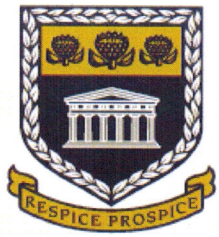

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The adequacy of support for community service practitioners at health care facilities in two sub-structures in the Western Cape

A mini-thesis submitted in partial fulfilment of the requirements for the Degree of Master in Nursing (Education) in the School of Nursing, Faculty of Community and Health Sciences, University of the Western Cape

By

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Key words:

Adequacy

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New graduates

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Orientation

Support

Transition

Western Cape

DECLARATION

I, Maria Sandy Lagrimas-Botha declare that "**The Adequacy of support for Community Service Practitioners at health care facilities in two sub-structures in the Western Cape**"

is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Maria Lagrimas-Botha May 2015

Signed: _____

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Abstract

Introduction: Community Service Practitioners' (CSPs'), Regulation 425 graduates are placed for a period of 12 months in the public sector designated health facilities where they may encounter possible challenges. The study aimed to determine the perceptions of CSPs' regarding the adequacy of the orientation and support for CSPs' at health care facilities in two sub-structures in the Western Cape Province. The objectives were i) to establish what support systems are in place for the CSPs' at health facilities; ii) to determine the adequacy for CSPs'; and iii) to identify possible gaps in the orientation and support structures offered at health facilities.

Methodology: The study is quantitative and adopted a descriptive design. The population (N = 57) included all the CSPs' that are placed in health care facilities within two sub-structures in the Western Cape. A sample of 48 participants was obtained through all-inclusive sampling. Data was collected using a self-administered questionnaire. Statistical Package for Social Science (SPSS) software version 22.0 was used for analysis of the data.

Ethical considerations: The researcher received approval from Senate Research Committee and ethical clearance from the University of the Western Cape. Permission was granted by Department of health and the facility managers of the health care institutions. Informed consent was obtained from participants who were made aware that participation was voluntary, prior to completing questionnaire.

Results: The results indicated that the CSPs' are receiving support in designated health facilities in the two substructures of the Western Cape. Macro- and Micro Orientation, supervision in the department and rotation to other departments have been revealed to

be an adequate type of support. Possible gaps were identified, namely inadequate length of orientation programmes, as well as some support structures which were either not accessible or known to participants. Recommendations were developed to overcome these challenges.

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List of Acronyms:

CDC:	Community Day Centre
CHC:	Community Health Centre
CSP:	Community Service Practitioner
HEI:	Higher Education Institutions
KESS:	Khayelitsha and Eastern Substructure
MDHS:	Metro District Health Services
MPKSS:	Mitchells Plain and Klipfontein Substructure
NEI:	Nursing Education Institutions
NLRN:	Newly Licenced Registered Nurse
NTSS:	Northern and Tygerberg Substructure
R. 425:	Regulation 425 relating to the approval of and the minimum requirement for the education and training of a nurse (General, Psychiatric and Community) and Midwife leading to registration.
R. 765:	Regulation 765 relating to performance of Community Service
SANC:	South African Nursing Council
SWSS:	Southern and Western Substructure

CHAPTER 1: INTRODUCTION

This chapter introduces the background of the study; defining concepts; the aims, objectives and the research question. The researcher has also discussed the significance of this study and has outlined the chapters that will follow.

1.1 Background

In South Africa, nursing is governed by the South African Nursing Council (SANC). One function of SANC is to set and maintain standards of nursing education and practice in the Republic of South Africa (SANC, 2015). This statutory body was established by the Nursing Act, 1944, and currently operates under the Nursing Act, 2005.

Upon completion of the Regulation 425 (R.425) relating to the approval of and the minimum requirement for the education and training of a nurse (General, Psychiatric and Community) and Midwife leading to Registration, there is a mandatory 12 month period of community service in public institutions (SANC, 2015). According to Regulation 765 (R.765) relating to performance of Community Service, "a person who is a citizen of South Africa intending to register for the first time to practice a profession in a prescribed category must perform remunerated community service for a period of 1 year " (SANC, 2015).

The mandatory community service year is only applicable to graduates of R.425 training. This addition to the Regulation was made by the previous Minister of

Health, Dr MantoTshabalala-Msimang in consultation with SANC as a strategy to retain nurses as there was an increase of experienced nurses leaving the public sector (Department of Health, 2008).

Reid (2002) wrote a chapter on community service for health professionals where he reports on the personal experiences of health professionals who completed the community service year. In this chapter, the author wrote that according to the Department of Health, the main objectives of the community service year is to ensure improved provision of health services to all the citizens of South Africa simultaneously providing novice professionals with an opportunity to develop skills, acquire knowledge, behavior patterns and critical thinking that will assist them in their professional development (http://www.hst.org.za accessed on the 25 March 2014).

The duration of the R.425 programme is four years, which is offered by Higher Education Institutions (HEI) as well as Nursing Education Institutions (NEI). During the fourth year of the nursing programme, application forms are distributed to the HEI and NEI for the students to select their top five preferences for community service placement.

Application forms for community service must be submitted to SANC by the HEI and NEI, with the required documentation within 30 days after the completion of the course. Once SANC has processed the application forms, the applicant is referred to as a practitioner and will receive a certificate of registration in the capacity of Community Service. This certificate is valid for a period of 2 years and inhibits the practitioner to perform community service outside the indicated

province or designated health care facilities for community service. There are two intakes for community service in a year namely; February and August.

After completion of the course, a list of the names of the graduates who have passed the R.425 programme is sent to the Provincial Department of Health, Directorate of Nursing for the placement process to begin. The Directorate of Nursing sends out the finalized placement list to the health care facilities, as well as the HEI and NEI's before commencement.

The commencement of placement of community service practitioners at designated health care facilities usually begins with an orientation programme for the new incumbents. The orientation programme's length and extent varies at each health facility. Following orientation, in-service training amongst other available support programmes becomes vital for a novice professional nurse. Therefore, this study seeks to determine what support is available and whether it is adequate in ensuring that transition from student to CSP is a smooth one and adds to the foundation which may shape the CSP in the nursing profession.

Studies have been conducted in countries such as United Kingdom and the Republic of Ireland regarding the perceptions of newly graduated nurses, which is described in detail in chapter 2. A literature search regarding the experiences of community service practitioners in South Africa yielded limited results regarding the adequacy of support they receive during community service year. This gap in literature sparked an interest in the researcher, as the researcher was a previous CSP and is currently involved with community service practitioners at a designated health facility.

1.2 Problem statement

Each year new community service practitioners are introduced in the health care system. Despite the 4 year comprehensive training, they still require continuous guidance and supervision from the senior registered nurses in the wards until they are confident enough to work independently. It is not known whether existing support programmes offered by health facilities are effective in paving the foundation for the CSPs' and overcoming possible challenges experienced by the CSPs' during their transition from graduate to community service practitioner.

1.3 Aim of the study

The study aimed to determine the perceptions of CSPs' regarding the adequacy of the orientation programme, and support structures for CSPs' at health care facilities in two sub-structures in the Western Cape.

1.4 This study aims to address the following objectives

i) To establish what support systems are in place for CSPs' at health facilities in two sub-structures.

ii) To determine the adequacy of support for CSPs' in two sub-structures in the Western Cape.

iii) To identify possible gaps in the orientation and support structures offered to CSPs' to ease their transition.

1.5 Research question

What support is available to the CSPs' and is the support adequate?

1.6 Definition of concepts

1.6.1 *Community service practitioner:*

Any person who is a citizen of South Africa intending to register for the first time as a professional nurse, who has met the prescribed requirements to qualify as such, performing remunerated community service for a period of one year (SANC, 2015). For the purpose of this study, community service practitioner is also known as newly qualified nurses.

1.6.2 *District hospital*:

A facility which supports primary health care and serves as a gateway to specialist care. The district hospital provides generalist services to in-patients and outpatients (A District Hospital Service Package for South Africa: A set of norms and standards, May 2002).

1.6.3 *Orientation*:

For this study, orientation is the introduction stage when a new employee is introduced into the organization. This is divided into two stages; namely macro – orientation and micro – orientation.

1.6.4 *Macro – orientation:*

The overview of the facility with regard to history of the facility, services rendered, organogram, departments and geographical location.

1.6.5 *Micro – orientation:*

The orientation conducted on a smaller scale, more specifically in the unit or department where CSP is placed. This includes specific related information about the unit or department e.g. use of equipment, where stock and supplies are kept and policies and procedures pertaining to the unit or department.

1.6.6 *Terms used interchangeably*:

Ward is referred to a separate room or areas in a hospital setting allocated to specific patients and in this study is interchanged with the term, department.

1.6.7 *Support*:

For the purpose of this study, support means the orientation to the health care facility designated for community service, in which CSPs are placed as well as support structures, which include macro – and micro - orientation, in-service training, supervision and guidance from senior staff, support from mentors and managers, and unit socialization.

1.6.8 An *8 Hour facility*:

A Community Day Centre (CDC) that functions for 8 hours.

1.6.9 A *24 Hour facility*:

A Community Health Centre (CHC) that functions for 24 hours.

1.7 Significance of the study

The study will have the following paramount importance: The results of the study are likely to assist the nurse managers and clinical tutors, who are involved directly and indirectly with the community service practitioners, in developing relevant and effective orientation and support programmes.

It is anticipated that the improvements made to the support programmes, based on the findings of the study, will assist in getting the CSP fully functional within the health facility in a shorter period of time. This can have a positive impact on service delivery and patient outcomes. This study can serve as a platform for future research in clinical areas.

1.9 Outline of the thesis:

Chapter 1 introduces the reader to the background, the aims, objectives, problem statement and significance of the study.

Chapter 2 reviews literature regarding the experiences of newly qualified nurses in the health setting, and is subdivided into appropriate themes that are contextualized for this study.

Chapter 3 discusses the methodology used in this study, the data collection tool, data analysis, reliability and validity; and ethical considerations.

Chapter 4 presents the findings of the quantitative data in forms of tables, graphs and pie charts to display the information. The researcher has briefly discussed the trends using Statistical Package for Social Science (SPSS) version 22.0.

Chapter 5 presents the conclusion of the study, outlines the limitations and highlights possible recommendations regarding the findings.

1.10 Conclusion

This chapter introduced the background of the phenomenon. The research problem, aims and objectives of the research was discussed. The significance of the research study was elaborated on. Chapter two discusses and focuses the study by the review of available literature.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The literature used in this study was gathered from searches on the World Wide Web including electronic databases such as: EBSOHOST and CINAHL; journals and books.

The available literature was related mainly to qualitative rather than quantitative studies. The researcher however used the qualitative studies to sketch a background regarding nurse graduates experiences. Limited literature was found regarding the adequacy of support for the community service practitioner; however studies such as one that was conducted in Australia which reported on transition programmes established to support nursing graduates was found.

The literature review presents a discussion of research conducted on nursing graduates with regards to reality shock; the transition process; their responsibility and accountability; stress experienced by newly qualified nurses; continuous development and training for newly qualified nurses; orientation of newly qualified nurses to the health facility and support and guidance of newly qualified registered nurses.

What is known about the phenomenon was categorized into international, national and local contexts. The available literature was then categorized and focused on the research question for discussion within the three contexts mentioned.

Several developed countries; the United States of America, Republic of Ireland, Canada, Norway and Australia, have conducted research regarding the transition from student nurse to registered nurse. The majority of research papers have expressed that the experience of the transition process from a student nurse to a registered nurse has been difficult, but foremost it's seen as multidimensional and complex. This phenomenon has attracted the attention of researchers for decades (Bjerknes and Bjork, 2012).

Literature authored by Marlene Kramer in 1974 regarding reality shock is presented below, which has been referenced by various authors since the 1970's.

2.2 Reality shock

In 1974, Marlene Kramer wrote a book entitled *Reality Shock: Why nurses leave nursing*. The author describes research done on baccalaureate graduates on how school-bred values differ from the real world, and that this transition process is met with reality shock (Kramer, 1974). This was an enormous addition to the body of literature, as further research confirmed Kramer's theory of reality shock which is visible in articles throughout the past four decades.

