STRATEGIES TO IMPROVE NURSES WORKING CONDITIONS IN SELECTED PUBLIC CLINICS OF THE LIMPOPO PROVINCE, SOUTH AFRICA.

by

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DISSERTATION

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DECLARATION

I declare that the dissertation hereby submitted to the University of Limpopo, for the degree of Master of Nursing Science has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

.... 20 August 2020

Thembi Julia Motsepe Date

DEDICATION

I, Motsepe Thembi Julia dedicate this dissertation to my son, Motsepe Amogelang Prosper and to my beloved mother, Thandi Betty Mahlangu, who encouraged and supported me throughout my studies.

ACKNOWLEDGMENTS

I thank Almighty God for His mercy upon my life and for giving me the strength and courage to complete this study. My study would not have been a success if it were not for the following individuals and institutions. I, therefore, acknowledge their contributions during this study.

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- The Department of Health, Limpopo Province, for allowing me to conduct the study.
- The district managers of the Sekhukhune, Waterberg, and Capricorn districts for allowing me to conduct the study at the clinics under their management
- All the professional nurses who participated in the study.

DEFINITION OF CONCEPTS

Clinic

According to Stevenson (2010), a clinic is an establishment where outpatients are given medical treatment or advice. In this study, a clinic is a level 1 healthcare facility with selected members of a multi-disciplinary team, including nurses, where outpatients receive medical assistance.

Professional nurse

A professional nurse is a person who has completed the three or four-year nursing study course, been granted a certificate as evidence and is registered with the nurses' statutory body (South African Nursing Council) in terms of section 31(1) and has permission to provide patient care (Nursing Act 33 of 2005). In this study, a nurse is a person with nursing qualifications and who practices at the selected public clinics of Limpopo Province.

Strategies

According to Nickols (2011), strategy is the determination of the basic long-term goals and objectives of an enterprise, the adoption of courses of action and the allocation of resources for carrying out these goals. In this study, strategy refers to the planning of actions to be taken to solve problems related to nurses' working conditions.

Working conditions

According to Ali, Ali and Adan (2013), working conditions refers to the working environment and all existing circumstance affecting labour in the workplace, including job hours, physical aspects, legal rights, responsibility and the organisational climate and workload. In this study, working conditions is the condition of the organisational environment in which nurses are performing their work and all the aspects affecting their work, selected public clinics of the Limpopo Province, South Africa.

LIST OF ABBREVIATIONS

DOH: Department of Health

EN: Enrolled Nurse

ENA: Enrolled Nurse Assistant

EU: European Union

EWP: Employee Wellness Programme

HOD: Head of Department

MEC: Member of the Executive Council

OPM: Operational Manager

SANC: South African Nursing Council

TREC: Turfloop Research Ethics Committee

USA: United State of America

ABSTRACT

In this study, the working conditions of nurses in the public clinics are assessed as the nurses are not satisfied with their working conditions. The dissatisfaction on nurses working conditions by nurses was identified and observed by the researcher at certain clinics in the Sekhukhune District. Strategies are suggested to improve nurses' working conditions in the selected public clinics of the Limpopo Province, South Africa.

The study aims to develop strategies to improve nurses' working conditions in selected public clinics of Limpopo Province, South Africa.

A qualitative exploratory and descriptive research approach, using a phenomenological design has been used. Data were collected from professional nurses from the selected public clinics, using semi-structured interviews. Data were audiotaped and field notes were taken. The eight Steps of Tesch's inductive, descriptive open coding technique, described by Creswell was used, followed by independent coding. Purposive sampling recruited 20 professional nurses from seven selected clinics in the Limpopo Province. The Turfloop Research Ethics Committee gave ethical clearance. The Department of Health gave permission for the study to be conducted in the selected clinics. Ethical considerations and measures to ensure trustworthiness have been observed.

The results show that nurses' working conditions are affected by the shortage of human and material resources, poor health clinic structures, unacceptable duty schedules, large numbers of clients which to lead to nurses' burnout. In addition, there is the challenge of the different roles played by nurses, which impede the provision of quality patients' care.

The nurses suggested that the Department of Health should be transparent regarding any information regarding issues of the health system. Furthermore, strategies to improve patients' awareness regarding the nurses' working conditions have been developed from the themes that emerge from this study. The findings of the study cannot be generalized to other clinics of the Limpopo province and of other provinces.

Keywords: strategies, working conditions

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CHAPTER 1
OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Healthy and satisfying working conditions contribute to nurses providing quality services with quality care and favourable patient outcomes. The working conditions determine the quality of care provided to the patients (Er & Sokmen, 2018). Satisfactory nurses' working conditions enable nurses to render high-quality nursing care services to the public (Lambrou, Merkouris, Middleton & Papastavrou, 2014). The above-mentioned information is supported by the aim of the Basic Conditions of Employment Act no 75 (1995), under advancing economic development and social justice, and ensuring fair labour practice.

According to the Basic Conditions of Employment Act no 75 (1997), lawful, accepted working conditions should include: adequate resources, shifts, working hours of not more than 45 hours a week or 9 hours for more than 5 working days; payment or compensation for all work done and for overtime; and an hour's meal time and different types of leaves.

The study conducted by Er et al. (2018) described the working conditions of nurses in Turkey, according to the study nurses provide direct care to patients and with a lack of resources, nurses are prone to contracting infections during their working shifts. In most cases, the working shifts of nurses involve long working hours without adequate breaks, with a heavy workload, lack of support from managers and low professional status. This results in stress and nurses leaving the nursing profession, which then results in a shortage of nurses.

Further, in the study conducted in Europe and the United States by Aiken, Sermeus, Van den Heede, Sloane, Busse, McKee, Bruyneel, Rafferty, Griffiths, Moreno-Casbas and Tishelman (2012), it is confirmed that factors associated with working conditions affect patient outcome. Such factors include positive factors such as a better staffing ratio of patient to nurses, nurse involvement in decision-making and positive nurse-doctor relations.

The study conducted at Queensland by Al Maqbali, (2015) indicates that working conditions have become a critical issue for the healthcare organisation, particularly in nursing. Al Maqbali (2015) further states that labour shortages and the associated costs result in poor working conditions. The issue of shortage of nurses is supported by Rivaz, Momennasab, Yektatalab and Ebadi (2017) who indicate that in Iran shortage of nurses results in increased workloads, unstable working conditions and medication errors.

According to Gwebe (2017), nurses' working conditions are affected by the burdens of disease, poor governance, economic issues, poor distribution of resources and political instability. Moreover, Boafo (2018) states that nurse productivity and quality of care depend on the availability of adequate nursing staff. This makes the shortage and the high turnover rates of nurses a critical issue in considering their working conditions. Boafo (2018) further states that the nurse-patient ratio is perceived to be inadequate in many countries, with sub-Saharan Africa being the worst affected region.

Job satisfaction contributes to this global shortage as it is often linked to nurses' exiting the profession. The issue of shortage is further emphasized by Tagoe and Quarshie (2016) who claim that in the African continent, especially in sub-Saharan Africa, there is a human resource crisis in health care delivery. The shortage of healthcare personnel, particularly nurses, is a result of the migration of professionals in the health sectors. This has been the case in many sub-Saharan African countries, for example, Ghana.

However, a study by Bakibinga, Forbech, Vinje and Mittelmark (2012) in sub-Saharan Africa found different nurses' responses. Even though nurses experience difficult working conditions and migrate to other countries, some nurses choose to remain in sub-Saharan Africa and serve their countries. The study further states that the stressful nursing working conditions in sub-Saharan Africa are to the result of dissatisfaction with remuneration and the workload. The study by Msuya, Blood-Siegfried, Chugulu, Kidayi, Sumaye, Machange, Mtuya and Pereira (2017) indicates that in Tanzania, nurses working in rural areas are working without physicians. This forces them to operate beyond their qualification levels.

Nurses' working conditions in South Africa are affected by increasing patient workloads, long working hours, shift work, poor infrastructure, shortage of staff and budgetary constraints (Manyisa & Aswegen, 2017). The study conducted by Haskins, Phakathi, Grant and Horwood (2014), indicates that nurses dislike the nursing profession as a result of dissatisfaction with working conditions resulting from staff shortages and poor interpersonal communication.

Furthermore, according to Mokoka, Oosthuizen and Ehler (2010), dissatisfaction with working conditions is a result of dissatisfaction with remuneration packages, lack of facilities or resources, high patient load, absenteeism, heavy workloads and unsafe working.

The living environment contributes to nurses' decisions to leave South Africa for better employment out of the country. This is supported by the study of Mcur and Mulaudzi (2015) that finds that South African nurses experience poor remuneration, leading to nurses leaving the country. As a result, there is a shortage of staff, which causes work overload that leads to poor nurses' working conditions.

The Mokoena's (2017) study shows that South African nurses' working conditions are affected by the shortage of nurses. This shortage of nurses is a result of dissatisfaction with nurses' remuneration. These results in nurses' leaving the public sector for the private sector or for other countries for better salaries. The issue of the shortage of nurses is supported by the study of Mothoa (2016) which finds that South Africa is experiencing a shortage of nurses because of increased demand for patient care. There is a continuous growth in the trend of unemployment amongst nursing graduates because of poor budget planning by the Department of Health.

In Limpopo province, a lack of resources as a factor to nurses' working conditions was identified in the study of Mokoena (2017). The results state that one hospital ran out of Tenofovir, an antiviral medicine used to treat HIV, the Province's main depot was out of stock of Lamivudine, and Stavudine, both also used in the treatment of HIV, resulting in short supplies in several health facilities. According to the study of Shihudla, Lebese and Maputle (2016) in the

Vhembe district, the shortage of nurse's increases the workload of the remaining nurses (Mbombi, Mothiba, Malema & Malatji, 2018).

An increased workload leads to patient mis-management from mistakes committed during the execution of multiple duties. Moreover, Mutshatshi, Mothiba, Mamogobo and Mbombi (2018) attest that nurses' overloaded working conditions result in poor patient documentation, such as late recording of nurses' activities and illegible, inaccurate and incomplete documentation. Nyathi's study (2016), conducted in the Greater Tzaneen Sub-District, shows evidence that job satisfaction, workload, health aspects, resources, situation factors, support service, staffing, knowledge and skills all contribute to nurses' working conditions.

Furthermore, the study of Mmamma, Mothiba and Malema (2015) identifies another contributing factor to nurses' working conditions to be staff turnover. A high staff turnover has negative financial implications with regard to recruiting new staff members and paying nurses who are working overtime to close the gap before new members are employed. Furthermore, the matter of a 24-hour service as a strategic plan for high quality patient care in the clinics of Limpopo Province is failing because of a shortage of nursing staff and resources (Nyathi, 2016).

According to Khamisa, Peltzer, Illic and Oldenburg (2017) in Gauteng Province, nurses' working conditions are most affected by long working hours, burnout, heavy workloads and low income, all of which contribute to poor patient outcomes. However, Tshitangano (2013) Limpopo Province has an even worse shortage of nurses, more than 60%, which contributes to poor nurses' working conditions. It is against this background that the current study seeks to explore and describe the experiences of nurses of their working conditions in public clinics and to develop strategies to improve the working conditions in public clinics of Limpopo Province, South Africa.

1.2 PROBLEM STATEMENT

Nursing is a profession in which nurses are expected always to be available for patients at healthcare facilities, including those in the primary healthcare sector

(kieft, Brouwer, Francke & Delnoij, 2014). The nature of the nursing profession means that nurses work in shifts to cover the 24 hours as indicated by Stimpfel, Sloane & Aiken, (2012). Therefore, the nurses' working conditions must be satisfactory for better health outcomes of community members (Wei, Sewell, Woody & Rose, 2018).

The South African nurses' working conditions are regulated by the Basic Condition of Employment Act no 75 (1997). This Act regulates leave, remuneration and working hours.

Nurses' working conditions are also regulated by different policies designed to maintain a high standard of nursing practice.

These policies regulate working shifts and the nurse-patient ratios stipulated by the South African Nursing Council (SANC), South African national core standards, and the Department of Health (Rispel, 2015). Furthermore, the provincial Department of Health is responsible for quality healthcare services within the sector and regulates the working conditions by ensuring that the hospitals and clinics implement the basic conditions of Employment Act. Thus, the department, working together with nurse managers, develops policies or guidelines that stipulate how many nurses are to report on duty, in the setting up of duty rosters.

The researcher observed that in certain clinics around the Sekhukhune district, poor working conditions remain a challenge and only one professional nurse reports for duty. This goes against the Basic Conditions of Employment.

These professional nurses are expected to work seven days a week consulting patients: acute, chronic, mother and child stream, pharmacy updates and supervision, and emergency cases, all this with limited resources. The shortage of staff and resources, coupled with disproportional nurse-patient ratios, contribute to increased workloads and the poor performance of nurses.

It is against this background that the researcher seeks to develop strategies to improve nurses' working conditions in selected public clinics of Limpopo Province, South Africa.

1.3 AIM OF THE STUDY

The study aims to develop strategies to improve nurses' working conditions in selected public clinics of Limpopo Province, South Africa.

1.4 RESEARCH QUESTION

What are the experiences of nurses with regards to working conditions in selected public clinics in Limpopo Province, South Africa?

What strategies can be developed to improve nurses' working conditions in selected public clinics in Limpopo Province, South Africa?

1.5 OBJECTIVE OF THE STUDY

The objectives of the study are to:

- Explore the experiences of nurses with regards to working conditions in selected public clinics in Limpopo Province, South Africa?
- Explore strategies to improve nurses' working conditions in selected public clinics of Limpopo Province, South Africa.
- Describe the strategies to improve nurses' working conditions in selected public clinics of Limpopo Province, South Africa.
- Develop strategies to improve nurses' working conditions in selected public clinics of Limpopo Province, South Africa.

1.6 THEORETICAL FRAMEWORK

The researcher uses Neuman's system model which, according to Shambaugh (2011), was developed for nursing education and practice. Currently, the model gives direction for the development of innovation in nursing, and healthcare in general.

Shambaugh (2011) further indicates that the model is based on the client's continuous relationship to environmental stress factors, affecting client variables causing the client to react in a way that needs prevention or intervention. The researcher uses Neuman's model to understand nurses' working conditions in order to develop strategies to improve them.

Figure1.1 Illustrates the main concepts of Neuman's model:

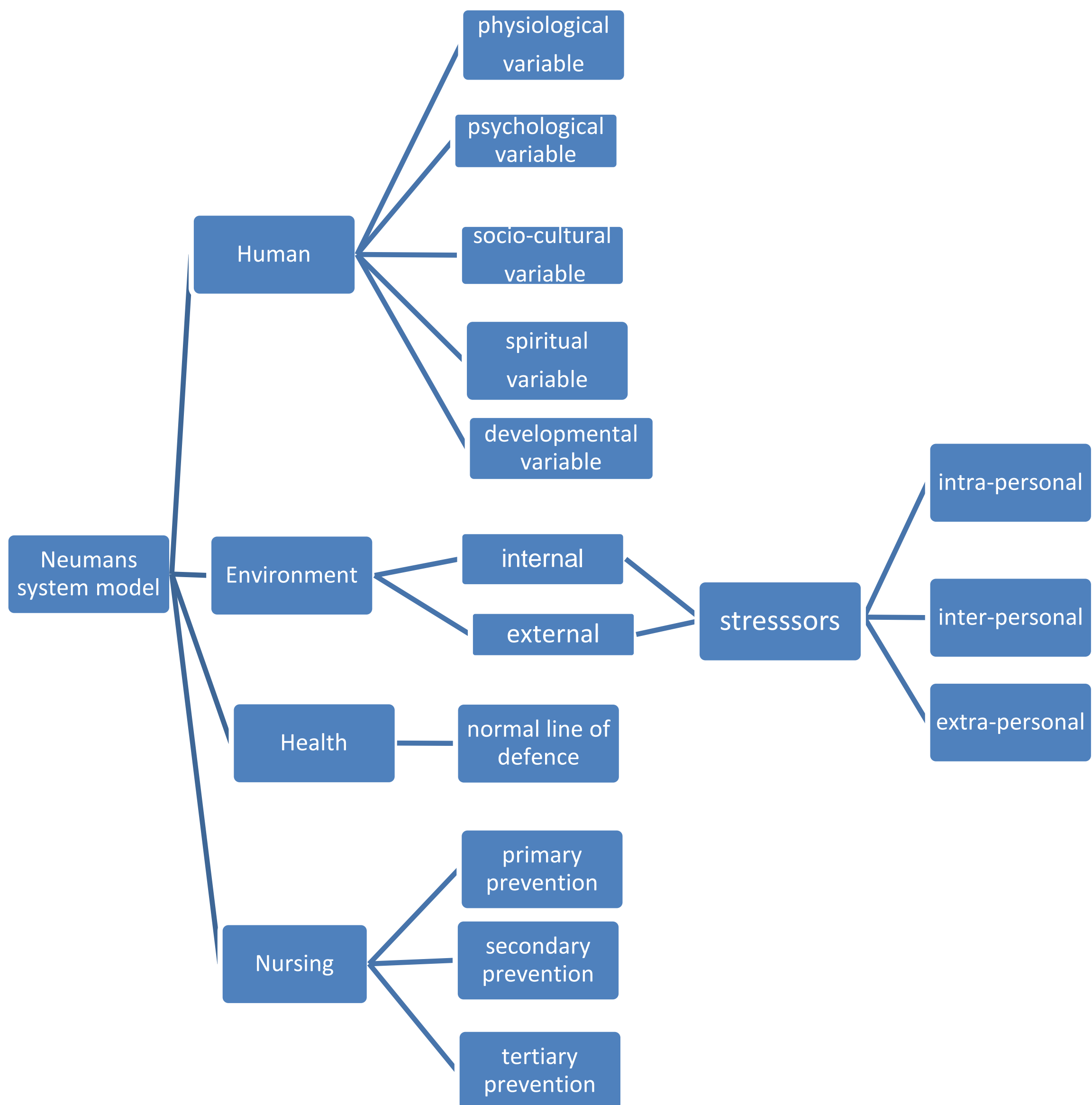

Figure 1.1: Neuman's Model

1.6.1 <u>Human</u>

According to Shambaugh (2011) human is an open system that interacts with the environment to promote harmony and balance between the internal and external environments. The primary, secondary or tertiary prevention interventions are to retain, attain and maintain optimal variables of a human. Human variables include physiological, psychological, socio-cultural, developmental and spiritual variables. In this study human refers to professional nurses from the selected public clinics that the researcher chose to participate in the study as the sample of the study.

