After the first Nominal Group was conducted, it was not necessary to make any changes to the research question, since it produced abundant and appropriate data and therefore the first session's data was included as part of the research data.

2.8.3 The research question

The research question that will be tested is:
"*What recommendations can you make to improve the work environment of professional nurses working at the ……Private Hospital".* As mentioned, this question seemed effective to elicit the necessary information from the participants.

2.8.4 The facilitator

The role of the facilitator, also called moderator or interviewer is described by authors such as Polit and Beck, (2008:394); Denscombe, (2010:353); Hesse-Biber and Leavy, (2006:216). Within this study the person will be called a facilitator.

The facilitator needs to be proficient in managing group discussions to be able to handle group activities. Order and structure must be maintained to prevent outspoken individuals taking over the session.

The facilitator further has to be a good listener, be able to keep the group focussed on the topic, and in the case of the NGT, abide strictly to the different steps of the technique. Denscombe (2010:353) emphasised that the discussion should be kept focused and on track and that no intimidation or abuse should occur. The facilitator that facilitated the group sessions was experienced in the Nominal Group Technique. She is a Lead Researcher at the School of Nursing and implemented this method in her own PhD study and acted as facilitator in several other research projects. Due to the fact that the facilitator has been a tutor for many years, working with students, made her experienced in handling all types of different personalities.

2.8.5 Recruitment of participants

The recruitment was done first by just talking to the professional nurses about the proposed study. The goal, method and procedure were broadly discussed with them upon which the researcher received positive approvals from all the prospective participants. Some were actually quite eager for the research to start, to be able to get a chance to voice their opinion. The fact that participation was voluntary and that the researcher would not be present during the group sessions were emphasised from the start.

More or less a week before the proposed date of the first group session, the researcher approached the proposed participants and gave them the information brochure (see

Addendum B). This was to enhance their right to execute self-determination and act autonomously (Bothma, *et al.*, 2010:13). They were also presented with an informed consent form (see Addemdum C) to complete if they decided to participate (Brink, 2008:35-36; Polit & Beck, 2008:177).

No persuasion of participants took place as the voluntary state of the research was stressed and maintained from beginning to end of the research.

2.8.6 Preparation for the groups

The venues where the Nominal Groups were conducted had to meet certain criteria as described in the literature.

2.8.6.1 Criteria for the venues

Burns and Grove, (2009:543); Delbecq, Van de Ven and Gustafson, (1975:41) stipulated that the venues should be big enough to accommodate 5 to 9 chairs and tables placed in a U shape. The venues had to be situated within a quiet environment to facilitate critical thinking. The participants should also be familiar with the venue to minimise feelings of insecurity and intimidation.

The flip chart should be placed at the open end of the U shape for the facilitator to write down the responses of the participants. See Figure 2.1

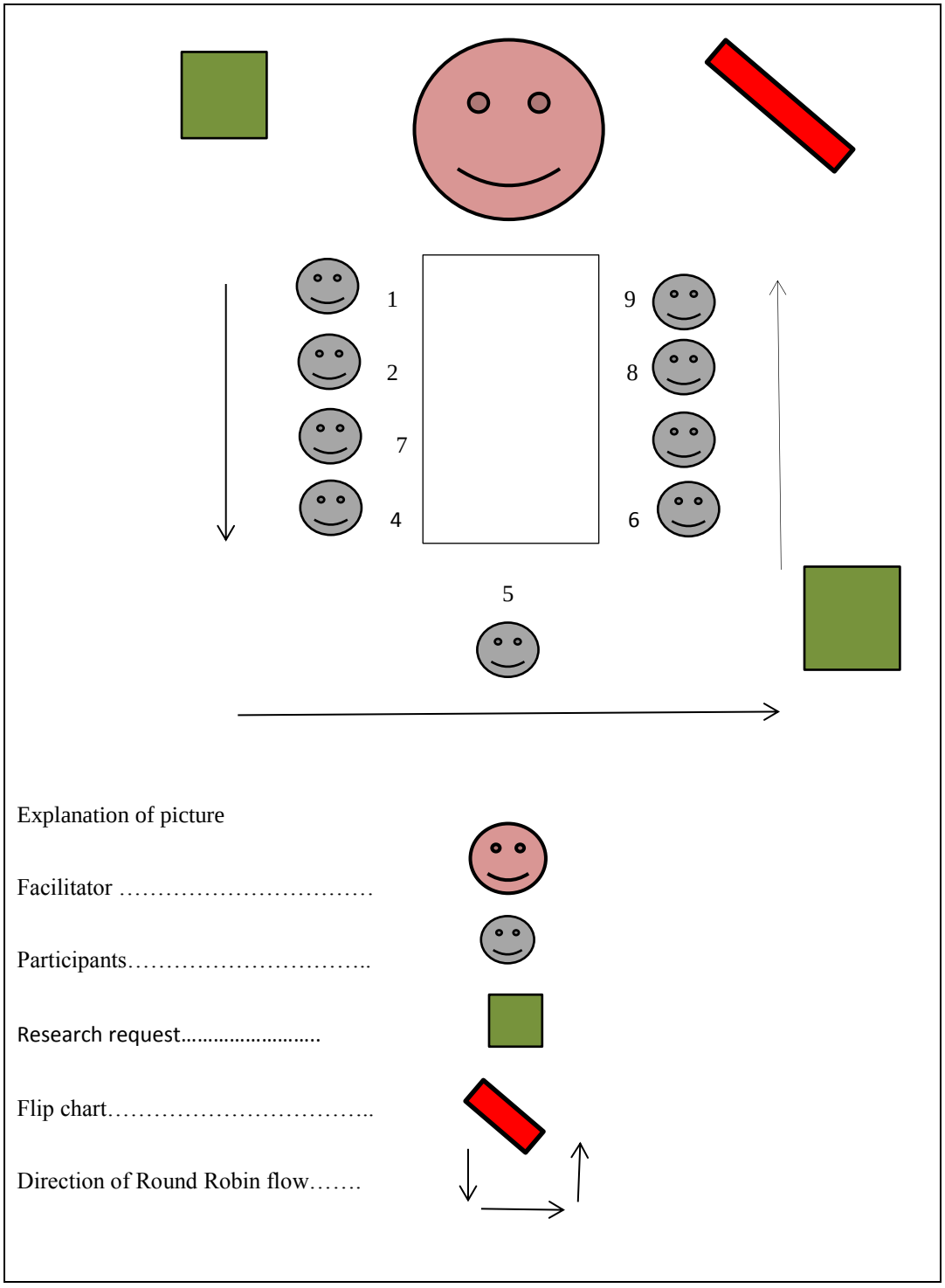


Figure 2.1: Arrangement of the venues used for the Group sessions

2.8.6.2 General preparation

The boardroom of the hospital was booked well in advance to ensure availability of it. The researcher prepared the venues two hours before the time that the groups commenced. Stationary and pens were placed on the tables for each participants' use. Four different coloured felt pens were provided for the facilitator to use on the flip chart. Index cards (5 per participant in different colours according to the different groups) provided to each participant coded with the specifications according to specific hospital and group. The use of an independent assistant was utilised during all the groups. The role of the assistant was to be of support to the facilitator for, amongst other, collecting of informed consent forms, handing out of cards and sticking the flip chart papers on the wall (after the discussion phase) (Berg, 2007:124)

2.8.7 Conduction of the Nominal Group sessions

Hesse-Biber and Leavy, 2006:216 highlighted the fact that the session should be started with a catching phrase, joke or anecdote to set the participants at ease. The facilitator had good sense of humour that could make the groups feel relaxed.

On the date when the first Nominal Group should have been conducted, all arrangements were in place. The facilitator, researcher and assistant waited at the proposed venue for the participants to arrive. Twenty minutes after the set time, only one participant turned up. Upon investigation it appeared the theatre unit manager relieved most of the professional nurses from theatre to go off duty since all the operations were cancelled for that day. This was due to the elevators not being in working order and the patients could not be brought down from the wards (on the ninth floor) to theatre (on the ground floor). It was therefore not possible to conduct this group as there were not enough participants to conduct the group session.

The second session was held in the same hospital as the first. The professional nurses arrived and the session started. The researcher greeted everybody and introduced the facilitator and the assistant to the group. The researcher thanked everybody for attending and explained the aim for the research again. After that the researcher left the room for the rest of the session to continue.

The facilitator discussed the information as on the information brochure (see Addendum B) and asked the participants to complete the informed consent form (see Addendum C) which were available in each participant's file. The assistant gathered the consent forms for safekeeping. The facilitator then explained the Nominal Group Technique to the group and made sure all the participants knew what was expected of them. The facilitator commenced with the Nominal Group session through the different steps as described by Delbecq, Van de Ven and Gustafson (1975:41).

Step 1 - Silent generation of ideas

The participants were asked to creatively and objectively think about what management could implement to improve the work environment of the professional nurses and write down their thoughts. During this stage no discussion was allowed. This stage lasted about then minutes and the participants had to put down their pens as an indication that they were through thinking. Then the facilitator proceeded to step 2 namely the **Round-Robin reporting of recommendations.**

Step 2 – Round-Robin reporting of ideas

During this step the participants were asked to report their ideas in a Round-Robin fashion. The advantage of a Round-Robin fashion is the fact that each participant gets equal chance of voicing her opinion. This democratic style of reporting prevents overpowering, well-spoken individuals to dominate the session.

All the recommendations were written in the participant's own words on the provided flip chart and each recommendation was numbered. The participants could skip a round if they did not have a new recommendation or join the discussion at any time if they thought of a new recommendation. Recommendations were mentioned only once and when no new recommendations were generated, it meant that the stage of saturation was achieved. The facilitator could move on to the **discussion phase**.

Step 3 – Discussion phase

This was the stage where the participants clarified the recommendation and explained what was meant regarding the inputs written on the flip chart. Ambiguous words and phrases were clarified to ensure accurate and clear data capturing. The added explanations were written on the flip-chart next to the original recommendation, but in a different coloured pen.

The flip-chart papers were torn off and stuck on the walls of the room to be visible to all the participants, in order to proceed to the next step, **raking of recommendations**.

Step 4 – The ranking of recommendations

During this phase the participants had to **rank the written recommendations** according to their perceived importance of the recommendation. They were requested to write down the five most important recommendations, each on a separate card, starting with 5 for the most important recommendation, 4 for the second most important recommendation while 1 represented the least important recommendation.

Each participant received five cards of the same colour but different colours for different groups, that is group 1 had pink cards, group 2 blue and group 3 had beige cards. These cards were differently identified for the different groups. Thereafter the participants were asked to prioritise these recommendations from most important (receiving nr. 5) to least important (receiving nr.1) (see figure 2.1).

The participants were asked to pack out the cards in front of them from highest score to lowest. This was done so the facilitator could ensure that all cards were numbered and had only one number and one recommendation per card on it. The cards were then collected and shuffled by the facilitator to minimise the recognition of the card owner. An example of a **recommendation card** can be seen in Figure 2.2.

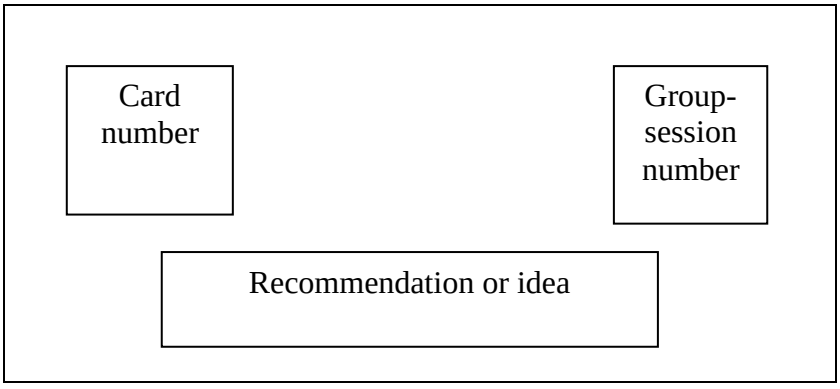


Figure 2.2: Illustration of how the recommendation cards looked like.

- Explanation of recommendation card: Each participant received a file with five of these cards, numbered 1-5 each on the card number block (in the left corner). The

Group session number (in the right corner) reflected the specific group the participant belonged to, for example, Group 1-3. Each participant received the 5 cards (in a different colour per group) for easier recognising the cards during analysis of the cards. The participants had to write each recommendation on a different card.

The recommendations and priority were written on the **control card (**by the facilitator), and the total of the priorities were calculated and written in the last column on the control card. The control card was stuck on the flip chart and the facilitator entered the recommendations and priority according to the participants' input.

This was done during the ranking of the recommendations. The recommendation with the highest total was re-numbered as priority number one; second highest, number two and so on till the least important is number five. In this way the five main recommendations were ranked or prioritised. An example of a control card can be seen in Table 2.2.

Table 2.2 Example of the control card

Recommendation Nr	Idea / Recommendation	Priority Nr of recommendation	Total	Final priority of 5 most important recommendations (Top5)
1	Sit rakke in diensstasie…	1	1	
10	Monthly meeting…..	1,2	3	
2	Skuif saal…….	5,2	7	5
11	Address acuity……	1,4,3	8	4

- Explanation of control card. Idea or recommendation nr 1 (sit rakke in diensstasie sodat dit netjies gehou kan word) had a priority nr of 1, only one person voted for it and the recommendation did not have a top5 priority. Recommendation nr 2 (skuif

saal na Netcare-gedeelte) had a priority of 5 from the one person and 2 from another, getting a total of 7 with a final priority of 5 (lowest priority in the Top5).

With this final step the group session was completed and the participants were thanked for their input. Due to the fact that the sessions took place during the lunch break, a light lunch was offered to the participants.

2.9 ANALYSIS OF THE NOMINAL GROUP DATA

"*The true test of a competent qualitative researcher comes in the analysis of the data, a process that requires analytical craftsmanship and the ability to capture understanding of the data in writing"* (Henning, Van Rensburg & Smith, 2004:101).

What makes the NGT unique is the fact that the data analysis is done making use of qualitative methods, for example the establishing of categories or categories as discussed by Tesch (1990:95-97) (see 12.2.1) and quantitative methods using numerical values for interpretation as described by Van Breda, (2005:7).

In short the data analysis was done using the following steps:

Step 1: Data capturing as described by Van Breda

Step 2: Prioritising of recommendations per group as described by Van Breda

Step 3: Analysis of the context as described by Tesch

Step 4: Endorsing of categories and sub-categories as described by Tesch

Step 5: Prioritising of combined group recommendations as described by Van Breda

Step 6: Commentary of data results as described by Van Breda

Step 3-4 were done qualitatively according to the principles as set of by Tesch (1990:95-97) and step 1, 2, 5 and 6 were quantitatively done according to Van Breda, (2005:7).

Qualitative data analysis is the interpretation and assessment of data in a nonnumeric way obtained by a researcher using qualitative research methods. Instead of using numbers and statistics (as used in quantitative research), qualitative research uses words and expressions (Babbie 2011:369).

2.9.1 Qualitative analysis following the principles of Tesch

According to Brink (2008:184) the qualitative researcher becomes involved or submerged into the data during qualitative data analysis or "dwells with the data".

The researcher submerged herself into the results by firstly typing it verbatim or exactly as it was said by the participants. By reading it repeatedly categories emerged from the recommendations and out of the categories, sub-categories were formulated.

Renata Tesch (1990:95-97) described ten principles that can generally be made applicable to all types of qualitative research. The ten principles will be described simultaneously with the application thereof in table 2.3.

Table 2.3 The ten principles of Tesch in relation with the application thereof

Data analysis according to Tesch	**Application thereof**
Principle 1: The analysis of data is not the last step in the research process but happens the same time as data collection or in a cyclical or recurrent way.	During the NGT sessions the data collection and start of data analysis all happened within each group session.
Principle 2: The analysis process might be methodical, and complete but never rigid.	The categorising and sub-categorising were done by the researcher and controlled by another person but it is not inflexible or absolute. Another researcher might do the coding of responses differently.
Principle 3: Attending to data or analysis of data occurs in a reflective way by means of "memoing" or adding analytical notes to the data. These added notes not only help the researcher moving forward from data to conceptual level, but adds accountability due to their reflectiveness.	During the third phase of the NGT short notes, explanations or memos were written next to the responses or recommendations as clarification. This was taken into consideration when the categorising took place.
Principle 4: Data are divided or segmented into relevant and meaningful sections or units. The analysis always starts with sense of the whole and from there divisions are made.	Inputs were read and divided into categories and sub-categories. After a response was read, it was attached to a main concepts (a whole) of the managerial process, for example "physical environment" or "personnel". Thereafter sub-categories were identified, for instance under the category "physical environment" one of the sub-categories was "accessibility" and from the category "personnel" the sub-category "salaries" emerged.