The term 'reality shock' has been cited in almost every article found relating to the 'experiences of newly qualified registered nurses' in a number of countries. This concept has become one of the main themes that graduate nurses' encounter in their first year in the working world.

A qualitative study by Bjerknes and Bjork (2012) in Norway conducted research on the opportunities and challenges faced by new graduates in the clinical area. The researchers aimed to gain insight into the perceptions of 13 new graduates in

their daily work. Their findings did not entirely confirm Kramer's findings of a "massive transition" as their results displayed a psychological shift from being a student and this was mainly due to the heightened responsibility factor.

A qualitative study conducted by Makhakhe in Lesotho (2010) on 18 nurse graduates investigated why new graduates had a change in attitude in their first year of work. The researcher describes that new graduates did not have the same positive outlook to their profession as shown in their senior year as students. From the analyzed data, reality shock emerged as a theme. New nursing graduates experience reality shock when they discover the difference between being a nursing student and the expectations of the nursing profession. New graduates associate this experience to "jumping in the deep end of the pool" (Duchscher, 2009).

Roziers, Kyriacos and Ramugondo (2014) conducted a study regarding the experiences of eight community service nurses in the Western Cape two weeks prior to placement and six weeks post commencement of the community service year. The researchers agree that new qualified nurses experience reality shock when hospital staff were not welcoming. Participants perceived that senior nurses were reluctant to acknowledge the graduate's new status, thus displaying negative attitude towards the new graduate nurses. This was further influenced by the high acuity level and the environment not being conducive for quality patient care.

From reality shock, there is a transition process that occurs. The following section discusses the framework of the transition process that a new graduate nurse experiences:

2.3 Transition process

An article by Duchscher (2009) discusses the theory of the transition process a new graduate experiences within the first 12 months. This article reports on four qualitative studies conducted over ten years regarding the transition experiences of new graduates. The latest study on 14 female graduates from one nursing school was done to create and substantiate the transition stages of new graduates into the nursing practice profession. The researcher describes the stages of transition that a new graduate experiences.

There are three stages, namely 'Doing'; 'Being'; and 'Knowing'. In the first stage 'Doing', the researcher confirmed that the participants attended an orientation session prior to the study commencing. The participants were already working in different units of the various hospitals. According to the author, the first stage occurs in the first three to four months. Although initially feeling excited for the transition process into the profession, this was soon met with the realization that they were unprepared for the responsibility and the functional workload in their new role which caused heightened stress levels for the participants.

The second stage, 'Being' occurs within the fourth to fifth month post orientation and participants displayed rapid thinking capabilities, knowledge level and skill competency. Towards the seventh and eighth month, participants reacquainted

themselves with the aspiration of professional growth and this mind shift assisted in their positive outlook on their professional growth.

The third stage, 'Knowing', occurs toward the 12th month post orientation where the participants have reached an unwavering level of confidence in their role and responsibilities.

Whitehead and Holmes (2011) conducted a literature study in the United Kingdom on newly qualified registered nurses preparation for practice. Literature was gathered from 1974. A total of 37 articles were generated but 33 did not meet the inclusion criteria. A total of seven articles were included in the review. Various themes emerged, one being transition and preparation of the new nurse graduate. Baillie (1999) as cited in Whitehead and Holmes (2011) found that transition is inevitable and the participants reported an elevated level of stress. Another study by Jasper (1996) as cited in Whitehead and Holmes (2011) suggested that the world of a student was shielded whereas the world of a newly qualified nurse was exposed.

Mc Kenna and Newton (2007) conducted a qualitative study on how new nurses developed their skill and knowledge over the first 18 months in Australia. The study comprised of 25 graduates from four Australian hospitals. The results indicated that the respondents felt initially unprepared for the first year post graduation, and reported that they faced many challenges within the transition period. After the initial 12 months, graduates start to gain confidence in their knowledge and skills.

A study by Levett-Jones and FitzGerald (2005) reviewed graduate nurse transition programmes in Australia. There was a need for some form of support for graduate nurses and the graduate transition programmes were developed to assist with the needed support. The findings of the review displayed that successful transition programmes encourage new nurses to remain in the workforce and maximize the community's investments in the education and training of nurses.

Duchscher (2009) describes the new nursing graduate to being new to the roles and responsibilities that are expected, their knowledge base is still developing and their leadership skills and interpersonal relationships with co-workers in the organization is strengthening. With the realization of being no longer students, this contributed to the new graduate feeling loss, doubt, confusion and disorientated towards the profession and their role expectations. With the increased stressful emotions, the new graduate experiences transition shock. An improved working environment would have assisted the transition process positively (Roziers et al, 2014).

2.4 Newly qualified nurses: responsibility and accountability

Draper (2013) a professor at The Open University in the United Kingdom reported on the experiences of student nurses becoming registered nurses and suggested that the most stressful situations for new registered nurses appear to be the increased responsibility and accountability that they are faced with. They receive much support from the university lecturers and mentors, but that support was no longer present once they started working.

Accountability and responsibility is another theme that emerged from a literature review by Whitehead and Holmes (2011) in determining whether newly qualified nurses are prepared for practice. Accountability and responsibility was a major stress factor that was mentioned in all articles that were reviewed by the authors. This theme was sub-divided into management, delegation, drug administration and prioritizing their duties. Baillie (1999) as cited in Whitehead and Holmes (2011), management skills were an area of concern. Mooney (2007) suggested that ward mangers had unrealistic expectations for the new graduates in the ward setting where they had to adapt quickly to their roles and responsibilities, which was found to be overwhelming.

In addition to this, Maben and McLeod Clark (1997) conducted a study on noted inconsistencies in preparation for management. They suggested that although newly qualified nurses receive adequate theoretical component, they lacked practical aspects in management which should improve their ability to be accountable and to act responsibly. This concurred with Gerrish (2000) who conducted a qualitative study on the comparison of two new nursing graduate groups in the United Kingdom. There were 10 and 25 participants in the 1985 and 1998 studies respectively. The researcher reported that the group that qualified in 1985 had challenges with managing a ward because of lack of organizational and management skills. In the 1998 group, this was still problematic although the participants worked in a team where there was a senior nurse taking responsibility. The participants were found occasionally responsible for managing the team and were overwhelmed by the amount of responsibility this entailed. This is in agreement with the findings of O'Shea and Kelly (2007) who conducted

a phenomenological study on the lived experiences of 10 newly qualified registered nurses in the Republic of Ireland. The results indicated that newly qualified nurses felt unprepared for their managerial role, however with time, their organizational abilities improved. The findings of O'Shea and Kelly coincide with that of Gerrish (1999) that newly qualified nurses' initial experience of the ward setting is stressful as they struggle to find a balance between patient care, dealing with doctors and managerial duties.

2.5 Stress experienced by newly qualified nurses

Graduates have high levels of energy, eagerness and readiness for their new role and being able to practice independently. The feeling of eagerness and readiness was transformed to overwhelming fear, doubt and stress (Duchscher, 2009). This is similar with Pellico, Brewer and Kovner (2009), who conducted a quantitative study on newly licensed registered nurses (NLRN) first experiences. There were a total of 1195 participants who completed a cross-sectional survey. In the secondary analysis of the study, the qualitative results presented indicated that novice nurses expected their role to be "appreciated and respected with adequate resources and support" but experienced an internal battle between their expected role and reality. This led to feelings of frustration, dissatisfaction and uncertainty of their chosen profession. This was similar to the responses in Duchscher (2009) which indicated that participants were terrified and scared. These feelings continued during the initial weeks of commencement as a newly qualified nurse.

Another situation of a stressful nature was greatly influenced by individuals with whom the new qualified nurse interacted during the introductory period. A

dominant theme in a study by Pellico et al. (2009) revealed that new graduate nurses were being mistreated by their colleagues. This included physician criticism, arrogance and rudeness which found new graduate nurses feeling intimidated and dissatisfied, which also heightened stress levels. Reasons for uncertainty and fear included their participant's inability to manage conflict, hospital staff expectations about the participants' immediate competency, communication with "difficult doctors", nurses' rights, and legal aspects of nursing (Roziers et al., 2014).

Physical strain due to performing their duties as a new qualified registered nurse without revealing how challenged they felt and what difficulties they had faced was an additional stress factor. The adjustment of their established personal routine as a student and having to adjust to working shifts took its toll on them.

Participants spent hours thinking of what was done during their previous shift and preparing for what they may encounter on their next shift. Some even dream about work. All these factors contribute to the physical demand that they experience (Duchscher, 2009).

Ferguson and Day (2007) conducted a study on the challenges for new nurses in evidence-based practice in Canada. One challenge that was noted was that the nursing programme did not prepare the new qualified nurses adequately on responsibility and accountability. As new nurses rely on theoretical knowledge and principles learned during formal education, and once their knowledge seems to be inadequate, they experience a higher level of anxiety.

2.6 Continuous development and training for newly qualified nurses

In the first four months, the new graduates' main focus is to find their way in a world for which they had been preparing as a student. Findings from Duchscher (2009), shows that the focus of socio-cultural and professional growth within the initial four months is finding and trusting their professional selves; distinguishing themselves from others; acceptance from the nursing fraternity; balancing their personal and professional lives and finding a way to correlate what they have learned as a student and what they faced in the working world.

Relationships between the new graduate and their colleagues were an important factor in the transition process. Govender, Brysiewicz and Bhengu (2015) conducted a quantitative study on the perceptions of 107 newly-qualified nurses performing compulsory community service in KwaZulu-Natal and found that participants felt supported by nurses and mentors who assisted in the improved confidence levels by giving feedback and encouragement. Makhakhe (2010) found that in-service training is essential in updating and educating staff about the current requirements of the job.

2.7 Orientation of newly qualified nurses to the health facility

Introduction to the professional environment usually begins with an orientation programme. According to Pellico et al. (2009), orientation programs are seen as essential for providing nurses with necessary clinical skills, judgment, confidence and support. Graduates are offered some kind of orientation for the initial week, and are should have mentors in the hospital setting for guidance and support

(Bjerknes and Bjork, 2009). However, challenges such as staff shortages lead to premature termination of the orientation programme (Roziers et al, 2014). Ultimately, due to operational requirements, new qualified nurses are found to be functioning mostly on their own (Bjerknes and Bjork, 2009).

Oermann and Garvin (2002) explored stresses and challenges that new graduates face in the hospital. They agree that orientation is of much importance to adequately prepare new nurses for their role and practice. The researchers propose that most of the learning is not in the classroom, but takes place in the practical areas where the new nurse is exposed to the clinical area, hence micro-orientation.

In an unpublished qualitative study by Beyers (2013), adapting to a new environment can be seen as a hindrance where the community service practitioner may feel unprepared for their new professional role.

According to Beyers (2013), a structured orientation programme can assist the CSP to feel welcomed and valued to the new workplace and allows the CSP to be prepared mentally for what is expected in their new role. Participants who were orientated revealed that the programme was helpful and assisted in their transition process. CSPs' who did not receive orientation to the health facility reported experiencing confusion and discontentment (Beyers, 2013). Govender et al. (2015) indicated that orientation issues were identified and that participants agreed that an improved orientation would have made them feel more supported in the unit and would have been beneficial in their transition process.

2.8 Support and guidance of newly qualified registered nurses

In the qualitative study by Bjerknes and Bjork (2012), findings have shown that newly qualified nurses experienced a lack of guidance and little support from the senior nurse managers. Participants felt the loss of control and lack of support from the institutions, colleagues and the graduates themselves. The researchers further suggest that a mentorship programme will support the new graduate into the roles and responsibilities that the job entails.

Ferguson and Day (2007) suggest that nurse managers are in the ideal position to create supportive practice environments that facilitate the new nurse's integration into the setting. Oermann and Garvin (2002), is in agreement, as nurse managers, preceptors, mentors and other nursing staff play a vital role in easing the transition process, which could lead to less stress.

Gerrish conducted a qualitative study in the United Kingdom in 1985 to gain insight on the transition process as perceived by newly qualified nurses. She conducted another study in 1998 to compare these perceptions with those of the 1985 study. The findings showed that there were notable changes in the experiences of the two groups.