1.6.2 Environment

According to Shambaugh (2011), the environment contains both internal and external factors or influences surrounding the identified human. The environment consists of stressors which are defined as a tension producing stimuli that have the potential to cause system instability that can have positive or negative outcome. Lines of resistance in the clients' internal and external resources are activated to combat potential or actual stressor reactions. In this study, environment is the selected public clinics of the Limpopo Province. Internal stressors are all the factors in the clinics such as working resources; staff members; and the infrastructure. External stressors are all the factors outside the clinic that are either contributing or benefiting from the clinic such as the community; district; provincial; and the national department of health.

1.6.3 Health

According to Shambaugh (2011), health represents a usual dynamic stability state of the normal line of defense. A reaction to stressors is caused as the normal line of defense is penetrated, causing illness symptoms. In this study, health refers to the anatomical and physiological complications encountered by nurses as a result of the challenges of the nurses working conditions at the selected public clinics of Limpopo Province. Such complications include: burnout, fatigue, and mental stress.

1.6.4 Nursing

According to Shambaugh (2011), nursing is about the reduction of potential or actual stressor reactions through the use of primary, secondary or tertiary prevention interventions to retain, attain and maintain an optimal wellness level. In this study, nursing refers to the processes the Department of Health needs to undergo in order to improve the nurses working conditions. Bring satisfaction to nurses and correct the complications phased by nurses in response to their working conditions.

1.6.5 Main concept of the study

<u>Human variables</u>

Newman views the individual human holistically and considers the variables simultaneously and comprehensively. There are five variables:

- The physiological variable: refers to the structure and functions of the body. The human body is made up of cells that form tissues to make organs that work together to form a system. The wellness of a human body is determined by normal functioning of the body systems (Shambaugh, 2011). In this study, physiological variables include the physical and medical wellness of nurses' bodies and their ability to carry out their roles in the clinics. Nurses develop burnout and fatigue as a result of negative impact of the working condition to nurses physiological variable.
- The psychological variable refers to mental processes and relationships. Psychological variables are based on the human mind's functioning capacity and ability: consciousness, memory, emotions, cognition and behaviour (Shambaugh, 2011). In this study, psychological variables refer to the nurses' ability to use their minds to carry out their nursing roles, which include problem solving, analyzing patients' history and come-up with diagnosis, and keeping memory of treatment.
- The socio-cultural variable refers to system functions that relate to social and cultural expectations and activities (Shambaugh, 2011). In this study, the socio-cultural variable refers to the nurses' time of interacting socially and culturally with their communities and families.
- The spiritual variable refers to the influence of spiritual beliefs, one's religion (Shambaugh, 2011). In this study, spiritual variable refers to nurses' different beliefs and religions.
- The developmental variable refers to the processes that occur in the human body and life related to growth of an individual over his or her lifespan (Shambaugh, 2011). In this study, the developmental variable refers to nurses' ability to increase their knowledge and experience as they grow older in the nursing profession.

1.6.5 Defenses

Normal line of defense

The normal line of defense is the adaptation level of health developed over time and considered normal for a particular individual client or system; it is a

standard for wellness-deviance determination. It is when all the human variables are functioning as expected and the human needs met (Shambaugh, 2011).

In this study, a normal line of defence refers to a state where nurses are able to practise their roles in the clinic without anything affecting negatively on the nurses themselves or their working conditions.

1.6.6 Stressors

A stressor is any phenomenon that might penetrate both the flexible and normal lines of defense, resulting in either a positive or a negative outcome. In this study, stressors are challenges encountered by nurses, which contribute to their working conditions.

Shambaugh (2011) identifies and describes three types of stressors as interpersonal, intra-personal, and extra-personal stressors:

- Intrapersonal stressors are stressors that occur within the client system boundary and correlate with the internal environment. In this study intrapersonal stressors are factors that are within the selected clinics and have impact on nurses. Such factors include shortage of resources; long working hours; and poor infrastructures.
- Interpersonal stressors occur outside the client system boundary, are proximal to the system, and have an impact to the system. In this study interpersonal stressors are factors such as working of long shifts as a result of poor management and supervision by the district level.
- Extra-personal stressors also occur outside the client system boundaries but are at a greater distance from the system than are interpersonal stressors. In this study extra-personal stressors are factors from the national level such as allocation of small amount of money to the provinces that does not cover needs such as hiring staff and availing sufficient medication.

1.6.7 Prevention as intervention

Shambaugh (2011) categorises prevention as primary, secondary and tertiary prevention:

- Primary prevention occurs before the system reacts to a stressor; it includes the promotion of health and the maintenance of wellness. Primary prevention focuses on strengthening lines of defense through preventing stress and reducing risk factors. In this study primary prevention refers to preventing of challenging working conditions.

- Secondary prevention occurs after the system reacts to a stressor and is used for existing symptoms. In this study secondary prevention refers to measures to correct the working condition.

- Tertiary prevention occurs after the system has been treated through secondary prevention strategies. Its purpose is to maintain wellness or to protect the client system through supporting existing strengths and continuing to preserve energy. In this study tertiary prevention is changed to measures that needs to be corrected and implemented over long term in relation to long term problematic working conditions that developed over time.

1.7 SUMMARY OF THE RESEARCH METHODOLOGY

This study uses a qualitative approach for the researcher to gain insight into the lived experience of the participants with regard to strategies to improve nurses' working conditions in selected public clinics of the Limpopo Province, South Africa. A qualitative research approach is a way to gain insight through discovering meanings of the entire context through exploring the depth, richness and complexity of the phenomenon studied (Creswell, 2014).

A qualitative exploratory and descriptive research design using a phenomenological approach was used to explore and describe the experience of nurses of their working conditions in the selected public clinics of the Limpopo Province.

The population of this study was professional nurses working in the selected public clinics of the Limpopo Province, South Africa. Non-probability, purposive homogeneous sampling was used to select 20 professional nurses from

seven selected public clinics of the Sekhukhune, Capricorn and Waterberg districts of the Limpopo Province. The reason for choosing clinics was that they are the first entry level for patients into the healthcare system and they need to be in well cared for to provide quality patient care to avoid falling short of patients' needs with their first attempt to receive help.

Semi-structured interviews were used to collect data and the 8 steps of Tesch's open coding qualitative data analysis method was used to analyse collected data, as described by Creswell (2014). The details of the methodology used in this study are discussed in chapter 3.

1.8 SIGNIFICANCE OF THE STUDY

The development of strategies to improve nurses' working condition in the public clinics of the Limpopo Province, might benefit the following structures:

- Departmental benefits
  The results of the study might raise awareness of the Department of Health about factors that contribute to the poor working conditions of nurses. The Department of Health may also be guided by the suggested strategies for the improvement of their working conditions. Such factors that need to be addressed to create satisfactory working condition for nurses will maintain the good image of the department in terms of care provided by nurses.

- Clinics' benefits
  The results of the study might help to improve the service provided by the clinics and make clinics a more satisfactory working environment for nurses.

- Nurses' benefits
  Nurses might be satisfied with their working conditions following the awareness of the Department about the challenging working conditions nurses face. The action that may be taken by the Department in response to the awareness created might improve the productivity of nurses' work in terms of patient care.

- Patients' benefits

  The study might help improve patient care provided by nurses through the strategies suggested. This is because the study discusses how nurses' working conditions affect patient care.

1.9 BIAS

Bias is an influence which yields an error in an interpretation or estimation (Polit & Beck, 2012). Bias in this study has been minimised by adherence to the research methodology of the study, using a prepared interview guide and not adding the researcher's own opinions. The researcher asked direct questions. Purposive sampling was used to select participants for the study, thus avoiding bias.

1.10 OUTLINE OF THE STUDY

Chapter 1: This chapter provides an overview of the study.

Chapter 2: This chapter focuses on the literature review.

Chapter 3: This chapter describes the methodology used in the study.

Chapter 4: This chapter presents and discusses in detail the findings of the study.

Chapter 5: This chapter discusses the strategies developed to improve nurses' working conditions

Chapter 6: This chapter summarises, makes recommendations and concludes the study.

1.11 CONCLUSION

This chapter presents an overview of the study, including its background, problem statement, the purpose of the study, research methodology and its significance.

Chapter 2 presents the literature reviewed for this study.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 introduces and gives a background to the study. This chapter reviews the relevant literature. According to Nwanzu and Mbanefo (2017), a literature review refers to the study of a "selection of available documents which contain information written from a particular standpoint."

A literature review is a synthetic review and summary of what is known and unknown regarding the topic and the existing knowledge (Maggio, Sewell & Artino, 2016). Moreover, a literature review is an account of what has been published on a topic by accredited scholars and researchers (Oetting, 2011). The literature review helps with the identification of controversy or debate and helps formulate questions that need further research (Bolderston, 2008).

Nwanzu et al. (2017) further state that literature reviews help to fulfill certain aims or express certain views on the nature of the topic and how it is to be investigated. The researcher has compiled the current literature review to accumulate already existing information from other researchers to be guided by related information. The information was retrieved from Google, Scholar and Science Direct and other sources.

2.2 DEFINITION OF WORKING CONDITIONS

According to Manyisa and van Aswegen (2017), working conditions refer to the working environment and all existing circumstances affecting labour in the workplace. According to Granero, Blanch and Ochaob (2018), working conditions may be poor resulting in malaise and dissatisfaction, as well as various aspects covered by the model of burnout, such as physical and emotional exhaustion, depersonalisation, cynicism and inefficacy. Granero et al. (2018) further indicate the other side: good working conditions present with efficacy, satisfaction, realisation, as well as dedication.

2.3 FACTORS CONTRIBUTING TO POOR WORKING CONDITIONS IN PUBLIC HEALTHCARE INSTITUTIONS

According to Khunou and Davhana-Maselesele (2016), factors contributing to nurses' poor working conditions include inadequate remuneration, lack of education opportunities, rate of HIV/AIDS, stress, turnover, unfair treatment, workplace safety, shortage of staff and shortage of resources.

2.3.1 Leaving the profession and migration

According to the UK's Nursing and Midwifery Council, there is a drop in the number of nurses in their register as nurses leave the country due to unsatisfactory nurses' working conditions caused by multiple factors, including pay. This has led to a noticeable nursing workforce crisis (Twycross, 2018). Nurse turnover and nurses quitting their jobs often result from poor working conditions in which lead to reduced work productivity, increased health-related errors, and poor quality of nursing care (Mudallal, Saleh, Al-Mudallal & Abdel-Rahman, 2017). In addition, nurse turnover is further influenced by work-related factors such as psychological exhaustion and unfair treatment (Mazurenko, Gupte & Shan, 2015).

According to a study conducted in Spain between 2010 and 2013, more nurses requested approval of their degrees so that they could work abroad. This was a result of the poor working conditions caused by low payment and nurses emigrating to other developed countries in Europe (Galbany-Estragues & Nelson, 2016). In Canada, nurses are leaving the profession due to high levels of job dissatisfaction arising from their poor working conditions, characterised by heavy workloads, limited participation in decision making and the lack of development opportunities (Purdy, Laschinger, Finegan, Kerr & Olivera, 2011). Increased nurse turnover results in decreased patient access, patient safety and the quality of care, leading to adverse patient outcomes, while increasing workload, job stress and burnout on remaining nurses (Mazurenko et al. 2015).

A study conducted in Namibia indicates that poor working conditions resulting from heavy workloads, insufficient remuneration, lack of professional autonomy, limited career development opportunities, the lack of management and challenging leadership styles also contribute to nurses' migration

(Washenya, 2018). According to Khunou et al. (2016), in South Africa nurses are leaving rural public sectors in search of more lucrative work in urban areas, private sectors and in developed countries because of their experiences of poor working conditions.

2.3.2 Shortage of resources

Shortage of medical equipment

According to the study conducted by Moyimane, Matlala and Kekana (2017) in South Africa, one of the hospitals in Mpumalanga was suffering from a shortage of medical equipment needed for the prevention, diagnosis and treatment of diseases and the rehabilitation of patients. In most facilities, it was reported that the working equipment was old and that maintenance and replacement of such equipment was a challenge, impacting negatively on service delivery and patient care. Moyimane et al. (2017) report that the shortage of medical equipment resulted from the unavailability and non-functioning of such equipment, as it was not calibrated, maintained, repaired, employees are not well trained on the use of the machines and the machines end-up being damaged. The study of Awases, Bezuidenhout and Roos (2013) supports the fact by indicating that there was not enough working equipment, while the available equipment was malfunctioning with insufficient medical supplies. This leads to a poor working environment and poor care outcomes.

Chen, Han, Hsieh, Lin and Wu (2018) reported that there is overcrowding of patients in some areas of the facilities. This results in insufficient available resources such as beds. If there is no available bed for aged clients, they sit and wait on a wheelchair even when needing a urine catheter and intravenous line. It is almost impossible to carry out these procedures in patients in a sitting position (Munedzimwe, 2018). In South Africa, there is an issue with unavailability of medicine due to frequent stock out and poor communication with stakeholders (pharmaceutical depots). It has been indicated that this has led to an increase in HIV/AIDS, which in turn has led to an increase in the demand for treatment for these patients who may also have developed TB. Gray and Manasse (2012) found other reasons for the shortage of medical supplies. These include the dependence on a limited number of manufacturers

who may run out of supplies due to increased demand, as well as the shutdown of medicine producing factories because of their failure to meet prequalification status or registration with the stringent regulatory authority.

Shortage of nurses

Manyisa et al. (2017) describe a shortage of nurses as an imbalance between a nursing staff supply and service demand. This results in service disruption, task shifting, poor clinical nursing practice, occupational injuries, increased workload and stress among the remaining nursing workforce leading to poor working conditions. According to Haddad and Toney-Butler (2018), factors contributing to the shortage of nurses include the lack of potential educators, high turnover and inequitable distribution of the workforce.

It was found that in Namibia, the shortage of nurses is due to an insufficient number of medical schools, heavy nurses' workload, job security, remuneration and the migration of nurses to developed countries (Ndikwetepo, 2018). Haddad et al. (2018) further indicate that, due to shortages, there is a high patient-to-nurse ratio that leads to nurses experiencing burnout which leads to job dissatisfaction and patients experiencing poor outcomes and high mortality rates.

The shortage of nurses is evident in many African countries as they do not adhere to the recommended nurse-to-patient ratio because of factors such as increased patient care demands, unavailability of skilled personnel, and financial constraints (Ndikwetepo, 2018). Shortages of nurses' result from the poor working conditions, poor communication and poorly resourced work places, lack of workplace safety, low morale, inadequate salaries, lack of visible nursing leadership, limited career progression and high workloads (Manyisa et al., 2017).

According to Khunou et al. (2016), in South Africa, the high shortage of nurses is an enormous barrier to achieving the goals of the National Department of Health. These are to make health care affordable, equitable and accessible to all. The shortage of nurses is a problem and even nursing agencies make no difference in correcting the shortage (Ndikwetepo, 2018). Awases et al. (2013) claim that the shortage of nurses is a constraint to delivering effective

healthcare services, especially with the huge workload that means that most nurses work beyond their scope of practice. This is a further challenge to achieving the millennium development goal of reducing diseases for many African countries. It has been found that, in Africa, a shortage of healthcare personnel including nurses has made it normal for newly qualified healthcare providers to be left alone to perform tasks that would normally be beyond their ability. This brings about the risk of misdiagnosis and wrong prescriptions, leading to medical errors (Manyisa et al., 2017).

2.3.3 Workplace violence

Banda, Mayer and Duma (2016) define workplace violence as incidents where members of staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health. According to Haddad et al. (2018), there are indications that violence in the healthcare setting plays a role in the nursing shortage, the ever-present threats of emotional or physical abuse add to a stressful environment. According to Park, Cho and Hong (2015), most nurses experience verbal abuse, followed by physical and sexual abuse, with the main perpetrators being patients, followed by physicians and patients' families. Ferri, Silvestri, Artoni and Di Lorenzo, (2016) found that workplace violence against health professionals is a global problem, with nurses frequently being assaulted. Violent incidents more frequently occur in psychiatric, emergency and geriatric wards.