Principle 5: Categorisation of the segments or divisions takes place. This is an inductive process where categories are formed based on a conceptual framework or theory.	Categories and sub-categories were formulated keeping the conceptual framework in mind.
Principle 6: Comparisons are made to find the boundaries, segments and summarising of the content to find patterns.	After the categories and sub-categories were identified, it was re-read to identify boundaries and patterns.
Principle 7: These categories remain flexible and tentative and can change during the process of data analysis.	During the analysis process, some of the segments allocated to a specific category and sub-category were moved to another, more suitable category/sub-category.
Principle 8: The manipulation of qualitative data is an eclectic or diverse activity as there is no only or right way of doing the analysis.	It could be seen within this research as the categories and sub-categories were identified and formulated at least twice before it was finalised.
Principle 9: Qualitative analysis is an art, neither scientific nor mechanistic but also not limitlessly inventive. It requires a great amount of methodological knowledge and intellectual competence and is by no way straightforward as quantitative research.	Since the researcher, in qualitative research acts as the "instrument" the intellectual competence and knowledge of the researcher and study leader was instrumental in the analysis of the data.
Principle 10: The final result of qualitative analysis is a synthesis of the segments or categories, to be able to create a consolidated whole.	The final result of the analysis in this study resulted in strategies that management could apply to enhance the work environment of the staff.

As Tesch (1990:95-97) puts it, these principles are not a comprehensive prescription or recipe of how to do qualitative data analysis but rather a guideline or pattern of the qualitative analysis process.

2.9.2 Data capturing according to Van Breda

Van Breda and colleagues (2005:7) developed a procedure to capture the data acquired from multiple groups during the NGT. The six steps already mentioned on page 21 (2.12) will now be described in full.

2.9.2.1 Data capturing on the computer

During the first step the recommendations of the participants were captured on a spread sheet. Six columns were created and named group, category, recommendation, scores, average and top 5 (see Table 2.4).

Table 2.4 Example of data capturing according to Van Breda.

Group	**Category**	**Recommendations**	**Scores**	**TOTAL average**	**Top5**
2 (n5)		1. Sit rakke in diensstasie sodat dit netjies gehou kan word	1	1	
		2. Monthly meeting between top management and staff to address possible problems	1,2	3 **0.6**	
		3. Skuif saal na [redacted]- gedeelte gebruik ongebruikte vloer 2	5,2	7 **1.4**	
		Re-address acuity of staff levels	1,4,3	8 **1.6**	

Explanation of table 2.4: In the first column (A) the code of the different groups were typed, e.g. Group 2… , the recommendations were typed into column C, the different scores allocated to the specific recommendation were indicated in column D, the total of these scores as well as the average thereof were typed in column E. During this first step, the second column (category) and the sixth column (Top5) were deliberately left open as that knowledge was not known at that stage.

The data of all three groups were captured following the same procedure.

2.9.2.2 Identifying of the Top Five

During the second step the identification of the five most important recommendations took place within each group. According to column A, the spread sheet was sorted in ascending order (from low to high). Group one's data was still at the top of the list and then group two and so on.

Then the data was sorted according to column E in descending order (from high to low). The average column started with a high number and worked down to a low number within each group. The top five statements for each group were marked with an 'X' in column F (sixth column). See an example in table 2.5.

Table 2.5 Identifying of the Top5 recommendations

Group	**Categories**	**Recommendations**	**Scores**	**Average**	**Top 5**
2		Dedicated [redacted] lifts	5,5,5	3	x
(n5)					
		Daar moet minimum stock levels gehandhaaf word	2,5,4,1	2.4	x
		Employ more staff, move away from agency personnel	2,4,4	2	x
		Re-address acuity of staff levels	1,4,3	1.6	x
		Skuif saal na [redacted]-gedeelte, gebruik ongebruikte vloer 2	5,2	1.4	x

Explanation of table 2.5: The participants were within group 2 and there were 5 participants (n5). The second column (B) was still left open as the content analysis was not done yet. The recommendations, scores and averages were arranged according to the Top5 within each group, organised from highest to lowest within each group and marked with an X.

2.9.2.3 Analysis of the data according to content

The third step required the individual statements that were collected during the NGT, to be chategorised into categories. All the specific statements were now reduced to general categories. The researcher read through all the statements until general categories emerged. These emerging categories were written next to the statements. This was done a few times with the help of the study leader, facilitator and another experienced qualitative researcher, until all the statements were covered in different categories.

No two categories may say the same thing and each statement may only fall within one category. The categories were written on a list and numbered. The categories were defined according to literature which represented the issues that the groups raised. On the spread sheet, the numbers of the categories were written next to each statement. The statements were grouped according to the categories and printed.

2.9.2.4 Confirming of the content analysis

The fourth step is optional according to Van Breda (2005:7). To be able to have concise and true data analysis the researcher felt this step necessary. During this step the analysis of the content and the categorising of statements into categories were confirmed and verified with two other individuals not connected to the study. A list of the numbered categories and definitions along with a printed spread sheet with all the statements printed on, were given to each individual. On the spread sheet (see table 2.7) the column B (categories) were deleted and each separate individual had to categorise the statements into categories according to the definitions. They were asked to put in the number of the categories next to each statement. The outcome of the analysis done by the individuals was confirmed with the results obtained by the researcher, study leader, facilitator and another expert. The results deemed to be similar and the content analysis proved to be concise and a true reflection of the NGT sessions.

The fourth step concluded the qualitative part of the data analysis. The quantitative part of the analysis was done from here onwards.

2.9.2.5 Calculating the combined ranks

During this step (step five) the general importance of the categories was ranked through the entire sample. The data analysis was done keeping the groups separate during step one to

four. From step five and onwards the categories generated from the different groups were treated as one whole entity.

Using the spread sheet (see table 2.7), the data were sorted in an ascending order (from low to high) in column B (first column or categories column). Column F (Top5) was sorted in a descending order (from high to low). This version of the spread sheet was saved and printed.

A second spread sheet was created with the following headings: Categories, Top5 1, Top5 2, Number 1, Number 2, Average 1, Average 2, and Final Rank in column H. See Table 2.6

Table 2.6 Step 5

Categories	Top5 1	Top5 2	Nr 1	Nr 2	Av 1	Av 2	Final Rank

In spread sheet 2.6, in column A, the categories and the numbers allocated to it, e.g. '1. Environment' was inserted. In column B (Top5 1), the number of X's that each category scored, were reflected. Column C (Top5 2) was left open at this stage. Column D (Nr 1) contained the amount of recommendations per categories. Column E (Nr 2) was left blank at this stage. In column F (Av 1) the average score of the statements within each category was recorded by adding up the average scores from the previous spread sheet (column F) and dividing that into the number of statements for each category. During the next phase the ordering of the information took place according to column B (Top5 1) in an ascending order (from low to high). In Column C (Top5 2) the categories were numbered 1, 2, 3, etc. to the end of the list. After this the numbered categories were ranked according to the procedure explained below.

During the ranking of the categories the subsequent steps were followed.

- The numbers in Column B (Top5 1) were compared with the numbers entered in Column C (Top5 2). If two or more of the statements in Column B received the same score, the average of the Column C score was calculated and changed to the average score. For example, if both statements 1 and 2 in Column C got a score of 18 in Column B, the

average of 1+2 would be 1.5 and numbered 1.5 in column C. Column C would be numbered 1, 2, 3.5, 3.5, 5 and so on as can be seen in Table 2.7.

Table 2.7 Ranking of the second Top5

A	B	C	D	E	F	G	H
CATEGORY	**TOP5 1**	**TOP5 2**	**NUMBER 1**	**NUMBER 2**	**AV 1**	**AV 2**	**FINAL RANK**
2. Nursing care environment	1	1	9		0.62		
5. Psychological environment	2	2	5		0.88		
3. Personnel/staff	4	3.5	6		0.73		
4. Physical environment	4	3.5	9		1.37		
1. Managerial involvement	5	5	12		1.1		

During this step the ranking of the second Top5 took place. Because of the fact that Personnel and Physical environment had a Top5 score of 4, the ranking in Column C were 3.5 for both (Column C number 3 plus Column C number 4 equals 7, giving 3 and 4 an average of 3.5).

- When the ranking of the categories were completed the spread sheet was saved and printed to check that everything was correct.
- All the information was selected and sorted in an ascending order according to Column D. The ranking process was repeated in Column D and E and sorted in ascending order.

- For the third time the file was sorted in ascending order according to Column F and the ranking process was repeated in Column F and G. Column B, D and F were now converted into ranks with the higher numbers of greater importance.
- The three sets of ranks within Column C, E and G were added up and the total entered in Column H (final rank). All the data were selected and sorted according to Column H in descending order. The spread sheet was saved and printed as can be seen in Table 2.9.

Table 2.8 The final categorised, ranked and scored data

CATEGORY	TOP5 1	TOP5 2	NUMBER 1	NUMBER 2	AV 1	AV 2	FINAL RANK
1. Managerial involvement	**5**	5	12	5	1.1	4	14
4. Physical environment	**4**	3.5	9	3.5	1.37	5	12
3. Personnel/staff	**4**	3.5	6	2	0.73	2	7.5
5. Psychological environment	**2**	2	5	1	0.88	3	6
2. Nursing care environment	**1**	1	9	3.5	0.62	1	5.5

In Table 2.9 can the Top5, Number and Average be seen which all have different meanings but equally important.

The three dimensions (**Top5, Number and Average**) are important for different reasons. The **Top5** are of importance because they were the statements the group felt the most strongly about. Twenty statements might have received votes but only a few were of great importance to them (were implicated within the Top5). The **Number** score implicated how often the group referred to a categories or how many related statements were mentioned

within each categories although they might not have been in the Top5. The **Average** score reflected a combination of all the statements in a standardised way from the highest to the lowest irrespective of the size of the group. The Final Ranks represented the combination of the scores and provided a multidimensional combination of all the statements generated by the respondents.

Van Breda mentioned a sixth step where the data were compared demographically. A demographic comparison was done and replicated in the beginning of chapter 3. The **trustworthiness** of the research will now be explained.

2.10 TRUSTWORTHINESS

Trustworthiness is a term used during qualitative research and relates to credibility, dependability, confirmability and transferability (Moule & Goodman, 2009:188). Polit and Beck, (2008:539-540) described the framework suggested by Lincoln and Guba. According to Lincoln and Guba, (Polit & Beck, 2008:539) trustworthiness is attained through maintaining the criteria of credibility, dependability, confirmability and transferability.

Botma, Greeff, Mulaudzi and Wright (2010:233) described trustworthiness in epistemological standards, strategies and criteria. Truth value is the epistemological standard for credibility with prolonged engagement and member checking being some of the criteria. Applicability is the standard for the strategy, transferability and the standard consistency holds dependability as the strategy. The standard neutrality has confirmability as strategy.

Within this study the criteria for trustworthiness as stipulated by Botma *et al*., (2010:233) will be used.

2.10.1 Truth value

Truth value as epistemological standard is attained through **credibility** which refers to the assurance or confidence in the truth the researcher has in the data and interpretation of it. The study should have been done in such a way that firstly believability of the findings is reached and secondly to demonstrate the credibility of the study to readers of the study (Polit & Beck, 2008:539). The reader of the study must be convinced that the data presented within the study is the true reflection of the participant's view. A number of methods can be used to assure credibility such as triangulation, prolonged engagement within the field or expert

review (Moule & Goodman, 2009:188). Within this study member checking was used as the participants were present during the data collection and part of the data analysis due to the nature of the NGT. The participants therefore checked whether their inputs and calculations were correct. Expert review was used during the data analysis as stipulated by Van Breda (2005:7) by presenting the analysed data to independent co-coders. Where differences occurred, it was clarified through discussion until consensus was reached.

2.10.2 Consistency

Credibility cannot be achieved without **dependability**. Consistency means solidity or permanence of the research over time and circumstances. If another research is conducted within similar conditions and with similar participants, the question that must be asked is if the findings would be the same (Polit and Beck, 2008:539). Each step in the research is clearly described so that if necessary the study could be duplicated under the same circumstances with similar participants and it is expected that the same outcomes will be obtained. Dependability is closely related to **conformability** which is the strategy for neutrality.

2.10.3 Neutrality

The epistemological standard neutrality is accomplished through the strategy **confirmability.** This is the assurance that the findings, conclusions and recommendations are supported by the research data and should indicate a link between the research data and the interpretation of the researcher (Brink, 2008:119).

The data and findings of this research were supported through a thorough literature analysis conducted after the data was gathered (chapter 3). The utilisation of a co-coder enhanced conformability because data analyses was verified.

Applicability is the last standard of trustworthiness and is attained through the strategy **Transferability.**

2.10.4 Applicability

Applicability is made possible by the strategy t**ransferability,** which implies that the findings of the study could be transferred to another setting. The description of the data collection and design details should be of such a nature that transferability can take place,

although it is not the purpose of qualitative research to generalise findings (Brink, 2008:119; Moule & Goodman, 2009:190; Polit & Beck, 2008:539).

In this study applicability could be identified if other researchers could determine, through the detailed description whether the findings were appropriate in similar settings.

2.11 ETHICAL CONSIDERATIONS

Polit and Beck (2008:753) defined ethics as: *"a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants."*

The protection of human beings against unethical research was promulgated after the Nuremberg trails that tried the members of the Nazi Party for their involvement in the Holocaust. The Nuremberg code of 1947 was the first of its kind and was compiled to protect participants in research (Neuman, 1997:445). The ethical principles of respect for persons, beneficence and justice will be dealt with as stipulated by the Belmont Report in 1978 (Brink, 2008:30; Burns & Grove, 2009:184; Polit & Beck, 2008:170).

2.11.1 Respect for persons

Respect for persons is the first principle stipulated by the Belmont Report for the protection of human participants of research. Respect for persons involves the right to self-determination and the right to full disclosure (Polit & Beck, 2008:170).

The right to self-determination includes the principle that humans are autonomous and therefore capable of regulating or directing their own activities. The right to full disclosure involves the participant's right to be informed about the benefits of the research and the risks involved.

The right to self-determination and the right to full disclosure encompass the principle of informed consent (Moule & Goodman, 2009:56; Polit & Beck, 2008:170). See Addendum C.

Brink (2008:32) and Burns and Grove (2009:190) also highlight the rights of individuals with diminished autonomy who need protection such as children, patients who are unconscious, patients who are institutionalised and the mentally impaired. The professional nurses who

participated in this study were not a vulnerable group who needed additional protection against exploitation. They could and did exert their rights as autonomous individuals, deciding whether to participate or not, to withdraw if they wanted and to decide what they wanted to disclose or not to disclose.

2.11.2 Beneficence

The principle of **beneficence** stipulates the researcher to do good and causes no harm to the participants (Burns & Grove, 2009:188). The researcher should protect the participants of the effect of the research which could be physical, emotional, spiritual, economic or social (Brink, 2008:32). Qualitative research is usually non-invasive but the research questions and or process might cause emotional damage by delving into issues from the past that might have been traumatic or uncomfortable for the participants (De Vos, *et al.,* 2009:58).

In this study the research focussed on the participants' work environment and asked from them to indicate ways in which the work environment could be enhanced. This was not a threatening situation and because an external facilitator was conducting the groups, the possible fear or discomfort of disclosing information was minimised.

The data was further depersonalised so that no inputs could be connected to a specific participant, which further enhanced a neutral environment where participants could freely participate.

2.11.3 Justice

The principle of **justice** includes the subjects' rights to fair selection and treatment, the subjects' right to privacy, and lastly the responsibility of the researcher to ensure anonymity and confidentiality (Brink, 2008:33). Anonymity could not be ensured, since the participants were visible and recognisable during the group sessions, but due to the fact that the inputs were depersonalised, as well as the fact that the information obtained were kept and managed by the researcher and co-coders only, enhanced confidentiality.

The participants' **right to fair selection** refers to the fact that no discrimination took place if participants decided not to participate in the study. Participants could voluntarily decide to participate or not. No coercion took place (Brink, 2008:33) and the use of selection criteria made the selection fair and objective.

The subjects' **right to fair treatment** entails strict adherence to the information leaflet and informed consent form that the researcher distributed amongst the participants. The participants were fully informed about the nature of the research as well as the information required from them (Botma, Greeff, Mulaudzi & Wright, 2010:19).

The subjects' **right to privacy** required that the researcher ensured that the data gathering took place in a secluded setting where the information discussed was only in the presence of those who were involved in the research (Brink, 2008:34 and Moule & Goodman, 2009:54). By respecting a participant's privacy the principle confidentiality of the participant is adhered to.

The responsibility of the researcher to ensure confidentiality entails the researchers' actions to keep the information safe and use it only for the research purpose. The actions of safeguarding confidentiality by the researcher should be of such a nature that even the researcher should not be able to link the information gathered to the specific participant. The usage of a code-system is advisable where the identifying particulars of the participants are kept separate from any data collection or study information and this was maintained throughout this study (Brink, 2008:34). The privacy of the institution was also respected by blocking of the name of the institution as it appeared in this report of the study.

In the case of publishing the findings of the research, confidentiality should still be maintained and there should be no reference to any participants where the data could be connected to any person (Brink, 2008:34). Participants of this study were informed at the onset of the study that an article would be published to disseminate the results but that this would be in a depersonalised manner.

2.11.4 Entering the field

Permission to perform the research with the participants working at the hospital group was first discussed with the Nursing Services Manager of both hospitals where the group sessions took place. An institutional permission form was completed and referred to the company head office after which the necessary permission was granted (see Addendum C and D).

The proposal of the study was submitted and accepted by the Expert and Evaluation Committees of the School of Nursing followed by submission to the Ethics Committee of the Faculty of Health Sciences. Ethics approval was obtained (see Addendum I). After obtaining

permission from all the necessary institutions and committees the recruitment of prospective participants started.

