DEVELOPMENT OF A MODEL FOR SUPPORT OF EMOTIONAL LABOUR OF NURSES IN TERTIARY HOSPITALS IN NIGERIA

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A thesis submitted in fulfillment for the degree of Doctor Philosophiae in the School of Nursing, University of the Western Cape

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KEYWORDS

Deep Acting

Emotions

Emotional labour

Nurses

Surface Acting

Support

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ABSTRACT

Experience of emotional labour by nurses reflects a stressful work environment where services are guarded by organization and professional display rules and rendered with "a-smile-on-the-face" to shield the negative effect. Poor working conditions, the nature of the nursing job, lack of (or inadequate) resources, lack of role clarity, recognition and autonomy, time constraints, long working hours; a poor referral system are some of the causes of emotional labour for nurses. To regulate their emotions, service sector workers, including nurses use surface acting and deep acting strategies to cope with emotional labour at the workplace.

The aim of this study was to develop a model for support of emotional labour of nurses working in tertiary hospitals in Nigeria. Proportional stratified sampling was used to select a sample of 312 professional nurses from all units for the quantitative study while 50 Nurse Managers were purposively selected to participate in the qualitative study at the three selected tertiary hospitals. Data collection was done using integrative review process on emotional labour in relation to nurses, nursing care and support for nurses working in tertiary hospitals to determine the strategies that nurses use in regulating their emotions. The Emotional Labour Scale (Weiss & Cropanzano, 1996) was used for the quantitative study while focus group discussion was used for the qualitative study. Thematic data analysis was carried out for the integrative review on 12 articles to identify categories from which ten (10) themes were derived. Quantitative data were analysed using SPSS version 24, descriptive and inferential statistical analyses and confirmatory factor analysis. Qualitative data analysis was conducted by means of Tesch's method of content analysis. The model was developed by means of the four steps of theory-generating process: The first step was concept development

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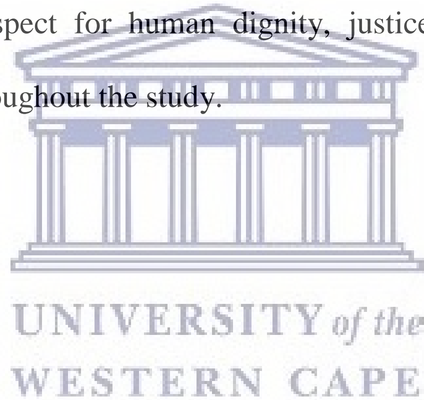
which has two sub-steps–concept identification and concept definition. A total of fifteen (15) concepts were identified. These were further synthesised into six (6) main concepts that were used to develop the model. The main concepts were then placed in relation with each other to form the model for support of emotional labour of nurses working in tertiary hospitals in Nigeria. Model description was done in the third step using three levels of policy development: policy formulation, implementation and evaluation. By visual application, the model portrays the main concepts, the process and the context. In the fourth step, guidelines for the implementation of the model for support of emotional labour of nurses were developed. Five criteria for model evaluation according to (Chinn and Kramer, 2018), were used to give a critical reflection of the model. Trustworthiness of the data during the study was ensured using Guba's model of truth value, applicability, consistency and neutrality. Respect for human dignity, justice and beneficence, and ethical principles were duly applied throughout the study.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DECLARATION

I declare that *Development of a Model for Support of Emotional Labour of Nurses in Tertiary Hospitals in Nigeria* is my own work, that it has not been submitted for any other degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

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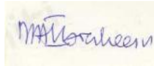
Signed: 

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DEDICATION

To all nurses worldwide

who toil day and night

to care for the sick

at the expense of their emotions.

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ACKNOWLEDGEMENTS

I am immensely grateful to Almighty Allah (swt) for lifting me up when the road was rough.

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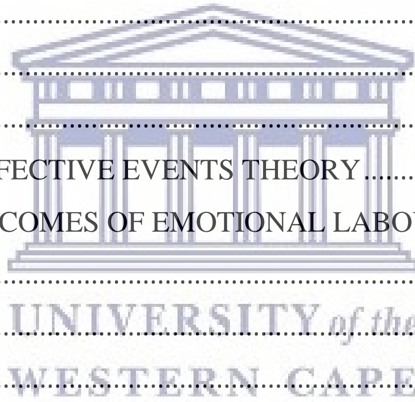
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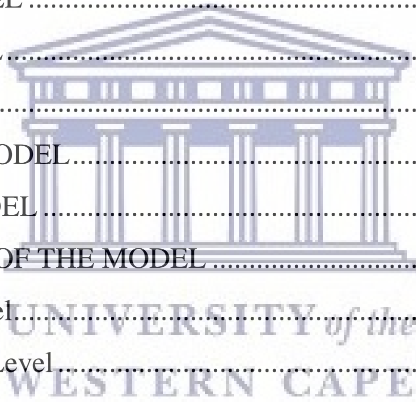
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LIST OF ABBREVIATIONS

FGN	Federal Government of Nigeria
FMC	Federal Medical Centre
NBC	National Broadcasting Commission
NBER	National Bureau of Economic Research
NBO	National Budget Office
NBS	National Bureau of Statistics
NMCN	Nursing and Midwifery Council of Nigeria
NPC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
OAUTHC	Obafemi Awolowo University Teaching Hospital Complex

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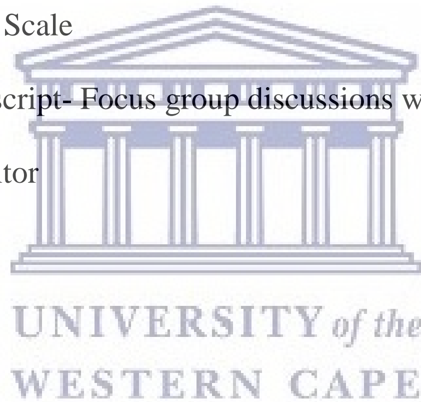

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Emotional labour in nursing is a crucial job requirement as it involves a relationship between nurses and the environment with the primary aim of knowing how to manage self and others' emotions in an organisational setting (A. R. Hochschild, 2012). Healthcare services is a principal sub-sector of the service sector that requires face-to-face interaction when dealing with patients. Regulation of emotion is a fundamental quality of face-to-face interaction. The concept of emotional labour is thus relevant to nursing practice where face-to-face interactions between nurses and care receivers have become dominant and inevitable.

Sharma (2018), observed that therapeutic relationship between nurses and patients and their families is a significant source of stress for nurses. Thus, while caring for the patients, nurses experience strong emotions which they consciously use to improve and refine nursing. This is because emotional labour requires perseverance and great sincerity. Furthermore, Jan, Kour & Para (2017) pointed out the association of nursing with intense pressure due to its demanding, challenging, and stressful professional characteristics. They linked occupational stressors in nursing to increased workload, low levels of support, workplace factors, and psychosocial factors.

Understanding the feelings of patients and making efforts to display a particular emotion for professional and organisational purposes is evident in certain tasks in nursing (Bakker, & Sanz-Vergel, 2013; Pisaniello, Winefield, & Delfabbro, 2012). Hochschild (2012), states that employees in emotional-labour occupations are expected to exert control over their emotions in order to "create a publicly observable facial and bodily display" that is "sold for a wage and therefore has exchange

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value". This is premised on the employees' frequent interactions with people and institutional display rules that mandate them to conform to in relating effectively with people. Hence, the capacity of nurses or health workers to manage and regulate their emotions has been reported to be crucial to the quality of health services as well as their wellbeing and that of the patients (Hochschild, 1983; Morris & Feldman, 1996). Diefendorff & Gosserand (2003), thus express emotional labour as a process that encompasses explicit emotional requirements and the effortful strategies that must meet these requirements.

1.2 BACKGROUND TO THE STUDY

Organisations in the service sector subject employees to display rules that regulate their emotions when interacting with clients. Two emotion regulation strategies that are used during emotional labour are surface acting and deep acting (Brotheridge & Lee, 2003; Hochschild, 1983). During surface acting, there is transformation of the emotional expression without a change in the original feelings experienced by the employee, but during deep acting, the employee experiences a cognitive change in order to balance felt emotions with required emotions (Brotheridge & Lee, 2003). "Fake emotion" is displayed by employees during surface acting in order to satisfy the emotional demands of their duty. This means that, the employee is not modifying the real inner feeling in order to satisfy display rules of the organization (Choi & Kim, 2015; Hochschild, 1983) whereas, in deep acting, there is modification of inner feelings in order to display genuine emotional requirements of the job. In essence, to meet the organisational requirements, workers use surface and deep acting strategies for emotional expressions (Song et al., 2023).

Nurses who engage in deep acting experience a sense of personal accomplishment and happiness because when they display a genuine emotion during interaction with patients, they do not engage

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in cognitive dissonance, that is, conflict between the inner feeling and the actual emotion one expresses (Hochschild, 2012).

Bosnjakovic and Radionov (2018) expressed that social relationship of people is based on understanding of mental state (emotions, behaviours and intentions) of others. Also, that empathy is one of the means of achieving desired results of emotional and social interaction because it enables people to understand their social environment, inhibits aggression and promotes motivation through caring for others. Thus, when empathy-related behaviours such as gratitude, showing concern, helping and comforting, are displayed, it promotes the psychological health of patients and also accelerates quick recovery to normal daily activities (Glenton et al 2013; Pandey & Singh, 2015). Studies on emotional labour focus on how service workers manage their emotions or mood in accordance with organisational and professional display rules (emotional labour) without adequate consideration for resources such as personality traits, work motives and emotional abilities that employees require to manage their own emotions (Grandey & Gabriel, 2015).

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1.2.1 Concept of emotion

In the caring process, emotion plays an important role (Jiménez-Herrera et al., 2020). In everyday life, emotion has been identified as a core part which cannot be separated and work-life is saturated with feeling. Likert, 1967; Mayo, 1945; Roethlisberger & Dickson, 1943 lament that the role of emotions in organisational life has been neglected, noting that it is an important part of research. (Frijda, 1986) described emotion as a biological response that is experienced due to environmental stimulus, which results in physical and psychological changes in ensuing preparation for necessary action. Also, Fischer et al., (1990 pp. 84) define emotion as a “discrete, innate, functional, biosocial action and expression system”.

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Nursing is inherently stressful, challenging and prone to burnout for nurses (Golay et al 2021; Lee & Jang, 2019). The emotional dimension of nursing is embedded in the nurse's affective responses through positive emotions that helps to nurture wellbeing (Roto et al., 2011), while negative experiences as a result of negative emotions adversely affects wellbeing (Pavot & Diener, 1993) because these emotions are linked with burnout and occupational stress of nurses (Szczygiel, & Mikolajczak, 2018). Therefore, a positive experience at the workplace foster employee's wellbeing. Shafipour et al., (2014) explain that emotions are generated through the relationships that exist between nurses, patients and their relations. As a result of these relationships, assistance in care and overcoming illness, and the protection and comfort given to the patients, the nurses feel satisfied (Cecil & Glass, 2015).

There is spontaneous emergence of both positive and negative emotions among experienced nurses during professional relationships while the ensuing emotional commitment instilled by nurses in the therapeutic relationship is viewed as a part of their professional requirement for nursing care (Font-Jimenez et al., 2020). This signifies that the main key to nurses' relationship with patients is their emotions which is an element of social reality (Font-Jimenez et al., 2020; Cottingham & Erickson, 2020). In essence, emotions assist the employee by indicating adaptive behaviours to resolve a challenging situation (Ashkanasy & Dorris, 2017).

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Throughout the day when caring for patients, nurses experience many emotions that require great efforts to regulate (Lee & Jang, 2019). Professional nursing practice expect nurses to express emotions that are appropriate, empathetic and caring while they contain those that are unpleasant such as anger, distress or frustration (Gonnelli et al, 2016). This is because their emotions is viewed

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as a tool that promotes healing and a central part of the therapeutic relationship (Jahl et al., 2017). Emotion is thus an important index in directing the lives and careers of individuals (Lee & Jang, 2019).

1.3 STUDY CONTEXT: THE FEDERAL REPUBLIC OF NIGERIA

The World Population Review (WHR, 2021), reveals that Nigeria's population in 2021 was estimated at 212,914,388 with an annual population growth rate of 2.60% making it the most populated country in Africa, and about 2.35% of the entire earth's population ranking 7th. The country has multiple ethnic groups with Hausa-Fulani ethnicity accounting for about 30%, Yoruba 15.5% and Igbo (Ibo) 15.2% (World Population Review, 2021). The country is constitutionally divided into 36 states and a Federal Capital Territory at Abuja. It has six (6) geopolitical zones which serves as the administrative division that are not carved out based on geographic locations of their states but due to similarities in ethnicity, common political and cultural history. These zones are: North-Central, North-West, North-East, South-East, South-South and South-West (www.nigerianfinder.com). Nigeria is a middle-income nation with a mixed economy. In the last five years, the service sector has contributed enormously to the GDP of Nigeria. In 2015 it was 53.18%, with a growth rate of 4.78%; 2016 (53.59%, growth rate 0.82%); 2017 (52.66%, growth rate 0.91%); 2018 (52.62%, growth rate: 1.83%); while in the 1st Quarter of 2019, the sector contributed 54.60% (World Fact book, 2016; NBC, 2012, 2015; NBS, GDP report 2016, 2017, 2018 & 2019). Despite this, the health sector budgets in Nigeria fall short of the World Health Organisation's (WHO) recommendation of 15% of total annual budget.

Allocations to the health sector in the last five fiscal years have been on the decline from 6.2% of the total budget in 2015 to a peasant 3.9% in 2020 (Tejuoso et al., 2018). In 2015, out of the total

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budget only 5.78% was earmarked for the health sector; 2016 (5.8%); 2017 (5.11%); 2018 (5.79%) and 2019 (5.3%) while 4.45% was proposed for year 2020. (National Budget Office (NBO, 2016); Eneji et al., 2013; www.yourbudget.com; National Bureau of Statistics, 2019). It thus indicates that Nigeria being the host country for the Abuja Declaration has not met the target of 15% for the 23rd year running.

Meanwhile, the Federal Ministry of Health in Nigeria spends approximately 70% of the budget in urban areas where 30% of the population reside (Issue Nigerian Gross Domestic Product Report National Bureau of Statistics, 2014). Nigeria has also not met the WHO benchmark of 2.5 doctors per 1,000 people and nurse/population ratio of 700 because the country has less than 35,000 medical doctors (1:5000) and only 150,000 registered nurses (1:1166) (Parmar, 2015).

Due to lack or scarcity of healthcare resources, Nigeria is faced with problems such as shortage of health personnel, poor referral systems and high mortality rates. Sub-Saharan Africa has the highest record of maternal deaths worldwide at 62% (179,000) with 17% occurring in Nigeria (Gulland, 2014). Lack of or poor referral systems has resulted in 92.9% of new patients that reported at a tertiary hospital in Nigeria for care with no referral notes because people seek healthcare services where their health needs will be met (Abodunrin et al., 2010). This describes the referral systems in Nigeria as "non-operational". There is thus overcrowding at tertiary healthcare facilities resulting in increase in maternal and child burden of diseases and death; work overload of health workers, burden on human, material and other health resources and shortage of healthcare workers including nurses. The Federal Ministry of Health, Nigeria also reported a disconnection between the three tiers of healthcare delivery in Nigeria, noting that the tertiary, secondary and primary levels of healthcare are not accountable to one another (FMoH, 2014).

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1.3.1 Nigeria Health System

In the World Health Report (WHR, 2006), a health system is described as a series of activities with the primary goal of improving the status of the people; the health workforce who is involved in activities enhancing health," an essential part of a functioning health system and when absent clinical and public health services cannot be delivered to the population. Ubochi et al., (2019) posit that healthcare resources include basic equipment, stock of drugs, vaccines, portable water, constant supply of energy (power), medical record tools, ambulances for mobility of patients, solar freezers, availability of qualified health officers and medical personnel among other.

Nigeria health system is pluralistic because it includes orthodox, alternative and traditional healthcare delivery systems operating alongside each other which are all recognised and regulated by the Federal Government of Nigeria. It is organised into three interrelated levels of primary, secondary and tertiary healthcare services which are provided by the local government, the state government and the federal government respectively.

There are 20,278 Primary Health Care (PHC) centres at primary level; 33,303 General Hospitals (GH) at secondary level and 59 Federal Teaching Hospitals (FTH) (www.health.gov.ng). Omole et al (2017) described tertiary hospital as comprising of federal teaching hospitals (FTH) and federal medical centres (FMC) that provide specialised care which requires expertise, experience and high technological facilities. The FMC are situated in states where there are no teaching hospitals. Out of the 59 FTH, 22 are FMC. Seven (7) of these FTH are located in the Southwestern part of the country where the study was carried out. These are: University College Hospital, Ibadan (Oyo state); Lagos University Teaching Hospital, Idi-Aba, Lagos (Lagos state); Obafemi Awolowo University Teaching Hospital Complex (OAUTHC), Ile-Ife (Osun state); FMC Abeokuta (Ogun

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state), FMC Owo (Ondo state); FMC Ido-Ekiti (Ekiti state); and FMC Ebute Meta, Lagos, (Lagos state) respectively.

Primary Health Care has been identified as the entry point into the healthcare system and a link with referral facilities. The referral facility is an essential part of the healthcare system (Nakayuki et al., 2021; National Primary Health Care Development Agency (NPHCDA, 2013). Research findings reveal that sixty to ninety percent of patients are self-referred because they do not access health care at PHC facilities but rather seek care at higher levels (Koce et al., 2019; Okoli et al., 2017). The reasons include: inadequate knowledge of referral system, lack of confidence in the care they will receive, lack of access to competent staff, need for quality services, shortage of health workers, poor road network, lack of resources such as drugs and basic equipment for laboratory services, and lack of access to health insurance (Okoli et al., 2017; Omole et al., 2017; Daniels & Abuosi, 2020; Nakayuki et al., 2021; Koce et al., 2019). This results in health care burden (work overload) and overcrowding, shortage of healthcare personnel (particularly nurses), emotional burden, emotional cost of caring, reduced level in conducting research in the healthcare system and depletion of resources in the management of advanced ill-health conditions at secondary and tertiary levels of care with patients who attend with minor ailments that could have been treated at the primary health care level (Makama et al., 2015; Omole et al., 2017; Koce et al., 2019). Ubochi et al., (2019) and Koce et al., (2019), asserted out that building a functional health system will require strong policies, committed leadership, adequate financing, essential healthcare supplies, including medical products and technologies; service delivery that meets patient healthcare needs and a formidable human resource for health.

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Inadequacy of the healthcare delivery system in Nigeria may be attributed to peculiar demographics of the Nigerian populace. Seventy percent of health care services is provided by private vendors and only 30% by the government, with over 70% of drugs dispensed being substandard (Ubochi et al., 2019). There are also prevailing problems within the health sector that includes incessant strike actions of health workers, dilapidated hospital buildings, ill-equipped laboratories, lack of healthcare financing and inadequate remuneration for health workers (Koce et al 2019). According to the International Council of Nurses (ICN, 2021), nurses are responsible for a broad range of services such as promotion of health, prevention of illness, restoration of health, and alleviation of suffering. In addition, they also constitute between forty-five to sixty per cent of the entire health workforce. This view is supported by Sodeifya and Habibpour (2020), that in health care organisations, eighty per cent (80%) of direct care are given by nurses because they are the largest professional group and are often expected to provide quality care through identification and treatment of diseases and individual's reactions to health.

1.3.2 Profile of Southwestern zone of Nigeria

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The Southwestern zone is the study site and mainly a Yoruba speaking area, although there are different dialects even within the same state. It comprises of six states namely: Ekiti, Lagos, Ogun, Oyo, Ondo and Osun. The zone covers a landmass of 16,409sqkm sharing international border with Republic of Benin to the west, and interstate boundaries with Oyo state to the north, Lagos and Atlantic to the south and Ondo state to the east (www.nigerianfinder.com).

The population estimate in 2021 on state basis has a record of Lagos – 9,013,534; Oyo – 5,591,589; Ogun – 3,728,098; Ondo – 3,441,024; Osun – 3,423,535 and Ekiti – 2,384,212 respectively (www.nigerianfinder.com). The Yoruba ethnic group is estimated to be approximately 21% of the national population (Action on armed violence (aoav.org.uk). It is worthy to note that only four (4)

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FMC and four (4) federal teaching hospitals are located in the zone (www.health.gov.ng; https.nimedhealth.com.ng). These eight (8) tertiary hospitals are inadequate to provide required healthcare services in the Southwestern zone.

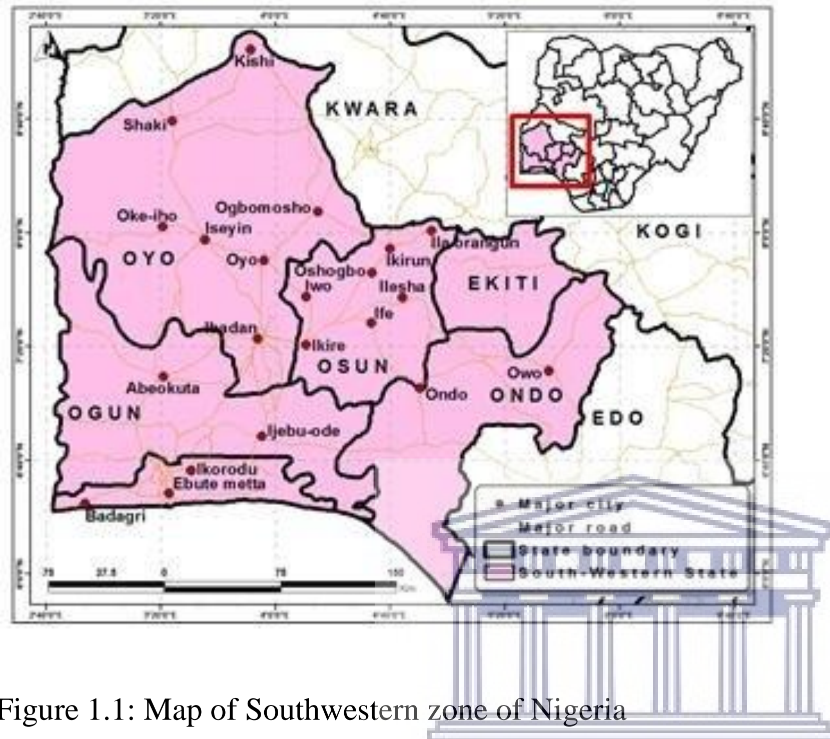

Figure 1.1: Map of Southwestern zone of Nigeria

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1.4 RESEARCH PROBLEM STATEMENT

Emotional labour in nursing is important in promoting patient recovery which is crucial to effective healthcare delivery services through interpersonal relationship between nurses and patients. This is done by displaying positive emotion and empathy which promotes patients' psychological wellbeing. However, while patients' satisfaction is of paramount importance to the hospital management, it is emotionally expensive for the nurses because their emotional resources are drained which might eventually lead to a negative outcome of emotional labour (Glenton et al., 2013; Pandey & Singh, 2015).

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Global crisis in health workforce statistics show that 1 in 20 nurses who were trained in Africa are currently working in developed countries resulting in a shortage of nurses in Africa (WHO, 2011). These shortages can be associated with lack of resources which often prevent training or retraining of an adequate number of nurses and other health professionals (Fagite, 2018). According to the WHO (2010), between 2016 and 2030, Nigeria will require 320,216 to 471,353 nurses and midwives with a mean of 391,274. Meanwhile, the current shortage exerts pressure and emotional exhaustion on the available workforce of nurses leading to negative outcomes of emotional labour.

Many researchers (Yadav & Pandey, 2021; Karimi, et al., 2020; Na & Park, 2019; Arshadi & Danesh, 2013), focus on antecedents and consequences of emotional labour, however, little attention has been paid to its mediators which include: work-family interface (work-family conflict and work-family enrichment), physically active leisure (exercise, sports) (Wu, Chen & Meyer, 2020), work environment, working conditions (for example - autonomy and remuneration), and effective communication**.** Different postulations on emotional labour in nursing have also emerged but none was found to have investigated these mediators on emotional labour of nurses in Nigeria hence, there is a need to support nurses working in healthcare settings (Jonker, 2012). This study explored and described the experiences of nurses regarding emotional labour and developed a model for support of emotional labour of nurses in tertiary hospitals in Nigeria. Support from the Federal Ministry of Health, hospital management team, nurses, other health workers and stakeholders is expected to include: organisational, supervisor and co-worker support, improved wellbeing of nurses, provision of resources (in quality and quantity), and effective communication system that will invariably improve quality of nursing care.

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1.5 AIM OF THE STUDY

The aim of this study was to develop a model for support of emotional labour of nurses in tertiary hospitals in Nigeria.

1.5.1 OBJECTIVES OF THE STUDY

1. To conduct an integrative review of literature on the concept of emotional labour.
2. To determine deep acting and surface acting strategies employed by nurses working in tertiary hospitals in Nigeria.
3. To explore professional nurses' experiences of emotional labour.
4. To develop a model for support of emotional labour of nurses in tertiary hospitals in Nigeria.

1.6 SIGNIFICANCE OF THE STUDY

Findings from this study may provide baseline data on the experiences of nurses regarding emotional labour and also improve patients' satisfaction or wellbeing as nurses may understand the effects of emotional labour thus raising their awareness of their own experience. It will inform policy makers in the development of support for intervention programmes such as emotion regulation training strategies for nurses. The findings shall expand the body of knowledge on emotional labour that could be useful for other sectors in the service industry. It can be applied by healthcare practitioners in organisational settings for problem solving in future.

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1.7 OPERATIONAL DEFINITION OF TERMS

Benefit: Merriam-Webster Dictionary, (2021), defines benefit as "Something that produces good or helpful results or effects or that promotes well-being."

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In this study, benefit refers to rules or codes the employers give nurses to enhance their performance and also being paid in exchange for loss or damage while in active service.

Emotional labour: Emotional labour is defined as being able to manage one's own emotions so as to elicit the desired emotions from the clients or co-workers (Hochschild, 2012).

In the study, emotional labour refers to the capability of a nurse to manage her emotions in order to render quality nursing care for the patients' wellbeing.

Model: A model is defined as "a symbolic representation of an empiric experience in the form of words, pictorial or graphic diagrams, mathematic notations, or physical materials (e.g. a model airplane) (Chinn, & Kramer, 2018).

In this study, a model refers to a schematic representation of identified concepts related to support of emotional labour in nursing.

Nurse: A nurse is defined as a person who is trained to care for the sick especially in a hospital." (www.oxforddictionary.com).

In this study, a nurse is a person who has undergone nursing and midwifery training programmes in accredited schools, passed the qualifying examinations, registered and licensed by Nursing and Midwifery Council of Nigeria to practice nursing and midwifery.

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Nurse Manager: A nurse manager is one responsible for the functions of a unit, performs the role of a nurse and an executive under direct supervision of 'a nurse leader (http://www.ahrp.gov/cusptoolkit).

In this study, a nurse manager is a registered and licensed nurse-midwife that is employed at the selected hospitals and has been working as a clinical nurse/midwife for a minimum of t ten years.

Professional Nurse/Midwife: A professional nurses/midwife is defined as a registered nurse with additional training as a midwife who delivers infants and provides prenatal and postpartum care,

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newborn care, and some routine care (such as gynaecological exams) of women (www.merriam-webster.com).

In this study, a professional nurse/midwife is a person who has undergone professional training in nursing/midwifery (or both) at nursing schools accredited by the Nursing and Midwifery Council of Nigeria, passed the final qualifying examinations and is registered and licensed to practice nursing / midwifery (or both).

Support: Support is defined as "to provide the right conditions (such as enough food and water) for life". (www.cambridgedictionary.com).

In this study, support refers to the aggregate of elements identified from the integrative review and participants' opinions put in a structural form that can be used to relieve the emotional labour experienced by the nurses.

Tertiary hospital: A tertiary hospital is defined as the highest (last) level of healthcare services where specialised care is rendered to patients.

In this study, it refers to the selected three tertiary hospitals namely Obafemi Awolowo University Teaching Hospital Complex (OAUTHC) Ile-Ife, FMC Owo and Abeokuta.

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1.8 RESEARCH METHODOLOGY

A mixed methods research approach was used to achieve the aim of the study. Quantitative data were collected on deep acting and surface acting strategies of emotional labour employed by nurses working in tertiary hospitals in Nigeria using a questionnaire. Qualitative data were collected on nurses' experience of emotional labour by means of focus group and in-depth interviews. An integrative review using the methodology of Whittemore & Knafl (2005), to analyse the concept of emotional labour was conducted. A theory generating design based on Walker and Avant (2019)

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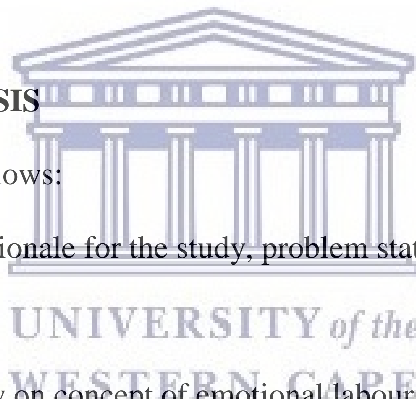
and Chinn & Kramer (2018), was used to theoretically connect data from the quantitative, qualitative and integrative review phases to develop the model. The methodology will be discussed in detail in chapter four.

1.9 DATA ANALYSIS

Data obtained from the quantitative method was analysed using SPSS version 24. Thematic analyses was done for results obtained from integrative review while Tesch's method of open coding was used for qualitative data. Findings from Phases 1 and 2 were collated to develop a model for support of emotional labour of nurses in Phase 3.

A detailed description of the model is presented in Chapter 6.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1.10 OUTLINE OF THE THESIS

The outline of the thesis is as follows:

Chapter One: Orientation and rationale for the study, problem statement, aim, objectives and significance of the study.

Chapter Two: Integrative Review on concept of emotional labour, nurse, nursing and hospital.

Chapter Three: Theoretical Framework.

Chapter Four: Methodology adopted for the study.

Chapter Five: Presentation of results and discussions of findings.

Chapter Six: Development process and a description of the model for support of emotional labour of nurses and guidelines for implementation of the model.

Chapter Seven: Conclusion, limitations and recommendations based on the findings of the study are outlined.

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1.11 SUMMARY

In this chapter, an outline of the background, rationale for the study, aim, objectives and the significance were stated. Main concepts related to emotional labour, service sector and other concepts used in the study were defined. The research design and methodology used to achieve the aim of the study were briefly alluded to.

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CHAPTER TWO

INTEGRATIVE LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of this integrative review was to identify the concept of emotional labour as it relates to nurses, nursing care and support for nurses in tertiary hospitals. The integrative review method has been identified as the most appropriate means of combining diverse methodologies and also has the potential for strong evidence-based nursing practice (Whittemore, & Knafl, 2005). In essence, an integrative review of literature is a specific method of summarising empirical or theoretical research work that has been done in order to provide in-depth understanding of a specific phenomenon or healthcare problem (Broome, 1993). Thus, it has the tendency to help build a body of nursing science, practice, research, and to initiate policy. Whittemore, & Knafl, (2005), point out that if it is systematically and rigorously carried out, the benefits include provision of a state of the science, helping to build theory development and being able to apply it to policy formulation and nursing practice. Based on this, Whittemore, & Knafl (2005), identify five (5) stages in conducting an integrative review, namely problem identification, literature search, data evaluation, data analysis and presentation. These five (5) stages were used in this study.

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An integrative review of literature using the five stages of Whittemore & Knafl (2005), were used to obtain information on research done in the area of emotional labour as it relates to nursing and nurses in order to assist in resolving the current research problem. The implementation of the stages during this process is described below:

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2.2 STAGE 1: PROBLEM IDENTIFICATION

Smiley et al., (2021), positioned nursing as the largest healthcare profession in the United States of America with working capacity of almost 4.2 million registered nurses. Hence, nurses are the largest group among professionals in the healthcare industry with 84.1% employed as nurses, and are involved in all aspects of patient care (US Bureau of statistics (2022). Nevertheless, WHO (2020), reported that the global nursing workforce is low for the universal health coverage initiative. In order to focus on the key problem and operate within the boundaries, the purpose of the integrative review gave credence to the development of the review question, which was:

What is the concept of emotional labour as it relates to nurses, nursing care and support for nurses in tertiary hospitals?

2.3 STAGE 2: LITERATURE SEARCH

This stage is described as critical because the researcher needs to do a rigorous search in order to obtain an adequate database that is unbiased and to obtain an accurate result (Conn et al., 2003; Cooper, 1998).The literature search stage focuses on time and the duration of the search, the search strategy, types of information collected during the search and the eligibility criteria.

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2.3.1 Time and duration of search

The initial search was carried out from March to May 2019 while an updated search was done from April to May 2020. The keywords and MeSH terms (descriptors) were used to search existing literature in consultation with the faculty librarian. These descriptors included emotional labour, nurse, nursing and hospital.

2.3.2 Search strategy

The literature search was done using: Computerised databases: CINAHL (Cumulative Index for Nursing and Allied Health Literature), PubMed/Medline, PsychARTICLES, Science direct, Google

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Scholar. Studies published in English from 1983 to 2017 were considered for inclusion in this review as the term 'emotional labour' was coined by Hochschild in 1983. There was proliferation of research on emotional labour in the last two decades reaching a peak between 2003 and 2015.

2.3.3 Types of information

Data were obtained from existing information on the review problem that is, the concept of emotional labour as it relates to nurses, nursing care and support for nurses in tertiary hospitals; and to determine the strategies that nurses use in regulating their emotions. This was done by searching studies in various research designs and approaches: descriptive, survey, quantitative and qualitative. This is to obtain information from previous studies on emotional labour experienced by nurses. Identifying the target population is a critical step at this stage which were the professional nurses working at the selected tertiary hospitals for the study.

2.3.4 Eligibility criteria

Studies conducted only in English, those that focused on: "Nursing", "Nurses", "Nurse/Midwife", "Tertiary Hospital", "Emotion", "Support", and "Emotional labour" were included in the review as they gave the researcher insight on causes, mediators, effects and reactions to emotional labour in nursing and on nurses. The eligibility criteria for further consideration of the selected articles included: descriptive studies, triangulated studies, comparative studies, quantitative and qualitative studies. Studies that had other health workers, inconclusive outcomes, and study designs, were excluded.

During the initial search, 2,058 articles were retrieved. Further filtering exercises were carried out rigorously with focus on the inclusion and exclusion criteria which yielded 356 articles. Twelve articles were found eligible for the study (Table 2.1 and Table 2.2).

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2.4 STAGE 3: DATA EVALUATION

At this stage, extraction of methodological features of primary studies was carried out to assess their general quality (Cooper, 1998). In an integrative review, quality assessment is a complex process and a unique measure of standard for calculating scores which can again be incorporated into the data analysis (Jadad & Rennie, 1998). Sampling frameworks are often used to determine evaluation of research quality with optimal results derived from articles that have similar research design while others can be discussed in the final report (Kirkevold, 2008; Whittemore & Knafl, 2005).

The researcher used the Critical Appraisal Skills Program (CASP Checklists, 2014) for cohort, quantitative and qualitative studies to assess the quality of articles selected for the review and to identify strengths and weaknesses that research may have in order to assist readers. This is premised on validity of the tool that helps in determining inclusion and exclusion criteria of an article in order to consider its quality. The appraisal tool has three steps: validity of articles; summary of study results, and determination of usefulness of results. The appraisal form has 10 to 12 questions with "yes" (2), can't tell" (1) and "no" (0) columns for summarizing the quality of an article for comparison. The cut-off scores for inclusion of quantitative articles was a minimum of 12 and maximum 18, and a minimum score of 16 and maximum of 20 for qualitative articles. Summaries of the appraisals for both quantitative and qualitative studies are in Table 2.1 and Table 2.2.

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Table 2.1: Appraisal of qualitative articles

Author, year	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the study?	Was the data collected in a way that addressed the research issue?	Was the data analysis sufficiently rigorous?	Has the relationship between researcher and participants been adequately considered?	Has ethical consideration been taken into consideration?	Is there a clear statement of findings?	Score *(Max=18)*
(Zamanzadeh, 2013)	1	2	2	1	2	2	2	2	2	16
McCreight (2005)	1	2	2	1	2	2	1	2	2	15
Gray (2009)	1	2	2	2	2	2	2	2	2	17
Hayward (2011)	2	2	2	2	1	1	2	2	2	16
Tuna (2017)	0	2	2	2	2	1	2	2	1	14
Cricco-Lizza (2014)	2	2	2	2	2	1	2	2	2	17

Scores: No = 0; Can't tell = 1; Yes = 2

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Table 2.2: Appraisal of quantitative articles

Author (year)	Did the study address clearly focused issues?	Did the authors use an appropriate method to answer their question?	Was the sample recruited in an acceptable way?	Was the follow up of subjects complete enough?	Was the exposure or outcome accurately measured to minimise bias?	Was the appropriate theoretical framework used?	Have the authors identified all important confounding factors?	Were the main study outcome measures clearly described and appropriate?	Were the main study findings clearly described?	Were the methods of data analysis adequately described and appropriate?	Were the conclusions supported by results?	Can the results be applied to the local population?	Score *(Max = 24)*
Thomas (2014)	2	2	2	1	1	0	2	2	2	2	2	2	20
Chou (2012)	2	2	2	1	1	0	2	2	2	2	2	2	20
Diefendorff (2011)	2	2	2	2	1	0	2	2	2	2	2	2	21
Kwon (2015)	2	2	2	2	1	0	2	1	1	2	2	2	19
Vermaak (2017)	2	2	2	2	1	0	2	2	2	2	2	2	21
Talebpour (2013)	2	2	2	2	1	2	2	2	2	2	2	2	23

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Scores: No = 0; Can't tell = 1; Yes = 2

2.5 STAGE 4: DATA ANALYSIS

This stage involves reducing data and utilizing the CASP tables of summaries to make a consolidated statement for comparison. (Cooper, (1998) affirms that data obtained from this type of review do not require statistical analysis. Data comparison was done to identify patterns and relationship of characteristics of the findings. Thematic analysis was done sequentially and repeatedly through data ordering, clustering, contrasting, noting common patterns until no new characteristic was identified (Whittemore & Knafl, 2005). The categories were subjected to meta-synthesis in order to produce a single comprehensive set of synthesized findings that will be used as a basis for evidence-based practice. Ten (10) themes were derived from the synthesized results and used to form part of the developed model for support of emotional labour of nurses at tertiary hospitals in Nigeria (**see Chapter 6**).

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2.6 STAGE 5: PRESENTATION OF RESULTS

Oxman, (1994), asserts that conclusions of integrative review should be drawn from the primary sources with a chain of evidence that support the findings. In this review, a total of 2,058 articles were obtained. Using the inclusion and exclusion criteria, after sorting out for title and relevance, 1,702 were excluded based on titles; 334 articles were excluded based on abstracts; 7 were excluded based on full text while 5 were excluded based on duplication. Overall, twelve (12) articles were finally selected for the review (see Table 2.3). Out of these twelve (12) articles, six (6) were quantitative studies while six (6) were qualitative studies. The flowchart below illustrates the search process (Figure 2.1).

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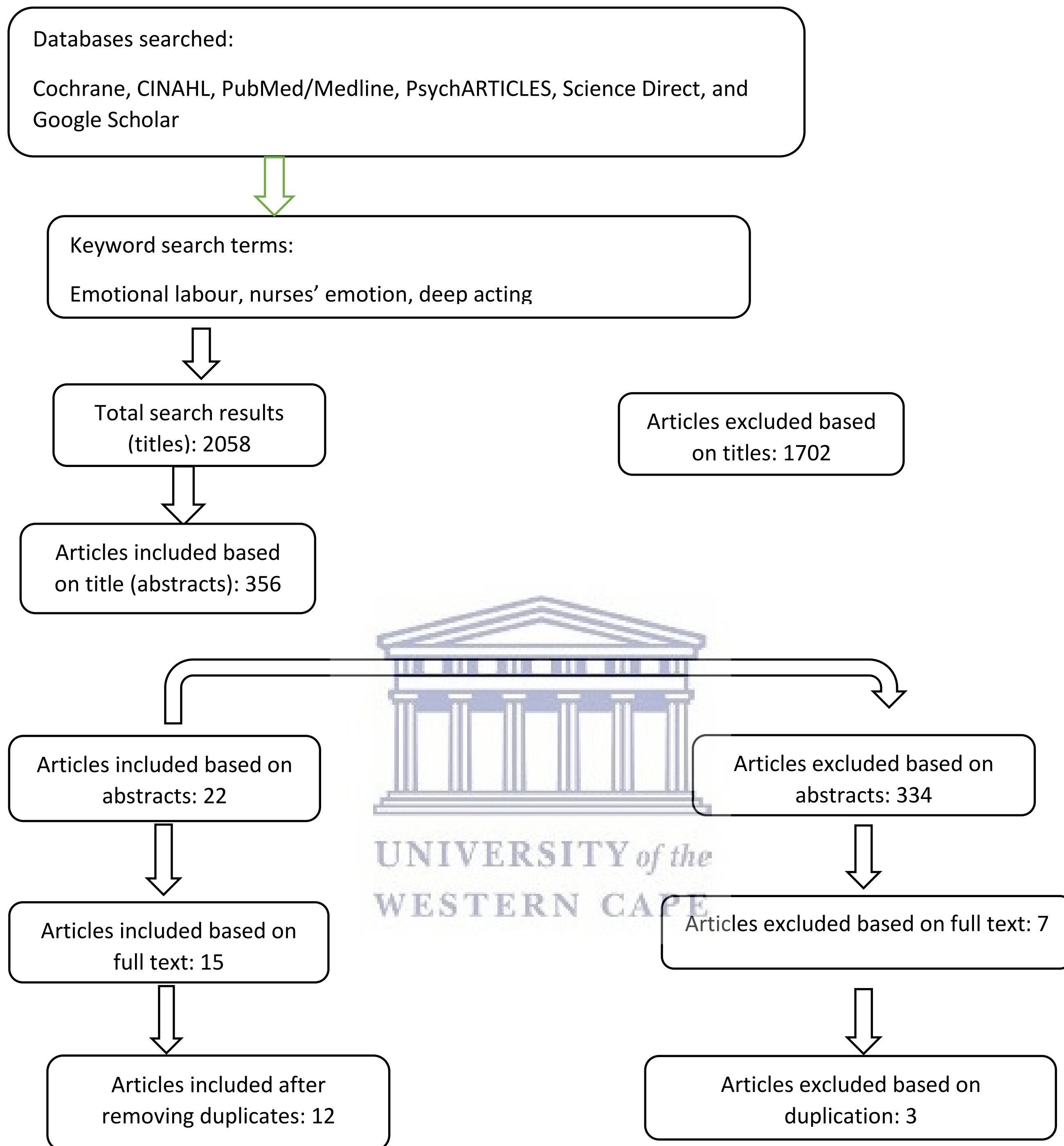

Figure 2.1: Flowchart: screening process of selected articles.

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Studies that were reported in the selected twelve (12) articles were carried out between 2004 and 2017 in eleven (11) countries: Iran (1), India (1), Ireland (1), United Kingdom (1), Taiwan (1), United States of America (2), Australia (1), Istanbul (1), Korea (1), South Africa (1), and Tehran (1). For the six quantitative studies, research were conducted using cross-sectional survey and survey by mail (Chou, Lin, & Chou, 2012; Diefendorff et al., 2011; Kwon, & Kim, 2015; Talebpour et al., 2013; Thomas & Abhyankar, 2014; Vermaak et al., 2017). Sample population ranged from 82 to 929 nurses while the sampling methods were incidental, survey by mail and convenience. The sample population of the six qualitative studies (Gray & Smith, 2009; Hayward & Tuckey, 2011; Zamanzadeh et al., 2013; Cricco-Lizza, 2014; McCreight, 2005; Tuna & Baykal, 2017) were nurses with sample size that ranged from 12 to 114; purposive and convenience sampling methods; data collection methods: semi-structured/in-depth interviews, ethnography (participant/observation), and phenomenology.

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Table 2.3: Description and summary of the 12 reviewed studies.

First author & year	Purpose	Theoretical framework	Research design	Setting & sample	Instruments & Data analysis	Major findings	Limitation	Conclusion
Zamanzadeh (2013) Iran	To describe the emotional labour experienced by nurses who care for hematopoietic stem cell transplantation (HSCT) patients	None	Qualitative	**Setting:** University hospital main HSCT centre, Iran **Sample:** n=18 Nurses. Purposive sampling	**Instrument:** Individual semi-structured interviews. **Data analysis:** Thematic: qualitative content analysis	**Identified themes:** . Emotional intimacy - Feeling overwhelmed with sadness and suffering - Changing oneself.	This study was limited to descriptions and experiences provided by female nurses No male nurse.	-Emotional labour is a characteristic of caring -Nurses experience positive and negative consequences of emotional labour (altruism, cultural contexts, and spiritual and religious beliefs). -Establishing support systems including

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								educating nurses on emotional labour, coping measures and challenges of caring.
First author & year	Purpose	Theoretical framework	Research design	Setting & sample	Instruments & data analysis	Major findings	Limitation	Conclusion
Thomas (2014) India	To explore the relationship between emotional labour and health among nurses	None	Quantitative Descriptive survey	Incidental sampling **Setting:** hospitals at Pune **Sample:** **n=**82 Nurses	**Instrument: Questionnaire** **Data analysis:** Pearson's product moment correlation Confirmatory Factor Analyses	**Pearson's product moment correlation revealed:** - Positive correlation between surface acting and health problems: ($r = .348$ $p < .001$) - deep acting was not significantly related with health problems: ($r = -.156$, $p > .05$) Physical and emotional strain Low monetary gains Low social support Minimum time to spend with family and loved ones. Play multiple roles at the same time Takes care of personal and professional needs Extend themselves totally to the service of others ignoring their own self Lack of needed recognition	Language barrier Study sample was from only Pune All were female nurses (gender bias).	This research aims at helping nurses to realize their physical and emotional needs Organisations should train nurses to enable them cope effectively with their physical and emotional needs.

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						Nurses are expected to do their duties with a smile on the face		
First author & year	Purpose	Theoretical framework	Research design	Setting & sample	Instruments & Data analysis	Major findings (themes)	Limitation	Conclusion
McCreight (2005) Ireland	To investigate nurses' experiences and feelings in dealing with parents who had experienced a pregnancy loss. Nurses' perceptions in relation to training related to pregnancy loss were also explored.	None	Qualitative: narrative method	**Setting:** ten hospitals in Northern Ireland **Sample:** (n=14) Nurses and Midwives	**Instrument:** Semi-structured in-depth interviews **Data analysis** QSR NUD*IST Vivo (NVivo) software package.	Potential for role conflict. Nurses' training is focused on disciplinary knowledge Development of a personal relationship with patients. Dilemmas and controversies within hospital units concerning nurses revealing their emotions to patients. Ward sister as a role model and source of training for nurses Lack of guidelines on hospital policy for dealing with 'gynaecological scraps'. Need for staff development with focus on informal knowledge and situated learning. Recognition of stressful nature of nurses' work. Colleagues were nurses main source of emotional support. Need for "time out" (break).	Not stated	Nurses adopted a structured approach to expression of emotion. Nurses had professional confidence to recognise their own emotional responses. They postulated emotion as a resource in professional behaviour. There is need for development of a nursing model of practice that draws on a broader range of ideological tools. It is imperative to develop how to evaluate patient needs (states of emotion) Need to prioritise task of evaluation rather than measurement.

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						Time constraints and staff shortages. Need for additional support to prevent 'burn out'		
First authors & year	Purpose	Theoretical framework	Research design	Setting & sample	Instruments & data analysis	Major findings (Themes)	Limitation	Conclusion
Gray (2009) UK	To explore experience of nurses' feelings and emotional labour at different clinical settings	Not stated	Qualitative design	**Setting:** Primary care, Mental health and Children's oncology in urban and multi-racial locations at East London **Sample:** n=16 Convenience sampling Nurses	**Instrument:** In-depth and Semi - structured interviews. Research meetings **Data analysis** Thematic analysis	Emotional labour is a relevant tool for planning, staff recruitment and retention in hospitals Nurses manage their own and others' emotions Nurses perform surface gestures (eg a smile) to ''keep things going'' Nurses use acting techniques such as "personal and work self" to manage interpersonal relations Creation of a relatively comfortable environment that is emotionally pressured, difficult and stressful Maintenance of a functioning work environment through good relations irrespective of nurses' own feelings Stress due to care and social control elements at work Nurses take the way they	Only one hospital was used for the research The findings are context-bound to a small area Majority of the participants were females Sample was ethnically diverse	Nurses use emotional labour strategies to support interpersonal relationships established with patients, relatives and colleagues. Nurses kept healthcare organisations running daily with different emotional labour techniques Organisations need to identify successful policies and good nursing practice to strengthen emotional labour and support of patients and relatives Emotional labour brought added value and help to the nurses through sustaining a caring environment between them and their patients

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						feel home - talk things over with family without the details Difficulty in getting to know the patient Fear of physical aggression Stereotyping patients Feeling of ‘‘anger’’ and ‘‘despair’’ due to lack of support from doctors and patient’s parent. Inability to cope with burnout		Emotional labour is viewed as an integral part of culture of care
First author & year	Purpose	Theoretical framework	Research design	Setting & sample	Instruments & data analysis	Major findings (statistical)	Limitation	Conclusion
Chou (2012) Taiwan	To examine the relationships between emotional job demands and resources and emotional labour strategies in the prediction of nurses wellbeing and emotional exhaustion.	None	Quantitative descriptive cross-sectional design	**Setting:** Teaching hospital at Taiwan **Sample:** (n=240) Registered Nurses Convenience sampling	**Instrument:** Questionnaire **Data Analysis:** Descriptive statistical analysis SPSS 15.0 Confirmatory Factor Analysis (CFA) Structural Equation Modeling (LISREL 8.8)	Standardised factor loading: 0.66 - 0.92 Factor loadings: 0.05 SEM: v2 138 = 197.33; RMSEA = 0.042; CFI = 0.97; GFI = 0.92; NNFI = 0.97) Nurses tend to use surface or deep acting in response to negative affective events while dealing with a rude or demanding patient Emotional job demand of dealing with difficult patients has a negative impact on nurses’ well-being. POS was positively related to job satisfaction and	Use of a convenience sample and a cross-sectional design. The research relied on self-report measures for all the constructs in the model (a Single-source strategy for data collection).	Frequency of interactions with difficult patients and perceived organisational support are important predictors of emotional labour strategies. Organisations should focus on training nurses in effective emotional regulation techniques Organisations should create a climate in which nurses feel supported

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						negatively related to emotional exhaustion. Surface acting was positively related to emotional exhaustion and negatively related to job satisfaction. Deep acting have a positive effect on how people feel about their jobs. Deep acting was not significantly related to emotional exhaustion.		
First author & year	Purpose	Theoretical framework	Research design	Setting & sample	Instruments & data analysis	Major findings	Limitation	Conclusion
Diefendorff (2011) USA	To provide empirical evidence on display rules at hospital unit-levels	None	Quantitative Descriptive survey	**Setting:** Two urban hospitals in Midwestern USA **Sample:** (n=929) Registered Nurses	**Instruments:** Questionnaires : Seven-item scale (Best, Downey & Jones, 1997; Brotheridge & Grandey, 2002). Positive and Negative Affectivity Schedule (PANAS). **Data analysis:** Multilevel Confirmatory Factor Analysis (CFA).	Emotional display rules are shared by nurses who work in the same unit. Unit-level display rules and individual-level dispositional affect predicts surface acting and deep acting. Nurses who worked in the same unit exhibited agreement in their display rule perceptions. Work units differed in the level of display rules. It demonstrated how job burnout and satisfaction are influenced by a complex set of direct and indirect effects of unit-level display rules.	Majority were females and white Results are correlational therefore causal inferences should be made with caution. All variables were assessed from the same source The measure of display rules referenced the individual and not the work unit. Some of the interactive effects in predicting emotion regulation were fairly small, especially for deep acting.	It revealed existence and importance of shared emotional display rules in a sample of nurses. Unit-level display rules had indirect (through individual-level display rules) and interactive effects with individual dispositional affect in predicting deep and surface acting. Shared display rules were indirectly (through individual display rules and emotion regulation strategies) related to emotional exhaustion and directly and indirectly (through

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						Nurses depend on their affective disposition to conform to high levels of unit-level display rules.	Focus on nurses within one hospital Some of the variables (affect, emotion regulation) may vary within persons over time. The need to better define and measure the deep acting and surface acting constructs in the emotional labour literature and to explicate what it means to report low levels of these constructs.	individual-level display rules and emotion regulation) related to job satisfaction. Further research is needed on how emotional display rules become shared among individuals and the mechanisms by which these shared perceptions influence employee behaviour and wellbeing.
First author & year	Purpose	Theoretical framework	Research design	Setting & sample	Instruments & data analysis	Major findings	Limitation	Conclusion
Hayward (2011) Australia	To examine *how* and *why* emotion regulation is carried out by nurses.	Not stated	Qualitative Design	**Setting**: two public hospitals **Sample:** n=12 ?purposive sampling Nurses Sample selection by email	**Instruments:** semi-structured cognitive interviews **Data analysis:** Content analysis NVivo8	Emotions were described as preparing nurses for what may likely happen. Nurses used discrete antecedent-focused strategies to manipulate emotional boundaries Nurses used personal conversations to manipulate the degree of emotional connection	The results may not represent the full range and combination of emotion regulation strategies available to employees in this and other occupations. This exploration was limited to the retrospective verbal descriptions of typical and novel/emotionally arousing patient interactions.	The process of emotional boundary manipulation is a highly adaptive approach to managing emotions at work that does not threaten one's sense of self in the work context and that allows externally and internally-driven goals to be achieved. Emotional boundaries are presented as a multi-pronged and comprehensive way to conceptualise work-related emotional management that is connected to the

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								adaptive function of emotion.
First authors & year	Purpose	Theoretical framework	Research design	Setting & sample	Instruments & data analysis	Major findings	Limitation	Conclusion
Tuna (2017) Istanbul	To determine the opinions of oncology nurses on concept of emotional labour and its use and specify the individual and organisational effects.	Not stated	Qualitative Phenomenological design	**Setting:** Oncology center **Sample:** n = 25 Nurses Purposeful sampling	**Instruments:** Semi-structured interview **Data analysis:** Content analysis	Performance of emotional labor of oncology nurses is an essential value in quality of healthcare. Emotional labour facilitates interpersonal relationships and continuation of healthcare. Nurses empathised with patients and their families causing them to experience emotional conflict while providing care. Nurses experience intolerance in their social lives and become depersonalised about concept of death. Nurses expressed desire for change of unit due to organisational effects of using emotional labour.	Limited number of qualitative studies on emotional labour of oncology nurses	Emotional labour is strengthening nursing practices through delivering sustainable and desirable care.
First authors & year	Purpose	Theoretical framework	Research design	Setting & sample	Instruments & data analysis	Major findings	Limitation	Conclusion
Kwon (2015) Korea	To identify the effects of emotional intelligence and emotional labour on burnout among	Not stated	Quantitative Survey Design	**Setting:** Five mental hospitals in C&D city **Sample:**	**Instruments:** Questionnaires Wong and Law Emotional Intelligence	Study identifies factors that influence burnout in psychological nurses, thereby providing fundamental data on burnout management programme.	Note stated	Intervention programme of burnout should be developed in order to improve psychological support, manage emotional

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First authors & year	Purpose	Theoretical framework	Research design	Setting & sample	Instruments & data analysis	Major findings	Limitation	Conclusion
	psychological nurses.			n = 200 Psychological nurses	Scale (WLEIS) Dutch Questionnaire on Emotional Labour (D-QEL) Choi & Jeong (2003) self-reported questionnaire on mental burnout **Data analysis:** SPSS 19.0	Burnout had negative relation with emotional intelligence and positive relation with emotional labour.		intelligence and reduce emotional labour among psychological nurses.
Vermaak (2017) South Africa	To explore the effect of emotional labour and the psychological experience of shift work on the PWBW of nursing staff.	Not stated	Quantitative Non-experimental research design	**Setting:** Four long term care institutions **Sample:** Convenience sampling n=206 Nurses	Instruments: **Questionnaires:** Index of Psychological Well-being at Work (IPWBW) **Data analysis:** SPSS 22.0 Principal Component Analysis (PCA) Confirmatory Factor Analysis (CFA)with LISREL 8.8	Emotional labour facet of surface acting was negatively related to psychological wellbeing at work. Working shifts as a nursing staff member places a significant psychological burden on the employees.	Not stated	Organisations could alleviate the adverse psychological effects of shift work through proper management.