In the 1985 study, there was no induction for the newly qualified nurses and they found themselves in charge of the ward within a few days of being appointed, with no support, this made their transition process very stressful. The findings of the 1998 study showed that the newly qualified nurses appeared to be experiencing stress, but were better supported through their transition process.

An integrative review was conducted by Rush, Adamack, Gordon, Lilly and Janke (2013) on articles ranging from 2001 – 2011. The presence of a new graduate programme resulted in good retention and improved competency of new graduate nurses, which in essence lessens anxiety and increases confidence in these new graduate nurses, and ultimately leads to cost benefits emerged from the review of literature. Additionally, the use of mentors provides support for the new graduates. Ideally, mentors should be available in the unit where the new nurse is placed, to serve as an expert with whom the new nurse can consult with.

A nationally conducted study by Moeti, van Niekerk and van Velden (2004), found that graduate nurses had sufficient theoretical knowledge, but had the inability to correlate theory to practice. They suggested that nurse managers should have a novice nurse shadow an experienced registered nurse for supervision and further learning on a one to one basis. The findings further illustrated that the newly registered nurses felt that their managerial skills were inadequate. International literature confirms that new nursing graduates feel that they have a deficit in managerial skills (Bjerknes and Bjork, 2012; Gerrish, 2000; Morrow, 2009; O'Shea and Kelly, 2006).

Roziers et al. (2014) found that new CSPs' experience reality shock, which led to the researcher proposing that a structured 4 year course would assist the new CSP transition better.

Govender et al. (2015) indicated that majority of participants were supported by fellow nurses in the unit which contributed towards their adjustment to the health care facility and in the improvement in their level of their confidence.

The Western Cape: Department of Health created an Employee Assistance Programme (EAP) which is available to all public sector workers and their family. This support can be accessed through telephone and face-to-face counseling. Services include access to an on-line wellness service; trauma management services, on-site debriefing; management and employee orientation; providing training on health and wellbeing matters; family care-, legal- , financial advice and the referrals or resources (ICAS, 2015).

2.9 Summary

Based on literature found, studies regarding orientation and support during transition have been researched since 1974. There is a range of avenues in which transition and its contributing factors has been contextualized and researched. Understanding reality shock and transition process are vital in understanding what the new graduate experiences on completing of the programme when they must enter the practice environment. Contributing factors such as those discussed in this literature review indicates that globally, nationally and locally this phenomenon has the capacity for further research.

This study however adds to the body of literature regarding the topic as it pertains to the Western Cape and the greater South Africa.

The following chapter will discuss the methodology of this research process.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

Kothari (2011) defined research as a scientific and systematic search for information on a specific topic. The author further states that research is an art of scientific investigation.

According to the National Institute of Nursing Research (NINR, 2013), nursing research can be defined as research that supports and develops the work that nurses do in order 'to improve the health of individuals, families, communities and populations'. Burns and Grove (2009) defines nursing research as a scientific process that validates and refines existing knowledge and generates new knowledge that directly and indirectly influences the delivery of evidence-based nursing practice.

According to Rajasekar, Philominathan, and Chinnathambi (2006), research methods are the various procedures, schemes and algorithms used in research. All the methods used by a researcher during a research study are termed as research methods.

Rajasekar et al. (2006) described research methodology to be a systematic way to solve a problem. Essentially, the procedures by which researchers go about their work of describing, explaining and predicting phenomena are called research methodology. It is also defined as the study of methods by which knowledge is gained. Its aim is to give the work plan of research.

This chapter gives an overview of the methodology that is used in this study. The following will be discussed in the chapter: research approach and design method; setting; population and sample; data collection method, tools and process; validity and reliability, and research ethics.

3.2 Research approach

This study is quantitative in nature. According to Burns and Grove (2012), quantitative research is a systematic approach in which numerical data is used to obtain information about the world. Creswell (2013) states that a quantitative approach is one in which the researcher primarily employs strategies of inquiry such as experiments and surveys, and collects data on predetermined instruments that yield statistical data.

3.3 Research design

Polit and Beck (2006) describes research design to be the overall plan for obtaining answers. The design specifies what approaches the researcher should follow.

This study adopted a quantitative descriptive survey design in which a self – administered questionnaire was used. The purpose of a descriptive study design is 'to provide a picture of situations as they naturally happen' and to gain more information about the characteristics within a particular field of study (Burns and Grove, 2012). This design can offer a way to discover new meaning to a

phenomenon, describe what exists, determine the frequency of occurrence and categorize information.

3.4 Research setting

This study was conducted in the Metro District Health Services in the Western Cape. According to the Western Cape Government's official website (2015), the Western Cape Government consists of 13 departments, of which one is the Department of Health. In the health sector, there are: 34 district hospitals; eight regional hospitals; six tuberculosis hospitals; four psychiatric hospitals; one rehabilitation hospital and three central hospitals.

Within the Department of Health, the Deputy Director-General of District Health Services and Programmes oversees three sub departments namely: Metro District Health Services, Rural District Health Services and Health Programmes. The Metro District Health Services (MDHS) has four sub-structures; Northern and Tygerberg sub-structure, Khayalitsha and Eastern sub-structure, Western and Southern sub-structure and, Mitchells Plain and Klipfontein sub-structure (Western Cape Government, 2015).

This study focuses on the Northern/Tygerberg (NTSS) and Khayalitsha and Eastern sub-structures (KESS). The researcher is familiar with the two sub-structures, and is employed at one of the health facilities as a clinical facilitator in the Personnel Development Department.

3.5 Population

The population has all of the elements (individuals, objects, or substances) that meet certain criteria for inclusion in a given universe (Burns and Grove, 2012). Polit and Beck (2006) describes this as the cumulative of all the individuals or objects with some common, defining characteristics.

The population for the study includes all the CSP's who are placed at the health care facilities in the Northern / Tygerberg and Khayalitsha / Eastern sub-structures. According to the Directorate: Nursing Services in the Western Cape Province, there were 52 CSPs who commenced in February 2014 and five CSPs who commenced in August 2014 within the two sub-structures, therefore a total of 57 CSPs formed the population for this study (N = 57).

Table 3.1: Allocation of CSPs' in NTSS and KESS

Sub – structure	Health Facilities	No. of facilities	No. of CSPs'
Northern / Tygerberg	District Hospital	1	12
	CHC	8	15
Khayalitsha / Eastern	District Hospital	3	17
	CHC	3	13
TOTAL:			57

The table above summarizes the distribution of community service year nurses with regard to the type of facilities and number of CSPs' that are placed in the two sub-structures.

3.6 Sample size

A sample is a subset of the population that is selected for a particular study (Burns and Grove, 2012). Polit and Beck (2006) argue that using a sample is more practical than collecting data from the population, but poses a risk that the sample will not be representative of the population. Thus, this study samples 100% of the population, referred to as an all-inclusive sampling.

Of the entire population of 57, 53 consented to participate in the study. Of the four participants who did not participate, two were on maternity leave at the time when the data was collected; and two participants refused to participate in the study.

3.6.1 Inclusion criteria

The sample group should have been in community service for the year 2014 - 2015 and should have been placed for a minimum of five months in a designated health facility prior to completing the questionnaire.

3.7 Data collection

3.7.1 Data collection method

A self-administered questionnaire was used to collect data from the participants. Survey research is non-experimental research that focuses on obtaining information regarding the activities, beliefs, preferences, and attitudes of people via direct questioning of a sample of respondents (Polit and Beck, 2006).

This method was selected because questionnaires can derive descriptive statistics. A self-administrated questionnaire is less time consuming thus preventing disruption of services at the health facilities, and in the light of this, the required data could be collected.

3.7.2 Data collection tool

A structured survey (Appendix A) which includes components of the Casey-Fink Graduate Nurse Experience Survey (2006), developed by Kathy Casey and Regina Fink from the University of Colorado. Permission from the authors to utilize the tool (Appendix B) was obtained. The tool was developed in 1999 and revised twice in 2002 and 2006 respectively.

The questionnaire consisted of 49 questions which took the participants approximately 15 – 20 minutes to complete.

The questionnaire was sub-divided into three sections:

Section one focused on demographics of the participants which included questions relating to age, gender, ethnicity, marital status, dependents, highest level of education, distance traveled to work and mode of transport. This biographical information depicts the participants' background.

Section two focused on the orientation programme which included both macro (health facility orientation programme) and micro (unit / department) orientation.

Section three dealt with the availability of support structures which included questions on CSP's further training and transition from student to community service practitioner.

3.7.3 Data collection process

Approval from the Faculty Higher Degrees Committee was obtained and ethical clearance was received from the Ethics Committee of the University of the Western Cape (Appendix C). An application to the Department of Health Research, for permission to conduct the study at government health facilities, in the Western Cape: Department of Health (Appendix D and E) was submitted. Approval from the Department of Health, the Directorate: Health Impact Assessment was obtained.

Attempts were made to have all the participants placed at the facilities complete the questionnaire at the same time, on the same day. There were instances when the researcher arrived at the facilities to find the participants were off sick or had attended a course. In such situations, the necessary arrangements with the registered nurse-in-charge to return when the participant was on duty again were made.

Data collection took place at the various health facilities from November 2014 until March 2015.

The participants received and signed a consent form (Appendix F), after they were briefed about the study (Appendix G). Participants were able to complete the questionnaire with the researcher available to answer any questions.

After completion, the researcher collected the questionnaires and placed them in an envelope. The questionnaires and the consent forms were put into separate envelopes to maintain the confidentiality of the participants and to ensure the safe keeping of the data.

Of the 53 questionnaires distributed to CSPs who consented to participate in the study, 48 questionnaires were collected immediately after completion (90.5%). The researcher made a second attempt to contact the participants to collect the outstanding 5 questionnaires however, after numerous attempts the researcher was still unsuccessful. The response rate in the study was therefore 90.5%.

3.8 Reliability and Validity

3.8.1 Reliability

According to Polit and Beck (2006), reliability refers to the consistency with which an instrument measures the identified elements.

Reliability was calculated by using Cronbach alpha coefficient (α) for internal consistency on SPSS version 22.0. A series of steps was followed to calculate the reliability of the instrument on SPSS. Internal consistency $\underline{\alpha}$= 0.791. Burns and Grove (2012) suggest that a coefficient of 0.70 is acceptable; therefore the

instrument is internally consistent. The instrument was also sent to a statistician to confirm internal consistency.

3.8.2 Validity

According to Jackson (2012), Validity refers to whether a measure is truthful or genuine.

To ensure content validity the instrument was pretested on 5 subjects who were not included in the study. The following adjustments were made to the instrument:

In section one: Question seven 'Did you complete a diploma or degree?' This was changed to 'Which qualification have you obtained?' giving the participant the choice of 'Diploma: National Diploma in Nursing R.425' or 'Degree: Baccalaureus Curationis'

In section three: Question 33: 'What mode of transport do you use', did not include the option 'walk to work', which was then added to the question.

In section three: Question 38: 'Is the training programme visible in the department/ward?', an option of 'did not notice' was added, as the pretest participants verbalized that they did not notice if there was a training programme in the department / ward.

Face validity was also ensured by having experts in the field confirm whether the items are appropriate and that the questionnaire's content covers what it supposed to cover, and to ensure that the objectives of the research are met. The researcher consulted a statistics coach from the University of the Western Cape and made use of feedback from the supervisor.

3.9 Data analysis

The researcher used IBM Statistical Package for Social Sciences (SPSS) software version 22.0 to organize and analyze the data once collected.

The researcher allocated each completed questionnaire a numerical figure as a code to assist in capturing of the data, and to ensure that the questionnaires were not captured twice.

A structured coding system was added in the survey to assist in cleaning and coding of the data before it was loaded onto SPSS. In instances of multiple answers for a question, a coding system using the alphabet was used.

Each option was coded for either a YES = 0 and NO = 1, which was upload onto SPSS as a single question. This assisted to organize the data in a simplified manner.