However, Haddad et al. (2018) indicate that the emergency departments and psychiatric nurses are at greater risk because of the patient population and patient conditions. Haddad et al. (2018) further indicate that work colleagues of healthcare professionals are sometimes perpetrators. This is attributed to differences in professional values; psychological violence in the form of verbal abuse is the most common form of violence. A study conducted in Malawi indicates that nurses experience physical and psychological violence more than sexual abuse, wherein perpetrators are patients, patients' relatives, nurses, nurse managers and other multidisciplinary team members (Banda et al., 2016). Banda et al. (2016) further indicate that violence by patients might be due to patients' conditions such as psychological disorders, drug abuse,

confusion and head injuries, while with patients' relatives it might be due to a long waiting time or the minimum number of visitors allowed by institutional policy. Ferri et al. (2016) further indicate that patients with dementia, mental retardation, drug and substance abuse or other psychiatric disorders cause the violence at times.

2.3.4 **Nurses' remuneration**

Differences in preferences for working conditions, race, age and education often exacerbate wages differences and intensify measures of wage inequality (Maestas, Mullen, Powell, Von Wachter & Wenger, 2018). According to McHugh and Ma (2014), an unsatisfactory wage is associated with job dissatisfaction and the intent to leave the profession. Nurses' remuneration plays an important role in the satisfaction of nurses and the outcome of their work. Low salaries may lead to stealing, loss of interest, poor performance, decrease in commitment to the job and psychological effects as nurses cannot meet their financial needs (Singh & Loncar, 2010).

Bae (2013) found that British nurses are not satisfied with their salaries. As a result, nurses work overtime for extra money regardless of the physical effects. In Namibia, nurses expressed dissatisfaction with the unfair distribution of salaries. One nurse claimed she had she reached her maximum salary, which would remain the same until she went on pension more than 20 years later, unless there was an increment for all civil servants. Someone with less experience would reach the same salary within 10 years (Awases et al., 2013). There is a huge salary gap between professional nurses of South Africa and other developed countries, for example, the United State of America (Khunou et al., 2016).

2.3.5 **Absenteeism**

According to a study conducted in South Africa, family matters, lack of motivation to attend work, illness, finance, favouritism, unfriendly nurse managers, long working hours, increased workload, unsatisfactory work conditions, lack of equipment, unfair promotions, staff shortages and the lack of reward system causes nurse absenteeism (Mudaly & Nkosi, 2015). However, Kanwal, Riaz, Riaz and Safdar (2017), found that nurses are absent

from work because of illness, a heavy workload which is difficult to cope with and lack of recognition and reward. According to a study conducted in South Africa, 69% of nurse participants agreed that absenteeism was due to job dissatisfaction and that the amount of work is overwhelming because the patient-to-staff ratio was too high, while 51% agreed that insufficient working equipment was a cause (Kovane, 2015).

A study conducted in Limpopo Province by Maluleke, Thopola, and Lekhuleni (2014) indicates that repetitive tasks caused boredom, which contributed to absenteeism, as did work-related issues such as low pay, lack of incentives and job dissatisfaction, which demoralised nurses. Absenteeism aggravates poor working conditions for nurses as it affects both the nurses' psychological and professional well-being, as well as the quality of patient care provided because of the psychological stress, low morale and increased workload of nurses (Mbombi, Mothiba, Malema & Malatji, 2018). Kanwal et al. (2017) further identify the effects of absenteeism as staffing instability, work overload, job dissatisfaction, poor nursing outcomes and nurses' in effectiveness and low productivity which overall lead to poor working conditions. Absenteeism causes both physical and psychological strain. This applies particularly to the nurses who are present at work in that they are forced to hurry through meals, work extended hours and curtail their interaction with patients, to cover for the absent nurses (Maluleke et al., 2014).

2.3.6 Long working hours

Nurses work different shifts, some 8 hours and some 12 hours. Nurses working 12-hour shifts have less sleeping time which has negative physical effects (Rheaume & Mullen, 2018). They have less than 6 hours sleep which is considered unhealthy, and they respond with fatigue that results in errors that might harm patients, nurses and colleagues, (Caruso, 2014). According to Manyisa et al. (2017), long working hours have physical and cognitive effects on healthcare personnel including fatigue, stress, reduced sleep, excessive use of tobacco, drug and alcohol abuse that leads to occupational injuries and errors. Long working hours increase the risk of reduced performance on the job, while increasing obesity, injuries, fatigue and a wide range of chronic diseases (Caruso, 2014).

Moreover, a study conducted in Taiwan, indicates that long working hours cause chronic insomnia which may lead to needle stick and other sharp object injuries (Lo, Chiou, Huang & Chien, 2016). Nurses working shifts of 12 hours or more experience job dissatisfaction, an urge to leave their profession, depersonalisation and burnout; the emotional exhaustion may bring risks to the safety of patients and nurses (Dall'Ora, Griffiths, Ball, Simon & Aiken, 2015). Nurses' working long hours have significantly lowered the maintenance of patients' safety and care and led to unbalanced staffing and less effective teamwork (Wu, Fujita, Seto, Ito, Matsumoto, Huang & Hasegawa, 2013).

2.3.7 Workload

Manyisa et al. (2017) define workload as the relationship between work demands that are placed on the employee given for a specific amount of time and resources. According to Van den Oetelaar, van Stel, Van Rhenen, Stellato and Grolman (2016), a good balance between patient needs and nursing staff, because of good workload management, presents with excellent service to patients, good quality care, operational excellence and retaining employees. Nurses with the excessive patient workload and poor working environments are more likely to be burnt out and dissatisfied with their work (McHugh et al., 2014).

An increase in nurses' workloads is caused by an increase in daily patient numbers in health facilities which results in a decrease in the time spent caring for each patient; this consequently increases job stress and reduces the quality of patient care (Mudallal et al., 2017). An increase of 88% of patient admissions in hospitals was reported in South Africa. This led to stress and exhaustion among healthcare personnel (Manyisa et al., 2017). According to a study conducted in Canada, over 50% of nurses reported that they often arrived at work early or stayed late and worked through breaks to complete their work. Sixty-seven percent reported that they had too much work for one nurse (Purdy et al., 2011). Awases et al., (2013), indicate that an increase in workload due to either absenteeism or staff shortages results in unfair staffing of work schedules and this decreases the quality of care rendered.

2.3 The effect of poor working conditions on patients and staff

According to Magnago, Lisboa, Griep, Zeitoune and Tavares (2010), nursing is classified as one of the main illness and tension high-risk occupations in the health area. Nursing is a stressful job that may cause depression, isolation from patients and absenteeism. Further, the above may manifest in a form of tiredness, harsh behaviour, anxiety, increased blood pressure, lack of self-confidence and a lack of job satisfaction (Najimi, Goudarzi & Sharifirad, 2012). Kowalczuk, Krajewska-Kulak and Sobolewski (2017) concur with these findings and indicate that nurses experience a great deal of stress during work because of excessive workloads, role ambiguity and interpersonal conflict. Nurses become physically and psychologically exhausted and that reduces their quality of service leads to high job stress (Mudallal et al., 2017).

According to Mudallal et al. (2017), nurses experience burnout as a state of emotional, intellectual and physical exhaustion manifested by fatigue, job dissatisfaction, low self-esteem, poor concentration and reasoning. This may lead to emotional depletion, uncaring perceptions of their clients, negative self-evaluation and finally, quitting the job. Nurses working under poor conditions are negatively affected as they experience job dissatisfaction, work-related stress, burnout and fatigue (Ndikwetepo, 2018). Moreover, a study by Manyisa et al. (2017), reports that HIV/AIDS is another contributing factor that impacts negatively on nurses' working conditions. It is also a leading cause of death among healthcare personnel in the developing world.

Nurses working overtime are prone to experience fatigue, restlessness, inadequate sleep, pain and a deficit in performance and reaction time because of increased exposure to physical demand (Bae, 2013). Nurses experience fatigue, which increases the risk of injury, medical errors and affects their levels of concentration, their decision-making and their performance (Banakhar, 2017). Another way is which the physical and psychological health of nurses is jeopardised is that they spend more time providing direct care to patients than other healthcare professionals and they their shift work means an excessive workload and irregular working hours (Er & Sokmen, 2018). According to Manyisa et al. (2017), there is growing evidence that nurses experience hypertension, cardiovascular diseases, fatigue, stress, depression,

musculoskeletal disorders, chronic infections, diabetes mellitus and general health problems. Furthermore, Banakhar (2017) claims that, due to poor working conditions, nurses are at risk of musculoskeletal disorders, cardiovascular symptoms, hypertension, injury diabetes, as well as increased mortality and morbidity rates, and a higher rate of accidents.

Nurses experience psychological suffering when they can no longer perform their work adequately, are unable to find a balance between their psychic and physiological needs, and their work (Magnago et al., 2010). Nurses are unable to achieve satisfaction with their performance of care because of overcrowding; their concerns about client safety lead to feelings of anxiety not being able to perform the duties of a caring nurse (Chen et al., 2018).

Washenya (2018) maintains that poor working conditions cause an increase in patient mortality rates, patient morbidity, and patients' increased length of stay in the healthcare facility. According to Chen et al. (2018), situations such as the overcrowding of patients, mean that nurses work in a hurry to render service to all patients and this results in poor quality service provided and patient care is compromised. Patients in well-staffed healthcare institutions where nurse-patient ratio balances, have good patient outcomes, including full recovery, fewer readmissions, reduced acquired infections, shorter stays, and reduced patient mortality (Aiken, Ceron, Simonetti, Lake, Galiano, Garbarini, Soto, Bravo & Smith, 2018). Torres (2017) states that poor working conditions have negative outcomes like high mortality rates, increased complication rates, failure to resuscitate, poor nurse effectiveness, poor patient outcomes, medication errors and healthcare-associated infections.

In Namibia, 80% of healthcare workers are nurses, those nurses are found to be overworked, demoralised, showing signs of burnout, and they complain of no recognition of their contribution (Awases et al., 2013). While nurses experience excessive workloads and inadequate staffing, less is known about other workplace factors such as access to resources, support, information, and opportunities for development, and their effect on quality (Purdy et al., 2011). Nurses' statements indicate that there is little that nurses can do to change their

working conditions as the conditions are constructed and reproduced at many levels (Chen et al., 2018).

In a study conducted in South Africa by Manyisa et al. (2017), a nurse indicated that most South African patients are AIDS patients and come to the hospital when critically ill. Caring for terminally ill patients places additional burdens on an already overburdened and emotionally exhausted workforce. Patient safety is affected negatively by the nurses' mental and physical health resulting from the poor working conditions of nurses (Kowalczuk et al., 2017). Due to the poor working conditions experienced by nurses, patients receive substandard patient care, resulting in the risk of medical errors (Mbombi et al., 2018). Maluleke et al. (2014) report that patients do not receive the best care they deserve, especially the helpless ones who are dependent on nurses. This may result in long hospitalisation and increased mortality among patients.

2.4 CONCLUSION

Chapter 2 presents a review of the literature that helped the researcher gain insight into the findings of other researchers on nurses' working conditions. The literature reviewed indicates that nurses' working conditions may be good or poor and that factors contributing to poor working conditions include shortages of nurses and medical equipment, workplace violence, absenteeism, nurses' remuneration, workload and long working hours. These may result in nurses' leaving the profession or emigrating. Poor working conditions affect both nurses and patients negatively, causing physical and psychological disorders in nurses and poor recovery and increased mortality in patients.

Chapter 3 focuses on the research methodology chosen for the study.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 2 reviews the literature relevant to this study. This chapter describes the methodology used to carry out the research study. According to Brink et al. (2012), research methodology includes a series of steps and procedures that the intended research study undertakes to meet the objectives of the study.

The headings discussed in this chapter are research method, research design, sampling, data collection, analysis, and the ethical considerations the study.

3.2 STUDY SETTING

The study setting is the physical location and conditions where data collections take place (Brink et al., 2012). This study was conducted at selected public clinics of Limpopo Province, South Africa. Limpopo Province is comprised of five districts namely: Vhembe, Mopani, Capricorn, Sekhukhune, and Waterberg.

This study was conducted in the three districts of Sekhukhune, Capricorn and Waterberg.

Seven clinics were selected from the three districts, as illustrated in Table 3.2. The reason for choosing these clinics is that they are the first entry level for patients into the healthcare system and the clinic needs to be in a good condition. The researcher chose to visit different clinics from different districts to acquire a broad information and not a centralized information. On the seventh clinic the researcher received the same information from the participants, data saturation was reached and the researcher stopped with the interviews. Figure 3.1, illustrates the Limpopo map and indicating the seven selected clinics used in the study:

Figure 3.1: Limpopo Province map showing districts and the selected clinics

Table 3.1 below is the health structure of the Limpopo Province, showing districts, population, public and private health facilities. An illustration of Limpopo Province Department of Health organogram.

Table 3.1: Health structure of Limpopo Province

Districts	Population	Private Facilities	Spec-ialised Hospitals	Fixed clinics	Comm-unity Health-care Centers	District hospitals	Regional hospitals	Tertiary hospital
Vhembe District	1294722	02	01 Psychiatric	116	08	06	01	00
Capricorn District	261463	05	01 Psychiatric	96	04	06	00	02
Mopani District	1092507	02	01 Psychiatric	95	08	06	01	00
Sekhukhune District	1076840	01	00	84	03	05	02	00
Waterberg District	679336	05	00	61	02	07	01	00

Below is the Limpopo department of health organogram. At the top is the MEC who implement national and provincial laws; developing and implementing provincial policies which guides the healthcare system in the province. Followed by the Head of Department; Chief Financial Officer; Chief Directors; Deputy Director Generals; chief directors; Departmental Spokesperson; Nursing Director; District Manager; Local Area Manager; and Professional Nurses.

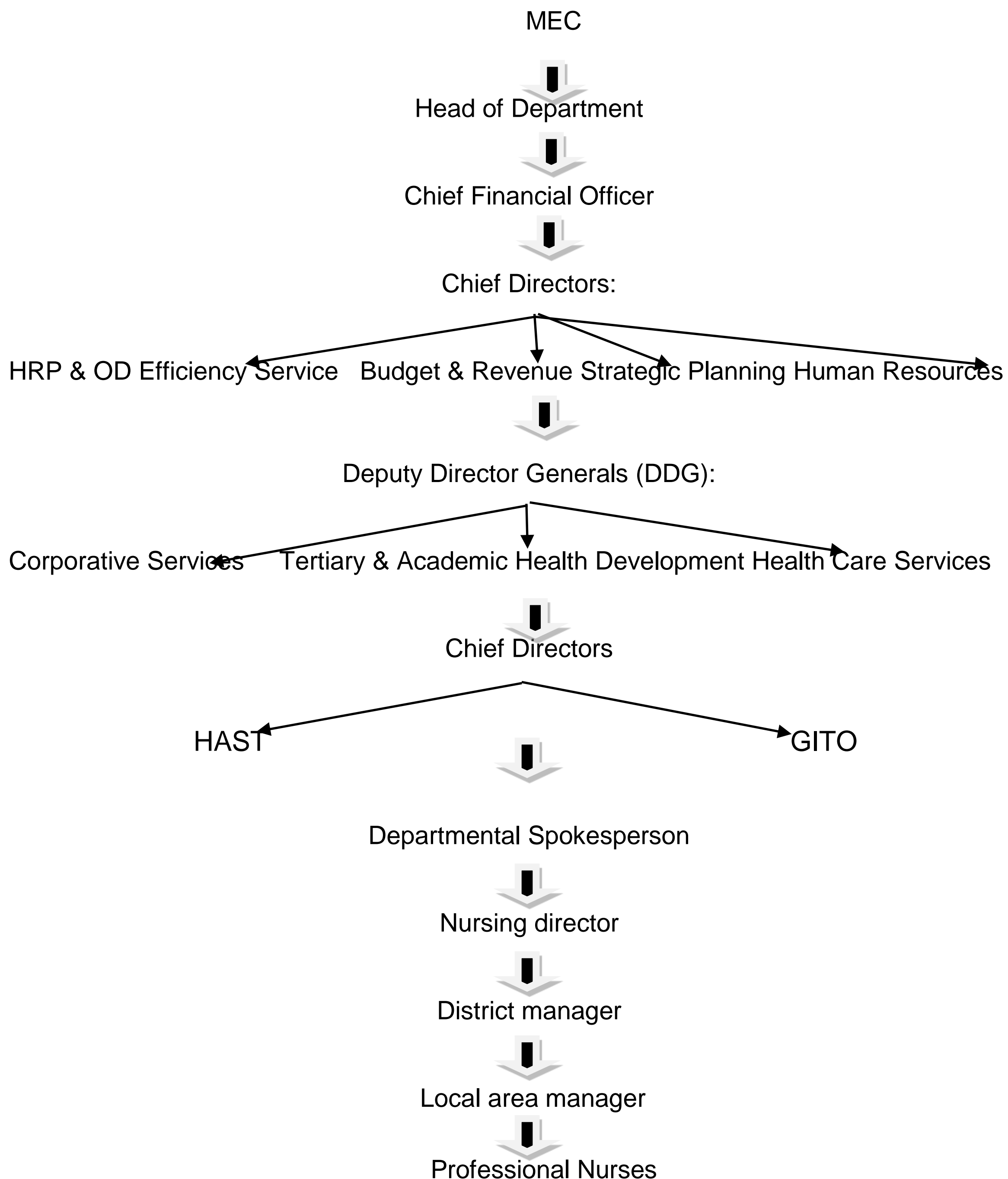

Figure 3.2: Limpopo Province organogram

3.3 RESEARCH APPROACH AND METHOD

Research methodology refers to the steps, procedures, and strategies used to gather and analyse information in a systematic fashion (Polit et al., 2012). The researcher has used a qualitative approach, which, according to Brink et al., (2012), refers to a broad range of research designs and methods used to study the phenomenon of social actions to gain insight into and information about the lived experience of the participants. This research approach was used to obtain in-depth details about the awareness of the nurses' working conditions and to explore strategies to improve those (Austin & Sutton, 2014).