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					Pearson correlations Regression analysis			
First author & year	Purpose	Theoretical framework	Research design	Setting & sample	Instruments & data analysis	Major findings	Limitation	Conclusion
Talebpour (2013) Tehran	To investigate social factors associated with emotional labour among nurses	4 theories were used: Hochschild Ashforth & Humphrey Morris and Feldman Grandey	Quantitative Descriptive survey	**Setting:** Eight Tehran West Region hospitals **Sample:** n=315 Nurses	**Instruments:** Questionnaire 61-item self-developed questionnaire **Data analysis:** Regression model ANOVA Test	>Surface acting: Mean 3;1202 >Deep acting: Mean 3.6005 >Regression model: R Square 0.664 >ANOVA Test: Regression: Sum of squares 50.135; df = 11. Residual 25.337; df = 301. Hospital pays attention to the physical needs of patients but neglect emotional labour about patients High level of emotional exhaustion Job hierarchy of nurses at the hospitals is not fair. Granting job autonomy increases the effectiveness of emotional labour There is an increase in the process of commercialising care at the studied hospitals.	There were more female than male nurses	Increasing level of job satisfaction to help reduce emotional exhaustion of nurses. Hospitals should pay attention to nurses' job hierarchy. More job autonomy and independence should be granted to nurses in scope of their job duties. Trend in the process of commercialising care at the studied hospitals should be stopped,
First author & year	Purpose	Theoretical framework	Research design	Setting & sample	Instruments & data analysis	Major findings	Limitation	Conclusion
Cricco-Lizza,	To explore emotional labour and coping	Not stated	Qualitative approach	**Setting:** NICU of a children's	**Instruments:** Interviews	Nurses used emotional labour to suppress feelings at work.	Majority of the nurses were females (only one male) and white (97)	Participants were able to cushion some of the emotional demands

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(2014) USA	strategies of Neonatal Intensive Care Unit (NICU) nurses.		Ethnography	hospital in Northeastern USA **Sample:** Purposive n=114 Nurses	Participant observation **Data analysis:** QSR NUD*IST (1997) Thematic analysis	Nurses experienced personally demanding problems of miscarriage, infertility, failed relationships, difficult pregnancies, sick children at home and chronically ill and dying parents, along with serious illnesses of their own but had to expend emotional labor to meet the challenging conditions at work. Nurses take home images and sounds from work but family did not comprehend the nature of their work and were unable to support them. Nurses face multifaceted needs of babies, parents, and professionals. Intense demands of caring for unstable infants due to "high acuity", 'long hours of work', "juggling and multitasks", "overwhelming demands" "trying not to panic". Majority of the nurses expressed their "love" for the babies, and being attached to the neonates over multiple crises and prolonged hospitalisations. Emotionally contagious environment with high demand of emotional labour	The NICUs have multiple resources.	with their sense of mission and purpose in the care they provided to suffering babies and families. Administrators offered many orientation and continuing education sessions for high-tech, clinical skills but did not provide training sessions to develop skills to manage emotional labour. Administrators provided social service referral for troubled family members, but did not replace a psychologist who had been hired to help the nurses. Some nurses resorted to avoidance and withdrawal when the emotional demands of the job exceeded their ability to handle them. Some nurses transferred out of the unit or left the hospital. Hospitals should consider the need to nurse the nurse to bolster the wellbeing of

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						making them to ”…come in and put on your sort of happy face” Nurses expend considerable emotional labour to maintain a “happy face” persona. Nurses expend emotional labour trying to deal with out-bursts of parents and allowing them to ventilate their concerns without feeling personally attacked. Nurses’ experience amplified demands on their emotions due to uncertainty in outcomes for unstable infants, the dying process and actual death of infants. Multiple organisational changes increase the emotional demands on nurses. Nurses use varied strategies (personal wellness strategies, adaptive professional strategies and strategies based on available organisational resources) to handle their own emotions to respond to the challenges of work.		the staff and ultimately facilitate the nurturing of families. Emotional labour was not recognised at organisational level, and NICU nurses were not prescreened, evaluated or rewarded for it. Administrators should consider the unique needs of their staff and NICU culture when they examine and support the emotional labour of nurses.

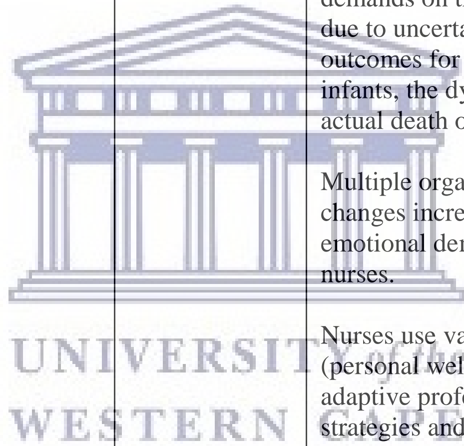
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Table 2.4: Categories and themes of major findings in the 12 reviewed articles

Themes	Categories	Codes
Perception of emotional labour	Nurses perceived emotional labour as a means of preparing for future, a tool for hospital management, essential for quality care, an integral part of culture, facilitates interpersonal relationship and continuation of care.	Tool for hospital management Essential for quality care An integral part of culture Facilitates interpersonal relationship Facilitates continuation of care.
Physical and emotional strain	Participants felt overwhelmed with executing multiple roles at the same time, working in a stressful environment, working long hours, time constraints, not spending enough time with family and loved ones, and thus expressed the need for "a break".	Need for a break Time constraints: long work hours Stressful work environment Multiple roles at the same time
	Nurses expressed feeling frustrated, unfulfilled, emotional burden, heavy demand on their emotions, depersonalised and experiencing intolerance in their social lives.	Nurses experienced frustration felt unfulfilled Psychological - emotional burden Heavy demand on nurses' emotions Experience intolerance in social lives Feeling of depersonalization
Welfare	Participants expressed dissatisfaction about low monetary gains, inadequate resources including shortage of staff.	Low monetary gains Resources Staff shortages
Support	Nurses in most organisations felt concerned about weak support system in areas of emotional support, frequent changes at unit level, low social support, lack of needed recognition, stressful nature of their work and physical aggression from patients and their relations which requires efforts to prevent negative outcomes of emotional labour particularly burnout.	Emotional support Organisational support Low social support Lack of needed recognition and stressful nature of nurses' work Lack of perception of emotions Organisational changes Fear of physical aggression Need for additional support to prevent 'burnout'.
Conflict	Conflict was identified as being harmful to productivity at work resulting in role conflict between nurses and some health workers.	Role conflict Harmful to productivity at work

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Policy	Participants stated that organisations do not have guidelines for hospital policy of care, nurses lack job autonomy, unfair job hierarchy of nurses and increasing commercialisation of care.	Lack of guidelines for hospital policy of care, Job autonomy should be granted Unfair job hierarchy of nurses Increasing commercialisation of care Job hierarchy of nurses at the hospitals is not fair
Coping strategies	Nurses used empathy and redefining self; and are expected to utilise deep and surface acting techniques to cope in the work environment	Doing their duties with a smile on the face" Deep acting strategy Empathy Redefined self Creating a relatively comfortable environment
Communication	Communication skills such as interpersonal relations, personal conversations were used to create good relations and to develop emotional intimacy in caring for the patients.	Emotional intimacy IPR good relations Use of personal conversations
Health problems	The nurses experienced poor health due to physiological problems of miscarriage, infertility and difficult pregnancies.	Physiological problems of miscarriage, infertility, difficult pregnancies
	Nurses suffer from psychological problems as a result of failed relationships, family ill health, unsatisfactory work environment and trying to cope.	failed relationships, sick children at home, chronically ill and dying parents, intense demands of caring long hours of work depersonalisation to death, juggling and multitasks" "trying not to panic".
Training	Participants expressed dissatisfaction in nursing training being traditionally based and focused on disciplinary knowledge hence advocated for staff development with focus on informal knowledge and situated learning.	Training traditional, burnout program Nurses' training is focused on disciplinary knowledge Need for staff development with focus on informal knowledge and situated learning.

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2.7 NARRATIVE SUMMARY OF THE THEMES

Objective 1: To conduct an integrative review of literature on the concept of emotional labour.

Integrative review of the concept of emotional labour was carried out on twelve (12) selected articles. The outcome led to the identification of codes which were formulated into categories from which ten (10) themes were generated. This include: perception of emotional labour, physical and emotional strain, welfare, support, conflict, policy, coping strategies, communication, health problems and. training.

2.7.1 Perception of emotional labour

Nurses perceived emotion as a means of preparation for future events Hayward & Tuckey, (2011), and emotional labour as a relevant tool in hospital management for planning, staff recruitment and retention, an essential value of quality healthcare and an integral part of culture of care (Gray & Smith, 2009). Some of the nurses expressed that emotional labour facilitates interpersonal relationship and continuation of care (Tuna & Baykal, 2017). Some of the characteristics of emotional labour identified in the review were empathy, compassion, exposure to stressful work environment, support, work overload, subjective wellbeing, stress and conflict.

2.7.2 Physical and emotional strain

Majority of the participants were overwhelmed with executing multiple roles while at the same time (Cricco-Lizza, 2014; Thomas & Abhyankar, 2014), working in a stressful environment (Gray & Smith, 2009), sadness and suffering (Zamanzadeh et al., 2013), having to work long hours and time constraints (McCreight, 2005). Also, that they do not spend enough time with family and loved ones (Thomas & Abhyankar, 2014) hence expressed the need for "a break" (McCreight, 2005).

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The nurses felt frustrated, unfulfilled, emotionally burdened and exhausted (Gray, & Smith, 2009; Talebpour et al., 2013; Vermaak et al., 2017) and being unable to cope with burnout (Gray & Smith, 2009). They felt heavy demands on their emotions such as ‘‘anger’’ and ‘‘despair’’ because they have to take care of personal and professional needs making them feel depersonalised and intolerant in their social lives (Gray & Smith, 2009; Thomas & Abhyankar, 2014; Tuna & Baykal, 2017).

2.7.3 Welfare

Participants expressed dissatisfaction about low monetary gains (Thomas & Abhyankar, 2014), even though they "love" caring for the babies (Cricco-Lizza, 2014). Vijayarani & Suresh (2015) perceive employee welfare from a general perspective of social welfare that is, welfare of the total society including labour welfare where workers are provided a conducive working environment with better working conditions. According to them, employee welfare implies the provision of facilities in the organisation internally and externally, such as rest rooms, canteens, housing, recreation centres, that will enhance efficiency and also improve the well-being of workers. Welfare measure is a way of recognising the special place that workers occupy in the society, hence organisation should treat them fairly, keep and sustain their morale and motivation, in order to encourage and retain them for a longer duration (Varadaraj & Charumathi, 2019). Pérez-Francisco et al, (2020), in a literature review, identified that high pressure of work negatively impacts on nurses' health which plays an important role in impairment of quality of care, safety of patents and changes in their emotional well-being (McVicar, 2016).

2.7.4 Support

Some of the nurses acknowledged that ward sisters served as role models (McCreight, 2005). Nevertheless, nurses working in many of the organisations felt concerned about lack of support

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from family (Cricco-Lizza, 2014), organisations' weak support system, low emotional and social support (Gray & Smith, 2009; McCreight, 2005; Thomas & Abhyankar, 2014). They expressed dissatisfaction about frequent changes at unit and organisational levels (Cricco-Lizza, 2014), lack of needed recognition (McCreight, 2005; Talebpour etal., 2013; Thomas & Abhyankar, 2014) and the stressful nature of their work (Gray & Smith, 2009; McCreight, 2005). Fear of physical aggression from patients and their relations in a mental health setting motivated nurses to long for change of units (Gray & Smith, 2009; Tuna & Baykal, 2017).

2.7.5 Conflict

The nurses perceived conflict as being harmful to productivity resulting in role conflict between them and some health workers and a controversial issue about nurses revealing their true emotions to patients (McCreight, 2005). In a study carried out on nurses in Zagreb, Cavar and Petrak (2018), reports that superiors are the causes of conflict which often occur due to character traits, unclear division of work, unreliability of coworkers and bad management. Conflict was described as a very destructive experience that leads to aggression, hostility, confrontations and insults (Cavar & Petrak, 2018).

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2.7.6 Policy

Despite the fact that nurses in a study carried out by Gray & Smith (2009), revealed that emotional labour is a relevant tool for effective hospital management, participants in other works stated that their organisations do not have guidelines for hospital policy of care (McCreight, 2005). Nurses lack job autonomy, unfair job hierarchy of nurses and experienced an increasing commercialisation of care (Talebpour et al., 2013).

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2.7.7 Coping strategies

Nurses used empathy (Tuna & Baykal, 2017), to redefine themselves (Zamanzadeh et al., 2013) and create a relatively comfortable work environment to regulate their emotions (Gray & Smith, 2009). Due to organisations' expectations, nurses expressed using varied and discrete antecedent-focused coping strategies (acting techniques) such as: "doing their duties with a smile on the face" (Gray & Smith, 2009; Hayward & Tuckey, 2011; Thomas & Abhyankar, 2014) to meet the challenging conditions at work (Cricco-Lizza, 2014). Also, "…come in and put on your sort of happy face"; maintain a "happy face" persona (Cricco-Lizza, 2014) to manipulate emotional boundaries during care delivery.

2.7.8 Communication

Communication skills such as interpersonal relations and personal conversations were used to create good relations and also to develop personal relationship and emotional intimacy with patients while caring for them (McCreight, 2005; Zamanzadeh et al., 2013)

2.7.9 Health problems

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The nurses experienced poor health due to physiological problems of miscarriage, infertility and difficult pregnancies (Cricco-Lizza, 2014). Nurses suffered from psychological problems as a result of failed relationships, sick children at home, chronically ill and dying parents (Cricco-Lizza, 2014), depersonalisation to death (Tuna & Baykal, 2017), 'long hours of work' (Thomas & Abhyankar, 2014), intense demands of caring due to "high acuity" "juggling and multitasks", "overwhelming demands", and "trying not to panic"(Cricco-Lizza, 2014).

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2.7.10 Training

Although, ward sisters were identified as a source of training (McCreight, 2005), participants expressed dissatisfaction in nursing training being traditionally based and focused on disciplinary knowledge (McCreight, 2005), which was not always helpful in enabling them to cope with the emotional demands of their work because they have not been adequately prepared during training. Nurses' emotions thus should be considered a source of weakness since it is the only guidance received through codified disciplinary method.

2.8 SUMMARY

In this chapter, the integrative review of literature on the concept of emotional labour, using Whittemore & Knafl, (2005) method to address objective one was described. The search was conducted from March to May 2019 with an updated search from April to May, 2020. During the search 2,058 articles were retrieved and only 12 articles were finally selected for the review. Critical Appraisal Skills Program (CASP Checklists, 2014) for cohort and qualitative studies was used to assess quality of articles selected for the review and to identify strengths and weaknesses that a research may have in order to assist the readers. Many categories were identified that generated ten (10) themes.

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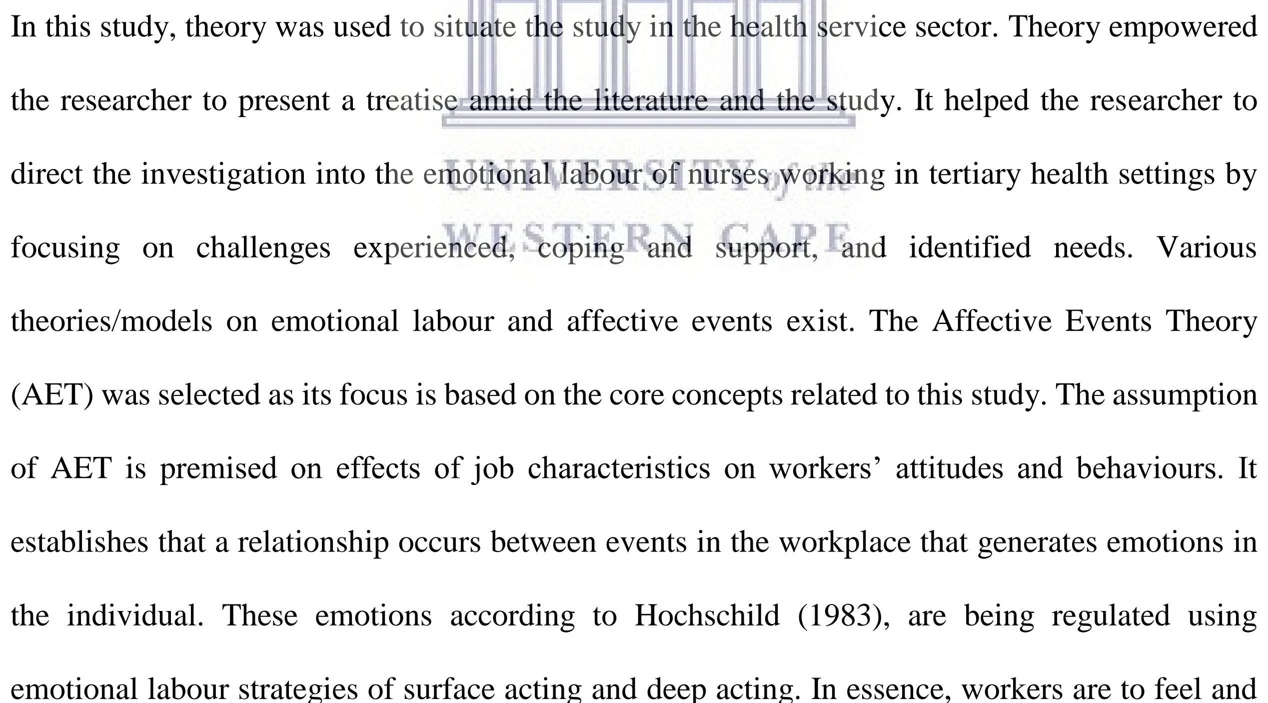
CHAPTER THREE

THEORETICAL FRAMEWORK

3.1 INTRODUCTION

A theory is a set of related statements that describes or explains a phenomenon systematically (Nieswiadomy & Bailey, 2018). Theory therefore assists the researcher to understand the basis that will augment investigations to arrive at a concise stand for a phenomenon. Theoretical framework in a research helps to focus on two main simplified concepts namely: the research problem and the rationale of investigating the issue. A theoretical framework helps the researcher to identify which key variables impact a phenomenon of interest and highlights the need to examine how these variables might differ and under what circumstances (Davis, 2021).



In this study, theory was used to situate the study in the health service sector. Theory empowered the researcher to present a treatise amid the literature and the study. It helped the researcher to direct the investigation into the emotional labour of nurses working in tertiary health settings by focusing on challenges experienced, coping and support, and identified needs. Various theories/models on emotional labour and affective events exist. The Affective Events Theory (AET) was selected as its focus is based on the core concepts related to this study. The assumption of AET is premised on effects of job characteristics on workers' attitudes and behaviours. It establishes that a relationship occurs between events in the workplace that generates emotions in the individual. These emotions according to Hochschild (1983), are being regulated using emotional labour strategies of surface acting and deep acting. In essence, workers are to feel and

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express their emotions in a socially desirable manner according to the display rules set by their organisation and/or profession.

3.2 DESCRIPTION OF THE AFFECTIVE EVENTS THEORY

The Affective Events Theory (AET) is expounded with reference to the process, limitations, strengths and appropriateness to this study. The theory as propounded by Weiss & Cropanzano, (1996), was selected for this study because it focuses on the processes of effects of events at work, i.e. how emotions and moods influence job performance and job satisfaction - and therefore meets the objectives of this study. The AET is premised on the principles and thoughts of Weiss & Cropanzano, (1996) and explain the impact of employee emotion and mood on predicting work outcome. The AET emphasises that the internal emotional state of employees determine whether they will exhibit behaviours that benefit or those that are against organisational development. The work environment can give rise to a need for workers to regulate their emotions because sudden occurrence of events may have instant effect on their emotions (Gopinath, 2011). Affective work behaviour such as emotional labour is predominantly determined by the employees' emotional state and mood.

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Affective events theory postulates that the attitudes of employees at the workplace have a dual view, namely cognitive and affective. The cognitive view refers to the internal emotional state of an individual which informs the reactions to events that happen in the work environment while the affective view determines the occurrence of *positive* or *negative* work events (Jonker, 2013). A positive emotional state is more likely to generate a display of positive and genuine emotions such as deep acting while a negative emotional state will produce negative emotions expressed through surface acting. Whether an individual worker engages in emotional labour or not, the emotional

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condition of such employee at that point in time, according to the AET, is very crucial in making this decision. The assumptions of the AET are as follows: 1) events happen over time and it brings about changes in affect; 2) events create positive or negative reactions; 3) the degree of intensity varies according to events and 4) affect is dynamic.

Affective events theory focuses on those components of the organisational environment that are considered to promote or impair the progress of organisational members with respect to workplace goals (i.e. experienced hassles or uplifts, often in response to events derived from superior officials' decisions). Events in the traditional sense of AET are understood or perceived to be intra-organisational and often includes stress-related workplace events (Ashton-James & Ashkanasy, 2009), elements of the physical setting (Wasserman et al., 2000), work-group characteristics (Barsade, 2000) and Manager-Staff or leader-member relationships and exchange (Dasborough, & Ashkanasy, 2002). In some situations, affective events may include extra-organisational events which sometimes impact on the overall activities of the organisation.

Organisational change has been identified as a major cause of stress for leaders and members of an organisation. Currently, researchers have studied the emotional responses of various organisational members in relation to varying organisational change circumstances and scenarios such as retrenchment (Torkelson & Muhonen, 2003), mergers (Schweiger & DeNisi, 1991), job restructuring (Mak & Mueller, 2001) as well as other factors relating to organisational change (Everly et al., 1999). The findings reveal that severe occupational stress often has a devastating aftermath on a family's functionality, psychological or emotional health, physical health, job satisfaction, organisational commitment and loyalty (Everly et al., 1999; Schweiger & DeNisi, 1991; Torkelson & Muhonen, 2003).

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Although organisational change and innovations are required for organisations to keep pace with global changes and standards, it usually has a negative impact on employees' affective wellbeing (Ashton-James & Ashkanasy, 2009). As a result, researchers are proposing that organisational events such as political, economic, legal, technological and socio-cultural, which may pose an actual or conceived hazard to an organisation's functionality and also affect employees' emotional states, should be adequately managed.

3.3 ANTECEDENTS AND OUTCOMES OF EMOTIONAL LABOUR

The affective events theory (Weiss & Cropanzano, 1996) explains the impact of employee emotion and mood on predicting work outcome (see Figure 2.2). The affective events theory emphasises that the internal emotional state of employees determine whether they will exhibit behaviours that benefit organisational development or those that are against their interests.

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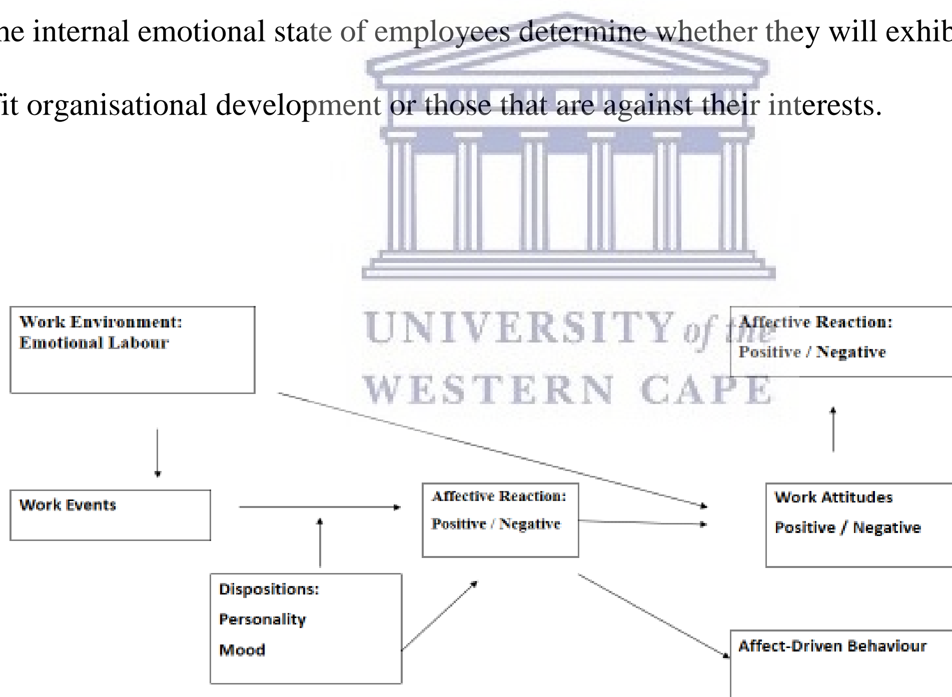

Figure 2.2: Affective Events Theory: Macro structure (Weiss & Cropanzano, 1996)

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3.3.1 Work Environment

The work environment can give rise to a need for workers to regulate their emotions because sudden occurrence of events may have an instant effect on their emotions (Gopinath, 2011). Affective work behaviour such as emotional labour is predominantly determined by the employees' emotional state and mood.

Organisational behavioural norms which state mode of interacting with subordinates, peers, and superiors in a professional, courteous, and respectful manner while simultaneously discourage the manifestation of negative emotions to colleagues or clients are not usually spelt out in black and white. Also, Diefendorff & Richard, (2003), opined that it is very unrealistic on the part of employers to think that employees will authentically feel positive emotions all the time in the workplace. As a result, dissonance arises when there is discrepancy between sincere emotional state and organisation's emotional display rubrics which mandate employees to cope with their emotional responses during interaction with their clients (Diefendorff & Richard, 2003).

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(Grandey, 2000), posits that external emotional regulation (surface acting) is used when an employee's underlying emotion is still present whereas the displayed external expression of emotion relates with the organisation's stipulated display rules. In deep acting, the employee make a cognitive effort to process the underlying emotion in order to match the display rules, hence facilitating a more suitable emotional reaction. In a similar vein, Hochschild (2012), views the employee in the service sector as actively managing the feeling and expression of emotion as an *essential* prerequisite of their work personality, which must align with organisational rules concerning the feeling and exhibition of emotion. Deep acting on one hand modifies felt emotion in order to alter emotional display and yields a genuine emotional display, while surface acting on

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the other hand, only changes the outward expression of emotion and produces a falsified emotional display.

In addition, emotion regulation can be described from two distinct perspectives, namely focus of regulation and trend of change in emotion. The focus on regulation is concerned with whether or not the stratagem will change the emotional feeling or emotional display. It implies that the employee may alter the emotional feeling (surface acting) or exhibit the exact emotion (deep acting). Hochschild (2012), reveals that deep acting is more accurately referred to as 'antecedent-focused' strategy since it changes the situation or discernment of the situation in order to adjust emotion (Grandey, 2000). It therefore deals with the issue of emotional-rule dissonance which signifies permitting the applicable exhibition of emotion. However, in surface acting, there is modification of emotional display making it more accurately labelled 'response-focused' strategy. It leaves felt emotion unchanged while publicly exhibiting emotion distinctive from felt emotion, thus, creating falsified emotional displays. According to Matsumoto et al., (2005), direction of change in emotion is premised on whether approaches aim to overwhelm, which is inhibit, stifle, or counteract emotional behaviour, or augment (express or enhance) the emotion (Diefendorff & Greguras, 2006).

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3.3.2 Workplace Events

Workplace stress can impact healthcare professionals' physical and emotional wellbeing by decreasing their efficiency and having a negative impact on their overall quality of life. Being exposed to stress for too long, may lower a person's efficiency and could trigger negative consequences on one's health or family and social life (Grandey, 2000).

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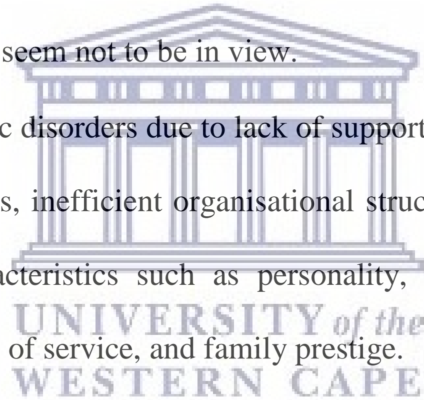
Some of the factors according to Grandey, (2000) that may stimulate workplace-related emotional disorders and could have a negative impression on the health professionals' emotional health include the following:

- The nerve-wracking nature of the profession in relation to psychosomatic pursuits, principled tight spot and the patients' demands constitute a burden on the professional emotional state of nurses.
- Anxiety and pressures could lead to inferior quality of care, resulting in decreased professional satisfaction and quality of life.
- Feeling of frustration owing to constant contact with patients and their family members which spawns emotions of anger, discomfiture, fear, and extreme anxiety when solutions to the patients' problems seem not to be in view.
- Predilection to psychiatric disorders due to lack of support from coworkers and superiors, conflicts among members, inefficient organisational structure and administration-related factors, individual characteristics such as personality, individual experiences, socio-economic standing, years of service, and family prestige.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3.3.3 Personal disposition

According to Grandey & Gabriel, (2015), the focal antecedents of emotional labour are: personality traits, work motives and emotional abilities of the employee that makes him suitable for the job. These are the personal characteristics of an individual. In a simpler term, personality can be described as a complex human characteristics and distinctions. Moods/emotions and customer mistreatment are event characteristics inherent in an organisation. The objective of event characteristics is achieving the goal of the organisation through employees managing and regulating their emotions and performing their tasks according to the display rules. In the context

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of social interactions at the workplace, emotion rules are structured by either feeling rules which manage the type and magnitude of emotional feeling or display rules that monitor the nature and extent of emotional expressions (Ekman & Friesen, 1975).

Emotional rules comprise of principles, roles and impressions of emotion which are naturally utilised and reflect schemes about how the feeling and expression of emotion can be used to attain better performance by inducing others (Rafaeli & Sutton, 1987), while (Goffman, 1967) and (Ronald De Sousa, 1990)) are of the opinion that it integrates the role of emotion in ethical behaviour such as the nurse being kindhearted towards the sick. Zapf, (2002) explains that when an employee's felt emotion and its continuous manifestation relate with emotion rules, it becomes a spontaneous and relatively uncomplicated process with successive behaviour being a genuine display of fundamental emotion.

3.3.4 Affective emotional reactions

The affective events theory postulates that the attitudes of employees at the workplace have a dual view: cognitive and affective. The cognitive view is the internal emotional state of an individual which informs the reactions to events that happens in the work environment while the affective view determines the occurrence of *positive* or *negative* work events (Jonker, 2013)

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A positive emotional state is more likely to generate display of positive and genuine emotions such as deep acting while negative emotional state will produce negative emotions expressed through surface acting. Whether an individual worker will engage in emotional labour or not, the emotional condition of such employee at that point in time according to the AET is very crucial in making this decision. The assumptions of the AET are:

1) events happen over time and it brings about changes in affect;

2) events create positive or negative reactions;

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3) degree of intensity varies according to events and

4) affect is dynamic so also its effects on behaviour.

Ashton-James & Ashkanasy (2009), identify the principles of AET as "environmental exigencies" that generate "affective events" that cause emotional reactions in organisational members which in turn, determine members' attitudes and behaviours. In essence, managers experience moods and emotions as responses to workplace events which could be positive or negative. It was postulated that events in the organisation sparks affective reactions among organisation members leading to exhibition of attitudes, cognition and behaviours of its members. The affective events theory is thus a process that begins with antecedents of affect, through nature of affect and the implication of these in the long run affects organisational cognition.

In every organisation, there are elements that impair members' advancement in achieving workplace goals (Weiss & Cropanzano, 1996) which eventually leads to affective reactions that can be positive or negative. Thus, it can be said that affective reactions start from the occurrence of an event in the workplace. A series of changes take place that leads to affect which influences behavioural responses of an individual. These behavioural responses can be displayed indirectly through job attitude and viewed as a job-driven behaviour. These responses occur immediately following an event whereas in judgement-driven behaviour, it's a thought process that take some time to emanate in a behavioural pattern making it a deliberate action. The event is re-interpreted severally to arrive at a decision in behavioural form which can be positive or negative (Weiss & Cropanzano, 1996).

Caring for patients in a unique way emanates from reactions to stimuli by nurses. This is dominant in internal and external demands of the environment. The internal demands have to do with their

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characteristics associated with family and training while external characteristics relate to working environment.

3.3.5 Affect-driven behaviours

Grandey & Gabriel, (2015), postulate that the focal outcomes of affective-driven behaviours are either positive leading to job satisfaction or negative leading to burnout in employees. Bakotic, (2014) defines job satisfaction as employees' general perception about the job or the compilation of attitudes towards various aspects of the job. It is also viewed by Spector, (1997) as the emotional response that people have about their jobs and the various aspects associated with their jobs.
Nurses play a fundamental role in patient care and therefore contribute immensely to the healthcare services (Kaddourah et al., 2013). In healthcare services, job satisfaction is directly related to job performance, this eventually leads to positive care outcome. Lu, et al (2005), in a review conducted on job satisfaction of nurses, identified organisational, professional and personal variables that contribute to nurses' job satisfaction. They identified that stress related to the work place, low level of satisfaction from lack of reward and poor working conditions are some of the causes of job dissatisfaction among nurses. Also, global shortage of nurses have impacted positively on the quality of interpersonal relationships at the workplace which used to be a reinforcement of job satisfaction and organisational commitment. Individual unmet expectation also lowers job satisfaction (Lu et al., 2005).

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Emotional labour experiences with patients are frequently demanding. Nonetheless, the clampdown of emotions for the benefit of the patient is a vivacious and fundamental characteristic of a nurse's work (DiCicco-Bloom, 2012). On the contrary, secondary emotional labour does not assist the client or the professional, and outside of depriving nurses of essential emotional and

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informational provision, it can escalate the likelihoods of burnout and also destabilise the organisations goals for quality care in favour of the supposed expedience of superiors and administrators (Grandey, & Gabriel, 2015).

In order for a nurse to effectively perform emotion work while also recognising patients' emotion, nurses are expected to be empathetic. They are expected to abide by the standards of behaviour which designate the most suitable emotions in peculiar circumstances and also how these emotions are to be overtly displayed in relation to job performance. This is in line with the view of Hochschild (2012) who states that emotional labour requires employees to suppress feelings in order to withstand the outward countenance that produces the appropriate state of mind in other for better job performance and attainment of organisational goals. Furthermore, employees in the service sector are expected to guide and control their emotions in accordance with the demands of their organisations (job performance). They are requested by employers to expend physical and emotional labour(s) when carrying-out their work.

3.4 CRITICISM OF THE AFFECTIVE EVENTS THEORY

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Based on previous research in emotions experienced at work, Ashforth & Humphrey, (1995), note that it is directly related to the quality of service rendered, how conducive nature of work event and the various emotion displayed by employees. A critical review of Hochschild (1983) notion on emotional labour by Ashforth & Humphrey (1995), led to a rigorous definition of emotional labour and its importance to the service sector of economy. They argue that the service sector employees need to conform to display rules and that emotional labour can ease work effectiveness and improve problems associated with interpersonal relationship. On the other hand, emotional labour may increase expectations of clients on quality service, predispose employee to distress and negatively alter emotional response to events. They affirm that inclusion of the concept of identity

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will further give credence to emotional labour through recognition of the roles employee play in the organisation. Their argument is therefore based on the use of display rules that is felt rather than feeling rules since it is related to behaviour thus depicting emotions to be expressed publicly instead of that which the employee feels.

Morris & Feldman (1996), noted that emotional labour has a strong relationship with emotion in organisational environment where yet it has not been satisfactorily researched. Employees are to control and display emotions to customers as directed by the organisation. Emotional labour is defined as "the effort, planning and control needed to express organisationally desired emotions during interpersonal transactions." This definition according to Morris & Feldman (1996), is coined within the context of the interactionist model of emotion with consideration to relevance of social factors that determine expression of emotions. The argument goes further that individuals still exhibit some degree of effort to express felt emotion as organisationally desired emotions in line with Hochschild's (1983) stance on definition of emotional labour Morris & Feldman (1996), state that emotional labour should be viewed with a public lens because emotional expression is now part of service work as an expression of behaviour as desired by the organisation. Within the context of their definition of emotional labour, display rules depict a standard behaviour that reflects appropriate emotion and how it is expressed. Previous works (Hochschild, 1983; Morris & Feldman, 1996), on emotional labour developed a framework that shifts from a generalised perception of emotional labour to four distinct dimensions: frequency of appropriate emotional display, attentiveness to required display rules, variety of emotions to be displayed, and emotional dissonance generated by having to express organisationally desired emotions; not genuinely felt emotions. Frequency of customer satisfaction in interaction with service providers determines the likelihood of patronage having established likeness, trust and respect from employee behavior. As

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the level of attentiveness increases so does the intensity of psychological energy and physical efforts the job demands from employees. This is experienced through duration of emotional display – length of time they spend together which determines efforts required for emotional display (Badolamenti, et. al., 2017). Longer emotional display will need greater attention and emotion stamina (Hochschild, 2012), and both sides will be disposed to more information about each other which is likely to reveal personal feelings of the employee.

Grandey, (2000), views emotional labour as a stressful means of managing emotion and observed that prior to the evolvement of the concept of emotional labour, emotions were not recognised as a workplace phenomenon. As research advanced on the role of emotions in organisational behaviour, more findings (Grandey & Gabriel, 2015; Riley & Weiss, 2015), reveal that it is relevant to individual and organisational outcomes as individual change how they feel and show their emotions when relating with customers. In order to modify how an employee expresses emotion he needs to suppress or enhance how he feels. This is guarded by display rules of the organisation or job (Ekman & Friesen, 1975; Goffman, 1959; Hochschild, 1983), which may be written or observed from co-workers on the job. These rules differ depending on the type of the individual. Some organisations expect the individual (like nurses) to show 'smiles and humour' to customers while some require 'angry demeanor' like bill collectors and law enforcement agents ((Hochschild, 1983; Sutton, 1991; van Maanen & Kunda, 1989). Proponents of emotional labour identified that it is stressful and may lead to burnout while understanding the relationship between emotional labour and stress have not been clarified; neither has there been a standard definition of emotional labour). (Grandey, 2000)

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In the quest to have a grip on the concept of emotional labour, Grandey, (2000) critiqued previous works on emotional labour to adopt emotional regulation as a theory to guide the comprehension

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of how emotional labour might be stressful experience for an employee and yet benefit the organisation. Conceptualising emotional labour. Grandey, (2000), made some submissions that surface acting and deep acting can be beneficial:

a) Inherently value-laden: the strategies may have positive or negative results on individuals as stress and health problems.

b) As utility – to be used by the organisation for policy making in the areas of capacity building and stress management.

c) Attached to an existing theoretical model.

Criticising Hochschild (1983) general emotion theory, Grandey (2000), identified that the theory did not explicitly apply to the proposed relationship thereby projecting that a theory should be able to organise and predict the process of emotional labour which brings about the review of the theory of emotional regulation in relation to emotional labour. According to .Hochschild (1983), the concept of emotion has not been particularly focused in the literature on emotional labour. Hence, she viewed emotion as physiological arousal and the cognitive appraisal of the situation. In the analysis of the emotion regulation theory, she identified the importance of emotional labour as providing a framework for guiding emotional labour and giving adequate consideration to the role of physiological arousal.

3.10 SUMMARY

The affective events theory was utilised based on its relevance to emotional labour. This theory was described and the application to this study was highlighted. Based on the focus, strengths and limitations of the affective events theory, it was established as being suitable in meeting the objectives of the study. Hence the theory was selected to guide the exploration and description of

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the nurses' experiences in tertiary hospital settings in Nigeria based on the processes, strengths and limitations.

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CHAPTER FOUR

METHODOLOGY

4.1 INTRODUCTION

The objectives of the study were to conduct an integrative review of literature on the concept of emotional labour, determine the deep acting and surface acting strategies employed by nurses, explore their experiences of emotional labour, and to develop a model for support of emotional labour of nurses working in tertiary hospitals in Nigeria.

In this chapter, a step-by-step description of the methods used to achieve the stated objectives is discussed. Research methodology signifies various ways of efficiently solving a research problem through scientific methods towards achieving stipulated objectives (Surbhi, 2018). Polit & Beck (2014), stated that research methods are the techniques researchers use to structure a study and to gather and analyse relevant information. They represent the ways a research is carried out and how to collect, sort and analyse information for meaningful conclusions (Walliman, 2018). The research design can be quantitative, qualitative or mixed methods.

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4.2 RESEARCH APPROACH

A mixed methods research approach was used to achieve the aim of the study. Mixed methods research is the means by which a researcher "collects and analyses both qualitative and quantitative data rigorously in response to research questions and hypotheses, integrates (or mixes or combines) the two forms of data and their results, organises these procedures into specific research designs that provides the logics and procedures for conducting the study, and frames these procedures within theory and philosophy" (Creswell & Plano Clark, 2018:41). Their combined use also

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provides an expanded understanding of research problems. Quantitative research is used to explain events through collection of numerical data that are analysed with statistical methods while qualitative research on other hand is a subjective exploration of experiences of people about a phenomenon.

4.2.1 Quantitative research approach

Quantitative research is used to examine the relationship among variables which can be measured with instruments to obtain numbered data for analysis using statistical procedures. In quantitative research, there is objectivity, research situation is tightly controlled and findings can be generalised (Nieswiadomy & Bailey, 2018). The researcher often have assumptions about deductive testing, guiding against bias and being able to generalise and replicate the findings (Creswell, 2014). Being an objective method of obtaining information about a phenomenon, the researcher used this approach to determine deep acting and surface acting strategies that nurses in tertiary hospital adopt to regulate their emotions at workplaces.

4.2.2 Qualitative research approach

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Qualitative research is an approach used to explore and understand the meaning people ascribe to a particular social or human problem in their natural environment using a small number that volunteers as research participants to obtain information about a phenomenon (Creswell & Plano Clark, 2018; LoBiondo-Wood & Haber, 2014). This type of approach involves a set of questions and procedures to generate data from participants in their natural setting and inductively derive particular to general themes from analysed data while the researcher make interpretations of the meaning of the data to arrive at a flexible structure. It enables in-depth exploration of experiences and perspectives of individuals and community on research problem (Newman et al., 2021). The approach being a person-centered way of discovering thoughts and actions of people, enabled the

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researcher to explore and describe the experiences of emotional labour among professional nurses in the selected tertiary hospitals.

4.2.3 Mixed methods research approach

Mixed methods is a practical approach (Pelto, 2015) which enables researchers to utilise data collection and data analyses methods of quantitative and qualitative approaches to explore complex problems such as those inherent in healthcare (Shneerson & Gale, 2015). This approach involves combining the two forms of data, and applying specific designs based on philosophical assumptions and theoretical frameworks to provide a comprehensive understanding of a research problem (Creswell & Plano Clark, 2018). Researchers assumed that both forms of data provide different types of information from open-ended data obtained in qualitative and closed-ended data in quantitative inquiries. Mixing or blending of these data provide a stronger understanding and wider perspective of the problem (Greene, 2015) and helps to overcome the weaknesses or complement the strength of one design Tilley & Tailor (2018), than each approach on its own. Knowledge gained from both approaches can yield powerful and impactful results (Tilley & Tailor, 2018).

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In mixed methods research, six strategies were identified by Creswell, (2014). These are: sequential explanatory, sequential exploratory, sequential transformative, concurrent triangulation, concurrent nested and concurrent transformative. The researcher used concurrent triangulation strategy for gathering data to corroborate study findings. In other words, data gathering was done simultaneously. This researcher found the approach suitable for the study in order to determine the deep acting and surface acting strategies employed by nurses working in tertiary hospitals in Nigeria; to explore and understand their perception of emotional labour; to

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identify the support needs of nurses as well as the existing support system of the hospital management team in alleviating the emotional labour of nurses.

4.3 RESEARCH DESIGN

A research design outlines the plan or strategy used in examining a research problem and can be regarded as the blueprint for conducting research (Christensen et al., 2011). The quantitative method of the mixed method approach involved a descriptive survey design and the qualitative method, an exploratory descriptive theory-generating design.

4.3.1 Descriptive research

Descriptive research design is used to provide complete and accurate account of a particular situation, social setting or relationship (Schurink et al., 2011). Descriptive research can be concrete or abstract. It often provokes abstract questions relating to the "How?" rather than "Why?" question of the explanatory research. Descriptive research is a theory-based design in which the researcher is predominantly interested in describing a topic that is the subject of the research (Jovancic, 2020). It is often applied to case studies, naturalistic observations and survey, among others. This method involves data collection, analysis and presentation. It permits the researcher to clearly present the problem statement in order to allow others to better understand the need for the research under study. It must be noted that descriptive research cannot be conducted without a clear statement of a research problem.

The design was therefore appropriate for this study as it described the deep acting and surface acting strategies of emotional labour employed by nurses working in tertiary hospitals in Nigeria through use of questionnaire that was administered by the researcher. The responses of nurses on how they experience emotional labour in tertiary hospitals were also described.

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4.3.2 Theory-generating design

The theory-generating design is described as a research design that explains and describes existing relationships without foisting any prejudiced ideas. Theory according to (Polit and Beck, 2014), is explained as an abstract generalization of how phenomena are interrelated, or a broad characterisation of a phenomenon. Theory describes why the research problem under study exists. It therefore explains how relevant research concepts are interrelated and gives vivid clarification of why things occur in the manner they do. Conceptual meaning originates from the nurses' point of view, which are labelled in words (concepts). Conceptual meaning is concerned with the mental or imaginary thoughts of certain concepts or incidence. It assist researchers to delineate borders which guide the course of any research work. A theory-generating design based on Walker and Avant, (2019) and Chinn & Kramer (2018), was used in response to objective 4 to theoretically connect data from the quantitative and qualitative phases in order to develop concepts and group these concepts to form a structure.

Elements of Theory Building

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There are three basic elements of theory building, namely concepts, statements and theories.

- **Concepts**

Concepts provide an imaginary picture of a certain phenomenon, an idea or a construct in the mind about a thing or an action. The meaning of concept is formed by: (1) the word; (2) the event; and (3) feelings, values and attitudes associated with word and the event (Chinn & Kramer, 2018). Concepts enable us to classify our experiences in a meaningful way both to ourselves and to others. Classifying experiences is a very useful and effective ability to express the relationship between two or more concepts.

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Concepts surfaced during the process of qualitative content analysis whereby categories and themes were identified and concepts were generated from themes. Concepts which were similar were grouped and these formed the main concepts. The main concepts were defined conceptually by means of both dictionary and discipline specific definitions. The foundation for developing a model for support of emotional labour of nurses in tertiary hospitals in Nigeria was provided by these concepts. Concepts that demarcate theory and practice of phenomena in nursing (nursing care and nursing practice respectively) are quintessential for providing, documenting, communicating about and studying care processes.

- **Statements**

A statement is the product of articulating a relationship amongst concepts. A statement is extremely vital when building a scientific body of knowledge such as nursing to permit further predictions and explanation of events (Walker & Avant, 2019). The two basic forms of statements are relational and non-relational statements. Relational statements affirm some sort of relationship between two or more concepts while non-relational statements are the way by which the theorists clarify meanings in the theory. Non-relational statements may be either a prevailing statement that exerts the existence of the concept or a definition, either theoretical or operational. Theoretical and operational definitions are indispensable in theory building (Walker & Avant, 2019).

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- **Theories**

A theory is described as "an internally reliable group of relational statements that presents a systematic view about a phenomenon that is useful for description, explanation, prediction and prescription or control" (Walker & Avant, 2019:65). A set of definitions that are specific to concepts in the theory may be associated with a theory. The study sought to develop a model rather

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than a theory about support for emotional labour of nurses in tertiary hospitals in Nigeria as testing was beyond the scope of the study.

The diagrammatical representation of a theory is called a model (Walker & Avant, 2019). A model for the support for emotional labour of nurses in tertiary hospitals in Nigeria was developed by identifying concepts during the content analysis of the study. The relationship between two or more concepts was identified and related statements which clarified the type of relationship were formulated. A model was illustrated, which depicts how the concepts were related. This is because carefully formulated theories provide an integrative understanding of phenomenon by systematically organising relevant concepts and statements.

Approaches to Theory Building

The approaches to theory building are interrelated, that is, no single approach is complete in isolation of the others. The process of theory building requires the researcher to move back and forth among the three basic approaches to theory building, namely derivation, synthesis and analysis (Walker & Avant, 2019). These authors therefore advised against the combined use of all the approaches but suggested the use of a single strategy at a time until it is deemed inadequate before using another.

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- **Derivation**

The theory derivation process permits the theorist to rearrange and outline a concept, statement or theory from one perspective or field to another. It therefore assists the theorist in fundamentally representing existing relationships with concepts. This implies that the researcher may take a concept such as emotional labour from human science and with the aid of analogy describe how

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emotional labour is interpreted by teachers employed in rural communities. This approach is usually applied in areas in which a theory base does not exist.

- **Synthesis**

Synthesis allows the researcher to combine isolated pieces of information that are, as yet, hypothetically unrelated (Bloom, 1956; cited in Walker & Avant, 2019). Synthesis is fundamental when a researcher is collecting large data which must be interpreted with the use of any explicit theoretical framework. The concepts that surfaced during the analysis of data were developed (identified and defined) by concept synthesis. Concept synthesis is a strategy that adopts diverse procedures of empirical substantiation as a foundation for the development of concepts (Walker & Avant, 2019). Synthesis, put simply, is the process of combining concepts to form a multifaceted whole. Concept synthesis always begins with raw data which was obtained in this study from respondents during focus group discussions/interviews. Large amounts of data were collected in the hope of filtering out significant elements and relationships (Walker & Avant, 2019). This approach was used to generate new concepts and perceptions which enhanced the development of the theoretical model.

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- **Analysis**

Analysis permits the theorists to dichotomise a whole into its component parts so that they can be better understood in Walker & Avant (2019). In analysis, the theorist examines the relationship of each of the parts and to the whole. Analysis allows the researcher to clarify, refine or sharpen concepts, statements or theories. It allows the theorist to examine and re-examine existing knowledge about certain phenomena, as a way of improving the accuracy, currency or relevance of the knowledge.

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In this study, the elements of theory adopted by the researcher for the development of the model were concept synthesis, statement synthesis and theory synthesis. Concept, statement, theory, analysis and derivation were not used in this study as concepts were not analysed but rather emerged from the data inductively. Since there is an existing theory on emotional labour, it was unnecessary for the researcher to utilise the derivation approach.

Table 4.1: Process of Model development (Chinn & Kramer, 2018; Walker & Avant, 2019) adapted from Bruce & Klopper (2010).

	Walker & Avant (2019)	Chinn & Kramer (2018)	Model development processes used in this study
Concept development	Concept analysis, synthesis, derivation	Creating conceptual meaning	Concept synthesis: To develop (identify and describe) concepts from empirical evidence – data collected for the study - integrative review, quantitative and qualitative approaches.
Statement development	Statement analysis, synthesis, derivation	Generating and testing relationships	Statement synthesis – to specify relationships between the developed concepts.
Theory/model development	Theory analysis, synthesis, derivation	Application of theory	Theory synthesis – to express new insights into the phenomenon and present a model.

The process of model development as introduced in Table 4.1 was conducted based on three major steps of theory generation as proposed by Chinn & Kramer (2018) and Walker & Avant, (2019). These steps are concept synthesis, statement synthesis and theory synthesis (presented as a model).

4.4 RESEARCH SETTING

The study setting was Southwest, Nigeria which has six (6) states, namely Ekiti, Lagos, Ondo, Ogun, Osun and Oyo. The estimated population of the zone in 2016 was 38,257,260 (NPC, 2016;

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NBS, 2016). Historically, Osun and Ekiti states were carved out of former Oyo and Ondo states respectively while Lagos and Ogun states share many features ranging from tribe, ethnicity, cultural practices, to industrial layouts. Each of the states in the zone has a federal health institution owned and managed by the Federal Government of Nigeria (FGN). Based on these features, the researcher conducted the study in three states: Osun, Ondo and Ogun. However, the researcher purposively selected three (3) tertiary hospitals: one from each state for the study. This is based on their being referral centres for other hospitals (secondary and primary levels and private hospitals) within and outside the states covering a large catchment area invariably increasing patient load despite scarce resources. The selection of these hospitals also enabled the researcher to obtain information on the experiences of nurses about emotional labour. These hospitals were: Obafemi Awolowo University Teaching Hospital Complex (OAUTHC), Ile-Ife; Federal Medical Centre (FMC), Abeokuta; and Federal Medical Centre (FMC), Owo.

Obafemi Awolowo University Teaching Hospital Complex (OAUTHC), Ile-Ife (with an annex at Ilesha) in Osun state was established on 8th May, 1972 and one of the first-generation teaching hospitals in Nigeria. It has six (6) healthcare units; 806 beds and 756 nurses. Federal Medical Centre (FMC), Abeokuta in Ogun state was established on 21st April, 1983 through conversion of former State Hospital, Idi-Aba, Abeokuta. It is a 250-bedded regional specialist hospital with 333 nurses. Federal Medical Centre (FMC), Owo in Ondo state was established in 1993. It is a 401-bedded hospital staffed with 340 nurses. This study was carried out in three phases in order to achieve the stated objectives.

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4.5 PHASE ONE: INTEGRATIVE LITERATURE REVIEW

This integrative review was conducted out using the methodology of Whittemore & Knafl, (2005) namely:

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- **Problem Identification**: To analyse the concept of emotional labour.
- **Literature Search-Focus**: Emotional labour as it relates to nurses, nursing care and support for nurses in hospitals?
- **Search Strategy**: Computerised databases: CINAHL (Cumulative Index for Nursing and Allied Health Literature), Pubmed or Medline, PsychARTICLES, ScienceDirect, SCOPUS, and Google Scholar. Studies published in English language were considered for inclusion in this review. Studies published from 1983 to 2017 were considered for inclusion in this review as the term 'emotional labour' was coined by Arlie Hochschild in 1983.
- **Data evaluation:** A quality evaluation of the process was carried out. The Critical Appraisal Skills Programme (CASP Checklists, 2014) instruments were used to critically analyse the identified literature. Empirical and theoretical reports of the final integrative review were written on the research. Data were extracted from various sources, including reference to the concept of emotional labour. The data extracted included specific details about the phenomena of interest, populations, study methods and outcomes of significance to the review question and specific objective.
- **Data analysis:** Ordering, coding, categorising, summarising into unified and integrated conclusion about the research problem was carried out. Data reduction, data display, data comparison and the drawing of conclusions and verification were also included in this stage (Whittemore & Knafl, 2005). Qualitative research findings were, where possible, pooled which involved the aggregation or synthesis of findings that generated a set of statements that represent the aggregation, through assembling the findings rated according to their quality, and categorising these findings on the basis of similarity in meaning. These categories were analysed in order to produce a single comprehensive set of synthesised

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findings that can be used as a basis for evidence-based practice. Synthesis of results in the form of a model for support of emotional labour of nurses in tertiary hospitals in Nigeria was developed. The results of the integrative review were discussed in chapter two.

4.6 PHASE TWO: QUANTITATIVE AND QUALITATIVE APPROACH

This phase was conducted in two steps. Step one was quantitative study while step two was qualitative study.

Study setting: This phase took place in the environment of each selected hospital as described above.

Study population: The selected three hospitals have a total of 1429 nurses (registered nurses and midwives) who work in various units of the hospitals such as emergency, maternity, medical, surgical, trauma and operating theatre. These nurses were chosen because they offer direct patient care in three shifts that span twenty-four (24) hours.

4.6.1 Step one: Quantitative approach

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A descriptive survey was conducted to determine deep acting and surface acting strategies employed by nurses working in tertiary hospitals in Nigeria.

Population: 1429 nurses (registered nurses and midwives) who work in various units of the selected hospitals.

Sample: This is "a set of elements taken from a larger population" (Johnson & Christensen, 2014:345). It has the same characteristics of the population from which it is drawn. How a researcher selects participants often determines the extent to which generalisations of research findings can be made. In this study, the researcher selected a sample of 312 nurses that have the

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same characteristics with the general population (1429) according to the proportion of each hospital. If the population of a study is too large, demographically diversified, it might be very challenging to gain admittance to a representative sample (McCombes, 2021)

Sampling technique: A proportional stratified sampling technique was used to select the participants. Stratified sampling technique permits the researcher to draw more specific inferences by ensuring that every subgroup is properly represented in the sample (McCombes, 2021). The steps involved were as follows:

- Categorisation of the population (nurses) into different strata according to the various units in which they work. Nurses who work in units that require close and constant interactions with patients and those that experience traumatic events were put together as members of the same stratum.
- Identification number was given to every member of each stratum.
- Simple random sampling was used to select samples from each stratum based on primary proportion of each hospital.