2.12 SUMMARY

This chapter explained the essence of the methods and methodology used during the study and the next chapter will focus on a discussion of the analysed data according to the literature and interpretation of the findings.

CHAPTER 3:

DISCUSSION OF THE RESEARCH RESULTS AND LITERATURE ANALYSIS

"Imagination is the beginning of creation: you imagine that you desire, you will what you imagine, and at last you create what you will" George Bernard Shaw.

3.1 INTRODUCTION

The research design and methodology used during the study were discussed in the previous chapter. During the course of this chapter the discussion of the research results together with literature control will be done. In relation to the results obtained from the Nominal Groups, strategies will be formulated to improve the work environment of the professional nurses within the specific setting. Initially it was planned to have four (4) nominal groups. The initial Group session one did not take place as the prospective participants could not leave their place of work to attend the group session on the specific day due to staff shortages. The following groups, renumbered 1, 2, and 3 consisted of 5 participants each, giving a total of 15 participants for the study.

The data gathered from these 3 Nominal Groups are now discussed.

3.2 DEMOGRAPHIC DATA

The population, unit of analysis, data collection and data analysis of the research were discussed in detail in Chapter 2. The following demographic data was obtained:

3.2.1 Gender and qualification

The participants were homogeneous regarding gender as they were all females partaking in the study. There are two male full time employees working at the hospital, but they did not comply with the inclusion criteria as they were not professional nurses.

One recommendation from the groups regarding gender was raised, being "*Bestuur moet sensitief wees vir die spesifieke behoeftes van vroue personeel, bv.*

Familieverantwoordelikhede: Increase limit on telephone bill in order to cater for family responsibilities", but this recommendation did not receive a high score and was not selected amongst the Top5.

Roussel (2009:632) proposed that gender differences should not be perceived as problematic, but that gender differences within a group should be accepted and the strong gender qualities within the team be utilised such as men usually being more analytical thinkers and women being more caring (Meleis, Hilfinger Messias & Arruda, 1996:53-61).

Due to the fact that the inclusion criteria required only professional nurses to participate, the participants were also homogeneous regarding qualification, registered at the SANC as professional nurses. No recommendations were generated from the participants regarding qualification, so it appears as if this did not influence the work environment for these particular groups. Within the literature, qualification had a definite influence on how the work environment is perceived (AL-Hussami, 2008:286-295; Hayes, Bonner & Pryor. 2010:804-814; Nabirye, Brown, Pryor & Maples, 2011:760-768).

AL-Hussami, (2008:290) specifies that the level of education plays a role in nurses' job satisfaction, which includes work environment. The author did not indicate on the reasons why. Hayes, Bonner & Pryor (2010:808) concluded that lower category nurses experience more satisfaction with their work and work environment because they do not have a need for autonomy such as Professional Nurses. If the work environment does not provide opportunities for the Professional Nurses to perform their autonomous role within decision making, it leads to feelings of not being appreciated and unhappiness.

Nabirye, *et al.*, (2011:764) also identified the higher qualified nurses experienced less satisfaction with the work environment than the lower categories nurses, such as Enrolled Nursing Assistants and Enrolled Nurses. The author reasoned it could be because this category of nurses has more job opportunities than the higher qualified nurses. An article written by Hackman and Oldham, authors of the Job Design Theory, dating back to 1976, already suggested that jobs that involve higher authority and have more task significance that involves more autonomy leads to a higher level of satisfaction with the work environment if the employee have higher authority and task significance (Hackman & Oldham, 1976:159-170). The inputs of the participants in this study did not reflect anything on autonomy issues which leads to the assumption that this was not problematic for them in their situation. It

could also be that because their lower order needs according to Maslow are not fulfilled, the higher order need of esteem (self-esteem, achievement, mastery, independence, status, dominance and managerial responsibility) is not problematic.

3.2.2 Home language

Differences in language can indeed influence the work environment positively or negatively. The manager needs to take difference in language amongst staff into consideration. Vital information might get lost due to people not understanding or experience difficulty listening to instructions and discussions such as handing over of patients' progress reports in a worker's second or third language (Zerwekh & Garneau, 2012:220; Roussel, 2009:666-676; Kelly, 2008:537-544).

Within this study there were no recommendations regarding language differences although there were language differences between the three groups (see Figure 3.1). A possible explanation is that this might be due to the fact that English is the preferred language as per company policy.

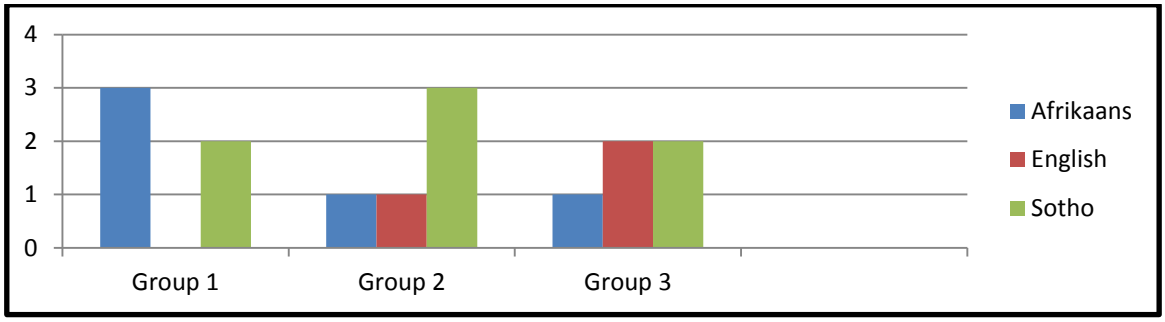


Figure 3.1 Home language

Figure 3.1 shows that the participants in Group 1 were only Sotho and Afrikaans speaking while Groups 2 and 3 had English speaking participants as well. In total there were 5 participants whose home language are Afrikaans, 3 had English as home language and 7 of the participants' home language were Sotho. As already mentioned, there were no recommendations from the different groups regarding home language.

3.2.3 Work place

Although the different hospitals offer different services both provide: ICU-care (one general ICU per hospital), a medical and a surgical ward, a referral unit, and operating theatres.

Of the total number of 15 participants, 7 were from the ICUs, and 8 were from either the medical or surgical wards. One participant was from the Referral unit. She has recently transferred to Referral, but worked in the medical ward for more than 6 months prior to her transfer. There were no participants from the operating theatres. The distribution of the participants' work place is presented in figure 3.2.

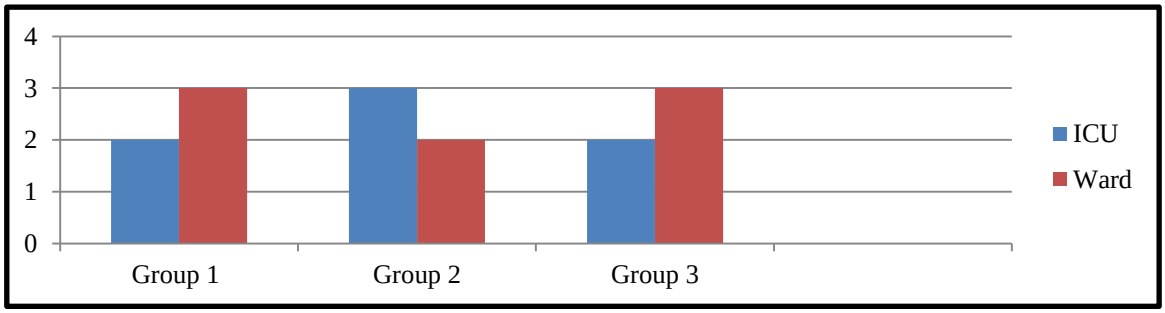


Figure 3.2 Work place

The demographic data displayed in figure 3.2 show that there was a similar distribution regarding workplace in groups 1 and 3 but this was reversed in group 2. Within groups 1 and 3, three (3) participants worked in the wards and 2 in ICU but in group 2, three (3) participants worked in ICU and 2 in the wards.

The workplace forms part of the physical work environment and this is discussed under 3.4.2 of this chapter.

3.2.4 Age

The age of the participants ranged between 20 and 60 years, as can be seen in figure 3.3.

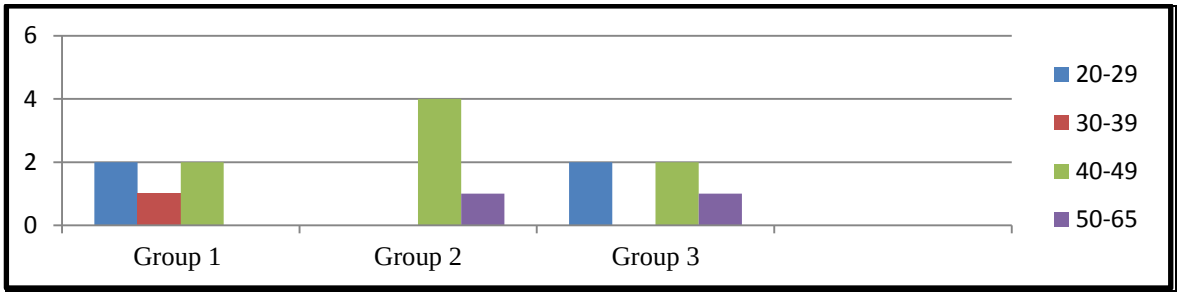


Figure 3.3 Age

Figure 3.3 depicts that group 2 had the largest number of participants (4) from the age group 40-49 years of age. This was also the only age group that were represented in all three groups.

The age groups 30 - 39 and 50 - 65 had one respondent each. Of the total 15 participants 4 were in the age group 20-29 years, 1 in the age group 30-49, 8 in the group 40 – 49 and 2 in the age group 50 – 65 years of age.

The participants of different age groups have besides their professional roles different social roles, for example the role of mother, wife or partner, nurse, community member and a sports team member. These roles can influence their perceptions of their work environment (Hahn, 2009:9).

Hahn (2009:9) states that veterans (aged 50 years and older) prefer a work environment with little stress and few or no challenges or difficult decisions to make. They prefer stability in the work environment and changes, such as a change in shifts; scheduling or working hours are not appreciated or well tolerated. They are usually hard working and dedicated to the task at hand (Hahn, 2009:9).

No recommendations regarding stress or challenges in the work environment were raised from the participants in the three groups, although there were 2 participants in the veteran age group.

The age group 40-49, referred to as the Baby Boomers prefer autonomy, such as increased responsibility and independent decision making over professional status. They are usually driven by a strong work ethic and are committed to the company they work for (Hahn, 2009:9; Wieck, Dols & Landrum, 2010).

The participants did not refer to an increased need for autonomy, responsibility or decision making or professional status.

According to Apostolidis and Polifroni (2006:506) and Hahn (2009:9) the Generation X people (aged 30 – 39) prefer a work environment where professional growth through continued in-service training, and communication with colleagues through team building, are encouraged.

The strive for continued education and in-service training can be seen in the following recommendations from the participants: "*Meer opleidings geleenthede vir alle personeel, nie net in-service training nie*" and "*Designated clinical facilitator to assist in training needs – person presently appointed to do infection control*".

The need for collegial communication and team building sessions to be facilitated were reflected in recommendations such as: "*The opportunities should be created for different healthcare groups to be sensitised toward each other*" and "*Skep die geleentheid vir team building sessies*".

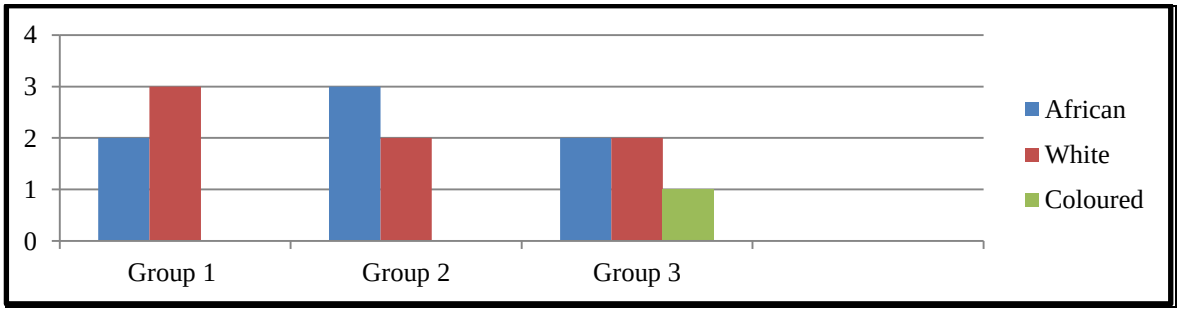
The Millenials (aged 20 – 29) prefer a technologically advanced work environment where information technology is used and computerised capturing of patient data are enhanced (Hahn 2009:8-10). No recommendations suggesting a need for a technologically advanced work environment were generated amongst the groups, although there were 4 participants representing the Millenials group. ICUs are highly technical environments and much of the administrative tasks are computerised. Since there were no recommendations regarding technology it can be assumed that these groups were competent and satisfied with the technological environment.

The biggest conflict between generations are usually between Baby Boomers and Generation X'ers as the Baby Boomers see the Generation X'ers as irresponsible and the Generation X'ers see the Baby Boomers as authoritative and old fashioned (Apostolidis & Polifroni, 2006:506).

3.2.5 Racial differences

Race is defined as "one of the main groups that humans can be divided into according to the colour of their skin and other physical features" (Longman, 2009:1429).

The racial differences of the participants are depicted in Figure 3.4.



[1]*Figure 3.4 Racial differences*

[1] According to Section 21 of the Employment Equity Act 55 of 1998 of the Department of Labour:
i. " …the alphabet "A", "C", and "W"…. must be interpreted as Africans, Coloureds, Indians and Whites…"
j. "Designated groups means black people (i.e. Africans, Coloureds and Indians)…."

Within Group 1 the most participants belonged to the white racial group but in Group 2, the majority of the participants belonged to the [1]African race. Only group 3 had a coloured participant.

The literature stressed the fact that racial differences can influence the work environment through situations such as the implementation of the Employment Equity act that forces institutions to have vacant posts, because nurses belonging to certain race groups have not applied for the available vacant positions (Oosthuizen & Ehlers, 2011: online). This may cause stress in the work environment firstly due to shortage of staff due to the implementation of the Act, and secondly it may cause stress among racial groups.

Another example of racial differences might be student nurses or newly qualified professional nurses who are faced with colleagues of different racial groups who have customs and value systems different from themselves (Meyer, Naude & Van Niekerk, 2004:121).

No recommendations were raised regarding differences in values and/or customs, so it is accepted that the participants are comfortable regarding race.

3.3 CATEGORIES ACCORDING TO THE RECOMMENDATIONS

There were 90 responses in total between the three groups, of which 75 received a score. Only the responses that received a score were categorised and will be discussed, but the rest are tabled in Addendum I as according to Van Breda (Van Breda, 2005:5).

Five categories were formulated from the 75 responses which will be described in descending order of importance, and according to the prioritised ranking in Figure 3.5.

1. MANAGERIAL INVOLVEMENT
2. PHYSICAL ENVIRONMENT
3. PERSONNEL/STAFF
4. PSYCHOLOGICAL ENVIRONMENT
5. NURSING CARE ENVIRONMENT

Figure 3.5 Prioritised categories of the three groups

The five categories which were formulated are a representation of all the recommendations made by the participants. The categories were divided into sub-categories to enhance the completeness of the categories.

3.4 DEFINING AND DISCUSSION OF THE CATEGORIES AND SUBCATEGORIES

Definitions and discussions of the categories and subcategories will be done according to their grading and prioritisation.

3.4.1 Managerial involvement

The first category is managerial involvement, which is problematic according to the participants. The subcategories are displayed in figure 3.6.

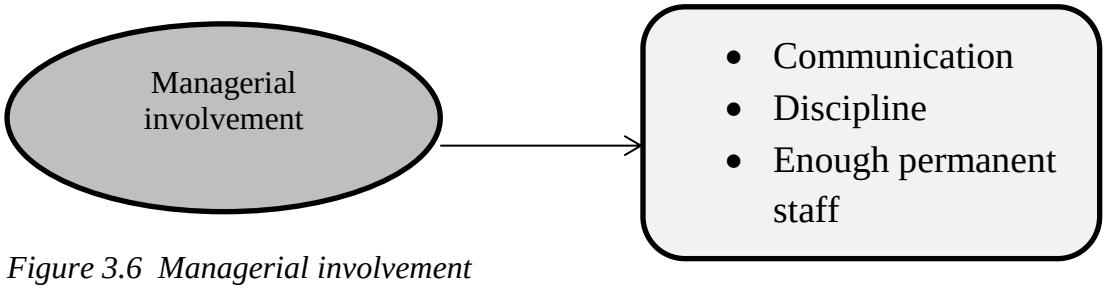


Figure 3.6 Managerial involvement

Henri Fayol (1946), the father of modern management, defined management in these words: "*To manage is to forecast and plan, to organize, to command, to coordinate, and to control. To foresee and provide means (of) examining the future and drawing up the plan of action. To organize means building up the dual structure, material and human, of the undertaking. To command means binding together, unifying and harmonizing all activity and effort. To control means seeing that everything occurs in conformity with established rule and expressed demand*".