Descriptive analysis was used to describe the scores which were visually presented by percentages in form of tables and pie charts. As suggested by Burns and Grove (2012), descriptive statistics are used to describe the data which can be presented in the form of graphs, tables and charts to assist the researcher to identify patterns in the data.

3.10 Research ethics

3.10.1 Approval

Research approval was received from the Senate Research Committee, and ethical clearance from the Ethics Committee of the University of the Western Cape.

3.10.2 Permission

Permission was obtained from the Department of Health, Western Cape to gain entry to the health care facilities. Permission was also granted by the health facility managers.

3.10.3 Informed consent

A consent form was distributed to the participants to voluntary consent to participate in the study. The contents of the consent form were explained to the participants. The researcher explained what the study entailed and informed the participants that they may withdraw from the study at any time.

3.10.4 Voluntary participation

It was made clear to the participants that they may stop at any time, if they feel that they do not wish to continue with the questionnaire. It would not affect them negatively in any way. There were no participants who withdrew from the study.

3.10.5 Confidentiality

Confidentiality was maintained throughout all phases of the study. Completed surveys and consent forms were put into a sealed envelope to ensure confidentiality. Both envelopes were kept in a locked drawer, which was only accessible to the researcher.

3.10.6 Anonymity

Participant anonymity was kept through the use of codes over their identity when data was uploaded and analyzed. The participants were encouraged to not write their names on the questionnaires to assist in maintaining anonymity.

3.10.7 Dignity

The researcher ensured that the participants were treated with dignity, respect and fairness at all times during data collection. The researcher ensured dignity by giving participants an option to participate. Participants could withdraw at any time and would not be held against them.

3.11 Conclusion

The details of the methodology used in the study were discussed extensively within this chapter. Chapter four includes visual representations of the findings.

CHAPTER 4: PRESENTATION AND DISCUSSION OF RESULTS

4.1 Introduction

This chapter presents the findings of quantitative data that was collected by the researcher and analyzed using the Statistical Package for Social Science (SPSS) version 22.0 to form the data into statistical value. Due to the nature of the SPSS software version 22.0, results were rounded off to the next decimal, therefore giving a total of 100.1% or 99.99%. Descriptive statistics are presented by means of tables, pie charts and graphs which address the three objectives of this research study namely: to establish what support systems are in place; to determine the adequacy of support and to identify possible gaps in the orientation and support offered to CSPs' at health care facilities in two sub-structures in the Western Cape. Based on the interrelatedness of these objectives, the findings are presented in an integrated way.

An integrated discussion of the results with existing literature around this subject is then presented. The researcher is able, through this process, to highlight new findings from the study which will strengthen the existing body of literature as it concurs or refutes existing literature on this topic. A total of 53 questionnaires were distributed to the sample group, of which 48 questionnaires were returned. The response rate was therefore 90.5%.

The questionnaires that were returned were mostly fully completed. There were six open ended questions which majority of the participants did not complete as

the question did not apply to them. These were mainly follow-up questions e.g. question 11:'if no, why was there no orientation'; question 13: 'if no, when was orientation given'; question 40: 'if no, give reasons why you did not have an opportunity to attend a training session'. Two other questions which were not completed by all participants were: question 20: 'in which department were you placed in when you started at the health facility'; and question 43: 'what other training are you interested in?' The last open–ended question: question 46: 'what was your overall experience of community service year' was the only open ended question that was completed by all participants.

Question 42 – 46 focused on the transition process from a student to a community service practitioner, which can be regarded as an error as they were not linked to the objectives of this study. The researcher therefore did not report on their findings. The information however, assisted the researcher to gain insight into the perceptions of their transition process, which may be further investigated in another study.

There was no missing data on the closed-end questions therefore; the researcher was able to use the questionnaires to obtain data. There were no spoilt questionnaires as the participants seemed to understand how to complete the questionnaire.

The results are discussed in the following categories:

i) Demographic information of community service practitioners

ii) Micro and macro orientation of community service practitioners to the health facility

iii) Available support structures for community service practitioners at the health facilities and the adequacy thereof

4.2 Demographic information

Table 4.1: Demographic information of participants

Factor	Value (n = 48)	
Age (%)		
	21 – 30	(81.3)
	31 – 40	(16.7)
	41 – 50	(2)
Gender (%)		
	Male	(6.25)
	Female	(93.75)
Ethnicity (%)		
	African	(66.7)
	Coloured	(33.3)
Marital status (%)		
	Single	(79.2)
	Married	(20.8)
Highest Level of Education (%)		
	National Diploma of Nursing (56.25)	
	Bachelor in Nursing (43.75)	

4.2.1 *Age distribution of community service practitioners*

The researcher enquired about the ages of the participants. There were 5 categories from which participants could choose namely 21-30; 31-40; 41-50; 51-60 and above 60. The age group that is most prevalent amongst community service practitioners in this study ranged between 21 – 30 years (81.3%). The data suggests that the trend of participants is of the younger generation. Many studies report on the age distribution of nurses. An article by Casey et al. (2004), reported on a study conducted in United States of America (USA) on graduate nurse's experiences, and found that new graduate nurses' mean age was 35 years and younger. This suggests that graduate nurses could have previously completed other courses prior to studying nursing. It is assumed therefore that the graduate nurses did not enter the nursing programme directly after completing high school.

In the local context, Govender et al. (2015) found in their study that 71% of the age distribution was between 21 to 27 years, while 28. 9% were between the ages of 28 and 33years.

This is almost similar to statistics gathered by the South African Nursing Council which reports that the average age of completion of the 4 year programme in 2014 was 29 years of age (SANC, 2015). There was a minimum age of 20 years and the maximum age of 62 years. However, in the current study, only 2% were of an older age - between 41- 50 and there were no participants in the age group 51 – 60 and above 60 years. This finding is congruent with SANC statistics that there are a small percentage of mature people who completed the 4 year programme in 2014.

This study focuses on the adequacy of support for community service practitioners in two substructures of the Metro District Health Services in the Western Cape, it is clear that the two studies have different focal areas, although in the same province and have the same target population group.

According to SANC, 4% of registered nurses / midwives are younger than 30 years of age in 2014. This suggests that the 4% is derived from new qualified registered nurses hence, community service practitioners. In the two sub-structures, the CSPs are mainly of the younger generation but cannot be compared to the overall age distribution of community service practitioners in the Western Cape. This group forms a relatively small percentage of all registered nurses/ midwives in South Africa.

4.2.2 *Gender*

The female gender is prominent (93. 75%) as indicated in table 4.1. Nursing has been known, historically, as a female dominated profession due to its caring and compassionate characteristics. Govender et al. (2015) found in their study of 107 participants that 82 were female and 25 were male. This statistic has changed throughout the years as there are more males that enter the nursing profession. According to SANC (2015), in 2005 there were a total of 451 male registered nurses in the Western Cape, and male students in training, the same year, amounted to 188. In 2014, this number increased to 1110 male registered nurses in the Western Cape and 529 male students in training. This gives a 59. 3% increase of the number of males entering the profession as a registered nurse. It is

evident therefore that there is a rise in males entering the profession. In this study the number of male participants is not a representative of male community service practitioners in the Western Cape, as placement of the CSPs are done in accordance with the available posts at health facilities and in line with the CSP's five choices of placement.

4.2.3 *Ethnicity*

In the two sub-structures, 32 (66.7%) of the participants were found to be of an African cultural group and 16 (33.3%) are of the Coloured cultural group. There was an absence in the White and Indian participants in the study. According to the Western Cape Destination Marketing, Investment and Trade Promotion Agency – South Africa (2011), the ethnic groups in the Western Cape were Coloured (50.2%); African (30.1 %); White (18.4%) and Indian/Asians (1.3%).

Although the Coloured community comprises more than half the population in the Western Cape, this amount is not reflected as the most common ethnic group in this study. This can be due to the fact that the health facilities in KESS that have posts for community service practitioners are mostly in African language spoken areas. CSPs choice of where they completed their community service is usually influenced by language, proximity to where they live and personal preferences. According to the CSP allocation for the two substructures, 30 participants are from the KESS, therefore explaining the large number of participants in the African ethnic group in this study.

4.2.4 *Marital status*

A total of 38 (79. 2%) of participants reported being single which is probably in line with the high number of younger CSPs in the study (81.3% aged 21 – 30) as discussed in 4.2.1 . A total of 10 (20.8%) of the participants reported being married. There was an absence in divorced or widowed participants in the study. There were 26 participants (54. 1% of the respondents) who indicated that they have dependants. Of those, 26 (22.9%), which is the highest, has two dependants. A total of 24 (6.3%) have more than 3 dependents.

4.2.5 *Highest level of education*

For the purpose of this study, the highest level of education refers to the type of nursing programme that was completed prior to registering as a community service practitioner. A total of 56.25% (n=48) completed a Diploma in Nursing and 43.75% completed a Bachelor Degree in Nursing. This is comparable with Govender et al. (2015) who found that 85 participants completed their training (diploma) at a nursing college and 22 participants completed their training (degree) at a university. Most participants attended a College of Nursing for a diploma in nursing as there were more nursing student posts available in the College of Nursing in KwaZulu-Natal.

Although the study did not aim to compare the responses of the CSPs from the diploma of degree programmes, any distinctive findings from a particular group could assist in preparing "tailor-made" support programme if necessary. As mentioned in chapter 1, community service in nursing is applicable to R. 425

graduates in South Africa which includes both the Diploma of Nursing and the Bachelor in Nursing.

4.2.6 *Distribution of CSP in health facilities in NTSS and KESS*

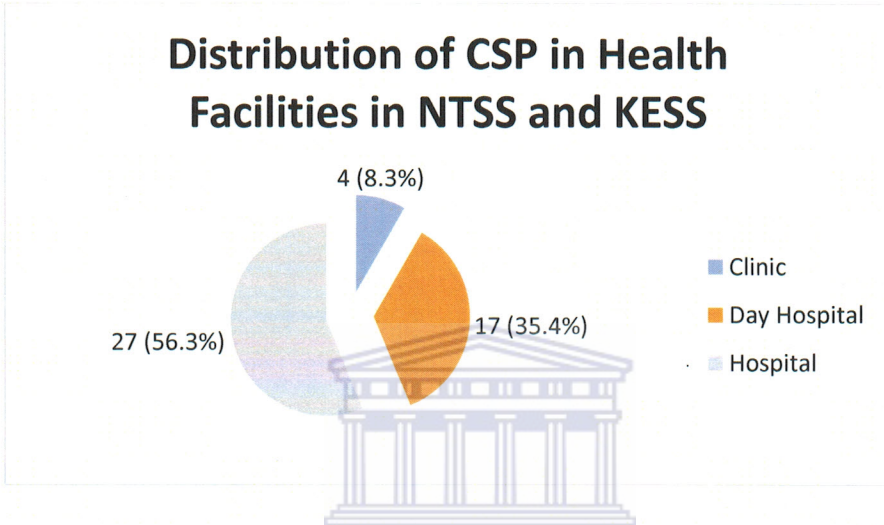

Figure 4.1: Distribution of community service practitioners in health facilities in the NTSS and KESS

In figure 4.1 more than half of CSP's in the two sub-structures is serving their community service year in a hospital setting, while 35.4% is placed in a community health centre (CHC) setting. A total of 8.3% are placed in a community day centre (CDC) or clinic. The distribution of CSP to pre-designated health facilities for community service is managed by the Department of Health (DoH). The number of community service posts for nurses is set and therefore the distribution is related to the available posts.

4.2.7 *Length of time employed at the health facility*

The respondents were asked their duration of employment as a community service practitioner in the health facility. A total of 87.5% (n = 48) indicated that, at the time of data collection, they were in the 9 – 12 month period of their community service year. There were 10.41% (n = 48) who were in their 5^{th} – 6^{th} month and 2.09 % (n = 48) who were in their 7^{th} – 8^{th} month.

In order to meet the inclusion criteria of the sample group, the researcher had to ensure that the participants should have been, at least, in their fifth month of community service. This was to ensure that there was sufficient time from the beginning of the community service year until when the CSP was expected to report on their experiences of the support for CSPs. Hence, the importance of noting the length of time employed at the health facility.