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Sample size: The calculated sample size of 312 was obtained by applying Yamane (1967) standard sample size calculating formula. However, to ensure that the number needed remains after expected loss of study subjects, a non-response rate of 10% was added to the sample size.

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Table 4.2: Sample size of respondents

Hospital	No of nurses	Percentage	Sample
Obafemi Awolowo University Teaching Hosp Complex, (OAUTHC) Ile Ife	756	756/1429 = 52.9% (53%)	165
Federal Medical Centre, (FMC), Owo	340	340/1429 = 23.8% (24%)	74.88 (75)
Federal Medical Centre, (FMC), Abeokuta	333	333/1429 = 23.3% (23%)	71.76 (72)
Total	1429	100%	312

Data collection

Data was collected using a structured questionnaire which is described below:

Data collection instrument: Questionnaire is a self-reporting research tool that is presented in many formats to obtain information from subjects about a research problem (Nieswiadomy & Souter, 2018). They identified advantages and disadvantages of questionnaire to include the following:

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Advantages

- It is a quick and inexpensive
- It is easy to test for validity and reliability
- Its administration is less time consuming.
- It can be used to obtain data from respondents in a wide geographical area.
- It ensures anonymity of respondents which can lead to honest responses.

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Disadvantages

- Researcher may experience low response rate.
- The respondents must be literates.
- Mailing of questionnaire can be expensive.
- Mails may be undeliverable

An existing, structured self-administered questionnaire namely Emotional Labour Scale (ELS) developed by Brotheridge & Lee (2003), was used to collect data (Appendix 10). The researcher adopted this questionnaire because it has been validated and found reliable to elicit information on emotional labour of service workers including nurses. The ELS has 15 close-ended questions: 5-point Likert scale type relating to surface acting and deep acting strategies of emotional labour with the following anchors: “Never”, “Rarely”, “Sometimes”, “Often”, and “Always”. Scoring of the anchor were: “Never, 1 point“, “Rarely, 2 points”, “Sometimes, 3 points”, “Often, 4 points” and “Always, 5 points”. The questionnaire was in English language which the respondents understand. Completing the questionnaire took about 10 - 15 minutes (Appendix 10).

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Reliability of the instrument: The ELS has been used in diverse studies and has demonstrated good internal reliability. A reliability coefficient value of 0.77 for surface acting and 0.68 for deep acting (Ünler-Öz, 2007) and 0.73 to 0.85 (Akhter & Haque, 2017) were found in their studies. Cronbach’s Alpha value of 0.80 for deep acting and 0.81 for surface acting (Yalcin, 2010) and 0.75 to 0.85 (Akhter & Haque, 2017) were found in their studies indicating high internal consistency among scale items.

Validity of the instrument: Validity refers to whether meaningful and useful inferences can be drawn from scores generated by an instrument. Validity of scores assist in identifying the quality of an instrument for a survey research (Creswell, 2014).

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Table 4.3: Validity

Objective	Domain	Items
To determine deep acting and surface acting strategies employed by nurses working in tertiary hospitals in Nigeria.	Deep acting strategies	Really try to feel the emotions I have to show as part of my job? Try to actually experience the emotions that I must show? Make an effort to actually feel the emotions that I need to display toward others?
	Surface acting strategies	Resist expressing my true feelings? Hide my true feelings about a situation? Pretend to have emotions that I don't really feel?

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Data collection method:

The researcher contacted the Director/Head of Nursing Services (DNS/HNS) of each hospital on phone to solicit for their consent and cooperation. The topic, objectives and significance of the study were explained to each one of them. They expressed great interest in the study stating that it is coming up at an appropriate time for the nurses and hospital management. Each DNS/HNS directed the researcher to the head of Continuing Education Unit (CEU) who also served as the gatekeeper. With the collaboration and guidance of head of Continuing Education Unit, a letter seeking for permission to carry-out the study was written to the Ethical Committee of each hospital. Copy of letter of approval of UWC was attached. The letters were approved by each committee (Appendices 2, 3, & 4). Permission from the Director/Head of Nursing Services at the three tertiary hospitals was obtained to enable the researcher meet with the nurses to introduce the study, to

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request for their participation, to answer any questions they might have in order to commence data collection.

The research team comprised of the researcher, a research expert and two research assistants who were received by the DNS/HNS and some Nurse Managers including the head of CEU of each hospital. They were briefed about the topic, objectives and significance of the study. The head of CEU accompanied the research team round the wards and units to meet and interact with the nurses. All the nurses were given a copy of the information sheet. Voluntary participation, freedom to withdraw at any stage of the study; and keeping all information strictly confidential were explained. Consent forms were given to the nurses who volunteered to participate in the study. Three hundred and twelve (312) copies of questionnaires were administered to the participants by the researcher and two (2) research assistants who were trained for this purpose. FMC Owo (75), FMC Abeokuta (72) and OAUTHC, Ile Ife (165). The signed consent forms were collected immediately while the questionnaires were collected on the second day with the assistance of unit heads and head of CEU. The response rate was 100% at each hospital, while questionnaire items were checked and found to be correctly filled.

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Data Analysis: Data obtained were analysed using Statistical Package for Social Science (SPSS) version 24. Data analysis was guided by the research objective. The demographic section was grouped as follows: the ages of respondents six age groups: 26-30; 31-35; 36-40; 41-45; 46-50, and >51; gender: male and female; qualification was coded into: RN; RM; BNSc; and Masters; marital status: single; married; separated; and divorced; religion: Christianity; Islam and others; tribe: Yoruba; Ibo; Hausa; and others; years of experience was grouped into six: <10; 11-15; 16-20; 21-25; 26-30; and > 31. Descriptive and inferential statistics used were Chi-square, frequency

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distribution, percentages, standard deviation (sd), mean and *p* value calculations. All these were applied in chapter 5 of the study.

Data presentation: The data was summarised using tables and figures. The socio-demographic data of respondents were presented in a summary table. The table displayed descriptive data in numbers, frequency distribution, and percentages. This was done to give a pictorial view of findings of the study. Also, to display plan for analysis of results. Graphs, pie charts and bar charts were also used to display and summarise data for consistency.

4.6.2 Step two: Qualitative Approach

This approach was used to obtain subjective data from the nurses' perspectives about emotional labour in nursing (Creswell, 2014; Kothari, 2004). According to LoBiondo-Wood and Haber (2014), qualitative research focuses on individual's subjective meaning of experiences about a particular phenomenon and that it occurs in a natural setting among small group of people who are willing to give information using a narrative format.

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This section gives a report on research design, the study population, sample size, sampling technique, method of data collection using focus group discussion guide, and field notes. It also includes strategy for concurrent triangulation, steps for the model development, process of ethical permission and principles of research ethics.

Research design: An exploratory, descriptive design was used to explore, examine and explain the participants' experiences of emotional labour.

Study population: All Nurse Managers in the three selected hospitals working in units that require intensive care were considered eligible to participate in the study.

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Sample size: Two focus group discussions were carried at each setting. A sample size of eight (8) Nurse Managers volunteered to participate in each focus group discussion at Federal Medical Centre, Owo (16); eight (8) and eleven (11) participants at Federal Medical Centre, Abeokuta: (19) and, seven (7) and eight (8) participants at Obafemi Awolowo University Teaching Hospital Complex, Ile-Ife (15). This was to generate detailed information for the study. A sample size of 50 nurses for the three hospitals was achieved for a total of six (6) focus group discussions.

Sampling technique: Purposive sampling technique was used to select the participants. This is a type of non-probability sampling technique used to choose sample elements from a population (Nieswiadomy & Dougal, 2018). It encompasses the use of expertise by the researcher to select a sample that is most useful to the purposes of the research. It enables the researcher to obtain detailed knowledge about a specific phenomenon rather than making inferences, or where the population is rather very small and specific (McCombes, 2021). In non-probability sampling, generalization of research findings may be restricted due to some elements of the population not having the chance of being a part of the sample. Nevertheless, the sampling method is widely accepted in nursing research because it is convenient as available subjects are selected through convenience, quota or purposive method and used for the study (Nieswiadomy & Dougal, 2018). An all-inclusive sampling was used. Each potential participant was approached individually by the researcher in their various wards/units. The ward/unit selected were those that requires intensive care: Intensive Care Unit (ICU), maternity wards, operating theatre, surgical wards, Accident and Emergency unit (A&E), general outpatient department (GOPD). The Nurse-Managers who participated selected venue for each focus group discussion. The selected locations within the hospital were serene environment found conducive for the discussions.

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Data Collection Instrument: The development of the data collection tool (Appendix 8) was influenced by the Affective Events Theory for emotional labour (see 3.3). The objectives of the study guided the questions that were asked. A focus group discussion guide was used for data collection. Yin (2003) clarifies that focus group discussions are "guided conversations rather than structured investigations" which means that the researcher follows the line of inquiry and guides the conversation towards the problem under investigation with the use of the focus group guide.

Focus group discussion guide: Focus group discussion is a purposive discussion of a specific topic or related topics which is structured around a set of carefully predetermined questions, usually not more than ten but the discussion remains free-flowing (Schurink et al., 2001). This method enables the researcher to obtain data based on the feelings and opinions of the participants. The researcher used focus group discussion to explore and describe lived experiences of nurses about emotional labour in nursing. This research involved asking open-ended questions to a group of participants usually ranging from 6-10, while also providing feedback (Formplus, 2020). Six (6) – ten (10) people per focus group was recommended but several focus groups can be used in order to get a more objective and macro view of the investigation (Ganapathy, 2015).

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Procedure for focus group discussion

The researcher met with the Director of Nursing Services of each selected hospital to describe the aim and significance of the research, and the research process, and also used him/her as the gatekeeper to gain access to nurses in the hospital. Appointments were then made with the Nurse-Managers that head each ward. The researcher met with the nurses at their various units to describe the aim and significance of the research and the research process. At least one Nurse-Manager from the selected units of the three hospitals participated in the focus group discussions. Information sheet, consent form, focus group confidentiality binding form, and focus group

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discussion guide were given to each participant. The researcher and participants read through the information sheet. They were informed of they can withdraw at any stage of the study. Also, that all information obtained will be kept confidential including their identity. The consent form was filled and signed by nurses who volunteered to participate in the study. Same was collected and kept confidential. When consent was given, time and place of interview were chosen by the participants with due consideration for privacy.

FMC Owo: The focus group discussions were held at Continuing Education Unit and medical ward seminar rooms. Nurse-Managers who participated work in the following units: ICU, surgical ward, medical ward, Paediatric emergency, operating theatre, Accident and Emergency unit, Obstetrics and Gynaecology emergency, Ante-natal clinic, and Continuing Education Unit.

FMC Abeokuta: The focus group discussions were held in the Continuing Education Unit seminar room of the hospital. Nurse-Managers who participated were from: Specialty clinic 1 and 2, Cardiology/Renal ward, Ante-natal ward, Intensive Care Unit, Accident and Emergency unit, surgical ward, and Continuing Education Unit.

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OAUTHC, Ile-Ife and Ilesha annex: The sessions were held in the Intensive Care Unit and Operating Theatre seminar rooms. The Nurse-Managers were from: Trauma ward, Intensive Care Unit, Surgical ward, medical ward, Paediatric emergency, operating theatre, Accident and Emergency unit, Obstetrics emergency, Ante-natal clinic, and Continuing Education Unit.

The researcher acted as the moderator for all the focus group discussions. Two research assistants performed the role of co-moderators. Their duty was to take comprehensive field notes on the group dynamics and body language of the group members. Before beginning the focus group discussions, the researcher welcomed all the participants and introduced the co-moderators and

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herself. Participants were encouraged to introduce themselves as they were not acquainted with everyone in the group. The researcher then informed the group of the purpose of the study, in order to eliminate any assumptions about the nature of the study.

The participants were required to sign a consent form (Appendix 7) and focus group confidentiality binding form (Appendix 8) prior to the commencement of the focus group discussion. The participants were also given identification codes – participant 1, 2, 3 and son on which they announce each time they want to make contributions during the discussion. This is to ensure confidentiality and anonymity. Permission was obtained from the participants for audio recording of the discussions using phones and tablet to ensure comprehensive recording and clarity. Open-ended, follow-up, probing and prompted questions were used to elicit information from the participants during discussions. Initial transcription was done in verbatim followed by data cleansing for grammatical corrections, to remove sounds, and words that connote mannerism. Notes were taken to complement the discussion. The length of the discussions ranged from one hour and one minute to one hour and forty-two minutes.

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All the participants were encouraged to participate fully in the group discussions. The participants were pre-informed that there were no right or wrong answers and guaranteed that all their contributions will be appreciated. Probing comments or questions were used to navigate the deliberations and to explain aspects that were indistinguishable to the researcher (Paton, 2002). Verbal prompts such as 'uh-huh', 'mm' and non-verbal cues such as head-nodding were used to inspire participants to continue speaking. Elaboration probes such as 'and then what happened?' were used to encourage participation (Green & Thorogood, 2009).

Most of the participants communicated their experiences of the healthcare settings in English language (Appendix 11). However, a few participants intermixed the communication of their

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experiences with Yoruba terms to express themselves more eloquently during the discussions. This transpired mainly when they expressed their feelings, for example – "*mo gbe osuba fun yin ni bi yi"* (I duff my cap for you). In South-Western Nigeria, both English and Yoruba languages are widely spoken; some of the nurses' local language/dialect is Yoruba. The other respondents nodded in understanding during this English-Yoruba dialogue, which indicated to the researcher that they understood what these participants were saying. The focus group discussion guide (Appendix 9) was the same for all the study settings.

Data collection continued until data saturation was reached. Data saturation is described as "the point in data collection when no additional issues or insights emerge from data and all conceptual categories have been identified, explored, and exhausted" (Hennink et al., 2017).

At the end of focus group discussions, the researcher briefly summarised the main points of the interview and sought verification from the participants. The researcher conducted a total of six focus group discussions with fifty Nurse-Managers as participants. All the participants were thanked for their participation at the end of each session (Nyamathi & Shuler, 1990). The length of FGD ranged from one hour and one minute to one hour and forty-two minutes.

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Advantages of focus group discussions

Focus group discussions have the ability to usually provide very detailed information required on the phenomenon under study. The group perspective of focus group discussions concentrates on the active encouragement of group interaction between participants (Greeff, 2011; Webb & Kevern, 2001). This method reveals speed and efficacy in the stream of outcomes on the phenomenon. The open-response format of focus groups provided an opportunity for the researcher to obtain data in the participants' own words (Bickman & Rog, 2009). Group synergy has the ability to obtain information that may be lost if the students were interviewed individually.

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The group also assists in uncovering the emotional processes that determine behaviour (Greeff, 2011).

Disadvantages of focus group discussions

The focus group discussions demands interviewers cum moderators that are carefully and properly trained. If care is not taken by the researcher, a few vocal voices can drown out the rest.

Field Notes

Field notes are the qualitative transcribed interpretations of the researcher in the course of field research, during or after their observation of a specific phenomenon of study (Canfield, 2011). Field notes were made after each focus group and individual interview. These included the seating arrangement, the order in which the respondents spoke, non-vocal actions and conspicuous themes (Greeff, 2011). The research methodology, data analysis methods, ethical predicaments and the researcher's frame of mind were also included in terms of note taking (Bogdan & Biklen, 2007). Field notes enhanced the richness of the data obtained through description, interpretation and reflection of all the occurrences during the interview by the creation of a detailed record (Schwandt, 2015). The researcher and the co-moderators discussed the notes after each of the focus group interviews. The transcribed notes assisted in developing categorisations in preliminary concepts synthesis (Walker & Avant, 2019).

Trustworthiness

The quality criteria most often cited by qualitative researchers are those proposed by (Lincoln & Guba, 1985). These are: transferability credibility, dependability, conformability, and authenticity. They enhance good qualitative work that is descriptively sound and explicit and interpretively rich and innovative (Polit & Beck, 2012). Transferability refers to the extent to which findings can be

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transferred to or have applicability in other settings or groups. The researcher provided sufficient descriptive data such that consumers can evaluate the applicability of data to other contexts. Credibility is the confidence in the truth of the data and its interpretation. The researcher established confidence in the truth of the findings by correlating interpretations with raw data and process notes. Dependability is the stability of data over time and conditions. This was ensured through internal consistency during data collection process through audit trails throughout the study. Confirmability is the potential for congruence between two or more people about the data's accuracy, relevance or meaning. This was ensured throughout data collection and analysis process and properly documented. Checking and rechecking of data was done by the research team to avoid biases. Authenticity is the extent to which the researcher fairly and faithfully showed a range of realities – allowing the participants to express their experiences which will enable readers to better understand the lives being portrayed "in the round" with some sense of the mood, feeling, experience, language and context of those lives (Polit & Beck, 2012). The researcher encouraged participants to express themselves through the use of probing questions. Also, each session of the focus group discussion ended when saturation level has been reached.

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4.6.3 Concurrent triangulation strategy

The researcher utilised a concurrent triangulation strategy of mixed methods research whereby data from both quantitative and qualitative approaches were obtained simultaneously. Data mixing or merging were done at the interpretation or discussion stage of the study to identify similarities and differences in the emerging themes.

4.7 PHASE 3: MODEL DEVELOPMENT

The model development process comprises concept development and statement development. McEwen & Wills (2011), note that research–based concepts are the results of conceptual

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development that is grounded in research process. Model development thus involves concept development and statement development. Synthesis was used as the approach to model development. Synthesis assisted the researcher in the interpretation of the data (Walker and Avant, 2019).

Concept development is a rigorous process of bringing clarity to the definition of the concepts used in science. Concepts identified in phase two of the study were named. Concept synthesis was used as an approach to model development in this study. Data that emerged from phase two required theoretical connection and it helped the researcher during interpretation of data because there is explicit theoretical framework that guides this study (Walker and Avant, 2019).

Concept synthesis involves categorising attributes through introduction of a new strategy for logical sequence. It is used when concepts require development based on observation or other forms of evidence. This can be achieved through finding new aspects of old concepts, identifying common attributes of those in use or looking at prime events. New concepts were produced from current research through combination of data obtained from quantitative, qualitative and literary approaches. Data were gathered on a step-by-step basis, repeating the steps until the researcher reached theoretical saturation. Those that were relevant to the use of the concepts were extracted while the concept was defined from its existence in nature (Lincoln & Guba, 1985). Grouping or ordering into concepts and then naming these concepts were done.

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Verification of new concepts was carried out using qualitative, quantitative and/or literary approaches, and nurses in the clinical areas to discover if the concept is empirically supported. Reason being if any of these data sources provided additional information that can clarify or limit the concept. Modification was done where necessary. When the researcher was satisfied, that no new information was being received, the process was stopped and the new concept was considered

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adequate (Walker and Avant, 2019). On identifying the concepts from obtained data, the researcher used definitions to clarify concepts (Chinn & Kramer, 2018). The researcher then described the new concepts in theoretically and also determined if it fits into existing theory in clinical nursing (Walker and Avant, 2019). Information for concept synthesis in this study was derived from results obtained after data triangulation.

Statement development: Theoretical statements (or propositions) are statements about the relationship between two or more concepts and are used to connect concepts to devise a theory (McEwens & Wills, 2011). Statement synthesis was used to specify relationships between two or more concepts that were derived from concept development level. In this study, the researcher used statement synthesis, to develop from observations of phenomena, one or more statements about relationships that exists among these phenomena. This occurred by means of literary methods: scientific literatures that were supported by empirical evidence. The literary methods were also used to make generalisations from specific inferences to more abstract ones (Walker and Avant, 2019). Data gathered was used to establish the experiences of nurses' emotional labour while literature control was used for inductive processes of statement synthesis (Walker and Avant, 2019).

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Development of the Model: An essential ingredient of a situation-producing theory is a survey list. The researcher adopted Dickoff et al., (1968), recommended six vantage points of surveying activity together with the six aspects of activity for developing this model. These were:

Agency - *Who or what performs the activity?*

Patiency or recipiency - *Who or what is the recipient of the activity?*

Framework - *In what context is the activity performed?*

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Terminus - *What is the end point of the activity?*

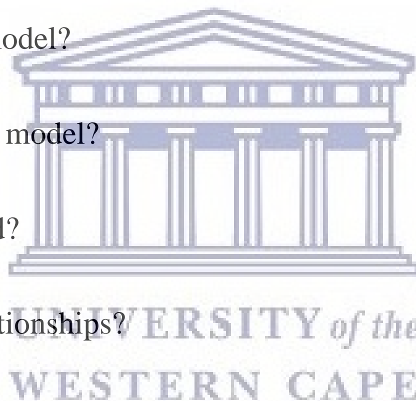
Procedure - *What is the guiding procedure, technique or protocol of the activity?*

Dynamics - *What is the energy source for the activity?*

These steps are aimed at the logical organisation of the concepts and their related concepts. The six concepts were defined by means of dictionary definitions and subject definitions which used their essential qualities to elucidate the concepts in terms of their significance to the study.

Model Description To describe the model that the researcher developed for support of emotional labour of nurses in Southwest, Nigeria the following questions were asked as postulated by Chinn & Kramer (2018):

- What is the purpose of this model?
- What are the concepts of this model?
- How are the concepts defined?
- What is the nature of the relationships?
- What is the structure of the model?
- On what assumptions does the model build?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Guidelines to operationalise the model: According to Chinn, and Kramer (2018), deliberative application and validation involves the use of empirical knowledge to direct practice and practice-oriented methods that will play significant roles in empirical knowledge development. This involves three sub-components and they were used in this study:

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1) Selecting the clinical setting – The clinical setting for deliberative application for this research was identified by the participants in phase 2 of this study.

2) Determining outcomes variables for practice – The outcome variables for this study were to ensure that a model for support of emotional labour meet the emotional needs of nurses in Southwest, Nigeria.

3) The model that was developed was not implemented or tested in this study. Guidelines were developed to operationalise the model.

4) Validate the model by meeting with policy makers and requesting their inputs.

4.8 ETHICS

The researcher obtained ethics permission from the Research Ethics Committee of the University of the Western Cape for this study (Appendix 1: BM/17/8/4). A letter for permission to conduct the study was written to the Chief Medical Director of each selected hospital stating the topic, objectives and purpose of the study (Appendices 2, 3 and 4). A copy of ethics permission obtained from the Research Ethics Committee of the University of the Western Cape was attached to each letter. Official approval was obtained from the Ethical and Research Committees of the selected hospitals (Appendices 2, 3 and 4), while the broad principles on which standards of ethical conduct in research are based were strictly adhered to during the study.

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Permission- Permission was obtained from the management of the three hospitals before the study began. The research team was introduced to the hospital management team members in their various offices individually by heads of continuing education unit. At Federal Medical Centre Owo, the research team met with the Head of Nursing Services (HNS), Head of Clinical Services (HCS) who doubled as Chairman, Management Advisory Committee (C-MAC) and Director of

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Administration (DA); at Federal Medical Centre Abeokuta, Head of Nursing Services, Chief Medical Director (CMD), Chairman, Management Advisory Committee (C-MAC), Head of Clinical Services (HCS) and Director of Administration (DA); while at Obafemi Awolowo University Teaching Hospital Complex, Ile Ife, Director of Nursing Services and Chairman, Management Advisory Committee (C-MAC) respectively to seek permission to conduct the study at the selected sites.

Respect for Persons- The study and target populations were fairly selected. Participants were given full information about the study, the right to decide to participate and withdraw at any stage of the study without reason and also allowed to give informed consent voluntarily without coercion or persuasion was granted.

Principle of Beneficence- This means "doing good" (Bincy, 2013).That is, the actions one take should be done in an effort to promote good. The principle is concerned with avoiding harm to participants, seeking for what benefits they can derive from the study and how the findings of the research will promote their wellbeing. In this non-invasive study, the participants were not exposed to any form of harm (physical or mental). The focus group discussions were held in the seminar rooms of each hospital, which are situated in a quiet environment. The researcher sought to find out the causes of emotional labour among them and to propose supports to reduce its effects.

Principle of Justice-This refers to right treatment and maintenance of privacy of the participants. All data obtained from interview transcripts were kept confidential and used only for the purpose of the study. Only the researcher, supervisor and statistician(s) had access to the data gathered.

Principle of privacy- It refers to protection of individual's right to participate in a research study. The participants volunteered to participate in the study. All the focus group discussions were held

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in selected places in the hospital premises by the participants where the discussions cannot be overheard or observed by other people.

Confidentiality- Saunders, Kitzinger and Kitzinger (2015), refers to confidentiality as all information that is kept hidden from everyone except the primary research team. This means information obtained during the research will not be disclosed without the permission of the participants and identity of research participants will be protected throughout the research processes unless they specifically choose to be identified. The participants were given codes to avoid identification while the researcher ensured that all the information gathered during the research process were kept private.

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Table 4.4: Summary of the methodology process

THEORY-GENERATION LEVEL	RESEARCH METHODOLOGY		REASONING STRATEGY	RESULTS
Step 1: CONCEPT IDENTIFICATION Identification of concepts, classification of concepts, definition of concepts	*Population* Nurses *Sample* Purposive sampling *Method of data collection* Focus group discussions, Emotional Labour Scale Concept identification from validated narratives, observation and literature	Coding according to Tesch's method: Independent coder Themes and categories Literature control Survey list (Dickoff et al 1968) Dictionary and subject definitions of concepts	Inductive analysis Concept analysis	Identification of concepts Concept classification Definition of concepts
Step 2: MODEL DEVELOPMENT Development of relational statements		Concept development Statement development (Walker & Avant, 2019)	Synthesis	Relational statements
Step 3: MODEL DESCRIPTION Overview Purpose		Structure and process description according to Chinn & Kramer (2018) Evaluation of the model by using the strategies of Chinn & Kramer (2018)	Synthesis	Process description of the model
Step 4: GUIDELINES TO OPERATIONALISE THE MODEL		Guidelines to operationalise the model in practice and research	Synthesis Deduction	Guidelines

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Guideline development		Deductions and recommendations		

4.8 SUMMARY

A comprehensive explanation of the research design and methods which were utilised in this study was presented. An explanation of the theory-generating process in the development of the proposed model was also elucidated with a summary of the methodology process (see table 4.3) Research principles and reliability were also discussed.

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CHAPTER FIVE

PRESENTATION OF RESULTS AND DISCUSSION

5.1 INTRODUCTION

The results of data analysis of the quantitative and qualitative data is presented. A structured questionnaire was used to determine deep and surface acting strategies from professional nurses and focus group discussion was used to explore the experiences of emotional labour of nurse managers at the three selected tertiary hospitals in Nigeria for development of a model for support of emotional labour of nurses. For quantitative data, SPSS version 24, descriptive statistical analyses were carried out, and Tesch's method of thematic analysis was used to generate categories and derive themes from the qualitative data.

This section is structured as follows:

Section A: Quantitative results and discussion of the findings

Section B: Qualitative results and the discussion of the finding

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5.2 SECTION A: QUANTITATIVE RESULTS AND DISCUSSION OF THE FINDINGS

The demographic findings of the respondents and the ELS is presented in this section.

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5.2.1 Sample realization

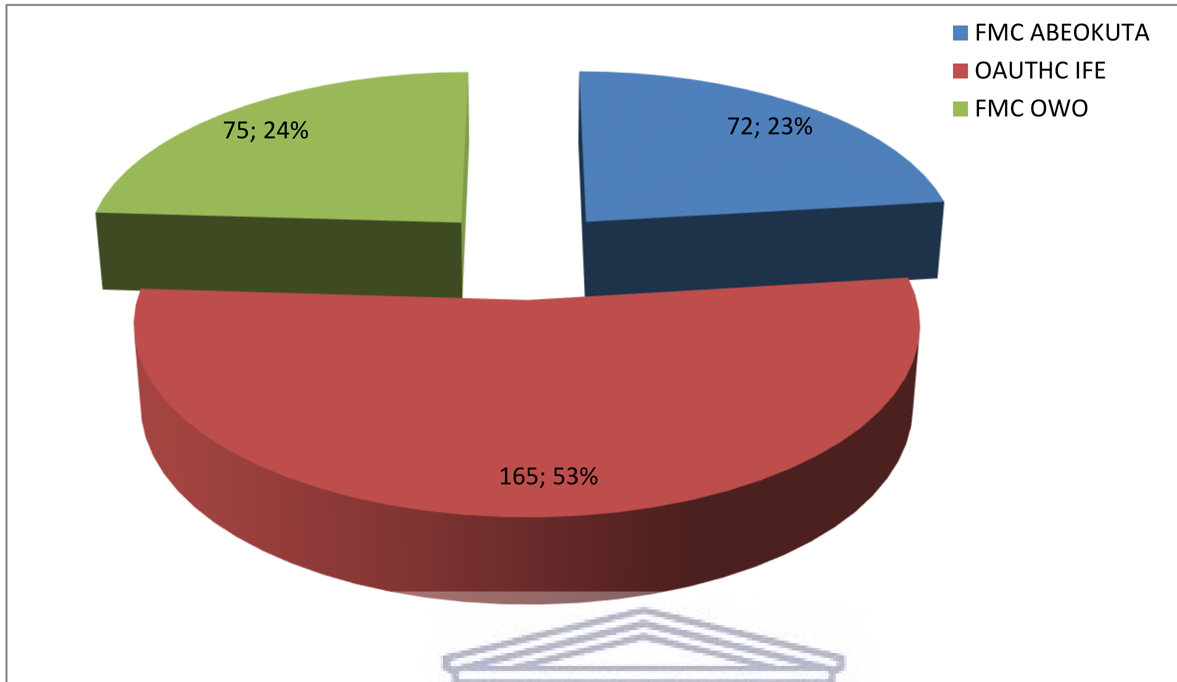

Figure 5.1: Distribution of tertiary hospitals sampled

More than half of the respondents 165 (53.0%) were sampled from Obafemi Awolowo University Teaching Hospital Complex at Ile-Ife, 75 (24.0%) at Federal Medical Centre Owo and 72 (23.0%) at Federal Medical Centre, Abeokuta. The response rates for each of the hospital was 100%. Hence, the total response rate for the three settings was 100%.

More than a third 34% (n=25; n=26) from Abeokuta and Owo respondents were in the age group 36 to 40 years respectively. This was followed by 22% who were less than 30 years of age in Abeokuta and 29% who were between 41 and 45 years in Owo. Majority of the respondents were females (n=70, 97%; n=110, 67%) in both Abeokuta and Ife while about half of the respondents were males (n=38, %) in Owo. More than half of the respondents 61% (n=44) and 64% (n=105) in both Ife and Abeokuta were BNSc holders while 73% (n=55) were registered nurses in Owo.

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Table 5.1 Demographics of respondents

Variables	Tertiary hospitals				
	Abeokuta (%) n=72	Ife (%) n=165	Owo (%) n=75	χ²/F	p-value
Age groups				44.037	< .001
26 – 30	16 (22.2)	23 (13.9)	1 (1.3)		
31 – 35	11 (15.3)	34 (20.6)	10 (13.3)		
36 – 40	25 (34.7)	38 (23.0)	26 (34.7)		
41 – 45	8 (11.1)	39 (23.6)	22 (29.3)		
46 – 50	6 (8.3)	30 (18.2)	16 (21.3)		
≥ 51	6 (8.3)	1 (0.6)	0 (0.0)		
Gender				41.157	< .001
Male	2 (2.8)	55 (33.3)	38 (50.7)		
Female	70 (97.2)	110 (66.7)	37 (49.3)		
Qualification				145.688	< .001
Registered Nurse	7 (9.7)	16 (9.7)	55 (73.3)		
Registered midwife	16 (22.2)	29 (17.6)	19 (25.3)		
Bachelor of Nursing Science	44 (61.1)	105 (63.6)	1 (1.3)		
Masters	5 (7.0)	15 (9.1)	0 (0.0)		
Marital Status				12.594	.050
Single	15 (20.8)	20 (12.1)	7 (9.3)		
Married	54 (75.0)	139 (84.2)	62 (82.7)		
Separated	2 (2.8)	2 (1.2)	2 (2.7)		
Divorced	1 (1.4)	4 (2.4)	4 (5.3)		
Religion				13.155	.001
Christianity	55 (76.4)	114 (69.1)	68 (90.7)		
Islam	17 (23.6)	51 (30.9)	7 (9.3)		
Ethnicity				13.132	.051[y]
Yoruba	66 (91.7)	145 (87.9)	70 (93.4)		
Igbo	5 (6.9)	19 (11.5)	1 (1.3)		
Hausa	0 (0.0)	0 (0.0)	0 (0.0)		
Others	1 (1.4)	1 (0.6)	4 (5.3)		
Years of experience				59.726	< .001
≤ 10	16 (22.2)	8 (4.8)	24 (32.0)		
11 – 15	12 (16.7)	44 (26.7)	34 (45.4)		
16 – 20	11 (15.3)	36 (21.8)	7 (9.3)		
21 – 25	20 (27.8)	34 (20.6)	10 (13.3)		
26 – 30	9 (12.5)	30 (18.2)	0 (0.0)		
> 30	4 (5.6)	13 (7.9)	0 (0.0)		
Average duration of interaction with patients. (Mean ± Median)	34.14 ± 28.94	30.59 ± 22.61	42.87 ± 30	2.358	.096

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There was a statistically significant association that existed between age groups of study respondents as most of them in all three research sites were in age groups 36 to 40. There were more females in Abeokuta and Ife as compared to Owo where a little above half of them were males and this was found to be statistically significant. Many of the respondents in Abeokuta and Ife were Bachelor's degree holders and this was statistically significant with $p < 0.001$. However, there were no significant association based on marital status, tribe and years of experience.

5.2.2 Results of Emotional labour of respondents

Emotional labor was described by examining the duration of interaction with patients and by using the Emotional labour scale. The ELS measured emotional labour through five domains of: Deep acting, Surface acting, Variety, Frequency and Intensity. ELS scores are given on a dimensional level, as the emotional labour constructs cannot be reflected in a total score (Brotheridge & Lee, 2003). Low scores on the dimensions of ELS are evidenced by scores below 2, average scores ranged from between 2 and 4 and high scores are those above 4. The overall mean score for the items on the ELS for the respondents from the three research sites is provided thereafter the findings of each domain with the related items on the ELS was presented and interpreted.

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Duration of interaction

The range of time interacting with patients, ranged from 2 to 300 minutes (average 35.2, sd 45. 9 minutes), and median 25 minutes. This again varied by sites with the average duration of interaction with patients was 30 minutes in both Abeokuta and Ife while it was slightly higher in Owo where it was 42 minutes, though this was not significant.

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Table 5.2: Emotional labour scale responses among respondents (n=312)

	Mean ± S D	Never	Rarely	Sometimes	Often	Always
Deep Acting Domain						
Really try to feel the emotions I have to show as part of my job?	3 , 1 ± 1 . 3	40(12,8%)	41(13,1%)	101(32,4%)	94(30,1%)	36(11,5%)
Try to actually experience the emotions that I must show?	3 , 1 ± 1 . 3	34(10,9%)	56(17,9%)	105(33,7%)	94(30,1%)	23(7,4%)
Make an effort to actually feel the emotions that I need to display toward others?	2 , 9 ± 1 . 3	56(17,9%)	49(15,7%)	106(34%)	69(22,1%)	32(10,3%)
Surface acting domain						
Resist expressing my true feelings?	2 , 5 ± 1 . 2	68(21,8%)	89(28,5%)	98(31,4%)	50(16%)	7(2,2%)
Hide my true feelings about a situation?	2 , 4 ± 1 . 1	71(22,8%)	99(31,7%)	96(30,8%)	33(10,6%)	13(4,2%)
Pretend to have emotions that I don't really feel?	1 , 9 ± 0 . 9	143(45,8%)	76(24,4%)	65(20,8%)	25(8%)	3(1%)
Variety Domain						
Use a wide variety of emotions in dealing with people	3 , 3 ± 1 . 3	34(10,9%)	33(10,6%)	99(31,7%)	90(28,8%)	56(17,9%)
Display many different emotions when interacting with others?	2 , 7 ± 1 . 2	70(22,4%)	76(24,4%)	83(26,6%)	51(16,3%)	32(10,3%)
Express many different emotions when dealing with people?	2 , 7 ± 1 . 2	54(17,3%)	89(28,5%)	104(33,3%)	36(11,5%)	29(9,3%)
Display many different kinds of emotions?	2 , 7 ± 1 . 1	44(14,1%)	99(31,7%)	99(31,7%)	44(14,1%)	26(8,3%)
Frequency Domain						
Display specific emotions required by your job	3 , 7 ± 1 . 3	11(3,5%)	22(7,1%)	107(34,3%)	71(22,8%)	101(32,4%)
Express particular emotions needed for your job	3 , 4 ± 1 . 2	12(3,8%)	37(11,9%)	127(40,7%)	87(27,9%)	49(15,7%)
Adopt certain emotions as part of your job	3 , 3 ± 1 . 2	19(6,1%)	43(13,8%)	137(43,9%)	61(19,6%)	52(16,7%)
Intensity domain						
	Mean	Never	Rarely	Sometimes	Often	Always
Show some strong emotions?	2 , 8 ± 1 . 1	56(17,9%)	38(12,2%)	150(48,1%)	54(17,3%)	14(4,5%)
Express intense emotions	2 , 7 ± 1 . 2	34(10,9%)	111(35,6%)	94(30,1%)	46(14,7%)	27(8,7%)

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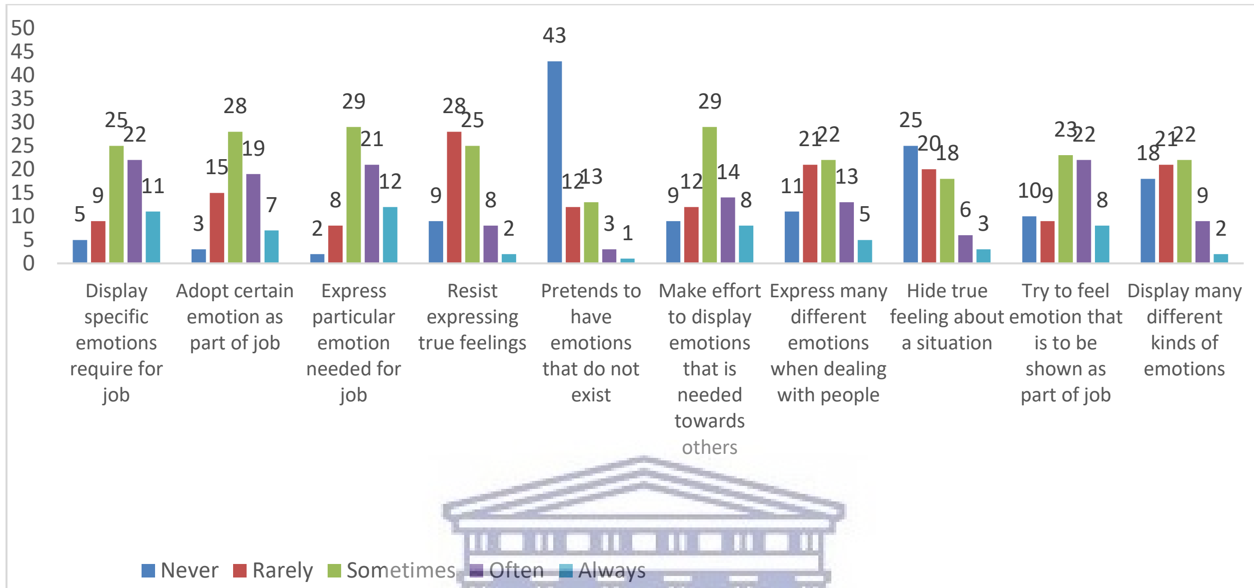

Figure 5.2: Emotional Labour Scale among respondents in Abeokuta

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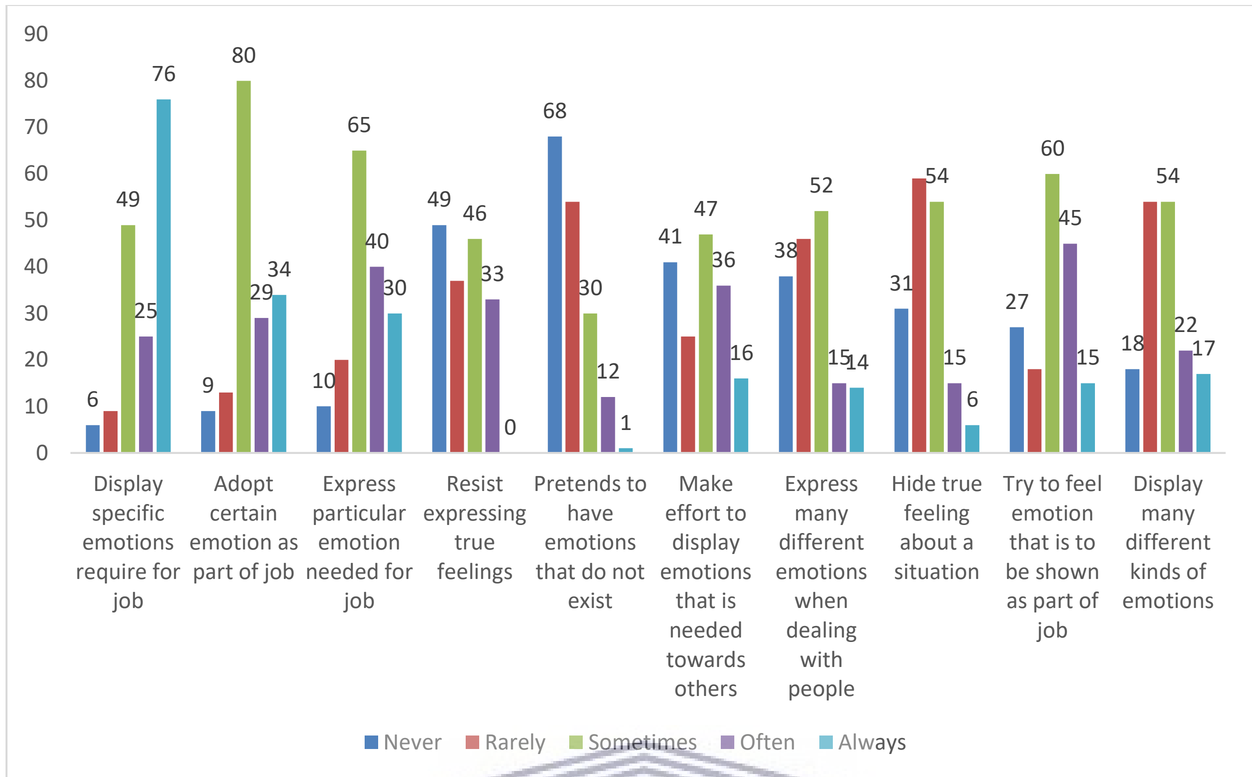

Figure 5.3: Emotional Labour Scale among respondents in Ife

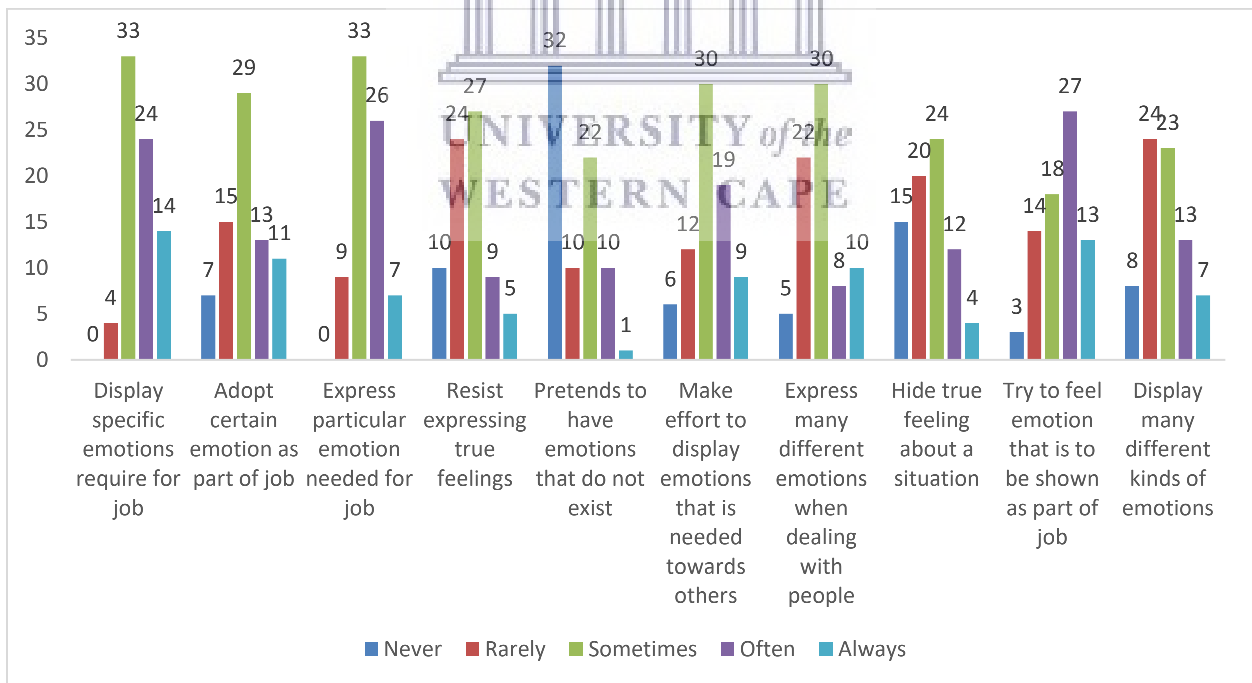

Figure 5.4: Emotional Labour Scale among respondents in Owo

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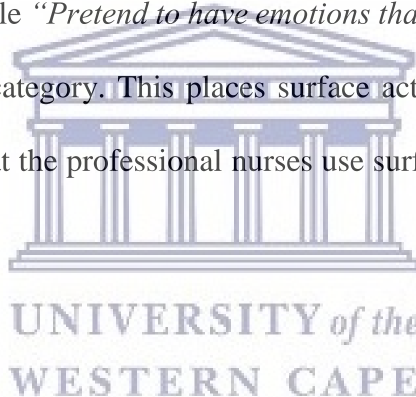
Deep Acting domain

The three items in this domain: *"Really try to feel the emotions I have to show as part of my job"; "Try to actually experience the emotions that I must show";* and *"Make an effort to actually feel the emotions that I need to display toward others"* had 3.1, 3.1, and 2.9 mean scores respectively. This places deep acting dimension in the average category. This reveals that the respondents use deep acting strategy to regulate their emotions at workplace.

Surface Acting domain

There are three items in this domain. Two of the items: *"Resist expressing my true feelings"*; and *"Hide my true feelings about a situation"*; had mean scores of 2.5 and 2.4 respectively placing them in the average category while *"Pretend to have emotions that I don't really feel"* had a mean score of 1.9 falling in the low category. This places surface acting dimension relatively in the average category. It indicates that the professional nurses use surface acting strategy less often at the workplace.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Variety domain

This domain has four items with their mean score range in the average category. Only *"Use a wide variety of emotions in dealing with people"* had a mean score 3.3 which is higher than the rest three items: *"Display many different emotions when interacting with others"*; *"Express many different emotions when dealing with people"*, and *"Display many different kinds of emotions"* with each having a mean score of 2.7. Thus indicating that the respondents use a variety of emotions to regulate emotional labour when interacting with their patients.

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Frequency domain

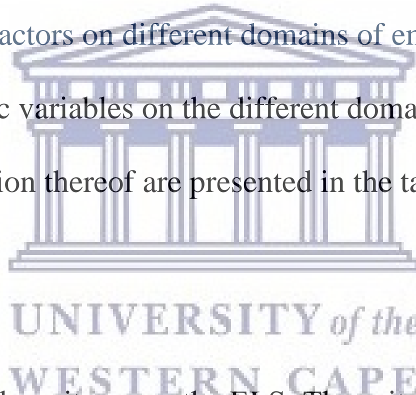
It has three items: *"Display specific emotions required by your job"; "Express particular emotions needed for your job"* and *"Adopt certain emotions as part of your job"* with means scores of 3.7, 3.4 and 3.3 respectively. The scores are in the upper limit of average range. This signifies that the level of respondents' interactions with patients is high.

Intensity domain

There are two items in the domain: *"Show some strong emotions"* and *"Express intense emotions"* with mean scores of 2.8 and 2.7 respectively placing them in the average range. This signifies that the nurses use their emotions moderately.

5.2.3 Influence of demographic factors on different domains of emotional labour

The influence of the demographic variables on the different domains of the emotional labour scale per item and the interpretation thereof are presented in the tables in this section.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Domain: Deep acting

Deep acting was determined by three items on the ELS. These items were: "Really try to feel the emotion I have to show as part of my job?"; "Try to actually experience the emotions that I must show"; and "Make an effort to actually feel the emotions that I need to display towards others". The results of the respondents demographic factors with the three items for deep acting are presented in the tables below and the interpretation of the findings alluded to after each table.

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Table 5.3: Really try to feel the emotion I have to show as part of my job?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ^2	ρ
Age groups							16.228^{y}	.70
26 – 30	3.2 ± 1.1	5 (12.5)	3 (7.5)	14 (35.0)	13 (32.5)	5 (12.5)		
31 – 35	3.1 ± 0.9	3 (5.5)	13 (23.6)	19 (34.5)	17 (30.9)	3 (5.5)		
36 – 40	3.2 ± 1.2	11 (12.4)	11 (12.4)	29 (32.6)	25 (28.1)	13 (14.6)		
41 – 45	3.1 ± 1.2	10 (14.5)	9 (13.0)	19 (27.5)	23 (33.3)	8 (11.6)		
46 – 50	3.0 ± 1.2	9 (17.3)	5 (9.6)	17 (32.7)	15 (28.8)	6 (11.5)		
≥ 51	2.8 ± 1.4	2 (28.6)	0 (0.0)	3 (42.9)	1 (14.3)	1 (14.3)		
Gender							9.794	.04
Male	3.3 ± 1.0	4 (4.2)	16 (16.8)	33 (34.7)	30 (31.6)	12 (12.6)		
Female	3.1 ± 1.2	36 (16.6)	25 (11.5)	68 (31.3)	64 (29.5)	24 (11.1)		
Qualification							19.163^{y}	.08
Registered Nurse	3.5 ± 1.0	2 (2.6)	11 (14.1)	23 (29.5)	29 (37.2)	13 (16.7)		
Registered midwife	3.1 ± 1.2	9 (14.1)	10 (15.6)	18 (28.1)	19 (29.7)	8 (12.5)		
Bachelor of Nursing Science	2.9 ± 1.1	25 (16.70	20 913.3)	54 (36.0)	39 (26.00	12 (8.0)		
Masters	3.2 ± 1.3	4 (20.0)	0 (0.0)	6 (30.0)	7 (35.0)	3 (15.0)		
Marital Status							15.099	.23
Single	3.1 ± 1.2	7 (16.7)	3 (7.1)	15 (35.7)	12 (28.6)	5 (11.9)		
Married	3.1 ± 1.1	30 (11.8)	35 (13.7)	83 (32.5)	79 (31.0)	28 (11.0)		
Separated	2.5 ± 0.6	0 (0.0)	2 (50.0)	2 (50.0)	0 (0.0)	0 (0.0)		
Divorced	3.2 ± 1.6	3 (27.3)	1 (9.1)	1 (9.1)	3 (27.3)	3 (27.3)		
Religion							5.064	.28
Christianity	3.1 ± 1.2	35 (14.8)	28 (11.8)	74 (31.2)	71 (30.0)	29 (12.2)		
Islam	3.2 ± 1.0	5 (6.7)	13 (17.3)	27 (36.0)	23 (30.7)	7 (9.3)		
Ethnicity							6.510^{y}	.59
Yoruba	3.1 ± 1.1	37 (13.2)	37 (13.2)	89 (31.7)	87 (31.0)	31 (11.0)		
Ibo	3.1 ± 1.0	2 (8.0)	4 (16.0)	11 (44.0)	5 (20.0)	3 (12.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	3.7 ± 1.5	1 (16.7)	0 (0.0)	1 (16.7)	2 (33.3)	2 (33.3)		
Years of experience							31.658^{y}	.35
≤ 10	3.0 ± 1.0	3 (12.5)	3 (12.5)	9 (37.5)	9 (37.5)	0 (0.0)		
11 – 15	3.3 ± 1.1	6 (7.5)	11 (13.8)	27 (33.8)	25 (31.3)	11 (13.8)		
16 – 20	3.2 ± 1.1	8 (9.9)	13 (16.0)	22 (27.2)	29 (35.8)	9 (11.1)		
21 – 25	3.0 ± 1.1	9 (14.8)	8 (13.1)	25 (41.0)	12 (19.7)	7 (11.5)		
26 – 30	3.1 ± 1.3	9 (18.4)	5 (10.2)	12 (24.5)	17 (34.7)	6 (12.2)		
> 30	2.8 ± 1.4	5 (29.4)	1 (5.9)	6 (35.3)	2 (11.8)	3 (17.6)		

^{y}=Yates corrected value

There were no significant associations between the sample demographics and the statement: *Really try to feel the emotion I have to show as part of my job,* except for Gender with male respondents

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having significantly higher deep acting emotional labour scores than female respondents (3.3 sd=1.0 vs 3.1 sd-1.2, X^2=9.79, p=.044).

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Table 5.4: Try to actually experience the emotions that I must show?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ^2	P
Age groups							19.124[y]	.51
26 – 30	2.7 ± 1.1	7 (17.5)	9 (22.5)	11 (27.5)	13 (32.5)	0 (0.0)		
31 – 35	2.9 ± 1.0	7 (12.7)	10 (18.2)	22 (40.0)	14 (25.5)	2 (3.6)		
36 – 40	3.2 ± 1.1	9 (10.1)	14 (18.2)	22 (40.0)	14 (25.5)	2 (3.6)		
41 – 45	3.0 ± 1.0	6 (8.7)	13 (18.8)	27 (39.1)	18 (26.1)	5 (7.2)		
46 – 50	3.2 ± 1.0	3 (5.8)	10 (19.2)	17 (32.7)	17 (32.7)	5 (9.6)		
≥ 51	2.8 ± 1.3	2 (28.6)	0 (0.0)	2 (28.6)	3 (42.9)	0 (0.0)		
Gender							5.654	.22
Male	3.2 ± 0.9	5 (5.3)	16 (16.8)	35 (36.8)	33 (34.7)	6 (6.3)		
Female	2.9 ± 1.1	29 (13.4)	40 (18.4)	70 (32.3)	61 (28.1)	17 (7.8)		
Qualification							24.700[y]	.01
Registered Nurse	3.4 ± 0.9	1 (1.3)	16 (20.5)	22 (28.2)	29 (37.2)	10 (12.8)		
Registered midwife	3.1 ± 1.1	7 (10.9)	9 (14.1)	22 (34.4)	23 (35.9)	3 (4.7)		
Bachelor of Nursing Science	2.7 ± 1.1	25 (16.7)	31 (20.7)	54 (36.0)	33 (22.0)	7 (4.7)		
Masters	3.6 ± 0.9	1 (5.0)	0 (0.0)	7 (35.0)	9 (45.0)	3 (15.0)		
Marital Status							10.067	.61
Single	2.8 ± 1.1	8 (19.0)	5 (11.9)	15 (35.7)	12 (28.6)	2 (4.8)		
Married	3.1 ± 1.1	25 (9.8)	47 (18.4)	87 (34.1)	77 (30.2)	19 (7.5)		
Separated	2.7 ± 0.9	0 (0.0)	2 (50.0)	1 (25.0)	1 (25.0)	0 (0.0)		
Divorced	3.4 ± 1.3	1 (9.1)	2 (18.2)	2 (18.2)	4 (36.4)	2 (18.2)		
Religion							2.984	.56
Christianity	3.1 ± 1.1	26 (11.0)	40 (16.9)	77 (32.5)	74 (31.2)	20 (8.4)		
Islam	2.9 ± 1.0	8 (10.7)	16 (21.3)	28 (37.3)	20 (26.7)	3 (4.0)		
Ethnicity							19.727[y]	.01
Yoruba	3.0 ± 1.1	31 (11.0)	52 (18.5)	92 (32.7)	87 (31.0)	19 (6.8)		
Ibo	3.0 ± 0.9	2 (8.0)	4 (16.0)	12 (48.0)	6 (24.0)	1 (4.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	3.8 ± 1.6	1 (16.7)	0 (0.0)	1 (16.7)	1 (16.7)	3 (49.9)		
Years of experience							19.332[y]	.50
≤ 10	2.4 ± 1.1	6 (25.0)	6 (25.0)	7 (29.2)	5 (20.8)	0 (0.0)		
11 – 15	3.1 ± 1.1	9 (11.3)	13 (16.3)	24 (30.0)	31 (38.8)	3 (3.8)		
16 – 20	3.2 ± 1.1	7 (8.6)	12 (14.8)	28 (34.6)	26 (32.1)	8 (9.9)		
21 – 25	3.0 ± 1.1	5 (8.2)	13 (21.3)	24 (39.3)	14 (23.00	5 (8.2)		
26 – 30	3.0 ± 1.2	6 (12.2)	10 (20.4)	15 (30.6)	12 924.5)	6 (12.2)		
> 30	3.2 ± 0.9	1 (5.9)	2 (11.8)	7 (41.2)	6 (35.3)	1 (5.9)		

[y]=Yates corrected value

There were significant associations between the sample demographics and the statement: *"Try to actually experience the emotions that I must show"* and qualifications and tribe. Nurses with

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Master's degree have higher deep acting emotional labour mean score 3.6, sd = 0.9, than BNSc degree holders with mean score 2.7 sd = 1.1, p= .016. Also, other tribes have higher deep acting emotional labour mean score 3.8, sd = 1.6 than Yoruba and Ibo with mean scores 3.0 each and sd = 1.1 and 0.9 respectively, while the p-value was .011. In both variables the p- values were less than .05.