A semi-structured, one-on-one interview was used to gather in-depth information and understanding of the phenomena of the study (DeJonckheere & Vaughn, 2019). This approach creates openness and encourages participants to expand on their responses about strategies to improve nurses' working conditions at the selected public clinics of the Limpopo Province, South Africa (Stuckey, 2013).

3.3.1 Research design

Research design is the overall plan for addressing a research question, including the specifications for enhancing the study's integrity (Polit & Beck, 2010). A qualitative exploratory and descriptive research design, using a phenomenological approach, has been used in this study. According to Brink et al. (2012) qualitative approach refers to a broad range of research designs and methods used to study phenomenon of social actions.

- Phenomenological design

  Creswell (2014) describes a phenomenological design as a design that reflects the meaning of the lived experiences of a phenomenon. This study uses this phenomenological design to develop strategies to improve patient awareness of their rights (Creswell, 2014). This design was chosen because the researcher aims to explore and describe the nurses' working conditions in public clinics of Limpopo Province, South Africa.

- Explorative design

According to (Brink et al., 2012) an exploratory design is the design used when little is known about the phenomenon. The explorative design was used to explore the experiences of professional nurses with regard to the working conditions at the selected public clinics of the Limpopo Province.

- Descriptive design

  Descriptive design is a design aims to describe the distribution of one or more variables without regard to any casual or other hypothesis (Aggarwal & Ranganathan, 2019). In this study, a descriptive design has been used to describe the day-to-day experiences of professional nurses of the selected clinics of the Limpopo Province.

3.3.2 Population

According to Brink et al. (2012), population is the entire group of persons that is of interest to the researcher. The population of the study comprised all professional nurses working in the selected public clinics of the Sekhukhune, Waterberg and Capricorn districts of Limpopo Province, South Africa.

3.3.3 Sampling

Sampling refers to the researcher's process of selecting the sample from a population to study a phenomenon in a way that represents the population of interest (Brink et al., 2012). Non-probability, purposive homogeneous sampling was used to recruit 20 professional nurses from seven selected public clinics. According to Etikan, Musa and Alkassim (2016), purposive sampling is the deliberate choice of a participant because of qualities the participant possesses.

Professional nurses were chosen, as they are knowledgeable about the phenomenon under investigation and could provide information about their working conditions. The sample size was determined using data saturation.

Data saturation is when there is enough information to replicate the study, when the ability to obtain additional new information has been attained, and when further coding is no longer feasible (Fusch & Ness, 2015). The researcher interviewed nurses of different clinics until the participants gave the researcher

the same information and the researcher reached data saturation and stopped with the interviews.

3.3.3.1 Recruitment strategy

The researcher visited each of the selected public clinics and introduced herself to the operational manager, explained that she needs to conduct a research study at the selected clinics. The researcher explained the topic of the study, the aim and the objective of the study. Also mentioned the benefits of the results that they will be submitted to the DOH for intervention. The operational manager then informed the staff, while at some other clinics the researcher was given an opportunity to explain to the available nurses and the operational manager later explained to the nurses who were absent.

Table 3.2 illustrates the seven clinics selected and the number of professional nurses per clinic.

Table 3.2: Demographic data of the participants

District	Selected clinics	Number of participants
Capricorn	Moretse-Thamagane clinic	3
	Mankweng clinic	3
Sekhukhune	Mashabela clinic	2
	Mphanama clinic	4
	Probeering clinic	2
Waterberg	Sterkwater clinic	3
	Lekhureng clinic	3

3.3.4 Ethical issues related to sampling

The researcher to ensure ethical conduct related to sampling used the principle of justice; the researcher was guided by the fundamental ethical principle of justice throughout the research process. The “principle of justice” refers to the participants’ right to fair selection and treatment (Brink et al., 2012). It is determined in terms of fairness and equality.

This principle is based on the human rights that need to be protected in research, namely: the right fair treatment (Brink et al., 2012).

All participants were selected fairly and were treated according to the following discussion:

- Selection of the study population
  The researcher chose the study population from professional nurses working in the selected public clinics of the Limpopo Province, South Africa, to obtain quality information related to the problem, i.e. nurses' experience of their working conditions. The study population was not chosen because they were readily available, but because of their lived experience and knowledge of the phenomenon. Inclusion criteria were used when sampling was carried out as follows: all professional nurses working in the selected public clinics of three districts of Limpopo province who were willing or able to participate.

- Justice
  All participants were treated in the same way, irrespective of their status and other factors like age, race, and gender. Interviews were conducted in each of the participants' language of preference. The researcher, after the introduction, gave participants the option to participate or not in the research study. Each interview session lasted between 15 and 30 minutes. All participants could withdraw at any time during the interview sessions. All participants were asked the same central question.

3.3.5 Inclusion criteria

All professional nurses working at the selected public clinics of the Limpopo Province, South Africa, who were willing or able to participate, were included in the study to ensure voluntary participation.

3.3.6 Exclusion criteria

All professional nurses working in the selected public clinics of the Limpopo Province, South Africa, who were not willing or able to participate, were

excluded from the study. Newly qualified professional nurses were excluded, as they had not experienced the working conditions of the clinics. Professional nurses with less than one year working in the clinics were excluded, as they had not experienced the working conditions of the clinics.

3.4 DATA COLLECTION

The purpose of data collection is to obtain information, to keep on records, to make decisions about important issues and to pass that information to others (Pilot et al., 2012).

3.4.1 Development and characteristics of the data collection instruments

Data collection instruments, according to Polit et al. (2012), refer to the formal written document used to collect and record information, such as questionnaires, but when unstructured methods are used, there is typically no formal instrument. The researcher used semi-structured interviews with a central question accompanied by probing questions.

Semi-structured interviews were used because questions could be prepared before the interview sessions, and they allowed the researcher to seek clarity by probing (DeJonckheere et al., 2019). This allows the interviewer to prepare for the interviews and to appear competent during the interview. Semi-structured interviews also allow participants to express their views in their own terms, thus encouraging two-way communication (Creswell, 2014).

3.4.2 Pilot study

According to Janghorban (2014), a pilot study refers to a small-scale of the complete survey or a pre-test for a particular instrument, such as an interview guide. A pilot study asks whether the survey can be done, whether the interviewer should proceed with it, and if so, how (In, 2017). The researcher conducted a pilot study to identify possible errors that might occur during the data collection process.

The researcher conducted the pilot study at Vlakplaats clinic in the Sekhukhune district and Makanye clinic in the Capricorn district. Two professional nurses from each clinic were interviewed. Participants of the pilot study and their

results were excluded from the sample and findings of the main research study. The researcher reviewed the results of the pilot study and identified the need to add another question and adjustment of when and how to interview participants, outcomes are discussed below.

The outcomes of the pilot study were the following:

- The researcher found the need to add a question for the professional nurses to suggest strategies to improve nurses' working conditions. The added question was as follows: "B*ased on your challenges, what do you think the district, provincial and national level can do to solve the challenges*?"

- Most participants preferred dates when they were off duty and chose to conduct the interviews telephonically rather than face-to-face.

3.4.3 Data collection process

The data collection process consisted of the following three phases:

The preparatory phase, interview phase, data saturation and post-interview phase.

- <u>Preparatory phase</u>

  The researcher received approval to conduct the study from Turfloop Research Ethics Committee (Annexure A), Limpopo Province Department of Health (Annexure D), district managers of the three selected districts (Annexures E, F and G), and the managers of the selected clinics (Annexures H, I, J and K). The managers informed the professional nurses about the research and arranged the date, time and place for the interviews. The managers then informed the researcher about the arrangements.

  Informed consent forms for those who chose telephonic interviews were left with managers and the researcher arranged a time to collect the forms. Nurses who were off duty were called and arrangements were made with them.

The researcher discussed the purpose of the study, gave a summary of the study and asked for their permission from those who were willing to participate. Each participant was given an opportunity to choose their language of preference between: Sepedi, IsiZulu, IsiNdebele, Venda, English, and Tsonga to be used for communication between the researcher and participant (DeJonckheere et al., 2019).

Participants were given informed consent forms, which the researcher explained to them before they consented to participate in the study (Nijhawan, Janodia, Muddukrishna, Bhat, Bairy, Udupa & Musmade, 2013).

The researcher had a notebook, pen, audio recorder, with extra batteries, and a charger as resources required for data recording during the interview sessions.

- Interview phase

Interviews conducted at the clinics were conducted in a prepared room, free from distractions such as noise; the prepared rooms differed from clinic to clinic (DeJonckheere et al., 2019). The provided room was within the selected clinic. Interviews were only conducted with professional nurses who had signed the consent forms. The interviews were conducted using semi-structured, one-on-one interviews; some were face-to-face and some were telephonic (Cachia & Millward, 2011). Interview sessions took 15 to 30 minutes.

Participants were asked the same central question, which guided the research: ***"What is your experience of the working conditions in your clinic with regard to resources*?"** This was followed by seven sub-questions. Following the central question, the researcher asked the prepared probing questions as indicated on the interview guide (Annexure C) (Bolderston, 2012).

The researcher asked probing questions to get more detailed information from the participants (Polit et al., 2012). By following the probing questions of the interview guide, the researcher was able to get useful and extra

information about the participants' experience of their working conditions (DeJonckheere et al., 2019).

The researcher used non-verbal communication such as nodding the head to encourage participants to be free and open. Skills such as clarification, reflection, paraphrasing, maintaining eye contact and summarising were used during the interview to ensure the capturing of quality information (Bolderston, 2012). In addition, the researcher used open-ended questions to allow probing for better understanding, to avoid a limitation of explanations of the response, and to allow exploration of the answers (Mears, 2012).

The researcher introduced herself and discussed the purpose and the nature of the study and explained the research question and what the expectations of the participants were (Morgan & Bhugra, 2010). It was explained to the participants that their participation was voluntary and that signing the informed consent form indicated their agreement. All those participating in the research signed the form (Appendix R) (Nijhawan et al., 2013).

Participants were also told of their right to withdraw from the study at any time if they wanted to do so. The participants were informed of the use of the voice recorder and the writing of the notes during interviews (Bolderston, 2012). The introduction and explanation created a welcoming, relaxed and supportive atmosphere (Morgan et al., 2010). After the participants had given consent in writing, the interview session began, with the information being recorded and notes written.

Field notes of what the researcher experienced, heard and saw were made during the interview, using a reflective journal for the researcher to capture the non-verbal behaviour posture of participants, such as eye contact, sobbing, teary and other facial expressions (Bolderston, 2012). The researcher created a secret access code to the voice recorder, known by the researcher and supervisor only. This was to ensure that no one not involved in the study could access the data.

The same procedure was followed for participants who opted for telephonic interviews. The only difference was that the researcher asked them to select an area for the interview that would be, free from distraction. They all complied with this request. Participants opted to use English as their language of choice to be used throughout the interview. Therefore, no language translation was done.

- Post-interview phase

  At the end of every interview, the researcher summarised and reflected on the interview and allowed the participants to correct and/or clarify any information (DeJonckheere et al., 2019). This was to ensure that she had understood them correctly. All participants were thanked by the researcher for their time and participation. The participants were informed of the possibility of further contact with should the need for clarity arise.

  Data was collected over a period of one week in the selected public clinics of the Limpopo Province, South Africa. The period of data collection was because most nurses chose to conduct the interviews telephonically with no restriction on the length of the calls. This allowed the researcher to conduct about 5 to 7 interviews per day.

3.5 DATA ANALYSIS

Data analysis is the systematic organisation and synthesis of research data. Qualitative data analysis is the organisation and interpretation of narrative data to discover important underlying themes, categories and patterns of relationships (Polit & Beck, 2010).

Basic steps of data analysis include preparing the data, reading and reflection, coding, categorising and developing themes (Ravindran, 2019). The Steps of Tesch's inductive, descriptive open-coding technique (Creswell, 2014) was used.

The steps are outlined below:

- Step 1 – Reading through the data

The researcher got a whole sense of the responses by reading all the verbatim transcripts carefully. This gave ideas about the data segments and how they should look. The meanings that emerged during reading were written down, as were all ideas as they came to mind. The researcher carefully and repeatedly read all the transcripts of all the participants until she had a clear understanding of them understood them. An uninterrupted period to digest and think about the data in totality was created. The researcher engaged in data analysis and wrote notes and impressions as they came to mind.

- Step 2 – Reduction of the collected data
  The researcher scaled-down the data collected to codes based on the existence or frequency of concepts used in the verbatim transcriptions. She then listed all the topics that emerged during the scaling down and grouped similar topics; those that did not have association were clustered separately. Notes were written in the margins and the researcher started recording thoughts about the data in the margins of the verbatim transcripts.

- Step 3 – Asking questions about the meaning of the collected data
  The researcher read the transcriptions again and analysed them. This time she asked herself questions about the interviews, based on the codes, which existed from the frequency of the concepts. The questions were: “Which words describe it?”, “What is this about?” and “What is the underlying meaning?”

- Step 4 – Abbreviation of topics to codes
  The researcher started to abbreviate the topics that had emerged as codes. These codes needed to be written next to the appropriate segments of the transcript. The codes were differentiated by including all meaningful instances of a specific code’s data. All the codes were noted in the margins against the data they represented – each in a different pen colour from the one used in Step 3.

- Step 5 – Development of themes and sub-themes

  The researcher developed themes and sub-themes from coded data and the associated texts and reduced the total list by grouping topics that related to one another to create meaning of the themes and sub-themes.

- Step 6 – Compare the codes, topics, and themes for duplication

  In this step, the researcher reworked from the beginning to check the work for duplication and to refine codes, topics and themes where necessary. Using the list of all codes, she checked for duplication. She then grouped similar codes and recoded others that were necessary to fit in the description.

- Step 7 – Initial grouping of all themes and sub-themes

  The data belonging to each theme were assembled in one column and preliminary analysis was performed. A meeting followed this between the researcher and co-coder to reach consensus on the themes and sub-themes that each one had come up with independently.

3.6 METHODS TO ENSURE TRUSTWORTHINESS

Polit and Beck (2010) describe trustworthiness as the degree of confidence that qualitative researchers have in their data. In the current study, this was ensured through the use of Guba's model criteria (Creswell, 2014).

3.6.1 Credibility

Credibility refers to the truth of the data and the researcher's interpretation and representation of them (Polit et al., 2012). This was established through prolonged engagement where the researchers remained in the field until data saturation was reached. In this way, the researchers gained an in-depth understanding of the phenomenon, as well as of specific aspects of the participants, such as their perceptions or views and experiences. It also built the trust and rapport between the researcher and participants needed for the gathering of rich data (Brink et al., 2012). The credibility of the findings was

ensured through triangulation, member checking and peer debriefing (Liao, 2015).

Triangulation is a search for converging evidence from multiple data sources, methods, theories and investigators (Liao, 2015). Triangulation strategy helps to compensate for weaknesses of one method or technique of data collection with an alternative strategy (Cohen, Manion & Morrison, 2011). In this study, the researcher used triangulation of sources and compares information.

A member checking strategy is a method of returning an interview or analysed data to the participant (Liao, 2015). Research participants were actively involved in checking and confirming the results to reduce the potential of research bias. Member checking was also used to validate, verify and assess the trustworthiness of the qualitative results of the study (Cohen et al., 2011).

The interpretation of the results acquainting the participants with the analysed and interpreted data for them to evaluate the interpretations made by the researcher and to allow changes if they were not happy with the interpretations or did not feel that they accurately reflected what they had said.

Peer debriefing is engaging professional colleagues in analytic discussion and data interpretation (Liao, 2015). In this study, the researcher submitted the study to the supervisor who gave feedback on corrections and made suggestions. The goal is not to reach an agreement between the researcher and debriefer but to challenge the research assumption and be alert to researcher bias (Liao, 2015).

3.6.2 **Transferability**

Transferability is the extent to which qualitative findings can be transferred to other settings or groups (Polit et al., 2012). In this study, this was ensured through detailed descriptions of data within the given context that were provided, purposive sampling maximised information about context by purposefully selecting the participants. Data saturation occurred when additional participants provided no new information and when themes that emerged become repetitive (Faulkner & Trotter, 2017).

3.6.3 Confirmability

Confirmability refers to the objectivity or neutrality of data and the interpretations (Polit & Beck, 2010). In this study, confirmability was ensured by a confirmability audit where the researcher verified data against recorded responses and checked the findings of the study. Confirmability was also ensured by the writing of field notes, the use of a voice recorder during interviews and by submitting the research study for evaluation. Two qualitative researchers from the University of Limpopo who have access to both the audio recordings and the field notes supervised this research.

3.6.4 Dependability

Dependability refers to the provision of evidence that if the research were to be repeated with the same or similar participants in the same or similar context, its findings would be similar (Brink et al., 2012). It refers to the extent to which the study was consistent in its enquiry process, which included the techniques used in data collection, findings of the study, interpretations, and recommendations of the study (Polit & Beck, 2012). In the current study, code record data was analysed by the researcher and the independent co-coder with at least one- or two-week's period between each coding (Polit et al., 2012).