Management by objectives, first advocated by Peter Drucker and made famous by George Odiorne, defined management as "*a process whereby the superior and subordinate managers of an organisation jointly identify its common goals, define each individual's major areas of responsibility in terms of the results expected of him [sic], and use these measures as guides for operating the unit and assessing the contribution of each of its members*" (Odiorne, 1965).

For the purpose of this study, the management process as stipulated by Fayol (1949) (planning, organizing, coordinating, and controlling) will be used. The first two functions: planning and organisation usually take place within lower and middle management; and coordinating and controlling take place within the ranks of top management (Kelly, 2008:4; Jones *et al.*, 2000:8). The five sub-categories of managerial involvement (communication, discipline, enough permanent staff, performance appraisal and team building) that elicited responses from the research participants are all within the responsibilities of the unit manager or middle management (Timmreck, 2000:50-66).

Managerial involvement as category is divided into five sub-categories according to the inputs of the participants.

3.4.1.1 Communication

"Communication is an interactive process that occurs when a person (the sender) sends a verbal or nonverbal message to another person (the receiver) and receives feedback" (Kelly, 2008:186). *"Communication is the art of being able to structure and transmit a message in a way that another can easily understand and accept"* (Huber, 2000:203).

Communication is mutually affected by multiple factors such as emotions, background, tone of voice or attitude, preconceived ideas, perceptions, etc. Within a professional setup, communication usually occurs from employer to employee as policy changes, work schedules, task delegation, etc. take place. The communication process is a two-way process and the employee must have the assurance and confidence to be able to interact freely with the management team. Communication within a ward or unit mainly centres around the rendering of care to the patients. If there is a break in communication, the care of the patient is compromised leading to prescriptions not followed, or orders interpreted incorrectly (Du Toit, Erasmus & Strydom, 2010:223; Jooste, 2010:205; Kelly, 2008:186).

The responses of the participants regarding communication were as follows:

Group 3: "*Have meetings: R/n + management on regular basis Should be like this and not only include HR-issues, Nursing manager must be present"*
Group 2: "*Personnel to be informed about decisions that influence them e.g. uniforms"*
Group 3: "*A structured monthly meeting to address managerial issues, amongst nurses with nursing manager"*

The staff requested more meetings to take place between themselves and management as they feel they do not get informed about decisions concerning them, for instance changes in the policy regarding the company uniform.

The professional nurses were of the opinion that there is insufficient communication between the Nursing Services Manager (Top Management of the hospital) and themselves. Discipline is the second sub-category that will be discussed

3.4.1.2 Discipline

Jones, George and Hill (2000:51) defined discipline as: *"Obedience, energy, application, and other outward marks of respect for a superior's authority"* according to Fayol's principles of management. Fayol (1949) stipulated that discipline is about the respect of the employee towards the manager, as well as the fair and equitable treatment of the manager towards the employee.

According to Jooste (2010:173-176) discipline and disciplinary action are intertwined with fairness. If discipline is not maintained with fairness, it can cause more harm than good as employees can become rebellious and turn to labour action against the organisation. Discipline should also rather be remedial and corrective than punitive and negative (Meyer, Naudé & Van Niekerk, 2004:231; Booyens, 2008:675). Huber (2000:242) adds the points that discipline should never be delegated and be handled on the lowest managerial level possible. Before discipline can be enforced, a sound policy for the correct and appropriate behaviour should be in place and the employee should be knowledgeable about it (Gerber, Nel & Van Dyk 1998:355; Jooste, 2010:175). Mace, (2005:57-61) discussed situations where discipline is used incorrectly: "*Negative reinforcement is a flawed concept. It doesn't prevent anyone else from making the same error, and it may encourage others to cover up or fail to report mistakes or near misses in order to avoid reprimand*". This shows the importance of managers to implement discipline correctly in order to achieve positive outcomes.

The availability and utilisation of a grievance policy and procedure for the employees is vital and should be present in any organisation. Grievances could be distinguished from general complaints, and should always be treated with the necessary concern (Booyens, 2008:678-683).

The following responses reflected the respondents' recommendations on discipline.

> Group 2: *"Disciplinary action should follow if personnel do not abide to procedure/policy. Policy = in place – need to follow it"*
> Group 1: *"Daarstelling en implimentering van 'n klagte-prosedure"*

The participants are of the opinion that disciplinary action is not followed as it should be. They are aware that the policy is in place but it is problematic to them that the manager does not enforce discipline accordingly. They were not aware of a grievance policy and procedure that is in place. This calls for concern, since such a policy and procedure is available.

3.4.1.3 Enough permanent staff

When staff are permanently employed by an organisation, in-service-training and professional development should commence on a continuing basis. The employees should be constantly made aware of what the organisation expects of them, and the employer should be aware of the staffs' expectations. Through this knowledge a cohesive bond can form which enhances the working together to reach the organisations' goal - in this case being the rendering of quality patient care (Gerber, Nel & Van Dyk, 1998:321).

The utilisation of temporary staff that rotates between multiple different institutions impacts on these expectations. The commitment of temporary staff will not be similar to that of permanent staff and mistakes and discipline are handled in a different manner, or not at all (Jooste, 2010:162; Roussel, 2009:348-349).

The biggest advantage of using temporary staff especially in a small hospital with low to medium levels of occupancy is the cost saving. During off-peak times the institution still has to pay permanent staff working their shifts according to their set hours, although they are not 100% productive then. Permanent staff also has to be remunerated for inactive times such as annual leave, sick leave or educational leave (Jooste, 2010:162). In contrast to this, temporary staff is employed as the work demand rises. Although the utilization of temporary staff causes challenges, the advantages should be weighed against these challenges. The usage of temporary staff could be limited by employing more permanent staff as recommended by the participants.

The last recommendation regarding permanent staff relates to the staff mix or acuity of staff levels. To be able to plan nursing staff accurately, a patient classification system is

necessary. According to a patient classification system the amount of time spent with each patient, severity of patient condition, skill and mix of staff are all taken into consideration to calculate the number and category of staff that are necessary (Booyens, 2008:337; Roussel, 2009:318; Tervo-Heikkinen, Kiviniemi, Partanen & Vehvilainen-Julkunen, 2009:986-993). Trinkoff, Johantgen, Storr, Gurses, Liang and Han (2011:1-8) associated incorrect nurse staffing with patient mortality (Moore & Waters, 2012:16-19).

Upenieks, Akhavan, Kotlerman, Esser and Ngo (2007:243-252) iterated the use of non-professional staff to lighten the burden of the professional nurses to concentrate on the rendering of quality nursing care and record keeping. Examples of non-nursing tasks are transporting of patients between departments, filing of reports, transporting stock and equipment between departments and checking of bar-codes on equipment (Roussel, 2009:320).

The participants recommended the following with regard to staff:

Group 1*: "Employ more staff, move away from agency staff"*
Group 1: *"Maak gebruik van 'n ander verpleegagentskap"*
Group 2: *"Fill all vacant nursing posts with skilled staff and employ more staff"*
Group 1: *"Re-address acuity of staff levels, (ratio professional nurse/non-professional nurse in ward and ICU"*

The participants of group 1 especially felt that the staffing is not done appropriately. They indicated that more permanent staff should be employed to limit the usage of temporary staff and they also raised their concern about the current skills mix of professional nurses compared to auxiliary staff.

3.4.1.4 Performance appraisal

Performance appraisal is a systematic, standardised method of evaluating a person's work contribution, capabilities, quality of work and potential for advancement (Huber, 2000:327). The appraisal should be done according to the employee's job description to be able to measure the performance according to a standardised set of objectives (Roussel, 2009:551). According to the literature is it important for management to show appreciation when the staff did well or when they went out of their way to satisfy needs of a patient (Parker, Giles & Higgins, 2009:667-677; Strachota, Normandin, O'Brien, Clary & Krukow, 2003:111-117).

Two recommendations concerning performance appraisal were raised:

> Group 2: *"Re-address award system – no favouritism. Unit managers should check personnel quarterly - but they don't then they are pressurized if HR asks for forms"*
> Group 2: *"Promotion on merit not affirmative action"*

It appears as if the staff perceives the current reward system as not being implemented equally and fairly. They indicated that it is not done frequently enough and that appraisals are not given on merit but affirmative action.

3.4.1.5 Team building

Huber (2000:563) defined team building as *"the process of deliberately creating and unifying a group into a functioning work unit so that specific goals are accomplished"*. Because nursing is such a complex and diverse work environment, team work is an important strategy for the manager to encourage (Jooste, 2010:139; Moola, Ehlers & Hattingh, 2008:81; Van der Walt & Du Plessis, 2007:48-49). According to Roussel, (2009:212) team building improves cohesion amongst staff, fosters greater commitment from employees, and reduces operating costs.

Booyens, (2008:206) specified that team building reflects on role clarity among the group, knowledge and acceptance of strong points and weaknesses within the group, goal setting within the group and it involves frequent get-togethers both formally and on an informal basis.

Team building can be conducted off-site, using external moderators, or it can entail a well prepared workshop at the hospital site organised by the management. Another manner in which team work can be encouraged is by peer-mentoring programmes with frequent feedback which can lead to a collective feeling of efficiency and support (Jooste, 2010:141; Booyens, 2006:158).

One recommendation underlined the groups' concern about team building.

> Group 3: *"Skep die geleentheid vir team building sessies"*

To be able to improve and increase the managerial involvement in the units and wards, all the subcategories under the category "managerial involvement" should be utilised.

The hospital management team consist of the hospital manager, who is the head of the executive committee of the hospital. There are four departmental managers (also part of the EXCO team) assisting the hospital manager in the coordinating and controlling of the hospital (top-management of the hospital). The line-manager (unit manager) forms part of middle management of the hospital (reporting to the Nursing Manager) and are responsible for planning and organising within the different departments or units where delegation to and supervision of personnel are taking place.

Strategies that can be implemented by the hospital management team are discussed with regard to each separate category. One of the recommendations regarding managerial involvement was the need for more staff as well as more regular meetings to take place. The management must recognize this need for increased communication of the staff. One way of addressing the increased need is through providing more contact sessions, such as conducting meetings. These contact sessions or meetings should, be meaningful and not time wasting (Yoder-Wise, 2007:549).

Three types of contact sessions or meetings can be implemented, namely a five-minute meeting, weekly meetings and monthly ward meetings. The length, purpose, and conduction of these meetings are all different and will be explained.

The quick **five minute meeting** can be implemented after patient hand-over in the morning. This kind of meeting serves to guide the staff with regard to the nursing care that has to be rendered during the shift and done by the unit manager with the staff.

Weekly meetings can be done on an occasional basis such as discussing pressing issues regarding patient care that comes up, for example discussion of the weekends' problems on Monday mornings, or possible changes in procedures that has to be implemented. These meetings should last less than an hour and should be conducted by the unit manager with her staff.

Lastly, **monthly ward-meetings** should be implemented. These meetings should be formal meetings where an agenda is available 24 hours in advance. These meetings should be conducted in a structured and formal manner. The content of these meetings should reflect on managerial issues, patient care, and issues that concern the personnel. New policies or procedures can be introduced and discussed. Minutes should be kept for future reference and if staff could not attend to keep up to date.

When nursing managers attend these meetings as observers they are more visible to staff and there is more contact (Yoder-Wise, 2007:549).

Written communication can further be used by the unit manager to inform and keep staff up to date. Besides agendas and minutes posters, bill boards and notices can also be used as a method to convey information and messages.

Communication, whether written, spoken or electronic, forms the crucial basis of management of staff as well as patient care. All staff members, including doctors and managers should continuously, through in-service or formal training, be encouraged to improve their ways of communication. Various teaching methods can be applied such as role play, or recording of communications sessions and discussion thereof.

To become a good communicator, certain skills must be acquired such as the skill to listen properly, the asking of open-ended questions, reflecting on what is conveyed and the appropriate use of silence (Chitty, 2001:460). Giving of feedback during interaction is another skill that has to be learnt. The appropriateness of a reply during a conversation is important. The reply should not be a whole speech when only one word is enough or a "yes" when the receiver actually expects an explanation. Flexibility is necessary when communicating, especially when the communicator planned to convey a message and the receiver is not ready to receive the message (Chitty, 2001:460).

By having better and more communication in the nursing ward or unit, staff might have more confidence and trust in the unit manager. They will easier divulge their burning issues and a more trusting relationship will be fostered. **Disciplinary difficulties** will be minimal due to a better understanding and having more respect between manager and staff.

Performance appraisal of staff is a useful strategy to motivate staff if it is done appropriately. It should be done regularly in both a formal and informal way. (Formal appraisal is done in the form of a discussion with the staff member and informal is to be continuously aware of the actions and reactions of staff and making note of it. This could be complementing staff in general after a busy period without any problems, or subtly telling a staff member to wear gloves when working with patients (Yoder-Wise, 2007:294-295).

Staff shortage can be addressed by better **staff planning** and using of the available permanent staff more efficiently. More staff can be scheduled around busy times and less during quiet times (Yoder-Wise, 2007:228).

Staff agencies should be approached to allocate specific temporary staff for certain wards. In doing so, the ward will have "permanent-temporary" staff available. This will be staff who know the permanent staff, the ward and routine. Due to the fact that they are aware that they will be preferably allocated to the specific unit again, they will act with more responsibility. The unit manager can appraise them by including them in ward activities and functions (Jooste & Prinsloo, 2013:1-10).

The **acuities** within the ward are calculated on a computer programme for 24 hour periods according to the patient dependency. The unit manager must ensure that these calculations are done correctly to ensure validity and trustworthiness.

Team building sessions might be costly if done off-premises by professionals, but it is not the only way to do it. Team building sessions on site ask for innovation and will also result in increased team spirit if well planned and executed. Examples of team building sessions that can be held on site are a fancy-hat parade or other fun events on nurses' day or involving as much as possible of the staff in the arrangement of special events such as: the hospital's anti-smoking campaign, HIV/Aids awareness day, Breast feeding day, and Emotion wellness day (Chitty, 2001:356).

3.4.2 Physical environment

The physical environment forms part of the work environment of the professional nurse and consists of the layout of the unit, hygiene and maintenance of a clean area and ergonomically friendly environment.

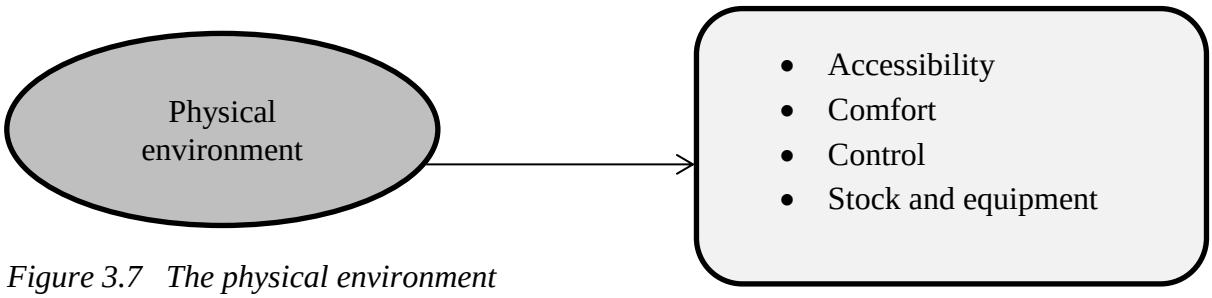


Figure 3.7 The physical environment

The sub-categories under physical environment that were indicated by the participants are accessibility, comfort, control, stock and equipment.

3.4.2.1 Accessibility

The Longman Dictionary of Contemporary English (2009:9) defines accessibility as: *"a place, building, or object that is (accessible) and is easy to reach or get into"*.

Booyens (2008:116) emphasised that hospitals should be designed to function as a healing environment that responds to the needs of the patients, visitors and staff members. Hospitals that are designed with the staff in mind, attract more staff as they feel motivated and valued to work in a positive work environment supportive of them. Booyens (2006:243) identified specific physical environmental aspects that directly contribute to patients' welfare and suitability for staff to work in such as safety, cleanliness, heat, ventilation and lighting.

Participants' recommendations reflected some of these aspects:

Group 1: *"Dedicated Hospital A lifts"*
Group 1: *"Skuif saal na hospitaal A gedeelte: gebruilk ongebruikte vloer 2"*
Group 2: *"When identifying acuities take logistics of this hospital into consideration"*

Both the recommendations of group 1 are about the wards that are located on the ninth floor with the elevators either not enough for the patient, staff and visitor loads or not being in working order at all. This situation is an on-going problem and even drew the attention of the press (Damons, A. 2012; Gericke, M. 2012; Steyn, P. 2012; Steyn, P. 2012). Group 2 recommended that the difficult logistics of the hospital should be taken into consideration when considering staffing.

3.4.2.2 Comfort

An environment that is too cold or hot does not contribute to the health of patients and staff. Infection control becomes difficult if the ambient temperature is too hot and staff finds it uncomfortable to work in such an environment. If it is too cold, the recovery of specifically surgical patients can be compromised due to metabolic changes within the body. The older medical patients also find a too cold ambient temperature uncomfortable (Jooste, 2010:88; Booyens 2006:260.