O'Shea and Kelly (2007) who conducted a study on the lived experiences of newly qualified nurses on clinical placement during the first six months following registration in the Republic of Ireland also selected their sample group according to the number of months the nurses were in the health setting. Nurses in that study was in their sixth month of placement, which was thought, would be enough time for them to be able to adequately describe the nurse graduate experiences. Pellico et al. (2009) in their study had criteria that NLRN who completed their National Council Licensing Exam for the first time, and had to have at least have six months experience prior to completing the survey.

As indicated, in the current study, majority of participants (87. 5%) were in their 9^{th} – 12^{th} month and 10. 41% were in their 5^{th} – 6^{th} month of community service, suggesting that they had adequate experience to complete the questionnaire.

4.3 Orientation at the facility

To ascertain whether there are support systems in place at the health facilities, the researcher asked a range of questions which included questions on the CSP's orientation to the health facility and micro orientation to the ward.

Support and support structures available for CSPs, must be viewed in the light that that CSPs working in a hospital setting might have better access to support as there are designated training departments in hospitals that deals with training and support for students, CSPs and staff. CHCs and CDCs report to the sub-structure. All training needs are organized by the training coordinators who are located at the sub-structure offices and not in the health facilities. They have an overview of the broader training, more primary health care settings type of training activities rather than internal training relating to orientation and support within the facility. The CSPs that are placed in these health facilities are therefore dependent on support from senior colleagues and not from a defined training department within the health facility.

4.3.1. *Macro - orientation to the health facility*

Table 4.2 Participants macro - orientation at facilities

Factor	Value (n = 48)	
Orientation to Facility (%)		
	Yes	(93.75)
	No	(6.25)
Factor	**Value (n = 45)**	
Orientation given on first day (%)		
	Yes	(100)
	No	(0)
Duration of Orientation (%)		
	1 Day	(60)
	2 – 3 Days	(4.4)
	4 – 5 Days	(17.7)
	< Week	(17.7)

The data in table 4.2 shows that 93.8% (n=48) of the participants received orientation to the facility, while 6.25% reported that they did not receive orientation. Orientation to the facility is an integral support system which introduces the community service practitioner to the health facility to ensure that the CSP will become functional and effective in the shortest period of time. Govender et al. (2015) agree that orientation supports nurses in making the transition into their new role.

The result of this study indicate that 93, 8% of the CSPs underwent orientation; however it is still a concern that not all CSPs received orientation. This is congruent with the findings of Govender et al. (2015) that not all participants received orientation.

Beyers (2013), suggests that participants who did not receive orientation may have felt unhappy and out of place.

Of the total number of participants that indicated they received orientation, all participants indicated that orientation was given on the first day of commencement as a community service practitioner. A delay in orientation may cause the CSP to feel unprepared, unsure and may intensify their stress levels (Beyers, 2013). Govender et al. (2015) found that a total of 62 participants (59%) received orientation less than one week after commencement, while 30 participants (28. 6%) were still continuing with orientation during the data collection phase of their study. For both these studies, conducted in KwaZulu-Natal and the Western Cape, it appears that orientation is given within the first week of placement in the facility. This is important as Duchscher (2009) proposes that a heightened stress level causes a lack of confidence in the workplace and leads to the transition shock. Therefore, since all participants were orientated from the first day it is assumed that heightened stress levels are less likely to occur.

It was found that the duration of orientation differed according to type of facilities and internal protocols of the health facility. Majority of respondents (60 %) reported that orientation was one day; while 40% responded to have orientation for more than one day. This percentage is broken down in table 4.2.

Hillman and Foster (2010) conducted a quantitative study on the impact of nursing transition programmes on the retention of graduate nurses and its' implications on cost-effectiveness in Michigan state of the United states of America, they initially had an orientation programme for five days, which evolved

to a residency programme of 16 weeks. Changes to the orientation showed a drastic improvement in the retention of graduate nurses. This finding concurs with the suggestion by O'Shea and Kelly (2007) that a three month orientation should be made available for newly qualified nurses to ensure a smooth integration to the service.

Oerman and Garvin (2002) conducted a study on the stresses and challenges for new graduates in hospitals in the Midwest region of the USA proposed that although graduates begin with an orientation programme, there is still much to be learnt. For many new graduates, orientation is stressful as there is much to remember therefore those CSPs who only had a one day orientation might have experienced information overload. Morrow (2008) highlighted further that organizational demands may interrupt orientation programmes that lead to frustration and discontent. Therefore, the ideal orientation programme according to Duchscher (2009) includes knowledge regarding professional role transition. Such a programme would include knowledge and practice related to the stages of transition shock; workload delegation and management; life style adjustments; unit specific skills; and professional roles and responsibilities. However, these topics cannot be covered in one day. Furthermore, Oermann and Garvin (2002) suggest that interactions and communication that occur during orientation is important to foster open communication between managers, mentors and graduates. This suggests that based on its inherent purpose and value, an orientation programme should not be rushed.

4.3.2 *Macro - orientation programme at health facility*

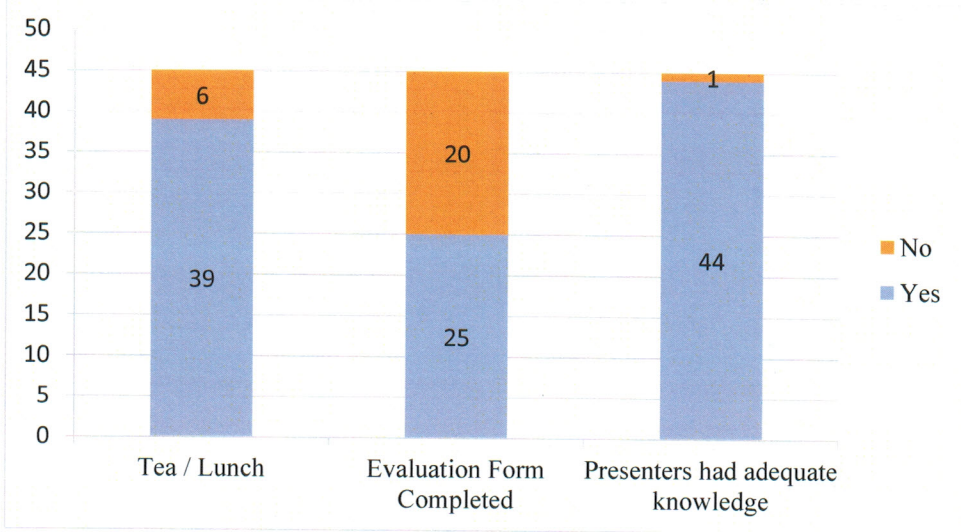

Figure 4.2: Macro - orientation programme at health facility

The above figure presents the responses of the participants on the content of the orientation programme at the health facility.

The researcher is aware that although 3 participants (6.25 %) indicated that they did not receive orientation, this section, which refers to content of macro-orientation, was completed by all participants including the 3 referred to above. However, whilst cleaning the data for this question, the researcher removed responses of the 3 participants as their input is regarded as unreliable. A total of 45 participants indicated that they underwent an orientation programme and who completed questions relating to the content of the macro orientation.

All participants (n=45) indicated that they can recall what was presented during orientation and that they had a clear understanding of the presentations. A total of 6 participants (13.3%) have reported that they did not receive a tea/ lunch break.

A total of 44 participants (97.78%) have indicated that presenters had adequate knowledge about the presentations at hand. Hillman and Foster (2011) discussed the importance of having content experts to present a topic as they should have the knowledge and expertise.

A total of 25 participants (55.5%) reported that they had completed an evaluation form regarding the adequacy of the orientation programme. This concurred with Hillman and Foster (2011) that an evaluation can display the effectiveness of the programme and to accurately know whether efforts are making any difference. Changes to the programme are based on direct feedback provided.

4.3.3 *Micro - Orientation*

Micro-orientation is the continuation of the Macro – orientation of the organization and happens in the department or unit and is therefore specific to the department. This will be discussed in detail under the sub-heading supervision from senior staff. A total of 91.67% (n=48) of the participants indicated that they received micro-orientation to the ward in which they were placed. The other 8.33% indicated that they did not receive orientation at departmental level. A total of 21 (43.75%) participants reported that there was orientation file in the ward, while 27 (56.25%) participants indicated that there was no orientation file.

Results reflect that 37 (77.1%) of CSPs' took 1 – 2 months to gain confidence in the initial department they were placed in. Orientation would help the new incumbent become familiar with the setting and somewhat alleviates their initial anxieties and fears and to become functional in a shorter period of time. In

addition an orientation file acts a source for referral should the incumbent have forgotten something that was covered in the orientation or could be used to looked up anything that was not covered in the orientation. Although literature speaks of preceptors and mentors rather than a designated orientation file as a source for referrals, this adds to the body of literature on how Hillman and Foster (2009) has implemented the use of preceptors in their residency programme and has evolved to have a lead preceptor in each unit, these preceptors and mentors assist new graduates, students and staff on a departmental level. This is a type of resource to assist integration in the department. No studies in nursing have been found that deals specifically with the usefulness of support documents such as an orientation file on the graduate's transition.

4.4. Support structures

The participants were asked whether they had support from family and friends to ascertain whether support is present in their personal lives. This is an important factor as this may influence the way support, in general, is perceived and internalized at the health facilities. A total of 46 (95.83%) of the participants confirmed that they have support while 2 (4.16%) participants indicated that they do not have support from family or friends.

The researcher enquired whether the participants were experiencing stress and 27.08% (n=48) indicated that they are experiencing stress. The causes of their heightened stress levels were attributed to a variety of factors. The stress of job expectation was the highest (31.25%) cause of stress, which could be due to the

fact that the participants are in their 9 – 12 month of community service. at the time of data collection. It can be anticipated that since they were at the end of their community service year, more was expected of them. This is also the period when CSP are applying for jobs for the year after community service. These causes of stress were however not explored and are therefore not conclusive.

Financial concern was the next highest level of stress as 6 (12.5%) participants indicated. This may be linked to the insecurity of securing a job once community service year is completed. Although the stress of existing student loans is also related to financial stress, only 3 participants (6.25%) indicated that they were affected. This is followed by stress from personal relationships (7; 14.6%); living situations (4; 8.3%) and child care (1; 2.1%) participant. According to Duchscher (2009), changes to established life patterns and routines such as modified living arrangements; relationship changes; the acquisition of debt may be both exciting but somehow are a financial burden for new graduates.

4.4.1 *Mode of transport*

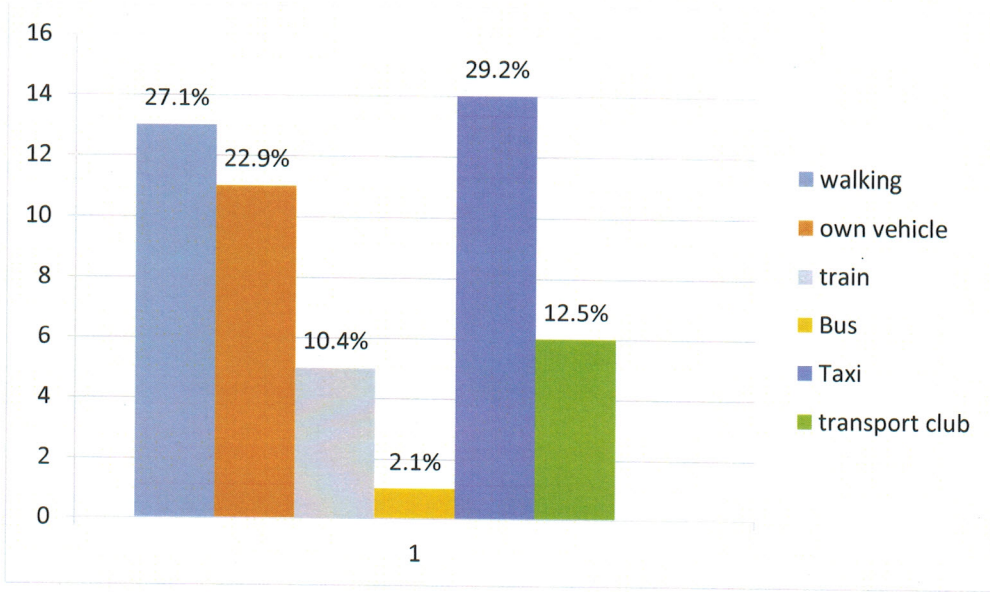

Figure 4.3 Mode of transportation to health facilities

A total of 14 (29.2%) of the participants travel to work using taxi's, which was the most frequently used mode of transportation followed by 13 participants who walked to the facility (27.1%). Those who indicated that they used the own vehicle to travel to work amounted to 11 participants (22.9%). Other public transport that is used included the train (5; 10.4%); transport club: (6; 12.5%) and bus: (1; 2.1%).