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Table 5.5: Make an effort to actually feel the emotions that I need to display toward others?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ^2	P
Age groups							20.367^{y}	.43
26 – 30	3.1 ± 1.2	7 (17.5)	3 (7.5)	16 (40.0)	9 (22.5)	5 (12.5)		
31 – 35	2.6 ± 1.1	10 (18.2)	15 (27.3)	17 (30.9)	11 (20.0)	2 (3.6)		
36 – 40	2.9 ± 1.3	17 (19.1)	13 (14.6)	26 (29.2)	21 (23.6)	12 (13.5)		
41 – 45	2.9 ± 1.2	12 (17.4)	11 (15.9)	22 (31.9)	15 (21.7)	9 (13.0)		
46 – 50	2.9 ± 1.1	7 (13.5)	7 (13.5)	22 (42.3)	13 (25.0)	3 (5.8)		
≥ 51	2.4 ± 1.5	3 (42.9)	0 (0.0)	3 (42.9)	0 (0.0)	1 (14.3)		
Gender							2.669	.61
Male	1.0 1.2	17 (17.9)	13 (13.7)	29 (30.5)	23 (24.2)	13 (13.7)		
Female	2.8 ± 1.2	39 (18.0)	36 (16.6)	77 (35.5)	46 (21.2)	19 (8.8)		
Qualification							12.611^{y}	.398
Registered Nurse	3.2 ± 1.1	8 (10.3)	15 (19.2)	28 (35.9)	24 (30.8)	3 (3.8)		
Registered midwife	2.8 ± 1.1	12 (18.8)	10 (15.6)	27 (42.2)	11 (17.2)	4 (6.3)		
Bachelor of Nursing Science	2.8 ± 1.3	18 (12.0)	33 (22.0)	52 (34.7)	33 (22.0)	14 (9.3)		
Masters	2.0 1.4	5 (25.0)	2 (10.0)	6 (30.0)	6 (30.0)	1 (5.0)		
Marital Status							20.502^{y}	.058
Single	3.1 ± 1.1	6 (14.3)	1 (2.4)	21 (50.0)	11 (26.2)	3 (7.1)		
Married	2.9 ± 1.2	48 (18.8)	45 (17.6)	77 (30.2)	57 (22.4)	28 (11.0)		
Separated	1.7 ± 0.9	2 (50.0)	1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)		
Divorced	3.1 ± 0.8	0 (0.0)	2 (18.2)	7 (63.6)	1 (9.1)	1 (9.1)		
Religion							4/629	.326
Christianity	2.9 ± 1.2	41 (17.3)	34 (14.3)	78 (32.9)	57 (24.1)	27 (11.4)		
Islam	2.7 ± 1.2	15 (20.0)	15 (20.0)	28 (37.3)	12 (16.0)	5 (6.7)		
Ethnicity							3.519^{y}	.898
Yoruba	2.9 ± 1.2	50 (17.8)	44 (15.7)	95 (33.8)	62 (22.1)	30 (10.7)		
Ibo	2.8 ± 1..2	5 (20.0)	4 (16.0)	8 (32.0)	7 (28.0)	1 (4.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	2.8 ± 1.3	1 (16.7)	1 (16.7)	3 (49.9)	0 (0.0)	1 (16.7)		
Years of experience							22.836^{y}	.297
≤ 10	2.6 ± 1.1	5 (20.8)	4 (16.7)	12 (50.0)	2 (8.3)	1 (4.2)		
11 – 15	3.0 1.2	14 (17.5)	8 (10.0)	29 (36.3)	20 (25.0)	9 (11.3)		
16 – 20	2.9 ± 1.2	13 (16.0)	18 (22.2)	21 (25.9)	20 (24.7)	9 (11.1)		
21 – 25	2.8 ± 1.1	12 (19.7)	10 (16.4)	22 (36.1)	13 (21.3)	4 (6.6)		
26 – 30	3.0 ± 1.3	8 (16.3)	8 (16.3)	17 (34.7)	7 (14.3)	9 (18.4)		
> 30	2.9 ±1.2	4 (23.5)	1 (5.9)	5 (29.4)	7 (41.2)	0 (0.0)		

^{y}=Yates corrected value

There were no significant associations between the sample demographics and the statement: *"Make an effort to actually feel the emotions that I need to display toward others"*.

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Domain: Surface acting

Surface acting according to the ELS was determined by three items. These are: “Resist expressing my true feelings”; “Hide my true feelings about a situation”; and “Pretend to have emotions that I don’t really have”. The three items results for the respondents from the three settings are depicted in the tables that follow.

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Table 5.6: Resist expressing my true feelings?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ²	ρ
Age groups							20.781^{y}	.41[illegible]
26 – 30	2.4 ± 1.1	5 (12.5)	16 (40.0)	12 (30.0)	17 (17.5)	0 (0.0)		
31 – 35	2.7 ± 1.2	13 (23.60	16 (29.1)	16 (29.1)	10 (18.2)	0 (0.0)		
36 – 40	2.3 ± 1.2	21 (23.6)	24 (27.0)	30 (33.7)	10 (11.2)	4 (4.5)		
41 – 45	2.4 ± 1.2	12 (17.4)	20 (29.0)	23 (33.3)	14 (20.3)	0 (0.0)		
46 – 50	2.4 ± 0.9	15 (28.8)	12 (23.1)	15 (28.8)	9 (17.3)	1 (1.9)		
≥ 51	2.7 ± 1.2	2 (28.6)	1 (14.3)	2 (28.6)	0 (0.0)	2 (28.6)		
Gender							9.498	.05[illegible]
Male	2.6 ± 1.1	16 (16.8)	21 (22.1)	33 (34.7)	21 (22.1)	4 (4.2)		
Female	2.3 ± 1.2	52 (24.0)	68 (31.3)	65 (30.0)	29 (13.4)	3 (1.4)		
Qualification							13.628^{y}	.32[illegible]
Registered Nurse	2.5 ± 1.1	11 (14.1)	23 (29.5)	31 (39.7)	8 (10.3)	5 (6.4)		
Registered midwife	2.5 ± 1.2	17 (26.6)	19 (29.7)	18 (28.1)	9 (14.1)	1 (1.6)		
Bachelor of Nursing Science	2.3 ± 1.1	34 (22.7)	43 (28.7)	44 (29.3)	29 (19.3)	0 (0.0)		
Masters	2.5 ± 1.3	6 (30.0)	4 (20.0)	5 (25.0)	4 (20.0)	1 (5.0)		
Marital Status							8.643^{y}	.73[illegible]
Single	2.5 ± 1.1	5 (11.9)	15 (35.7)	11 (26.2)	10 (23.8)	1 (2.4)		
Married	2.4 ± 1.1	57 (22.4)	72 (28.2)	82 (32.2)	38 (14.9)	6 (2.4)		
Separated	2.3 ± 0.9	2 (50.0)	1 (25.0)	0 (0.0)	1 (25.0)	0 (0.0)		
Divorced	2.5 ± 1.5	4 (36.4)	1 (9.1)	5 (45.5)	1 (9.1)	0 (0.0)		
Religion							2.173	.70[illegible]
Christianity	2.3 ± 1.1	52 (21.9)	71 (30.0)	73 (30.8)	35 (14.8)	6 (2.5)		
Islam	2.6 ± 1.2	16 (21.3)	18 (24.0)	25 (33.3)	15 (20.0)	1 (1.3)		
Ethnicity							2.934^{y}	.93[illegible]
Yoruba	2.4 ± 1.2	60 (21.4)	84 (29.9)	87 (31.0)	43 (15.3)	7 (2.5)		
Ibo	2.5 ± 1.1	7 (28.0)	4 (16.0)	9 (36.0)	5 (20.0)	0 (0.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	2.5 ± 0.8	1 (16.7)	1 (16.7)	2 (33.3)	2 (33.3)	0 (0.0)		
Years of experience							20.411^{y}	.43[illegible]
≤ 10	2.4 ± 0.8	3 (12.5)	12 (50.0)	6 (25.0)	3 (12.5)	0 (0.0)		
11 – 15	2.5 ± 1.2	16 (20.0)	26 (32.5)	23 (28.8)	13 (16.3)	2 (2.5)		
16 – 20	2.4 ± 1.2	21 (25.9)	21 (25.9)	26 (32.1)	10 (12.3)	3 (3.7)		
21 – 25	2.3 ± 1.2	8 (13.1)	16 (26.2)	26 (42.6)	11 (18.0)	0 (0.0)		
26 – 30	2.3 ± 1.0	15 (30.6)	13 (26.5)	10 (20.4)	11 (22.4)	0 (0.0)		
> 30	2.4 ± 1.0	5 (29.4)	1 (5.9)	7 (41.2)	2 (11.8)	2 (11.8)		

^{y}=*Yates corrected value*

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There were significant associations between the sample demographics and the statement: *"Resist expressing my true feelings"* and gender with males having higher surface acting emotional labour scores than females (2.6, sd = 1.1 vs 2.3 sd = 1.2, X^2=9.498, p-value=.05).

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Table 5.7: Hide my true feelings about a situation?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ^2	ρ
Age groups							17.502^y	.62
26 – 30	2.3 ± 0.9	8 (20.0)	18 (45.0)	10 (25.0)	3 (7.5)	1 (2.5)		
31 – 35	2.5 ± 1.0	9 (16.4)	17 (30.9)	22 (40.0)	4 (7.3)	3 (5.5)		
36 – 40	2.6 ± 1.1	21 (23.6)	21 (23.6)	28 (31.5)	14 (15.7)	5 (5.6)		
41 – 45	2.2 ± 1.0	18 (26.1)	25 (36.2)	18 (26.1)	6 (8.7)	2 (2.9)		
46 – 50	2.3 ± 1.0	13 (25.0)	17 (32.7)	15 (28.8)	6 (11.5)	1 (1.9)		
≥ 51	2.5 ± 1.4	2 (28.6)	1 (14.3)	3 (42.8)	0 (0.0)	1 (14.3)		
Gender							10.041	.04
Male	2.6 ± 1.0	12 (12.6)	35 (36.8)	29 (30.5)	13 (13.7)	6 (6.3)		
Female	2.3 ± 1.0	59 (27.2)	64 (29.5)	67 (30.9)	20 (9.2)	7 (3.2)		
Qualification							11.176^y	.51
Registered Nurse	2.6 ± 1.0	14 (17.9)	21 (26.9)	28 (35.9)	12 (15.4)	3 (3.8)		
Registered midwife	2.3 ± 1.0	17 (26.6)	17 (26.6)	25 (39.1)	3 (4.7)	2 (3.1)		
Bachelor of Nursing Science	2.4 ± 1.1	35 (23.3)	54 (36.0)	38 (25.3)	16 (10.7)	7 (4.7)		
Masters	2.3 ± 1.1	5 (25.0)	7 (35.0)	5 (25.0)	2 (10.0)	1 (5.0)		
Marital Status							9.578^y	.65
Single	2.5 ± 1.1	7 (16.7)	14 (33.3)	15 (35.7)	3 (7.1)	3 (7.1)		
Married	2.4 ± 1.1	61 (23.9)	79 (31.0)	78 (30.6)	27 (10.6)	10 (3.9)		
Separated	2.2 ± 0.9	1 (25.0)	1 (25.0)	2 (50.0)	0 (0.0)	0 (0.0)		
Divorced	2.4 ± 1.1	2 (18.2)	5 (45.5)	1 (9.1)	3 (27.3)	0 (0.0)		
Religion							4.856	.30
Christianity	2.4 ± 1.0	56 (23.6)	73 (30.8)	71 (30.0)	29 (12.2)	8 (3.4)		
Islam	2.4 ± 1.0	15 (20.0)	26 (34.7)	25 (33.3)	4 (5.3)	5 (6.7)		
Ethnicity							8.278^y	.40
Yoruba	2.4 ± 1.1	64 (22.8)	91 (32.4)	84 (29.9)	31 (11.0)	11 (3.9)		
Ibo	2.4 ± 1.1	6 (24.0)	7 (28.0)	10 (40.0)	0 (0.0)	2 (8.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	2.8 ± 1.1	1 (16.7)	1 (16.7)	2 (33.3)	2 (33.3)	0 (0.0)		
Years of experience							14.835^y	.78
≤ 10	2.1 ± 0.9	8 (33.3)	8 (33.3)	6 (25.0)	2 (8.3)	0 (0.0)		
11 – 15	2.5 ± 1.1	14 (17.5)	25 (31.3)	29 (36.3)	7 (8.8)	5 (6.3)		
16 – 20	2.4 ± 1.1	20 (24.7)	22 (27.2)	23 (28.4)	12 (14.8)	4 (4.9)		
21 – 25	2.2 ± 0.9	14 (23.0)	24 (39.3)	19 (31.1)	3 (4.9)	1 (1.6)		
26 – 30	2.4 ± 1.1	11 (22.4)	17 (34.7)	12 (24.5)	7 (14.3)	2 (4.1)		
> 30	2.6 ± 1.1	4 (23.5)	3 (17.6)	7 (41.2)	2 (11.8)	1 (5.9)		

y=Yates corrected value

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There were significant associations between the sample demographics and the statement: *"Hide my true feelings about a situation"* and gender with males having higher surface acting emotional labour scores than females at 2.6, sd = 1.0 vs 2.3, sd = 1.0, X^2=10.041, p-value =.040.

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Table 5.8: Pretend to have emotions that I don't really have?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ^2	P
Age groups							23.101^y	.28
26 – 30	2.0 ± 0.9	13 (32.5)	17 (42.5)	7 (17.5)	2 (5.0)	1 (2.5)		
31 – 35	1.8 ± 0.9	28 (50.9)	12 (21.8)	11 (20.0)	4 (7.3)	0 (0.0)		
36 – 40	1.7 ± 0.9	49 (55.1)	18 (20.2)	16 (18.0)	6 (6.7)	0 (0.0)		
41 – 45	2.2 ± 1.1	26 (37.7)	17 (24.6)	16 (23.2)	8 (11.6)	2 (2.9)		
46 – 50	2.0 ± 1.0	22 (42.3)	12 (23.1)	13 (25.0)	5 (9.6)	0 (0.0)		
≥ 51	1.6 ± 0.9	5 (71.4)	0 (0.0)	2 (28.6)	0 (0.0)	0 (0.0)		
Gender							17.753	.00
Male	2.3 ± 1.1	28 (29.5)	26 (27.4)	27 (28.4)	13 (13.7)	1 (1.1)		
Female	1.7 ± 0.9	15(53.0)	50 (23.0)	38 (17.5)	12 (5.5)	2 (0.9)		
Qualification							13.659^y	.32
Registered Nurse	2.1 ± 1.1	36 (46.2)	11 (14.1)	19 (24.4)	11 (14.1)	1 (1.3)		
Registered midwife	1.8 ± 0.9	29 (45.3)	18 (28.1)	13 (20.3)	4 (6.3)	0 (0.0)		
Bachelor of Nursing Science	1.8 ± 0.9	70 (46.7)	42 (28.0)	29 (19.3)	7 (4.7)	2 (1.3)		
Masters	2.1 ± 1.1	8 (40.0)	5 (25.0)	4 (20.0)	3 (15.0)	0 (0.0)		
Marital Status							13.262^y	.35
Single	2.3 ± 1.1	13 (31.0)	13 (31.0)	9 (21.4)	6 (14.3)	1 (2.4)		
Married	1.9 ± 1.0	121(47.5)	61 (23.9)	52 (20.4)	19 (7.5)	2 (0.8)		
Separated	4.0 0.0	4 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Divorced	1.9 ± 0.9	5 (45.5)	2 (18.2)	4 (36.4)	0 (0.0)	0 (0.0)		
Religion							1.551	.81
Christianity	1.9 ± 1.0	106(44.7)	57 (24.1)	51 (21.5)	21 (8.9)	2 (0.8)		
Islam	1.8 ± 1.0	37 (49.3)	19 (25.3)	14 (18.7)	4 (5.3)	1 (1.3)		
Ethnicity							5.478^y	.70
Yoruba	1.9 ± 1.0	126(44.8)	69 (24.6)	62 (22.1)	21 (7.5)	3 (1.1)		
Ibo	1.7 ± `1.0	15 (60.0)	5 (20.0)	2 (8.0)	3 (12.0)	0 (0.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	2.2 ± 1.2	2 (33.3)	2 (33.3)	1 (16.7)	1 (16.7)	0 (0.0)		
Years of experience							21.833^y	.35
≤ 10	1.9 ± 1.0	10 (41.7)	8 (33.3)	4 (16.7)	1 (4.2)	1 (4.2)		
11 – 15	1.9 ± 1.0	37 (46.3)	19 (23.8)	14 (17.5)	10 (12.5)	0 (0.0)		
16 – 20	1.9 ± 1.1	39 (48.1)	16 (19.8)	18 (22.2)	6 (7.4)	2 (2.5)		
21 – 25	1.9 ± 0.9	27 (44.3)	14 (23.0)	17 (27.9)	3 (4.9)	0 (0.0)		
26 – 30	1.7 ± 0.9	25 (51.0)	15 (30.6)	5 (10.2)	4 (8.2)	0 (0.0)		
> 30	2.2 ± 0.9	5 (29.4)	4 (23.5)	7 (41.2)	1 (5.9)	0 (0.0)		

^{y}*=Yates corrected value*

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There were significant associations between the sample demographics and the statement: *"Pretend to have emotions that I don't really have"* and gender with males having higher surface acting emotional labour scores than females (2.3, sd = 1.1 vs 1.7 sd = 0.9, X^2=17.753, p-value of .001.

Domain: Variety

The domain, variety of emotions used was determined by four items on the ELS. These are: "Use a wide variety of emotions in dealing with people"; "Display many different emotions when interacting with others"; "Express many different emotions when dealing with people"; and "Display many different kinds of emotions". The results of each item is displayed below in a table form with the interpretation of the results.

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Table 5.9: Use a wide variety of emotions in dealing with people?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ²	P
Age groups							8.475[y]	.988
26 – 30	3.3 ± 1.3	5 (12.5)	5 (12.5)	12 (30.0)	9 (22.5)	9 (22.5)		
31 – 35	3.3 ± 1.1	4 (7.3)	7 (12.7)	23 (41.8)	13 (23.6)	8 (14.5)		
36 – 40	3.4 ± 1.2	9 (10.1)	8 (9.0)	29 (32.6)	25 (28.1)	18 (20.2)		
41 – 45	3.4 ± 1.1	9 (13.0)	4 (5.8)	18 (26.1)	26 (37.7)	12 (17.4)		
46 – 50	3.2 ± 1.1	6 (11.5)	7 (13.5)	16 (30.8)	16 (30.8)	7 (13.5)		
≥ 51	3.1 ± 1.6	1 (14.3)	2 (28.6)	1 (14.3)	1 (14.3)	2 (28.6)		
Gender							16.655	.002
Male	3.6 ± 0.9	4 (4.2)	3 (3.2)	38 (40.0)	31 (32.6)	19 (20.0)		
Female	3.2 ± 1.3	30 (13.8)	30 (13.8)	61 (28.1)	59 (27.2)	37 (17.1)		
Qualification							10.239[y]	.595
Registered Nurse	3.4 ± 1.1	5 (6.4)	8 (10.3)	32 (41.0)	19 (24.4)	14 (17.9)		
Registered midwife	3.2 ± 1.2	8 (12.5)	10 (15.6)	18 (28.1)	19 (29.7)	9 (14.1)		
Bachelor of Nursing Science	3.4 ± 1.2	19 (12.7)	11 (7.3)	44 (29.3)	44 (29.3)	32 (21.3)		
Masters	3.1 ± 1.1	2 (10.0)	4 (20.0)	5 (25.0)	8 (40.0)	1 (5.0)		
Marital Status							8.182[y]	.771
Single	3.3 ± 1.2	4 (9.5)	6 (14.3)	14 (33.3)	9 (21.4)	9 (21.4)		
Married	3.4 ± 1.1	25 (9.8)	26 (10.2)	80 (31.4)	79 (31.0)	45 (17.6)		
Separated	2.5 ± 1.0	1 (25.0)	0 (0.0)	3 (75.0)	0 (0.0)	0 (0.0)		
Divorced	2.7 ± 1.6	4 (36.4)	1 (9.1)	2 (18.2)	2 (18.2)	2 (18.2)		
Religion							5.007	.287
Christianity	3.3 ± 1.2	29 (12.2)	26 (11.0)	68 (28.7)	70 (29.5)	44 (18.6)		
Islam	3.4 ± 1..1	5 (6.7)	7 (9.3)	31 (41.3)	20 (26.7)	12 (16.0)		
Ethnicity							2.354[y]	.968
Yoruba	3.3 ± 1.2	31 (11.0)	31 (11.0)	86 (30.6)	79 (28.1)	54 (19.2)		
Ibo	3.2 ± 1.0	2 (8.0)	2 (8.0)	10 (40.0)	9 (36.0)	2 (8.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	3.0 ± 1.1	1 (16.7)	0 (0.0)	3 (50.00	2 (33.3)	0 (0.0)		
Years of experience							12.117[y]	.912
≤ 10	3.0 ± 1.2	3 (12.5)	4 (16.7)	10 (41.7)	4 (16.7)	3 (12.5)		
11 – 15	3.5 ± 1.1	5 (6.3)	6 (7.5)	28 (35.0)	24 (30.0)	17 (21.3)		
16 – 20	3.3 ± 1.1	9 (11.1)	8 (9.9)	25 (30.9)	27 (33.3)	12 (14.8)		
21 – 25	3.4 ± 1.2	5 (8.2)	8 (13.1)	19(31.1))	17 (27.9)	12 (19.7)		
26 – 30	3.2 ± 1.6	8 (16.3)	5 (10.2)	14 (28.6)	16 (32.7)	6 (12.2)		
> 30	3.1 ± 1.2	4 (23.5)	2 (11.8)	3 (17.6)	2 (11.8)	6 (35.3)		

[y]=Yates corrected value

There were significant associations between the sample demographics and the statement: *"Use a wide variety of emotions in dealing with people"* with gender: male respondents use more varieties

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of emotions than female respondents 3.6, sd = 0.9 vs 3.2 sd = 1.3, X^2=16.655, p-value=.002, the p-value was < .05.

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Table 5.10: Display many different emotions when interacting with others?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ^2	ρ
Age groups							18.883[y]	.52
26 – 30	2.7 ± 1.3	6 (15.00	15 (37.5)	7 (17.5)	7 (17.5)	5 (12.5)		
31 – 35	2.4 ± 1.2	18 (32.7)	11 (20.0)	16 (29.1)	8 (14.5)	2 (3.6)		
36 – 40	2.7 ± 1.3	23 (25.8)	17 (19.1)	24 (27.0)	16 (18.0)	9 (10.1)		
41 – 45	2.8 ± 1.2	10 (14.5)	21 (30.4)	15 (21.7)	15 (21.7)	8 (11.6)		
46 – 50	2.8 ± 1.2	10 (19.2)	12 (23.1)	18 (34.6)	4 (7.7)	8 (15.4)		
≥ 51	2.3 ± 1.2	3 (32.9)	0 (0.0)	3 (42.9)	1 (14.3)	0 (0.0)		
Gender							5.272	.26
Male	2.8 ± 1.2	14 (14.7)	26 (27.4)	26 (27.4)	19 (20.0)	10 (10.5)		
Female	2.6 ± 1.3	56 (25.8)	50 (23.0)	57 (26.3)	32 (14.7)	22 (10.1)		
Qualification							8.262[y]	.76
Registered Nurse	2.7 ± 1.2	15 (19.2)	20 (25.6)	23 (29.5)	14 (17.9)	6 (7.7)		
Registered midwife	2.5 ± 1.3	20 (31.3)	14 (21.9)	15 (23.4)	9 (14.1)	6 (9.4)		
Bachelor of Nursing Science	2.7 ± 1.3	32 (21.3)	40 (26.7)	40 (26.7)	21 (14.0)	17 (11.3)		
Masters	3.3 ± 1.3	3 (15.0)	2 (10.0)	5 (25.0)	7 (35.0)	3 (15.0)		
Marital Status							7.151[y]	.84
Single	2.7 ± 1.4	9 (21.4)	12 (28.6)	6 (14.3)	10 (23.8)	5 (11.9)		
Married	2.7 ± 1.2	57 (22.4)	60 (23.5)	73 (28.6)	41 (16.1)	24 (9.4)		
Separated	1.7 ± 0.9	2 (50.0)	1 (25.0)	1 (25.0)	0 (0.0)	0 (0.0)		
Divorced	2.9 ± 1.5	2 (18.2)	3 (27.3)	3 (27.3)	0 (0.0)	3 (27.3)		
Religion							4.282	.36
Christianity	2.7 ± 1.3	49 (20.7)	58 (24.5)	68 (28.7)	36 (15.2)	26 (11.0)		
Islam	2.6 ± 1.3	21 (28.0)	18 (24.0)	15 (20.0)	15 (20.0)	6 (8.0)		
Ethnicity							3.587[y]	.89
Yoruba	2.7 ± 1.3	64 (22.8)	67 (23.8)	71 (25.3)	48 (17.1)	31 (11.0)		
Ibo	2.4 ± 0.9	5 (20.)	7 (28.0)	10 (40.0)	3 (12.0)	0 (0.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	2.7 ± 1.4	1 (16.7)	2 (33.3)	2 (33.3)	0 (0.0)	1 (16.7)		
Years of experience							19.620[y]	.48
≤ 10	2.6 ± 1.3	5 (20.8)	8 (33.3)	4 (16.7)	5 (20.8)	2 (8.3)		
11 – 15	2.7 ± 1.3	18 (22.5)	20 (25.0)	16 (20.0)	19 (23.8)	7 (8.8)		
16 – 20	2.6 ± 1.2	22 (27.2)	15 (18.5)	26 (32.1)	12 (14.8)	6 (7.4)		
21 – 25	2.8 ± 1.2	7 (11.5)	20 (32.8)	17 (27.9)	10 (16.4)	7 (11.5)		
26 – 30	2.5 ± 1.3	15 (30.6)	12 (24.5)	12 (24.5)	3 (6.1)	7 (14.3)		
> 30	3.1 ± 1.3	3 (17.6)	1 (5.9)	8 (47.1)	2 (11.8)	3 (17.6)		

[y]=Yates corrected value

There were no significant associations between the sample demographics and the statement: *“Display of many different emotions when interacting with others”*.

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Table 5.11: Express many different emotions when dealing with people?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ^2	P
Age groups							11.661[y]	.927
26 – 30	2.9 ± 1.2	5 (12.5)	9 (22.5)	17 (42.5)	4 (10.0)	5 (12.5)		
31 – 35	2.6 ± 1.3	13 (23.6)	12 (21.8)	19 (34.5)	4 (7.3)	7 (12.7)		
36 – 40	2.6 ± 1.1	17 (19.1)	26 (29.2)	30 (33.7)	10 (11.2)	6 (6.7)		
41 – 45	2.7 ± 1.1	10 (14.5)	24 (34.8)	21 (30.4)	7 (10.1)	7 (10.1)		
46 – 50	2.6 ± 1.0	7 (13.5)	18 (34.6)	16 (30.8)	9 (17.3)	2 (3.8)		
≥ 51	3.2 ± 1.0	2 (28.6)	0 (0.0)	1 (14.2)	2 (28.6)	2 (28.6)		
Gender							9.904	.042
Male	2.9 ± 1.2	10 (10.5)	24 (25.3)	37 (38.9)	10 (10.5)	14(14.7)		
Female	2.5 ± 1.1	44 (20.3)	65 (30.0)	67 (30.9)	26 (12.0)	15 (6.9)		
Qualification							11.256[y]	.507
Registered Nurse	2.8 ± 1.1	9 (11.5)	18 (23.1)	36 (46.2)	6 (7.7)	9 (11.5)		
Registered midwife	2.6 ± 1.1	13 (20.3)	18 (28.1)	22 (34.4)	5 (7.8)	6 (9.4)		
Bachelor of Nursing Science	2.6 ± 1.2	30 (20.0)	46 (30.7)	39 (26.0)	22 (14.7)	13 (8.7)		
Masters	2.7 ± 1.0	2 (10.0)	7 (35.0)	7 (35.0)	3 (15.0)	1 (5.0)		
Marital Status							12.631[y]	.396
Single	3.1 ± 1.2	5 (11.9)	7 (16.7)	18 (42.9)	3 (7.1)	9 (21.4)		
Married	2.6 ± 1.1	44 (17.3)	78 (30.6)	83 (32.5)	32 (12.5)	18 (7.1)		
Separated	2.5 ± 1.9	2 (50.0)	0 (0.0)	1 (25.0)	0 (0.0)	1 (25.0)		
Divorced	2.4 ± 1.2	3 (27.3)	4 (36.4)	2 (18.2)	1 (9.1)	1 (9.1)		
Religion							2.683	.612
Christianity	2.7 ± 1.1	37 (15.6)	70 (29.5)	82 (34.6)	27 (11.4)	21 (8.9)		
Islam	2.6 ± 1.3	17 (22.7)	19 (25.3)	22 (29.3)	9 (12.0)	8 (10.7)		
Ethnicity							3.464[y]	.902
Yoruba	2.7 ± 1.2	50 (17.8)	82 (29.2)	90 (32.0)	31 (11.0)	28(10.0)		
Ibo	2.7 ± 0.9	3 (12.0)	7 (28.0)	11 (44.0)	3 (12.0)	1 (4.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	3.0 ± 1.0	1 (16.7)	0 (0.0)	3 (50.0)	2 (33.0)	0 (0.0)		
Years of experience							16.543[y]	.682
≤ 10	2.7 ± 1.1	4 (16.7)	5 (20.8	11 (45.8)	2 (8.3)	2 (8.3)		
11 – 15	2.9 ± 1.2	12 (15.0)	16 (20.0)	33 (41.3)	7 (8.8)	12(15.0)		
16 – 20	2.6 ± 1.1	16 (19.8)	23 (28.4)	28 (34.6)	8 (9.9)	6 (7.4)		
21 – 25	2.5 ± 1.0	8 (13.1)	25 (41.0)	17 (27.9)	9 (14.8)	2 (3.3)		
26 – 30	2.7 ± 1.3	10 (20.4)	14 (28.6)	11 (22.4)	9 (18.4)	5 (10.2)		
> 30	2.5 ± 1.3	4 (23.50	6 (35.3)	4 (23.5)	1 (5.9)	2 (11.8)		

[y]*=Yates corrected value*

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There were significant associations between the sample demographics and the statement: *"Express many different emotions when dealing with people"* with gender: male respondents express many different emotions than female respondents 2.9, sd = 1.2 vs 2.5 sd = 1.1, X^2=9.904, p value = .042.

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Table 5.12: Display many different kinds of emotions?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ²	P
Age groups							6.707[y]	.997
26 – 30	2.7 ± 1.3	8 (20.0)	10 (25.0)	15 (37.5)	4 (10.0)	3 (7.5)		
31 – 35	2.4 ± 1.1	5 (9.1)	21 (38.2)	16 (29.1)	10 (18.2)	3 (5.5)		
36 – 40	2.7 ± 1.3	11 (12.4)	33 (37.1)	25 (28.1)	13 (14.6)	7 (7.9)		
41 – 45	2.8 ± 1.3	11 (15.9)	17 (24.6)	24 (34.8)	11 (15.9)	6 (8.7)		
46 – 50	2.7 ± 1.3	7 (13.5)	17 (32.7)	16 (30.8)	6 (11.5)	6 (11.5)		
≥ 51	2.3 ± 1.2	2 (28.6)	1 (14.3)	3 (42.9)	0 (0.0)	1 (14.3)		
Gender							11.154	.025
Male	2.8 ± 1.2	6 (6.3)	30 (31.6)	36 (37.9)	11 (11.6)	12 (12.6)		
Female	2.6 ± 1.3	38 (17.5)	69 (31.8)	63 (29.0)	33 (15.2)	14 (6.5)		
Qualification							10.069[y]	.610
Registered Nurse	2.7 ± 1.2	8 (10.3)	24 (30.8)	26 (33.3)	14 (17.9)	6 (7.7)		
Registered midwife	2.5 ± 1.3	12 (18.8)	20 (31.3)	15 (23.4)	12 (18.8)	5 (7.8)		
Bachelor of Nursing Science	2.7 ± 1.3	19 (12.7)	52 (34.7)	50 (33.3)	14 (9.3)	15 (10.0)		
Masters	3.3 ± 1.3	5 (25.0)	3 (15.0)	8 (40.0)	4 (20.0)	0 (0.0)		
Marital Status							7.014[y]	.857
Single	2.7 ± 1.4	10 (23.8)	11 (26.2)	14 (33.3)	3 (7.1)	4 (9.5)		
Married	2.7 ± 1.2	30 (11.8)	84 (32.9)	80 (31.4)	40 (15.7)	21 (8.2)		
Separated	1.7 ± 0.9	2 (50.0)	0 (0.0)	2 (50.0)	0 (0.0)	0 (0.0)		
Divorced	2.9 ± 1.5	2 (18.2)	4 (36.4)	3 (27.3)	1 (9.1)	1 (9.1)		
Religion							7.721	.102
Christianity	2.7 ± 1.3	39 (16.5)	73 (30.8)	74 (31.2)	29 (12.2)	22 (9.3)		
Islam	2.5 ± 1.3	5 (6.7)	26 (34.7)	25 (33.3)	15 (20.0)	4 (5.3)		
Ethnicity							4.070[y]	.851
Yoruba	2.7 ± 1.3	40 (14.2)	92 (32.7)	85 (30.2)	40 (14.2)	24 (8.5)		
Ibo	2.4 ± 0.9	2 (8.0)	7 (28.0)	12 (48.0)	3 (12.0)	1 (4.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	2.7 ± 1.4	2 (33.3)	0 (0.0)	2 (33.3)	1 (16.7)	1 (16.7)		
Years of experience							13.407[y]	.859
≤ 10	2.6 ± 1.3	6 (25.0)	7 (29.2)	7 (29.2)	3 (12.5)	1 (4.2)		
11 – 15	2.7 ± 1.3	7 (8.8)	25 (31.3)	26 (32.5)	14 (17.5)	8 (10.0)		
16 – 20	2.5 ± 1.2	7 (8.6)	33 (40.7)	24 (29.6)	10 (12.3)	7 (8.6)		
21 – 25	2.8 ± 1.2	12 (19.7)	19 (31.1)	21 (34.4)	8 (13.1)	1 (1.6)		
26 – 30	2.5 ± 1.3	8 (16.3)	12 (24.5)	16 (32.7)	6 (12.2)	7 (14.3)		
> 30	3.1 ± 1.3	4 (23.5)	3 (17.6)	5 (29.4)	3 (17.6)	2 (11.8)		

[y]=Yates corrected value

There were significant associations between the sample demographics and the statement: *"Display many different kinds of emotions"* and gender: with male respondents displaying many kinds of

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emotions higher than female respondents (2.8, sd = 1.2 vs 2.6 sd = 1.3, X^2=11.154, p-value=.025; p value was < .05.

Domain: Frequency

The domain frequency of emotions on the ELS of respondents was determined by three items. The three items are: “Display specific emotions required by your job”; “Express particular emotions need for your job”; and “Adopt certain emotions as part of your job”. The results of each item is presented in tables followed by the interpretation thereof.

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Table 5.13: Display specific emotions required by your job?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ^2	ρ
Age groups							13.610[y]	.849
26 – 30	3.5 ± 1.2	3 (7.5)	4 (10.0)	13 (32.5)	8 (20.0)	12 (30.0)		
31 – 35	3.8 ± 1.2	3 (5.5)	4 (7.3)	15 (27.3)	12 (21.8)	21 (38.2)		
36 – 40	3.7 ± 0.9	1 (1.1)	7 (7.9)	29 (32.6)	29 (32.6)	23 (25.8)		
41 – 45	3.7 ± 1.1	1 (1.4)	5 (7.2)	30 (43.5)	8 (11.6)	25 (36.2)		
46 – 50	3.8 ± 1.1	2 (3.8)	2 (3.8)	18 (34.6)	12 (23.1)	18 (34.6)		
≥ 51	3.6 ± 1.4	1 (14.2)	0 (0.0)	2 (28.6)	2 (28.6)	2 (28.6)		
Gender							6.908	.141
Male	3.7 ± 0.9	0 (0.0)	6 (6.3)	39 (41.1)	21 (22.1)	29 (30.5)		
Female	3.7 ± 1.2	11 (5.1)	16 (7.4)	68 (31.3)	50 (23.0)	72 (33.2)		
Qualification							10.133[y]	.604
Registered Nurse	3.7 ± 0.9	0 (0.0)	5 (6.4)	32 (41.0)	22 (28.2)	19 (24.4)		
Registered midwife	3.7 ± 1.1	2 (3.1)	7 (10.9)	20 (31.3)	15 (23.4)	20 (31.3)		
Bachelor of Nursing Science	3.8 ± 1.2	8 (5.3)	7 (4.7)	48 (32.0)	31 (20.7)	56 (37.3)		
Masters	3.5 ± 1.2	1 (5.0)	3 (15.0)	7 (35.0)	3 (15.0)	6 (30.0)		
Marital Status							4.784[y]	.965
Single	3.6 ± 1.2	3 (7.1)	4 (9.5)	13 (31.0)	10 (23.8)	12 (28.6)		
Married	3.7 ± 1.1	8 (3.1)	16 (6.3)	91 (35.7)	57 (22.4)	83 (32.5)		
Separated	3.2 ± 0.9	0 (0.0)	1 (25.0)	1 (25.0)	2 (50.0)	0 (0.0)		
Divorced	4.2 ± 1.1	0 (0.0)	1 (9.1)	2 (18.2)	2 (18.2)	6 (54.5)		
Religion							4.019	.403
Christianity	3.7 ± 1.1	9 (3.8)	13 (5.5)	84 (35.4)	54 (22.8)	77 (32.5)		
Islam	3.7 ± 1.1	2 (2.7)	9 (12.0)	23 (30.7)	17 (22.7)	24 (32.0)		
Ethnicity							16.202	.039
Yoruba	3.7 ± 1.1	9 (3.2)	19 (6.8)	92 (32.7)	67 (23.8)	94 (33.5)		
Ibo	3.5 ± 1.0	1 (4.0)	0 (0.0)	14 (56.0)	4 (16.0)	6 (24.0)		
Hausa	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)		
Others	2.5 ± 1.4	1 (16.7)	3 (49.9)	1 (16.7)	0 (0.0)	1 (16.7)		
Years of experience							17.364[y]	.629
≤ 10	3.6 ± 1.3	3 (12.5)	1 (4.2)	5 (20.8)	7 (29.2)	8 (33.3)		
11 – 15	3.7 ± 1.0	1 (1.3)	5 (6.3)	34 (42.5)	17 (21.3)	23 (28.8)		
16 – 20	3.6 ± 1.1	3 (3.7)	7 (8.6)	28 (34.6)	22 (21.3)	21 (25.9)		
21 – 25	3.7 ± 1.1	1 (1.6)	7 (11.5)	22 (36.1)	10 (16.4)	21 (24.5)		
26 – 30	3.9 ± 1.0	1 (2.0)	2 (4.1)	16 (32.7)	12 (24.5)	18 (36.7)		
> 30	4.1 ± 1.4	2 (11.8)	0 (0.0)	2 (11.8)	3 (17.6)	10 (58.8)		

[y]*=Yates corrected value*

There were significant associations between the sample demographics and the statement: *"Display specific emotions required by your job"* and Yoruba respondents having significantly higher

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emotional labour scores by displaying specific emotions at work more than other tribes with mean score 3.7 sd = 1.1 (X^2 = 16.2, p = .039).

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Table 5.14: Express particular emotions needed for your job?

Variables	Mean ±SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ^2	P
Age groups							15.455[y]	.749
26 – 30	2.7 ± 1.2	1 (2.5)	7 (17.5)	10 (25.0)	11 (27.5)	11 (27.5)		
31 – 35	2.5 ± 1.0	2 (3.60	4 (7.3)	30 (54.5)	14 (25.5)	5 (9.1)		
36 – 40	2.8 ± 1.1	1 (1.1)	8 (9.0)	37 (41.6)	28 (31.5)	15 (16.9)		
41 – 45	2.9 ± 1.2	4 (5.8)	7 (10.1)	27 (39.1)	22 (31.9)	9 (13.0)		
46 – 50	2.6 ± 0.1	3 (5.8)	10 (19.2)	20 (38.5)	11 (21.2)	8 (15.4)		
≥ 51	2.3 ± 0.7	1 (14.3)	1 (14.3)	3 (42.9)	1 (14.3)	1 (14.3)		
Gender							3.375	.497
Male	2.9 ± 1.1	2 (2.1)	13 (13.7)	34 (35.8)	31 (32.6)	15 (15.8)		
Female	2.7 ± 1.1	10 (4.6)	24 (11.1)	93 (42.9)	56 (25.8)	34 (15.7)		
Qualification							11.404[y]	.495
Registered Nurse	2.8 ± 1.1	0 (0.0)	7 (9.0)	38 (48.7)	22 (28.2)	11 (14.1)		
Registered midwife	2.5 ± 1.1	3 (4.7)	5 (7.8)	27 (42.2)	19 (29.7)	10 (15.6)		
Bachelor of Nursing Science	2.8 ± 1.1	9 (6.0)	22 (14.7)	51 (34.0)	40 (26.7)	28 (18.7)		
Masters	3.0 ± 1.3	0 (0.0)	3 (15.0)	11 (55.0)	6 (30.0)	0 (0.0)		
Marital Status							6.229[y]	.904
Single	2.5 ± 1.3	1 (2.4)	7 (16.7)	16 (38.1)	11 (26.2)	7 (16.7)		
Married	2.8 ± 1.1	11 (4.3)	27 (10.6)	107 (42.0)	72 (28.2)	38 (14.9)		
Separated	2.0 ± 0.8	0 (0.0)	2 (50.0)	1 (25.0)	1 (25.0)	0 (0.0)		
Divorced	2.5 ± 1.0	0 (0.0)	1 (9.1)	3 (27.3)	3 (27.3)	4 (36.3)		
Religion							4.162	.384
Christianity	2.8 ± 1.1	10 (4.2)	27 (11.4)	94 (39.7)	72 (30.4)	34 (14.3)		
Islam	2.6 ± 1.0	2 (2.7)	10 (13.3)	33 (44.4)	15 (20.0)	15 (20.0)		
Ethnicity							8.009[y]	.433
Yoruba	2.8 ± 1.1	10 (3.6)	31 (11.0)	111 (39.5)	82 (29.2)	47 (16.7)		
Ibo	2.4 ± 0.8	2 (8.0)	3 (12.0)	13 (52.0)	5 (20.0)	2 (8.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	2.7 ± 1.2	0 (0.0)	3 (50.0)	3 (50.0)	0 (0.0)	0 (0.0)		
Years of experience							19.931[y]	.462
≤ 10	2.8 ± 1.2	1 (4.2)	6 (25.0)	5 (20.8)	5 (20.8)	7 (29.2)		
11 – 15	2.5 ± 1.0	2 (2.5)	4 (5.0)	43 (53.8)	22 (27.5)	9 (11.3)		
16 – 20	2.7 ± 1.1	5 (6.2)	8 (9.9)	31 (38.3)	26 (32.1)	11 (13.6)		
21 – 25	2.9 ± 1.2	0 (0.0)	9 (14.8)	24 (39.3)	20 (32.8)	8 (13.1)		
26 – 30	2.6 ± 1.0	3 (6.1)	8 (16.3)	19 (38.8)	10 (20.4)	9 (18.4)		
> 30	2.8 ± 1.2	1 (5.9)	2 (11.8)	5 (29.4)	4 (23.5)	5 (29.4)		

[y]=Yates corrected value

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There were no significant associations between the sample demographics and the statement: *"Express particular emotions needed for job"*.

Table 5.15: Adopt certain emotions as part of your job?

Variables	Mean ±SD	Never (%)	Rarely (%)	Sometim es (%)	Often (%)	Always (%)	χ^2	P
Age groups							14.236^{y}	.81
26 – 30	2.9 ± 1.0	4 (10.0)	6 (15.0)	22 (55.0)	4 (10.0)	4 (10.0)		
31 – 35	3.2 ± 1.2	7 (12.7)	5 (9.1)	25 (45.5)	8 (14.5)	10 (18.2)		
36 – 40	3.3 ± 1.0	3 (3.4)	14 (15.7)	36 (40.4)	23 (25.8)	13 (14.6)		
41 – 45	3.3 ± 1.0	1 (1.4)	10 (14.5)	29 (42.0)	16 (23.2)	13 (18.8)		
46 – 50	3.3 ± 1.2	4 (7.7)	7 (13.5)	21 (40.4)	8 (15.4)	12 (23.1)		
≥ 51	3.1 ± 0.7	0 (0.00	1 (14.3)	4 (57.1)	2 (28.6)	0 (0.0)		
Gender							4.385	.35
Male	3.3 ± 0.9	3 (3.2)	12 (12.6)	49 (51.6)	17 (17.9)	14 (14.7)		
Female	3.3 ± 1.1	16 (7.4)	31 (14.3)	88 (40.6)	44 (20.3)	38 (17.5)		
Qualification							10.184^{y}	.59
Registered Nurse	3.2 ± 1.1	5 (6.4)	15 (19.2)	29 (37.2)	14 (17.9)	15 (19.2)		
Registered midwife	3.2 ± 1.2	8 (12.5)	5 (7.8)	31 (48.4)	9 (14.1)	11 (17.2)		
Bachelor of Nursing Science	3.3 ± 1.0	5 (3.3)	21 (14.0)	68 (45.3)	34 (22.7)	22 (14.7)		
Masters	3.4 ± 1.1	1 (5.0)	2 (10.0)	9 (45.0)	4 (20.0)	4 (20.0)		
Marital Status							11.126^{y}	.51
Single	2.9 ± 1.1	5 (11.9)	5 (11.9)	23 (54.8)	4 (9.5)	5 (11.9)		
Married	3.3 ± 1.1	12 (4.7)	36 (14.1)	110(43.1)	55 (21.6)	42 (16.5)		
Separated	2.7 ± 1.3	1 (25.0)	0 (0.0)	2 (50.0)	1 (25.0)	0 (0.0)		
Divorced	3.6 ± 1.5	1 (9.1)	2 (18.2)	2 (18.2)	1 (9.1)	5 (45.4)		
Religion							3.007	.55
Christianity	3.3 ± 1.1	14 (5.9)	35 (14.8)	99 (41.8	50 (21.1)	39 (16.5)		
Islam	3.2 ± 1.1	5 (6.7)	8 (10.7)	38 (50.7)	11 (14.7)	13 (17.3)		
Ethnicity							3.595^{y}	.89
Yoruba	3.3 ± 1.1	16 (5.7)	41 (14.6)	123(43.8)	53 (18.9)	48 (17.1)		
Ibo	3.4 ± 1.0	2 (8.0)	1 (4.0)	11 (44.00	8 (32.0)	3 (12.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	2.8 ± 1.3	1 (16.7)	1 (16.7)	3 (49.9)	0 (0.0)	1 (16.7)		
Years of experience							10.610^{y}	.95
≤ 10	3.0 ± 1.1	2 (8.3)	4 (16.7)	12 (50.0)	3 (12.5)	3 (12.5)		
11 – 15	3.2 ± 1.1	6 (7.5)	11 (13.8)	38 (47.5)	14 (17.5)	11 (13.8)		
16 – 20	3.2 ± 1.1	6 (7.4)	10 (12.3)	36 (44.4)	19 (23.5)	10 (12.3)		
21 – 25	3.3 ± 1.1	1 (1.6)	10 (16.4)	25 (41.0)	12 (19.7)	13 (21.3)		
26 – 30	3.9 ± 1.0	3 (6.1)	6 (12.2)	22 (44.9)	10 (20.4)	8 (16.3)		
> 30	4.1 ± 1.4	1 (5.9)	2 (11.8)	4 (23.5)	3 (17.6)	7 (41.2)		

^{y}***=Yates corrected value***

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There were no significant associations between the sample demographics and the statement: *"Adoption of certain emotions as part of job".*

Domain: Intensity

Intensity of respondent's emotion according to the ELS was determined by two items. The items are: "Show some strong emotions" and "Express intense emotions". Results of the items are presented in the tables below and are interpreted.

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Table 5.16: Show some strong emotions?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ^2	P
Age groups							16.597^{y}	.67
26 – 30	2.9 ±0.8	3 (7.5)	7 (17.5)	22 (55.0)	7 (17.5)	1 (2.5)		
31 – 35	2.7 ± 1.0	12 (21.8)	2 (3.6)	32 (58.2)	7 (12.7)	2 (3.6)		
36 – 40	2.8 ± 1.1	13 (14.6)	14 (15.7)	39 (43.8)	17 (19.1)	6 (6.7)		
41 – 45	2.7 ± 1.1	16 (23.2)	8 (11.6)	29 (42.0)	15 (21.7)	1 (1.4)		
46 – 50	2.8 ± 1.1	8 (15.4)	7 (13.5)	26 (50.0)	8 (15.4)	3 (5.8)		
≥ 51	2.1 ± 1.5	4 (57.1)	0 (0.0)	2 (28.6)	0 (0.0)	1 (14.3)		
Gender							7.986	.09
Male	3.0 ± 0.9	11 (11.6)	8 (8.4)	50 (52.6)	22 (23.2)	4 (4.2)		
Female	2.7 ± 1.1	45 (20.7)	30 (13.80)	100 (46.1)	32 (14.7)	10 (4.6)		
Qualification							13.043^{y}	.36
Registered Nurse	3.2 ± 0.9	5 (6.4)	6 (7.7)	44 (56.4)	17 (21.8)	6 (7.7)		
Registered midwife	2.6 ± 1.1	13 (20.3)	10 (15.6)	29 (45.3)	9 (14.1)	3 (4.7)		
Bachelor of Nursing Science	2.6 ± 1.1	34 (22.7)	20 (13.3)	69 (46.0)	23 (15.3)	4 (2.7)		
Masters	2.8 ± 1.1	4 (20.0)	2 (10.0)	8 (40.0)	5 (25.0)	1 (5.0)		
Marital Status							4.475^{y}	.97
Single	2.8 ± 0.9	5 (11.9)	7 (16.7)	23 (54.8)	5 (11.9)	2 (4.8)		
Married	2.8 ± 1.1	48 (18.8)	29 (11.4)	118 (46.3)	48 (18.8)	12 (4.7)		
Separated	3.0 ± 0.0	0 (0.0)	0 (0.0)	4 (100.0)	0 (0.0)	0 (0.0)		
Divorced	2.3 ± 1.0	3 (27.3)	2 (18.2)	5 (45.5)	1 (9.1)	0 (0.0)		
Religion							3.910	.41
Christianity	2.8 ± 1.1	39 (16.5)	32 (13.5)	111 (46.80	44 (18.6)	11 (4.6)		
Islam	2.7 ± 1.1	17 (22.7)	6 (8.0)	39 (52.0)	10 (13.3)	3 (4.0)		
Ethnicity							1.437^{y}	.99
Yoruba	2.7 ± 1.0	48 (17.1)	35 (12.5)	138 (49.1)	48 (17.1)	12 (4.3)		
Ibo	2.7 ± .1.1	6 (24.0)	3 (12.0)	10 (40.0)	5 (20.0)	1 (4.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	2.8 ± 1.6	2 (33.3)	0 (0.0)	2 (33.3)	1 (16.7)	1 (16.7)		
Years of experience							10.182^{y}	.96
≤ 10	2.7 ± 1.0	4 (16.7)	3 (12.5)	13 (54.2)	3 (12.5)	1 (4.2)		
11 – 15	2.9 ± 1.0	11 (13.8)	7 (8.8)	43 (53.8)	14 (17.5)	5 (6.3)		
16 – 20	2.8 ± 1.0	12 (14.8)	11 (13.6)	39 (48.1)	16 (19.8)	3 (3.7)		
21 – 25	2.8 ± 1.0	12 (19.7)	10 (16.4)	26 (42.6)	11 (18.0)	2 (3.3)		
26 – 30	2.7 ± 1.1	10 (20.4)	6 (12.2)	21 (42.9)	10 (20.4)	2 (4.1)		

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There were no significant associations between the sample demographics and the statement: *"Show some strong emotions"*.

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Table 5.17: Express intense emotions?

Variables	Mean ± SD	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)	χ^2	P
Age groups							15.589[y]	.742
26 – 30	2.7 ± 1.1	7 (17.5)	11 (27.5)	11 (27.5)	8 (20.0)	3 (7.5)		
31 – 35	2.5 ± 1.0	6 (10.9)	27 (49.1)	10 (18.2)	10 (18.2)	2 (3.6)		
36 – 40	2.8 ± 1.1	9 (10.1)	28 (29.0)	31 (34.8)	12 (17.4)	9 (13.0)		
41 – 45	2.9 ± 1.2	6 (8.7)	20 (29.0)	22 (31.9)	12 (17.4)	9 (13.0)		
46 – 50	2.6 ± 1.1	5 (9.6)	22 (42.3)	17 (32.7)	2 (3.8)	6 (11.5)		
≥ 51	2.3 ± 0.7	1 (14.3)	3 (42.9)	3 (42.9)	0 (0.0)	0 (0.0)		
Gender							5.441	.245
Male	2.9 ± 1.1	8 (8.4)	27 (28.4)	33 (34.7)	18 (18.9)	9 (9.5)		
Female	2.7 ± 1.1	26 (12.0)	84 (38.7)	61 (28.1)	28 (12.9)	18 (8.3)		
Qualification							9.393[y]	.669
Registered Nurse	2.8 ± 1.1	7 (9.0)	27 (34.6)	27 (34.6)	10 (12.8)	7 (9.0)		
Registered midwife	2.5 ± 1.1	13 (20.3)	20 (31.3)	18 (28.1)	10 (15.6)	3 (4.7)		
Bachelor of Nursing Science	2.7 ± 1.0	12 (8.0)	58 (38.7)	43 (28.7)	24 (16.0)	13 (8.7)		
Masters	3.0 ± 1.3	2 (10.0)	6 (30.0)	6 (30.0)	2 (10.0)	4 (20.0)		
Marital Status							11.895[y]	.454
Single	2.5 ± 1.1	11 (26.2)	10 (23.8)	11 (26.2)	7 (16.7)	3 (7.1)		
Married	2.8 ± 1.1	20 (7.8)	96 (37.6)	78 (30.6)	37 (14.5)	24 (9.4)		
Separated	2.0 ± 0.8	1 (25.0)	2 (50.0)	1 (25.00	0 (0.0)	0 (0.0)		
Divorced	2.5 ± 1.0	2 (18.2)	3 (27.3)	4 (36.4)	2 (18.2)	0 (0.0)		
Religion							2.425	.658
Christianity	2.8 ± 1.1	25 (10.5)	81 (34.2)	71 (30.0)	37 (15.6)	23 (9.7)		
Islam	2.6 ± 1.0	9 (12.0)	30 (40.00	23 (30.7)	9 (12.0)	4 (5.3)		
Ethnicity							3.603[y]	.891
Yoruba	2.7 ± 1.1	31 (11.0)	97 (34.5)	83 (29.5)	44 (15.7)	26 (9.3)		
Ibo	2.4 ± 0.8	3 (12.0)	10 (40.0)	10 (40.0)	2 (8.0)	0 (0.0)		
Hausa		0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)		
Others	2.7 ± 1.2	0 (0.0)	4 (66.70	1 (16.7)	0 (0.0)	1 (16.7)		
Years of experience							12.017[y]	.915
≤ 10	2.8 ± 1.2	3 (12.5)	7 (29.2)	7 (29.2)	4 (16.7)	3 (12.5)		
11 – 15	2.5 ± 1.0	11 (13.8)	31 (38.8)	23 (28.8)	12 (15.0)	3 (3.8)		
16 – 20	2.8 ± 1.1	9 (11.1)	24 (29.6)	29 (35.8)	14 (17.3)	5 (6.2)		
21 – 25	2.9 ± 1.2	5 (8.2)	23 (37.7)	13 (21.3)	10 (16.4)	10 (16.4)		
26 – 30	2.6 ± 1.0	5 (10.2)	19 (38.8)	16 (32.7)	6 (12.2)	3 (6.1)		
> 30	2.8 ± 1.1	1 (5.90	7 (41.20	6 (35.3)	0 (0.0)	3 (17.6)		

[y]***=Yates corrected value***

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There were no significant associations between the sample demographics and the statement: *"Express intense emotions"*.