The following recommendations came from the groups:

Group 1: *"Make use of mobile aircon units if can't fix existing aircon in wards and ICU"*
Group 2: *"Temperature control in wards should be regulated"*
Group 1: *"Create a dedicated space for a tearoom in all units"*
Group 2: *"Dedicated tearoom = not according to hospital policies – does not meet criteria smokers to be accommodated"*
Group 3: *"Create a personal space for healthcare workers outside ward in order to take a break and not be in the ward for 12 hours"*

Group 1 and 2 recommended the air-conditioning system to be repaired or an alternative measurement of temperature control should be used. According to a newspaper article (Cloete, H. 2012) reported on the hospital being too hot and uncomfortable. The participants only gave a general recommendation about temperature control and did not refer to it being too hot or cold.

3.4.2.3 Control

Control is the last function in the managerial process. Jones *et al.*, (2000:10) define control as: *"Evaluating how well an organisation is achieving its goals and taking action to maintain or improve performance ..."* Control does not only involve the evaluation of actions but also the creating of standards, policies and procedures. Data collection (on control) must be done through the attainment of records and statistics, deviations in performance must be evaluated and corrective action must be taken (Jooste 2010:87). Control should not be seen as a punitive action, but also a chance for the employees to increase their professional knowledge and care (Booyens, 2006:295).

The participants perceived control as not efficient as reflected in the following responses:

Group 1: "Provide clear guidelines regarding cleaners and kitchen personnel"
Group 2: "Cleaners should clean direct environment of pt. on daily basis = policy - they are not following the policy"

One of the basic physical environmental pre-requisites is a clean environment according to Maslow's attainments of needs hierarchy. Participants recommended that there should be control to ensure a clean environment and they perceived it as function of management to

ensure that control is done to keep the environment clean. Although the cleanliness of the ward and control of the domestic staff is not within the jurisdiction of the unit manager, the provision of a clean, hygienic environment for the patient stays the responsibility of the unit manager (Booyens, 2006:244).

3.4.2.4 Stock and equipment

Stock is defined as *"an amount of something that you keep so that there is always some available when you need it"* (Longman, 2006:1733). Quality of nursing care cannot be provided if the necessary stock is not available at all times

Equipment on the other hand includes the permanent fixtures such as sinks, air cons, lockers, cabinets, pneumatic tubes and cascade oxygen as well as apparatus. Apparatus of a nonexpendable nature could be subdivided into articles that should last more than five years (furniture, lamps, stretchers and wheelchairs) and items lasting less than five years. These items can usually be used repeatedly before being replaced, for example theatre instruments, bedpans, urinals, etc. (Booyens 2006:266). Equipment can also be divided into general items such as tables, chairs and beds and medical equipment like electrocardiographs, vital data monitors syringe drivers and/or infusion pumps to mention a few. Sides (2010:15) stressed the importance of always having equipment available and in working order. If an important piece of equipment such as a suction apparatus is faulty, the consequences can be disastrous (Mattox 2012:61; Campbell, Wilson & Engelhardt, 2011:815-823).

The recommendations of the participants reflect their views of availability of stock and equipment in their work environment:

Group 1: *"Daar moet minimum stock levels gehandhaaf word. Realistic minimum levels to be used"*
Group 1: *"A complete monitor per patient in ICU must be working"*
Group 3: *"Bestuur moet realistiese voorraad vlakke bepaal vir elke saal. Stel aksieplanne voor om voorraad tekort aan te spreek"*

It appears that they were experiencing challenges regarding enough supplies, maintaining these supplies and determining realistic level of supplies and equipment.

The **physical environment** of the hospital cannot be changed as the building was erected 45 years ago when different priorities were important. Certain arrangements and proper planning by management can alleviate the problems experienced by the professional nurses. The **accessibility** issue can be improved by reporting of broken elevators every time it happens to ensure management know about the problem. More supplementary staff must be appointed to help with transporting of patients between departments. Currently only one porter is appointed per ward which is not enough especially when there are multiple theatre patients.

The second subcategory under physical environment concerned with the **comfort** of patients and staff specifically a comfortable ambient room temperature. Timeous reporting of the problem is important to inform management of the problem who can notify the technical department. The recommendation of the participant for an alternative means of warming or cooling of an area is a good suggestion and could be implemented.

The importance of a **tearoom** or facility where staff can relax cannot be emphasised enough. Nursing staff work 12 hour shifts and must be afforded during their allocated lunch time to be alleviated from the stresses of the ward.

The current tea room is utilised for a storage area which could be changed to accommodate staff during their lunch and teatimes.

The problem of **control** over the cleaning staff and kitchen personnel is due to poor communication between the departments. Dirty areas or beds in the ward should be reported to the cleaning supervisor who will ensure the area to be properly cleaned. The culinary manager must be informed if there are any concerns about the food presentation or amount of food.

Enough **stock and equipment** in working order should be available all the time in the ward. Currently the replacement of stock is done on a basis of "what is used gets replaced" which can be problematic as the recording of the stock usage by the nursing staff is not always accurate. The cleaning, storing and maintenance of the equipment is part of the unit managers' and part of the ward administrators' responsibility. Due to other important and priority issues the equipment is not always maintained as it should be and equipment can become faulty or non-operating.

To alleviate this problem a **stock/equipment controller** should be appointed who can take control of the levels of stock, usage and replacement thereof. The equipment will be checked frequently, properly maintained and faulty or broken equipment can be sorted timeously.

3.4.3 Staff

Staff are the people working for a certain company (Longman, 2009:1297). The nursing personnel of these particular hospitals consist of the Nursing Services Manager, Unit Managers, Professional Nurses, Enrolled Nurses and Nursing Assistants. Care workers are employed as temporary workers to fulfil the role of porters transporting the patients to other departments like theatre and X-rays. The care workers also help the nursing staff with turning and bathing of patients.

Sub-categories that emerged related to staff are displayed in figure 3.8

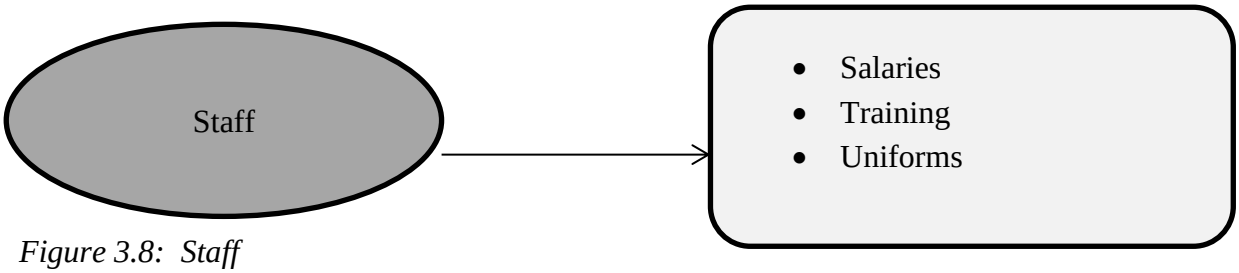


Figure 3.8: Staff

The participants raised concerns about salaries, training and uniforms in the different Nominal Groups.

3.4.3.1 Salaries

Salaries refer to the set remuneration of personnel as agreed upon on employment. This can comprise a base payment and fringe benefits. The composition of the remuneration will depend on the specific organisation (Huber, 2000:157; Jones, George, & Hill, 2000:374).

Remuneration forms part of work environment and is an important factor in staff satisfaction. Basic or entry salary is not sufficient and annual increases peak quickly leading to the situation where the employee can only improve the salary by upgrading skills or education or by getting promoted (Oosthuizen & Ehlers, 2011: Online; Tourangeau, Hall, Doran & Petch, 2006:128-136; Strachota, Normandin, O'Brien, Clary & Krukow, 2003:115).

Sengin (2003:318) brings a new view on salaries by stating that inadequate salaries as a single attribute might not cause dissatisfaction as such. It is in combination with added

unhappiness and discontentment with the work environment, that staff reflects as feeling dissatisfied with salaries.

The participants of the Nominal Groups were of the opinion that the salaries should receive attention as indicated through their recommendations:

> Group 3: *"Salaries bettered for R/N Competitive with other hospitals"*
> Group 3: *"Increase salaries to compete with the market and other local hospitals"*

At the hospitals where this research took place the pay level and pay structure for each job category are decided upon by the executive management (head office) of the company. This is fixed and not easily adapted. Salary negotiations take place during the final interview of all prospective job applicants between the unit manager and the prospective employee. During that session the salary package is discussed. This package includes basic salary, medical and life insurance, allowances for working unsocial hours, sick leave and annual leave. The prospective employee has the choice to accept or decline the offer and post.

From the recommendations it appears as if the participants feel a need that their salaries should be revised.

3.4.3.2 Training

Training is a short-term process and involves the acquirement of knowledge and skills necessary to be able to perform a certain job or task. Development on the other hand prepares the employee for future work responsibilities and is a more long-term focused process (Du Toit, Erasmus & Strydom, 2010:304; Gerber, Nel & Van Dyk, 1998:449).

Staff development and training is the responsibility of the management of an organisation who oversee that the human resources department fulfils the needs of the staff in this regard. Knowledge and skills training, such as the use of equipment, interpretation of an ECG, and executing specific procedures are usually done by the line-manager, and development training such as utilizing of policies and company procedures is conducted by the human resources department (Booyens, 2006:169).

The Nursing Act (No 58 of 2005) section 39 gives guidelines about the requirements of the continuing professional development (CPD) for nurse practitioners who are registered already. Until such a time that the CPD system is implemented and controlled, it is mostly the responsibility of the professional nurses themselves to maintain current competencies and keep up to date with development of skills and knowledge (Geyer, 2013:115; Booyens, 2008:390). Jooste (2010:223) stated in her publication that it is the responsibility of the nursing management to uphold the competencies and knowledge of their staff as well as their own. The setting of a work environment conducive to learning by utilising the teachable moment in the clinical areas, is an important teaching method to keep staff interested and focused (Jooste, 2010:223; Roussel, 2009:594).

The Occupational Health and Safety Act (No. 85 of 1993) gives clear guidelines of the duties and responsibilities of the employee and employer regarding the training, health and safety of staff and patients alike (Du Toit, Erasmus & Strydom, 2010:347).

The participants indicated their needs for development and training opportunities as follow:

Group 1: *"Meer opleidingsgeleenthede vir alle personeel, nie net in-service training"*
Group 3: *"Create in-service training opportunities in the form of workshops where personnel are responsible for the content, and lectures on a weekly basis. Also debating patient cases, this would assist in morbidity and mortality discussions with doctors"*
Group 3: *"Skep die geleentheid vir nagraadse studies vir professionele nurses. Selfs buite hulle huidige veld"*

Participants in two of the three groups voiced a need for formal education and more in-service training which indicates the fact that there is a lack of staff development opportunities. Within the national skills-development strategy the government aims to develop the skills of the existing employees and enable employees to become more productive and competent through legislation (Du Toit, Erasmus & Strydom, 2010:342).

3.4.3.3 Uniforms

Uniforms can be defined as: *"a particular type of clothing worn by all the members of a group or organization …"* (Longman, 2009:1922).

The purposes for nurses to wear uniforms are amongst other, to portray a professional image and for infection control purposes (Thompson, 2010:24). In Wales, Scotland and Northern

Ireland standardised uniforms were introduced to be able to recognise nurses easier (Thompson, 2010:24.

The issue on the preferred colour and or pattern of uniforms will be an on-going debate. Children seem to fear nurses dressed in white, while adults are of the opinion that white attire portray professionalism and confidence. Both children and adults prefer nurses to wear bold printed tops and plain colour pants (Wocial, Albert, Fettes, Birch, Howey, Na & Trochelman, 2010:320).

The hospitals where the research took place provides a monthly allowance to each staff member to purchase uniforms from a specific company who provides the corporate range. Shoes and accessories are not included. A recommendation from a participant in group1 reflected that staffs were not satisfied with the services rendered by the appointed clothing company:

> *Group 1: "Make use of another company to provide uniforms, and revise uniform criteria"*

To be able to create a professional image and create a feeling of "belonging to a selected group" calls for a uniform to be worn. It is a managerial responsibility to consult with employees regarding the service provided by a clothing company chosen by management to provide clothing.

Strategies for the third category involve personnel issues upsetting the staff such as salaries, uniforms and training.

The **salary structure** is below the other hospitals in the same company and hospitals from different companies. Nationally staff salaries are calculated according to the size, occupancy and location of the hospital. The hospitals where the study was done are small in relation with other hospitals within the same company and maintain an occupancy (<50%) lower than the average in the rest of the company (>80%). Bloemfontein is also seen as part of the countryside and small in relation to places such as Cape Town and Johannesburg.

The best strategy the unit manager can have about salary queries is to explain the situation to them to keep them informed about the reason why their salary scales are lower than others.

Programmes for **staff development and training** should be in place regarding general orientation, in-service training, and self-directed training programmes. Each employee's development should be recorded and kept up to date by the human resources department, line manager and employees themselves. The human resources department and the line manager should help and guide the employees regarding self-directed training but employees are simultaneously responsible for their own professional development (Jooste 2010:250).

Preceptorship as part of staff development within the work environment should also be encouraged where the senior professional nurses guide and teach the younger nurses in clinical and practical skills and professional development. A **teacher-learner culture** should be cultivated by the management of the institution where an enquiring mind is nurtured and stimulated and staff should never feel scared or embarrassed to ask questions (Gopee & Galloway, 2009:209; Roussel, 2009:594; Booyens, 2008:382; Kelly, 2008:298).

Occupational health and safety training should also be addressed. Mistakes, and near-misses negatively affect the company. Examples of this are: financial loss due to a fire, poor health of employees (due to needle-prick injury because of improper use of equipment) and law suits following visitors that sustain injuries (due to staff negligence by not using a "wet floor" warning sign board) (Gerber, Nel & Van Dyk, 1998:251).

The **uniforms** and the company providing the uniforms are decided upon by head office and cannot be changed without difficulty. A strategy regarding this problem could be to order uniforms well in advance (even when not necessary) or to purchase uniforms from staff who resigned.

3.4.4 Psychological environment

Following the analysis of the recommendations of the participants, the psychological environment involves the subcategories employee wellness programme and sensitive attitude as displayed in figure 3.9.

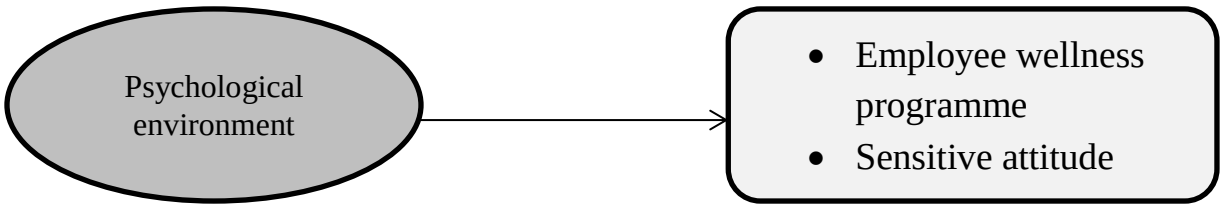


Figure 3.9: Psychological environment

There is no clear-cut definition within the literature of what the psychological environment entails, but organisational culture is well defined. Organisational culture refers to the professional and social relationships that exist amongst management, the health care team members and colleagues. It also entails the personal and professional interpersonal relationships and attitude amongst co-workers and management. Other aspects of organisational culture refer to team spirit, team cohesiveness, as well as availability and support of management.

An employee wellness programme, which is a service rendered and/or supported by the company to deal with the promotion of health and wellbeing of employees, improving productivity and reducing absenteeism, contributes to enhance the organisational culture (psychological environment) (ICAS, 2013:Online).

3.4.4.1 Employee wellness programme

Traditional employee programmes focused on reactive programmes to reduce alcohol and substance abuse (employee assistance programme). Opposed to this view, the services offered by the current employee wellness programmes are much more focused on health promotion in general and prevention of disease. The wellness programmes focus on programmes on physical fitness, stress management, psychological and mental health issues, nutrition and dietary related needs. Programmes to prevent alcohol and chemical dependency and rehabilitation programmes are also offered (Benavides & David, 2010:292). Unfortunately there seems to be a negative stigma connected to staff that make use of an employee wellness programme. In general employees feel they might be labelled by their peers as ‘not coping’ or ‘soft’ it they make use of such programmes (Benavides & David, 2010:292; Pollack, Austin & Grisso, 2010:729). A participant in group 3 recommended that the present programme of the company, ICAS (Independent Counselling and Advisory Services) should be more available. The recommendation is depicted in the box below:

> Group 3: “Program should be localized to be more accessible to all healthcare personnel. This will decrease absenteeism”

The participants felt the service should be based locally, be more accessible and that participation would reduce absenteeism. This recommendation leaves the impression that such a programme is accepted by the staff involved in this study. The researcher recently

referred two employees to this specific company's employee wellness programme. They did attend it and reported back that they found the programmes encouraging and very supportive. This supports the impression that the programme is accepted in contrast with mentioned possible stigmatising.

According to the ICAS information brochure the five most common presenting problems for 2013 are as follows: relationship problems, stress associated problems, organisational problems, legal issues and child and family care problems. The company's wellness programmes (ICAS) are well utilised and information about the programme is electronically available for easy access to staff (ICAS, 2013: Online).