More than half of the participants, 54.2% (n = 48) indicated that they live less than five km from the health facility. There were ten participants who indicated that live between six and ten km away and five participants that live between 10 – 15 km away from the health facility, while 14.6% live more than 15 km from their placement facility.

The researcher asked this question to ascertain the ease with which CSP traveled to the health facility as well as the distance that they lived from the health facility. Mention is made in the introduction that CSPs on application have five choices in terms of the community service facility they wish to be placed at. This finding indicates that most participants are living reasonably close to the health facility; however the study did not ascertain whether or not this was the CSPs first choice out of the five choices they had. A possible reason is that CSPs are living in areas in the Metro District and that they preferred to be placed closer to their home.

It was important to determine the mode of transport CSPs used, and how far they worked from the health facility as this could affect the CSPs interpretation of support, should they be affected by an unreliable mode of transport. Transport to the health facility may cause stress in terms of traveling far distances to get to work, which can be influenced further in bad weather. The cost of traveling can also be a stress factor for those who live a far distance from the health facility. These factors, which may be regarded as non-work related, can indirectly affect the CSPs performance, which may create conflict between the CSP and their senior and may be interpreted by the CSP as a lack of support. Their absenteeism profile may also be affected if the CSP become ill or encounters problems with transport to the facility. No studies have been found to ascertain the impact that transport has on the new graduate's socialization into nursing.

4.4.2 *Support structures at facilities*

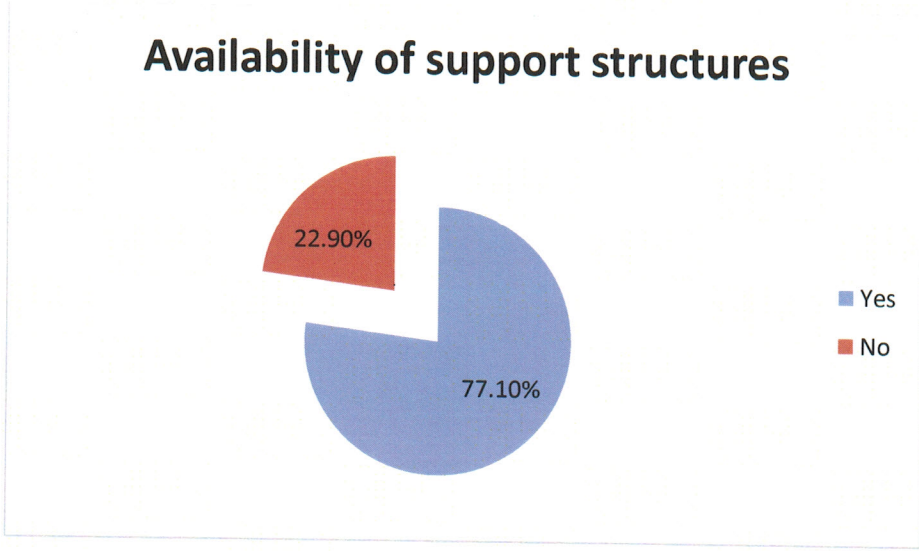

Figure 4.4: Availability of support structures to CSPs in NTSS and KESS

The figure 4.4 shows the perceptions of community service practitioners about the availability of support at their facilities. A total of 77.1% (n=48) responded that support is available to them at the health facility. With regard to the distribution of CSPs in the two substructures, there are more CSPs allocated in a hospital setting, where there is a designated training department or personnel. The data suggest that those who are placed in a hospital setting might be exposed to receiving more support because of the availability of a training department. In the smaller health facility, there is no training department or dedicated personnel at the facility who offers training. Community Health Centres and Community Day Centres have clinical co-ordinators who are based in the sub-structure office and who go out to the facilities to train staff. The responsibility of training and orientating the new CSPs is therefore that of the facility manager; the operational managers in charge of the department and the senior staff. Those who indicated that they do not have

available support systems at their facility might not be aware that support is available to them. The following table presents the type of support structures that are available to community service practitioners.

Table 4.3: Available support structures in NTSS and KESS for CSPs

Factor	Value (n = 48)
Adequate Supervision (%)	
	Yes (64.58)
	No (35.41)
In-service Training (%)	
	Yes (83.3)
	No (16.7)
Occupational Health (%)	
	Yes (22.91)
	No (77.08)
Peer Training (%)	
	Yes (33.3)
	No (66.7)
Employee Assistance Programme (%)	
	Yes (12.5)
	No (87.5)
Rotation to other Departments (%)	
	Yes (75)
	No (25)

Participants were asked to indicate which support systems were available for CSPs at their facilities. Table 4.3 displays what support systems are available in the two sub-structures.

4.4.2.1 Adequate supervision

Micro-orientation occurs in the ward where the new incumbent is introduced to the department setting. Further supervision is provided by the unit manager; senior registered nurse or identified personnel in the department. Data suggests that 62.5% of the CSPs received adequate supervision and support in the wards. Duchscher (2009) reported that a support network of colleagues and peers was identified as an important link to the ongoing professional development. Hillman and Foster (2011) support this notion and suggest that mentors and preceptors should be assigned to assist new graduates with department related matters.

All participants (100%) indicated that registered nurses were approachable, while only 2.1% felt that registered nurses were not always available when they had queries. A total of 91.7% (n=48) feel that the unit manager were approachable. The unit manager is senior to the registered nurse and it would be expected that the unit manager as well as the registered nurse act as role models.

As discussed earlier in section 4.3.1 orientation to the institution is vital to assist to ensure that new graduates have a solid foundation that assist to ease transition and have a positive outcome in terms of nurse retention and cost effectiveness in the long term (Hillman & Foster, 2011). According to Caliskan and Ergun (2012) as cited in Govender et al. (2015), orientation programmes are useful in helping

newly qualified nurses transition into their professional role and can decrease reality shock when nurses commence work.

Researchers ensured this by implementing a residency programme for new graduates that surpassed the initial few days of macro - orientation. It is important therefore that in the department where new graduates are placed they are linked up with mentors, preceptors and role models (Hillman and Foster, 2011; Makhakhe, 2010; Duchscher, 2009; O'Shea and Kelly, 2007; Levett-Jones and Fitzgerald, 2004; Evans, 2001; Gerrish, 2000). If this is not adhered to, as mentioned by Gerrish (2000), new graduates will find themselves in charge of a ward after 4 days of commencement, which caused them to feel inadequately prepared.

4.4.2.2 In-service training

A total of 40 participants (83.3%) were knowledgeable that the health facility had an in-service training programme, while the remaining 8 (16.7%) participants indicated that they were not aware of an in-service training programme at their facility. This may be due to the communication of the training programme to the staff by the senior registered nurse of the department. Often due to the immense workload on health workers in the departments, there is less time allocated for in-service training as patient care takes priority. Even where there is a designated training department in the hospital setting, CSPs in the hospital setting may also experience a lack of communication regarding available training.

Out of the 40 participants that indicated that there is an in-service training programme at the health facility, a total of 56.3% (n=40) have reported that in-service training was made available to the CSPs. Makhakhe (2010) agrees that in-

service training is essential in updating and educating staff about the current requirements of the job. The researcher adds that due to the profession that is continuously changing, there is a need for in-service education for health care professionals. It is of concern that only 47.9% perceive this type of support to be adequate.

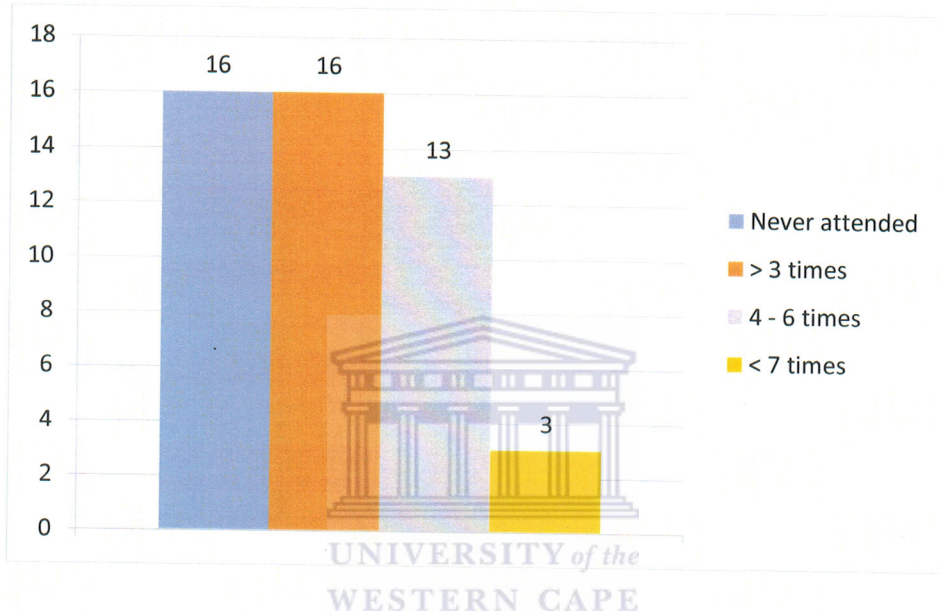

Figure 4.5: Total number of training sessions attended by community service practitioners

The above figure 4.5 displays the number of training sessions attended by the CSPs until the time data was collected. A total of 26 participants (54.16%) indicated that the training programme was visible in the wards, while 12 participants (25%) reported that the training programme was not visible. The rest of the participants, 10 participants (20.83%) did not notice whether the programme was visible or not. This question was asked to ascertain whether the CSP were aware of training occurring in the health facility, in attempt to ascertain whether they were aware and did not attend the training or whether they were not

aware of the training or whether due to workload CSPs are not sent for training. Due to excessive workload and staff shortages, new graduates often find themselves in charge of a ward while not focusing on their learning needs and objectives (Gerrish, 2000; Whitehead & Holmes, as cited by Baillie, 1999). This concurs with Whitehead and Holmes (2011) that staff shortages are a contributing factor to the lack of support given to newly qualified registered nurses which may lead to CSPs being placed in potentially unsafe situations (Morrow, 2008).

4.4.2.3 Occupational health

A total of 11 participants (22.9%) indicated that there was occupational health services available at their health facilities should they have required such services. This service is mainly found in a hospital setting and not in the CHCs and CDCs. The researcher did not ascertain whether CSPs who were allocated to CHCs and CDCs attend clinic when needed.

4.4.2.4 Peer training

For this study, peer and on-the-spot training is defined as learning amongst colleagues in a department. A total of 33.3 % (n=48) of the participants reported that they are aware that peer training is a type of support and that it is available to them. The majority of participants 66.7% (n=48) indicated that this type of support is not available to them. It is concerning that more than half of the participants perceive this type of support to be inadequate for professional development in the nursing profession.

Macro orientation, micro orientation and peer training or on-the-spot training adds substance to the CSPs professional development. Literature has shown that

ongoing professional development is vital for a smooth transition and to retain knowledgeable registered nurses in the institution (Whitehead & Holmes, 2011; Hillman & Foster, 2011). Managers are however found to be reluctant to add mentoring to the workload of already busy nurses (Morrow, 2008). This might be one reason why such a high percentage of CSPs do not receive peer training in the departments.