5.3 DISCUSSION OF THE FINDINGS

Results of this study signifies that the overall emotional labour of the respondents is average. This implies the respondents adopt emotional labour strategies to regulate their emotions in the workplace. Professionalism in nursing requires nurses to provide good quality service when caring for their patients while also maintaining friendly attitudes and positive emotions, alongside the psychological challenges and pressure from patients and patients' families. Grandey & Melloy (2017), asserted that nurses' tasks are overwhelming as they regulate their emotions to accomplish their job requirements due to high market competition and client-centred services in the healthcare business environment.

The duration of interaction was an average of 35.2 (sd 45. 9; median 25) minutes, ranging between 2 and 300 minutes across the study sites. Abeokuta and Ife had shorter interaction period than Owo. The variation though not significant.

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Respondents used deep acting to regulate their emotions in the workplace. The results of this study revealed that the use of deep acting strategy by nurses was average. Respondents use deep acting to regulate their emotions in order to cope with workplace demands as stipulated in organizational rules. Chou et al. (2012) and Ulufera and Soran (2019), reported that deep acting had a positive effect on how people feel about their jobs and it makes them to be appreciated by their managers, coworkers and clients. Similarly, researchers Gu et al (2020) and Mesmer-Magnus et al., 2012), avowed that deep acting helps to foster rewarding resources such as social efforts and competences which may yield positive consequences for both the employee and the organization especially on

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the long-term run. However, Bibi & Mahmood (2020) reported that there was no significant difference in the level of deep acting of male and female teachers used for their study.

On the contrary, Alabak et al, (2020) described deep acting as a harmful strategy because it is an effortful strategy which may drain mental resources and therefore undermine both employees' well-being and organizational well-being. However, respondents believe that deep acting is indeed beneficial to nurses' psychological well-being and organizational success because it can reduce the sense of emotional dissonance which is found to be detrimental to employees and organizations well-being. To support this, Chou et al. (2012), suggests deep acting as the preferred emotional labour strategy when dealing with difficult patients. Pan et al. (2019), in a study of emotional labour among nurses in Taiwan, reported that nurses generally experience moderately high degrees of emotional labor.

Surface acting behaviours were the least exhibited (mean range: 1.9 – 2.5) by the respondents in this study. Comparing the socio-demographic profiles of the nurses, only gender was a significantly associated variable with surface acting roles: male nurses had higher surface acting behaviours than their female counterparts on two components (*"Hide my true feelings about a situation"* and *"Pretend to have emotions that I don't really have"*). A previous study among nurses in the intensive care unit in Eastern and Southeastern Anatolian regions of Turkey reported similarly how they use surface acting strategy less often at the workplace than the others (Arslan Seker, et al., 2022). This study further revealed that surface acting was not significantly associated with any socio-demographic characteristics but was significantly negatively associated with mental health, with influence of positive group affective tone and the interaction surface acting. Therefore, the effect of surface acting on mental health was lighter when the level of positive group affective tone was high and vice versa.

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Surface Acting implies constant monitoring of the inner and expected emotions to express feelings that are not in consonance with inner feelings, often makes employees to exert continuous efforts to modify their outer emotional expression (Nguyen et al., 2021). To buttress this, Mesmer-Magnus et al,, (2012), expressed that such efforts depletes mental resources of service workers, which in turn impair employees' well-being such as lower levels of job satisfaction and higher levels of emotional exhaustion. In addition, Cho et al., (2017), suggests that the emotional dissonance resulting from surface acting reflects a mismatch between employee's feelings and their job expectations. In a similar vein, Nguyen et al., (2021), avows that worker facing an emotional-evoking situation such as mistreatment from co-workers, supervisors or the organization (e.g. organization dehumanization) entails emotional labour. In summary, Nguyen et al., (2021), reported that individuals engage in surface acting in a bid to comply with the organisation's display rules while facing organisational dehumanisation. It therefore becomes imperative for managers in the service sector (particularly in the healthcare management industry) to be cognisant by emphasising emotional labour and its influence on well-being costs of employees (Zou & Dahling, 2017). Crescenzo (2016), purports that job stressors can be minimized through workplace modifications and reorganization of production for less stress risk. It is necessary to take directions that exceed profit concepts and enters the overall quality of life of employees (Ogunsola, 2013; Ogunsola et al., 2020).

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The findings of this study showed that respondents adopted a variety of emotion as they regulate their emotions when dealing with their patients and patient's families. Findings alluded to more male respondents using varieties of emotions than female respondents when interacting with their patients while delivering healthcare services. This was found to support earlier findings of Gabriel & Diefendorff, (2015), that participants adopt varying emotional labour strategies during the same

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interaction, depending on the fluctuation in the customers', clients' or patients' uncivilly, in a bid to mitigate the discrepancy between felt and required emotions.

Frequency of displaying emotions on an average day: The findings of this study on frequency of displaying emotions on an average day show that the frequency with which nurses, although also moderate (between 2 and 4), has the highest or strongest mean scores (3.3 – 3.7) among other components of ELS. This indicates that the nurses on a daily basis use their emotions at a high moderate level of frequency. The study also a significant association with ethnicity, where the Yoruba respondents exhibited significantly higher scores in the frequency domain than the Igbos and others tribal affiliations on the "*Display specific emotions required by your job*." This finding on ethnicity is new as no previous study could be obtained comparing tribal or ethnic grouping and EL. However, in Nigeria, the Yoruba ethnic nationalities are generally believed to be the most emotional group. However, Kusakli and Hüsmenoğlu (2021), postulated that Nurse Managers must use their knowledge of diversity (which should include ethnic and tribal affiliations) to guide nurses in emotional labour in the caring environment.

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The result obtained also revealed the frequency with which nurses experience emotional labour differs based on ethnic affinity. The findings showed that nurses (respondents) who are of Yoruba ethnicity were found to experience emotional labour at the workplace more frequently than respondents from other tribes. This factor may be attributed to the locale of the hospital or still the natural affiliation individuals have with people of same ethnic origin.

The intensity domain of emotional labour depicts an average range of display among nurses. This implies that nurses often display their emotions moderately at the workplace for the achievement of good quality healthcare delivery. However, on the overall, the degree of emotional labour among the respondents was inconsequential. This is because there was no statistical significance

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in the relationship between the items that constitutes intensity of emotional labour and the socio-demographic characteristics of the respondents. This result may be attributed to the fact that nurses who are professionally-known as caregivers need not exhibit too much emotions when performing their duties. They need only to exhibit emphatic emotions in dealing with patients.

Findings on the intensity domains are generally low, with a very narrow range of 2.7 to 2.8 in the two components of intensity of emotions. This signifies that the nurses on a daily basis use their emotions at an average level of intensity. Manju & Smitha (2018), had stated that in hospital setting, nurses face diverse and complex working environments where misery and compassion issues are common. To care for the patients and their families, nurses must attain and maintain attitudes and emotions that are supportive thus increasing the psychological burden of care.

When comparing findings on both deep acting and surface acting behaviours, male respondents are reported to have significantly higher scores than the female respondents. However, in the deep acting role, other ethnic groups in Nigeria other than the Yoruba and the Igbos reported higher deep acting behaviours. Higher educational qualifications are also reported to be significantly associated with deep acting scores than other qualifications.

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The socio-demographic variables of this study participants show that the distribution of the respondents is a fair representation of the study setting and study participants' socio-demographic profile. Gender, age, marital status, religious, ethnic and educational groupings and years of working experiences of the nurses are strong parameters that could predict emotional labour. These indices have been tested with the ELS as presented.

Previous studies on emotional labour (Pan, et al., 2019; Harini, 2013), had emphasised the link between socio-demographic variables and emotional labour. This association is tested in this study

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and discussed in relation to the findings of the emotional labour domains. The results of this study supports the findings of Nkemakolam et al., (2021) which observed that gender (sex) is a significant and independent predictor of emotional labour in the service sector. In their study, Soumyaja, Sowmya and Joy (2022), also reported that there was a positive relationship between burnout and both surface and deep acting strategies with males being stronger than females. Taylor et al., (2021), pointed out that when males and females were compared in their study, females expressed feeling overwhelmed, tense and less respected thus reporting more negative feelings than males in all ranks in the organisation. However, it contradicts same in the sense that the present study discovered that male are those who use varieties of emotions than female but it is the opposite in the study of Nkemakolam et al (2021). This difference may be attributed to whether or not such service sector is a particularly gender-dominated type. The probable reason for this result may be connected to the fact that male nurses often use surface acting while dealing with emotion-evoking situations with their patients or while shoving-off their emotions especially when leaving the workplace. Taylor et al., (2021), viewed that different emotional demands and regulations might result in different behaviour and work outcomes due to workplace emotional experiences. Nurses and other emotional labourers use diverse coping strategies in an attempt to replenish their diminished mental and energy resources while performing their organizational expected rules.

5.4 SECTION B: QUALITATIVE RESULTS AND DISCUSSION OF THE FINDINGS

This section presents and discusses the results of focus group discussions carried out with professional nurses. The focus group result that is presented addressed objective 3 of the study:

- *to explore professional nurses' experiences of emotional labour.*

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The following questions and probes guided the focus group discussions to determine the stated objective:

- What are the biggest problems with nursing practice in this hospital?

Probes used: How significant are these problems? What does that mean? How did it happen?

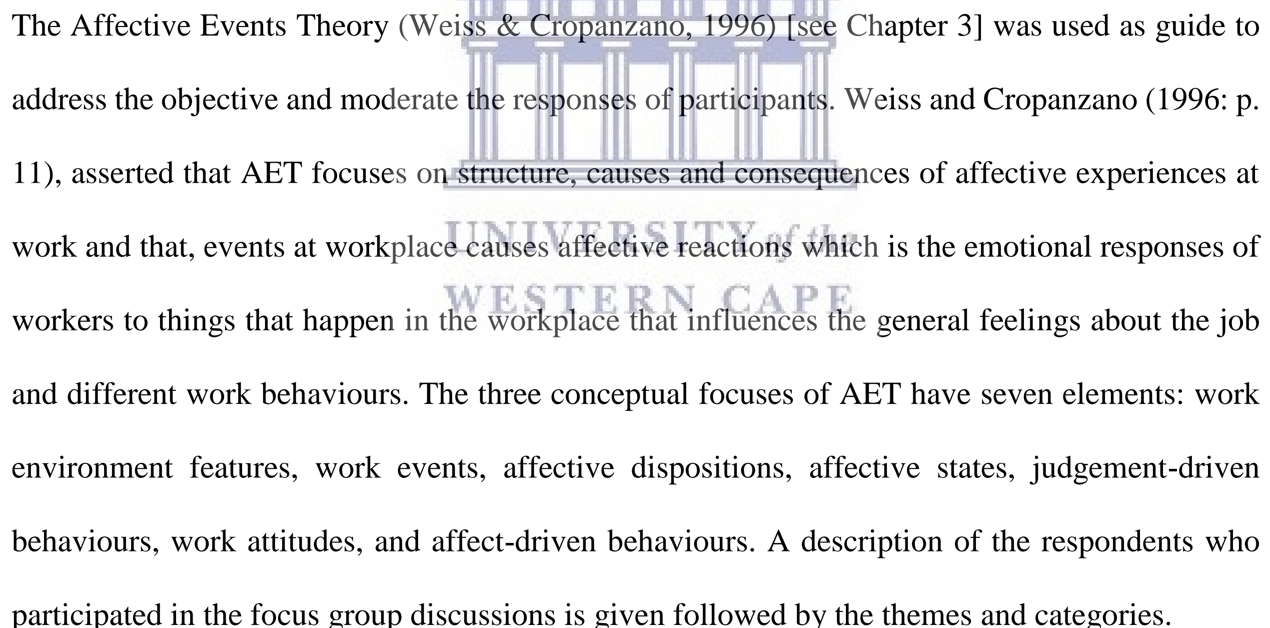
- What causes the problems?

Probes used: What did you do? Do you think these problems are sources of stress at work?

- What do you understand by emotional labour?

Probes used: When you think about emotional labour, what is the first thing that comes to your mind? Please tell me more. Please give me an example.

- How do you think the problems can be solved?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The Affective Events Theory (Weiss & Cropanzano, 1996) [see Chapter 3] was used as guide to address the objective and moderate the responses of participants. Weiss and Cropanzano (1996: p. 11), asserted that AET focuses on structure, causes and consequences of affective experiences at work and that, events at workplace causes affective reactions which is the emotional responses of workers to things that happen in the workplace that influences the general feelings about the job and different work behaviours. The three conceptual focuses of AET have seven elements: work environment features, work events, affective dispositions, affective states, judgement-driven behaviours, work attitudes, and affect-driven behaviours. A description of the respondents who participated in the focus group discussions is given followed by the themes and categories.

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5.4.1 Description of the sample

A total of 50 participants participated in the focus group discussions from the three research sites. The table below describes the characteristics of the participants at each of the research sites.

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Table 5. Socio-demographic characteristics of the participants

Items	Total n=50	FMC Owo n=16 (%)	FMC Abeokuta n=19 (%)	OAUTHC Ife n=15 (%)
Age group				
36 – 40 41 – 45 46 – 50 > 50	1 8 17 24	1 (6.3) 3 (18.7) 5 (31.3) 7 (43.7)	0 (0.0) 3 (15.8) 7 (36.8) 9 (47.4)	0 (0.0) 2 (13.3) 5 (33.3) 8 (53.4)
Gender				
Male	10	3 (18.7)	4 (21.1)	3 (20.0)
Female	40	13 (81.3)	15 (78.9)	12 (80.0)
Qualifications				
Registered Nurse/Midwife	16	09 (56.2)	04 (21.1)	03 (20.0)
Bachelor of Nursing Science	25	06 (37.5)	10 (52.6)	09 (60.0)
Masters	6	01 (6.3)	02 (10.5)	03 (20.0)
Marital status				
Single	0	0 (0.0)	0 (0.0)	0 (0.0)
Married	50	16 (100.0)	19 (100.0)	15 (100.0)
Religion				
Christianity	32	11 (68.7)	12 (63.2)	09 (60.0)
Islam	18	05 (31.3)	07 (36.8)	06 (40.0)
Tribe				
Yoruba	39	12 (75.0)	16 (84.2)	11 (73.3)
Ibo	8	02 (12.5)	03 (15.8)	03 (20.0)
Hausa	0	0 (0.0)	0 (0.0)	0 (0.0)
Others	3	02 (12.5)	0 (0.0)	01 (6.7)
Years of experience				
16 – 20	2	02 (12.5)	0 (0.0)	0 (0.0)
21 – 25	6	03 (18.7)	02 (10.5)	01 (6.7)
26 – 30	17	04 (25.0)	07 (36.8)	06 (40.0)
> 30	25	07 (43.8)	10 (52.6)	08 (53.3)

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Slightly less than half of the participants were over the age of 50 years. Most of the participants were females. Half of the participants had a Bachelor of Nursing Science degree. Half of the participants had more than 30 years working experience.

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5.5 THEMES AND CATEGORIES OF RESPONDENTS EXPERIENCE OF EMOTIONAL LABOUR

The results of the qualitative section are therefore presented using the conceptual focuses of structure, causes and consequences of affective experiences. The structure comprises themes 1 and 2; causes: themes 3 and 4; and consequences: themes 5 and 6 respectively. The results are presented per theme and category - focusing on the verbal and non-verbal responses, group interaction and field notes during the data analysis process. The themes elicited relating to the physical environment: burden bearing, crèche of other health professions, image of nursing, emotional and physiological responses of nurses working in tertiary hospitals in Nigeria. Table 5.18 depicts the themes and categories of the participant's experience of emotional labour. This is followed by a description of the themes and categories. The three settings were thus coded as: FMC Owo (FO); FMC Abeokuta (FA) and Obafemi Awolowo University Teaching Hospital Complex, Ile-Ife (OAUTHC) as (OA).

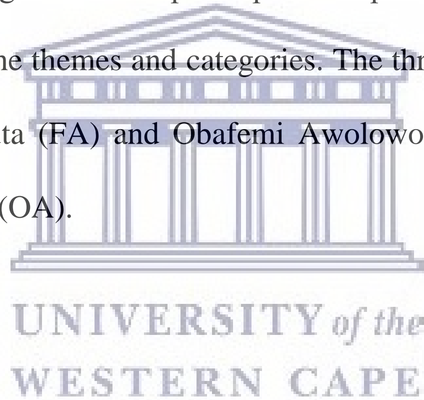
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Table 5.18: Themes and categories of participants experience of emotional labour.

THEMES	CATEGORIES
AET conceptual focus on structure	
Theme 1: Externalisation of feelings and behaviour by focusing on the physical environment and resources to aid in care provision	Lack of motivation, financial, human resources and poorly maintained infrastructure resulted in participants improvising to impact on patient care
	Participants reported verbal and physical abuse from patients and their families which resulted in feelings of helplessness and embarrassment
	Negative perception of nurses' knowledge by patients and relations impacted on nurses' ability to defend themselves in the face of adversity.
	Lack of support from policy makers and supervisors created a feeling of neglect among nurses.
	The use of coping strategies such as praying, keeping quiet and detaching from problems aided participants to cope with the working environment
	Participants expressed dissatisfaction about inadequate remuneration resulting in feeling of inferiority, under rating, unappreciated
	Perception of participants on the future of nursing
	Participants expressed disaffection on carrying out non-nursing tasks resulting in physical ill health and intention to leave.
Theme 2: Burden bearers	An unconducive working environment consisted of managing crises and being blamed for lack of resources to provide patient care.
	Participants' experience of emotional pain at workplace as a result of expectations of nursing as a caring profession.
AET conceptual focus on causes of affective experiences	
Theme 3: Crèche of other professions	Participants perceive themselves as being responsible for other professions working in the hospital.
Theme 4: Negative social image of nursing based on nurses' response to caring	Poor image of nursing as a result of inability to give adequate care due to stress at workplace; requirements to work are not readily available.
	Participants perceived themselves to be unappreciated whilst being in the forefront of complaints against them.
AET conceptual focus on consequences of affective experiences	
Theme 5: Emotional responses to the work environment	Participants expressed being unhappy and unappreciated by patients and other health workers due to unconducive work environment.
	Experienced a variety of negative emotions in response to being unfairly treated.

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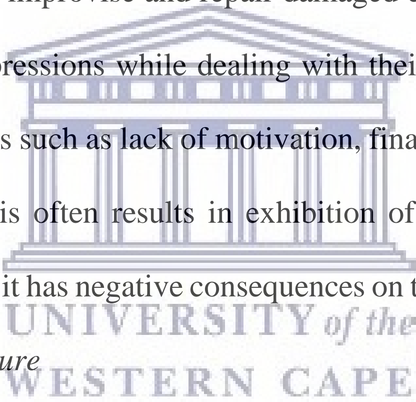
	Participants experienced being overworked due to increased patients' population which resulted in unhappiness and crises in the workplace.
	Participants expressed a variety of emotional responses as a result of work overload and patients' relations.
Theme 6: Physiological responses to the work environment	Physiological responses of nurses to unconducive work environment are reflected in some becoming ill, tired, exhausted and crying.
	Participants expressed the need for rest, advocates, being pro-active and participants agitated for support.

5.5.1 Theme 1: Externalisation of feelings and behaviour on the physical environment and resources to aid in care provision.

In this study, nurses expressed feeling tensed up, disorganized and not motivated due to shortage of resources. This makes them to improvise and repair damaged equipment. Nurses are expected to exhibit positive emotional expressions while dealing with their patients. They are faced with different work-related deficiencies such as lack of motivation, financial and human resources, and poorly maintained resources. This often results in exhibition of negative attitudinal behaviour towards their patients. In essence, it has negative consequences on the care provided to the patients.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Lack of resources and infrastructure

The lack or inadequacy of physical, financial and human resources, and the need to often improvise and repair broken equipment can impact on the emotional labour of nurses.

The excerpts from the participants below reflect the shortage of resources:

> *"Most of the things we need to use to work are not always available… you see us improvising, which sometimes does not augur well" (FO18)*
>
> *"…instruments, instruments and equipment to work with, we also have challenge on that, we need to improvise some of the times, you need to crack your brain to see how you can carry out proper nursing care to those patients" (OA15).*

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"…when you get to work in the morning you will first be faced with crises: "ha ha, ADNS [Assistant Director of Nursing Services] *there is no soap o, ADNS, there is no water o, ADNS this sphygmomanometer is not working…" you are starting from crises end early in the morning… (F016)*

"…we are not being motivated…if you go to our offices, you will pity us. Some of the offices the fans are not working, the air conditioners they put there, they are not working, the intercoms are not working … we just keep on patching and keep on managing ourselves" (FO11)

"…we don't have beds or couches to put patients …it is even worse when we have accident victims you see us rushing to take patients to somewhere, so that we can admit them" (FO17)

"…the things we need to use are not readily available for us" (FO12)

"…working in big hospitals has not been easy, finding somebody that will collect blood for you from the lab is a problem, to even get people that will sweep and mop the environment that you put your patients is a problem" (FO25).

"…the area of organization, when you are having about four, five ward rounds going on together at the same time, you're having two nurses …you find out that it makes the nurse to be tensed up, because she can't be among four, five consultants' ward round at the same time …the nurse is disorganised …sometimes you get to the ward you're confused, you don't even know where to start and where to end and the time is going and a nurse coming in the morning, emotionally you are disturbed when somebody is saying he wants to do round and you are not prepared for that round" (FA13)

Verbal and Physical Abuse

Nurses are expected to express certain emotions on the job towards their supervisors, patients and patients' family members. Nurses often feel helpless and embarrassed when they are confronted

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with cases of verbal and physical abuse when carrying out their tasks. Patients sometimes transfer their aggressions to nurses.

The excerpts below allude to the verbal abuse of participants:

"Our leaders should …realise that we are human beings…" (FA21)

"…I was not given the opportunity to explain what really happened …I was abused … I was washed down …I felt cheated … I felt humiliated. …I was punished … I was not balanced "…I was not myself for a whole year …I was only trying to help my patient" (FO28)

"…this woman needed to void and I was the only one on ground … I just said mama wait and the daughter was like answer her and she practically shouted on me" (OA13)

"We are faced with patients and relatives, shouting at us, that they have come since, no space, as if we don't have feelings for them …we find ourselves handicapped" (F017)

"…people are being beaten …also assaulted" (FO12)

"…patients will now shout on nurses or sidetrack you and go to the doctor …whereas what they are supposed to have is not available" (FO16)

"…when the patients accuse nurses or there is assault when I get home I don't feel happy, I will just squeeze my face" (FO14)

"…I was asking her what happened, she now flared up, she insulted me …started screaming …imagine being shouted at in the presence of everybody … I didn't say a word … I felt bad within me but I couldn't talk back … I was so embarrassed" (OA12)

Negative perception of nurses' knowledge

Nursing is a profession which requires a high level of knowledge on care-giving. The level of nurses' knowledge is sometimes negatively perceived by patients and their relations; the aftermath of which leads to nurses' ability in grooming themselves in the eventuality of having to face adversity. The participants expressed negative feelings of embarrassment and being incapable of

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caring when patients and their relations give an impression that they do not have adequate knowledge of care,

> *"…it makes the nurse to look like somebody that does not have the knowledge" (FO13)*
> *…when the nurse is so stressed, she will not be able to give out her best to the patient and also negative image of the profession (FO28)*

Lack of support (inadequate supervision)

Nurses need to be supported in order for them to effectively and efficiently perform their duties. The lack of support by policy makers and even supervisors often leave nurses with the feeling of inadequate supervision.

> *"…we have people in the Federal Ministry of Health representing nurses but there has never been a time they come down here to hear from us and see how we have been doing." (FO11)*

Coping strategies

Participants used various positive and negative coping strategies to deal with the working environment. These included seeking spiritual guidance and detachment in the face of adversity. Some of the participants expressed that whatever bothers them are left behind in order to reduce the problems at hand such as "dropping the home problems at hospital gate", "keeping quiet over a problem" and "praying".

> *"…the technique I now use is when I'm coming to the hospital I will drop my problems at home at the gate" (FO14)*
> *"You just close your mouth…" (FA210)*
> *"…I understand how you feel, don't worry, I won't disturb him…I didn't say a word" (OA12)*
> *"…I had to start praying…" (FO13)*

Lack of job satisfaction and inadequate remuneration

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Poor remuneration of nurses often results in the expression of dissatisfaction, having feelings of being unappreciated. The nurses felt that doctors are more recognised than them despite the long hours they spend caring for the patients. The poor remuneration of nurses may impact negatively on their emotional display.

> *…nurses are not adequately remunerated (FO12)*
>
> *"…when you look at some of the things we do in the hospital, we stay with the patients 24 hours …the doctors will just come and assess for five minutes …and at the end of the day he earns more than nurses …nurses are not adequately rated …that is the problem they guide against in the advanced countries, the nurses earn better because they know their roles" (FO12)*
>
> *"…after doing all these work, it is time for you to receive remuneration, it [remuneration] is being slashed" (FO28)*
>
> *"…nurses can't cry beyond the fences …if they know that if nurses are treated badly, they have people they can run to, they have advocates, they will treat us less inferior than the way we are being treated" (FO11)*

Future of Nursing

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The perception that nurses have on future prospects of nursing profession can trigger emotive responses and actions on their part. Their perception of how promising or otherwise the nursing profession will be in future can lead to proactive emotions and actions. Participants reported discouraging their family members from pursuing nursing as a career because nursing was seen as not having prospect in Nigeria.

> *"…I remember during one of our meetings, someone said: "the way things are going I won't want any of my children to become a nurse" …nursing will go into extinction if we don't take time …with time people will come and tell you that my child wants to be a nurse you will say "No, it is a no-go area instead let him go and read Yoruba (Language) in the university" (FO24)*
>
> *"…nurses should be pro-active" (FA13)*

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"…the leadership of the health sector should be neutral" (FO12)

Disaffection towards non-nursing tasks

Nurses have designated duties and tasks they are required to perform on the job. Nurses often display disaffection towards performing non-nursing tasks. This may lead to nurses' physical ill-health as a result of effects of work environment on their health, as well as the intention to leave.

"…carrying out ad-hoc duties ...we do a lot of porter's work" (FO11)
"…we are doing the jobs of attendants" (FA29).
"…in an area where a patient is being discharged and then he is owing …the social work department is there with nothing to do, while we will be running after hospital bills …if the money is not paid, the nurses would be held responsible" (FA18).

5.5.2. Theme 2: Burden bearers

There are many stakeholders responsible for the provision of care in the healthcare environment. However, nurses form the backbone of healthcare provision in many countries. They are at the cold face thus often roles are blurred thus they experience themselves assuming multiple roles in their caring roles. Nurses are also often left to carry the burden of the health system they find themselves. They are required to bear the brunt of managing crises and experiencing emotional pain.

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Unconducive working environment

Where the working environment is unconducive, nurses are often blamed for the inadequacy or unavailability of resources to be used to provide patient care.

"…everything bounces back on the nurses" (FA27)
"…to everybody it's like we are the burden bearer every time …. Everything is centred on the nurses" (FO15).

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"…the patients are receiving necessary assistance needed by them, but the nurses are the ones bearing the brunt, and every blame is on nurses" (F016)

"…we are always the ones that the patients want to talk to whatever service they need …if the water is not running they will come to the nurse, if it is light …if you look at it very well we are the first point of call" (FO12)

"…if the food is not well prepared - it's a nurse, if a door is bad - it's a nurse, if they are not having fan in the unit - it's a nurse" (F016)

"…if a doctor is not coming to attend to a patient - it is the nurse they (patients) believe that you are the one that didn't call that doctor" (F012)

"…you will be at home the number of calls you will receive will not allow you to rest … you don't have time to stay with your family" (FO15)

"If there is a mistake may be a patient dies, the nurse will be blamed" (FO24).

Expected behaviour of a professional nurse.

Participants alluded to the incongruence between the expectations of being a professional nurse and their affect when they encountered stressful situations at work. Nursing as a profession have certain display rules which should be adhered to. These rules are a skillset formed being a professional nurse. The skills are required to be professional. How one behaves in the work environment is often incongruent to how one feels. One participant described this as 'pain' whilst another alluded to being 'trained properly' to display expected behaviours. The following participant excerpts allude to the enacted behaviours expected:

"…pains that one pass through in the process of carrying out your duties" (FO13)

"…I went back to the station and I was doing my work …as professionals if you have been trained properly …you should not react in a way that will make your patient to be uncomfortable" (OA12)

"…I was pinned to the wall…I was stretched beyond my elastic limit… I was getting mad, so I just told myself "be calm, be calm"…who will I explain to that I was practically

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busy…the patient has paid for it…I don't see myself as a fulfilled nurse when I don't do what I am supposed to do" (AO13).

5.5.3 Theme 3: Crèche of other professions

Nursing as a profession is perceived by patients and their relations as the caring domain of health profession because patients and their relations perceive nurses as being in charge of caring services. As a result, nurses tend to express emotions to suppress their real emotions as alluded to in the following participants' excerpts:

"…most of the doctors will not come and review their patients and admit them into the ward. We keep calling them reminding them to come and review their patients and admit to the ward" (FO17)

"…anything that goes wrong in the hospital it is the nurse, any aggression from any staff or any area any shortage or failure of service delivery at any point is transferred on the nurse" (FA11).

"…we are thought to be the wife of every other profession, you know wife is submissive, submissive nature, so we are like where they keep everything" (FO24).

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"…nursing profession seems to be the last in the healthcare system …it is like "nurses and others". …we are thought to be the caring haven (crèche) of other professions" (FO24)

"…they [patients] see us as the one in-charge of the whole organisation" (FO12)

5.5.4. Theme 4: Negative social image of nursing based on nurses' response to caring.

The nurses expressed that the patients look at them as not participating in their care and that their complaints are on the nurses. They lamented that when stressed, they will not be able to give their

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best. This creates a negative image about nursing which makes them feel unappreciated and unhappy.

> "*...they are looking at us like we are not doing anything in their management" (FO15).*
> *"When the nurse is so stressed she will not be able to give out her best to the patient and also, it will give us a negative image of the profession…" (FO28)*
> *"When the public wants to leash out (complain) any problem in the hospital to anybody they will leash out (complain) on nurses" (FO22).*

Experience of stress

This is the resultant effect of the inability of nurses to give patients adequate care at the workplace due to stress and the unavailability of resources required for proper healthcare delivery.

Lack of happiness and appreciation of nurses

The lack of appreciation of efforts of nurses in giving care and continuous condemnation of the nurses breed emotional reactions. Nurses sometimes feel unhappy, unappreciated and embarrassed by patients and other health workers as a result of poor and unconducive working environment. Lack of resources sometimes affect the quality of nursing care given to patients resulting in negative patient behaviours towards nurses. Therefore, patients and their relations are in the forefront of complainants without giving credence to nurses' effort to provide care.

> *…they are looking at us like we are not doing anything in their management (FO12)*
> *"…in the theatre there is no air conditioner ...imagine how people will work under that situation …the stress they will undergo physically and emotionally" (FO22).*
> *"…when you are not happy you get to the society at times you are even ashamed to say "I am a nurse" ... you won't want any of your children to be a nurse" (FO24)*
> *…I lost a patient …the folder couldn't be found ……the relatives felt we killed the patient otherwise we wouldn't have hidden the folder ...looking at what I passed through while nursing the patient instead of being appreciated it is the opposite (FO13)*

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…any problem in the hospital …they (patients) will lash out (complain) on nurses (FO22) …one of our Gynaecologists came to the theatre to operate said…"what do you people do at least it's the same thing your nurses do at the bedside" I felt like "the ground should swallow me" (FO24)

"… if a patient comes in you have set up an i/v line and a doctor comes in and puts a stripe of plaster, the patient will say "ha Doctor e se o" (thank you, Doctor) the nurse who has been there since is not appreciated because the doctor touched him, it makes the nurse to look like a supportive staff" (FO24)

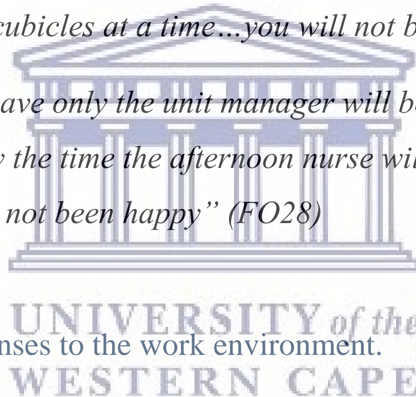
"…there are some wards in this institution where the nurses do not have any place to observe break …do you think that nurses will be happy?" (OA21)

"…you are not happy" (OA13)

"…it is making us to go home unhappy and prone to crises especially from the masses and the patients" (F012)

"…she cannot be in two cubicles at a time…you will not be happy" (FA210)

"…when nurses are on leave only the unit manager will be on morning duty nursing about 10-12 patients …by the time the afternoon nurse will come in fact she is so tired and exhausted …we have not been happy" (FO28)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5.5.5 Theme 5: Emotional responses to the work environment.

The work environment is a determinant factor of emotive responses and actions of nurses in the workplace. The work environment may contribute to nurses' experience of negative feelings such as unhappiness, un-appreciation, unfair treatment, frustration and embarrassment. Healthcare stakeholders are to consider three influencing factors: work stress, workload and regulations on job performance of clinical nurses.

"…we act as security officers …if such a patient should abscond …the nurse will write as if you are the one that encouraged the patient to leave the hospital" (FA12).

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Lack of job satisfaction: The nurses express dissatisfaction about their job because the increasing number of patients to be cared for is eliciting various emotional responses from them.

> *"…when nurses are on leave only the unit manager will be on morning duty nursing about 10-12 patients …by the time the afternoon nurse will come in fact she is so tired and exhausted …we have not been happy" (FO28)*

> *"…the nurses are not happy, no job satisfaction" (FO24)*

5.5.6 Theme 6: Physiological responses to the work environment.

The physical working environment often evoke physiological responses in the participants. An unconducive work environment, the need for advocates and place of rest can lead to nurses exhibiting physiological emotions.

> *"…most of all the stated problems have gone to the extent of affecting [nurses] physical health" (FO28)*

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Poor physical environment

Excessive exposure of nurses to poor physical environment results in physiological emotions such as falling ill, tiredness, exhaustion, crying, tearfulness and being touchy. The participants ventilated that they are sometimes alone nursing ten to twelve patients. Also, that they do not have a rest room on the wards.

> *"…nurses will be falling sick …it's really affecting us". (FO28)*

> *"…some of them are also having back pains, Spondylosis, aggravated by demands of the work, having some of them coming down with ill health" (FA13)*

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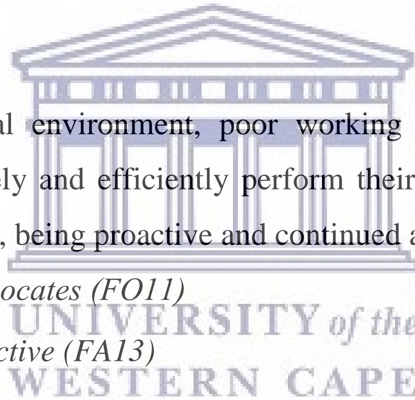
"When nurses are on leave only the unit manager will be on morning duty nursing about 10-12 patients, … by the time the afternoon nurse will come in fact she is so tired and exhausted …you become irritable …we have not been happy" (FO28)

Psychological stress, you are … harbouring something …affecting your emotion, and when you now get to work, you do not have a consoler [counsellor] what can console you… that is why you see some nurses when you …want to ask questions, they will just burst into tears because they are already emotionally stressed. (FA110)

…when you are overlabored, especially during ward round …and you are the only one …sometimes you will be touchy (FA18)
As nurses we need a place where we can rest. If you want to eat, it's a problem …and you cannot concentrate. (FO15)

…many of our ward managers are not assertive (FA14)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Need for support and advocates

The lack of conducive physical environment, poor working conditions, lack of/inadequate resources for nurses to effectively and efficiently perform their duties and responsibilities has gingered the desire for advocates, being proactive and continued agitation for support.

…nurses should have advocates (FO11)

…nurses should be pro-active (FA13)

5.6 DISCUSSION OF THE QUALITATIVE FINDINGS

In this study, nurses expressed feeling tensed up, disorganized and not motivated due to shortage of resources. This makes them to improvise and repair damaged equipment. This is supported by the findings of Zamanzadeh et al. (2013), in the study of that nurses' efforts in carrying out emotional labour when caring for patients often lead to personal emotional pain, depression and emotional exhaustion. Also, Maben et al., (2022), in their study reported that the nurses could not meet their expected standard of care due to the overwhelming situation demand in the work environment and shortage of nursing staff resulting in poor or delay in nursing work (Rivaz et al,

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2018; Ustun, 2021). Therefore, when the demand for services increase, shortage of nurses and imbalance in nurse/patient ratio becomes obvious (Raeissi et al., 2019).

In their studies, lack of incentives, inadequate equipment, increased workload due to unequal nurse/patient ratio, inadequate number of qualified nurses, sudden changes and swampy demand of the work environment negatively affected nurses' usual quality of care (Bender, et al., 2019; Johansen et al., 2021; Raeissi, et al., 2019; Maben et al., 2022). Raeissi, et al., (2019), note that when hospital services increase, shortage of nurses become obvious. The resultant effects are thus manifested in missed care, nursing care being delayed and eventually low job performance of nurses (Johansen et al., 2021). Contrarily, Al-Makhaita, Sabra, & Hafez, (2016) asserted that regardless of nurses' years of clinical work, their job performance is consistent though professional skills, values and perception may also influence their job performance (Nimako & Basatan, 2022).

When nurses work in a safe environment that is devoid of violence, and the number of nurses is adequate, then the quality of care will be correspondingly high thus improving their job satisfaction (Boafo, 2018). In this study, the nurses expressed feeling unhappy because of being verbally abused, sometimes assaulted or sidetracked by patients and their relations. Results of a research by Kibunja et al., (2021), on workplace violence against nurses at Kenya revealed an overall prevalence of 81.7% with indication of verbal abuse, physical violence and sexual harassment by patients and their relations. The nurses revealed that of the incidents, actions were not taken in about 50% while 28.6% and 57.1% were reported to their supervisors and security officers of the hospital respectively; and 42.9% were warned verbally.

The International Labour Organisation (ICN, 2003), describes workplace violence as 'any incidence where the staff is abused, threatened, or assaulted at work including committing to and from work, involving an explicit or implicit challenge to their safety, well-being or health'.

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Kibunja et al., 2021; Liu et al., 2019) also reported that the commonest form of workplace violence is verbal abuse which more than 80% of the nurses experience particularly those in the emergency department.

Previous studies identified poor physical and psychological problems such as burnout, increase in cases of musculoskeletal injuries, sleep disorders, (Laschinger & Grau, 2012), as responses to violence in a healthy workplace. Najafi et al., 2018; Tee et al., 2016; Zhang et al., 2018), pointed out that violence against nurses at work negatively affects their retention, job security, professional and work attitudes; while it can also cause poor communication between patients and nurses, and delayed care (Liu et al., 2019).

Similarly, Foster et al., (2019); Itzhaki et al., (2018) and Kelly et al., (2016), reported that verbal and physical assaults were the most prevalent forms of violence against nurses and the main stressors at the workplace. 83% of nurses who participated in the study carried out by Tonso et al., (2016), reported that they experienced one type of assault in the previous year.

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Participants in this study reported feeling embarrassed when looked upon as one who does not have the knowledge to care for their patients. Similar results were obtained from studies on perception and expectations of patients on quality nursing care. Report from the study of 168 patients at Kenyatta National Hospital, Nairobi by (Shawa et al., 2017), revealed that about 86% of the participants expressed that they were dissatisfied because they expected that nurses would be knowledgeable and competent in carrying out nursing care. Furthermore, in the study of Jordanian in-patients, the respondents had a relatively low expectation towards the competence (3.1/5) and knowledge level of nurses (3.1/5) on a Likert scale of 5 (Al-Hussami et al., 2017).

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Contrary to the results of this study, Sharma et al., (2019), reported that respondents (patients) in their study were satisfied with nursing care services received, rating nurses very high (94.21) in communication skills; 87.3% in caring skills and 88.7% on willingness to recommend others to utilise the hospital. The result obtained in the study carried out in a tertiary hospital at Pakistan by Ahsan (2014), more than two-thirds of participants expressed satisfaction on the knowledge base of nurses. Also, Girmay et al., (2018), in their study, "knowledgeable and competence of nursing care" ranked as one of the highest in the perception of patients on nursing care (56.1%; with Mean/SD at 3.23+ 1.11) even though about 56.1% of the participants perceived the nursing care as being poor.

In their study, Kewi et al., (2018) report that about half of the participants (patients) acknowledged having a good perception on the general quality of nursing care that they received from nurses. More than fifty percent had good perception on nurses' competency and knowledge when responding to their questions. This is because patients view quality nursing care as encompassing personalised information, competency of nurses and interpersonal care among others (Kewi et al., 2018). Peter, (2021), posited that patients trust that high quality care is delivered when healthcare providers have goodwill and competence. In the same vein Rivaz et al., (2018); Raeissi, et al., (2019), reported poor management support and high level of bureaucracy as findings from their studies. Nevertheless, patients still perceive that the good nature and competence inherent in healthcare professionals will make them to provide appropriate care (Peter, 2021).

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Provision of adequate infrastructure, incentives, good remuneration, proportionate distribution of nursing staff in the service areas (Konlan et al., 2021), system-change through modification of

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policies and procedures, and scheduling of procedures (Nepal et al., 2020) among other factors will help to boost the morale of nurses, improve patient satisfaction and achieve positive care outcome.

The coping strategies adopted by nurses in this study were keeping mute, praying, and leaving the problems behind in order to reduce stress. In the study of nurses' experiences during Covid-19 pandemic, planful problem-solving adaptive coping strategy was used to sustain their general well-being, low level burnout and social support when they experience any stressor (Nimako & Basatan, 2022).

Nurses in this study expressed dissatisfaction about their job, poor remuneration, inadequate supervision and felt unappreciated and unrecognized. Similarly, studies on quality of work life of nurses in Iran was revealed to be low for 70.5% to 81.2% of the participants while 67.2% of the nurses expressed dissatisfaction with their quality of work life in Ethiopia (Chegini et al., 2019; Kelbiso, 2017). Studies conducted by researchers such as Purpora & Blegen (2012; Valizadeh (2018), have described a situation of non-appreciation of nurses and exposure to offensive attitudes by their patients, patients' family caregiver and other health officials. Iqbal et al., (2018) in their study, corroborated other findings that emotional labour has positive relationships on emotional exhaustion and job satisfaction and also a positive effect on emotional exhaustion.

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In their studies, lack of incentives, inadequate equipment, increased workload due to unequal nurse/patient ratio, inadequate number of qualified nurses, sudden changes and swampy demand of the work environment negatively affected nurses' usual quality of care (Bender et al., 2019; Johansen et al., 2021; Rivaz et al., 2018; Raeissi et al., 2019; Maben et al., 2019). Raeissi, et al.,

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(2019) note that when hospital services increase, shortage of nurses become obvious. The resultant effects are thus manifested in missed care, nursing care being delayed and eventually low job performance of nurses (Johansen et. al., 2021).

Other factors that contributes to lack of job satisfaction include: poor working conditions, lack of safety, low status of nurses at work, and low salary (Raeissi et al., 2019). Raeissi et al., (2019), also reported that benefits (52.9%), salary (52%) and work accomplishment (50.4%) ranked highest on the level of dissatisfaction of participants in their study. Meanwhile, Azim et al., (2013) describe job satisfaction as the overall difference between what the employee expects and what he receives.

Contrary to the results of this study, Al-Makhaita et al (2016), pointed out that regardless of nurses' years of clinical work, their job performance is consistent though professional skills, values and perception may also influence their job performance (Nimako & Basatan, 2022). The nurses in this study thus experienced a proactive emotive responses of discouraging family members from becoming nurses perceiving that the future of nursing in Nigeria is bleak.

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The participants in this study expressed dissatisfaction with the many roles they play. They carryout non-nursing tasks such as managing crises, doing porter's work, keeping an eye on patients that owe hospital bills, and being held responsible for unpaid bills if the patient abscond. Setoodegan et al., (2019), discovered in their study that nurses were overburdened by assignments and responsibilities which are not part of their primary roles. This is because there was no clear parameters of job description or pre-defined tasks and duties. In essence, they were obliged to perform duties and tasks which were not originally their responsibilities or area of specialty.

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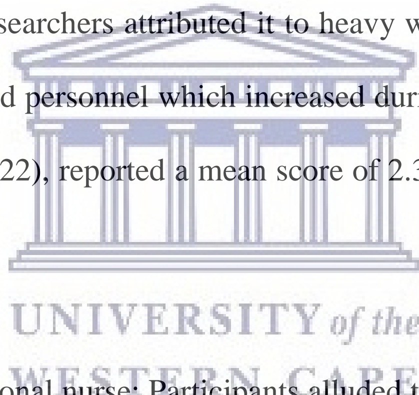
Unconducive working environment

Where the working environment is unconducive, nurses are often blamed for the inadequacy or unavailability of resources to be used to provide patient care. Cho & Han (2018), stated that nurses experience burnout in an unhealthy workplace when resources are either not available or inadequate in quantity. Similarly, Raeissi et al., (2019) report that respondents (nurses) were dissatisfied with their unsafe work environment. Alsaqri (2016) reiterated that when a healthy work environment is formed, the caring behaviour of nurses will improve thus, quality of care and patient satisfaction will be positively affected. Also, Afriyie (2021) and McDerid et al. (2021), found out that nurses working in oncology and critical care units are emotionally affected, experience high level of burnout and work-related stress when compared with nurses in other units (medical and surgical). These researchers attributed it to heavy workload, time pressure, lack of equipment and insufficient skilled personnel which increased during Covid-19 pandemic. On the contrary, Nimako & Basatan (2022), reported a mean score of 2.3159 that indicated low burnout level in their study.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Expected behaviour of a professional nurse: Participants alluded to the incongruence between the expectations of being a professional nurse and their affect when they encountered stressful situations at work. One participant described this as ‘pain’ whilst another alluded to being ‘trained properly’ to display expected behaviours. Findings of the study carried out by Hogg et al., (2018), reveals poor attitudes, communication and behaviour impact negatively on the emotional status of patients and carers. Therefore, it is important for nurses to understand the concept of emotional labour in order to provide a language for the meaning of both giving and learning to care.

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Contrarily, in the study carried on nurses, Boafo (2018), reported that majority of nurses expressed being respected at the workplace

Nursing as a profession is perceived by patients and their relations as the caring domain of health profession because patients and their relations perceive nurses as being in charge of caring services. As a result, nurses tend to express emotions to suppress their real emotions.

The emotional labour of nurses can arise due to inter and intra-personal conflicts such as inadequate working facilities, poor policy, team conflict or disagreements, undefined roles, responsibilities and benefits, poor communication network and unrealistic performance expectations of nurses in relation to caregiving (Mervat et al., 2019).

This is the resultant effect of the inability of nurses to give patients adequate care at the workplace due to stress and the unavailability of resources required for proper healthcare delivery. (Rushton, 2017), reported that participants had a challenging experience during the Covid-19 waves due to overwhelming demand for resources which led to poor and impoverished care. Participants in this study expressed feeling unhappy and unappreciated by patients and their relations despite their efforts to deliver good nursing care.

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The lack of appreciation of efforts of nurses in giving care and continuous condemnation of the nurses breed emotional reactions. Nurses sometimes feel unhappy, unappreciated and embarrassed by patients and other health workers as a result of poor and unconducive working environment. Lack of resources sometimes affect the quality of nursing care given to patients resulting in negative patient behaviours towards nurses. Therefore, patients and their relations are in the forefront of complainants without giving credence to nurses' effort to provide care.

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Emotional responses to the work environment.

Kaur (2019), in the study of nurses at selected hospitals in Punjab, reported that heavy work load has negative effects such as feeling physically and mentally exhausted, spending little time with family members, depression and anxiety. There is need for hospital management to provide cohesive work environment, reduce nurses' work load, provide recreational units, improve working conditions, and to organise training programs that will enhance performance (Kaur 2019).

The work environment includes: supervisor support, open communication and teamwork while the physical environment comprises of quality of patient area, and work spaces quality and safety (Butt et al., 2012). Therefore, nurse, patient and organisational outcome is dependent on the working environment of nurses because a healthy environment determines overall health of nurses, safety and quality of patient care and effectiveness of an organisation (Murugan & Flower, 2015). When a nurse is satisfied with her job then supervision has been supportive (Bailey, 2014).

Overwork has been attributed to stress in the healthcare environment particularly with current global shortage of nurses thus contributing to nurses' health problems (Karodia et al., 2016).

van den Oetelaar et al., (2016:3), described workload as "the amount of work that is given to a staff as well as on the resources available to handle this amount of work". Nursing workload is therefore the proportion of demands for available resources (Alghamdi, 2016).

Heavy workload has been linked with health related problems, job dissatisfaction and intention to leave job (Rajan, 2018). Work stress that is not well managed will result in negative consequences such as physical and mental illnesses, and psychological distress (Bhui et al., 2016), in the forms of coronary heart disease, cancer, lung problems, diabetes and accidents.

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Excessive exposure of nurses to poor physical environment results in physiological emotions such as falling ill, tiredness, exhaustion, crying, tearfulness and being touchy as expressed by participants of this study. Elbejjani et al., 2020) identified musculoskeletal diseases, emotional exhaustion, and mental health problems as the major outcomes of nurses' poor physical environment while nursing task allocation, teamwork, self-perceived workload, availability of resources can be used as a comprehensive approach to reduce the effect on nurses.

Long work shifts make the nurses vulnerable to variety of health problems and contributes to higher level of burnout in nurses; (Yarmohammadi et al, 2017; Vandeyala et al., 2017). The negative effects of work shifts on family and social lives was reported by 69 (95.8%) of the participants. Among these side effects, biological rhythm disorder, sleep disorder, health problems, decrease of performance, job dissatisfaction and social isolation are notable (Moradi et al., 2014). The lack of conducive physical environment, poor working conditions, lack of/inadequate resources for nurses to effectively and efficiently perform their duties and responsibilities has gingered the desire for advocates, being proactive and continued agitation for support among this study participants.

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The traditional nature of nursing, lack of confidence, knowledge of policy making and mentorship impacted negatively on passive participation of nurses in politics which is part of why the society have not heard nor heeded to their voice Oestberg, 2012; Santill_an-Garc_ia, 2020; Rasheed, et al. 2020; Salvage & White, 2019). As a result of marginalization of nurses in decision making, they have been relegated to the level of policy implementers (Rasheed et al., 2020).

The opinions of participants in this study on the need for nurses to be involved in politics were supported by several findings (Rooddehghan et al., 2019) opine that nurses have knowledge of

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social values and concern for caring; and advocates for the patients (Mason et al., 2020). Also that, among prominent professionals, nurses have been identified as the most ethical, trusted and honest (Gallup, 2019). Therefore, nurses should be involved in politics to bring the profession into limelight.

Scholars have thus suggested that including politics and policy making in nursing education, constant mentoring, training of nursing students at every level of policy making, including the students as part of policy discussion forum at unit level, striving to improve the image of nursing, resisting the dominance of males especially Physicians, lobbying by Nurse Managers and introducing change strategies to compliment the aforementioned will help to motivate and increase the interest of nurses to participate in politics Rasheed et al., 2020; Turale & Kunaviktikul, 2019; Benton et al., 2017; Shariff, 2014).

5.7 CONCURRENT TRIANGULATION STRATEGY

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The researcher used a concurrent triangulation strategy of mixed methods research. Data from both quantitative and qualitative approaches were obtained simultaneously, and information obtained from existing literature through integrative review were used for the triangulation. Data mixing or merging was done at the interpretation or discussion stage of the study to identify similarities and differences in the emerging themes. In the following sections, the concluding statements are discussed. The main concluding statement is explained, followed by sub-conclusions related to each main conclusion.

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Concluding Statement 1: Workplace events

This concluding statement relates to workplace events such as existing policy or the lack thereof as well as lack of support for nurses from the management of the hospital. Furthermore, there was lack of recognition for staff who had to cope with high workload and frequent changes in the unit. This statement also relates to the stressful nature of the job which was overwhelming for nurses. This resulted from intense demands of caring for high acuity patients, long working hours and the need to juggle or multitask. The long working hours robbed staff of spending time with their family and loved ones. These work environment features were exacerbated by nurses' experience of aggression from patients and their relatives. The impact of the workplace events and work environment features left staff feeling that they needed a break.

(a) Workload

van den Oetelaar, Stel, van Rhenen, et al. (2016), described workload as "the amount of work that is given to a staff as well as on the resources available to handle this amount of work". Nursing workload is therefore the proportion of demands for available resources (Alghamdi, 2016).

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Interactions with the Nurse Managers revealed that inadequate number of nurses place a heavy workload on them at work. This is evident by frequent night shifts and being recalled while on a night off to continue a shift resulting from the inability of the nurse currently on duty as a result of ill health. Hence the few nurses on the ground are over-burdened. Majority of the nurses lamented that frequency of night shifts is high and that they do not have the privilege of spending the night off with their families before being recalled to start another shift.

Nurse Managers in the study identified workload as a major source of emotional labour at their workplaces. This was premised on low nurse/patient ratio that resulted in additional tasks for them,

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running frequent night shifts, ill health culminating in excused duty and the few nurses on ground having to be recalled while on their day off to continue the shift duty. The Nurse Managers view the heavy workload as a great burden on their work life as it reduces the time they spend with family and loved ones. Also, at the workplace, most of them do not have a rest room for break time which makes it more stressful.

Heavy workload was also reflected in the responses of some participants when they ventilated that unit Nurse Managers can be alone on duty, especially when nurses are on leave. She has to carry out nursing procedures including wound dressing for about 10 patients, attend to doctors on ward round and also do administrative duties. Failure to distribute manpower based on "actual workload" results in either underutilisation in some hospitals or "overloading" in others.

Corroborating this, some participants expressed displeasure at the many roles nurses play, apart from core nursing duties such as acting as security officers on the wards to ensure that patients who have not paid hospital bills at time of discharge do not abscond.

Despite few nurses on duty, the activity schedules of medical doctors in the area of ward rounds are not well organised. Often times this activity starts at about 7am involving many groups coming into the ward at different times. This invariably affects the nurses leading to confusion and lack of concentration. The working hours are most times exceeded due to the many tasks nurses are expected to execute. This leads to many nurses falling ill, eventually being excused from duty, and more work for the remaining nurses.

Majority expressed that one or two nurses are often on morning duty attending to 10-12 patients who are critically sick, carry out nursing procedures (including wound dressing), ward rounds and administrative duties, and act as security officers to ensure that patients that have not paid hospital

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bills do not abscond from the wards. The nurses decried long working hours and eventual "breakdown" (fall sick) of members due to additional burden placed on the remaining few on the ground which often leads to psychological and physiological illnesses among them. Heavy workload has been linked with heath related problems, job dissatisfaction and intention to leave job (Rajan, 2018). Work stress that is not well managed will result in negative consequences such as physical and mental illnesses, and psychological distress (Bhui et al., 2016), in the forms of coronary heart disease, cancer, lung problems, diabetes and accidents.

Where the workload pressure is presumed to be positive, there is an increase in productivity and underutilisation of human skills while employees who experience high workloads are predisposed to high levels of job stress. This was expressed by the Nurse Managers as resulting in lack of concentration and a stressful work environment, invariably leading to a *"suffering and smiling"* scenario where *"the voice we are using is to cover the pain inside"* has become the slogan.

While the Nurse Managers are putting in all efforts, sometimes going an extra mile to ensure quality care is given to the patients, they are often assaulted by patients and relatives. In some units, where there are handicapped situations such as Accident & Emergency unit with inadequate bed spaces to contain increasing influx of patients, doctors do not review the patients as scheduled, consumables are "out-of-stock", shortage or failure of service delivery at any point, nurses are blamed, shouted upon (or screamed at) and sometimes beaten by patients and their relatives.