3.4.4.2 Sensitive attitude

A sensitive attitude from the nursing management is important for the employees to be able to experience a positive work environment. The attitudes, values and behaviours of the employees are shaped by the nursing management (Kane-Urrabazo, 2006:193). The employees imitate behaviours of the manager towards each other and towards authority. If the employees experience or see the manager being disrespectful or inconsistent, the same behaviour will manifest with the employees (Noda, 2010:1). Examples of a sensitive attitude towards employees are the encouragement and support of a staff member to be able to breastfeed her new baby even while returning to work (Chow, Wolfe & Olson, 2012:1042-7), mentoring and leading staff to attain their full professional and or work potential, to encourage and support staff to maintain and promote a healthy personal lifestyle (Clarke & Shaffer, 2000:6-8).

The participants were quite outspoken on the topic of sensitive attitudes of management and this is alluded to in literature (Booyens, 2008:195; Du Toit, Erasmus & Strydom, 2010:206; Jooste, 2010:144-146; Kelly, 2008:243; Roussel, 2009:530-531; Yoder-Wise, 2007:36; Zerwekh & Garneau, 2012:243-244).

Group 1: *"Gee meer positiewe terugvoer direk na personeellid goed gedoen het"*
Group 1: *"Management should show that they care for their personnel e.g. flower, card – not only reward checks"*
Group 1: *"Respekteer die unit manager, unit manager must also respect the personnel"*
Group 2: *"When off-duty not to be contacted re. hospital issues"*
Group 2: *"Management should treat personnel professionally"*
Group 3: *"Managers must show compassion when listening to staff, not only be concerned with financial implications"*
Group 3: *"Managers should praise personnel when praise is due"*
Group 3: *"Bestuur moet sensitief wees vir die spesifieke behoeftes van vroue personeel, bv. Familie verantwoordelikhede. Increase limit on telephone bill in order to cater for family responsibilities"*
Group 3: *"The go-getters/movers & shakers should be embraced in the hospital and not pushed out or feel threatened"*

For the professional nurses participating in this study it is important to be recognised when work was done well, to be acknowledged on special events such as their birthdays, to be respected and to be treated professionally. They expressed their concern that the approved amount of money allocated for personal calls to be too little to meet their needs. The professional nurses also feel they cannot express themselves fully for the fear of managerial retribution, especially when management experience them as opinionated or outspoken.

A more lenient, accommodating, and sensitive attitude should be portrayed towards professional nurses in order to provide a positive work environment for the professional nurses for the hospital to be able to retain them and decrease the rate of turnover (Hahn 2009:8-10; Zerwekh & Garneau, 2012:200).

The strategies regarding the psychological environment involve the employee wellness programme and the need for a sensitive attitude shown towards the professional nurses.

The staff lacks knowledge about the **employee wellness programme** of the company. This is due to poor communication with staff from the unit manager. This could be alleviated by keeping the staff informed about the programmes by communication about the programmes during meetings, notices on the notice board and cell phone messages. Staff that feels the need to utilise a wellness programme will be better equipped to cope with problematic areas within their lives if they make use of the services.

A **sensitive attitude** regarding staff issues should be maintained by management. Staff might perceive management as being uncompromising, inflexible, rigid, insensitive and oblivious

regarding matters they feel strong about. Examples of a sensitive attitude could be to get to know each staff member individually with regard to their fears, aspirations, likes and dislikes. Another example of a sensitive attitude is the encouragement and support of viable goals of the staff. The enrolled nurses who want to further their professional development should be reinforced and helped in the pursuing of their goals.

Good communication and listening skills will be a starting point to acquiring a culture of a sensitive attitude towards staff.

3.4.5 Nursing care environment

The last category identified is the nursing care environment. The nursing environment includes issues relating to the rendering of nursing care, such as continuity of care, different health care groups, doctors and workload, as shown in figure 3.10.

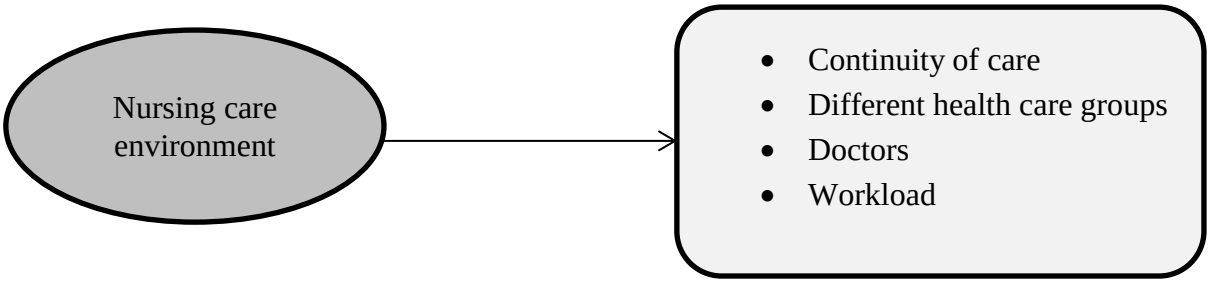


Figure 3.10 Nursing care environment

A positive nursing care environment will allow professional nurses to render continuity of care, allow effective interaction with members of the different health care groups, including the doctors, and provide an acceptable workload.

3.4.5.1 Continuity of care

Longman, (2009:366) defines continuity as *"the state of continuing for a period of time, without problems, interruptions or changes"*. If this definition is applied to the nursing care of a patient, it refers to the care that is rendered over a period of time (the time the patient is in hospital) and that the specific care should not be interrupted or changed. In practice this would indicate that nursing care should continue over a 24 hour period on the same level of quality on-going, until the patient is discharged. The care includes the physical care of the patient (observations, comfort, and hygiene amongst others) as well as emotional support.

The rendering of this care should be done in such a way to prevent potential problems from occurring.

Interruptions of the care occur if for example medication that is not given on time due to stock not being available. This interruption of treatment causes problems for the patients, resulting in poor quality of care (Sears, O'Brien-Pallas, Stevens & Murphy, 2013:(Online). Interruption of care also occurs if staff members neglect to communicate important information to one another, resulting in poor outcomes for the patient. Change in the patient care is sometimes required when the applied care does not elicit the perceived responses, but this is not routinely done.

The recommendations regarding the continuity of care were the following:

Group 2: *"All nurses should attend pt-hand-over at shift changes"*
Group 3: "Managers need to attend daily ward rounds in the morning that will assist her to be actively involved in the ward"
Group 3: "Matron on call after hours should be in a position to relieve in any section of the hospital"

The importance of the handover rounds between different shifts was highlighted by the participants. This is a crucial part of continuity of nursing care. Poor hand-over or poor conveying of messages leads to medico-legal hazards in a unit (Pothier, Monteiro, Mooktiar & Shaw, 2005:1090). The participants emphasized the fact that all nurses should attend these rounds and they also indicated that the nursing manager should attend these rounds.

It is important for the unit or ward manager to be informed about the diagnosis and condition of all the patients to be able to help and guide the staff regarding maintenance of continuity of care.

The after-hours matron performs an important part of the 24-hour supervision of, amongst others, the continuity of care. Less managerial staff and doctors are available after hours, although the nursing care continues. The recommendation that the matron on call should have to be able to relieve any staff member in any section of the hospital is not feasible as some of the departments need specialised staff such as theatre and ICU.

3.4.5.2 Different health care groups

The different health care groups include the physiotherapist, phlebotomist, and dietician. They are all integral parts of the health care team (Chitty, 2001:473). The doctors were kept as a separate sub-category due to the number of recommendations elicited. One response related to different health care groups was raised:

> Group 3: *"The opportunities should be created for different healthcare groups to be sensitized toward respecting each other"*

The need for members of the different health care groups to be sensitised with regard to showing respect towards each other was a recommendation. To be respected is a fundamental right and the protection thereof is part of the country's constitution, although staff do not always conform to this (Constitution see South Africa).

Work environments where nurses and non-nursing health care professionals respect each other are characterised by a milieu of support and understanding from the hospital management. The value of nurses is recognised by the non-nursing health care professionals, and more substantial contributions are made by the nurses, contributing to a positive work environment and professional nurses feeling fulfilled and self-actualised (Kelly, 2008:71).

3.4.5.3 Doctors

Nursing care and medical care are intertwined and the doctor-nurse relationship is supposed to be a relationship of collaboration and co-operation, with the well-being of the patient as the ultimate goal. The Royal College of Nursing (2009) describes the relationship as follows: "…*collective knowledge, skills and actions of many disciplines and professions*" are required to address the complex needs of the patient and the health care services (Geyer, 2013:186). Geyer (2013:137) also emphasises the role of the professional nurse as autonomous practitioners who do not follow prescriptions blindly but should be able to justify why a prescription was not executed.

Unfortunately this is not always the case due to unfavourable previous experiences on both sides by doctors and nurses (Chitty, 2001:472). The general opinion is usually that the nurse is not specific enough and uncooperative as experienced by the doctor, and the nurse is of the opinion that doctors are rude and pedantic (Zerwekh & Garneau, 2012:219). Gender

differences also complicate the situation as doctors are usually males who studied at male-dominated medical schools being taught a hierarchical model of teamwork with the doctor at the top of the hierarchy (Chitty, 2001:472).

To be able to sustain a positive and creative relationship of mutual respect and collaboration, communication and interaction is necessary for the sake of a therapeutic environment for the patient.

The participants' concern about the doctors are reflected in their recommendations

Group 1: *"Set a policy in place that will address disrespectful behaviour of Dr's toward personnel"*
Group 2: *"Dr's should practise sterility guidelines and that should be forced down by management, Dr's signed "best care" practise guidelines – but they don't follow the guidelines"*
Group 2: *"Platform to be created for dr's + nurses to discuss attitude issues Hospital A = clear on this – has policies – R/n should act on the policies"*

The professional nurses feel the doctors do not treat them with the necessary respect and they ask for discussion to be established. Where policies and procedures are put in place and are to be followed by all persons involved in rendering of patient care and are neglected by the doctors, it creates feelings of misunderstanding and irritation amongst the nursing staff.

3.4.5.4 Workload

Workload refers to the amount of work that is done in a specific section (Yoder-Wise, 2007:276). The concept "amount of work done" is perceived differently by individuals, such as the nurse manager, the staff and the patients. This leads to unhappiness amongst staff. There are several ways in which workload is calculated, for example, according to the average daily census, calculation of average length of stay of patients and the percentage of bed occupancy (Yoder-Wise, 2007:276). The way it is calculated will depend on the institution. Improving on procedures and cutting out time-wasters assist to lessen the workload of professional nurses. The participants of the Nominal Groups recommended that a better planned system of patient admission and gathering of information is needed to be able to utilise the nurses' time better.

Their recommendations were:

Group 3: *"Geel leers moet saam met die pasient vanaf ongevalle na saal gestuur word, omdat verpleegsorg andersinds vertraag word"*
Group 2: *"Modify ICU form – tick sheet"*

The "yellow files" that were mentioned are opened on admission either at the reception of the hospital (for a pre-booked admissions) or at the emergency department in case of an emergency. The files contain the patients' personal information as well as medical aid information. This is the basic but most important information that is needed to further care for the patients. Without this information, bookings and ordering of medicine is not possible therefore the recommendation.

In the ICU, monitoring of the patients and the recording thereof takes up a lot of time, which the participants perceived as increased workload. Streamlining procedures can minimise workload and in such a way enhance the work environment.

If inputs of staff are acknowledged and implemented it further enhances the work environment and increase quality of care rendered (Kelly, 2008:552; Zerwekh & Garneau, 2012:210).

Strategies that will improve the work environment of the professional nurses regarding the fifth category, nursing care environment will now be discussed. The subcategories were: continuity of care, different health care groups, doctors and the workload of the professional nurse.

Continuity of care is important for the improvement of the condition of the patient, and unnecessary interruptions could hinder the progress of the patient. Interruptions in the care of the patient will be reduced, if the staff are knowledgeable about the consequences of unnecessary interruptions in care. With **continuous training and re-enforcing** of the expectations of the patients about their care, the nurses will be more careful and motivated to give continuous quality nursing care.

Different health care groups need to work together for the sake of the patient. The unit manager can keep the different team members together by introducing new staff members to the whole team. Another strategy is to make all the team members (physiotherapists,

dieticians etc.) part of the ward activities, such as a ward fundraising exercise. The physiotherapist could help with training sessions on topics such as 'how to take care of your back when lifting heavy objects'. In this way the different team members will get to know each other securing a better work relationship and respect for each other.

The improvement of the relationship between **doctors** and nursing staff will lead to better-quality medical and nursing care of the patient. The relationship will be improved by **ensuring accuracy and diligence from the nursing staff** when taking care of patients to reduce the amount of mistakes, near misses and faults from the nursing staff. The assistance of the nursing manager and hospital manager could be sought to inform the doctors about the intention of the nursing staff to improve the relationship.

The last strategy to deal with regarding the nursing care environment involves the **workload of the professional nurses** which is problematic according to them. The two areas that need improvement can be rectified by, firstly **inform and train the reception personnel** responsible for the admission of the patients the importance of a quick and fast admission. The consequences of a slow admission could be explained to them to get more cooperation from them. Secondly the ICU chart can be improved by **lodging a complaint** to the training department of the company, who can make alterations to the ICU admission forms. The complaint should be verified and an alternative example must be included. If the alternative is accepted, the form will be changed to a tick sheet variation.

3.5 OTHER INPUTS

The participants felt the need to keep the nurses' station tidy and required shelves to be installed.

Group 1: *"Sit rakke in diensstasie sodat dit netjies gehou kan word"*

The recommendation generated from a need of the staff to have a tidy and well organised workspace or physical work environment.

No literature could be found regarding the organisation of the nurses' station, but Booyens (2006:244) described the importance of safety within a nursing unit. The patient will not be harmed at the nursing station but valuable information, patient reports or medical prescriptions might get lost if the area is cluttered and unorganised.

The strategy to improve the situation is to **involve the maintenance department** in deciding where extra shelves and storage space should be added to be able to clear the nurses' station of unnecessary clutter.

3.6 CONCEPTUAL FRAMEWORK OF THE WORK ENVIRONMENT

The work environment can be divided into internal and external aspects (Ehlers and Lazenby 2010:8-9) which will now be discussed (see figure 3.11).

3.6.1 Internal and external work environment

The internal work environment or nursing practice environment of the professional nurse consists amongst other factors, of a **physical environment** (layout of the unit, hygienically clean, temperature, lighting, workspace crowding etc. (Booyens 2008:9; Ehlers & Lazenby, 2010:112). The availability and functionality of stock and equipment also forms an important part of the physical environment, but influence the nursing care environment as well. The milieu or the **psychological environment** of a facility like the nature of the relationships between management and staff, the relationship between physicians, management and staff, and the status of the professional nurse within the hospital hierarchy, as well as social support like an employee wellness program, and role description establishes a caring and valued feeling amongst the staff. The **nursing care environment** involves the professional development, in-service training, the availability of post graduate studies and the availability and implementation of nursing care policies and procedures. The amount and quality of staff forms part of the **personnel environment.** They are recruited and employed by the hospital management, who through **managerial involvement,** are responsible for maintaining staff discipline, performance appraisal of staff, ensuring the availability of enough permanent staff, and strategic steps such as communication workshops and teambuilding efforts (Djukic, Kovner, Budin, & Nornam,2010:441-451 and Lake 2002:176-188).

If the hierarchical order of needs according to Maslow (see figure 1.1) is taken into consideration the most important needs to meet first by the nursing management are the **physical or environmental needs** [1]**.** These needs need to be met to be able to enhance to higher levels, ending at the top level of self-actualization [5] (see integration with conceptual framework, figure 3.11).

A company has some control over the internal environment (Ahmad, 2010:582-583; Andrews & Dziegielewski, 2005:291-292; Bae, 2011:706; Begat, Ellefsen & Severinson, 2005:221-230). Changes can be made within the internal environment that can either improve or hamper the work environment, such as changes in policies, strategic planning to improve patient care or changes in staff planning for example (Verhaeghe, Vlerick, Gemmel, Van Maele & De Backer, 2006:646-654; Tomey, 2008:15-25).

In contrast to the internal environment, the external environment consists of elements such as the global **economic environment, technological environment, political environment, social environment,** and number and type of stakeholders over which the company has little or no control (Ahmad, 2010:582-583; Andrews & Dziegielewski, 2005:291-292; Ehlers & Lazenby, 2010:140-148).

The availability of capital, the current interest rate and the rate of inflation (**economic environment**) over which the organization does not have control has an influence on the retaining of staff. An example of external environmental factors influencing the internal environment of a company is for instance, if the inflation rate increases (**external economic environment**) ensuing increases in staff remuneration (**internal staff environment**) (Booyens 2008:10; Ehlers & Lazenby, 2010:137).

Availability or the absence of technology influences the productivity of an organization, because it can enhance the care of patients, or it can delay or hamper the care of the patient if the equipment is not functioning. Within the hospital sphere the newest X-ray equipment could increase the amount of patients treated dramatically, and the number of patients treated affect the number of budgeted staff directly (Ehlers & Lazenby, 2010:115).

The **political environment** is regulated and controlled by the laws and regulations of the country and it can have a major impact on any company, whether it is state or privately

owned. The well-known issue of "black employment" therefore also affects the work environment as different cultural groups are working together within one work environment. The external political environment influences the company and specifically the internal environment of a company, by setting laws and specifications in the employment of different cultural groups (Gerber, Nel & Van Dyk, 1998:155).