3.6.5 Reflexivity

According to Haynes (2012) reflexivity is an awareness of the researcher's role in the practice of research and the way this is influenced by the object of the research, enabling the researcher to acknowledge the way in which he or she affects both the research process and outcomes. When the researcher's biases cause him or her to unconsciously influence participants, this result in contaminating both the process and the outcome; and the more rigorously this influence is minimized or isolated, the better the study (Probst, 2015). In this study the researcher was involved in the entire process of research study at different stages of designs, interview, transcription, analysis, and the interpretation of the results as the primary researcher and this helped to identify personal perspectives, biases, and suppositions.

3.6.6 Bracketing

Bracketing is a method used in qualitative research to mitigate the potentially deleterious effect of preconceptions that may taint the research process (Tufford & Newman, 2012). In descriptive phenomenology bracketing entails researchers setting aside their pre-understanding and acting non judgementally (Sorsa, Kiikkala & Astedt-Kurki, 2015). According to Peters and Halcomb (2015) bracketing is not possible without reflexivity as the researcher requires an awareness of what particular pre-conceptions need to be bracketed to prevent their undue influence. Furthermore, the phenomenological design attempts to prevent bias and assumptions of human feelings and experiences of a particular situation (Brink et al., 2012). The researcher ensured bracketing by the use of audio recorder and writing notes throughout data collection and analyse the notes as a means of examining the researchers' engagement with the data.

3.7 ETHICAL CONSIDERATIONS

3.7.1 Permission

Ethical clearance was obtained from the University of Limpopo, TREC, and researcher project number of TREC/79/2019: PG. Permission to conduct the study was obtained from the Limpopo Province Department of Health, three selected districts of Limpopo Province as well as from the selected public clinics where the study was conducted.

3.7.2 Informed consent

Informed consent is an ethical and legal requirement for research involving human participants (Nijhawan et al., 2013). Information about the study including its aim and objectives was given to the participants before their giving consent to ensure their voluntary willingness to participate (Manti & Licari, 2018). Participants were informed that they could withdraw from the study at any time (Melham, Moraia, Mitchell, Morrison, Taere & Kaye, 2014). Written consent was obtained from each participant.

3.7.3 Principle of confidentiality and privacy

Confidentiality refers to respecting and protecting someone else's information (Brennan, 2010). The researcher asked for the participants' permission to use a voice recorder during the interview sessions. The voice recorder used to capture data had a code known only by researcher and her supervisor; the information was not made available or divulged to anyone to maintain confidentiality (Parker, 2011).

Information obtained from participants was not shared with anyone and the names of participants were not mentioned in the interview process of collecting data. Privacy refers to an individual's interest in controlling access to his/her information. (Resnik, 2010). In this study, privacy was ensured by not forcing participants to respond to questions that they were not comfortable to answer.

Privacy was also ensured by conducting the interviews in a closed room, where only one participant was allowed into the interview room at a time during the process of data collection to ensure privacy (Parker, 2011).

3.7.4 Principle of anonymity

Anonymity is when the subject's identity cannot be linked to personal responses (Fouka & Mantzorou, 2011). Anonymity was ensured by using numbers instead of participants' names. Participants' names were not mentioned, written or recorded during the interview sessions to ensure anonymity.

3.7.5 Principle of autonomy

Autonomy means having the capacity to self-govern, i.e. the ability to act independently, responsibly and with conviction (Motloba, 2018). In this study, the participants had the right to ask questions, refuse to give information or to withdraw from the study at any time without the risk of any prejudicial treatment or penalty (Polit & Beck, 2010).

3.7.6 Principle of beneficence

The principle of beneficence refers to the Hippocratic injunction to "be of benefit, do no harm". It includes the professional mandate to carry out effective and significant research to better serve and promote the welfare of the constituents (Fouka et al., 2011).

Participants were not subjected to unnecessary risks of harm or discomfort. Involvement in this study did not place participants at a disadvantage or expose them to situations for which they were not prepared.

The information provided by participants will not be used against them in any way.

3.7.7 Principle of non-maleficence

The principle of non-maleficence refers to an obligation not to inflict harm on others (Jahn, 2011). In this study, there was no physical contact between researcher and participants which might cause harm and the interview guide consists of no offensive language.

3.7.8 Principle of justice

Justice means participants' right to fair and equal treatment (Owonikoko, 2013). In the study, justice was ensured by giving the participants the same information about the study, the same consent form and none of the participants was treated according to their status in life, they were all treated in the same way.

The researcher treated people who declined to participate in the study or to withdraw from it in a non-prejudicial manner.

3.8 CONCLUSION

Chapter 3 discusses in detail the research methodology used in this study, indicating the steps for the researcher to follow to carry out the study (Brink et al., 2012). The research methodology used includes a qualitative approach with a phenomenological design.

The population of all professional nurses was considered with a sampling of 20 professional nurses from seven selected public clinics from three districts of Limpopo Province; non-probability purposive sampling was used and data were collected using a semi-structured interview, Tesch's method was used to analyse the data, and the principles to ensure ethical considerations are discussed. Guba's model criteria is described and used to ensure trustworthiness (Creswell, 2014).

The following chapter discusses the results and findings of the study, using the currently described methodology.

CHAPTER 4

RESEARCH FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION

The previous chapter discusses the research methodology. The main objective of this chapter is to provide critical reasoning and to present the results to provide a foundation to the way participants view strategies to improve nurses' working conditions in the selected public clinics of Limpopo Province, South Africa. The findings are discussed in conjunction with the literature control that reinforces the study results.

4.2 DATA MANAGEMENT AND ANALYSIS

The data, which were collected during the individual, semi-structured, in-depth interviews, were analysed using the eight steps of Tesch's open coding qualitative data analysis method as described by Creswell (2014), and as outlined in the research methodology chapter. Data were also submitted to an independent coder who also used eight steps of Tesch's open coding method of qualitative data analysis. A consensus meeting was held between the researcher and the independent coder to discuss and agree on the final themes and sub-themes, based on those that emerged when analysing independently.

4.3 RESULTS AND DISCUSSION OF FINDINGS

The professional nurses in the study had general nursing experience and a comprehensive four-year course and they were aged between 25 and 55; five professional nurses had post-graduate qualifications and there were 4 males and 16 females. The findings are presented in a narrative format after the descriptions of the findings are presented. Verbatim excerpts of the participants' responses are presented and relevant literature to support the findings is described. The findings of this study are discussed, based on the themes and the sub-themes that emerged during the data analysis of the individual semi-structured interviews conducted with the participants.

Table 4.1 depicts the final themes and sub-themes agreed upon by the researcher and independent coder.

Table 4.1: Themes and sub-themes reflecting the working conditions of nurses providing care in selected public clinics of Limpopo Province, South Africa

Themes	Sub-themes
Theme 1 **Differences between nurses' experiences related to their working conditions**	**Sub-theme 1.1** Lack of resources during provision of care, which causing suffering at multiple levels for both patients and nurses.
	Sub-theme 1.2 Challenges with lack of staff related to provision of quality patient care
	Sub-theme 1.3 Problems with relation to health clinics structures which impede the provision of quality patient care
	Sub-theme 1.4 Patients care concerns related to insufficient clinic structures
	Sub-theme 1.5 Burnout related to clinics catering to large geographical areas which leads to large numbers of people served
	Sub-theme 1.6 Acceptable versus unacceptable duty schedules common to all clinics

Theme 2 **Nurses working outside their scope of practice during the provision of patient care in the clinics**	**Sub-theme 2.1** Execution of pharmacists' roles related to ordering and control of medication by clinic nurses
	Sub-theme 2.2 Execution of data capturers and clerks' role over weekends by clinic nurses
Theme 3 **Poor health care provided to patients related to challenges experienced by clinic nurses**	**Sub-theme 3.1** Shortage of resources which affects the provision of quality patient care, leading to defaulting treatment
	Sub-theme 3.2 Earning too low salaries for the services provided
	Sub-theme 3.3 Physical, emotional and mental stress related to providing services in the clinics
	Sub-theme 3.4 Fear of lawsuit related to poor provision of quality care by the community against nurses
	Sub-theme 3.5 Misdiagnosis of patients related to lack of material resources
	Sub-theme 3.6 Affected provision of care related to shortage of nurses, for various reasons

Theme 4 **Suggestions for how marked challenges could be resolved**	**Sub-theme 4.1** An increased budget should be requested to extend the clinics' buildings to create more space
	Sub-theme 4.2 A suggestion that salaries be increased to compensate for the increased workloads experienced by clinic nurses
	Sub-theme 4.3 Existing duty schedules should be discussed to come up with better options
	Sub-theme 4.4 A suggestion that the Department of Health needs to improve all resources they provide to clinics
	Sub-theme 4.5 A suggestion that there is a need for the Department of Health to raise awareness to communities about challenges the department experience

4.4 OVERVIEW OF RESEARCH FINDINGS

The results and findings regarding nurses working conditions are discussed below according to the themes and sub-themes indicated in the above table

4.4.1 Theme 1: Differences between nurses' experiences related to their working conditions.

The findings of the current study indicate that professional nurses experience different working conditions in the different clinics. The poor working conditions relate to a lack of resources, inadequate staff, infrastructural problems, unacceptable duty schedules, too heavy workloads that leads to burnout. The sub-themes below provide a detailed explanation of the theme.

- Sub-theme 1.1: Lack of resources during the provision of care causing suffering at multiple levels of both patients and nurses

  The findings indicate that there is a lack of resources such as suction machines, treatment and generators that prevents the provision of quality patient care.

  The findings were confirmed by the participants who said:

  "We do not have a generator that is also a need during an emergency if electricity run off." (P8)

  "We do not have treatment. When a teenager comes for family planning, we do not have contraceptives." (P14).

  "In case of maternity we don't have CTG machine, we don't have suctioning machines that are working properly and most of the time we do not have oxygen like our cylinders are not refilled on time, and with the paperwork we run out of the papers, files, the toners." (P2)

  "We do not have a pharmacy assistant, lay counsellor, and a data capture." (P5)

  "We do not have height measure it was broken and never repaired." (P7)

  In some clinics, the participants stated that they did have resources but they were not in good working condition as a result of poor maintenance. This is evident from participants who said that:

  "Our resources are not well, such as our BP machine it sometimes goes off while in use and we have to wait until it starts working again, our suction machine is completely not working and we are struggling during emergencies, our scales and blood glucose machines run out of batteries and as the stuff we buy from our own pockets." (P8)

  "We have a shortage of nurses we are balancing but we are not enough." (P5)

In addition, participants indicated the effects of the lack of resources in the selected clinics of the Limpopo Province as evidenced by:

"Default rate increase, patients are dying, and the teenage pregnancy rate is going high." (P14)

"Shortage of treatment affect patient care negatively because as patients end up with severe effects like stroke, multi-drug resistant and death." (P17)

"This shortage makes our paperwork to be poor and be delayed like now we do not have toner." (P2)

- <u>Sub-theme 1.2: Challenges with lack of staff related to provision of quality care to patients</u>
  The findings indicate that in the selected public clinics of the Limpopo Province the number of allocated staff rendering quality healthcare services to patients differs at each clinic.

This finding was confirmed by the participants who said:

"We have ten professional nurses including OPM; three ENs; and one ENA." (P7)

"It is the operational manager, seven professional nurses, two enrolled nurses, three enrolled nursing assistants." (P8)

"One OPM, operational manager, six professional nurses, four enrolled nurses, two enrolled nurses' assistants, one clerk, one data capture, two grounds-man, two cleaners and the following are from Non-Government Organization: mother mentor, two lay counsellors, and ground woman." (P1)

"Our staff is fifteen nurses all in all. It is one OPM; seven professional nurses; four ENs and three EN assistants. We have one clerk and one data capture." (P4)

Although there is staff at some clinics, it varies from clinic to clinic and at some clinics, there is a shortage of staff. The participants who said confirmed this finding:

"We do not have a pharmacy assistant." (P10)

"We only have data capture with no clerk." (P7)

"We do not have a pharmacy assistant, lay counsellor, and a data capture." (P5)

"We are balancing but we are not enough." (P5)

While at some clinics the participants indicated that the staff was balanced, and at other clinics, there was an imbalance. The participants who said confirmed this finding:

"And our nursing staff is not balancing well." (P4)

"With the two groups, our staff is not balancing fairly." (P16)

- <u>Sub-theme 1.3: Problems with relation to health clinics structures which impede the provision of quality patients care</u>

  This finding indicates that among the selected public clinics of the Limpopo Province there are clinics with poor physical structure, such as limited space, small-sized waiting areas and shortage of rooms necessary for the provision of quality care; such poor infrastructure prevents quality care.

  This was confirmed by the following claims by participants:

  "Our facility has all the rooms we need but patient waiting areas are small and fail to accommodate our patients, especially our chronic patients when they come for renewal of treatment prescription, they are a lot. Also, our filing room is too small to accommodate enough shelves for patient's files." (P8).

  "We do not have emergency room." (P16)

"Our clinic is old, we have four consultation rooms only, three serves as consultation rooms and the other one serving as matron's office, and we do not have observation room." (P7)

The participants further indicated the effects of the poor infrastructure on the provision of quality patient care in the selected public clinics of the Limpopo Province, South Africa.

"Few consultation rooms cause more delay for the patients on queue." (P1)

"We use part of the waiting area for observation like a vital sign which does give patient privacy." (P7)

"Our patients get overcrowded on the waiting area some even wait outside standing." (17)

"Patients' files are over packed in one room some files are not on shelves." (P8)

"If an emergency patient comes, one consultation room has to stop and accommodate the emergency and that delays patients on the queue and they go hungry while some are diabetic." (16)

- Sub-theme 1.4: Patients care concerns related to insufficient clinic structures

  This finding indicates that the limited space in the selected public clinics of the Limpopo Province causes cross-infection amongst patients.

  The participants who said confirm the findings:

  "Some people are infected with TB due to congestion at our small waiting area." (P8)

  "Overcrowding at the waiting area causes cross-infection of diseases like TB and flu." (P7)

  "Patients become overcrowded on the waiting area with high chances of, of eh cross-infection." (P1)

- Sub-theme 1.5: Burnout related to clinics catering to large geographical areas which leads to large numbers of people served

  This finding indicates that nurses in the selected public clinics of the Limpopo Province, South Africa serve large populations and these results in their suffering from burnout.

  The findings are confirmed by the following responses of participants:

  "The workload is too much we are serving six villages. Our monthly headcount ranges from four thousand to five thousand." (P16)

  "Our daily headcount is about one hundred per day; rendering patient care daily to this number is very strenuous to us." (P4)

  "As nurses, we experience exhaustion due to strenuous work that we do, we serve many villages about five." (P1)

  "The workload is way too much like we have a lot of headcounts and we end up developing burnout." (P12)

- Sub-theme 1.6: Acceptable versus unacceptable duty schedules common to all clinics

  This finding indicates that the selected public clinics of the Limpopo Province, South Africa have different duty schedules. The schedules differ from one clinic to the other, some are acceptable, and some are not. However, the perception of what is acceptable and what is unacceptable is common to all the clinics.

  The difference in the schedules is confirmed by the following:

  "We are working eight days in six and days off; we are off from Thursday to Tuesday and work from Wednesday to Wednesday, from 07h00 to 18h00 and on Wednesday those who go for off knock off at 10h00." (P1)

  "We are working for seven days and rest seven days, we do not do night shift but some nurses agreed to do call system and others like

are not doing it due to non-compliance with call system policy, we work from 07h00 to 19h00." (P6)

"Our working shifts are like ten days in and four days out, working from 07h00 to 16h30, only on half days we eh knock off at 13h00." (P10)

Some participants indicated their negative, as well as their positive, feelings about the duty schedules:

"I am so happy of these shifts because we rest enough and have time for our families." (P1)

"We work very long shifts with one-half day. I do not like these shifts as we come back to work while we are still tired and we do not have enough time for social life." (P10)

"We are strained by this long shift that our bodies cannot function well." (P10)

"We experience mental block because of these long shifts." (P6)

"We are working long shifts and two or three days before off days we take sick leaves because we are tired, and this increases absenteeism." (P8)

4.4.2 Theme 2: Nurses working outside their scope of practice during the provision of patient care in the clinics

The findings of the current study indicate that there are different roles played by nurses during provision of patient care in the clinics. These include different categories of nurses and their responsibilities; nurses carry out pharmacy assistants' roles related to the ordering and control of medications and further, nurses act as data capturers and clerks over weekends.

The sub-themes provide a detailed explanation of the theme.

- <u>Sub-theme 2.1: Execution of pharmacists' roles related to ordering and control of medication by clinic nurses</u>

  The participants indicated that the nurses are carrying out the duties of pharmacy assistants, as there are no pharmacy assistants allocated to their clinics.

  This was confirmed by participants who said:

  "In the pharmacy, we do not have pharmacy assistant but the pharmacy duties need to be done, and as nurses, we do stock taking, report the treatment, we order; we do a lot of stuff." (P2)

  "Nurses receive pharmacy stock, balancing pharmacy stock, and do stock-taking because we do not have a pharmacy assistant." (P20)

- <u>Sub-theme 2.2: Execution of data capturers and clerks' role over weekends by clinic nurses</u>

  The participants raised concerns that they had to act as data capturers and clerks over the weekends.