(b) Lack of management support (management policy and training)

The Federal Ministry of Health has the responsibility of overseeing the activities of all tertiary hospitals in Nigeria with every profession being adequately represented. The lack of management support intensified nurses' experience of helplessness. The nurses expressed disappointment on

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lack of supervision by their representatives at this level of authority. This is also reflected in the expressions of participants on how nurses are rated low (undervalued) by their hospital management with little recognition being given to the office of their overall leader, nurses not being involved in decisions that affect them as "end users", high level of bureaucracy, poor welfare and inadequate remuneration, and having to do ad hoc duties.

In a work environment, employees operate in excellent physical conditions and fully furnished offices. When the work environment is poorly managed and in a bad condition there is potential exposure of workers to great danger to their health and security of life and property. Nurse Managers expressed dissatisfaction toward low management support in the areas of provision of furniture, air conditioners, lack of communication gadgets (intercoms), as well as spending personal money to buy airtime without refund, lack of insurance coverage for nurses, lack of financial support such as loans for childcare and purchase of vehicles, supply of sub-standard hospital equipment and instruments, inadequate planning and poor maintenance culture as a result of not prioritising needs, inadequate security system, and lack of sick bay for nurses (and staff generally). Due to the malfunction of the air conditioning system, medical staff and their patients encounter stifling work environments in most consulting rooms such as maternity ward, orthopaedic ward and paediatric ward with some breakdowns lasting from a few hours to days.

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They pointed out that nurses who are on supervision are not provided incentives such as menus during shifts and also lack adequate protection. Often times, nurses on night duty have to be extra vigilant as the security system is inadequate making it easy for miscreants to sneak into the hospital to perpetrate evil acts such as theft of personal effects of nurses, (mobile phones, money etc.) and attempting to steal newborn babies.

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Motivation has been described by many scholars as a driving force that enhances good performance. The nurses lamented that management has not adequately motivated them. They expressed that promotion should be on an annual basis but has not been regular and often times, there is no monetary backing. Annual commendation of hard work or consideration for special promotion based on exemplary performance has never been done and there is delay in approval of national budget which invariably affects activities at the levels of these hospitals because they are being financed by the federal government.

Another problem encountered that often puts the Nurse Managers in a precarious situation is the communication system. Nurse Managers are not happy that there is a high level of bureaucracy in the management system. They expressed that the process is very slow, tortuous with sometimes devastating effects. Citing purchases of bulbs, the nurses expressed that it could take days/weeks before there is approval for such request.

Inadequate support for capacity building of nurses was an area that the nurses focused on. Nurses are often not released to attend continuing education programmes whenever they signify interest. Majority stated that management frequently does not release them to go for professional training programmes due to shortage of nurses, sometimes they are offered half-salary for a specified period of time, or not paid at all throughout the training programme. Many of the nurses claimed to have funded themselves to upgrade their knowledge within and outside Nigeria, yet they apply the newly acquired knowledge to improve nursing services in the same hospital.

(c) Ill health

On ill health, many of the nurses reported developing occupational related (physical and psychological) health challenges such as loss of pregnancy, and diseases ranging from cardio-

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vascular disease, depression to orthopaedic conditions (Spondylosis) that required hospitalisation and use of devices (e.g. cervical collar), death of colleagues (Lassa fever); exposure to occupational hazards such as falls with their patients due to rough walkways and bad stretchers/wheel chairs. Some of these occurred as a result of lifting patients, carrying oxygen cylinders, prolonged standing/bending during nursing procedures (observation of vital signs) on more than 100 children by one/two nurses.

Concluding Statement 2: Work environment features (job climate) and Affective reactions/ personal disposition.

This concluding statement relates to work environment features (job climate) and affective reactions/personal disposition. Emotional labour caused by work environment features and work place events were addressed through employee value proposition which included benefits, and work environment improvement. Gender, ethnicity and years of experience were associated with deep acting strategies, while gender and ethnicity were associated with surface acting strategies.

Scholars in the field of emotional labour premised its occurrence in the realm of workplace events and its affect chain of reactions that could be positive or negative. Experience of feeling frustration by Nurse Managers was reflected in their responses to being recalled during night shift off duty to run another shift which they claimed is affecting their health and reducing time spent with family members. Also, that sometimes on resuming duty in the morning some of them are bombarded with request for materials which are often not available. This results in them becoming irritable, aggressive, unhappy and unfulfilled.

Emotional burden occurs when you do not have what you need to work despite being trained with many years of experience. Most of the participants reported that they felt stressed and

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overwhelmed. One the participants stated that *"...nobody feels what we (nurses) feel, nobody thinks the way nurses think, and nobody faces what the nurses face".* Hence, they need to develop coping strategies to be able to balance their mental state to avoid transfer of aggression to the family and larger society.

The Nurse Managers expressed being emotionally traumatised due to non-availability or insufficient supply of materials to enhance their productivity. They felt demoralised due to lack of manpower because sometimes a nurse has to work two shifts on a stretch. A participant expressed feeling of being cheated and humiliated following an event which she was not given a fair hearing and was also punished. Also, doctors' ward rounds are not well organised because most times they experience many medical teams conducting ward round simultaneously with only two nurses on duty leading to the nurses being confused and touchy. Janib et al (2021) further reports that in the working environment, workload is regarded as a broad range of activities involving professional duties and responsibilities and pursuance of work-related interests. Their study revealed negative consequences which includes burnout and depression.

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Gender, tribe and years of experience were significantly associated with the questionnaire item: "Try to actually experience the emotion that I must show"; while surface acting strategy was found to be associated with demographic variable gender (females) and "Pretend to have emotions that I don't really have"; "Hide my true feelings about a situation"; "Use a wide variety of emotions in dealing with people"; "Express many different emotions when dealing with people"; "Display many different kinds of emotions" and "Really try to feel the emotions I have to show as part of my job". There is also a significant association between ethnicity (Yoruba) and "Display specific emotions required by your job".

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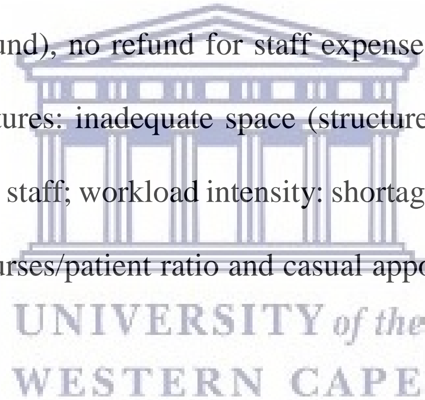
Concluding Statement 3: Work environment features (Job characteristics): inadequate resources and dissatisfaction about low monetary gains

The third concluding statement relates to work environment feature of job characteristics focused on inadequate resources and dissatisfaction about low monetary gains. The identified causes of emotional labour among nurses in the three settings were: inadequate remuneration, irregular promotion and work-oriented environment (unfriendly environment); materials: inadequate number (lack) of equipment, instruments and consumables; some are obsolete, lack of furniture, air conditioner, intercom, etc. drugs: “out-of-stock”, lack of linens (bed sheets, pillow sleeves), lack of modern technology: electronic devices such as computers (personal health records, e-laboratory, e-pharmacy, mobile X-ray unit), inadequate supply of water and electricity, finance, mismanagement of resources (fund), no refund for staff expenses, and no financial backing for promoted staff; space and structures: inadequate space (structures/bed), structural defects, poor ventilation, and lack of toilets for staff; workload intensity: shortage of staff: nurses and supportive staff: inadequate number, low nurses/patient ratio and casual appointment coupled with irregular payment of salary.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(a) Inadequate resources: Materials, finance, space and structural detects.

i. Materials: Low quality and insufficient quantity of equipment, instruments and consumables were the main problems expressed by the Nurse Managers as major causes of experiencing emotional labour at their workplaces. They further expressed that often times these materials are supplied by those who are not oriented about hospital equipment and supplies. Patients do not get to buy their prescribed drugs in the hospital pharmacy because of “out of stock” syndrome. This adversely affected nurses’ care through delay in administering the drugs at the expected time.

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Lack of modern technology in the forms of electronic devices such as computers, personal health records, e-laboratory, e-pharmacy, mobile X-ray units, etc. hamper the effectiveness of quality nursing and increase risk of health problems for the nurses. Irregular water supply and erratic nature of electricity supply were said to be affecting their activities. Nurse Managers expressed that during night duty they have to use the flash light of their cell-phones and rechargeable lanterns to carry out nursing procedures. Coupled with this is a bushy environment which is exposing everyone to the risk of attack by reptiles.

ii. Finance is the bedrock of an effective organisation. This resource has been identified as the principal factor that is affecting smooth running of the hospitals. The Nurse Managers pointed out that imprest is not allocated directly to the nursing departments of their hospitals. There is mismanagement of fund as allocations are often not used for their purposes, and it is also spent without prioritising needs. Also, when nurses spend their personal money in the cause of discharging care to the patients they are not refunded despite evidence of purchase, and that there is no financial backing when promoted.

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iii. Space and structural detects: These were identified as major problems faced by Nurse-Managers. They pointed out that the Accident & Emergency units of their hospitals are not well designed as they lacked reception area, toilets, rest rooms for nurses, consulting rooms for doctors and cubicles for patients. All these make the unit to be overcrowded and poorly ventilated. Patients are sometimes placed on a chair/floor when receiving intravenous fluids; nurses on call/night shift sit/lie on a couch and two (2) doctors might be found consulting in the same room because some consulting rooms have been converted to an observation bay for patients.

Furthermore, though the wards are not far from each other the walkways are tortuous and not smooth (has pot-holes) which sometimes lead to nurses and patients falling down. In one of the

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settings, out-patients trek from one service point to another despite the distance because hospital management did not provide shuttle buses.

(b) Dissatisfaction about low monetary gains

The Nurse Managers pointed out that welfare of the workers is not appropriately taken care of. They reported that they are not given incentives and their remunerations are often reduced when promoted and that the hazard allowance paid to a nurse is just a meager amount of ₦5,000 (about US $10) per month, despite nurses being in the frontline of healthcare delivery. This is made complex by an irregular promotion exercise for nurses because management claimed that there is no vacancy for upward movement or that affected nurses do not have a first degree in nursing (BNSc).

The nurse managers perceive their work environment as being work-oriented because of lack of motivation and the negative attitude of management towards provision of what they need in order to give quality nursing care. This results in some junior workers developing a negative attitude to work which one of the participant described as *"... it is the headache of the leaders let them sort things out by themselves"*. This is because when nurses complain about work-related problems, the tone of management's response is usually that of: *"... go and sort it out yourself"*, so the nurses perceive that management does not feel concern about what happens to them. All they are interested in is getting the work done.

(c) Work event features (Workload intensity): Shortage of nursing and support staff

Shortage of nurses was a general challenge in all the settings. Participants expressed that management has not been able to meet the WHO recommended ratio of one nurse to four critically ill patients (1:4). The Intensive Care Unit (ICU) was cited as an example with a four-bedded unit

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which WHO recommended one nurse to one patient (1:1), but only one or two (2) nurses are often on duty attending to four patients. Also, in the general ward the situation is the same as two (2) or four (4) nurses may be on morning duty in a 20-bedded fully occupied ward while only two (2) are on night duty. The Nurse Managers were quick to add that the situation got to this level because of embargo on employment and non-replacement of those who have disengaged due to retirement or death. Support staff are inadequate while casual workers who are supposed to be on the ground were not paid regularly resulting in them quitting the service. Due to insufficient nurses in the country, nurses are under stress and this affect their delivery of nursing care services. Therefore, nurses are facing a great challenge in coping with the pressure of the healthcare profession.

5.8 SUMMARY

The results revealed that the participants mostly use deep acting strategy of emotional labour to regulate their emotions as required by their profession. The deep acting strategy is especially used by female nurses, nurses of Yoruba tribe and nurses with many years of work experience. The execution of multiple roles, working long hours, and time constraints create a stressful work environment for these nurses. In addition, job demands, inadequate resources, a lack of recognition, as well as a lack autonomy and role clarity further put strain on the emotional labour of the nurses. All the results and discussions relating to the wellbeing of nurses were identified with the aim of developing a model for support of emotional labour that provides and promotes a positive working environment.

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Description of the model will be done in Chapter six using concept development, classification and definition while the main concepts will be linked with the six elements of the survey list (Dickoff, 1968) to show its relevance to emotional labour support.

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CHAPTER 6

THE DEVELOPMENT AND DESCRIPTION OF A MODEL FOR SUPPORT OF EMOTIONAL LABOUR OF NURSES IN TERTIARY HOSPITALS IN NIGERIA

6.1 INTRODUCTION

Chapter five focused on results, the interpretations and integrated discussion of these results from integrative review of literature on concept of emotional labour, quantitative study and focus group discussions with nurses on emotional labour experienced at tertiary hospitals. The findings were discussed according to the themes and categories that emerged from the data in order to contextualize with literature control. Thereafter, concluding statements were formulated based on the themes which cut across responses of the participants. The process of model development in this study followed the process described in chapter 4: 4.5 according to Chinn & Kramer (2018) Walker & Avant, (2019).

Identification of main concepts was done from concluding statements to create conceptual meaning. The conceptual meaning provided a foundation for developing a model for support of emotional labour of nurses in tertiary hospitals and, to achieve the fourth objective of this study which was to:

"develop a model for support of emotional labour of nurses in tertiary hospitals".

This chapter is focused on identification of concepts (step one), development of model (step two), model description (step three), and development of guidelines (step four) for the implementation of the model. Concept identification entails the identification of main and related concepts. Model development entails the classification and definition of the concepts. Model description is guided by the following sub-headings: overview of the model, context, purpose and assumptions on which the model is based. The structure, definition, relation statement and a process description of the

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model is given. Guidelines for operationalisation or implementation in tertiary hospitals are developed.

6.2 CONCEPT SYNTHESIS

Concepts are mental images of a phenomenon which helps to organize or categorise environmental stimuli (Walker & Avant, 2019). The process of concept development involves identifying (step one) classifying and defining concepts (step two).

Identifying and classifying and defining the main concepts facilitated the creation of conceptual meaning which is a theory building approach. Walker and Avant, (2019) stated that conceptual meaning is the process whereby individuals use ideas, thoughts or feelings to represent their experiences which would not likely to be expressed through the definitions. The thoughts are expressed in discipline-specific or everyday language. Whilst conceptual meaning is complex, it displays a mental picture of what the phenomenon is like and how it is perceived in human experience – the context determine the meaning given.

6.2.1 Step one: Concept synthesis

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Purpose of the study guided concept identification and expressed the value related to the purpose (Chinn & Kramer, 2018). Values that influenced the identification of concepts included the researcher's beliefs about the nature of nursing, the person, society as well as the environment and health. Concepts help the individual to identify how experiences are alike by categorising all the things that are similar about them. The survey list of Dickoff et al., (1968), (see 6.2.2.2.1) were used to classify the concepts and main concepts.

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Identifying concepts and main concepts

Concept identification was guided by purpose of the study through 'searching out' of words and groups of words that represent the phenomena and their related actions (Chinn & Kramer, 2018) in the concluding statements. A total of fifteen concepts were identified (Table 6.1). These concepts were further synthesized by means of examining the similarities and differences which resulted in the final deductive formation of six main concepts. These main concepts were used to develop a model for support of emotional labour of nurses in tertiary hospitals. The *main concepts* as depicted in Table 6.1 are:

- Conducive working environment
- Patient care
- Effective communication
- Working conditions
- Teamwork
- Affective reactions in the work environment

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The main concepts were structured using affective events theory of (Weiss & Cropanzano, 1996) as a framework (see table 6.1) to capture the responses to job characteristics affected by emotional labour, workplace events impact on wellbeing and employee value propositions of nurses in tertiary hospitals.

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Table 6.1: Process of identifying and classifying concepts and main concepts

Horizontal Themes	Concluding statements	Concepts	Main concepts
Work place events and work environment features	Job characteristics such as the nature of the work, resources, role clarity, autonomy and hierarchy as well as the job demands such as patient acuity, working hours, work balance affected emotional labour. It resulted in job dissatisfaction, low morale, feeling of depersonalisation, etc.	○ nature of the work, ○ resources ○ role clarity, ○ autonomy ○ hierarchy ○ patient acuity, ○ working hours, ○ work balance	Conducive working environment Patient care Effective communication
Work environment features (job climate) affected affective reactions and personal disposition	Workplace events such as staff support policies and guidelines, workload intensity due to staff rotation, staffing, commercialization and the quality of care, and patient behavior impacted nurses physiological, psychological and social wellbeing	○ Staff support ○ policies and guidelines, ○ workload intensity ○ commercialization and the quality of care, ○ patient behavior ○ nurses wellbeing.	Working conditions Teamwork Affective reactions in the work environment
Work environment features (Job characteristics).	Emotional labour caused by work environment features and work place events was addressed through employee value proposition which included benefits, and work environment improvement. Females of Yoruba ethnic group with 21-25 years of experience were associated with deep acting strategies.	○ employee value proposition	

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6.2.2 Step two: Concept Classification

Classification of concepts was carried out using the survey list developed by Dickoff et al., (1968) and defined according to dictionary and subject definitions in the section that follows.

Classification of the main concepts for model structure

The main concepts of the study identified in table 6.1 were classified according to the survey list developed by Dickoff et al., (1968).The survey list highlights six activity aspects which included ways of looking at emotional support in the hope of revealing different features. Six questions relating to the activity aspects were used to survey activity and these include:

1) Context - *In what context is the activity performed?*

2) Agent - *Who or what performs the activity?*

3) Recipient - *Who or what is the recipient of the activity?*

4) Procedure - *What is the guiding procedure, technique or protocol of the activity*

5) Dynamics - *What is the energy source for the activity?*

6) Goal - *What is the end point of the activity?*

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The researcher's reasoning map related to the survey list as depicted in figure 5.1 below, will serve the purpose of clarifying how the main and related concepts were classified.

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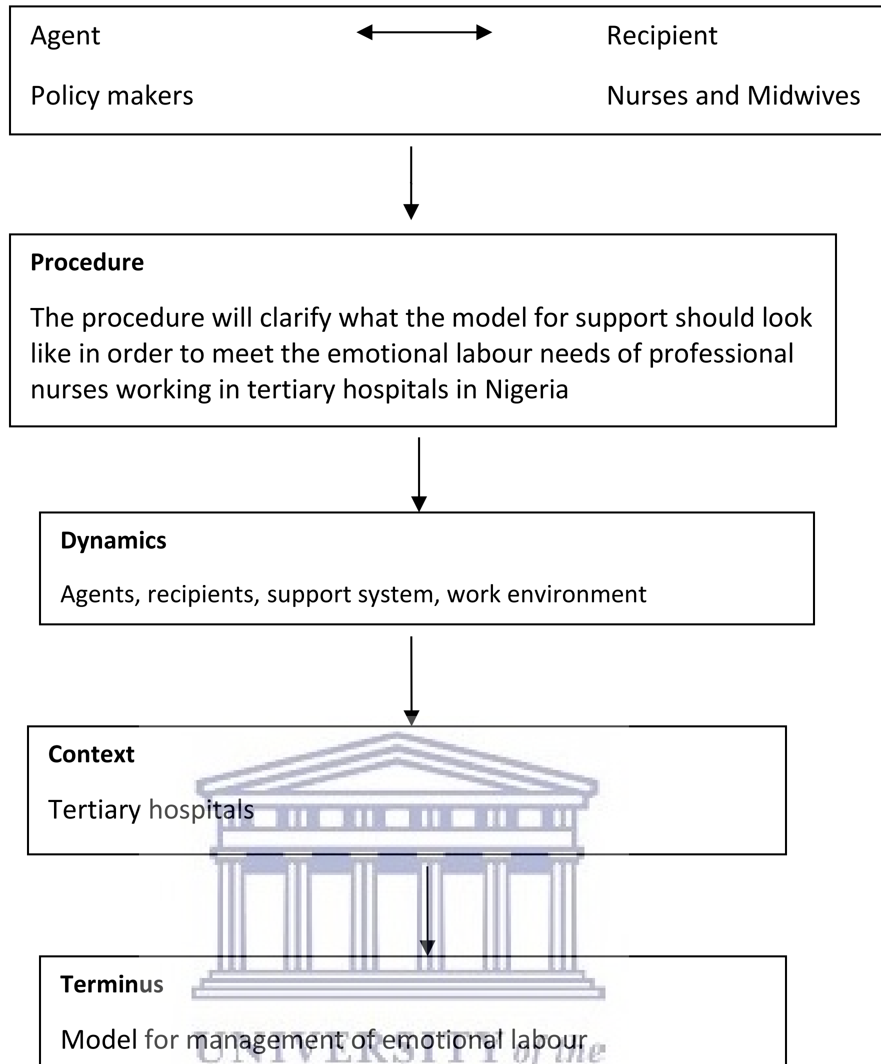

Figure 6.1: Reasoning map for clarification of classifying the concepts

The systematic ordering of the concepts is depicted in table 6.2 and it is followed by exposition of the concepts according to the six elements of the survey list.

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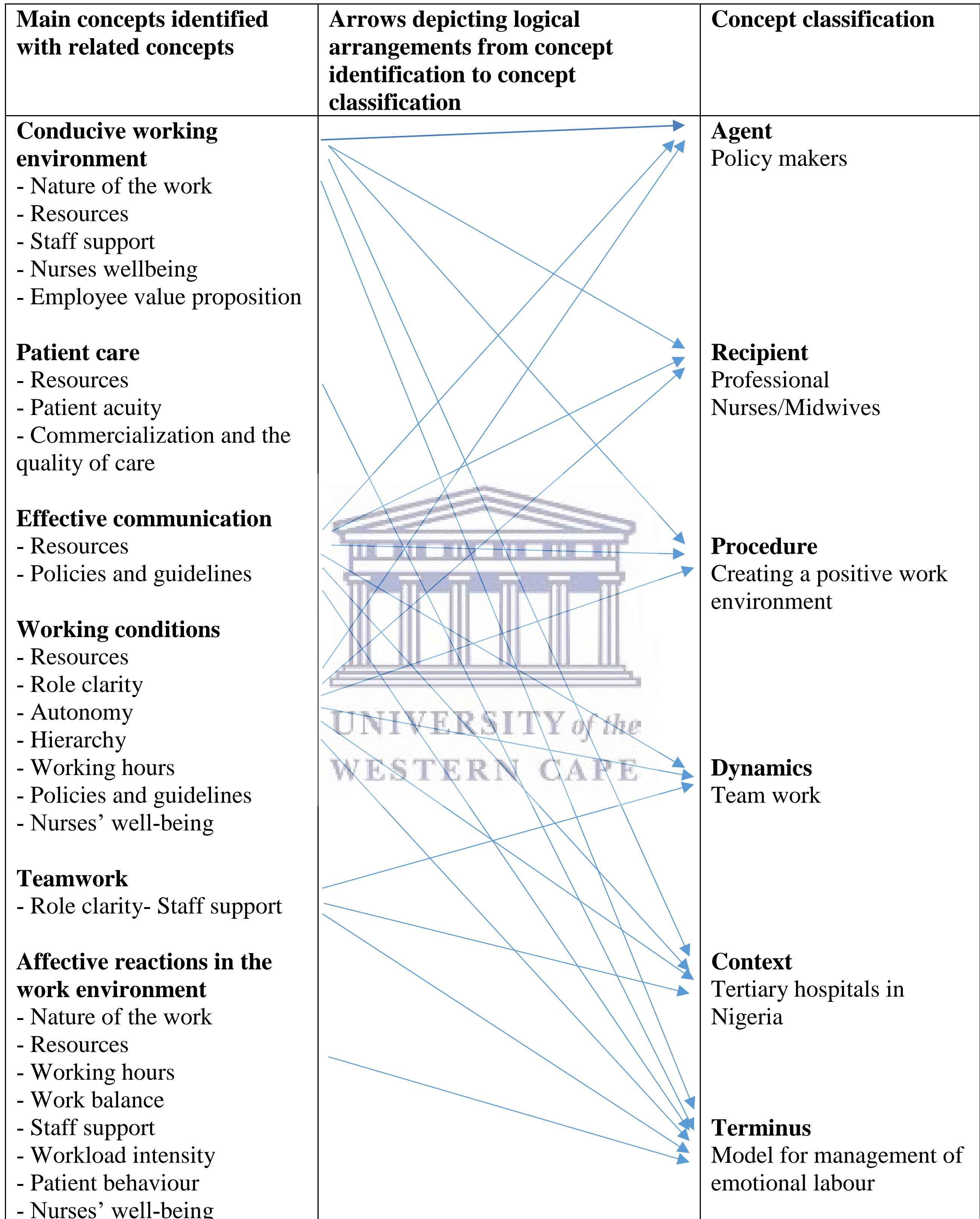
Table 6.2: Systematic ordering of concepts

Main concepts identified with related concepts	Arrows depicting logical arrangements from concept identification to concept classification	Concept classification
Conducive working environment - Nature of the work - Resources - Staff support - Nurses wellbeing - Employee value proposition **Patient care** - Resources - Patient acuity - Commercialization and the quality of care **Effective communication** - Resources - Policies and guidelines **Working conditions** - Resources - Role clarity - Autonomy - Hierarchy - Working hours - Policies and guidelines - Nurses' well-being **Teamwork** - Role clarity- Staff support **Affective reactions in the work environment** - Nature of the work - Resources - Working hours - Work balance - Staff support - Workload intensity - Patient behaviour - Nurses' well-being		**Agent** Policy makers **Recipient** Professional Nurses/Midwives **Procedure** Creating a positive work environment **Dynamics** Team work **Context** Tertiary hospitals in Nigeria **Terminus** Model for management of emotional labour

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6.3 EXPOSITION OF THE IMPLEMENTATION OF THE SURVEY LIST

The exposition is briefly given below on how the concepts and main concepts were used to answer the questions in the survey list. In other words, the arrows of Table 6.2 now points back/in opposite direction.

6.3.1 Agent

Who will be responsible for the support of professional nurses working tertiary hospitals? The agent in this model is the policy makers who are responsible for provision of resources and positive work environment of employees. The professional nurses shall also become the agent when they assume responsible for their own support on identifying areas of inadequacies in the workplace. The main concepts that were identified during classification process relating to the agent were:

- Conducive working environment
- Effective communication
- Working conditions

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6.3.2 Recipient

Who will benefit from a model for support of emotional labour?

The professional nurses are the recipients in this model in order to meet their support needs. Nevertheless, when these nurses' support needs are met, the Federal Ministry of Health and tertiary hospitals would benefit because these nurses would accept responsibility for meeting their support needs. The main concepts that were identified during classification process relating to the recipients were:

- Conducive working environment
- Effective communication
- Working conditions

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6.3.3 Procedure

What will the techniques, procedures and protocols associated with a model for support of emotional labour of nurses be? According to Dickoff et al., (1968), procedure refers to the path, steps or general patterns or the way to the accomplishment of the goal. The procedure that is positive work environment is expected to realize the goal of professional nurses accepting responsibility for meeting their own support needs. The main concepts that were identified during classification process relating to the procedure were:

- Conducive working environment
- Effective communication
- Working conditions

6.3.4 Dynamics

What is the energy source (motivation) of the activity? To enable professional nurses be supported on emotional labour there is need for collaboration among agent, recipient and context, The main concepts that were identified during classification process relating to the dynamics were:

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- Conducive working environment
- Effective communication
- Working conditions
- Teamwork

6.3.5 Context

In what context is the activity performed?

The study on support for emotional labour of nurses was conducted in three tertiary hospitals in Nigeria. The context provides these nurses with broad experiences in nursing care practice (and administration). This is premised on the assumption that the professional nurses who participated

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in the study experienced events and affects that culminated in a broad view of emotional labour. The main concepts that were identified during classification process in this context were:

- Conducive working environment
- Effective communication
- Working conditions
- Teamwork

6.3.6 Goal/Terminus

What will the aim of developing a support model for nurses in tertiary hospitals be? The aim of the model is to ensure provision of a positive work environment that will enhance quality nursing care and wellbeing of nurses in tertiary hospitals. The main concepts that were identified during classification process relating to the goal/terminus were:

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- Conducive working environment
- Patient care
- Effective communication
- Working conditions
- Teamwork
- Affective reactions in the work environment

6.4 DEFINITION OF CONCEPTS

In this study, six positive main concepts emerged from the concluding statements that will be used to form the model. Defining words help to clarify their conceptual meaning, how they are used and associated with a concept. Based on this, the main concepts are defined in two ways: according to the dictionary and subjectively, after which both definitions are synthesized to give a synopsis

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of the definitions as they relate to this study. Defined concepts are contextualized for this study and given meaning to the various aspects within the model for support of emotional labour of nurses in tertiary hospitals. The related concepts are referred to but will be integrated in the discussion of the structure (6.9) and process of the support model (6.11).

a) Conducive working environment

Conducive working environment is the first main concept with five related concepts: nature of the work, resources, staff support, nurses' wellbeing, and employee value proposition.

Dictionary definition of Conductive working environment

"Making it easy, possible, or likely for something to happen or exist in the manner of functioning or operating the conditions and influences that affect the growth, health, progress, etc., of someone or something" (www.merriam-webster.com).

Subject definition of Conductive Working environment

In this study, conducive working environment refers to a surrounding of all situation, people, events, technology, etc that have positive influence on physical, mental, psychosocial life of nurses which enables them to perform their duties in harmonious, pleasurable and ideal ways. This invariably results in quality care and wellbeing of the patients.

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Summary

Conductive working environment refers to a pleasurable situation where necessary resources are available in adequate quality and quantity for nurses to perform their professional duties resulting in satisfactory care outcome.

b) Patient care

Dictionary definition of patient care

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"Hospital services provided to a patient by a personnel member or a medical staff member" (lawinsider.com).

Subject definition of patient care

These are the activities that nurses will carryout to promote and sustain patients' health status. It can be achieved through application of evidence-based knowledge, focused on patient-centered care, collaboration and effective communication with other healthcare providers.

Summary

Patient care in essence are the activities that nurses render to individuals to keep them at optimal state of heath and to carryout activities of daily living.

c) Effective communication

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Dictionary definition of effective communication

"Producing a result that is wanted through the act or process of using words, sounds, signs, or behaviours to express or exchange information or to express your ideas, thoughts, feelings, etc., to someone else" (www.merriam-webster.com).

Subject definition of effective communication

Communication is germane to quality nursing care. Effective communication in this study subjectively implies prompt transfer of information about patient care among health care provides, stakeholders, patients and their relations in order to make informed decisions that will lead to satisfactory care outcome, improved interpersonal relationship and good therapeutic nurse/patient relationship.

Summary

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Effective communication in nursing care facilitates quality care and satisfying care outcome. It helps to create a harmonious work environment and organised care, improves interpersonal relationship among health workers, reduces patient waiting time and prevents prolonged hospital stay.

d) Working conditions

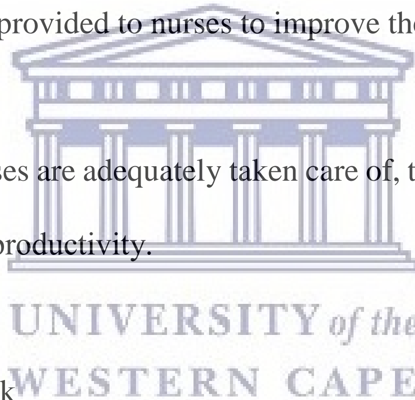
Dictionary definition of working conditions

"The manner of functioning or operating premised upon which the fulfillment of an agreement depends" (www.merriam-webster.com).

This is central to the total wellbeing of nurses to be effective and diligent. It refers to the benefits, incentives, facilities, etc that are provided to nurses to improve their living standard.

Summary

When working conditions of nurses are adequately taken care of, there will be improvement in job performance and organisation's productivity.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e) Teamwork

Dictionary definition of teamwork

"work done by several associates with each doing a part but all subordinating personal prominence to the efficiency of the whole" (www.merriam-webster.com).

It is the interrelatedness among healthcare workers in a bid to create a problem-solving environment in order to solve health problems of the patients. When nurses collaborate with other healthcare providers, it foster interpersonal relationships, creates a good environment for holistic and quality care that results in positive care outcome.

Summary

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Collaboration among stakeholders in healthcare delivery services give the workers a sense of belongingness, display of professionals' expertise and fosters teamwork.

f) Affective reactions in the work environment

Dictionary definition of affective reactions

Affective means "relating to, arising from, or influencing feelings or emotions" while reaction is "a response to some treatment situation, or stimulus" (www.merriam-webster.com).

Subject definition of work environment

In this study, it denotes the emotional state of nurses at various levels – personal, organisational and while interacting with other professionals. This is often impacted by quality and quantity of resources available at a given time to carry out their professional duties; state of their welfare; support from management team, supervisors and coworkers; work-life balance; level of job satisfaction and patients' behaviour.

Summary

Nurses emotions can be positively influenced when there is a conducive working environment where necessary resources are provided, care is patient-centered, communication is effective with prompt feedback, welfare of the nurses is taken care of, there is good collaboration with other healthcare providers that will guarantee quality care and nurses are supported by the management, supervisors, family members and other that are involved in caring for the patients and their relations.

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Step 2: Statement synthesis

The process of model development included the use of concepts which were identified and defined. Relational statements which links the concepts were then developed.

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According to Walker and Avant (2019), statement synthesis is targeted at specifying the relationships between two or more concepts premised on evidence which are sourced from research methods or based on literature. Therefore, relational statement are based on concept synthesis. Relational statement states the relationship between two or more concepts which can be an association or causality. In this study, the following relational statements have been derived:

Conducive working environment is a network of both internal and external milieu that promotes pleasurable experiences for worker which impacts positively on their overall job performance. The work force requirements and expectations are fulfilled, workers attain high level of **job satisfaction** and the organisational productivity increases. Due to the intensive **nature of nursing work**, **resources** should be made available with adequate **support** from employer (FMoH), hospital management team, Nurse Supervisors, coworkers and other stakeholders. The **wellbeing** and values of nurses are adequately taken care of by providing remunerations, benefits, compensations, prompt promotion and other incentives that can improve the morale of nurses at work place.

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Patient care encompasses series of activities that involves multi-disciplinary approach aimed at preventing, promoting and restoration of patients' health. **Quality care** has been viewed as a team activity that involves excellent individuals that have knowledge and skills working effectively for the benefits of the patients (Robson, 2017). When **resources** are available, **patient acuity** which is the complexity of patient care needs that requires the skill and care of nurses are easily met. **Effective communication** has been identified to be positively correlated to quality of care. It helps to build a good relationship between nurses and patients, which is achieved when technological devices for communication are supplied and staff are trained for effective usage. This will improve

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the communication skills of nurses and enable patients to make informed decisions about their health.

Working conditions involves the general **wellbeing of nurses** in relation to physical, mental, social, cultural conditions that makes them to perform at their best. When this is achieved, productivity of the organisation increases, labour force is secured, and there will be **job satisfaction**, reduced turnover, and increased retention of staff, improved staff loyalty and motivation. **Professional autonomy** of clinical nurses is viewed as the key element of nursing practice and a developmental achievement hinged on patient-based professional competence, decision making and interactions to provide quality care plan that will promote the patient's health in collaboration with other team members. When hospital management delineates **role** and recognises professional autonomy of clinical nurses, there will be independent judgment, self-control and self-governance, while **hierarchy** within the system will be devoid of professional dominance.

Teamwork is an integral part of healthcare services focused on achieving the goals of health system. It is a multi-disciplinary body that provides problem solving abilities beyond individual level, reduce conflicts at workplace, and provides professional and non-professional information for **quality care**. Teamwork provides a formalised structure and comprehensive way for health care delivery to contain the health needs of the patients and to achieve **inter-disciplinary collaboration** of healthcare professionals for improved care quality, patient safety and **job satisfaction** (de Souzal et al., 2016). Hence, formation of teams has been recognised as a common practice in healthcare settings aimed at establishing professional, disciplinary and sectorial boundaries (Schmutz, 2019).

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Teamwork enables the members to oversee the overall services rendered in the healthcare setting to provide holistic care for satisfactory outcome. Yule et al., (2006) and Gawande, et al. (2003), emphasised that when **role and responsibilities are clarified** the team members are more effective, because teamwork creates a safe environment. For a team to be effective, mutual **support** has been identified as a core attribute as it makes members to look after each other and look out for signs of **stress** and **work overload** among colleagues (Robson, 2017). In essence, when staff attain a higher level of satisfaction, there is a better quality of care (West and Dawson, 2012). In a review carried out to identify contributing factors to nursing team work, Polis (2015), noted that for nurses to deliver quality healthcare and patient safety, it requires effective team work predicted by interplay of **communication** and leadership. According to Rowlands and Callen (2013), communication is a vital tool in teamwork because it guarantees awareness of everyone's role and those of other members. When there is misconceptions about roles of members, their responsibilities and workload can impair communication (Thomson et al., 2015), different perceptions about goals, roles and responsibilities, cultural differences, and differing levels of understanding of hierarchy in the team (Pettit & Duffy, 2015). Therefore, effective teamwork has been demonstrated to improve safety of patients, reduce errors and mortality, and increase motivation of nurses (Montgomery et al., 2015).

Affective reactions in the work environment is influenced by availability of required **resources**, meeting recommended **nurse/patient ratio** which will enable the nurses to work for the normal eight hours per day and the privilege of enjoying days off particularly after night duty. This will improve nurses' **work-life balance** as they will have the opportunity of spending more time with family members and loved one. **Support of supervisor and coworker** is important in the

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maintenance of positive affect of nurses at the workplace. This will increase their **commitment to work, job satisfaction and fulfillment**. The high **work intensity of nursing care** and associated **stress** due to lack of required resources, high influx of patients, prolonged hospital stay often results in negative **patient behaviours** and **aggressive reactions** of their relations toward nurses.

Step 3: Theory synthesis

Theory synthesis is targeted at construction of a theory. Walker and Avant (2019:149), referred to theory synthesis as "an interrelated system of ideas developed through use of evidence". It is generated by pulling together information that is available about a phenomenon. The process involves: specifying focal concepts, literature review for identifying related factors to focal concepts and organizing these concepts and statements to form a representation of phenomenon of interest. A model can thus be designed to represent the relationship among synthesised statements.

6.5 OVERVIEW OF THE MODEL

The overview is premised on the model for support of emotional labour of nurses working in tertiary hospitals as presented in Figure 6.2. All through the study, professional nurses expressed dissatisfaction about stressful work environment where there is lack of (or inadequate) supply of materials, shortage of nursing and support staff, long working hours, heavy work load and defective structures. The working conditions were also identified as a source of emotional labour because they have not been well recognized, lack autonomy and often the last in the hierarchy of health workers. Promotion is not done as at when due, benefits, remuneration and compensation were grossly neglected. All these culminated into the experience of emotions labour as they felt frustrated, unfulfilled, depersonalized and not being able to spend enough time with loved ones and sometimes transfer of aggression to others.

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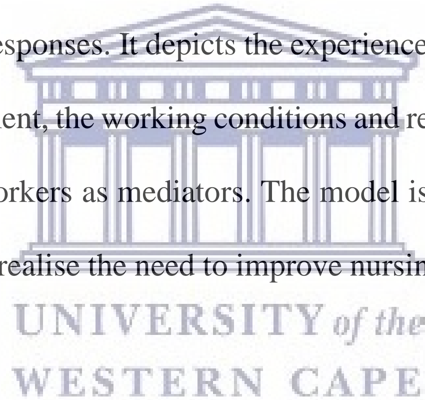
The nurses opined that management of their hospitals can support them to reduce the emotional impact they are experiencing by providing a conducive work environment where resources will be available to enable them carry-out their duties as trained nurses; improve condition of service through provision of welfare packages that includes prompt promotion, adequate remuneration, lift of ban on employment of nurses and support staff, and improved salary. Prompt response to urgent needs as against the prolonged course of bureaucracy, involvement in decision making, encouragement of philanthropists to donate infrastructure that will enhance performance, quality of care and positive care outcome; training and sponsorship for continuous professional education programmers; and adequate supervision by the Federal Ministry of Health.

This is an affect/event model that reflects the affective responses of nurses to workplace events and the emanating behavioural responses. It depicts the experiences emotional labour by nurses as they interact with work environment, the working conditions and relationship with FMoH, hospital management and other health workers as mediators. The model is viewed from a micro level for support of nurses with a view to realise the need to improve nursing care rendered at tertiary level of health system.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6.6 CONTEXT OF THE MODEL

In the model, the context lies in the realm of FMoH, and hospital management. FMoH is the parent body of the health system vested with working conditions and work environment, policy formulation, employment and disengagement among others for healthcare workers including teaching hospitals. The teaching hospital management teams are responsible for the implementation of policies that affect quality health care delivery, working conditions and immediate work environment of their workers.

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6.7 PURPOSE OF THE MODEL

The purpose of the model is to provide a guiding framework to managers (policy makers) to support nurses regarding emotional labour in tertiary hospitals. Therefore, the purpose of this model is hoped to be achieved through the identified operational guidelines, objectives and strategies. Within the context of nursing, the model is presumed to be useful in enhancing professional body of knowledge to support emotional labour experienced by professional nurses working at tertiary level of healthcare.

6.8 ASSUMPTIONS OF THE MODEL

The philosophical assumptions deduced for this model for support of emotional labour of nurses in tertiary hospitals in Nigeria is inferred from Affective Events Theory (Weiss & Cropanzano, 1996) and serves as a point of departure.

The model is based on the assumptions that:

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- Workplace features such as autonomy, support, recognition, generate emotions and moods in nurses.
- Level of job satisfaction of nurses determines their affective-driven behaviours.
- Positive working environment will modify nurses' behaviour and enhance job performance.
- Judgment-driven behaviours of nurses are premised on their level of job satisfaction.
- Continuing professional education programs is an important index that will improve job satisfaction and job performance of nurses.

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6.9 STRUCTURE OF THE MODEL

According to Chinn and Kramer (2019:164), structure is "the organization of ideas into various forms of empirical knowledge such as theories, descriptions or written analysis." It is a representation of organised concepts in linguistic or verbal forms to give them full meaning. Structures therefore give a total image to conceptual relationships.

The structure of this model emerged from the relationships among the six concepts which **are: conducive working environment, patient care, effective communication, working conditions, teamwork and affective reactions in the work environment.** Hence the model is presented as a composition of main concepts from which meaning is derived for clear discussion and explanation on the interaction among the concepts.

The main concepts in the model are described with letter C that means "concept". In other words, conducive working environment is described as C1 meaning concept 1, although numbering of the concepts as concept 1, 2, and so on does not follow an order of significance in the course of support for emotional labour of nurses in tertiary hospitals in Nigeria.

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The model is a depiction of a vehicle which illustrates that the conducive work environment (C1) which is necessary to ameliorate nurses' experience of emotional labour is mobilized by effective communication (C3), respectful working conditions (C4), teamwork (5) and appropriate affective reactions (C6). The ultimate purpose of nursing is effective patient care (C2) which is an outflow of a conducive work environment for nurses.

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A MODEL FOR SUPPORT OF EMOTIONAL LABOUR OF NURSES IN TERTIARY HOSPITALS

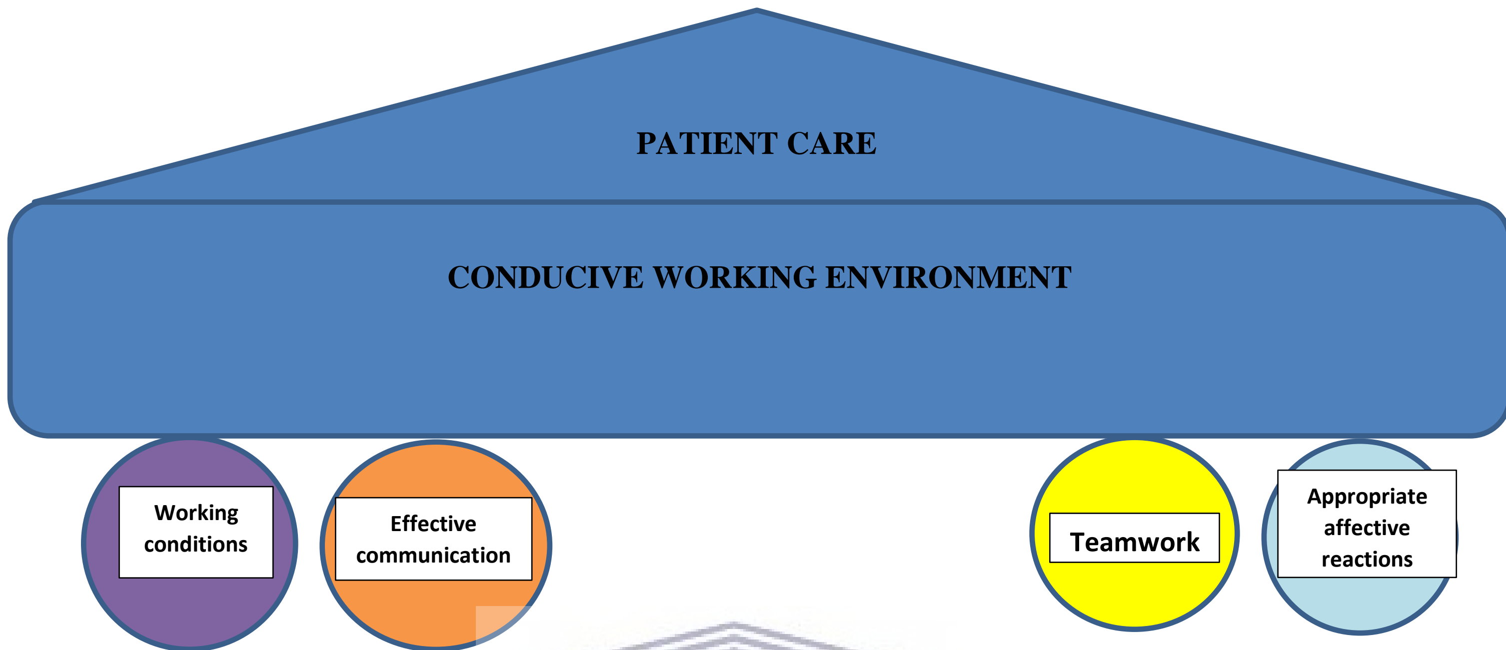

Figure 6.2 Structure of the model

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6.10 RELATION STATEMENTS OF THE MODEL

The relation statements of the model were developed by means of identifying the relationship between the concepts and the six elements on the survey list. The model depicts the inter-relatedness of the identified six concepts. For nurses working in tertiary hospitals in Nigeria to display appropriate affective reactions in the course of regulating their emotions, there must be good working conditions, effective communication system and teamwork in a conducive working environment that will enable delivery of quality patient care.

Conducive working environment (C1)

Nature of nurses' work: It involves a range of activities spanning across nursing care of patients, prevention of diseases and promotion of health. It also involves ensuring that people cope with their health problems. In the hospitals, nurses do not only perform nursing duties, they are also involved in managerial works and constant interactions with colleagues, other healthcare workers, the public and overwhelming number of patients. All these activities require that they regulate their emotions while interacting particularly with the patients.

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Resources: Oftentimes nurses are faced with insufficient supply of required resources that will enable them to work effective. Inadequate number of nurses and supportive staff can result in adverse effects on the physical and psychological health of nurses. When enough resources are provided, it will make their work easier to perform and also improve the health status.

Staff support: A conducive working environment is indicative of good staff support. When nurses enjoy support from hospital management, supervisors, coworkers, they will elicit positive affective reactions such as being happy and comfortable.

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Nurses' wellbeing: This is a major aspect of work-life. The well-being of workers involves the adequate remuneration, promotion, recognition, incentives, commendation for good performance amongst others. Provision of these will enhance performance and achievement of both personal and organisational goals.

Employee value proposition: This focuses on why people choose to work for an organisation. Nurses are expected to have clearly written documents stating the financial, emotional and professional rewards which are commensurate with the values they will generate for their employers at the workplace. Goldsmith (2022), stated that the health system should stipulate this in clear terms for nurses considering the current labour market competitions for nurses.

Patient Care (C2)

Patient care in any hospital requires resources, patient acuity as well as commercialisation and the quality of care. It is an essential aspect for the smooth running of any hospital. The ultimate goal of nurses is to care for the patient to wellness, thus helping him/her to independent care through understanding and knowledge of health condition.

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Patient acuity: This is the assessment of severity of illness and level of dependency needs of the patient. This will enable the hospital management to estimate manpower needs (particularly nurses) that will be required for quality nursing care and positive care outcome. Providing adequate number of nurses to meet patients' needs will reduce negative affective reactions of nurses at the workplace.

Commercialization and the quality of care: Hospitals are established to provide healthcare services for the people at affordable costs. When the cost of healthcare is highly commercialised, quality is often compromised. Wehkamp and Naegler (2017), posits that, economic framework

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conditions and steering concepts should be modified to accommodate feasible reformed funding regulations and improved healthcare structures that favours effective and efficient quality care by nurses.

Effective communication (C3)

In order to achieve effective communication at the workplace, there is need for adequate resources including modern devices for information technology and appropriate policies and guidelines. Positive nurse/patient/caregiver relationships are essential for constitution of core components of healthcare delivery because nurses are significant constituent of the workforce saddled with care delivery which impacts deeply on patient care outcomes.

Policies and guidelines: There is need to clearly outline policies and guidelines for effective communication between nurses and their patients. Communication between nurses and their patients should be professional and purposeful. Such written policies and guidelines will help in keeping nurses on track to prevent distraction from non-clinical objectives in their conversation with patients.

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Respectful working conditions (C4)

The working conditions of nursing staff entail the task as well as all provisions made available for them to effectively and efficiently perform their duties professionally and with little or no stress. With regards to working conditions of nurses, factors such as resources, role clarity, autonomy, hierarchy, working hours, policies and guidelines as well as nurses' well-being must be taken into cognisance.

Role clarity: It is the appropriate application of scope of practice for delivery of quality nursing care in the workplace. Healthcare organisations should properly and adequately clarify the role

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nurses are to perform in written, clear, easy and understandable terms. This is because such documents provide nurses with efficient tools that enable them to understand and perform their role.

Autonomy: This relates to when nurses are given an enabling environment to think critically and take actions related to patient care. Registered nurses should be allowed to practice based on their knowledge and training, and to make professional decisions without requiring to seek approval from physicians or other members of the healthcare team. Nurses should be availed with the freedom to independently or where necessary collectively take decisions and action in relation to care needs of the patient.

Hierarchy: There is need to understand the way nurses are ranked based on their hierarchy. Healthcare organisations use nursing hierarchy to define organizational structure. Ranking of nurses take into account their level of education that defines role clarity of each rank and level. Understanding nursing hierarchy enhances smooth management of activities in the hospital as well as delivery of tasks by nurses in professionally acceptable manner.

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Working hours: The working hours of nurses per week differ from one institution to another, therefore, the working hours of nurses are not exactly standardised. This is attributed to the caring nature of the job in relation to the many forms and levels of intensity of the work. It is necessary to understand that the duties and different sets of responsibility that nurses are assigned tends to determine the shift length and pattern of nurses' work. However, long working hours should be avoided to reduce negative affective reactions from nurses.

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Teamwork (C5)

Teamwork is an important component for building strong relationships, improving patient care and promotion of a good work environment. Nurses interact with healthcare workers through effective communication, and with positive attitude to work, coworker support and availability of resources healthcare team will be able to achieve organisational goals.

Appropriate affective reactions (C6)

Nurses react through the expression of various emotional behaviours when faced with different scenarios.

Work balance: Nurses are expected based on their profession to make a difference in the lives of others every day. Work-life balance is essential to ensure nurses effectively maintain a healthy and manageable personal and professional life. Nurses must maintain a healthy work- life-balance by caring for their own mental and physical health through activities that will reduce stress, enjoyment of hobbies, spending time with loved ones and preventing burnout.

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6.11 PROCESS DESCRIPTION OF THE MODEL

The model illustrates that through the process of public policy at implementation and evaluation stages, support for nurses can be met. It is envisioned that employer will assume responsibility for their role in reducing emotional labour of nurses.

6.11.1 Policy formulation level

Before engaging the nurses, stakeholders (FMOH and tertiary hospitals management teams) will be explored to collaborate on areas of working condition and positive work environment. Policies

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that are founded on wellbeing of nurses, working hours, nurse staffing, benefits, recognition, autonomy and hierarchy are made available and implemented at these tertiary hospitals.

For the nurses to be efficient and effective, resources should be made available and replenished from time to time and maintained. These include: modern equipment and instruments, physical infrastructure (renovation and new constructions) and regular supply of consumables. Adequate funding should be provided to run the hospital, support training programs for nurses, pay compensation for injuries and death of staff that occurs at work place.

6.11.2 Policy implementation level

Implementation of the model is focused on regular employment of nursing staff through lifting embargo on employment, striving to reduce nurse/patient ratio, commitment to quality nursing care through positive attitude and behaviour of nurses, improved relationships among health workers, patients, and public. Ensuring regular promotion of nurses, giving benefits, commendations and adequate remuneration, incentives such as providing loan, lounge for nurses will increase job satisfaction and performance. Involvement of philanthropists for donation of materials and sponsorship for training program will compliment management efforts and increase community involvement in providing quality care.

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6.11.3 Policy evaluation level

When all these are put in place it will ensure a reduction in the experience of emotional labour by nurses, promote job satisfaction and performance and improve quality of nursing care in the hospital and nurses will also exhibit positive affects at work. There should be periodic feedback at management level on welfare of the nurses within the work environment for prompt problem-solving actions.

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6.12 GUIDELINES FOR THE OPERATIONALIZATION OF THE MODEL IN PRACTICE

Broad guidelines to operationalise the emotional labour model for support of nurses in tertiary hospitals will be described within the context of federal ministry of health and tertiary hospital management teams. The guidelines will be discussed using the three stages of policy development: policy formulation, implementation and evaluation. Objectives and strategies to achieve the objectives will be mentioned

6.12.1 Policy formulation level

Guideline 1: Federal Ministry of Health and Tertiary Hospital management teams must create a conducive work environment that will ensure support, autonomy, recognition and motivation for nurses.

Objective (i)

- Improve conditions of service in order to create a conducive working environment for nurses.

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Strategies

- Provide support for nursing staff
- Strengthen capacity of the workforce to reduce turn-over and intention to leave by nurses..
- Provide necessary resources: instruments, equipment
- Broaden career structure and progression for nurses
- Develop training plans for nurses
- Improve welfare of nurses

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Objective (ii)

- To address problem of shortage of nurses in required quantity and quality to provide positive care outcome.

Strategies

- Increase number of skilled manpower (nurses) to provide quality nursing care
- Sponsor nurses for training programs in various specialties of nursing.
- Institute and maintain use of professionalism and ethics.
- Increase number of nurses for specialty training in various disciplines of nursing.

Objective (iii)

- Ensure availability or adequate, standardized, and appropriate equip in all units

Strategies

- Supply of standard hospital equipment and instrument
- Develop & implement guidelines on equipment management
- Inspect and verify quality of equipment and instruments supported
- Ensure adequate supplies through an efficient and effective logistic management system.
- Strengthen logistic management systems at all levels/units

Objective (iv)

- Promote research and development in nursing practice to improve quality of care

Strategies

- Develop research and development programs relevant to quality nursing care

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- Create budget line for research and development programs for nursing services.
- Build capacity within nursing services staff for research and development.

6.12.2 Policy implementation level

Guideline 1: The hospital management team must ensure implementation of policies in order to provide quality care.

Objective (i)

- Implement relevant policies and guidelines for use by all health workers

Strategies

- Ensure adequate supervision of nurses
- Ensure that welfare of nurses is adequately provided eg egular promotion for nurses
- Ensure effective implementation of referral system to reduce work overload at tertiary hospitals.
- Identify gaps and strengthens in the referral system
- Motivate nurses through provision of incentives, benefits, compensations, commendation and rewards to improve job satisfaction and job performance
- Establish effective communication system to reduce bureaucracy.

Objective (ii)

- To improve nurse/patient ratio

Strategies

- Increase number of nurses per shift
- Retain nurses at all levels of care

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Objective (iii)

- To improve capacity building of nurses

Strategy

- Implement training plans for nurses
- Training of nurses in logistic management

Objective (iv)

- Strengthen continuing education units for nurses and retrain personnel

Strategies

- Train nurses in management courses
- Provide fund to support units
- Measurement and Evaluation on adherence to OP development programs..