4.4.2.5 Employee assistance programme

Employee assistance progamme (EAP), also known as ICAS is a government initiated support system that is available to all government workers. Most of the participants were not aware of this support as 42 participants (87.5%) have indicated no knowledge of this support system and only 12.5% (n=48) reported having some knowledge about this support initiative. It is not known whether this was introduced to the CSPs during orientation to the health facility.

4.4.2.6 Rotation to other departments

Rotation to other departments in the facility was encountered by 37 (77.08%) of the participants, while 11 (22.91%) participants reported that they remained in the same department for the duration of the community service year. Of the 37 participants that rotated, 19 (51.35%) participants have indicated that they remained in the department for a maximum period of 3 months before rotation. This was followed by bi-monthly rotation 12 (32.43%) participants and more than 4 months 6 (16.21%) of the participants.

Rotation occurs in most health facilities, except in Community Day Centres. CDC's consist of two reporting departments namely City of Cape Town (CCT)

and Provincial Government of Western Cape (PGWC). Community Service Practitioners fall under PGWC, which means that they may not be allocated to CCT's section of the CDC. This limits the CSP to work in only certain areas. In the hospital and CHC settings, the CSPs are rotated to departments within the CHC. This assists in continuous professional development as the community service practitioner is exposed to learning opportunities in these departments.

The table below summarizes the types of support available in health facilities within the two sub-structures. A percentage above 50% was considered adequate in this study.

Table 4.4: Adequacy of support systems for CSPs' at health facilities

Type of Support	Percentage	Adequate	Not adequate
Macro - orientation	93.8%	✓	
Micro – orientation	91.7%	✓	
Supervision in the department	62.5%	✓	
In-service training	56.3 %	✓	
Occupational health	22.9%		✓
Peer training in the department	33.3%		✓
Employee assistance programme	12.5%		✓
Rotation to other departments	75%	✓	

4.5 Conclusion

This chapter presented the findings of the data collected from the CSPs. The findings of the study are largely supported by existing literature. Gaps in the orientation and support of CSPs have been identified in the study and possible areas for improvement have been highlighted and will be recommended. From the discussions, it is clear that community service practitioners have available support systems in their health facilities. The following chapter will present a summary of the findings, limitations of the study, conclusions and recommendations.

CHAPTER 5: SUMMARY OF FINDINGS, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the overview of possible limitations to the study; thereafter the researcher will outline the objectives of the study and arrive at a conclusion. Possible recommendations are described to ensure optimum awareness and utilization of support structures at health facilities in the Northern/Tygerberg and Khayalitsha and Eastern Substructures.

The purpose of the study was to explore what support systems are available in the two sub-structures and to ascertain the adequacy thereof.

5.2 Summary of findings

Support is essential for a newly graduated registered nurse to optimally function and grow within the nursing profession (Beyers, 2013; Duchscher, 2009; Morrow, 2008).

5.2.1 *Objective 1: To establish what support systems are in place for CSPs' at health facilities in two substructures*

The results of this study have revealed there is a presence of support systems for community service practitioners in the two sub-structures.

The type of support that is known to be available is orientation at a macro- and micro level of the facility for example, the ward and facility as a whole. Support also includes supervision in the departments; in-service training and rotation to other departments so that CSPs may gain a wide range of experience. The structures which are not readily available to the CSPs' are occupational health service for the workers at the health facility and peer training in the departments. ICAS was not a popular source of support as 12.5% (n=48) of the respondents were aware that this type of support is available.

5.2.2*Objective 2: To determine the adequacy of support for CSPs' in two substructures in the Western Cape*

The adequacy of support is measured by what type of support is recognized to be available and whether CSPs' are aware of the available support system. According to the findings five of the eight types of support systems available proved to be adequate.

5.2.3 *Objective 3: To identify possible gaps in the orientation and support structures offered to CSPs' to ease their transition*

It is a concern that not all CSPs are orientated to the health facility as this plays an essential role in ensuring that the foundation of the CSPs in the nursing profession is firm. The duration of orientation is found to be mostly for one day, and this could result in the huge amount of information not being internalized in one day.

Beyers (2013) suggest that orientation should be a structured programme for the initial month.

Poor communication regarding available support is a likely contributing factor that could be a challenge in ensuring that the CSPs' receive adequate support. For instance, should the in-service training not be effectively communicated to staff, there will be less awareness and attendance by the CSPs' which counterfeits the purpose of in-service training in the first place. Findings of the study show that 47. 9% of respondents identified in-service training as available support. The Employee Assistance Programme is not a popular type of support as only 12. 5% of respondents are aware of its availability; therefore, communication might be a possible gap in this regard.

The researcher enquired about the respondents' personal stress to explore possible contributing factors which may influence the interpretation and utilization of support in the health facility.

A possible contributing factor of personal stress may have been derived from the insecurity of not having a job after community service since the CSPs' were already in the 9th to 12th month of community service during data collection period. This phenomenon should be investigated further to explore in-depth understanding of factors that contribute to personal stress of community service practitioners.

5.3 Limitations of the study

This study was focused on community service practitioners in two sub-structures of the Metro District Health Services and the results can therefore not be

generalized to the entire community service practitioners' population of the MDHS or the Western Cape.

The researcher did not capture in-depth experiences of the CSPs regarding the phenomenon due to the type of research design that was chosen.

The researcher learnt during data analysis that additional questions should have been asked to gain a more comprehensive understanding of the phenomenon.

The absence of inferential statistics in this study may be viewed as a limitation however the researcher ensured that the minimum requirements for this mini thesis were met.

A limitation is that the researcher did not ascertain whether CSPs had mentors or preceptors assigned to them to verify whether they in fact did or did not have supervision.

5.4 Conclusion

This study gave insight into the perceptions of community service practitioners of support systems and the adequacy thereof. Support is a vital component which steers the CSP in their professional growth. From the initial day of commencement as a community service practitioner, the professional foundation is being laid to shape how the CSP will carry out their duties. Although possible gaps have been identified, through literature and the findings of this study, the researcher has compiled recommendations to bridge possible gaps so that support

systems are optimally utilized, which could envisage professional and personal growth in the nursing profession.

5.5 Recommendations

5.5.1 *Ensure adequacy of support to CSPs' in two substructures of the Western Cape*

Table 5.1 Recommendations to ensure adequacy of support for CSPs'

Recommendations	
Macro – Orientation of CSPs to the health facility	1. All new community service practitioners should be orientated to the setting as they are placed in that setting for one full year. 2. Orientation should be given from the first day of commencement at the health facility as this will set a solid start. 3. Orientation should include a full organizational orientation which informs the new incumbent about organizational structures, services, policies and protocols. 4. Specific orientation programmes of at least 3 days must be planned according the health facility in which the CSP is placed. 5. The duration of orientation should be extended to at least 2 weeks on commencement. 6. All support services must be communicated to CSPs during orientation.

Content of macro - orientation of CSPs to the health facility	1. Orientation programmes should have a tea or lunch break as it is unrealistic to expect the CSP to concentrate for a full day with a break. 2. Evaluation or the orientation must be done as feedback is of importance for improving the quality of the programme. 3. The orientation programme should be offered by experts in the organization (Hillman & Foster, 2010)
Micro - orientation of CSPs to the department	1. All CSPs' should undergo micro orientation in the department which relates to unit specific routines and use of equipment.
Health facility - In-service training programme	1. Training programmes must be communicated and visible in the ward to ensure CSPs are kept abreast with new information. 2. Attempt must be made for at least one staff member, on a rotational basis, to attend training which must be fed back to the staff in the ward
Peer training	1. A mentor or preceptor should be assigned to the CSPs' as part of orientation to the department (Moeti et al., 2004; Oermann and Garvin, 2002). 2. The implementation of an in-ward training programme may assist with keeping abreast with new nursing information and polishing up on existing knowledge.

Employee assistance programme	1. A structured orientation programme should introduce the availability of this support system and what it offers (ICAS, 2015). 2. Operational managers should effectively communicate this programme by ensuring visibility in the department by use of notice boards.

5.5.2 *Further research opportunities*

This study focused on two substructures of the Metro District Health Services, and incorporates the quantitative method to explore the availability of support structures and the adequacy thereof.

With minimal research studies exploring community service practitioners in the Western Cape, there is a need for further research to ascertain in-depth understanding of how the CSPs experience the adequacy of support systems in the Western Cape.

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UNIVERSITY OF THE WESTERN CAPE

FACULTY OF COMMUNITY AND HEALTH SCIENCE

Title: The adequacy of support for Community Service Practitioners at health care facilities in two Sub-structures in the Western Cape.

QUESTIONNAIRE (APPENDIX A)

Researcher: Maria S. Lagrimas-Botha

Student number: 2702888

INSTRUCTIONS

1. The questionnaire will take approximately 15 - 20 minutes to complete.
2. The questionnaire has 49 questions.
3. There are closed-ended and open-ended questions.
4. Please complete all questions.
5. Please tick in the clear columns. Shaded columns is for the researcher's use.
6. If you require clarification on any question, please do not hesitate to ask the researcher.

Section1: Demographics

Please tick the appropriate box in the middle column

1. How old are you?

21 – 30		0
31 – 40		1
41 – 50		2
51 – 60		3
Above 60		4

2. Gender:

Male		0
Female		1

3. Ethnicity:

White		0
African		1
Asian		2
Indian		3
Coloured		4

4. What is your current marital status?

Single		0
Married		1
Divorced		2
Widow		3

5. Do you have any dependants?

Yes		0
No		1

6. If Yes, How many dependants do you have?

1		0
2		1
3		2
More than 3		3

7. Which qualification have you obtained?

Diploma: Diploma in Nursing R425		0
Degree: Baccalaureus Curationis (B.Cur)		1

8. How many months are you in the health facility in the capacity of Community Service Practitioner?

5 - 6 months		0
7 – 8 months		1
9– 12 months		2

Section 2: Orientation Programme

Sub-section 2.1. Health Facility Orientation Programme

9. Which facility category are you placed at for Community Service?

Clinic		0
Day Hospital		1
Hospital		2

10. Were you orientated to the health facility?

Yes		0
No		1

11. If no, why was there no orientation?

---

12. Was orientation given on your first day?

Yes		0
No		1

13. If no, when was orientation given?

---

14. How many days was the orientation programme?

1 day		0
2-3 days		1
4 – 5 days		2
More than 1 week		3

15. Can you recall what was presented at orientation?

Yes		0
No		1
Vaguely		2

16. Did you receive a tea and lunch break during orientation?

Yes		0
No		1

17. Did you understand what the presenter/s was explaining to you?

Yes		0
No		1

18. Did you fill in an evaluation form at the end of orientation to evaluate the programme?

Yes		0
No		1

19. Did the person who conducted the orientation show adequate knowledge regarding the topics?

Yes		0
No		1

Sub-section 2.2.: Micro Orientation: In the ward

20. Which department were you place in when you started at the health facility?

21. Did you receive an orientation to the specific ward/ department?

Yes		0
No		1

22. Did the department / ward have an orientation file which captures what must be orientated to new staff?

Yes		0
No		1

23. How long did it take for you to gain confidence in the department?

1 – 2 months		0
2 – 3 months		1
4 – 5 months		2

Please note: The following questions 25 – 28 relates to your response in the question above.