  The participant who said ratified this finding:

  "We do not have clerk on weekends and nurses retrieve patients' files and file them back after consultation." (P7)

  "On the weekend we do not have a data capture, we do not have a clerk and then we do all that by ourselves." (P2)

  "We do not have data capture on weekend and while we are not trained on the new system of capture patients, therefore, patients sometimes have to be returned home without information in the computer like transfer out prints." (P17)

4.4.3 Theme 3: Poor health care provided to patients related to challenges experienced by clinic nurses

The findings of the current study indicate that there are challenges experienced by professional nurses, which lead to the provision of poor care. The challenges include a shortage of resources leading to defaulting of treatment; increased

nurse workload leading to burnout; low salaries for the services provided; nurses' physical, emotional and mental stress; small working spaces; lawsuits; and shortages of nurses.

The sub-themes below provide a detailed explanation of the theme.

- Sub-theme 3.1: Shortage of resources which affects the provision of quality patient care, leading to defaulting treatment

  The participants indicated that in the selected public clinics of the Limpopo Province, South Africa there is a shortage of resources, which leads to defaulting of treatment by of patients and to other complications.

  This finding was confirmed as follows:

  "People are defaulting treatment because of this shortage of treatment." (P9)

  "Most patients are defaulting treatment because they lose hope, this month they find treatment next month they do not find it." (P13)

  Professional nurses mentioned some of the complication, which patients experienced because of lack of treatment facilities:

  "Patients are becoming resistant to treatment as they relapse and start over again and again." (P17)

  "Most people are dying because their medical conditions are deteriorating when they are not taking treatment." (P12)

  "With the treatment, we get many defaulters because our clients do not afford to go to another clinic or nearby hospital, so they decide to quit." (P4)

- Sub-theme 3.2: Earning too low salaries for the services provided

  The participants expressed concern that the salaries they earn are insufficient for the services they provide.

  Participants said:

"We are being underpaid while what we do is too much." (P7)

"Our salaries are too low compared to our workload." (P1)

"We are working too much and for that, the compensation is too little, we are not being paid fairly." (P5)

- Sub-theme 3.3: Physical, emotional and mental stress related to providing services in the clinics

  The study revealed that nurses experience physical, emotional and mental stress at work resulting from the service they render.

  This finding was confirmed as follows:

  "At work, we are under pressure of too much work and that causes stress on us." (P3)

  "We are physically stressed by the heavy work that we do and our bodies respond with exhaustion and back pains." (P20)

  "We experienced a mental block in most cases towards the end of the shift, like our brains can no longer function well under such heavy load of work to be done." (P12)

  "The working condition is gradually draining me emotionally, especially with the challenges we are having in our clinic." (P14)

  Another participant indicated that*: "it affects us negatively as we are physically, emotionally and mentally drained by these long shifts and too much workload." (P2)*

  "Daily we give counselling, health education to the patients and have to remember the relationship of each medical condition with its treatment, diagnose then prescribe, which is too much for us to cope with psychologically." (P7)

- Sub-theme 3.4: Fear of lawsuit related to poor provision of quality care by the community against nurses

  Professional nurses at the selected clinics indicated that rendering poor patient care could lead to patients taking legal action against nurses.

  Participants claimed:

  "Patients are opening court cases against nurses, complaining of things like not getting medication at the clinic while the medication is out of stock." (P20)

  "Patients blame nurses for the shortage of resources, some even report to their lawyers for not getting what they want or poor service from nurses." (P19)

- Sub-theme 3.5: Misdiagnosis of patients related to lack of material resources

  The participants indicated that the resources at the clinics are not always functional and mislead nurses when it comes to diagnosing patients.

  Some said:

  "Our height measure is broken, and we tried to tie it up but still it is not accurate which leads to wrong body mass index." (P13).

  "Our BP machine after being used on several patients it starts giving a very high reading of which a nurse is not able to know if the reading is true or not." (P12)

- Sub-theme 3.6: Affected provision of care related to shortage of nurses, for various reasons

  The participants indicated that the shortage of nurses, for different reasons, affects the provision of nursing care.

  The participants who said confirmed this finding:

"With this shortage of nurses the queue is moving slow and some patients return home without being helped, due to hunger, as they spent a lot of time on the queue." (P3)

"As nurses, we experience cases of mismanaging patients as a result of attending emergencies alone due to shortage of nurses." (P5)

4.4.4 Theme 4: Suggestions for how marked challenges could be resolved

The participants suggested how the challenges could be resolved. For example, by requesting increased budgets; increasing salaries of nurses and discussing better duty schedules for nurses. Further, the Department of Health should: improve resources provided to clinics and raise awareness of communities about the challenges they experience.

This was confirmed by the following sub-themes that emerged from this theme:

- Sub-theme 4.1: An increased budget should be requested to extend the clinics' buildings to create more space Increased budget should be requested to extend the clinics' buildings to create more space suggested
  Participants claimed that more space was needed at the clinics; therefore, an increased budget was needed to extend the space:

  "District office can be informed so that it requests more budget at the province for containers or for extending the building." (P1)

  "Our provincial office needs to include an extension of buildings when sending items for the budget to the national department of health so that it can increase the budget to extend our facilities." (P8)

- Sub-theme 4.2: A suggestion that salaries be increased to compensate for the increased workloads experienced by clinic nurses
  The participants indicated that nurses' salaries need to be increased to compensate for their increased workload.

  This finding was confirmed thus:

"As nurses, we have too much workload but we earn a little, our government need to increase our salaries." (P15)

"Our employer needs to reconsider our salary is too low when compared to our workload." (P1).

- <u>Sub-theme 4.3: Existing duty schedules should be discussed to come up with better options</u>

  The participants indicated that the duty schedules need to be changed for better options:

  "I think our managers should just understand the negative impact of this type of shift and announce the relevant and suitable shifts for us." (P2)

  "We have said it many times that we need our shifts to be changed." (P10)

  "This long shift needs to be changed." (P17)

- <u>Sub-theme 4.4: A suggestion that the Department of Health needs to improve all resources they provide to clinics</u>

  The participants indicated that the Department of Health needed to improve all the resources provided for the clinics.

  This finding was confirmed as follows:

  "I think the district needs to request budget at provincial for containers or for extending the building, hire more nurses and buy us suitable furniture and machines, national can increase the amount of delegated amount to our province." (P1)

  "The national level needs to prioritise the availability of treatment at the health facilities have" (P5)

  "We need more ambulances for our clinics." (P19)

- Sub-theme 4.5: A suggestion that there is a need for the Department of Health to raise awareness to communities about challenges the department experience

  The participants indicated that the Department of Health needs to make the communities aware of the challenges the department experiences. Participants claimed:

  "The Department of health needs to publicly inform the community about anything that the department fails to afford so that the community can stop blaming nurses for the shortage of resources." (P5).

4.5 DISCUSSION OF THE RESEARCH FINDINGS

4.5.1 **Theme 1: Differences between nurses' experiences related to their working conditions**

The findings of the current study indicate that professional nurses experience different working conditions from their different clinics. These working conditions related to lack of resources, inadequate staff, infrastructural problems, unacceptable duty schedules, too much workload which leads to burnout.

The sub-themes below provide a detailed explanation of the theme.

- Sub-theme 1.1: Lack of resources during the provision of care causing suffering at multiple levels of both patients and nurses

  The study found that there is a lack of resources in the selected public clinics of the Limpopo Province. The resources refer to treatment, height measures, blood pressure machines, CTG (cardiotocography) machines, suction machines, plain paper for patient notes, files, and toner. One of the participants indicated that a reason for the lack of resources is failure to plan and distribute the budget, starting from the national level down to the district level. In addition, it was also indicated that resources in some other clinics exist but are not properly functional because of a lack of maintenance. The nurses also expressed their concern regarding the lack of resources as it leads to complications such as teenage pregnancy, treatment default, multi-

drug resistance, stroke and death. Moreover, the shortage of resources negatively affects nurses' perceptions of the quality of practice environment (Rivaz et al., 2017).

The study of Awases et al. (2013) in Namibia indicates that there is a shortage of necessary instruments and medication, and that the available instruments need maintenance and repair. The study further reports that modern equipment was needed.

The study of Manyisa et al. (2017) reveals that there were inadequate resources in health care facilities and old equipment that was not functioning well because of a lack of maintenance. This affects the health care service rendered in South Africa. This was supported by the study of Maphumulo and Bhengu (2019) who also found that in South Africa there is shortage of resources which leads to delays in the diagnosis and treatment of patients.

The study of Moyimane et al. (2017) indicates that in 2012, a parliamentary committee visited one of the healthcare facilities in Mpumalanga, South Africa, and found critical shortages of essential medical equipment for sustaining human life or stabilising patients in an emergency.

However, South Africa has been found to have resources but, due to inefficiency, corruption and lack of accountability, these resources do not provide better healthcare services (Dhai, 2012). Moreover, the national core standard for health establishment in South Africa (2011) indicates that medical devices should be maintained to ensure safety and functionality.

<u>Sub-theme 1.2: Challenges with lack of staff related to provision of quality patient care</u>

The study findings indicate that there is shortage of staff in the selected clinics of Limpopo Province. The staff shortage includes the following categories: nurses, clerks, data capturers and assistant pharmacists. This study found that in one of the selected clinics in the Sekhukhune district, there are only three professional nurses, two have midwifery qualifications and the other does not.

The three include an acting Operational Nurse Manager (OPM). When one professional nurse with midwifery goes on leave, the local area manager has to ask for a temporary replacement from another clinic and if no replacement can be found, the leave must be rescheduled. In another clinic, there was no clerk. In this case, Enrolled Nursing Assistants (ENA) carry out the clerical work as well as being expected to carry out the duties of Enrolled Nursing Assistants. This makes their workload very heavy in other clinics, there are no pharmacy assistants to order, receive, pack and report pharmacy stock and the professional nurses perform these tasks.

There is a shortage of healthcare professionals in developing countries as a result of the migration of professional personnel to developed countries for better remuneration (Peñaloza, Pantoja, Bastías, Herrera & Rada, 2011). The World Health Organization has predicted an upcoming rise in the shortage of healthcare providers of about 12,9 million by the year 2035. This figure includes general practitioners, psychiatrists, nurses and pediatricians (Wu, Zhao & Ye, 2016). The study of Bradley, Kamwendo, Chipeta, Chimwaza, de Pinho and McAuliffe (2015) reveals that, in Malawi, there is a shortage of skilled nurses, which leads to an increase in patient mortality and poor patient outcomes through the delays in receiving timely and appropriate care.

- Sub-theme 1.3: Problems with relation to health clinics structures which impede the provision of quality patient care

  The study reveals challenges with the infrastructure of the selected public clinics of the Limpopo Province, South Africa. The challenges identified include small waiting areas, which lead to patients' standing outside in the sun, under the trees or in the parking waiting for their files. Other clinics report undersized file rooms, which result in patients' files being put on the floor. According to the Ideal Clinic Manual (2016), patients' files should be stored on shelves but not on the lower shelf, in case of water on the floor. A shortage of observation rooms was also reported. This means that vital signs are taken in the waiting areas and patients' privacy is not maintained. Another challenge with regard to infrastructure was a shortage of

consultation rooms. Some clinics had to use the emergency room as a consultation room and when there is an emergency, patient who were supposed to consult in the emergency room have to wait until the emergency case is resolved.

According to Manyisa et al. (2017), some health care facilities are old and small, compromising patients' rights to privacy and making it difficult for the health care workers to work. Furthermore, poor healthcare facility structures create poor working conditions for healthcare providers; such an environment limits and negatively affects the provision of patient care and healthcare services (Awases et al., 2013). Waiting times and queues should be managed to improve patient satisfaction and care as a way of reducing delays in care (Department of Health National Core Standard, 2011). The National Standard further states that areas should be convenient and provide adequate shelter and seating for patients.

- Sub-theme 1.4: Patients care concerns related to insufficient clinic structures

  The study found poor infrastructure in the clinics studied. Most participants in the Sekhukhune District were concerned about the limited space of the waiting areas of their clinics and that the congestion of patients might lead to cross infection as the Sekhukhune District has a high number of active Tuberculosis cases.

According to Beggs, Sheperd and Kerr (2010), cross-infection is the airborne transmission of infections like of conditions like tuberculosis, influenza and measles. It occurs where there is an infected person in an enclosed space or around a large number of people who are not infected. Cross infection in healthcare facilities occurs when there is a prolonged time around someone with an infectious disease like TB (He, van den Hof, van der Werf, Wang, Ma, Zhao, Hu, Yu & Borgdorff, 2010). The participants' concern is that all the patients awaiting their files wait in the same waiting area as Tuberculosis infected people not yet diagnosed, who are at the clinic for consultations. Often their coughing has not been diagnosed. The study of Maphumulo et al. (2019) indicates that public healthcare facilities in South

Africa are old buildings with poorly maintained infrastructures, which lead to poor quality healthcare. However, the Department of Health National Core Standards (2011) indicate that an Infection Prevention and Control Programme is in place to reduce health care-associated infections and specific precautions are taken to prevent the spread of respiratory infections.

- Sub-theme 1.5: Burnout related to clinics catering to large geographical areas which leads to large numbers of people served

  The study found that the nurses at the selected public clinics serve a large population due to the large geographical areas served by one clinic. The large headcount results in nurses experiencing exhaustion, burnout and being strained. One of the clinics in the Sekhukhune District serves approximately four thousand patients per month, being allocated seven villages in the area. A contributory factor to the large population was that in all the districts that patients preferred to go to clinics not allocated to their community because of the fear that people might discover their diagnosis.

  According Portoghese, Galletta, Coppola, Finco and Campagna (2014) to nurses experience a psychological syndrome of chronic exhaustion which is burnout, as a result of high workload resulting from the imbalance between nurses and patients. The study of Malatji, Ally, and Makhene (2017), conducted in South Africa, found that an unrealistic workload predisposed nursing staff to emotional and physical burn out and excessive fatigue. Nurses need to be socioeconomically and psychologically stable to provide emotional support to HIV positive patients (Bhargava & Booysen, 2010).

- Sub-theme 1.6: Acceptable versus unacceptable duty schedules common to all clinics

  The study found that the selected public clinics of the Limpopo Province, South Africa operate under different duty schedules drawn up in line with the Basic Conditions of Employment Act no.75 (1995). Some schedules were acceptable and some were not acceptable to the participants. The unacceptable schedules, which caused negative feelings in the participants,

were related to working long shifts with little time for rest or for social life. Most of the nurses in the selected clinics worked for ten days and with four days off. This results in nurses' experiencing mental blocks and in increased absenteeism.

The positive feelings about the accepted duty schedules were that some clinics worked seven-days-in and seven-days-out shifts or eight-days-in and six-days-out. Nurses reported having enough time for rest and a social life.

According to Sagherian, Clinton, Abu-Saad Huijer and Geiger (2017), insufficient time to rest is a common complaint among nurses. Their research further highlighted the common occurrence of compulsory consecutive workdays, overtime and long working hours. The study of El Adoly, Gheith, and Fors (2018) indicate that nurses who work long hours are more likely to have job dissatisfaction. However, some nurses had no problem with them. Many nurses choose to work night shifts and long shifts for reasons such as avoiding home conflict (Estryn-Béhar & Van der Heijden, 2012)

According to Stimpfel et al. (2012) nurses who work long hours that are combined with overtime and shifts that rotate between night and day shift are at high risk of developing fatigue and burnout. Nurses find some working schedules such as night shifts and 12 hours shifts less favourable than day shifts. Such shifts may have a negative impact physically and mentally on nurses who may develop musculoskeletal disorders and not get enough rest (Attarchi, Raeisi, Namvar & Golabadi, 2014). It is scientifically proven that shift work has physiological and psychological effects and gastrointestinal disturbances are reported more often by rotating shift workers than by day shift workers (Saberi & Moravveji, 2010).

4.5.2 Theme 2: Nurses working outside their scope of practice during the provision of patient care in the clinics

The findings of the current study describe different roles played by nurses during the provision of patient care in the clinics. These include: different categories of nurses and their responsibilities; nurses carrying out pharmacy

assistants' roles related to ordering and control of medications and nurses execute the roles of data capturers and clerks over weekends. The sub-themes below provide a detailed explanation of the theme.

- Sub-theme 2.1: Execution of pharmacists' roles related to ordering and control of medication by clinic nurses

  The study found that at the selected public clinics of the Limpopo Province, South Africa, nurses carry out the duties of pharmacy assistants when there is no pharmacy assistant allocated to the clinics. According to the performance agreement of professional nurses, professional nurses order pharmaceutical and surgical stock. However, ordering of pharmaceutical and surgical stock currently is included in the performance agreement of pharmacy assistants. Beside these being one of the functions of the professional nurses, professional nurses at the some of the selected clinics perform duties such as receiving stock, stock taking, reporting of treatment, balancing pharmacy stock and some even dispense medication without any dispensing certificate.

  Dispensing medication without a certificate can lead to litigation against unqualified professional nurses. For this reason, participants suggested that each clinic should have a pharmacy assistant to relieve professional nurses of additional duties and save them from litigation.