The employees, customers, potential customers and the **customers view point** and attitude towards work, labour actions, products and business form part of the **social environment.** The opinion of society or **customer view point** regarding their expectations toward nursing services gets largely shaped by their level of education and skill level (Du Toit, et al. 2010:107; Ehlers & Lazenby, 2010:141; Nel, et al. 2010:6). Within the milieu of a private hospital most of the patients are employed within the formal employment setup, and mostly belong to a medical scheme that make it possible for them to make use of private medical services. Their expectations regarding the quality of medical- and nursing care is therefore more informed and specific due to their higher level of education and income, creating a patient base capable of making choices and frequent changes in medical care. The vast amount and availability of information on the internet and search engines also makes the general public aware of information unknown to the lay person in previous generations (Roussel, 2009:112-113).

Similar to the economic, technological, political, and social environments the organization has little or no control over the number and type of stakeholders, but the stakeholders can have a vast impact on the sustainability of an organization (Du Toit, Erasmus & Strydom, 2010:159).

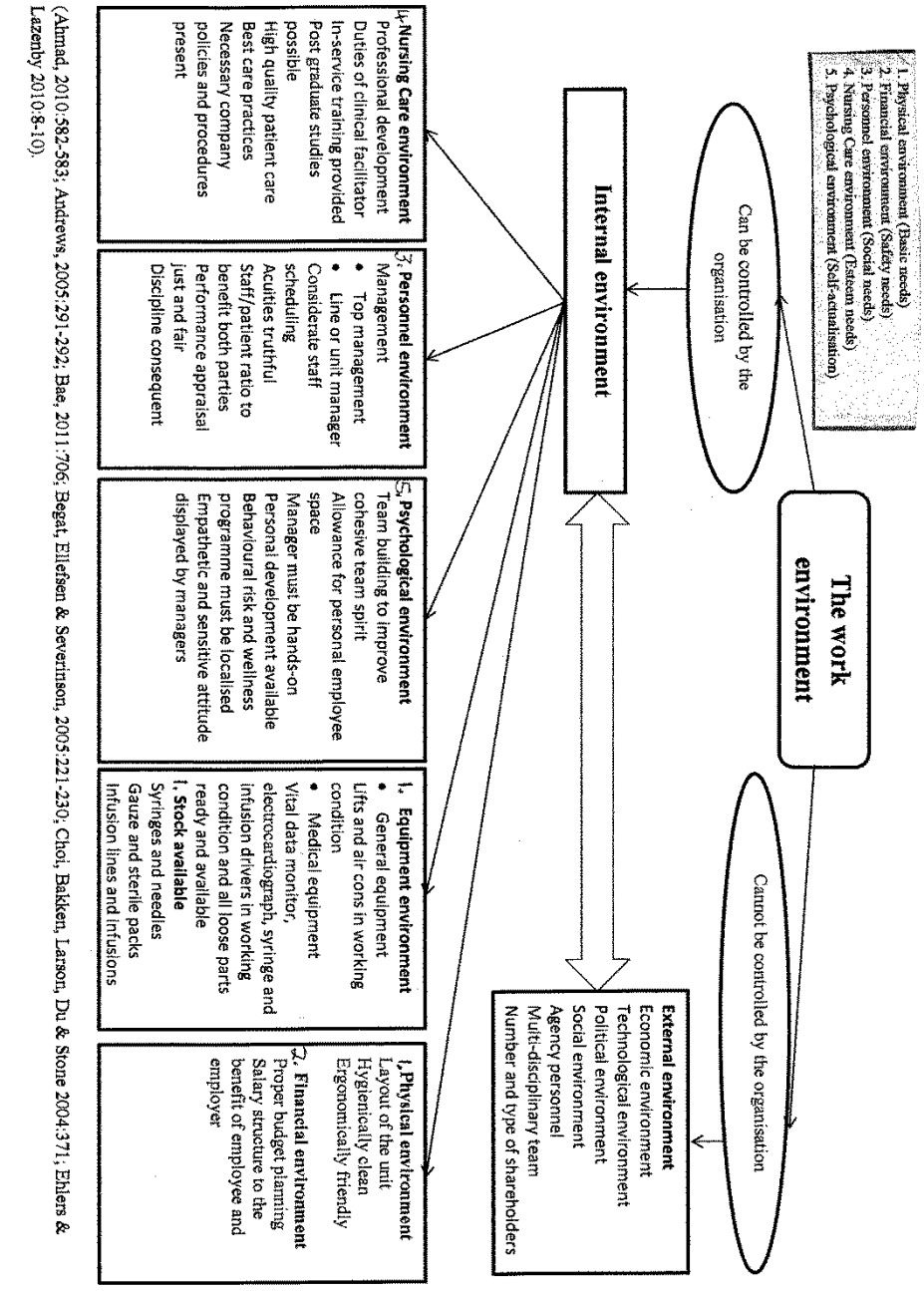
Stakeholders are people or groups of people who have an effect on the organisation, or who might be affected by the organisation (Du Toit, Erasmus & Strydom, 2010:159). Stakeholders can be divided into two groups, namely an internal group of stakeholders (employees and owners of the company), and external group of stakeholders (shareholders and customers) (Du Toit, Erasmus & Strydom, 2010:159). In the case of a hospital the internal stakeholders would be the staff working at the hospital and the owners of the company. The external stakeholders are the shareholders (on the stock market) and the patients visiting the hospital for medical treatment.

A company has a responsibility towards both groups of stakeholders in the sense of providing stable employment to the employees and ensuring a highly profitable, but low risk product for the shareholders (Du Toit, et al. 2010:89; Jones, George & Hill, 2000:155; Ehlers & Lazenby, 2010:15-16).

Owing to the fact that the product of a health care system is patient care, the level of quality patient care within a health care system or hospital is of cardinal importance for the sustainability of the organisation. For the nursing staff to be able to deliver good quality nursing care, a positive well organised work environment is necessary (Booyens, 2008:299; Jooste, 2010:222-223; Roussel, 2009:516-517).

The internal work environment of the hospital, where this study took place, exists of a nursing care environment, the personnel environment, the psychological environment, the equipment and stock environment, the physical environment, and lastly the financial environment. (Figure 3.11 depicts the conceptual framework conceptualising the work environment of the professional nurses.)

Strategies to improve the work environment of professional nurses working at a private hospital in Bloemfontein



(Ahmad, 2010:582-583; Andrews, 2005:291-292; Bae, 2011:706; Begat, Ellefsen & Severinsson, 2005:221-230; Choi, Bakken, Larson, Du & Stone 2004:371; Ehlers & Lazenby 2010:8-10).

Figure 3.11 Conceptual framework of the work environment

3.7 SUMMARY

In summary, five categories that received the highest rating from the participants', namely managerial involvement, physical environment, staff, psychological environment and the nursing care environment were discussed.

Participants of Group 1 and 2 had most of their recommendations on the physical environment while Group 3 had more recommendations concerning the psychosocial environment. Relating to Maslow's hierarchy, the first two basic needs of the staff are not yet met. The need for education and training which are higher level needs, were addressed, but it was not concerned to be a high priority.

To be able to retain professional nurses in the clinical work environment it is important to enhance a positive work environment by the hospital management, where nursing staff will feel valued and cared for, to be able to deliver quality nursing care.

CHAPTER 4 RECOMMENDED STRATEGIES OF THE GROUPS, SHORTCOMINGS AND CONCLUSION TO THE STUDY

The recommended strategies of the groups, shortcomings and the conclusion to the study will now be discussed

4.1 INTRODUCTION

During the course of Chapter 3 the research results and related literature analysis were discussed. Within this chapter the recommended strategies for the improvement of the work environment will be conversed, the shortcomings mentioned, and closure of the study will be done.

The purpose of the study was to describe strategies to enhance the work environment of professional nurses in a private hospital setting. The strategies were deducted from the recommendations made by the participants.

An improved work environment can lead to a positive attitude amongst the professional nurses, and this will lead to fewer resignations, lower rate of turnover, retaining more permanent staff and ultimately improving on the quality of patient care.

4.2 RECOMMENDED STRATEGIES OF THE GROUPS

An analysis of the recommendations of the participants of the Nominal Groups provided five (5) categories with sub-categories pertaining to issues that can enhance the work environment.

Strategies are defined as plans of action to attain a certain goal and it is not possible to provide different strategies for all categories and/or sub-categories since one strategy will address more than one issue. The strategies provided are selected to have the biggest impact on most of the categories and related sub-categories.

4.2.1 Managerial involvement

The first strategy is the **involvement of management** into the clinical setup as percieved by the professional nurses. The management play an integral part in the success of an organisation and can lead their staff in the attainment of higher order needs or self actualisation according to the hierarchical needs assessment of Maslow. If the lower order

needs on a physical or basic level are not fulfilled, self actualisation will not be a priority for the professional nurse. Feelings of low self-worth, anger and frustration due to lack of fulfilling and the hopelessness of the situation will drive the professional nurse away from nursing.

The management of an organisation can improve the managerial functions by using certain skills such as **communication, performance appraisal and team building**. To be able to communicate properly and understandably is an art well worth persuing by managers who do not only want to manage their staff but lead them into the attainment or fulfillment and self actualisation. Programs and short courses on the skills of effective communication can be encouraged and pursued by management to adress the problem of inadequate communication within the hospital setup.

Implementing **discipline** that is fair and appropriate, but also across the board is another strategical action that can make a difference in the work environment of the professional nurse. Discipline need not be punitive and negative but if done in a constructive manner, it could be useful to uphold standards of quality nursing care such as possitive re-inforcement. The aim of disciplinary action should be to teach or inform the employee of wrong behaviour, and to be able to instill a desire to maintain and strive for only the best care for the patient.

Performance appraisal should be done continuously to keep staff informed about their progress and if they are on track in attaining their preset goals of the appraisal process. Good work should also be rewarded as employees should know when they are performing well, or what mistakes or weak areas can be improved on.

Actions of **team building** is important to facilitate a feeling of cohesion and togetherness within the team. Nursing cannot be done within a vacuum and each employee is reliant on colleagues most of the time. Collaboration amongst team members is of utmost importance and should be instilled, and maintained by the nursing management to ensure a safe, well organised nursing environment for the patient, positive work environment for the professional nurse and a reduction in staff turnover.

Ensuring enough **nursing staff** is the last managerial tool that can make a differense in the work environment of the professional nurse. With proper calculation of acuities and skill mix, reasonable and well planned sheduling of off-duties and neccessary filling of vacancies, the shortages of nursing staff will be addressed. Management must involve the professional nurses in the calculation and planning of staff for the next 24 hours.

The usage of **supplementary staff** such as a ward hostess to deliver beverages to the patient, porters to transport patients to and from different departments, and a ward secretary to see to all the administrative duties within the ward or unit, can alleviate the professional nurse from tasks that could be done by supplimentary staff.

4.2.2 Physical environment

According to the needs assessment of Maslow are the basic needs to fulfill, the needs which could be seen in the recommendations of groups 1 and 2. Nursing care cannot be done as it should be, in a work environment where accessability is hampered, none or limited stock and equipment is available, and the nursing unit is not hygienically clean or the ambient temperature is too hot or cold. The professional nurse feels responsible for the care of the patient and if this goal cannot be met for whatever reason, a feeling of failure and inadequacy sets in.

4.2.3 Personnel environment

The financial remuneration is important to the professional nurses, but as can be seen in the results of the study, not the most problematic. It is third on the list preceded by managerial involvement and physical work environment. By rectifying and updating the salary scales and remuneration of the professional nurse, the management can futher improve the physical and second level (safety needs) of the needs assessment according to Maslow. If remunerated according to the market value, the professional nurses will feel valued and secure within their work environment ensuring the priority for higher needs.

4.2.4 Psychological environment

The psychological needs are placed rather low within the Top5 recommendations and indicated that the priority needs to be met, are the managerial and physical needs. Once the lower order needs according to Maslow are attained, the higher order needs will become more important as can be seen with group 3 who recommended improvements in aspects such as the employee wellness program, and using of a more sensitive attitude towards them. The employee wellness program should be better utilized and introduced by the nursing

management, as a lack of knowledge lead to the professional nurses to be ill informed about the program.

4.2.5 Nursing care environment

The nursing care environment rated last on the prioritised recommendations of the professional nurses. By improving the first and second categories of recommendations, a substantial amount of the nursing care environment will be improved such as continuety of care will improve by rectifying the accessability of the wards, appropriate enforcing of discipline and control to ensure continued quality care of all the patients. The workload will improve if the staff planning and allocation of staff are done with more insight and care to ensure enough appropriate skilled staff, enough stock and equipment available and in working order. An improved nursing work environment will lead to professional nurses experiencing the work environment as positive and well organised, reduce the feelings and intentions of resigning and therefore reduce the staff turnover.

4.3 SHORTCOMINGS OF THE STUDY

The shortcomings of the study were, amongst others, stumbling blocks experienced during the research process by the researcher. The staff shortages during the data collection was experienced by the researcher as unfortunate as the group sessions had to be rushed to be able to be finished within one hour. All the staff who indicated that they are willing to participate in the study, could also not participate as the nursing units could not be left without a professional nurse.

Only the professional nurses working in the clinical setup were included in the study, but a vast amount of other staff were excluded from the study such as nursing managers, enrolled nurses and nursing assistants. This was neccessary as the other categories of nursing staff would not percieve the work environment the same as the professional nurses and the highest amount of turnover is experienced amongst the professional nurses which made this study neccessary.

4.4 RECOMMENDATIONS FOR FURTHER STUDIES

Further study about the work environment of the professional nurses could be to expand the study and involve all the professional nurses working at this company or involve more than

two hospitals in the study. Another recommendation could be to do the research on other categories of staff or amongst the professional nurses working in the government hospitals.

4.5 CONCLUSION TO THE STUDY

Within this study the researcher tried to enlighten the plight of the professional nurse of today and the nursing profession for the future. The study was done on a small scale within two hospitals within one private hospital group but most of the problems are experienced universally and improvement thereof will also provide improvement on a bigger scale.

To improve and change the work environment of the professional nurse is vitally important for the nursing as well as the medical profession. The work environment could be improved by decreasing the high rate of turnover amongst the professional nurses which will have an uplifting effect on the health sector of the country.

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ADDENDUM A: Information brochure

Dear research participant

You are invited to take part in a research study. The aim of the study is to make recommendations to the hospital management that might help to improve the working environment at the hospital for the professional nurses. All the obtained information will be kept confidential and the results will be used for academic purposes. The recommendations will be forwarded to the hospital management after completion of the study.

The title of the study is proposed recommendations that can be applied to improve the work environment of the professional nurses working at a private hospital in Bloemfontein.

Your participation is voluntary and you may withdraw at any stage. Whether you participate or not will not affect the attitude towards you in any way in future. If you decide to participate, you might take this information brochure to be used for further reference. You will be asked to complete and sign a consent form as proof that you gave informed consent. You will get a copy of your signed consent form during the group session.

Complete a copy of the consent form and return the signed copy to the researcher. You will be asked to attend a group session of not more than two hours during your lunch time or off duty time. A meal will be provided that can quickly be taken after the group session. If you are willing to participate, the researcher will contact you to confirm the time and place for the proposed group sessions. You will not receive any remuneration if you participate in this study, but you will also not incur any cost.

The recommended strategies generated from this study might be implemented at the hospital which might (but not definitely) have an impact in the future on the work environment of the professional nurses working at this particular hospital.

The data generated from this study will be kept separate from any identifying information. The group session will be held by a facilitator (from the School of Nursing) unknown to the participants. Only the study leader, researcher and facilitator will have access to the research data.

The results of this study will be used as data in a dissertation necessary for the completion of a Master's degree study and the results will be publicised in academic journals.

If you have any questions or concerns regarding the research study, you may contact the researcher. The contact number of the Ethics Committee will also be provided in case of further uncertainties (Moule & Goodman, 200962-63).

Thank you for your time

Yours sincerely

Kobie Ruder

ADDENDUM B: Informed consent form

I…….. (first name and surname) hereby give informed consent to participate in the research project about the recommendations that might help to improve the work environment at the [redacted] Private Hospital. If I agree to participate in the study, I know I will have to attend one group session of not more than two hours during my lunch time or of duty time.

I understand that I can withdraw from the project at any time and I will be treated in the usual professional fashion.

I understand that the information gained from the Nominal Group session will be treated confidentially but the results will be used for academic purposes and will be publicized in academic journals.

I understand that my participation in this research is voluntary, and I will not be penalized, lose benefits or be treated different from the past if I refuse to participate of decide to terminate participation.

I know that I can contact Mrs Kobie Ruder any time during the study.

I know that I can also contact the Secretariat of the Ethics Committee of the Faculty of Health Sciences, UFS at telephone number (051) 405 2812, if I have questions about my rights as a research participant.

Name and surname of participant.....

……

Signature of participant.....
Date.....

Signature of witness.....
Date.....

Signature of researcher.....
Date.....