Objective (v)

- Provide infrastructure to contribute to provision of quality nurse care

Strategies

- Conduct infrastructure assessment in the hospital
- Establish database for the hospital for adequate record keeping
- Develop an implementation plan for infrastructure construction, upgrading and maintenance
- Ensure adequate transportation of patients from one location to another and outside the hospital

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Objective (vi)

- Promote health and safety standards for nurses and patients

Strategies

- Conduct needs assessment for safety
- Fund for safety training for nurses
- Conduct in-house training on safety for nurses
- Employ Occupational Health Nurses
- Install and maintain safety devices in the hospitals
- Ensure all staff have personal protective equipment (PPE) appropriate for their job and assignments.

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Objective (vii)

- Improve interpersonal relationships amongst healthcare workers.

Strategies

- Periodic meeting of all healthcare workers in the hospital to ensure cordiality
- Ensure joint approach to problem-solving among healthcare workers
- Resolve conflicts at work to maintain a positive work environment
- Coordinates and integrate respect among hospitals.

6.12.3 Policy evaluation level

Guideline 1: Periodic evaluation of effectiveness of policies on wellbeing of nurses and care outcome.

Objective (i)

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- Improve management skills of managers

Strategies

- Ensure adequate training in leadership and management for Nurse-managers
- Ensure role clarity, authority and recognition of nurses in the health system
- Ensure periodic assessment to hierarchy of nurses in the health sector.
- Monitor and evaluate delivery of nursing care in all units.

Objective (ii)

- To ensure supply of standard equipment and instruments for quality care.

Strategies

- Ensure supply and maintenance of adequate quality and quantity of consumables and non-consumables in the hospital
- Ensure supply of quality materials
- Ensure optimal functioning of equipment and instruments

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6.13 EVALUATION OF THE MODEL

A guide for the reflection on theory was taken from Chinn & Kramer (2018) to evaluate this model for support of emotional labour of nurses in tertiary hospitals. Evaluation of the model was done using the following guidelines.

6.13.1 Clarity

How clear is the model? In addressing this question, it means that the researcher should consider semantic clarity, consistency and structural clarity. Meanwhile, clarity enquiries whether the model brings new knowledge. The concepts and main concept have been defined in a way relevant

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to the content. The structural description of the model is in accordance with the description of the model.

6.13.2 Simplicity

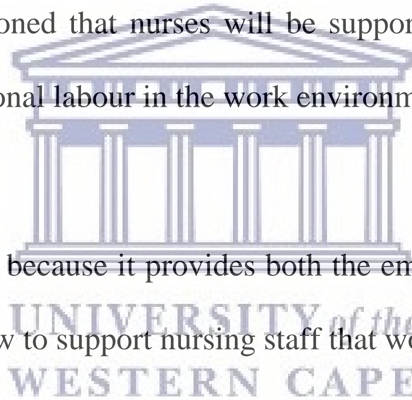
The model is simple because it only has six main conceptually identified relationships.

6.13.3 Generality

The six major concepts are significant for the reduction of experience of emotional labour of nurses and can be applicable to nursing, psychology and sociology. They can be applied in other disciplines which may also be a stressful working environment.

6.13.4 Accessibility

The aim of this study was to develop a model for support of emotional labour of nurses working in tertiary hospitals. It is envisioned that nurses will be supported by relevant stakeholders to reduce their experience of emotional labour in the work environment.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6.13.5 Importance

This model is deemed important because it provides both the employer and employees (Nurses) with applicable guidelines on how to support nursing staff that works in a challenging context.

6.14 SUMMARY

In this chapter, the model for support of emotional labour of nurses in TH was developed using the theory generating process of concept development, model development, model description and development of guidelines to operationalise the model. Chapter 7 focuses on summary, conclusion, limitations and recommendation of the study.

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CHAPTER SEVEN

SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

A description of the structure and the process of a model of emotional labour were provided in Chapter Six. Guidelines for the operationalisation of the model and a description of the critical reflection criteria for the evaluation of the model were also provided in Chapter Six. The final chapter details the summary and conclusions, limitations and recommendations of the study.

7.2 CONCLUSIONS

The purpose of this research was to obtain information regarding the experiences of nurses working in tertiary hospitals in Nigeria. The observed support requirements were also established. The relevant data collected were used to develop a model for support of emotional labour for nurses working in tertiary hospitals in Nigeria. This model would assist nurses in the hospital setting by providing emotional support relevant to the support needs as identified by nurses. The objectives to attain the aim of the study were achieved as follows:

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1. An integrative review of literature was conducted to understand the concept of emotional labour.
2. A descriptive survey was conducted amongst professional nurses to determine deep acting and surface acting strategies employed by nurses working in tertiary hospitals in Nigeria.
3. Focus group discussions were used to explore professional nurses' experiences of emotional labour.

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4. Results of the integrative review, survey and focus group discussion were triangulated, and concluding statements were generated and used to develop a model for support of emotional labour for nurses in tertiary hospitals in Nigeria.

It can therefore br concluded that the aim and objectives of this study have been achieved.

7.3 LIMITATIONS

The limitations experienced in the course of this study were as follows:

- The study was only conducted among participants from tertiary hospitals in Southwestern Nigeria, hence may not be generalised to other tertiary hospitals.
- The model was not reviewed by the study participants to confirm if it represented their support needs.

7.4 RECOMMENDATIONS FOR NURSING EDUCATION, PRACTICE AND RESEARCH

Recommendations are hereby proffered for nursing education, practice and research based on the conclusions of the study.

7.4.1 Recommendations for nursing education

- Inclusion of emotional labour in nursing education curriculum to prepare nurses at basic level for experience display of different emotions when carrying out nursing care.
- Creation and maintenance of a conducive clinical environment for nurses and nursing students to help them manage their emotions and also improve care.
- Inclusion of emotional labour in continuing professional nursing education programs. Emotional labour training will improve communication and interpersonal relationship of nurses which will help to promote quality nursing care.

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- Training and information will improve care initiative of nurses in terms of the time they spend with patients, health education given to patients, understanding and supporting the patients and inclusion of patients and relations in nursing care plan.
- Nurse educators should avoid correcting nursing students in the presence of patients, their relations and other people to preserve image of nursing and nurses.
- Creation of knowledge and awareness of on the importance and need for the use of emotional labour strategies through keeping personal diaries and clinical group discussions of personal experiences.

7.4.2 Recommendations for nursing practice

- The emotional labour support model could be adopted and implemented by health and hospital administrative stakeholders through prompt and sincere collaborative efforts since they are closer to grassroots with regard to the welfare needs of nurses and also serves as a key player in terms of implementation of health policies and research findings. This will avail nurses the benefits of the emotional labour support more promptly.
- Hospitals should be adequately equipped with necessary resources that can enhance ease of healthcare delivery on the part of nurses. This will assist tremendously in reducing the emotional labour burden of nurses while discharging their professional duties.
- The advancement of better commitment from healthcare workers to establish communication forums, such as monthly clinical meetings, where nurses can communicate felt needs, challenges, attend to and discuss nurses' matters arising.
- The physical environment of hospitals should be made more appealing and conducive for nurses. Necessary infrastructure and equipment required to positively impact on patient care should be adequately provided for nurses to work with.

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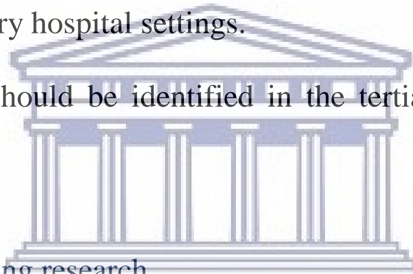
- The emotional labour support model should be propagated among relevant authorities so as to enhance better performance on the part of nurses towards productive healthcare delivery in the hospitals.
- Nurses should be given practicable and feasible emotional support by administrative officers while also giving credence to their needs and personal wellbeing. This will enable them to effectively and efficiently execute their job responsibilities without or with less hitches.
- The model can be used by nurses' support services to augment their current practices of offering general support to the nursing body. Every nurse has specific needs which should be catered for. This model needs to be presented at a stakeholders meetings within the hospitals, to propose various practicable and durable emotional support strategies and programmes to enable nurses coping in tertiary hospital settings.
- Definite support structures should be identified in the tertiary hospital setting for nurses' emotional labour support.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7.4.3 Recommendations for nursing research

- The emotional labour support model should be implemented within nursing practice, and the effectiveness thereof be appraised and developed through post-doctoral research;
- The application of the emotional labour support model in other challenging settings can be further investigated;
- The emotional labour support model could also be entrenched and confirmed in other tertiary hospitals in other parts of Nigeria among the nursing population;
- Research topics identified include:
  - Concept analysis of the term 'emotional labour' in tertiary hospitals in Nigeria

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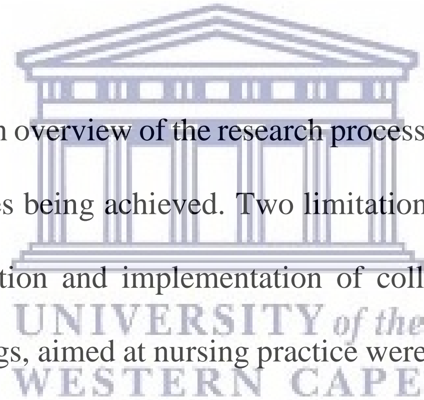
- Nurses’ perception of professionalism when dealing with patients and patients’ relatives who have a similar personal history as themselves.
- Examining the extent of perceived as against actual emotional labour of nurses working in tertiary hospital settings.
- A quantitative study to measure the level of emotional labour among nurses working in tertiary hospital settings as well as from other diverse healthcare settings.
- The design of the implementation of the model to ascertain if the model does reduce nurses’ emotional labour.
- Replication of the research topic in other socio-political zones of Nigeria

7.5 CONCLUSION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This final chapter has provided an overview of the research process, which reflected on the purpose of the research and the objectives being achieved. Two limitations of the study were mentioned. Recommendations for the adoption and implementation of collaborative efforts on emotional support in tertiary hospital settings, aimed at nursing practice were listed. Recommendations were made for potential topics which were considered suitable for research.

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Appendix 1

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X17, Bellville
7535
South Africa
T: +27 21 959 2988/2948
F: +27 21 959 3170
E: research-ethics@uwc.ac.za
www.uwc.ac.za

13 October 2017

Ms MA Ibraheem
School of Nursing
Faculty of Community and Health Sciences

Ethics Reference Number: BM17/8/4
Project Title: Development of a model for support of emotional labour of nurses in Tertiary Hospitals in Nigeria.

Approval Period: 29 September 2017 – 29 September 2018

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

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Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAL REC NUMBER -130416-050

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Appendix 2

Permission to conduct the study at Federal Medical Centre, Owo

E-mail:ajoke.beauty2012@gmail.com

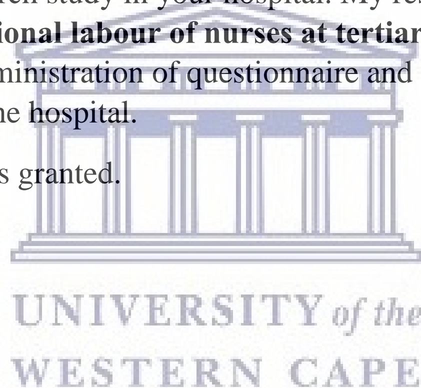
+2348038432495

The Chief Medical Director,
Federal Medical Centre,
Adekunle Ajasin road, Owo
Ondo state. Nigeria

Dear Sir,

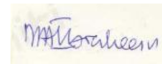
REQUEST FOR PERMISSION TO CARRY OUT A RESEARCH IN YOUR HOSPITAL

I am Ibraheem, Mulikat Ayoade a PhD student at School of Nursing, Faculty of Community and Health Sciences, University of the Western Cape, Bellville, South Africa. I humbly request for permission to carry out my research study in your hospital. My research topic is: **"Development of a model for support of emotional labour of nurses at tertiary hospitals in Nigeria".** The research process will involve administration of questionnaire and focus group discussions with Nurses and Nurse Managers in the hospital.


UNIVERSITY of the
WESTERN CAPE

I shall be grateful if my request is granted.

Thank you sir.



Mulikat Ayoade Ibraheem

https://etd.uwc.ac.za/

FEDERAL MEDICAL CENTRE, OWO.

Michael Adekunle Ajasin Road,
P.M.B. 1053, Owo,
Ondo State.
Tel:08035094545, 08062077773

Our Ref: FMC/OW/380/VOL. LV/36

Your Ref: ______________________

Date: 15th September, 2017

Mrs. M. A. Ibrahim
School of Nursing
Faculty of Community and Health Sciences
University of the Western Cape
South Africa

RE: APPLICATION FOR ETHICAL CLEARANCE

I am directed to refer to your application dated 11th September, 2017 on the above subject matter.

I am to inform you that your research proposal titled **"Development of a Model for Support of Emotional Labour of Nurses in Tertiary Hospitals in Nigeria"** has been considered and approved by the Health Research Ethics Committee.

In the light of the above, you are hereby permitted by the Health Research Ethics Committee to carry out the research since it is ethically acceptable.

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I am to add that you are to please submit a copy of your final research work to the Management after completion.

Thank you.

A. A. Salami
For: Medical Director

Medical Director: **DR. L. A. AHMED** *MBBS, FMCFM, FWACP*
Ag. Head of Clinical Services: **DR. A. O. ADESOKAN,** *MBBS, FWACP*
Ag. Head of Administration /Board Secretary: **MR L. A. OMOAREGBA** *BA (French) MPA AHAN*

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Appendix 3

Permission to conduct the study at Federal Medical Centre, Abeokuta

E-mail:ajoke.beauty2012@gmail.com

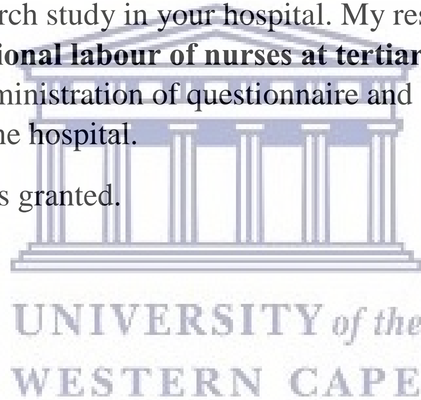
+2348038432495

The Chief Medical Director,
Federal Medical Centre,
Bisi Onabanjo Way
Idi-Aba, Abeokuta
Ogun state. Nigeria

Dear Sir,

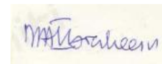
REQUEST FOR PERMISSION TO CARRY OUT A RESEARCH IN YOUR HOSPITAL

I am Ibraheem, Mulikat Ayoade a PhD student at School of Nursing, Faculty of Community and Health Sciences, University of the Western Cape, Bellville, South Africa. I humbly request for permission to carry out my research study in your hospital. My research topic is: **"Development of a model for support of emotional labour of nurses at tertiary hospitals in Nigeria".** The research process will involve administration of questionnaire and focus group discussions with Nurses and Nurse Managers in the hospital.


UNIVERSITY of the
WESTERN CAPE

I shall be grateful if my request is granted.

Thank you sir.



Mulikat Ayoade Ibraheem

https://etd.uwc.ac.za/

FEDERAL MEDICAL CENTRE

Bisi Onabanjo Way, idi-Aba, P.M.B. 3031 (Sapon Post Office), Abeokuta, Nigeria
08095948005-7
e-mail: fmcabk@yahoo.com, info@fmcabeokuta.org, info@fmcabeokuta.gov.ng

Medical Director
PROF. A.A. MUSA-OLOMU
MBBS, FWACS, FICS, MSc., PhD

Head of Clinical Services
DR. F. E. OJEBLENU
MBBS, FWACS (Ortho) Msc (Pub Health)

Director of Administration &
Secretary to the Board of Management
MR. A.O. VAUGHAN
B.Ed (Eng) Cert. Health Planning & Mgt.
MPA; AHAN

Our Ref: FMCA/470/ Your Ref: Date 5th January, 2018

NAME OF PRINCIPAL INVESTIGATOR: IBRAHEEM AYOADE MULIKAT

TITLE STUDY: DEVELOPMENT OF A MODEL FOR SUPPORT OF EMOTIONAL LABOUR OF NURSES IN TERTIARY HOSPITALS IN NIGERIA.

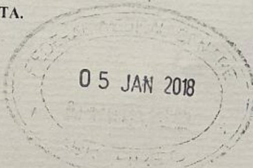
RESEARCH LOCATION: FEDERAL MEDICAL CENTRE, ABEOKUTA.

PROTOCOL NUMBER: FMCA/470/HREC/01/2018/003

NHREC ASSIGNED NUMBER: NHREC/08/10-2015

FEDERAL WIDE ASSURANCE: U.S/REG NO FWA/Q0018660

DATE OF RECEIPT OF VALID APPLICATION: 27/09/2017



NOTIFICATION OF EXECUTIVE APPROVAL OF PROTOCOL

This is to inform you that the Federal Medical Centre Abeokuta Health Research Ethics Committee (HREC) have decided to give Executive approval to your research proposal after necessary reviews and corrections under the regulations guiding experiment in human subjects.

This approval is for a period of one year from 6th January, 2018 to 5th January, 2019. If there is delay in starting this research, please inform the HREC so that dates of approval can be adjusted accordingly. Note that no activity related to this research may be conducted outside these dates. No changes are permitted in the research without prior approval by HREC.

All forms and questionnaires used in this study must carry the HREC assigned number and the duration of HREC Approval.

You are to note further that the National Code of Health Research Ethics requires you to comply with all institutional guidelines, rules and regulation of the codes. Please ensure that any adverse effect from your study is promptly reported to the HREC Federal Medical Centre, Abeokuta.

You are expected to submit a report to this Committee every three (3) months from the date of this approval. The HREC reserves the right to conduct compliance visits on your research sites without previous notification.

Thank you.

05 JAN 2018

J.A. ADETUMERUN
For: Chairman Research Ethics Committee

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Appendix 4

Permission to conduct the study at Obafemi Awolowo University Teaching Hospital Complex, Ile-Ife

E-mail:ajoke.beauty2012@gmail.com

+2348038432495

The Chief Medical Director,
OAUTHC,
PMB 5538,
Ilesa road, Ile-Ife.
Osun state. Nigeria

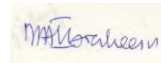
Dear Sir,

REQUEST FOR PERMISSION TO CARRY OUT A RESEARCH IN YOUR HOSPITAL

I am Ibraheem, Mulikat Ayoade a PhD student at School of Nursing, Faculty of Community and Health Sciences, University of the Western Cape, Bellville, South Africa. I humbly request for permission to carry out my research study in your hospital. My research topic is: **"Development of a model for support of emotional labour of nurses at tertiary hospitals in Nigeria".** The research process will involve administration of questionnaire and focus group discussions with Nurses and Nurse Managers in the hospital.

I shall be grateful if my request is granted.

Thank you sir.



UNIVERSITY of the
WESTERN CAPE

Mulikat Ayoade Ibraheem

https://etd.uwc.ac.za/

ETHICS AND RESEARCH COMMITTEE (ERC)

OBAFEMI AWOLOWO UNIVERSITY TEACHING HOSPITALS COMPLEX

Tel: +2348152092751 +2348152092755 +2348152092999
E-mail: oauthc ethicalcommittee@yahoo.com

CHAIRMAN: Prof.D. A. Ndububa MB.BS, (UNN), FWACP, AGAF.

REGISTRATION NUMBERS:

INTERNATIONAL: IRB/IEC/**0004553** NATIONAL: **NHREC/27/02/2009a**

CLEARANCE CERTIFICATE

PROTOCOL NUMBER: ERC/2018/03/02

PROJECT TITLE: DEVELOPMENT OF A MODEL FOR SUPPORT OF EMOTIONAL LABOUR OF NURSES IN TERTIARY HOSPITALS IN NIGERIA

INVESTIGATOR: MRS. MULIKAT AYOADE IBRAHEEM

DEPARTMENT/INSTITUTION: DEPARTMENT OF NURSING, FACULTY OF COMMUNITY AND HEALTH SCIENCES, UNIVERSITY OF THE WESTERN CAPE, SOUTH AFRICA

DATE OF FORMER APPROVAL: 01/03/2018

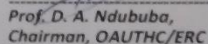
DATE OF RENEWAL: 09/07/2018

DURATION OF EXTENSION: Five (05) Months

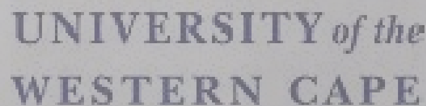
This is to inform you that the research described in the submitted protocol, the informed consent forms and other participant information materials have been reviewed and given full approval by the **OAUTHC Ethics and Research Committee.**

The approval is from **09/07/2018** to **08/12/2018**. You are to inform the Committee the commencement date of the research and if there is any delay in starting the research, please inform the Committee so that the date of approval can be adjusted accordingly. All informed consent forms used in the study must carry the **OAUTHC/ERC** protocol number and duration of approval of the study. In multi-year research you are to submit an annual report in order to obtain renewal of approval.

The National Code of Health Research Ethics required that you comply with all institutional guidelines, rules and regulations including ensuring that all adverse events are reported promptly to the **OAUTHC/ERC**. No changes are permitted in the research without prior approval by the **OAUTHC/ERC.** The **OAUTHC**/ERC reserves the right to conduct compliance visit to your research site without previous notification.



Prof. D. A. Ndububa,
Chairman, OAUTHC/ERC


UNIVERSITY of the
WESTERN CAPE

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Appendix 5

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 9345 Fax: 27 21-959 2679

E-mail: 3419072@myuwc.ac.za

INFORMATION SHEET FOR SURVEY

Project Title: DEVELOPMENT OF A MODEL FOR SUPPORT OF EMOTIONAL LABOUR OF NURSES IN TERTIARY HOSPITALS IN NIGERIA

What is this study about?

This is a research project being conducted by MULIKAT AYOADE IBRAHEEM at the University of the Western Cape. We are inviting you to participate in this research project because you are a nurse working in this tertiary hospital. The purpose of this research project is to develop a model for support of emotional labour of nurses in tertiary hospitals in Nigeria.

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WESTERN CAPE

What will I be asked to do if I agree to participate?

You will be asked to complete a questionnaire to obtain information on:

What you understand by emotional labour.

How you manage your emotions when interacting with patients

How you manage your emotions when patients annoy you

Do you fake you emotions when interacting with patients?

Do you express your emotions to patients in the true way you feel it?

It will take about ten (10) minutes to fill the questionnaire

a) Participate in individual interview or Focus Group interview to obtain information on:
Do you ever experience emotions of any sort?

Have you ever had (positive – or – negative) feelings as a result of your work?

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What are some of these feelings?

What do you think the management can do to improve the working conditions of nurses?

The interview will last for 45 to 60 minutes

The study will take place in your hospital premises.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, the survey is anonymous and will not contain information that may personally identify you.

For coded identifiable information:

(1) your name will not be included on the surveys and other collected data

(2) a code will be placed on the survey and other collected data

(3) through the use of an identification key, the researcher will be able to link your survey to your identity

(4) only the researcher will have access to the identification key.

To ensure your confidentiality, the researchers will keep all documents in locked filing cabinets and storage areas, use identification codes only on data forms, and password-protected computer files.

If we write a report or article about this research project, your identity will be protected.

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WESTERN CAPE

This study will use focus groups therefore the extent to which your identity will remain confidential is dependent on participants' in the Focus Group maintaining confidentiality.

This research project involves making audiotapes of you to identify common words or phrases expressed by you that indicates your view about emotional labour. Only the researchers and decoders will have access to the information that you will provide. The information will be stored in locked cabinets.

( ) I agree to be audiotaped during my participation in this study.

( ) I do not agree to be audiotaped during my participation in this study.

What are the risks of this research?

There may be some risks from participating in this research study. All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during

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the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about how nurses in this hospital manage their emotions and those of their patients while interacting. We hope that, in the future, other people might benefit from this study through improved understanding of emotional labour of nurses. Also, the result of this study may assist the hospital management team to design support interventions that will reduce the negative effects of emotional labour of nurses.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Mulikat Ayoade Ibraheem of School of Nursing at the University of the Western Cape. If you have any questions about the research study itself, please contact Mulikat Ayoade Ibraheem at School of Nursing, University of the Western Cape, Bellville, Cape Town, South Africa (+2348038432494) 3419072@myuwc.ac.za

UNIVERSITY of the
WESTERN CAPE

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof J Chipps

Head of Department: School of Nursing

University of the Western Cape

Private Bag X17

Bellville 7535

jchipps@uwc.ac.za

Prof A Rhoda

Dean of the Faculty of Community and Health Sciences

University of the Western Cape

https://etd.uwc.ac.za/

Private Bag X17

Bellville 7535

chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Research Ethics Committee. (REFERENCE NUMBER: *to be inserted on receipt thereof from the applicable Research Ethics Committee*)

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Appendix 6

UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 9345 Fax: 27 21-959 2679

E-mail: 3419072@myuwc.ac.za

INFORMATION SHEET FOR FOCUS GROUP DISCUSSION

Project Title: DEVELOPMENT OF A MODEL FOR SUPPORT OF EMOTIONAL LABOUR OF NURSES IN TERTIARY HOSPITALS IN NIGERIA

What is this study about?

This is a research project being conducted by MULIKAT AYOADE IBRAHEEM at the University of the Western Cape. We are inviting you to participate in this research project because you are a nurse working in this tertiary hospital. The purpose of this research project is to develop a model for support of emotional labour of nurses in tertiary hospitals in Nigeria.

What will I be asked to do if I agree to participate?

You will be asked to complete a questionnaire to obtain information on:

What you understand by emotional labour.

How you manage your emotions when interacting with patients

How you manage your emotions when patients annoy you

Do you fake you emotions when interacting with patients?

Do you express your emotions to patients in the true way you feel it?

It will take about ten (10) minutes to fill the questionnaire

b) Participate in Focus Group interview to obtain information on:
Do you ever experience emotions of any sort?

Have you ever had (positive – or – negative) feelings as a result of your work?

What are some of these feelings?

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What do you think the management can do to improve the working conditions of nurses?

The interview will last for 45 to 60 minutes

The study will take place in your hospital premises.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, the survey is anonymous and will not contain information that may personally identify you.

For coded identifiable information:

(1) your name will not be included on the surveys and other collected data

(2) a code will be placed on the survey and other collected data

(3) through the use of an identification key, the researcher will be able to link your survey to your identity

(4) only the researcher will have access to the identification key.

To ensure your confidentiality, the researchers will keep all documents in locked filing cabinets and storage areas, use identification codes only on data forms, and password-protected computer files.

If we write a report or article about this research project, your identity will be protected.

This study will use focus groups therefore the extent to which your identity will remain confidential is dependent on participants' in the Focus Group maintaining confidentiality.

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This research project involves making audiotapes of you to identify common words or phrases expressed by you that indicates your view about emotional labour. Only the researchers and decoders will have access to the information that you will provide. The information will be stored in locked cabinets.

( ) I agree to be audiotaped during my participation in this study.

( ) I do not agree to be audiotaped during my participation in this study.

What are the risks of this research?

There may be some risks from participating in this research study. All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during

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the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about how nurses in this hospital manage their emotions and those of their patients while interacting. We hope that, in the future, other people might benefit from this study through improved understanding of emotional labour of nurses. Also, the result of this study may assist the hospital management team to design support interventions that will reduce the negative effects of emotional labour of nurses.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Mulikat Ayoade Ibraheem of School of Nursing at the University of the Western Cape. If you have any questions about the research study itself, please contact Mulikat Ayoade Ibraheem at School of Nursing, University of the Western Cape, Bellville, Cape Town, South Africa (+2348038432494) 3419072@myuwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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Prof A Rhoda

Dean of the Faculty of Community and Health Sciences

University of the Western Cape

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This research has been approved by the University of the Western Cape's Research Ethics Committee. (REFERENCE NUMBER: *to be inserted on receipt thereof from the applicable Research Ethics Committee*)

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Appendix 7

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CONSENT FORM

Title of Research Project: DEVELOPMENT OF A MODEL FOR SUPPORT OF EMOTIONAL LABOUR OF NURSES IN TERTIARY HOSPITALS IN NIGERIA

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

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Participant's name……………………….

Participant's signature……………………………….

Date………………………

If you have any question regarding this study, please contact the researcher:

Researcher: Mulikat Ayoade Ibraheem

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone +27 21 959 9345

Cell: +2348038432495

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Appendix 8

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FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: DEVELOPMENT OF A MODEL FOR SUPPORT OF EMOTIONAL LABOUR OF NURSES IN TERTIARY HOSPITALS IN NIGERIA

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

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Participant's name………………………………………..

Participant's signature…………………………………...

Date………………………

If you have any question regarding this study, please contact the researcher:

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Appendix 9

Focus Group Discussion Guide

What are the biggest problems with nursing practice in this hospital?

How significant are these problems?

What does that mean?

How did it happen?

What causes the problems?

What did you do?

Do you think these problems are sources of stress at work?

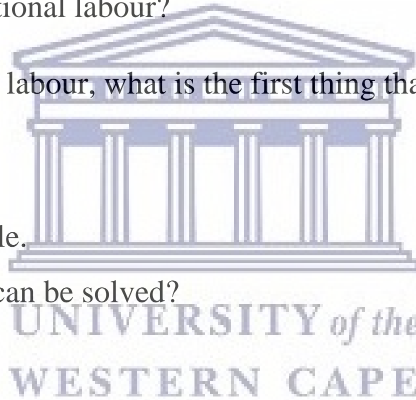
What do you understand by emotional labour?

When you think about emotional labour, what is the first thing that comes to your mind?

Please tell me more.

Please give me an example.

How do you think the problems can be solved?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Appendix 10

Emotional Labour Scale

Please indicate anyone that mostly describe your person by ticking (✓) **only one** of the responses in front of each of the statements.

Question: A typical interaction I have with a patient takes about ___ minutes.

On an average day at work, how frequently do you:

Item		Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
1	Display specific emotions required by your job?					
2	Adopt certain emotions as part of your job?					
3	Express intense emotions?					
4	Express particular emotions needed for your job?					
5	Use a wide variety of emotions in dealing with people?					
6	Resist expressing my true feelings?					
7	Pretend to have emotions that I don't really feel?					
8	Display many different emotions when interacting with others?					
9	Make an effort to actually feel the emotions that I need to display toward others?					
10	Show some strong emotions?					
11	Express many different emotions when dealing with people?					
12	Hide my true feelings about a situation?					
13	Try to actually experience the emotions that I must show?					
14	Really try to feel the emotions I have to show as part of my job?					
15	Display many different kinds of emotions?					

Adapted from: Emotional Labour Scale: Brotheridge & Lee (2003).

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Appendix 11

Example of transcript: Focus Group Discussion with nurses

Archival#: FGD: OA1
Site: Obafemi Awolowo University Teaching Hospital Complex Ile Ife
Data collector: M Ibraheem/N Umar
Date of data collection: 15/08/2018
Transcriber: M Ibraheem

Q: Can you tell us what you think are the biggest problems with nursing practice in this hospital? What are those problems that you have been able to identity since joining the services of this hospital and working as a nurse till you have risen to this level (the management level)?

P5: Thank you very much, actually, in answering that question, what just came to my mind is job dissatisfaction. In every institution particularly teaching hospitals and also bringing it home to nursing department, there is usually this common challenge. I don't want to say it's peculiar to this place, I think I want to speak generally, because of the type of government we have, presently. There was a time there was a kind of embargo on employment of staff and in nursing. The normal standard is to have a nurse attending to five (5) patients that's WHO standard, maximum of five (5), but you will discover that you will see a nurse particular during afternoon shift taking charge of eight (8), ten (10), twelve (12) bedded wards, and even fourteen (14) and like that. You see a nurse manning such a ward, and in some of the wards, you have patients that are bedridden, unconscious and all the rest, so you see this nurse going up and down and she has to fulfill her responsibility to these patients. An unconscious patient is expected to have total care. And please, how can only one nurse attend to these cases, and may be they have two unconscious patients in that ward with other patients that require attention and normal nursing care. So you discover that it becomes a challenge to nursing department and I want to say that it's a problem that up till now has not been solved. Although in this place, there was an interview conducted sometimes, so we are hoping that things will be better but that ratio one nurse to five patients is not happening now. And secondly, instruments, instruments and equipment to work with, we also have challenge on that. We need to improvise some of the times, you need to rack your brain to see how you can carry out proper nursing care to those patients, so these are the two issues I can mention.

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P2: From my own experience, I worked with private hospital and in that private hospital, I'm all in, all. I think you can get what I mean. I admit, I administer. I diagnose but for coming into teaching hospital, you are limited to some specific things, in that place, we use to set IV line, give IV drugs, take deliveries on my own, give episiotomy and suture it, here you can't do it. They said this is teaching hospital, doctors do this and that.

P6 (interjects): We have done division of labour. There are assignments that are allocated to nurses and there are some in this higher institution when you talk about something like venipuncture it is mainly doctors' assignment, whereas in the private hospital, nurses can do such, you know like when you are in the institution, you follow the rules. The policy of every institution varies, so like in this, our institution, we have different policies, like the one that affects the nurses, we know that from admission, when a patient comes in, it is the nurse that assesses a patient. After assessment, it is the nurse that will know whether this patient will be reviewed by a doctor or not, so a doctor comes around, sees, makes his or her own diagnosis. If that patient is transferred to the ward, you know most of the work goes to the nurses, feeding the patient, ensuring that the patient eats well, administering drugs and from time to time on daily basis the nurse will also diagnose because we use our Nursing Process format in taking care of our patients and so with that, you make your diagnosis on daily basis, you want to meet the needs tend this patient on daily basis. For instance, a patient who had pain yesterday, based on your intervention and everything, by today, the pain must have resolved, it may be another diagnosis that we will be talking about. So from time to time, that is the responsibility of the nurse to assess on daily basis and to care for the patient. We have various procedures like wound dressing that are fundamental to nursing practice.

Researcher: Fundamentally, we know we have basic nursing procedures, now when carrying out these procedures, what are the challenges?

P1: I just wanted to make sure that we come from the fact that we have responsibilities to carry out which is quite different from what happens in the private setting. That's what I was trying to balance up, now we have various challenges. My colleague mentioned instruments, she also talked about shortage of staffs but right now, we also have problem with water supply, our electricity supply also is erratic. We have problems with water supply, we also have electricity problem, we also have problem with disposal of used remnants, hospital wastes. Because at times you find out that the containers will be full and overflowing before they will come to empty them and you know

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if you don't have water in the hospital it's a big problem. The institution tried as much as possible to supply the water, though we don't have running water from the tap 24/7, they supply water most of the time. They bring tanker to supply but, you know the standard, you're supposed to even use elbow operated taps, so water flows, so when you want to prevent infection spread, you will prevent touching these valves, so you will use your elbow to control. So all those things are absent in our institution except probably in the theatre where we have those kinds of facilities but in the surgical wards, in the other areas of the hospital, we lack it. So those are some of the materials that are needed that are not available, and then water supply is not adequate, not that they don't give us water but it is not adequate. Then, on power supply, we have improved a lot of late, we have improved but we still need more improvement because at times during the night duty, the light may go, you see the nurse battling with rechargeable lamp, touch light or even the phone, at times she will use the phone as head lamp like a miner to be able to attend to patients, so those are the real (core) problems that we are really facing on daily basis. But the institution to be very candid, has been trying on daily basis to ensure that we reach that level, at least since you came, have you had any light surge? (Researcher: No), it has not been interrupted, so it can be like this for days without having interruption but at times also, it might be erratic. Before they will fix the problems and all that, we may have that kind of challenge. So let me give other people chance to talk.

P4: I just want to add something sorry, let me just add something to what she had talked about. Let me add the environmental issue, we have a lot of bushes around whereby we are killing snakes all about, even yesterday somebody mentioned that they killed one big snake somewhere around phase 4, something like that, and these are part of challenges we are facing, because you know they now have this contract (casual) staffs, working and when these people were not paid they down tool.

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P7: Some of the other challenges we are facing is supply of drugs to patients. In those days attendants used to go to pharmacy shop to bring or collect patient drug when prescribed. For the past two years now, relations go for their patient drugs and it has not been easy even for the nurses, because at times some of these relations has to go to their respective homes probably to look for money before coming back and one has to wait until drugs are supplied. Even when the drugs are supplied the relations are not able to buy all especially the expensive drugs so it’s giving us a kind of dilemma. Then we have drugs in the hospitals but not all of them are always available and some

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these patients' relations, at times I even feel for them some of them may be asked to go and buy drugs around 11pm. Thank God we have a pharmacy shop there that runs 24-hour service so any time relations or patients go there they open the doors for them. And this is a big challenge which I do not know what we can do about it, anyway it's like it has come to stay at least for now, our management is trying sure they cannot purchase all the drugs and thank God we have stable pharmacists around that are helping these patients. I do not know what they have done but I know there are pharmacy shops around that they can patent.

P5: Something just came to my mind, in this teaching hospital it used to be phase 1 phase 2, now we have phase 1, phase 2, phase 4, and phase 4 as I speak is bigger than phase 1 phase 2 put together. There is this expansion we are having a lot of challenges you know the patient relations even transferring patient is one, and patient relations when they are with their relations they want something from phase 1 and they are in phase 4 or outside they find it very difficult moving from one phase to another. At times, when we are taking care of patients, the patient relations becomes our patient again because by the time they go up and down they get stressed up and some of them collapse on the way - those are some of the things we are facing as very big challenges. I have experienced a situation like that outside this country whereby the institution has a shuttle that mount from one phase to another if a patient comes out of her room, you know, and the patient is going to the other phase there is always a shuttle bus and these things are free of charge and probably because of the hospital policy it may have been added to the patient bill but there is always a shuttle. So when you come out to pick up something somewhere for your patient who is on the bed there is always a shuttle to take you and immediately you finish from that place you will find another shuttle that is coming so if such a thing is done in this place I think it is going to help issues, that is a suggestion or solution.

Researcher: and what came to my mind is these different phases that you have, what services do they offer because if a patient absconds from phase 1, to move from phase 1 to phase 4 for a service it means the phases are segmented.

P3: There are different departments in these phases. If you think of phase 1 the medical wards are there, Gynaecology ward is there and renal ward is there. If you come to phase 2, it is mainly surgical cases, then when you get to phase 4 you will see an area that take care of orthopaedic cases, then you will see maternity complex and see children's wards in different levels those are

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the one manned best. The phases - I am sure they are divided for convenience sake and better care of the patients.

Researcher: Health system is a system that is interwoven

P6: Yes, so the area that you asked, if I may add is for instance if a patient in phase 4 needed to have X-ray done that person has to come to phase 2 and the facilities for that is not available. So, for the person to come here, it is either the person treks. If the person is an in-patient, the person can be brought with ambulance but for instance, if this person just came to the clinic and the person needs X-ray, the person needs to find his way even for laboratory services.

P2: Then in addition to our challenges, the patients are having serious financial challenges that is affecting our own care to them because is only when they provide what we need at any level from admission to discharge may be taking care of them in any form and at times we have debtors. Debtors that may stay for a long time some of them that are will I say “wise” or “too sharp” might even end up absconding with hospital bills not paid and that is causing a lot of stress for the institution and some of the nurses that might be on duty when that will happen because you will have to write letter (memo).

Researcher: How does it affect the nurses on duty?

P1: Ha, when you are in a ward, where a patient happened to abscond, there is no how it will not affect the nurses. The nurses attend to the patients 24/7 and you must be ready to account for any patient that absconds because you never can tell where the patient might have gone to, the patient might enter a bush or commit suicide, or go to any other place or may even have RTA (road traffic accident) on the way. Somebody that absconded like that definitely might not be in his or her right senses. He can do anything, especially when the person doesn’t have any hope of getting the money for his bills, he may enter into very dangerous place. So it can give both the patient and the nurse real emotional stress.

Researcher: Then what happens to the patients’ bill and what will happen to the nurses on duty when a patient absconds?

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P3: At times the medical social workers actually go after them, but most of the times, they are not met because as soon as the medical social workers are able to get in touch with such patients they bring them back to the hospital.

Researcher: So, the nurse will not be held responsible?

P2: Not to pay the bill. The nurse will be held responsible not to pay the bill but they have to write incident report - it has to be reported in the appropriate quarters.

P5: To me it is not supposed to be the responsibility of the nurse because it is something I keep fighting for. When a nurse is asked to go after an absconder, I always frown against that because nurse is very busy taking care of other patients and with the kind of serious shortage we have, if somebody should now abscond while you are trying to carry out the duty on other patients why should she be held responsible? And that is why we said security men should be attached to every ward so if security men are there, and a patient abscond or whoever absconds the person should be held responsible because once upon a time we used to have uniform but now I don't know whether our uniform are still there

P7: We have but the patients are not accepting them may be because they are not attractive.

Researcher: Have you ever encountered a similar problem like this? When a patient absconds and the nurse is held responsible?

P4: Yes, it happened but um the patient absconded, the nurse was asked to write memo, then they brought a bus with security and other social workers, and they all went in search of the patient.

Researcher: How significant are these challenges to nursing care and the nurse as an individual?

P3: The primary assignment that we have here is total care of our patients. Once you have shortage of manpower, there is no way you can give adequate nursing care to the patients that is number one. Number two, on the part of the person that is doing the work, maybe I should just share my personal experience. Yesterday, I did afternoon. Immediately I got to the ward the first shock was "you are the only one that will do this afternoon". My partner has been taken to the casualty. She was sick and the second shock was I have four patients in the theatre, two Chiroplasty, one for Thyroidectomy the fourth one, Herniorrhaphy, four patients only me on afternoon (8-bedded ward with serious cases). And the third shock was that I have another patient, a complete heart block

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waiting for admission from SOP (surgical out-patient). Only myself, in fact, ward head had to wait until 5pm before she could leave so I have to pick three patients from theatre -only a nurse for that shift. The fourth patient was transferred to ICU (intensive care unit). One of the three patients that I brought from the theatre, one of them the father was on my neck that "you have to take this boy to amenity ward because we have paid for amenity care and we had already told the doctor that the patient should not be managed in the open ward". I was like how will I transfer a patient from phase 2 here to phase 4? One of the patients I brought in from theatre, the one that had Herniorhaphy she was not on urethral catheter and I have other patients that I am going to do intake and output chart for, give IV drugs. So when the woman called me - the one that I brought from theatre - that she needed to urinate, it was like I was busy with one patient and the first thing I said was, Mama, please wait. We have 5 months' old baby that have Chirography - that one needed oral suctioning, I was like this child must not get aspirated, this woman needed to void and I was the only one on ground and I still have to do vital signs for all the patients so when the woman called me it was getting to a point that I was about raising my voice and naturally I don't do that but it got to a point that I was pinned to the wall that I have to respond to this woman, but I was saying, Mama, wait I was stretched beyond my elastic limit, so I just said, Mama, wait and the daughter was like answer her and she practically shouted on me. My body says please reply her but I just told myself that I am not going to reply her. So by the time I got to her she said "Do you want me to urinate on my body?" I could not tell her that you see I was also busy, I was not sitting down and the daughter said can she offer the potty but there is no way she could use potty. It was high - it's a high potty and we have the flat bed pan and I would not want her to handle the bed pan because anybody can just enter at any point in time (which is wrong). I will be queried. So "I just told myself that just be calm" but I was getting mad. So I just told myself just be calm, be calm. In fact, this morning I have to come as early as 7am. The one I admitted with complete heart block, I could not do the nursing diagnosis - those related to anxiety related to post surgery, but I could not do the nursing care plan. I had to come this morning to do that, because I would not want a situation whereby people will come and say who admitted this patient. Who will I explain to that I was practically busy because nobody was there to be a witness. So at times it could tell on the nurse because there is no way you can give adequate care to such patients and this care we are talking about, the patient has paid for it and to even yourself you are not fulfilled because you look at yourself that this is what I am supposed to do and you cannot do it, so you are not fulfilled you

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are not happy when you know that this what you are supposed to do and you can't do it; you can't help yourself. To me I don't see myself as a fulfilled nurse when I don't do what I am supposed to do.

Participants' chorus: (majority of the nurses) these are very common experiences that each and every one of us have encountered.

Researcher: Now, can you tell us what you understand by emotional labour?

P6: Emotional labour to my own understanding is a kind of tension that an individual may pass through based on the emotions, premorbid emotions without having stress, how individual react to situations so when the patient are now placed may be on a stage if other things surrounding it, how does emotions now come to play due the labour, stress or tensions placed on that individual thereby displaying such emotions like anger, talking too much and some other things.

P7: My own addition can be described as a negative energy that nurses imbibe in situations around them when on duty at any point in time; negative energy that nurses use to manage situations at work.

Researcher: What do you mean by negative energy?

P7: We said emotional labour is stress. Usually when you put emotion into labour it means you are stretched beyond limit; you are stretched beyond your ordinary or elastic limit in a normal environment or situation.

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P2: Emotional labour, I can say are series of problems, series of distractions that can affect somebody may be a nurse in the discharge of her duties that will really make her feel bad. These stressors, you know, come out as a nurse does her work - they will come out in form of distractions that may even affect the nurse ordinarily but because of the nature of our job we may not want to show it but right inside it is bothering us, these are the ways I can really package it together.

P5: Emotional labour can also be described as the ability or the process you now as a nurse use in managing your feelings, managing your stress, your expression in order to conform to the expected behaviour of your profession. Just to add to what she has said, though you are stressed but you are to remember that you should not add to the patient's problems that "I will be able to control

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myself". So that act of managing your expressions and feelings in order to conform to the expected behaviour of that particular profession (nursing).

Researcher: What readily comes to your mind when you hear the concept of emotional labour?

P1: What readily comes to my mind is stress. You know the major problem in relation to this is that when we go through emotional labour as professionals, if you are tagged a professional you would have been taught on how to cope and how to manage such stress. So in her own case you can see despite the pressure she was able to manage it because she is professionally endowed but it is not everybody that will get to that level. It is because she knows what she is to do. She has a conscience she knows that these are the things I am supposed to do to help this patient because anybody that comes to the hospital is under our care. So if you know that one, you will know that you are not supposed to fight back.

Researcher: Have you ever gone through one?

P2: So many.

Researcher: Can you give an example?

P2: For instance, I was on afternoon shift too sometimes ago and this patient was met in an unconscious state, a little child. When I got to my ward, my usual way of attending to my patient I use to interact like some of them will ask for this ask for this and that, so in the process of doing that before taking over I had a new admission in the previous unit and I went to the bedside of the patient and I said "E pele" (meaning: take care) I greeted the woman, the woman apparently was angry and I just look at the child, even looking at the child you will know that this patient was unconscious. So I was just trying to interact with the woman sitting by her. I was asking her what happened, she now flared up. She so insulted me on that day that "ha-ha since she came in she has been answering questions from children emergency they brought us here, since we got here, nurses have been asking from her and you have come again, can't you people read what has been written by other people? Why are you asking me questions? Please leave me alone oh, leave me." She started screaming but I just told her, I said Mama, sorry, I understand how you feel, don't worry, I won't disturb him, I just left, I didn't say anything in response. I didn't say a word. So what I did was when it was around 3pm when I went I touched the child body and I find out that she was febrile to touch. I went back to the nurses' station to prepare the vital signs tray and I went back to

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the woman. The bedside I did the vital signs. I did everything, I came again with a trolley, I did tepid sponging, the temperature was very high and I did not say any word to this mama but I took permission. I recorded everything. I went back to the station and I was doing my work, imagine being shouted on in the presence of everybody you know I felt bad within me but I couldn't talk back. Number one, I understood the situation the woman was going through. Number two, professionally I am supposed to be a succor to that patient and the family. Why should I now add more to her problems? So I decided not to say a word, I couldn't even say a word but later the father of the child came. That woman happened to be the grandmother of the child. When the father now came, who happens to be her son, she just grabbed the hand of the man and dragged him to the nurses' station and said "*o ya dobale kia kia kia*" (prostrate). I was so embarrassed since he is a man, so I was now saying, Mama what is the meaning of this? The woman also knelt down, and where I am from, we don't kneel down for younger ones so it's an abomination immediately. I said, Mama, whom are you kneeling down for? It is me - you are cursing me. Please stand up. We don't do that in our place (my tribe). I am not Yoruba, please stand up. So she saw that I started walking away. She now got up but she said definitely I am older than the son so "*iwo naa dobale si be*" (that the son should remain in that position) I said, Mama, "*kilode*" (why?) What happened? And she now said she has offended me and did not just offended me as a person but she has offended my (*Eleda*) (my creator) and that what she did she was so scared that despite the way she treated me I still went to do everything that even the people do not do that they did not treat that child the way I handled him - you understand? So as professionals, if you have been trained properly, I don't think whatever stress you are passing through you should now react in a way that it will make your patient to be uncomfortable. So that is my experience and I did not forget that experience.

P3: My own experience, it's not even with a patient - it was with a colleague. I happened to go there to supervise those under my jurisdiction. This lady, in fact, I give her kudos with what she did yesterday. This nurse happens to be a senior nurse in that area and when I was just going round to check how is your patient she now said "look, Mama D.D. I am alone on shift I just want to inform you that for me alone to be on this shift, I will only do the vital signs of the patients. I will write report, nothing more". I just paused and said, "You will just do the vital signs, write report, what about medications? But she said you better go and look for nurses since all these years that I have put in so I now realised that she is pouring out her emotions, tension because of frustration,

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manpower shortage again may be job dissatisfaction. I knew quite alright that she ought to have been promoted, so she was just pouring out her mind, no motivation which is another challenge, so I now said, Mrs. Lagbaja I understand you are no more a junior nurse. Nobody should put you on duty alone. Give two days I will address it. What I did was to move round and I got someone and I said go to so-so ward and help Sister Lagbaja. So the second day I now called her and counseled her that she is not to be put alone and she is no more a junior nurse. So that is my own even with a colleague - not even patient.

Researcher: Having gone this far we have been talking on emotional labour, is there a positive aspect of emotional labour?

P4: Yes

P5: Let me just say something again, I happened to be in charge of Communicable Diseases Clinic (CDC), also in charge of Adult Isolation Ward - these are related cases, and you know what people will just say about you. They will not want to come near you, and so even to the patient you are admitting. So, there is this young boy, a university undergraduate, he was admitted for PTB pulmonary tuberculosis. Every day when I am on duty I make sure I visit him. I will put on my mask, go into the room, chat with him. How are you feeling? Are you taking your drugs? What will you like to eat today? And you know, the parent has been fighting with nurses, I don't know, I do permanent morning, I don't know, that they used to abandon the boy, that why I will call you that the fluid have finished and you won't come, but I did not know. The issue kept going on for some time. So, I was just in my office, the mother just came. I can't even explain how many minutes she spent praying and praying, because when they need something I get it for them. I did not know that others have been doing things the other way. So the mother now came. She was praying and praising me, and I said that I was just doing my job and I love doing it - it's later that I was hearing negative comments from her about other colleagues.

P7: Emotional labour cannot be with patients and their relations all the time. Emotional labour occur when you are working with some of the doctors or other health workers. This one I want to say there was a patient with ovarian mass and she had surgery done for her about 21kg mass was removed. On that faithful day I was on afternoon duty alone, shortage of manpower, it's a long time, I was a senior nursing officer (SNO) then, so, this woman was brought back from theatre. When I came on duty I met her, I went round, from afar. I studied the way she was breathing. I

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could see that she was a bit restless, I went very close to her, I greeted her. She responded, she was actually restless. Then I checked the IV fluid it was flowing, I checked the wound drain, already the urine bag was filled with blood and the nurses on morning duty had already left the ward. So I got a bedpan and emptied the urine bag, the blood was clotted, as I was emptying it, it was clotted, so I said wow this patient must have had slipped ligature. She is having internal bleeding. So, I called the junior resident doctor on call, he came and I brought his attention to the blood clot in the bedpan. He saw it and the patient was still restless and I said this patient might be having internal haemorrhage. "Call your senior resident doctor", he said Sister, give the patient Pethidine let the patient relax. I said which patient? I said you should give the patient Pethidine. I said Pethidine? You know me I will never give this patient Pethidine because that is not what she needs. I said, "Call your senior Registrar to come and review this patient, this patient is still bleeding." In fact, as I was talking with him the urine bag was filling up again, I said, "Look at that, why not call your senior Registrar? I will never give Pethidine". So, he started murmuring - I ignored him. Immediately and called the Senior Registrar and told him what happened. He came down immediately and asked what happened. I took him to the patient's bedside and showed him the bedpan with blood clot that is supposed to be serosanguinous fluid but now frank blood, clotted even in the bedpan. I told the Senior Registrar to alert the theatre people that the patient is having internal bleeding before it is too late. He said, "You are right". There and then, he ran to the theatre, alerted them, within 20 minutes I wheeled the patient back to the theatre because I was alone on duty yours and behold they reopened and found slipped ligature blood was just gushing out. They ligated, cleaned the patient up and brought back to the ward alive. So, the doctor later came to the ward, he was looking at me and I was also looking at him, and we are looking at each other. I said, "You better don't do that again because this patient would have died". I was bitter because when I told him, he did not want to take action immediately and the patient would have died. All these efforts now made the patient to survive. Throughout the time the patient was there we did not speak with each other because he made a mistake which he does not want to admit but later we became friends. Thank God the patient survived but the irony of it is that the patient later absconded because she could not pay the hospital bill. I am happy that the patient survived.

Researcher: How do you think these problems can be solved in this health institution?

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P6: With all these problems that have been identified, I think if there is meeting or a seminar that can be organised for all health workers because some of the problems has to do with other health workers, the water supply we are talking about - its not the nurses that will supply the water we need or do the plumbing work. And then, including the leaders of all units to talk about all these problems in a meeting, we discuss about why we do not have water at the appropriate time, why are we not having enough staff to work with all the problems identified will now be gathered together for each unit head and the ones that will be addressed internally. Like the case of shortage of staff, like she has just said that she went to another place to look for someone. Something like that can be done, like somebody supervising the whole unit should move round check the roster to know where there is excess or where they need more hands then you bring some to where there is shortage. For the plumbing issue the water supply, the people in charge what are the things they need? At times these people may need something that does not cost much, but they may be waiting that until they write, pass it through (bureaucracy). So, if the leaders in charge can come out with temporary solution maybe the management can buy the items pending when the request will pass through the normal routes of bureaucracy and the problems will be solved, because nurses will finish working and there will be no water to wash their hands – proactive actions. Then we improve the way we relate because our emotions can be controlled, yes, we can control it that is on individual level. Maybe a seminar will come up then people that are in Psychology that know more about behavioural science will speak through that people that have high level of tension could reason and know how to bring it down because if emotions are beyond our control, even at home, it can cause problems – physical combat (assault). So, if seminars like that can come up once in a while, and it cuts across maybe the higher level, to the lower and then to the least, to all workers particularly nurses to relieve tension, emotional labour and stress that will help us.

P5: In addition to what she said I just want to say, and it is something that I kept talking about and I will not stop it, in our course of training as nurses, we have knowledge about nursing ethics, and that is part of foundational training for all nurses, so, with ethics in nursing, I think all we need to just do is like a reminder, because anybody who goes the wrong way probably you have physical combat or you beat up a patient, or you assault a patient or nurses fight, you know the consequences. If we are professionals, we are already trained to be able to control ourselves, so it is just like a reminder programme from time to time that *"remember you are not supposed to do this".* It's not just maybe calling somebody from somewhere to come and give lecture, somebody

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who is having a terrible attitude, there is no lecture they want to give because during our three (3) years programme in basic nursing and some of us have gone again for other courses and even to degree level and yet there is no change of attitude - you can see the way that young nurse addressed the situation, it is because she had that background knowledge (training). The thing kept coming and she said it that she wanted to react but that your professionalism will restrain you from reacting, That is what I want us to know, that in solving most of these problems, one, our management is very concerned in terms of water we may not have our taps running 24 hours, but we will always get water through tankers to each unit and then we have the boreholes too. Attitude has to do with personality and as professionals, we have to control it by reminding ourselves of what we need to do. Then there are some things I don't think ordinarily will just come like that, for instance, if you go to the management now that you want to go for a training, it is a big challenge for nurses (we did not mention it). You get to a level in nursing and they will tell you that you don't need to go further. You understand because you are in the clinical setting.

At a time I wanted to go for my Masters and was not given permission. I was told that "What do you need Masters for to nurse a patient?" You understand, that is a big challenge. Nurses should be included in policy-making body in our institutions, so when you are a policy maker, you are part of it you will know the things that your people will need. For instance, if not that people took their own decisions to go for first degree that we are talking about now. Most of us did the degree, so many people would have suffered, personal efforts and self-development (to obtain first degree) were made but that is not right if a medical doctor can go for programmes and get to PhD level and he is in the clinical area, why not nurses? This discrimination is still there. We should try as much as possible to eradicate discrimination - let us grow academically.

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P6: What I want to add is that Federal Government too has a role to play concerning this even though our management will request for more staff the Federal Government will tell them "no employment". I mean if embargo is lifted on employment it will help. If they are not owing contract workers cutting the grasses, we will not have a bushy environment though I do not know how much they pay them - you will just see them dropping the cutlass and going away.