  Nurses are not happy playing the role of pharmacists in a clinical setting. They consider pharmacist's good sources of drug information, but the nurses' expectations did not match their lived experience (Azhar, Hassali, Mohamed Ibrahim, Saleem, & Siow Yen, 2012). According to Sheridan, Kelly, Basheer, Jan & Lee (2011), the role of the pharmacy assistant is to be the first point of contact in the pharmacy.

  It was reported by participants that if they do not have pharmacy assistants, it means that the nurses will also have to work in the pharmacy. According to Crowley and Stellenberg (2015), nurses are legalised to order, receive, prescribe and dispense but the study argues that quality assurance is the responsibility of pharmacists and/or pharmacy assistants.

- Sub-theme 2.2: Execution of data capturers and clerks' role over weekends by clinic nurses

  The study found that at the selected public clinics of the Limpopo Province, South Africa, clerks and data capturers do not work over weekends, while some clinics do operate on weekends. Usually, Enrolled Nursing Assistants or Enrolled Nurses carry out the roles of clerks and data capturers, depending on who is available and sometimes-professional nurse's help. The nurses who take the roles of clerks and data capturers are also expected to accomplish their daily practice duties. These nurses are not trained in the work of the clerks and data capturers work, but have learnt through observation.

  In clinics where there is no allocated clerk or data capture, the sub-district will send one clerk and data capture to orientate the available staff on their work and the staff is expected to carry out their duties. On Mondays when the clerks and the data capturers arrive, they wrap up the work remaining from the weekend. The disadvantage of unavailability of clerks and data capturers is that patients' data and records are mismanaged, misplaced or wrongly captured in the electronic system.

  According to Manyisa et al. (2017), there is a shortage of support staff in health care facilities and this leads to highly qualified health care personnel, like nurses, performing the duties of support staff.

4.5.3 Theme 3: Poor health care provided to patients related to challenges experienced by clinic nurses

The findings of the current study indicate that there are challenges experienced by professional nurses, which lead to the provision of poor care. The challenges include a shortage of resources leading to defaulting of treatment; increased nurse workloads leading to burnout; small salaries for the services provided; nurses' physical, emotional and mental stress; small working spaces; lawsuits; and a shortage of nurses.

The sub-themes below provide a detailed explanation of the theme:

- Sub-theme 3.1: Shortage of resources which affects the provision of quality patient care, leading to defaulting treatment

  The study found that there is fallout in the treatment at the selected public clinics of the Limpopo Province, South Africa. This negatively affects the provision of good quality patient care as sometimes patients are treated and sometimes they are not. One of the participants indicated that twice a month professional nurse's order treatment and send the order to the allocated pharmacist electronically. However, when the order is delivered to the clinic the amount of stock is usually below the number ordered, despite the fact that the nurses order according to the clinic populations. Another participant reported that in his or her clinic, Anti-retroviral treatment is what they mostly have short supplies of and this has resulted in an increase in patients defaulting on their treatment, and some even died because of their increased viral load.

  This finding coincides with that of Vawda and Variawa (2012) which claims that in South Africa there is insufficient stock of ARVs. The result was the incident in the Free State in 2008 where about 30 HIV positive people died. However, in 2009, the Kwa-Zulu Natal MEC denied that there was a shortage of ARVs.

  However, according to the study of Endjala, Mohamed, and Ashipala (2017), TB patients default on their treatment because of poor communication between nurses and patients, in addition to the negative attitudes of nurses who do not give patients enough time during consultations to assess them and to give them health education. Furthermore, Habteyes Hailu, Azar and Davoud Shojaeizadeh (2015) maintain that there is a high number of TB patients who are co-infected with HIV, who do not adhere to their treatment factors such as: not having enough money to get to the clinic, lack of support, long duration of treatment and lack of knowledge.

- Sub-theme 3.2: Earning too low salaries for the services provided

  The study found that at the selected public clinics, nurses were not satisfied with their salaries. Nurses felt that their workload was too heavy and the compensation was too little. They felt they were being underpaid.

Participants indicated that they pick up the work of any personnel where the clinic is in short supply, but their salaries do not consider the extra work. If there is a shortage of professional nurses, the available professional nurse will close the gap by one professional nurse doing the work of two. There is no financial reward for this.

Even though nurses receive benefits such as rural and housing allowances, medical aid benefits, overtime pay, night allowances, weekend and holiday allowances, uniform allowances and Performance Management Development System (PMDS), they do not think that these benefits compensate for the extra work they do.

According to Gill (2011) nurses are dissatisfied with their salaries. According to Li, Nie, and Li (2014) nurses from developing countries are emigrating to developed countries for better remuneration including better wage and benefits such as better retirement package. Further indicates nurses of developed countries makes ten to twenty times more than nurses of developing countries.

- Sub-theme 3.3: Physical, emotional and mental stress related to providing services in the clinics

  The current study found that nurses in the selected clinics are negatively affected by their working conditions. Most participants indicated that they experience physical and mental stress, which leads to burnout, backaches and mental blocks because of the poor working conditions at their clinics.

  The research found that absenteeism was mostly caused by sick leave from nurses being booked off from work for bed rest, usually for three days at a time.

  This is ratified by the study of Circenis and Millere (2011) which maintains that nurses develop physical and emotional stress, characterised by headaches, fatigue, irritability and depression. They report that factors such as dissatisfaction with salaries and too heavy workloads may lead to psychological illness.

In addition, nurses experience work-related physical and emotional stress, this contributes to nurses taking substances such as caffeine just to cope at work for the duration of their shifts (Dorrian, Paterson, Dawson, Pincombe, Grech & Rogers, 2011).

Other factors contributing to occupational stress include too much paper work, criticism, instrument and equipment shortages and night shifts (Lu, Sun, Hong, Fan, Kong & Li, 2015).

- Sub-theme 3.4: Fear of lawsuit related to poor provision of quality care by the community against nurses

The study found that are facing court cases, opened by patients who complain of poor service and a lack of the necessary resources. In one of the selected public clinics, it was claimed that a nurse was taken to court by a family of a deceased patient, saying that she had not given the deceased patient anti-retroviral treatment for months. The client was on a second regimen and the type of the treatment for this had been out of stock for three months - on the dates that the deceased had visited the clinic. The patient had been referred to hospital to collect his/her treatment but he/she did not go to the hospital. It was found that nurses had ordered the correct amount of medication for the clinic patients every month but that the pharmacy supplied a smaller number, which did not cover all the patients, including the deceased patient. The matter had been reported several times to the district manager and the pharmacy but nothing had happened.

Nurses, in their work environment, experience physical, emotional, or/and verbal violence from patients. Often this is the result of factors like power struggles, battles for control and stigma. Nurses try various strategies to manage the incidents to create a safer working environment (Stevenson, Jack, O'Mara & LeGris, 2015). One of the participants reported how those patients at the clinic swore at the nurses if they were told that the clinic was running short of medication the patients would say, "*The patient is always right*". This is in line with the findings of Roche, Diers, Duffield and Catling-Paull (2010).

Workplace violence perceived by nurses includes emotional abuse and physical violence. This violence is associated with factors such as discrepancies in resources and supplies required delays in the provision of care, and unstable or negative qualities of the working environment. The study of Pich, Hazelton, Sundin and Kable (2010) claims that nurses are victims of verbal and physical abuse at work and that it happens frequently, nurses no longer report the incidents and that has normalised workplace violence and hindered strategies to prevent it.

The study further maintains that nurses are entitled to work in a safe working environment that is free from violence, under occupational health and safety legislation. However, Maphumulo's (2019) research found that in South Africa the DOH is experiencing a sharp increase in medical negligence litigation. This is corroborated by the report of the SANC of a rise in misconduct cases against nurses - these cases lead to the DOH losing money.

- <u>Sub-theme 3.5: Misdiagnosis of patients related to lack of material resources</u>

  The study found that some of the resources being used in the selected public clinics of the Limpopo Province, South Africa are not functional. This leads to wrong diagnoses and management. One of the participants stated that their blood pressure machine was not working, giving wrong readings. Often pregnant women were diagnosed with pregnancy-induced hypertension and given anti-hypertensive treatment. After being referred to the hospital, it is discovered that the women do not have such hypertension; their readings were due to malfunctioning of the blood pressure machine.

  However, the study of Singh, Schiff, Graber, Onakpoya, and Thompson (2017) found that misdiagnosis of patients is related to scarce resources rather than to the malfunctioning of equipment. This is supported by the study of Drain, Hyle, Noubary, Freedberg, Wilson, Bishai, Rodriguez and Bassett (2014) who claim that misdiagnoses are caused by the unavailability of resources or resources that are not maintained, which leads to delays in the correct initiation of treatment.

- <u>Sub-theme 3.6: Affected provision of care related to shortage of nurses, for various reasons</u>

  The current study found that the shortage of nurses affects negatively on the provision of care to patients. Patients face the consequences of the shortage of nurses by not getting the service they need. Some, do get the service but not of the necessary quality. In one of the selected public clinics, participants indicated that they boycotted to work night shifts even when their clinic did not meet the criteria of 24 Hour service. The reason was that the community complained about unavailability of health services at night.

  Gill's (2011) study of health care systems across the globe found that the shortage of nurses caused by s professional, economic and social reasons, led to doctors, pharmacists, dentists and physical therapists being trained as nurses and this negatively affected the provision of health care services. In Namibia Awases et al. (2013) found that there was an increase in the nurses' workload, which resulted in the absenteeism of nurses, which further contributed to the shortage of nurses.

  According to Manyisa et al. (2017), there is a shortage of health care professionals in developing countries, and in South Africa, the shortage of nurses is due to multiple factors including increased workloads, low morale and poor working conditions However, the Department of Health National Core Standards (2011) indicated that the human resource allocation plan should ensure sufficient staff to meet the health establishment's agreed service levels.

4.5.4 Theme 4: Suggestions for how marked challenges could be resolved

The participants suggested that the identified challenges could be resolved by requesting an increased budget; increasing salaries of nurses and discussing better duty schedules for nurses. The Department of Health also needs to improve resources provided to clinics and raise awareness of communities about the challenges they experience.

The following sub-themes emerged from this theme and explain the above in detail:

- Sub-theme 4.1: An increased budget should be requested to extend the clinics' buildings to create more space

  The study found that in the selected public clinics there is limited space. Nurses expressed a wish for an extension of the buildings. While awaiting the extension of the clinics, the DOH should provide temporary or mobile structures like containers, to serve as consultation rooms, observation rooms and waiting areas. They further suggested that the DOH needs to increase the allocated budget for the provinces in need of clinics, including Limpopo Province.

  Improving healthcare infrastructures is needed to improve the workplace of healthcare personnel to be effective and safe (Peñaloza, Pantoja, Bastías, Herrera & Rada, 2011). According to Gill (2011), the government needs to improve nurses' working conditions by providing adequate infrastructures for healthcare services.

- Sub-theme 4.2: A suggestion that salaries be increased to compensate for the increased workloads experienced by clinic nurses

  The study found that the clinic nurses were not satisfied with the salary they earn. Participants in the study suggested that the DOH needs to review nurses' salaries, consider increments, and provide compensation for the increased workload and the extra duties that nurses carry out because of staff shortages.

  According to Gyamfi (2011), the government must play a role in improving factors contributing to nurses' working conditions, including their dissatisfaction with their salaries. It should attempt to close the huge gap between nurses' and medical doctors' salaries. Nurses' salaries need to be increased as a way of responding to their dissatisfaction with their remuneration, which has a negative effect on their provision of care (Gill, 2011).

  The study of Awases et al. (2013) in Namibia found that most nurse participants were not satisfied with their salaries and felt that their benefits were insufficient and that they had not been clearly explained to them. The South African government introduced the Occupational Specific

Dispensation which recognises that there is dissatisfaction with the remuneration of nurses; the Occupational Specific Dispensation aims to improve remuneration to retain and attract nurses (Ditlopo, Blaauw, Rispel, Thomas & Bidwell, 2013).

- Sub-theme 4.3: Existing duty schedules should be discussed to come up with better options

  According to the current study, nurses are not happy with their duty schedules. They work forty hours per week, but they would not choose the way the days are broken up - they work ten days in and four days out. Participants suggested that the current duty schedule should be reviewed. They would prefer to work seven days in and seven days out or eight days in and six days out.

  Nurses' working schedules may harm nurses' health and contribute to job dissatisfaction and this needs to be discussed (Ferri, Guadi, Marcheselli, Balduzzi, Magnani & Di Lorenzo, 2016). Duty schedules need to be considered and strategies developed for, for example, 9 to 10 hour shifts that would allow rest; and strategies to avoid the short notice of shift changes (Estryn-Béhar et al., 2012).

  Nurses' desire to request the change of shifts is an indication of their dissatisfaction with the duty schedules. This has a negative impact on work output and nurses' health, whereas fulfilling nurses' desire could lead to better nurses' health and work output (Galatsch, Li, Derycke, Müller & Hasselhorn, 2013).

- Sub-theme 4.4 A suggestion that the Department of Health needs to improve all resources they provide to clinics

  The study found that the DOH needs to improve all resources needed to render patient care. This includes ensuring availability of resources and the availability and renovation of clinics. Most participants prioritised the availability of medication and some mentioned building new clinics and renovating the current clinics.

According to Maphumulo et al. (2019) the South African government initiated, modified, and tested many quality improvement programmes to improve healthcare service, but still the programmes did not produce the required level of healthcare service. This includes renovation and repairing of the facilities, maintenance and repairing of equipment and the supply of advanced equipment. In addition, the study of Gyamfi (2011) finds that the government and health agencies need help in improving good healthcare working conditions and developing lasting solutions to improve the rendering of quality healthcare services.

Nurses should be provided with functioning medical equipment to provide quality nursing care in South Africa (Moyimane et al., 2017). In addition, procurement and maintenance plans for medical equipment need to be developed and implemented by management, leadership and governance structures.

The Provincial Department of Health must offer effective management of contracts of suppliers to ensure accessibility and availability of essential medicine to citizens of South Africa (Modisakeng, Matlala, Godman & Meyer, 2020).

The Department of Health National Core Standards (2011) claims that a process is in place to manage the financial risks for payment of care and to protect patients from unnecessary costs

- Sub-theme 4.5: A suggestion that there is a need for the Department of Health to raise awareness to communities about challenges the department experience

  The study found that the nurses of the selected public clinics feel the need for the Department of Health to be transparent to the community about the departmental failure to supply adequate resources so that the community knows who to blame.

  Participants indicated that patients usually tell nurses that the nurses just say that there is no medication while the medication is there just because

nurses are selfish and want the medication for themselves and their relatives.

Participants suggested that the MEC of Health needs to be honest and transparent to the public and inform them if there is no budget, and specifically to indicate the areas that will be affected, for example, shortage of resources. If this were the case, patients would come prepared that might not get treatment and would not insult and blame nurses.

The government needs to use social media and the internet to address the population and share information regarding health issues and to allow the population to access the government, provide relevant sources of information that would provide real and clear information (Gibbons, Fleisher, Slamon, Bass, Kandadai & Beck, 2011).

The National Core Standards (2011) indicates that a communication strategy ensures that the public is informed about all relevant issues within and affecting the health establishment.

4.6 INTEGRATION OF FINDINGS TO NEUMAN'S MODEL

The study indicates that nurses' satisfaction at workplace is compromised by the poor working conditions in the selected public clinics resulting in nurses' developing medical conditions and becoming anti-social.

The stressors encountered by nurses in the selected public clinics compromise such variables. The stressors include the poor infrastructure of the clinics, the lack of resources, increased workloads, little remuneration and an insufficient allocated budget by the DOH.

The identified stressors leave the nurses' working conditions poor and unsatisfactory for the nurses.

Participants suggested that the DOH needs to increase nurses' salaries, ensure the availability of resources in the clinics and to provide new buildings or renovate the existing clinics. Working shifts need to be adjusted to suit the nurses.

The main concepts of Neuman's theory are integrated and summarised in Table 4.2:

Table 4.2: Integration of findings to theoretical framework

Main concepts	Sub-concepts	Results
Human	**Physiological variable** In this study, the physiological variable means physical and medical wellness of nurses' bodies and their ability to carry out their roles in the clinic.	• Participants indicated that the physiological variable is negatively affected as they overwork, resulting in the development of burnout and backache.
	Psychological variable In this study, the psychological variable refers to the nurses' ability to use their minds to carry out their nursing role, including problem solving in relation to medical conditions and their treatment (diagnose and prescribe).	• Experience of stress due to increased workloads, especially towards the end of the shift results in mental blocks.
	Socio-cultural variable In this study, the socio-cultural variable refers to nurses' time to interact socially and culturally with their communities and families.	• Participants indicated that they do not have enough time at home, they spend most of their time at work and this limits their interaction with socio-cultural activities

Environment	**Intra-personal stressors** In this study, intra-personal stressors are the challenges that arise in the selected public clinics, caused by factors that are internal to the selected public clinics	• The limited space of the structures cause congestion of the patients and leads to cross infection • Heavy workload due to an increased number of patients causes burnout • Limited and shortage of consultation rooms.
	Inter-personal stressors In this study, inter-personal stressors are the challenges that occur within the selected public clinics, caused by factors that are from outside but proximal to the inner system that affect the normal functioning of the clinics.	• Failure to maintain resources, • Shortage of resources: staff, equipment and medication.
	Extra-personal stressors In this study, extra-personal stressors are challenges that are caused by factors from far outside the selected public clinics and affect the inner systems.	• The distribution of funds by the Department of Health that is insufficient for necessary resources • Low salaries of nurses, • Poor updates by the Department of Health to the public.
Health	In this study, health refers to the nurses' working conditions in the selected public clinics	• The study indicates that nurses' working conditions in the selected public clinics are not satisfactory • Nurses indicated factors that contribute to their poor working conditions as discussed in the previous concept of environment

Nursing	Nursing in this study, is related to the suggestion on how to improve working conditions in the selected public clinics of Limpopo Province	• The participants suggested that the DOH needs to increase the salaries of nurses • The availability of resources in the clinics should be ensured • There needs to be the provision and renovation of clinic buildings • Working shifts need to be adjusted to suit the • More clinics should be built to accommodate the increasing population the increased workload of the current clinics • More nurses should be employed to balance nurse-to-patient ratio

4.7 CONCLUSION

This chapter discusses the findings and the literature review. According to the findings of the study, professional nurses of the public clinics in the Limpopo Province, South Africa are working under unsatisfactory working conditions resulting from many factors. Nurses experience physical, emotional and psychological strain and face lawsuits, while patients' mortality, defaulting on treatment and risking cross-infection increases.