24. Was a senior professional nurse **available** when you had a query during placement in the department?

Yes		0
No		1

25. Did you require assistance from the Senior Registered Nurse when performing the duties expected of you?

Yes		0
No		1

26. Was the senior professional nurse **approachable** during placement in the department?

Yes		0
No		1

27. Were the Unit Manager/ Operational Manager approachable during placement in the department?

Yes		0
No		1

28. Have you rotated to different departments/ wards during the Community Service year?

Yes		0
No		1

29. How many months were spent in one department before you rotated to another department?

1 month		0
2 months		1
3 months		2
more than 4 months		3
I have not rotated to other departments/ wards.		4

Section 3: Support Structures

30. Are you experiencing stress in your personal life?

Yes		0
No		1

31. Indicate what might be causing your stress. (You may indicate more than once choice.)

Finance		0
Child care		1
Student loans		2
Living situation		3
Personal relationships		4
Job expectation		5

32. What is the distance that you travel to work?

Less than 5 km		0
Between 6 – 10 km		1
10 – 15 km		2
More than 15km		3

33. What mode of transport do you use?

Walk to work		0
Own vehicle		1
Train		2
Bus		3
Taxi		4
Transport club		5

34. Do you have support structures at your facility?

Yes		0
No		1

35. What type of support structures are available for CSP' at your facility? (You may indicate more than once choice.)

I have adequate supervision from senior staff		0
Occupational health is available to me when I fall ill at work		1
In-ward training (peer training) is available		2
ICAS – I am aware of ICAS and how to access this service when I require assistance		3

Sub-Section 3.1: Further Training: In-service Training

36. Does the facility have in-service training programmes for the staff?

Yes		0
No		1

37. Are training programmes available to you?

Yes		0
No		1

38. Is the training programme visible in the department/ward?

Yes		0
No		1
Didn't notice		2

39. Have you had the opportunity to attend the in-service training sessions at your facility?

Yes		0
No		1

40. If No, give reasons:

_____

41. What is the total number of in-service training sessions you have attended since you started at the health facility in the capacity of a CSP?

I have never attended a training session		0
Less than 3 times		1
4 – 6 times		2
More than 7 times		3

42. What type of training are you interested in? (You may indicate more than once choice.)

Computer training		0
Basic Life support		1
Disease Management		2
Practical skills training regarding how to use equipment		3
Practical training on developing nursing skills		4

43. What other training are you interested in?

_____

Sub-Section 3.2.: Transition from student to community service practitioner

44. What difficulties, if any, are you currently experiencing with the transition from the student role to the CSP role?(You may indicate more than once choice.)

Role expectations (e.g. more responsibility, being in charge, tasks expected of you)		0
Lack of confidence (e.g. communication skills, delegation, knowledge deficit, critical thinking)		1
Workload (e.g. organizing, prioritizing, feeling overwhelmed, patient acuity)		2
Fears (e.g. patient safety, disciplinary actions)		3
Orientation issues (e.g. unit familiarization, information overload)		4

45. Indicate which aspects of your work environment are most satisfying?(You may indicate more than once choice.)

Peer support (e.g. belonging, team approach, helpful and friendly staff)		0
Patients and families (e.g. making a difference, positive feedback, patient satisfaction, patient interaction)		1
Ongoing learning (e.g.in-service training, on the spot training, courses)		2
Professional nursing role (e.g. challenge, benefits, fast pace, critical thinking, empowerment		3
Positive work environment (e.g. Good team work, available resources, great facility, up – to - date technology)		4
Nursing work environment (e.g. overflow of patients, shortage of staff, ineffectiveness of care)		5
System (e.g. outdated facilities and equipment, small workspace, paperwork)		6
Interpersonal relationships (e.g. gossip, lack of recognition, lack of teamwork, politics)		
Orientation (information overload, lack of feedback, not effective)		8

46. How is your overall experience as a CSP at your facility?

_____

_____

_____

We have come to the end of the questionnaire.

Thankyou for taking the time to complete this questionnaire.

Appendix B: Permission from the Authors

To: MARIA SANDY LAGRIMAS-BOTHA; Kathy.Casey@sclhs.net
Cc: Mancuso, Mary P
Subject: RE: Permission: Casey-Fink Graduate Nurse Experience Survey

Maria-

Your work sounds very exciting. You definitely have our permission. Have you accessed our website and been able to download the materials? We have undergone some recent changes in our web address. Please let us know if you experience any difficulty. Mary Mancuso is our research assistant who is helping us with the transition.

Sincerely,

Regina

From: MARIA SANDY LAGRIMAS-BOTHA <2702888@myuwc.ac.za>
Sent: Monday, May 26, 2014 1:15 PM
To: Fink, Regina; Kathy.Casey@sclhs.net
Subject: Permission: Casey-Fink Graduate Nurse Experience Survey

Good Evening Ms Casey and Ms Fink,

I trust this email finds you well?

I am Maria Lagrimas-Botha, from South Africa. I am a Registered Nurse and currently busy with my mini-thesis to complete the Masters Programme (M. Nur Education) at the University of the Western Cape, Cape Town.

My title for my mini-thesis is : A study to explore Community Service Practitioners' (CSPs') experiences of the induction / orientation programme and to investigate the effectiveness of existing support structures at health facilities in the Northern/Tygerberg sub-structure, Western Cape.

I am a clinical facilitator in a district health facility in the Western Cape, South Africa and what I have noticed, is that there is a knowledge gap regarding the CSPs' experiences and I believe that exploring these experiences will assist in improving the systems that are currently in place at the health facilities for the current CSPs' and for future CSPs'.

In South Africa, our graduate nurses are called community service practitioners as there is a mandatory 12 months placement in government accredited facilities, that has to be fulfilled before registration as a Registered Nurse.

I therefore, would like to ask permission to incorporate some questions of the Casey-Fink Graduate Nurse Experience Survey in the questionnaire that I, the researcher has developed in order to gain more meaningful feedback from the participants and in turn, from the results, recommendations will be made to health facilities in this sub-structure region in order to close the gap.

I hope my request will be granted.

Kind Regards,

Maria Lagrimas-Botha

M.Nur (Education) Student

University of the Western Cape

South Africa

Appendix C: Ethical Approval from University of the Western Cape

UNIVERSITY of the
WESTERN CAPE

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

08 September 2014

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Mrs MS Lagrimas-Botha (School of Nursing)

Research Project: The adequacy of support for Community Service Practitioners at health care facilities in two sub-structures in the Western Cape

Registration no: 14/7/13

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

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

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

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948 . F: +27 21 959 3170

Appendix D: Approval from Western Cape Government: Department of Strategy and Health Support: Letter 1

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857 / fax: +27 21 483 7921
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2014RP8_268
ENQUIRIES: Ms Charlene Roderick

University of the Western Cape
Faculty of Community Health Sciences
Robert Sobukwe Road
Bellville
7535

For attention: Mrs Maria Lagrimas-Botha

Re: THE ADEQUACY OF SUPPORT FOR COMMUNITY SERVICE PRACTITIONERS AT HEALTH CARE FACILITIES IN TWO SUB-STRUCTURES IN THE WESTERN CAPE

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries in accessing the following sites:

Bellville South CDC	M Farreira	Contact No. 021 951 2326
Bishop Lavis CDC	W Allies	Contact No. 021 934 6050
Delft CHC	J van Heerden	Contact No. 021 954 2237
Eerste River Hospital	G Perez	Contact No. 021 902 8014
Elsies River CHC	R Kasker	Contact No. 021 931 6023
Helderberg Hospital	E Erasmus	Contact No. 021 850 4700
Karl Bremer Hospital	L Naude	Contact No. 021 918 1222
Khayelitsha (Site B) CHC	D Binza	Contact No. 021 360 5208
Kleinvlei CDC	V Jonkers	Contact No. 021 904 3421
Kraaifontein CHC	L Steyn	Contact No. 021 987 0080
Macassar CDC	C Alexander	Contact No. 021 857 2330
Michael Mapongwana CDC	K Jacobs	Contact No. 021 361 3353

Parow CDC	H Stallenberg	Contact No. 021 938 8032
Ravensmead CHC	L Baron	Contact No. 021 936 8769

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.

2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR J EVANS
ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 22/12/2014

CC L BITALO DIRECTOR: NORTHERN / TYGERBERG
CC A HAWKRIDGE DIRECTOR: KHAYELITSHA / EASTERN

Appendix E: Approval from Western Cape Government: Department of Strategy and Health Support: Letter 2

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9896
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2014RP8_268
ENQUIRIES: Ms Charlene Roderick

University of the Western Cape
Faculty of Community Health Sciences
Robert Sobukwe Road
Bellville
7535

For attention: Mrs Maria Lagrimas-Botha

Re: THE ADEQUACY OF SUPPORT FOR COMMUNITY SERVICE PRACTITIONERS AT HEALTH CARE FACILITIES IN TWO SUB-STRUCTURES IN THE WESTERN CAPE

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Khayelitsha District Hospital	A Kharwa	Contact No. 021 360 4227

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR J EVANS
ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 09/01/15

CC A HAWKRIDGE — DIRECTOR: KHAYELITSHA / EASTERN

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2271, Fax: 27 21-959 2274

E-mail:kjooste@uwc.ac.za

CONSENT FORM (APPENDIX F)

Title of Research Project: The adequacy of support for community service practitioners at health care facilities in two Sub-structures in the Western Cape.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name.....

Participant's signature.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator: Maria Lagrimas-Botha

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)918-1280

Cell: 0768768090

Fax: (021)959-1409

Email: mslagrimas89@gmail.com

Supervisor: Prof F Daniels

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)9592271

Fax: (021)959-2679

Email: fdaniels@uwc.ac.za

PARTICIPANT INFORMATION SHEET (APPENDIX G)

Title: The adequacy of support for community service p

ractitioners at health care facilities in two Sub-structures in the Western Cape.

What is this study about?
I am Maria Lagrimas-Botha, a registered Masters in Nursing Education student at the University of the Western Cape. I am inviting you to participate in this research project because you form part of the population group that is of interest for this study. The purpose of this research project is to evaluate the adequacy of support that is available for Community Service Practitioners' at health care facilities in the Northern/ Tygerberg sub-structure in the Western Cape Province.

What will I be asked to do if I agree to participate?
You will be asked to complete a survey that will not take longer than 20 minutes. A written informed consent is required for participation in this research. The items in the questionnaire explore your experiences as a Community Service Practitioner of support structures, including orientation programme, available to you at your health facility.

Would my participation in this study be kept confidential?
Your information will be kept confidential. To help protect your confidentiality, the questionnaire will be numerically coded, so that your name does not appear anywhere. The surveys are self-administered by the researcher and after completion; the researcher will collect all forms, and place them in a sealed envelope. This prevents unauthorized people to access the data. Only the researcher will have access to the data. Your identity will remain anonymous throughout the research study and after completion of the study, the questionnaires will be destroyed.

What are the risks of this research?
There are no known risks associated with participating in this research project. However, arrangements will be made with a counsellor at the health facility, in the event that you should experience distress during the completion of the questionnaire.

What are the benefits of this research?

There are no monetary benefits attached to this study. The results may assist the researcher to learn more about what support structures are available to Community service practitioners and how Community service practitioners experience the adequacy of support. The anticipated results of the study may assist health providers to identify, improve and evaluate their existing systems.

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, it will not be held against you.

Is any assistance available if I am negatively affected by participating in this study?

Yes, there is. The researcher will refer you to the Employee Assistance Programme, otherwise known as ICAS if you are negatively affected by this study.

What if I have questions?

This research is being conducted by Maria Lagrimas-Botha at the University of the Western Cape. If you have any questions about the research study itself, please contact Maria Lagrimas-Botha at Personnel Development and Training Department, Karl Bremer Hospital. 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:

Director: Prof. K. Jooste
School of Nursing
University of the Western Cape
Private Bag X17,Bellville, 7535
Telephone: 021 959 2271
kjooste@uwc.ac.za

Research Supervisor: Prof F. Daniels
School of Nursing
University of the Western Cape
Private Bag X17,Bellville, 7535
Telephone: 021 959 2271
fdaniesl@uwc.ac.za

Dean of the Faculty of Community and Health Sciences: Prof J. Frantz
University of the Western Cape
Private Bag X17
Bellville 7535
Tel: +27 (0) 21 959 2631/2746
Fax: +27 (0) 21 959 2755
Email: jfrantz@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee

10 May 2015

Re: Services for Maria Lagrimas-Botha

To whom it may concern,

I have completed editing work of portions of Maria's Massters thesis on support systems for nursing students completing their community service.

This included:

- correcting spelling and grammar errors;
- the reading ease of the work;
- that the argument follows as indicated in introductory paragraphs;
- making suggestions as to how better sentences and paragraphs;
- correcting sentence structure;
- and correcting tense usage;

Regards,

Cassey Toi