ADDENDUM C: Consent form to gain permission from the hospital manager to be able to conduct the study at this hospital

P O Box 112

Waverley

BLOEMFONTEIN

9301

12 May 2011

Mr. [redacted]

Hospital Manager

[redacted]

[redacted]

[redacted]

Dear [redacted]

Re: Research project, M.Soc.Sc. (Nursing)

I, Kobie Ruder, am a Master's degree student in the School of Nursing at the University of the Free State. I would like to do my research at the [redacted] Private Hospital. The title of my study is:

Strategies to improve the work environment of the professional nurses working at a private hospital in Bloemfontein.

I intend using the Nominal Group Technique for gathering of the data. I will get consent from the Ethics committee of the faculty of Health Sciences of the University of the Free State before I commence with the study. The information will be kept confidential as only my study leader; the facilitator (who are both employees of the UFS) and I will have access

to the gathered information before publication. The professional nurses will partake in the study during their on or off duty time, but partaking in the study will not affect their work as the session will only take an hour of their lunch time. They will each receive an information brochure and a consent form (enclosed here) that must be completed if they wish to partake in the study.

Participation in the study is voluntarily and they will be treated in the usual professional manner if they wish not to participate.

The group session will take more or less an hour.

I hereby request your permission to continue with the study.

Yours sincerely

Researcher: Mrs Kobie Ruder

Student Number: 1981355843

Cell Number: 082 521 1578

Contact person Ethics Committee: Ms H Strauss

Tel Number: (051) 405 2812

Fax Number: (051) 444 4359

Email: StraussHS@ufs.ac.za

Ps. Verification of permission and Ethics number for the proposed study from the Ethics Committee of the Faculty of Health Sciences will be included once it is received.

ADDENDUM D: Permission from the Nursing Services Manager for the professional nurses to partake in the research during their on or off duty time

P O Box 112

Waverley

BLOEMFONTEIN

9301

12 May 2011

Ms. ……..

Nursing Services Manager

[redacted] Private Hospital

……..

……..

Dear Ms. …….

Re: Permission for professional nurses to partake in the research during their lunch or off duty time.

I, Kobie Ruder, am a Master's degree student in the School of Nursing at the University of the Free State. I would like to do my research at the [redacted] Private Hospital using the professional nurses as study participants.

The title of my study is: Proposed recommendations that can be applied to improve the work environment of the professional nursing staff working at a private hospital in Bloemfontein.

I intend using the Nominal Group Technique for gathering of the data. I have got consent from the Ethics committee of the faculty of Health Sciences of the University of the Free State. (Letter enclosed) The information will be kept confidential as only my study leader; the facilitator (who are both employees of the UFS) and I will have access to the gathered information before publication. The professional nurses will partake in the study during their lunch time or off duty time, but partaking in the study will not affect their work as the session

will not take more than two hours of their time. It will be done during their lunch time or of duty time and a meal will be provided for them. They will each receive an information brochure and a consent form (enclosed here) that must be completed if they wish to partake in the study. Participation in the study is voluntarily and they will be treated in the usual professional manner if they wish not to participate.

I hereby request your permission for the professional nurses to participate in the study during their lunch time or of duty time.

Yours sincerely

Researcher: Mrs Kobie Ruder

Student Number: 1981355843

Cell Number: 082 521 1578

Contact person Ethics Committee: Ms H Strauss

Tel Number: (051) 405 2812

Fax Number: (051) 444 4359

Email: StraussHS@ufs.ac.za

ADDENDUM E: Inligtingstuk vir deelnemers

Geagte deelnemer

U word uitgenooi om deel te neem aan ‘n navorsingstudie. Die doel van die studie is om faktore uit die werksomgewing van professionele verpleegkundiges te identifiseer wat verbeter moet word of kan word ten einde hul werksituasie meer aanvaarbaar te maak. U bydrae sal wees om te help om hierdie faktore te identifiseer. Wanneer al die faktore ge-identifiseer is, sal strategieë beplan word om dit aan te spreek. Hierdie strategieë sal aan die hospitaalbestuur voorgelê word. Al die versamelde data sal vertroulik hanteer word. Daar sal geen identifiserende data wees wat ‘n verband tussen u en u reponse aandui nie. Die resultate sal slegs gebruik word vir akademiese doeleindes en slegs die studieleier, navorser en fasiliteerder sal toegang tot die navorsingsdata hê. Die titel van die studie is: Strategieë om die werksomgewing van professionele verpleegkundiges, wat in ‘n privaat hospitaal in Bloemfontein werk, te verbeter.

U deelname is vrywillig en u kan op enige stadium onttrek indien u sou verkies. U sal op geen wyse benadeel word indien u nie sou deelneem nie. Indien u besluit om deel te neem kan u hierdie inligtingstuk hou en gebruik as verwysing. U skriftelike toestemming word verlang indien u besluit om aan die studie deel te neem. ‘n Kopie van u getekende toestemmingsvorm sal gedurende die groepsessie aan u oorhandig word.

Die proses van deelname is as volg:

Voltooi en teken die toestemmingsbrief en stuur dit terug aan die navorser deur dit onder deur die deur te stoot van die Nagmatrone se kantoor op die negende vloer van die hospital.

Die navorsingstegniek wat toegepas gaan word is die Nominale Groeptegniek. Dit behels dat u ‘n groepsessie nie langer as twee ure tydens etenstyd of afdienstyd sal bywoon. Geen vergoeding word vir deelname in die studie betaal nie, en daar is geen kostes verbonde aan deelname nie.

Ligte verversings sal beskikbaar wees indien die groep tydens etenstyd gehou word.

As u gewillig is om deel te neem sal die navorser u kontak om die tyd en plek van die groepsessie te bevestig.

Die aanbevole strategieë gegenereer deur die studie wat aan die bestuur van die hospitaal voorgelê gaan word, mag moontlik geïmplimenteer word. Dit mag die werksomgewing van die professionele verpleegkundiges by die hospital positief beïnvloed.

Die groepsessie sal deur ‘n fasiliteerder van die Skool vir Verpleegkunde gehou word. Hierdie persoon mag aan u onbekend wees.

Die resultate mag moontlik in ‘n akademiese joernaal na voltooiing van die studie gepubliseer word.

Indien u enige navrae rakende die navorsingstudie het, kan u gerus die navorser kontak. Vir enige navrae rakende etiese aspekte van die navorsing kan u die sekretaresse van die Etiekkomitee, Fakuteit Gesondheidswetenskappe, Universiteit van die Vrystaat kontak.

Dankie vir u tyd

Die uwe

Kobie Ruder

Navorser: Me. Kobie Ruder

Selfoon nommer: 0825211578

E-pos: kobi.ruder@yahoo.com

Kontakpersoon by die Etiekkomitee: Me. H Strauss

Tel nommer: (051) 405 2812

Faks nommer: (051) 444 4359

E-pos: strausshs@ufs.ac.za

ADDENDUM F: Ingeligte toestemmings vorm

Ek, …….
(eerste naam en van) gee hiermee skriftelik toestemming om deel te neem aan ‘n navorsingstudie oor faktore wat die werksomgewing van professionele verpleegkundiges by Universitas Privaat Hospitaal beïnvloed. Ek is bewus daavan dat ek ‘n groepsessie nie langer as twee ure sal moet bywoon as ek deelneem in die studie.

Ek verstaan dat ek enige tyd mag onttrek en dat dit geen negatiewe invloed sal hê nie.

Ek verstaan dat die inligting gegenereer in die Nominale Groepsessie vertroulik gehou sal word, maar die resultate gebruik sal word vir akademiese doeleindes en dat dit moontlik in ‘n akademiese joernaal gepubliseer mag word.

Ek verstaan dat my deelname aan die navorsing vrywillig is en dat ek nie benadeel sal word, voordele sal verloor, of anders behandel sal word as in die verlede, indien ek sou deelname weier of onttrrek nie.

Ek is bewus dat ek Me. Kobie Ruder enige tyd gedurende die verloop van die studie mag kontak.

Ek weet dat ek ook die Sekretariaat van die Etiekkomitee, Gesondheidswetenskappe UV, kan kontak by (051) 405 2812 rakende enige etiese aspek van die studie.

Naam en van van deelnemer

……

……

Handtekening van deelnemer

……

Datum ……

ADDENDUM G: CATEGORISING AND SUBCATEGORISING OF RECOMMENDATIONS

Categories	Subcategories	Recommendations	Group
Nursing care environment	Continuity of care	"All nurses should attend pt-hand-over at shift changes"	2
		"Managers need to attend daily ward rounds in the morning that will assist her to be actively involved in the ward"	3
		"Matron on call after hours should be in apposition to relieve in any section of the hospital"	3
	Workload	"Geel leers moet saam met die pasient vanaf ongevalle na saal gestuur word, omdat verpleegsorg andersinds vertraag word"	3
		"Modify ICU form - tick sheet"	2
	Different health care groups	"The opportunities should be created for different healthcare groups to be sensitized toward respecting each other"	3
	Doctors	"Set a policy in place that will address disrespectful behaviour of Dr's towards personnel"	1
		"Dr's should practise sterility guidelines and that should be forced down by management, Dr's signed "best care" practise guidelines – but they don't follow the guidelines"	2
		"Platform to be created for dr's + nurses to discuss attitude issues Hospital A = clear on this – has policies – R/n should act on the policies"	2
Managerial involvement	Discipline	"Daarstelling en implimentering van 'n klagte procedure"	1
		"Disciplinary action should follow if personnel do not abide to procedure/policy Procedure = in place – need to follow it"	2
	Performance appraisal	"Re-address award system – no favouritism. Unit managers should check personnel quarterly – but they don't then they are pressurized if HR asks for forms"	2
		"Promotion on merit not affirmative action"	2
	Enough permanent staff	"Employ more staff, move away from agency staff"	1
		"Re-address acuity of staff levels, (ratio professional nurse: non-professional nurse in ward and ICU"	1
		"Maak gebruik van 'n ander verpleegagentskap"	1
		"Fill all vacant nursing posts with skilled staff	2

		and employ more staff"	
		"Employ more staff so as to improve quality. Excluding temporary staff"	3
	Team building	"Skep die geleentheid vir team building sessies"	3
	Communication	"Monthly meetings between management and staff"	2
		"Have meetings: R/n + management on regular basis. Should be like this and not only include HR-issues, nursing manager must be present"	2
		"Personnel to be informed about decisions that influence them e.g. uniforms"	3
		"A structured monthly meeting to address managerial issues, amongst nurses with nursing manager"	1
Personnel/staff	Salaries	"Salaries bettered for R/N. Competitive with other hospitals"	2
		"Increase salaries to compete with the market and other local hospitals"	3
	Uniform	"Make use of another company to provide uniforms, and revise uniform criteria"	1
	Training	"Meer opleidings geleenthede vir alle personeel, nie net in-service training"	1
		"Create in-service training opportunities in the form of workshops where personal are responsible for the content, and lectures on a weekly basis. Also debating patient cases, this would assist in morbidity and mortality discussions with doctors"	3
		"Skep die geleentheid vir nagraadse studies vir professionele nurses. Selfs buite hulle huidige veld"	3
Physical environment	Accessibility	"Dedicated hospital A lifts"	1
		"Skuif saal na hospitaal A gedeelte: gebruik ongebruikte vloer 2"	1
		"When identifying acuities take logistics of this hospital into consideration"	2
	Comfort	"Make use of mobile aircon units if can't fix existing aircon in wards and ICU"	1
		"Create a dedicated space for a tearoom in all units"	1
		"Dedicated tearoom = not according to hospital policies – does not meet criteria – smokers to be accommodated"	2
		"Temperature control in wards should be regulated"	2
		"Create a personal space for healthcare workers outside ward in order to take a break	3

		and not be in te ward for 12 hours"	
	Control	"Provide clear guidelines regarding cleaners and kitchen personnel"	1
		"Cleaners should clean direct environment of pt. on daily basis = policy – they are not following the policy"	2
	Stock and equipment	"Daar moet minimum stock levels gehandhaaf word. Realistc minimum levels to be used"	1
		"A complete monitor per patient in ICU must be working"	1
		"Bestuur moet realistiese voorraad vlakke bepaal vir elke saal. Stel aksieplanne voor om voorraad tekort aan te spreek"	3
Psychological environment	Employee wellness program	"Program should be localised to be more accessible to all healthcare personnel. This will decrease absenteeism"	3
	Sensitive attitude	"Gee meer positiewe terugvoer direk na personeellid goed gedoen het"	1
		"Management should show that they care for their personnel e.g. flower, card – not only reward checks"	1
		"Respekteer die unit manager, unit manager must also respect the personnel"	1
		"When off-duty not to be contacted re. hospital issues"	2
		"Management should treat personnel professionally"	2
		"Managers must show compassion when listening to staff, not only be concerned with financial implications"	3
		"Managers should praise personnel when praise is due"	3
		"Bestuur moet sensitief wees vir die spesifieke behoeftes van vroue personeel, bv. Familieverantwoordelikhede. Increase limit on telephone bill in order to cater for family responsibilities"	3
		"The go-getters/movers & shakers should be embraced in the hospital and not pushed out or feel threatened"	3

ADDENDUM H: ANALYSIS OF RECOMMENDATIONS

RESPONSE NR	RESPONSE	PRIORITY NR OF RESPONSE	TOTAL	FINAL PRIORITY OF 5 MOST IMPORTANT RESPONSES
1	Sit rakke in diensstasie sodat dit netjies gehou kan word	1	1	
10	Monthly meeting between top management and staff to address possible problems	1+2	3	
2	Skuif saal na Netcare gedeelte, gebruik ongebruikte vloer 2	5+2	7	5
11	Re-address acquity of staff levels	1+4+3	8	4
4	A complete monitor per patient in ICU	1+2	3	
5	Employ more staff, move away from agency personnel	2+4+4	10	3
3	Daar moet minimum stock levels gehandhaaf word	2+5+4+1	12	2
16	Management should show that they care for their personnel eg. Flower, card	3	3	
19	Maak gebruik van 'n ander agentskap	3	3	
1	Dedicated Netcare lifts	5+5+5	15	1
17	Set a policy in place that will address desrespectful behaviour of Dr's towards personnel	3	3	
7	Meer opleidings geleenthede vir alle personeel	3	3	
6	Make use of mobile aircon units if can't fix existing aircons (wards & ICU)	4	4	
	Create a dedicated space for a tea room in all units			
	Gee meer positiewe terugvoer direk na personeellid goed gedoen het.			
	Strenger kriteria instel vir opname in ICU			
	Make use of another company to provide uniforms. + revise uniform criteria			
	Provide clear guidelines regarding cleaners and kitchen personnel			
	Daarstelling en implimentering van 'n klagte procedure			
	Respekteer die unit manager, unit manager must also respect the personnel			

JERSITY OF THE
FREE STATE
UNIVERSITEIT VAN DIE
VRYSTAAT
YUNIVESITHI YA
FREISTATA
UFS
UV

Research Division
Internal Post Box G40
☎(051) 4052812
Fax (051) 4444359

E-mail address: StraussHS@ufs.ac.za

Ms H Strauss

2012-05-29

REC Reference nr 230408-011
IRB nr 00006240

MS JC RÜDER
C/o CARMEN GRANT
HOSPITAL MANAGER
NETCARE

Dear Ms Rüder

ECUFS NR 20/2012
PROJECT TITLE: STRATEGIES TO IMPROVE THE WORK ENVIRONMENT OF PROFESSIONAL NURSES WORKING AT A PRIVATE HOSPITAL IN BLOEMFONTEIN.

- You are hereby kindly informed that the Ethics Committee approved the above project at the meeting held on 22 May 2012 after the Afrikaans translation of the Information Leaflet and Informed Consent were submitted.
- Committee guidance documents: Declaration of Helsinki, ICH, GCP and MRC Guidelines on Bio Medical Research. Clinical Trial Guidelines 2000 Department of Health RSA; Ethics in Health Research: Principles Structure and Processes Department of Health RSA 2004; Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa, Second Edition (2006); the Constitution of the Ethics Committee of the Faculty of Health Sciences and the Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines.
- Any amendment, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.
- The Committee must be informed of any serious adverse event and/or termination of the study.
- A progress report should be submitted within one year of approval of long term studies and a final report at completion of both short term and long term studies.
- Kindly refer to the ECUFS reference number in correspondence to the Ethics Committee secretariat.

Yours faithfully

.....
PROF WH KRUGER
CHAIR: ETHICS COMMITTEE

205 Nelson Mandela Drive/Rylaan, Park West/Parkwes, Bloemfontein 9301, South Africa/Suid-Afrika
P.O. Box/Posbus 339, Bloemfontein 9300, South Africa/Suid-Afrika, T: +27(0)51 401 9111, www.ufs.ac.za

ADDENDUM J: SERTIFICATE OF LANGUAGE EDITING

WORDSPICEcc

Christo Fourie

B. Tech. Language Practice (CUT)

Advanced Diploma in Interpreting (UFS)

DECLARATION CONCERNING LANGUAGE EDITING

This serves to certify that I was responsible for language editing of the following thesis submitted in fulfilment of the requirements for the Magister Societatis Scientiae in Nursing in the Faculty of Health Sciences, School of Nursing at the University of the Free State, Bloemfontein:

"Strategies to improve the work environment of professional nurses working at a private hospital in Bloemfontein"

by

Jacoba Christina Ruder

This thesis was proofread according to United Kingdom Oxford English.

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Langenhovenpark
9330

Mobile phone: 076 332 3839

Date: 29 June 2013