Researcher: Any other opinion?

P3: No, thank you.

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Researcher: On behalf of the research team I sincerely appreciate your efforts. God bless you all.

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Example of transcript: Focus Group Discussion with nurses

Archival#: FGD: FO2
Site: Federal Medical Centre Owo
Data collector: M Ibraheem/N Umar
Date of data collection: 18/12/2017
Transcriber: M Ibraheem

Researcher: What are the biggest problems in nursing practice in this hospital?

P1: Shortage of manpower, non-functioning equipment in terms of working environment.

Researcher: Can you expatiate on working environment?

P1: Shortage of manpower, when a nurse has to cover two shifts, you know, you will be the one on the morning duty and maybe due to one reason or the other because of lack of manpower, you are not able to go to your house in time you have to cover for another shift, spending extra time before the arrival of the evening nurse, so those things are demoralising.

Researcher: Do you think the same way? Any other opinions?

P5: In addition to that, those days we have the support staff that helps you know when you are rendering a service to patients but along the line the policy came from the government that um, they should be scrapped and contracted out. Nowadays, in fact, working in big hospitals has been not easy, finding somebody that will collect blood for you from the lab is a problem, to even get people that will sweep and mop that environment that you put your patients - is a problem. This morning a scenario happened in the medical ward while I was trying to sign the time book. On arrival, a patient needed urgent attention, come and see nurses running up and down pulling cylinder of oxygen, in this century when we should have pipeline oxygen [outlet], and if a patient needs oxygen you just connect the patient. The supportive staff are not adequate.

Researcher: So, it's not only nurses that are inadequate, even the supportive staff?

P8: To even justify that, it's because of this period that nobody is on leave. When nurses are on leave only the unit manager is on morning duty, nursing about 10-12 patients - doing dressing, the doctors will want you to be in the round with them, they want to do this procedure or the other just only you and at the same time the unit manager will still be doing the administrative work so by

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the time the afternoon nurse will come in fact she is so tired and exhausted. And we know when one is exhausted, we are all human beings, you become irritable. After doing all these work, it is time for you to receive remuneration, no incentives from the government even that which is your right when it is time to pay after much waiting it is being slashed. You know, we have not been happy. All we know is that we are just receiving patients - no adequate equipment to care for these patients - still using the obsolete methods of doing things to carry out nursing care.

Researcher: Of what significance are all of these to nursing services and individuals as nurses?

P4: The output is low, patients don't usually get what they are supposed to get from nurses. Also, one of the major reasons that we have all these problems with nursing practice in this hospital is that nurses we are not in decision-making body. You write a memo maybe you need an equipment, like where I work I am a peri-operative nurse - there is no air conditioner in the theatre - they are bad. I have written several times nothing has been done about it. I entered an office today. I saw brand new air conditioners packed there to be fixed that is an office and where we operate patients no air conditioner. You know, but if nurses' voices are heard in the health sector, when a nurse writes to make a request the management should be able to attend to it. For example, management just employed house officers now and they are all roaming around the hospital and we will be saying that we don't have enough manpower and nobody is looking at it because nobody feel what we feel, nobody thinks the way the nurse thinks, and nobody face what the nurses face. So whatever you are saying is just the nurses and others. That is the major problem in nursing.

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Researcher: What has been the impact on nurses?

P4: The nurses are not happy - no job satisfaction when you are not happy. You get to the society at times, you are even ashamed to say I am a nurse, yes, you won't want any of your children to be a nurse. I remember during one of our meetings, someone said: *"The way things are going I won't want any of my children to become a nurse".* Nursing will go into extinction if we don't take time. With time people will come and tell you that my child want to be a nurse - you will say NO it is a no go area, instead let him go and do Yoruba (language) in the university. You know is actually affecting us - you get back home. You are stressed up at times. Your children will not understand; your husband will not understand. You still have to balance your mental stay in order to be able to cope at home. If not, you likely to transfer aggressions on your family, yes, and to the larger society.

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P8: Most of all the stated problems have gone to the extent of affecting physical health. Day in day out nurses will be falling sick and a lot of nurses now because of too much physical stress many of them are coming up with high blood pressure. The number is increasing, so it's really affecting us.

Researcher: What are the implications of these on nurses and the management?

P8: When the nurse is so stressed she will not be able to give out her best to the patient and also, it will give us a negative image of the profession. Even the centre will have a negative image. You will hear people saying ha, don't go to FMC their *"wahala"* (trouble) is too much there. If you go there they don't have this, they don't have that, is better you take your patient to so so-so hospital. It is a negative impact on the centre and the system as a whole.

P4: If there is opportunity everyone will want to leave

P8: Yes

P4: Check out (brain drain)

Researcher: Of course when there is no job satisfaction.

P4: Go to a better place where nursing will be well practised

Researcher: We hope things will change for good.

Chorus: Amen,

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P4: The government too needs to reposition nursing because nursing profession seems to be the last in the healthcare system, even when they are trying to grade us, we are usually the least so it is like "nurses and others". You see like CHEW (Community Health Extension Workers). Before you know it they are ahead of us. You see Physiotherapy, we started very, very high but at the end of the day, they all ahead of us. Pharmacy, once they enter now they are coming out with doctorate degree. You know I have a friend, at times we discuss about nursing. She used to say maybe there is something wrong with our curriculum or we are not well prepared, or that we are thought to be the crèche of other professions; we are thought to be the wife of every other profession. You know, wife is submissive, submissive nature, so we are like where they keep everything. If there is a mistake, maybe a patient dies, the nurse will be blamed.

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P3: It will affect the influx of patients to the hospital, because when they are not getting what they are supposed to get, you are telling me not to go there (i.e. FMC) and I am telling another person not to go there, then nobody will like to go there - there will be drastic reduction in the number of people going there.

Res: How can we define emotional labour? What does emotional labour mean to you? What comes to your mind, what incidence can you relate it to?

P6: Working under pressure.

P4: Input without a corresponding output that will affect the holistic nature of that individual. If you are working, you are putting in your best but what is coming out is not making you to be what you are supposed to be - what you are bringing out. For instance, you want to administer Paracetamol to a patient and it is not available. I have to write it out for the relation to buy. I am waiting, and by the time the relation comes back, the next person on duty is around, yet, I have not finished my work. Will I now tell her that "Paracetamol o/s (out-of-stock) relative went to town to buy"? At the end of the day what you are putting in (your efforts) and what you are getting back is not balanced; it affects you holistically, it is not commensurate with the input. So, I will call that emotional labour "input and output imbalance".

Researcher: What is your concept of emotional labour?

P1: It is imbalance, inadequate result of efforts put into a task

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Researcher (interjects): Despite efforts invested into it, you are not getting the expected result.

P5: I am supporting what they said.

Researcher: Yes, can you say something different? Emotion labour, what does it mean to you?

P7: It's about temperament. Nurses are the most stressed cadre of health workers.

P2: Emotional labour is when one is being exposed to undue stress which under normal condition, when you have to rack your brain, you have to think; you have to put in extra effort which ought not to be before you can have that type of job done under duress. Referring to what one of us said that in the theatre where they operate there is no air-conditioner (AC). Under normal conditions, we all know what the atmosphere of the theatre will be, no external air coming in and there is no

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air conditioner, and you can imagine how people will work under that situation and they still have to stay in that theatre to do operation put on theatre suits and coats. You can imagine those people working under that type of condition, the stress they will undergo physically and emotionally. So when one is exposed to do all those types of things by the time they stress themselves and do the work; by the time they want to rate them or people want to talk about nurses they will not see all the efforts they are putting in. Am I communicating? (yes) People do not see all the stress nurses are undergoing and efforts they are putting in. They rate nurses low even within the health team. When the public wants to lash out (complain) any problem in the hospital to anybody they will lash out (complain) on nurses. That is what I will call emotional stress - doing the work you are stressed up, when you want to use facilities you are stressed, when you want to receive *encomium* for what you've done you are still stressed.

Researcher: If the word emotional labour is mentioned, what is the first thing that comes to your mind?

Chorus: Stress

Researcher: Can we break it down?

P2: Stress, any situation that will cause you internal or external conflicts, destroy your emotional balance.

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P4: Instead of the nurses standing by a nurse, not the system now, it's after the nurses has stood by a nurse you start thinking of system now. It's what the nurses has decided to tell the system that will depend on whether the system will stand by the nurse or the system would not stand by the nurses so if the nurses say crucify the nurse, the system cannot stand by the nurse, so it's the nurses "*gangan*" (themselves).

Researcher: Having identified all these challenges, can we share our experiences that gives us emotional burden or labour?

P8: I remember some years back I was attending to a patient, a drug was prescribed for the patient but it was not available at the pharmacy (out-of-stock) and they wrote it on paper for the patient to buy. I was on duty when the doctor on call came and we did ward round together, so Baba why have you not taken your drugs? He now said they don't have here, they wrote it for him to buy, he

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has searched everywhere and I was there so I said you've searched everywhere? Is it possible? Did you go so-so place? Meanwhile the person in charge of the pharmacy in this centre has a patient and it was a weekend and she happened to be there so she now came and said why should I send the patient outside to buy drugs and I said that I did not send the patient out to buy drugs, this drug was written out at the Pharmacy for the patient to buy. She said I was sending the patient outside. She reported to the Head of Nursing Services and I was called and was not given the opportunity to explain what really happened. I was abused, I was washed down and I was told to beg her, well, I had no choice. Even though I felt that I was cheated, humiliated, I went because I had no choice. I went to beg her and I was punished to go on morning duty for 11 days without off - then to night (duty). I was not balanced because anytime I see that woman the story will be replayed and I was not myself for a whole year, so imagine somebody that was passing through that! I was only trying to help my patient. I was not the one that wrote the drugs for the patient and I was not the one that sent the patient to go and buy from outside, so I don't know what my offence was then.

P3: Your offence is being a nurse.

Researcher: Madam, can you share your experience?

P6: The one I want to share my experience about - how I was insulted by a senior colleague in this FMC while working at the neonatal ward. I was to bathe the baby but the patient did not have money to buy an item that I will use. The mother of the baby was there so I said, "Madam, come" - I wanted to give her my own personal money. The HNS then was passing by and she said "Who is that animal?" and when she said it I went outside. Then she asked me to meet her in the office. I went there, I couldn't say anything I was just crying. She asked why I was crying. I told her she called me an animal. I cried for hours. When I got back home I documented it in my diary but after years, I am a Christian and I have to forgive then I tore the thing. That time, if not the Christ in me that one can make me to develop negative response to any patient that I will not help them, even make me have negative emotions towards the senior ones, and can make me to react in a way that will affect patients, me and the profession when I am transferring aggression to patients while caring for them and other people. One of the patient's relative said: *"Can't you reply her?"* I said *"No, she is my boss"*. She said okay, they should discharge her baby that she is not staying any longer, that you are helping a patient and you are being humiliated and I said it doesn't matter so

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far that the patient is okay. I thank God that the baby was well and discharged. I was affected emotionally and physically but thank God time healed the wound.

Researcher: We have discussed shortage of manpower, irregular promotion, inadequate remuneration, input and output imbalance. How do you think these problems can be solved?

P3: I think we should categorised this into three or four: individuals (nurses), Nursing (in that particular area), management and the government. Most of these problems we are discussing cannot be solved at this level. I want to suggest that nurses should be at the decision table. If we are there, it is nurses that knows where the shoe pinches them; it is not for another professional to dictate for nurses. Secondly, some policies should be established based on how practicable they can be. The issue of casual appointment for support staff is really affecting us. To call somebody to come and do something, he will say he has not been paid for some months and you see your patient in need of that particular thing, who will now do it? Is it the nurses that will run to the laboratory to bring blood or go to oxygen plant, of course, we have been doing it. We go with our cars to oxygen plant to take the oxygen cylinder and bring it for patients because of one policy that is happening somewhere on book, and it is affecting us directly here. Another one is that our pharmacy is nothing to write home about. We don't have the drugs. I feel like in a setting like this we should have all our drugs available there - all the pharmaceutical materials - everything there, that when patients need them you just write, they go there and they bring it out, not to the extent that some will not be available in the hospital, not even in the environment. A scenario happened sometimes ago when I was in medical ward. We had a patient that was treated for malaria at home and she was brought because the malaria refused to go. By the time this woman was in bed I wrote eh this Artesunate, something they didn't have in the hospital, so we were forced to ask her to buy outside of which we don't know which pharmacy to purchase from. This woman said she will not use it that they told the husband when he wanted to buy that it is only use for people that are fat and this woman was not fat. As a nurse, I encouraged her. I said, "Use it you will be okay". Lo and behold this woman accepted to use it and few days after the woman became deaf. As am talking to you the woman cries everywhere she goes and one day I was parking my car there few months ago, she saw me, she said "Ha, Mommy" and broke into tears. I controlled myself and I said, "What happened? She said she is about killing herself because if she wants to talk to the husband or to the children she have to be writing because she cannot hear them because of a drug

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that was purchased and used. But if it's in the hospital you know they can find out what is happening they will know institution they purchase this things from, so if we have our drugs in the hospital, all the equipment, we won't be faced with all these and like you said, emotional, you know throughout that day I was not myself - it was as if I forced her into what is wrong to some parts of her body

Researcher: Thank God the patient doesn't even think it that way - otherwise that was what I was thinking you will say the woman will accuse you for encouraging her to use the drug.

P3: She said it that you are the one that asked me to use it "*mo ti ni mi o lo ni igba yen*" *(*I have said that I will not use it, you are the one that said I should use it*)* I was looking at her, I felt bad.

Researcher: So these are some of the things that are not provided, consumables are not available.

P4: Can we discuss nursing main orientation because we are talking about emotional stress. I have also been able to identify that we nurses, we equally give our colleagues part of our contributors of this emotional stress, at the same time generally nurses need real orientation, you know, and the only way we can do this is start from the colleges and schools of nursing (training institutions) because nursing has the mentality that during the time of my seniors this was what I went through, you know, and as such, anybody coming up shall go through it, but if we start off now from the schools to change their orientation, you know it will actually reduce that internal conflict to a larger extent. To call all the nurses now and say you have to change their orientation it's difficult, but if we start off from the grassroots now as we are just bringing them into the school, and start giving them a different idea of the ideal of what nursing looks like and not the old idea, I think that too will help. Then we have problem of re-definition of nursing duties, it may look ambiguous but it's the truth. There was a day one of our gynaecologists came to the theatre to operate and the first thing he said *"What do you people do? At least it's the same thing your nurses do at the bedside".* Everybody commented but he has said what was on his mind. I felt like the ground should swallow me, like what kind of profession is this? Now, those things that we do, we need to re-define our roles, our job is very limited in the sense that you come in the morning, you give drugs, make bed you serve bedpan, you serve meals, give emotional support to patients, take patient to theatre, it's not more than that - that is how it goes everyday routinely. My younger sister studying nursing called me that these are the things that Practical Nurses do.

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When I wanted to register with Canadian College of Nursing (CCN), they said they will take me as a practical nurse but Nursing and Midwifery Council of Nigeria said they did not train me as a Practical Nurse but CCN said with what they saw in the transcript that is my role. Most of the time here they say nurses cannot give IV drugs, do venipuncture, there are so many things that nurses are supposed to do that we are not doing. For instance, if a patient comes in, you have set up an IV line and a doctor comes in and puts a stripe of plaster, the patient will say "*ha Doctor e se o*" (thank you, Doctor). The nurse who has been there since is not appreciated because the doctor touched him, it makes the nurse to look like a supportive staff. So, if there is something policy makers can do to get us roles in the actual treatment of a patient not as a supportive staff it will actually help the nursing profession.

Researcher: Thank you very much. The approach to these issues is wider than we are thinking. Do you have any other approach that can be used to ameliorate some of these problems associated with emotional labour?

P7: We should acquire knowledge - knowledge is power.

P6: In Canada that she referred to, Nurse Practitioners are those that have Master's, they consult but do not perform surgery or core procedures.

P1: We should acquire knowledge in order to be recognised.

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P3: I wrote something down by the time we started the discussion: *nursing now and in the future.* We have observed that it seems nursing is on the same level where it was; it is as if now it shall be and forever shall it be. How it was, it is now and if care is not taken so shall it be. I think that in nursing out there, we have professors, doctors, what are these people contributing to the development of nursing especially in Nigeria?

P8: I think as nurses, we should stand together as one, nursing now is divided (unity, unity) even different groups and even these groups are fighting among themselves. That is why the nursing profession is still static, you know by the time this one will be saying (I am so-so-so), this one should not talk while this one is talking, how are we going to move forward; why should we fight ourselves?

Researcher: That's even enough to cause emotional labour or internal conflict.

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P8: Exactly, is that not one of the major reasons why we don't have a tenable scheme of service till date, there is no one that has been stamped that this is really the scheme of service for nurses yet, we have been proposing for more than 20 years and nothing has come out.

P3: Other members of the health team are using that against us.

P8: Yes

P1: Another suggestion maybe they should phase out schools of nursing so that anybody that wants to be a nurse should come in through JAMB (Joint Admission and Matriculation Board).

Researcher: Yes, and that is why the universities are now encouraged to have Department of Nursing.

P2: One of the challenges that was mentioned is stress that one experiences. What is the stand of Nursing Council on the profession as a whole? Taking for instance, the Head of Nursing Services here is not deeply involved in the top management committee and whenever she has to go out for any official assignment there is no official vehicle. I think these are issues that Nursing Council should see to and what is their stand? The hospital is being depleted of basic equipment and instruments that the nurses can use, in most of the units there are no bed sheets, the instruments are getting worn out. I think they should have standard that they can communicate despite hospital policy that can be favourable to nurses.

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Researcher: Yes, I see Nursing Council have the responsibility of training, credentialing (registration and licensing) and accreditation to ensure quality nursing, thereafter, it is the responsibility of NANMN (National Association of Nurses and Midwives of Nigeria).

We have been discussing about emotional labour, the challenges we face in our places of work that leads to a kind of stress and affects us as an individual, affect our input as nurses and then also affect patient recovery. We also identified some of the problems such as: lack of incentives, shortage of manpower and lack of recognition of input (efforts that nurses are putting in). Suggested way forward are: reorientation of oneself, institutional training whereby nurses will be given orientation on what their roles are and the definition of their roles will be discussed and definition of nursing duty. Any other contributions?

Chorus: No, thank you.

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Researcher: In the absence of any other comments, questions or suggestions, I want to thank you most sincerely for attending this focus group discussion and your contributions despite the tight schedules. Thank you all.

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Example of transcript: Focus Group Discussion with nurses

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Transcriber: M Ibraheem

Researcher: What are the biggest problems of nursing practice in this hospital? The biggest problems that nurses are facing in this hospital?

P6: Biggest problem, shortage of manpower

Researcher: Generally or nurses?

P6: Generally. Nurses. Shortage of nurses in the hospital. Another thing is poor staff welfare.

Researcher: Poor staff welfare. Can you elaborate on it Ma?

P6: Especially for nurses. We are not being taken care of.

Researcher: In respect of which aspect?

P2: In many ways. Let me give you an example. For the people that do supervision, there is no protection for them, they are not handled well, there is no incentive for them, there are so many things, no menu during the shifts, we have not been made comfortable.

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Researcher: When you say you have not been made comfortable, can somebody elaborate on it? (Pause) She has made a point that nurses are not made comfortable.

P3: I want us to look at it from this angle. If you go to other departments they have seats, they have tables, they have the necessary amenities, necessary to make somebody comfortable in the areas of discharging your work as (Res: as a worker in this hospital) yes, and when we talk about the caliber of people doing supervision we are talking about Principal/Chief officers, no AC (air-conditioners) even the fans may not be working, the lighting system may not be working, the chairs are tattered; sometimes galloping and all that, and then the seats at times is even not okay and then when you get to the ward itself some of the chairs that the supervisors (the HoUs - Heads of Units) are using were purchased by themselves to sit down (Researcher: from their own pockets) yes, even they buy for patients, they buy for themselves. So, I am talking about this aspect that everyone

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of us should look into, because when you go to may be other departments you find them very, very comfortable - they have seats, they have settees, they have office executive chairs; they have their tables and they are not the ones really doing the major works when we talk about care about hospital delivering services to the patients. Nurses are really in full contact with the patients and they are supposed to look into the welfare of nurses. After you have walked through, energy sapping is nursing practice. And when we talk about you have gone round taking care of these patients, attending to their problems just to calm your nerves down, sit down and stretch your legs for another 10 or 15 minutes before you go for another round (errand). There is nothing on ground nurses will now come back and sit down on a bench. I think we should look into that because it will also affect the emotional status and wellbeing of the nurses.

P7: In addition to what she has just said, when a nurse is sick and needs admission, there is no sick bay for nurses and even for staff in this hospital, so you have to go and queue with other patients which is not good.

Researcher: So, how does that affect your job or your person?

P7: Surely, it will affect the job and the staff

Researcher: How?

P7: You are a staff working in this hospital and you need to see a doctor. Immediately you get there you should be attended to but in this case you have to go and queue with the patients, there should be a private clinic like a staff clinic for the staff.

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Researcher: So, psychologically you feel the system is not taking care of you, recognising your person when you are sick. Any other contributions?

P8: Another thing is no enough materials and equipment to work with, sometimes you have to improvise for some of the things you need to carry out… when you are attending to patients. We improvise.

Researcher: Give us an example.

P8: Like it's not all the wards that have "sliding sheet" when you want to turn a patient, you see nurses stressing themselves when they want to lift patient, turn patient - you understand - that's part of it.

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P5: Aside from that, just like what she had said about queuing with other patients, it can also affect our job in the sense that, the time you are supposed to be taking care of your patients you will be thinking of your job in the ward and at the same time you are sick you want to see the doctor so all those ones can affect your emotional person as a nurse.

P4: Can you ask the question again?

Researcher: What do you consider the biggest problems of nurses working in this hospital?

P4: Yes, very good. I think I want to categorise it: we have governmental factors, the management factor, (the system - institutional factor), very good and the staff (employee) factor. Let me now begin to explain that the aspect of the government is that there are no infrastructure in place that is 21st century compliant, which causes lot of stress on the performances of the staff, healthcare providers (on the nurses) and other healthcare providers too but with emphasis on nurses. There are no technology in place to enhance nurses' performance.

Researcher: Like what?

P4: Like in abroad, they have backward system of administering drugs; you have technology for maintaining Patient Health Record Data.

Researcher: Electronic personal health record

P4: In abroad or advanced places, we have technology to maintain patient data that is electronic health record, electronic laboratory, electronic pharmacy but in this part of the world we are still using manual and which aids to displace and misplace patient health information which poses strain and stress on both the patient and the nurses. Also, this hospital is not computerised which makes it difficult for us to give satisfactory health care to the consumer of health who come to nurses to access care. Also, physical factor is, there look at the structure in this hospital they are not actually befitting of what we can say is good for healthcare system. Structure in place, the architectural design so, I think it poses a lot of stress because if the environment, when you look at Florence Nightingale's definition of health, we will realize that when you make the environment conducive for the patient, naturally healing comes to that patient. So I think it has not been helping us to meet patients' expectation.

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Researcher: What is the structural defect that you have identified in the structural layout of this hospital that poses stress to the nurses?

P4: Nurses are not involved to give specifications when management wants to construct (physical planning); nurses are not involved. Nurses are not involved in decision making; decisions that will affect our practice, nurses are not involved. And when you look into many of our wards there is no bathroom for nurses, nurses' stations don't have furniture, and there are no facilities in it.

Researcher: How does it affect nurses? I mean the structural layout of the hospital, how does it affect nursing practice in this hospital?

P4: Yes, you see, when you are building a structure you should consider all staff that that planning will affect. Like now, many of our structure there is no restroom for nurses. Even those who run call (call duty) don't have rest rooms which poses a lot of psychological problems on them. Some of them sit or lie on a couch to take a rest because you understand which is not good as a call nurse you spend minimum of 24 hours in the hospital. As a shift nurse you spend minimum of 8 hours depending on the hospital policy and the onus lies on your employer to provide where you need to take your break, which we don't have. Even the little place they give, no furniture for comfort which can pose stress on the nurses because, that is on the structure.

Researcher: Are the wards far from each other? I mean the location of these wards and some other units of this hospital?

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P4: They are not far

P3: They are not far from each other but the road networks are not okay

Researcher: The walkway, the link?

P3: Yes, if I want to transfer a patient from Obstetrics and Gynecological ward to NMU and I want to bring the patient down to maybe this side; maybe ICU (intensive care unit), you still need to go through long route and you are looking at Obstetrics and Gynaecology. Between Obstetrics and Gynaecology and Gynaecology main ward you will find out that you are looking at them but are still going to take a long route.

Researcher: Okay there is no direct walkway linking the two units.

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P3: Yes, the linkages are bad.

P6: In addition to what she has just said, the structural defects how it affects nurses, where I work is the Emergency Unit. There are no cubicles (enough cubicles) where little procedures little surgical procedures can be done which means if you want to carry out minor procedures you have to transfer the patient from that place to the theatre. There is supposed to be a place where you can be doing some minor investigations like you want to do an X-ray, there should be a mobile X-ray unit or in a place where such a thing can be done but in this case you need to transfer the patient to Radiology department which is adding to the stress of nurses and it is really affecting the work.

Researcher: Ma, please can you say something?

P7: Yes. Where I work the laboratory there is not 24 hours open, not functioning. Like now if you want to do any investigation, like CT scan you have to move the patient out of the hospital which is really affecting the staff work schedule because the staff have to travel down then come back to continue with her duty. This can affect her duty.

Researcher: Yes, any other thing?

P4: Occupational hazards: lot of nurses, we have it on the record have been affected. We nurses, we are being faced with a lot of occupational hazards. Just about a year ago we lost one of our nurses due to Lassa fever in this hospital which bothers on inadequate medical consumables and lack of proper support for nurses in this hospital. So I think those areas affect our emotions. Because many people, she happened to be one of the best nurses, she was a trained Accident and Emergency nurse and that's why I am talking about structure, our Accident and Emergency structure is not well (designed) constructed, so in that case, management and stakeholders should deem it necessary to inform nurses to give specification of the structure, that they are one of the end users so I think that is also very important. Also in terms of emolument, we are not well remunerated. For our job hazard they pay us five thousand naira and nurses are at the forefront, the first point of contact when patient comes to the hospital, so we are faced with a lot of risks and hazards with little or no consumables. I think we are affected in that area. No modern facilities and equipment to work with which poses lot of stress and emotional labour on nurses. I think for training too we strain ourselves a lot in this hospital. You want to update yourself. We are not released to go for that course so you are working and will use your day off to go to school you will

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be running around which poses a lot of risk on nurses' lives; some have had accident during that course, some have break down. I think the training aspect too, we suffer a lot of emotion. We suffer a lot of emotions in this hospital as nurses. I think I have been able to identify that we need to be technologically inclined, our physical care should be well catered for, occupational hazard should be looked into because nurses are in the forefront of patient care, and management should design a better welfare package for nurses, Insurance too. Nurses in this hospital should be insured so that at any point if anyone dies in the course of carrying out her duties, running her shift, so the nurse should be insured and the family should be catered for, so facilities and equipment affect us. So I think those are the groups, I have been able to identify. Some staffs have negative attitude because of their trait (personality), they are not able to cope well with others. So I think those are the areas that affect our emotions...

Researcher: Thank you, Ma. Any more contributions?

P9: The light of the hospital, the electricity supply is not adequate. Electricity supply have been epileptic. Often times we make use of our phones when taking care of the patient, at times they put on the generator and sometimes the generator can break down. We use torch light and rechargeable lanterns, and sometimes the rechargeable do get exhausted, so we make use of our mobile phones and the water supply is not adequate, at times we buy pure water to wash our hands, when we don't have water. The issue of the relative still stands, we don't have a place where patient relatives can stay, most of the time the relatives will come in at interval to disturb you as you are caring for their patients and we keep on appealing to them, sending them out so that you will be able to concentrate on management of the patient of the ward. So these areas need to be well taken care of.

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Researcher: Thank you.

P4: There is low nurse-patient ratio in this hospital; we have not been able to meet up with World Health Organisation standard of one nurse to manage four patients (1:4).

Researcher: How many nurses do you have?

P4: We have over 300 nurses. But sometimes you find out that two nurses will be in a 20-bedded fully occupied ward

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Researcher: Fully occupied ward?

P4: Yes, overflowing.

Researcher: Where do you put them?

P4: On the chairs because we don't want them to go unattended to. It is affecting physical and psychological wellbeing of nurses in this hospital.

P1: There is an area we have not been addressing of patients' and relatives' response to healthcare providers, especially nurses. Anything that goes wrong in the hospital it is the nurse. Any aggression from any staff or any area any shortage or failure of service delivery at any point is transferred on the nurse. And because of economic constraints in the country, we do not have the wherewithal to finance the healthcare of their relations and the patients on the bed so they are already emotionally stressed and they transfer it to the nurses, and it makes them feel the nurses are not doing enough when they are not providing the things that are necessary to care, and this poses stress on the nurse because she wants to do much more for her patient but she is handicapped because you have to pay for the services, drugs and their investigations and all of that. And the nurse is not doing her duty as expected; she is stressed because the patient's relation is on her neck, there is nowhere to go 24/7.

P4: The attitude of other healthcare providers toward patient care affects the nurses.

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Researcher: How?

P4: Nurses coordinate care, but when laboratory does not run investigations on time, doctors or consultants coming late to check their patients; there is no quick response to attend to the patients most times not all the time. Those negative attitudes of other healthcare professionals affect our performance. Sometimes we need to be chasing after them which divert you from your own primary nursing care which will limit or reduce the level of satisfaction of the patients. Also, maintenance of equipment and instruments is inadequate, it is the nurses in this hospital that when you write paper for people to come and service an equipment or instruments that you are using: one or two weeks, you are not getting positive response which makes you to leave your work, you go to works the electrical department. So I think attitudes of other healthcare workers towards patients care affect our emotion because we are at the centre of care of these patients and we

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coordinate care. Sometimes there is this superiority complex from the doctors, they say: "Do you want to teach me my job?" which limits what you want to do.

Researcher: Can you please tell us any other thing you think are the problems of nurses working in this hospital?

P5: Timing is another factor that affects the nurses in the performance of their job. For example, when you have a patient who has to see the doctor the result of the investigations he has to show the doctor is not ready. For example, I took a patient yesterday to the see an orthopaedic doctor, my step mum, unfortunately, we were sent to do an X-ray of the affected part. We waited, we couldn't get the X-ray done after doing it again; we couldn't get it reported. They now reported that they have about five thousand films to report and on getting back to where she would see the doctor the doctor said, "Why can't it be done? We have a Radiologist. If you go outside to do it now it will be reported immediately so we couldn't do anything but if it is a patient in the ward that a nurse is taking care of that thing can slow down the progress of work because I will have to be sending the attendant or orderly to go there frequently, is it ready or not, so the timing of other auxiliaries of health that work with us is affecting our work.

Researcher: Any other comments?

P8: I want to say this, *"Nurses bite more than what they can chew"*. Though really nurses are not at the helm of affairs but notwithstanding there are some burden we put on ourselves. Like for example, in an area where a patient is being discharged and then he is owing, if you ask any doctor, please what do we do to this our patient, the doctor will say *"Mine is to care for the patient, I am not to source for fund or look for money for him to pay"*. But nurses we take it as if it is our own responsibility while the social work department is there with nothing to do, while we will be running after hospital bills.

Researcher: What exactly do nurses do in that situation?

P8: If the money is not paid, the nurses would be held responsible

Researcher: Nurses would volunteer to pay?

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P8: We are feeding, so if the patient refused to pay they must not go home most especially this Obstetrics and Gynaecology side we have gotten to a point, we use our money to buy them food even when they have their babies, and we cater for the babies.

Researcher: Please clarify this point. A patient is discharged, he or she doesn't have money to pay, how does that affect the nurses?

P8: It affects us in the sense that you know, the responsibility is always on us

Researcher: How?

P8: Because the patient has no money to feed herself and she must not go home.

Researcher: Okay

P8: And then the people that are really responsible for this we have their department, they will be saying another thing that it is the nurses that are sending, that the nurses are not cooperating with their department yet they leave their work undone for you

Researcher: So that becomes an additional burden for nurses okay.

P2: Another thing that is related to that is we act as security officers because if such a patient should abscond many of them do abscond, the nurse will write as if you are the one that encouraged the patient to leave the hospital. And for days, you can be on this you know distracting your attention as if you have done something grave. They will ask you so many questions that you cannot imagine as if you purposely asked the patient to leave the hospital. The accountants are there to monitor whether the patients are paying their money. The security are there at times we write them but there is nothing we can do because the patients reside in the ward and the onus is on you, especially as the head of the unit. Even if the nurses are there, you still have to write as well, you know. So you have to be looking after the patient so the patient will not go. You can even follow the patient to the toilet; you know monitoring the patient not to leave the hospital premises.

Researcher: What do you think are the causes of these problems?

P9: Most of these patients do not have money to pay hospital bills.

P2: It is the poverty stricken life in Nigeria.

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P10: They have exhausted the little they have; the relatives will stop coming to check on their family member then the patient will be depressed, and the nurses, the burden will be on us.

Researcher: what will make the relatives to stop coming to check on their family members that are on admission?

P2: Most of them do not have enough money (financial constraint).

Researcher: You have to be specific, so that you will not be misconstrued. Any other problem?

P5: Another aspect is the financial issue, if you are not…

Researcher: Still in line with money?

P5: No, to the staff, to the nurses,

Researcher: Okay

P5: If you are not financially buoyant and you need help, let me give you an instance, you want to pay your child school fees, you approach the cooperative there, the money is not forthcoming, and there are some things you are entitled to even in this hospital that they are not aware of, like, let me give you an example like in some institutions they do give salary advance.

Researcher: Ok.

P5: Yes, they do give car refurbishing loan, cause even last year, late last year.

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Researcher. Which year was that?

P5: 2017 that we heard about it and it's our own entitlement, it is supposed to be given to us every year, so in such case…

Researcher: Without asking or when you need it?

P5: When you need it.

Researcher: Okay

P5: You are supposed to have access to it both to junior and to senior staff but we don't have access. Then if you approach the cooperative, you want to pay your child's school fees, you approach the cooperative, the money is not forthcoming, they will not give it to you, and it's your

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money that you are contributing and there is no way the staff will not be affected, I think that one too should be looked into.

P3: One of the biggest problem that nurses have in this hospital is the area of organisation, when you are having about four, five ward rounds going on together at the same time, you're having two nurses and the nurse needs to get acquainted with the management of the patients. You find out that it makes the nurse to be tensed up, because she can't be flowing among four, five consultants' ward round at the same time, and it's not organised. Some of them can come now, 7 o' clock, another one is coming, another one is coming and all of them flocking round the wards, you find out that, at that particular point in time, the nurse is disorganised because she's supposed to be in control of the ward, and where the nurse doesn't have full control over them, because normally, they are not supposed to enter the ward without the permission of the ward nurse. But the ward nurse is not having grip on them, they come in at any point in time, they do their round anyhow and particularly male medical and surgical wards, those two wards is cumbersome and is barbaric when they come in. Most of the patients one way or the other, may not be seen for about four, five days where the nurse may, say please help us to see this one. Some of them will say he is not my patient and no attaché, I mean by the medical doctors and you find out, that all these things are having a lot of say upon the lives of the nurses' untouchable to us. Sometimes you get to the ward you're confused, you don't even know where to start and where to end, and the time is going and a nurse coming in the morning, emotionally you are disturbed when somebody is saying he wants to do round and you are not prepared for that round. You are setting trolleys, somebody is saying I need this, I need that, and you have to be going up and down. The traffic that you will be making within that ward is as if it's more than the ward that you are managing. At the end you are having critical conditions in your hands, so I think the organisation of the hospital by the medical, ehh medical team, generally when you say you are having about 15/16 teams, units, we have endocrinology, cardiology, all those ones, we have surgery and the surgical unit each is divided into about 4 units - again you have different kinds of consultants coming in - all of them are coming almost at the same time.

Researcher: So in essence, the ward rounds are not scheduled.

P3: Yes, they are not scheduled…they are not scheduled.

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Researcher. What do we think are the causes of this unscheduled activities of the medical doctors for the ward rounds?

P3: You want to answer?

P4: Yes. Or you don't want me to answer?

Researcher: Go ahead. Why not?

P4: Yes, let me say this I categorise that one, we have systemic problem, because I feel the management should have policies regarding how the hospital runs. Two, the ward nurse, many of our nurses are not assertive, many of our ward managers, because no consultant should come to your ward without prior planning, so I think some of our nurses are not assertive, and they are not, they still fidget with these consultants, but because we don't have management policy as to how to run each of these wards, and you know I still feel that management has error in conducting proper induction and orientation of all staff, they want to bring into the system which poses a lot of problems on the ward nurses and the ward managers. I equally want to talk about waiting time at the Outpatient Department, it poses lot of problems on nurses because many patients that access this facility for care come from other neighboring environment or state, like Lagos state, Oyo state, far even from Ekiti state because we have more than 60 specialties in this hospital with over 64 consultants, so we need management to plan their care and to do policies as required, they should have philosophy that will be well known to all members of staff, waiting time at the outpatient department is quite long and disheartening, yes, which possess problems on the nurses, because we have influx of patients. A consultant will come and say I'm only going to see 10 patients, nurses will have to be saying please, maybe we will schedule you, nor, they call for another scheduling, it's a lot on the head of the nurses

Researcher: What is the average waiting time of patients at the Outpatient Department?

P4: Let me say one hour or more.

Researcher: But if, if there are policies in place, it should be lesser than that?

P4: It shouldn't be more than 5 to 10 minutes

Researcher: That's what I'm saying, it should be lesser than one hour. Now any other point? Yes, we are on the causes of these various problems.

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P7: Yes, another issue that is still causing problems to the nurses, this issue of security, and ehh, I can say the security in this hospital is not strong enough, especially for the nurses on night duty. At times you will see some strange faces that you will be thinking what are they doing in the compound, and they pass through the main gate, they pass through many security posts before getting to the compound but you see this people will be challenging them, what do you want? Do you have patient? Some of them don't have patients in the hospital but you wonder why they are in the compound and is really posing a lot of problem on nurses because you have to be on the lookout, especially when we have patients that have their babies with them in the ward. We have some in neonatal ward, and we have to be on the lookout because we don't want a situation whereby a child will be taken away and you will not know how it's really problem.

Researcher: So when things like this happen what do you do? It's a general question.

P4: We report.

Researcher: I mean we have identified some problems, some causes of these problems. How do you think the problems can be solved?

P10: We have been reporting, we report, actually we report and we write to the management about it, but most of the times we don't get feedback on anything that we have written.

Researcher: Do you follow up?

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P10: Yes we do, we will just, they will just be encouraging us that they will do something about it - they are planning to do this, they are planning to do that and especially on that issue of security that she said, we have seen even this recently that they broke in, entered and they took nurses phones [ah ah] and they will go, yes, they take their money, they take their bags and there is nobody to, to, to support them in that area, so, we've been reporting, it has been the same and ehh, we just believe that there will be solution one day

Researcher: Ok, thank you very much. Do you think these problems are sources of stress to nurses?

Chorus: Yes, of course, yes they are.

Researcher: How?

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P8: Now because when you are over laboured, especially during ward round you are attending to this doctor, this other one will be calling you and you are the only one, the other person might be attending to a patient, you know, you will be confused and sometimes you will be touchy, and sometimes we don't have time to eat on the ward and when you don't have enough food in your stomach, the glucose, you will not be able to really give the efficient service to the patient and even the other relatives that are coming to ask you for enquiries.

Researcher: Thank you. Yes?

P3: Can I give you an example?

Researcher: Sure.

P3: There is this issue, we say if you are asking, are all these things causes of emotional labour stress of the nurse. Now you are having 2 or 3 nursing officers that are pregnant on the ward and the shortage of nurses made you to, you know, chart the 3 of them to be on morning duty. They are working with unit manager, sometimes they are even left with one person to manage a ward of about 22 patients that are having critical conditions, and then they are going to do dressing for about 10 patients, they are going to serve medication, they are going to attend to ward rounds, they are going to do some other chores within the ward system, and then at the end of the day they are not closing at 3:30 when they are supposed to close, you know, by the time they finish the dressing and all that, they are going to do the packing and all that, write reports and admits patients and all that, by the time they finish around to 5pm. The next day you are having maybe one of them on admission. the other one is having maybe premature contraction, the other one maybe one way or the other is taking sick off, after seeing doctor, so you find out this are causes of really breaking down [among the nurses] and then we can talk about some of them also having back pains, some having spondylosis, aggravated by some of this, you know, demands of the work on them, and so we are having some of them coming down with ill health and we are excusing them from this busy area and we are considering them for a lighter areas and we are over labouring some other people because they are hardworking, so all this things are…

Researcher: Despite shortage of nurses?

P3: Yes, so these are also contributing to the emotional labour of the nurse.

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P4: Also, it cumulates, all these problems we have identified. We only identify some, we have not exhausted the list but it cumulates into medical errors.

Researcher: Yes?

P4: And the nurses are given queries and you know in developed countries, they report their medical errors, so that, people learn from it and to guide against future occurrences. When we forward all these complaints to the management at all levels you know there is hierarchy in management, maybe at the level of nursing department, the admin department along that hierarchy and you have little or no response. It cumulates into medical errors and you are not exonerated - memo, queries will be generated. You know, we are not given good facilities, inadequate staffing of nursing, (nurses), when you are over laboured and overburdened and they get into your emotions there could be medical errors which nurses in this hospital pay dearly for, they seize their day off, they ask them to do work in intense places which affects their psychic.

Researcher: Ok, having gone this far, what do you understand by the concept of emotional labour? We have talked about problems, we have talked about what causes these problems, we have talked about what we can do when these problems arise; we have talked about if these problems are causes of stress to nurses. Now what do you understand by the concept of emotional labour?

P4: The concept of emotional labour is as a result of stress and stressors that accumulate during the process of nursing activities and procedures.

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Researcher: What exactly then is emotional labour because you are telling us the consequences of emotional labour, what exactly is emotional labour?

P4: Emotional labour is the psychological aspect of your work of an individual because, you know, just like you introduce, when we carry out bed bath, when we carry out bed bath, and when we offer bath pan to patient, when we serve medication, those are the physical aspect of our care, but this, you know, that physical aspect if is not well organised with a very good outcome will lead to emotional distress that is the simple concept I have.

Researcher: Any other person - emotional labour? Yes?

P10: Psychological stress. I'm a nurse and you have your own family problem at home. You are at your working place, there is this issue of going up and down, being given queries, and which

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you're not prepared for, you are still labouring, harbouring something in your mind that is already affecting your labour, your emotion rather, and when you now get to work, you do not have someone who can console you - consoler that can console you, can neutralise what you are bringing from home, and there is, is a pressure here and there, and that is why you see some nurses when you just call them to ask questions, they will just burst into tears because they are already emotionally stressed.

Researcher: More contributions?

P1: All those factors that make the nurse to perform in a substandard manner, all those factors that does not support you in bringing out the best as a nurse in your workplace, like all those factors we have been talking about, lack of water, lack of electricity supply, inadequate staffing, inadequate supply of consumables, lack of equipment and everything, you know what to do and you are already doing it but these factors are inhibiting your performance, they stress you up emotionally.

P2: Anything that would you know bring out emotional problem for anybody working in a particular environment that will not allow you to bring out the best in you is an emotional labour; is being an emotional labour.

Researcher: In essence, when you hear the word emotional labour what comes to your mind first is psychological stress. Right?

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Chorus: Yes

Researcher: In summary, right?

Chorus: Yes

Researcher: Not meeting, not having enough to carry out your work meanwhile you have your problems from home - it's bothering your mind and when you get to work again nothing too little or nothing to work with and you still have a stack of activities to carry out during that particular shift. You mentioned shortage of nurses, what about promotion and some other aspects of work that can give you satisfaction at your work place?

P7: As you can see, we are getting over that area, I think we are coming up on that area.

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Researcher: Which area?

P7: The area of promotion,

Researcher: How?

P3: Promotion comes as at when due.

P3: As at when due now?

Researcher: Yes

P4: Promotion in the last 10 years have been very good, and every nurse in this hospital get their promotions as at when due, but we have issue with graduate nurses. If you don't have BNSc, if you are not a graduate nurse you may terminate at CONHESS 13 which is grade level 14. We thank God that in FMC Abeokuta today, many of our nurses have their Bachelor of Nursing Sciences, and those who are chief nursing officer, whenever they are due and they have that [first degree] degree certificate, their first degree in nursing, they are called for promotion, so, that is the only consolation we think for now FMC Abeokuta nurses can lay hold on that keeps us doing the work we are doing.

Researcher: Thank you, any more contributions on this point? The last question is, how do you think the problem can be solved but you have summarised it that promotion comes as at when due and one of the ways of solving the problem is having your first degree, the moment you have your first degree you move,

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P4: We have just gotten a new Medical Director, who is just six month old in office and he has actually changed many bad practices he met on ground like approving people to go to school to advance or update their knowledge; people who have been stagnated. He has worked closely with the Department of Administration to ensure people, people's professional cases, issues are looked into and they are build - the last three months he has resolved quite a number of them.

Researcher: Any other contributions? No other contribution? Thank you. How do you think these problems can be solved?

P3: One, nurses should be pro-active in the way we handle our nursing practice, and then in the ward organisation and administration, we should be able to balance so that things would go on fine

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and we should mind our roles as nurses in this modern time, we are scientific nurses not like the archaic time that we will be depending on the medical doctors and all that. Healthcare delivery, we've been talking about and none of us are very relevant the way we work with our patients, so, nurses should give their best and stand in the place where they are supposed to be and should be able to man and see how we can influence and affect the situation on ground and also make sure that solution is being proffered to the problems that we having within the institution.

Researcher: Thank you

P4: We should also join politics because we are not part of decision making. We are not part of policy making so nurses should aspire to join politics of Nigeria so that we can be part of decision making, policy making to benefit the lot of nursing profession in Nigeria, and in addition to what she said, we should be more assertive, we should have self-esteem so that we will be able to be scientific as she said and let's organise our wards and work and continue to update our knowledge and skill, go for training, sponsor yourself even if management does not give you money then, at the end of the day, you can stand out and benefit the whole lot as a nurse professional and benefit the law of humanity, and as such you get more money, when you become PhD holder now, I'm sure you will leave Ilorin, you will be travelling all over the world, that is an additional benefit to you, you serve humanity and you benefit the lot of human race, thank you.

Researcher: Yes, matron. Any addition?

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P7: In addition to that, I think we need to improve on our area of communication, it's very essential because in the bid to take care of patients, to work on our emotions, we need to communicate, and the communication should be in biro, communication to the patient you are taking care of, communication to the institution and to all the necessary stakeholders, this will help us the more.

Researcher: Thank you, any other comment?

P7: Positive usage of social media is very important because most of the time when we are having our seminar or workshop, you find out that the media are not covering our programmes, so they don't know how relevant we are to the public and to the society, particularly to the tertiary institution in Ogun state Federal Medical Centre, Abeokuta. So when we are running our programmes they should go on air, let them know the relevance and the importance of our practice here and what we are doing, and how we are affecting lives and that will go a long way in

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promoting the image of nurses in this environment and also relieving us from this emotional stress, because when somebody is coming with a good confidence in you, it relieves your burden. They lay it before you and they are not going to interrupt and intercept your management, will go a long way in relieving emotional health from the relations and relatives and assault from patients and all that, because they place you on a high pedestal - the way they are going to look at your work, the way you are going to manage them and all that, thank you.

Researcher: Thank you.

P2: So, to add more to this issue of communication, I think as nurses there's need for us to have a confidant when you are working a lot of things are bothering you. If you have a confidant and you discuss like the earlier saying that "a problem shared is half way solved" and that can assist the individual nurse.

Researcher: A confidant in terms of what? Or in the person of who?

P2: The person you are, you know as an individual you are working, there's lots of stresses you are facing, like somebody said, not only at work, there are times you have stressors from home. If you have a confidant and you discuss, it is not as if you are exposing yourself, but you are trying to get the bulk, to relieve the tension and the stressors is off going and at least be able to get pieces of advice, yes, and be able to be focused on what exactly you are doing.

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P4: Also I want us to engage more in coaching and mentoring, Coaching and mentoring is very important and as nurse managers we should be available for young nurses and the Nurse Managers should also give them emotional support.

Researcher: Managers of nurses, what do you mean?

P4: Nurse managers, the leader of nurses,

Researcher: Like the head of nursing services?

P4: It could be head of nurses, we are all the top level managers in nursing. We need to supervise them more, our younger ones, so that even when we are not available, they would know the pattern just nurse manager like supervisor even when we are not available they know the pattern of work and that's why I said coaching and mentoring, and we need support from them too because many things we need we don't get and when it land us into problem, we give people query, we don't

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burst into, in abroad, a student of US, they will ask you about your emotional problem from home, they poke into your private life and not that they will go and unfold it to other people, and that's why sometimes people don't want to own up their problem because they feel when they share their problem those people, people are not there for them. So I think managers in FMC, we are all managers, all of us here, not our HOD. We are the grassroots, we know our nurses so we should give them the support they require and we should reduce or remove biases, you see. When doing posting of nurses some people will be working in a very busy area for over long period while you find out that some people are working in a less busy area as a young nurse, so I think those are the things that are affecting our practice in nursing at FMC. Our administrative department are not doing very well, they should, they are to bring out policies on how they want to run this hospital, which will be binding on every employee, so, that is those areas are very important for FMC nurses to move forward and contribute their quota and for Nigerian nursing profession to grow to that international standard, thank you very much.

Researcher: Any other comment?

P7: My own is nurses' public image - some people are coming to the hospital and they already have it in mind that nurses are bad and on getting to the hospital, they behave the same way because they already have that thought that when they get to the hospital the nurses are abusive and all sort so, and they are coming with that mind and on getting to you, you are attending to the patient you are saying something else, they are already saying something else [different] different, because they would get annoyed, and they will begin to say all sort on the nurses, so I think if we have good public image it will help us a long way.

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Researcher: And when they say such things, odd things about nurses to you, what will be your reaction? [we have] I mean instant reaction, an event has been created, so what, what will you do?

P7: I will take it easy.

Researcher: How?

P7: Because I know, already they are coming with that mind

Researcher: What will you do at that moment to that patient?

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P7: I will try to calm them down, because I will not fight them back. I will try to calm them down that, that it is not like that and then the voice with which I will communicate with them will make them to relax

Researcher: Pacify them.

P7: Yes.

P2: I will make friends with them, I used to tell them if they are annoyed my brother, my daddy, my sister, so, I will turn it into jovial matter. If I want to ask anything from them, I will say, where is that my friend, where is that my brother, that's how I will make friends with them.

Researcher: Despite the fact that you feel hurt, [yes] you still try to?

P2: To make everything, so that the atmosphere will be friendly. So the patient too, I will say my sister, where is my brother, where is my daddy?

Researcher: Thank you very much. Any other comment?

P3: Because we need to create a therapeutic environment, you find out that when these patients come, particularly in Nigeria, we have people, our psychology in Nigeria and emotional status of Nigerians is to have something immediately, you have to be very fast. If you are slow, and they are not getting what they are supposed to get, then it can bring hardship and all that and conflict. All that you just need to do is to create a therapeutic environment as you are coming and since I've said before, we are more educated than yester years, so when they come in we study each patient according to their level, and variations of needs and where they are coming and they see the way you are addressing them and the way you are relating with them, because interpersonal relationship and the way we command respect from them, we are not seeking their respect [but you earned it]. Yes, by the time we discuss with them you just find out that naturally, they just flow towards you and then you find out that the work goes on fine and you achieve more in that particular environment, instead of them assaulting you, they come round and call you. I have this kind of mind about nurses before, but in fact, you have changed the whole thing and I'm going back home to go and tell people about nurses. I've heard that from male medical surgical ward, one of the busiest ward in this centre that patients were telling us we are going back to tell people about the bad image of nurses to redeem it, that there are, in fact there are having a new understanding about

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what nursing is all about with the way we address them, so creating a therapeutic, conducive environment for people to come in and go out, like if I go to the bank, I normally tell them, they will sweep everywhere, as they are sweeping, they are sweeping back, and they are saying thank you, welcome to Skye bank and all that. I said that, what more we nurses if we do much more than that, it goes a long way in earning respect from patients and they will appreciate you from the hard wonderful work that you are doing is also going to bring recovery fast. This is one of all I have and it will reduce us of all this labour stress, emotional stress and all that, it will relieve it and by the time you are going back home, you are fulfilled that you have touch a life today, yes.

Researcher: Thank you, any other comment?

P1: The only area I want to add is in the aspect that concerns the management, establishment and government. They should also put in more effort to make available to us those things we require to work like all these things we've been mentioning like equipment, consumables and all that adequate funding, staffing and everything, so that, at least, all these our hospitals would not just be buildings only, that patients cannot get all the required services from us, despite the high level of manpower that we have trained more qualified nurses and they are handicapped by some of these challenges, so they should also improve on their funding and provision.

Researcher: You are welcome, any other comment?

P3: Motivational aspect from the government, from the institution that is the management team is very important because when you motivate people, they work extra mile, they do the extra, because when you are not motivating we are not supposed to solicit for promotion. I've not seen anybody given a special promotion since I resumed here. I've not seen anybody being commended for good work that they have rendered, good services that they have rendered, but when this aspects can be recognised, giving people motivational you know remuneration, commendation and all that it goes a long way and you find out that people doing extra to whatsoever they are doing,

Researcher: So it will bring about something like a job satisfaction? [yes] ok [and things like that]

P4: Can I say something more? You see, she raised a fundamental issue, adequate funding, that is from the government, then, from the management of our healthcare institution and tertiary healthcare institution, funds that government provides should be judiciously utilised for the purpose for which it is meant for. We have seen several instances where healthcare fund is being

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diverted for some political issues, so, government should ensure that they monitor any fund they release to make sure it is used judiciously for the benefit of the masses. Also, nursing leaders at Abuja, should make their impact known and people in our university training nurses, should make sure that they incorporate those of us who started life with RN and we are now trying to go to university. They should do abridged courses for us, they should make things easy, you are one of them Ma, please remember that nursing profession in Nigeria is just one incorporate us. Medical profession started with "A levels" now they have accommodated everybody and they have a line a career path, let all nurses in Nigeria have a career path. When you get to the meeting of stakeholders of Graduate Nurses of Nigeria, when you produce BSc Nursing, or BNSc nurses or whatever nomenclature we attach to it, if we at the clinical that have gone for RN, RM, full of experiences in practical do not accept them to put them through practical they cannot actualise their degree programmes so when you get to others tell them to have mercy and incorporate people at the clinical, make a very good programme for them like in abroad, so that everybody in nursing in Nigeria can be one.

Researcher: Thank you. Any other comment?

Chorus: No.

Researcher: I thank you for attending this focus group discussion. God bless you.

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①

Focus group discussion at FMC, Owo (FG1)

The hospital occupies a large expanse of land and the structures are well laid out.

Generally, the staff are homely as the Research team was warmly received by head of Continuing Education Unit for nurses. She also acted as the gatekeeper (focal person) who conducted the team round the hospital, introduced the team to principal officers of the hospital, Nurses and Nurse Managers, and other healthcare workers.

The two seminar rooms are well ventilated, adequately lighted with comfortable chairs and writing tables. It also has a white board, marker, duster and projector for powerpoint presentation.

Eight (8) Nurse Managers who are heads of units participated in the FGD. These Nurse-Managers are responsible for managing nursing activities and also involved in general administration of the hospital.

Comments

⇒ Current challenges

- There was a general chorus of "Shortage of nurses and bad equipments and instruments".
- Some participants mentioned:-
  - lack of supportive staff
  - inadequate remuneration
  - lack of incentives from the government
  - frequent night shift
  - "every blame is on the nurses"
    "nurses are burden bearers"
- One participant (P7) expressed that patients

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Appendix 12

Letter from the editor

TO WHOM IT MAY CONCERN

This letter confirms that the thesis with the title *Development of a Model for Support of Emotional Labour of Nurses in Tertiary Hospitals in Nigeria* by Mulikat Ayoade Ibraheem for the fulfilment of the requirements for the PhD degree in the School of Nursing, University of the Western Cape, South Africa, has been edited for grammatical and structural concerns by the undersigned language professional. Neither the research content nor the author's intentions were altered in any way during the editing process. The responsibility lies with the author to effect changes and to attend to any anomalies indicated during the editing process. Reference checking was not included. The editor's professional profile can be viewed on LinkedIn. (https://za.linkedin.com/in/gava-kassiem-a7569b39).

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