The following chapter discusses suggestions to improve nurses' working conditions.

CHAPTER 5
STRATEGIES TO IMPROVE NURSES' WORKING CONDITIONS

5.1 INTRODUCTION

The previous chapter presents and discusses the findings of the study. This chapter discusses strategies to improve nurses' working conditions. The strategies have been developed based on the findings of the study. The researcher to guide and support the development of the strategies used.

5.2 STRATEGIES TO IMPROVE NURSES' WORKING CONDITIONS

The researcher had developed strategies to improve nurses' working conditions based on the research findings. The development of strategies to improve nurses' working conditions is one of the objectives of this study. The strategies may be used to improve the essential quality of care that is a priority for patients and health care providers (So & Wright, 2012).

5.2.1 Strategies suggested by the researcher

- **Budgeting**

The provincial Department of Health needs to hire a team to review the allocated budget for facilities. The team should check each item and the requested amount for it and prioritise the requests according to the need for such items. The team should then reduce the budget allocated to other items that may have alternatives or may not be in high demand.

After a specific period, the team should visit each district to review each facility to confirm the implementation of the budget drawn up at provincial level. Any district failing to comply with the budget plan should be disciplined.

- **Utilization of Employee Wellness Programmes (EWP)**

At the clinic level there should be an appointed EWP committee with one professional nurse as a representative of each clinic. The representative should serve as the intermediary between EWPs provincially, employees and employers. The committee should arrange quarterly wellness assessment sessions. These services should be of benefit to every nurse serving the public.

This would serve to ensure fit and healthy nurses to provide quality nursing care and a strategy to retain nurses.

- **Delivering information to the public**

The Member of the Executive Council (MEC) of Health, Limpopo Province, needs to frequently update the public about any challenges the health care facilities face. This would prevent inappropriate blame and complaints of the public aimed at the nurses. The public needs to be informed in advance about the expected periods of shortage of resources. The information should be in writing and, if it is verbal, it should be directly from the MEC to the public, not via nurses.

The MEC of health needs to have a television and radio program where s/he will be able to address the public and give updates of the Department of Health.

- **Reducing delays in care**

The Department of Health National Core Standards (2011) manual states that delays in care should be monitored and reduced. Waiting times and queues should be managed to improve patient satisfaction and care, with serious patients being attended to first.

The Department of Health needs to formulate a statistic team to evaluate and monitor the delegated nurse-to-patient ratio, based on each clinic's patient headcount and the number of nurses per clinic. Where there is a large population, new clinics structured should be built.

The community also needs to be informed about the demarcation, the number of villages delegated for each clinic and the importance of following the demarcation to avoid exceeding the delegated nurse-to-patient ratio. The notice of demarcation for each clinic needs to be posted at the gate and in all the waiting areas.

5.2.2 Strategies suggested by the participants

- **Ensuring availability of resources**

Resources are people, equipment, places, funds or anything else needed to carry out a planned activity for which resources' availability needs to be ensured before-hand.
In this study, resources are divided into human resources and material resources.

- Human resources

The Department of Health needs to open vacancies and hire employees to close the shortage gap. The Department is training nurses, but currently, the nurses are not being employed because of insufficient funds. The Limpopo Department of Health has replaced circular 67 of 2011 with circular 1 of 2018 which states that post community service practitioners will not be absorbed because insufficient funds.

Research needs to be conducted as to where the money that used to be allocated for the absorption of post community service practitioners is. Meanwhile, the Department of Health could raise funds by cutting unnecessary overtime payments (call system of the multi-disciplinary team) and the delivery of documents by car, using email instead. Ensuring availability of staff in the clinics is in line with the ideal clinic manual (Hunter, Chandran, Asmall, Tucker, Ravhengani & Mokgalagadi, 2017).

- Material resources

The selected public clinics have material resources although they are not fully functional. Each district has a maintenance team that visits health care facilities to fix and service machines. The scheduled appointments of the maintenance teams need to be reviewed, as currently materials are not replaced or maintained. A review team needs to be hired by the province to review each district and be authorised to discipline any failure to comply with appointments or to provide quality service.

There is insufficient delivery of treatment at the facilities, which necessitates a review of the standard by Department of Health National Core Standards (2011) which states that medicines and medical supplies should be in stock and their

delivery reliable. A review team of pharmacists and clinic managers could be formed to match each clinic's headcount with the amount of treatment delivered, to avoid shortages.

- **Revitalization of the clinics ‘infrastructures**

Consultation rooms

According to Hunter et al. (2017) ideal clinic manual, a clinic needs to have four consultation rooms, a file room, an observation room, a maternity unit, a sluice room, an emergency room, a treatment room, a pharmacy and a storeroom. A team needs to report facilities that do not meet the prescribed standards to the district as a way of requesting a required structure. When drawing an annual budget plan, the building of the required structures needs to be included.

Waiting areas

The National Core Standard (2011) indicates that waiting areas should be convenient and provide adequate shelter and seating for patients. Yet nurses maintain that the waiting areas are small. A review team needs to be formed to draw a new plan for each clinic, based on the approximate headcount of patients, to avoid overcrowding.

Small waiting areas also lead to cross-infection, therefore, the new planned structure for waiting areas needs also to provide for sufficient ventilation. The plan needs to be built immediately as delays lead to the spread of air-borne cross-infectious diseases day by day.

- **Working schedules**

Nurses need to discuss and agree on the working schedules, looking at the number of staff, to avoid overworking and heavy workloads. Nurses in the facility need to work for a few days breaks between their working days. They need to avoid long working hours: too few nurses mean too much work for each nurse. Before working schedules can be approved by the sub-district, the sub-district manager needs to check that the proportion of working days fits the number of nurses at each facility.

- **Compensation**

The Department of Health needs to review the compensation for nurses in public clinics. This compensation should include: increased salaries, based on qualifications and workload, funeral, and life cover. The South African Nursing Council needs to develop a system that clarifies nurses' qualifications to assist in the compensation of nurses.

5.3 CONCLUSION

This chapter focuses on the development of strategies to improve nurse's working conditions. The researcher consulted literature for guidance on existing strategies the Department of Health is currently employing. The researcher identified the need for review teams to be formulated within the Department of Health.

The research teams should be guided by the researchers' suggested strategies and should follow up on existing strategies. The suggested strategies include reviews of maintenance and availability of resources, paying attention to medication and salaries and working schedules of nurses, and reviewing the structure and infrastructure of the clinics.

Chapter 6 summarises and concludes the study, and makes recommendations for improving nurses' working conditions.

CHAPTER 6

SUMMARY, RECOMMENDATIONS, AND CONCLUSION OF THE STUDY

6.1 INTRODUCTION

Chapter 5 discusses strategies to improve nurses' working conditions.

This chapter summarises the study its aim, objectives and research question. It includes an overall conclusion of the study, restates the main findings, and makes recommendations for improving nurses' working conditions.

6.2 SUMMARY OF THE STUDY

6.2.1 Aim of the study

The study aims to:

- Develop strategies to improve nurses' working conditions in selected public clinics of Limpopo Province, South Africa.
  Strategies to improve nurses' working conditions are discussed in chapter 5. They were developed from the research findings, using literature that guided and supported them.

6.2.2 Objectives of the study

The objective of the study was to:

- Explore strategies to improve nurses' working conditions in selected public clinics of Limpopo Province, South Africa.
  This objective was achieved in chapters 1, 2 and 3. Chapter 1 gives the background of the problem. In chapter two, the researcher reflects a comprehensive literature review to make the data broad and not contextual. Data from international, national and local sources were reviewed to acquaint the researcher with what was known and what was not yet known. In chapter three, a qualitative, phenomenological design was explicated, using a semi-structured interview to collect data from 20 participants from 12 public clinics of the Limpopo Province, South Africa.
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- To explore the experiences of nurses' regarding working conditions in selected public clinics of Limpopo Province, South Africa.
- To describe strategies to improve nurses' working conditions in selected public clinics of Limpopo Province, South Africa.

  These objectives were achieved in Chapter 4, where the research findings are identified through participants' codes and literature control. The results were further described and supported by the literature control. The research findings are discussed in section 6.3.

- To develop strategies to improve nurses' working conditions in selected public clinics of Limpopo Province, South Africa.

  This objective was achieved in chapter 5, where measures to improve nurses' working conditions in public clinics are formulated. Refer to section 5.2.

6.3 SUMMARY OF THE MAIN FINDINGS

Four themes and nineteen sub-themes were formulated from the interview transcripts of the participants. These themes include a description of different nurses' experiences of their working conditions; a description of different roles played by nurses during the provision of patients care in the clinics; a description of challenges experienced by clinic nurses leading to the provision of poor care; and suggestions how marked challenges could be resolved.

- Theme 1: Description of paradoxical nurses' experiences of their working conditions.

  Nurses experience a lack of resources during the provision of care, which negatively affects patient care. There is a shortage of staff personnel at the clinics, in addition to a shortage of resources like medication. Nurses work in unfavourable and unsuitable clinic structures, affecting the provision of quality patient care. The poor infrastructure of the clinics predisposes clients to cross-infection. Nurses indicated that their clinics served large geographical areas which leads to an increased number of patients, causing burnout in nurses. Nurses work different work schedules depending on clinics. Such schedules are favourable to some and unfavourable to others.

- Theme 2: Description of different roles played by nurses during the provision of patient care in the clinics.

  Nurses are forced, by the demands of their working conditions, to carry out the roles of other staff personnel. Some clinics do not have clerks, data capturers or pharmacy assistants and nurses must perform their roles. Nurses carry out the pharmaceutical duties of ordering, receiving, controlling and balancing pharmacy stock. Nurses also stated that they executed the roles of clerks and data capturers over weekends. Patients are sometimes given duplicate files and their data are not captured, as nurses are not competent in clerk and data capture's roles.

- Theme 3: Description of challenges experienced by clinic nurses leading to the provision of poor care

  There is a shortage of resources in the clinics that negatively affects patients, leading to their defaulting on their treatment. Participants were not satisfied with the salaries they earned. They raised the point that they earn poor salaries for the work they carry out. Nurses described the physical, emotional and mental stress they experience when providing patient care. They experience lawsuits by the community because of the poor provision of care. A lack of material resources at the clinics disturbs nurses and leads to misdiagnoses of patients. The shortage of nurses for different reasons, negatively affects their provision of care.

- Theme 4: Suggestions on how challenges could be resolved

  Nurses suggested that management needs to request an increase in budget so they can extend the clinic structures to create more space. Nurses also suggested that their salaries be increased; this is to justify the increased workload they are experiencing. Review nurses that are not happy with their work schedules and suggested that existing schedules to provide better work schedules. The Department of Health should improve on the provision of all the resources provided to the clinics for better services to be rendered. Participants suggested that the Department of Health be transparent to the

public by informing them about anything that the department fails to accomplish. This is to prevent the public from blaming nurses for departmental failure.

6.4 RECOMMENDATIONS

Based on the findings, the following recommendations were considered for the improvement of nurses' working conditions.

These recommendations are derived from the themes of the study:

- Disseminate the findings of the current study to the Head of Department (HOD) of Limpopo Department of Health, district managers and the nursing staff of the clinics as soon as possible. The results will be presented on the Limpopo Department of Health Research Day and a paper will be written for publication.
- An assessment tool of working conditions in the clinics be devised by the Limpopo Department of Health provincially for the assessment of the clinics.
- The HOD and the district managers should use the assessment tool to identify the working condition gaps in the clinics. Identified gaps, together with the developed strategies, should be used to plan for revitalisation and improvement programmes for the clinics, for the coming year. This should be an ongoing process.
- At the end of each year, the implementation of improvement plan initiatives and the quality of the nursing care rendered should be evaluated.
- Studies on the implementation and evaluation of the strategies to improve nursing practice as well as in other settings be conducted.
- Managers implement suitable work schedules for nurses to improve working conditions.
- Limpopo Department of Health initiate programs to combat burnout by forming a team for social and life skills training.
- Limpopo Department of Health EWP and psychologists initiate the provision of teambuilding, support as well as stress management training through in-service training at the clinics.

6.5 LIMITATIONS OF THE STUDY

The study was conducted at seven public clinics selected from three districts of the Limpopo Province, South Africa. The findings cannot be generalised to the clinics in the remaining districts of the Limpopo Province. They also cannot be generalised to clinics in other provinces. Most nurses on their off days and those on leave were not willing to participate.

At times, the researcher asked leading questions.

6.6 CONCLUSION

The study has found that nurses working in public clinics of the Limpopo Province are working under poor and unsatisfying conditions. The unfavourable working conditions result from many factors like a lack of resources, underpayment, development of medical conditions due to strenuous work, working long shifts, poor clinic infrastructure and lack of communication between the DOH and the public, which negatively affects both nurses and the public.

Strategies and recommendations to improve nurses' working conditions have been developed. The DOH needs to increase the budget allocated to the clinics to correct the factors contributing to poor working conditions of nurses.

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ANNEXURE A: APPROVAL BY TURFLOOP RESEARCH ETHICS COMMITTEE (TREC)

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: 14 May 2019

PROJECT NUMBER: TREC/121/2019:PG

PROJECT:

Title:	Strategies to Improve Nurses working Conditions in Selected Public Clinics of the Limpopo Province, South Africa.
Researcher:	TJ Mulsepe
Supervisor:	Mrs GO Sumbane
Co-Supervisor/s:	Prof RN Malema
School:	Health Care Sciences
Degree:	Master of Nursing

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0310111-031

Note:

i) This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.

ii) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.

iii) PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa

ANNEXURE B: CONSENT FORM CONSENT FORM

DEPARTMENT OF NURSING SCIENCE ENGLISH CONSENT FORM

Statement concerning participation in a Clinical Research Project

Name of Project / Study**:** Strategies to improve nurses working conditions in public clinics of Limpopo Province, South Africa.

I have been introduced to the study topic, aims and objectives and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurised to participate in any way.

I know that sound recordings will be taken of me. I am aware that this material may be used in scientific publications, which will be electronically available throughout the world. I consent to this, provided that my name and South African Nursing Council number are not revealed.

I understand that participation in this Study / Project is voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my position; neither will it influence the care that I receive from my regular doctor.

I know that this Study / Project has been approved by the Turfloop Research Ethics Committee (TREC). I am fully aware that the results of this Study / Project will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

The Study/Project envisaged may hold some risk for me that cannot be foreseen at this stage.

Access to the records that pertain to my participation in the study will be restricted to persons directly involved in the research.

Any questions that I may have regarding the research, or related matters, will be answered by the researcher/s.

If any medical problem is identified at any stage during the research, or when I am vetted for participation, such condition will be discussed with me in confidence by a qualified person and/or I will be referred to my doctor.

I indemnify the University of Limpopo and all persons involved with the above project from any liability that may arise from my participation in the above project or that may be related to it, for whatever reasons, including negligence on the part of the mentioned persons.

I hereby give consent to participate in this Study / Project.

Signature of researched person...

Signature of researcher………………………………………

Signed at……………………………this…………day of………………20.......

Contact no: ....

ANNEXURE C: INTERVIEWING GUIDE

ENGLISH INTERVIEW GUIDE

Central question:

What is your experience of the working conditions in your clinic with regard to resources?

Probing questions

1. What is the staffing arrangement in your clinic?
2. What is the physical appearance of the clinic?
3. What is the arrangement of the working shifts?
4. What is the workload in your clinic?
5. How is the remuneration?
6. What are the main challenges that your clinic encounters?
7. How do those mentioned challenges affect patient care?
8. How do those challenges affect nurses?
9. What do you think the district, provincial and national levels of management can do to solve your challenges?

ANNEXTURE D: LIMPOPO DEPARTMENT OF HEALTH APPROVAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Ref	:	LP_201908_004
Enquires	:	Ms PF Mahlokwane
Tel	:	015-293 6028
Email	:	Phoebe.Mahlokwane@dhsd.limpopo.gov.za

Thembi Julia Motsepe

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

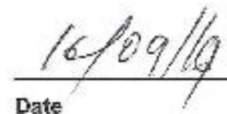
Your Study Topic as indicated below;

Strategies to improve Nurses working Conditions in selected Public Clinics of the Limpopo Province, South Africa.

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
   a. Present this letter of permission to the institution supervisor/s a week before the study is conducted.
   b. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
   c. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   d. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   e. The approval is only valid for a 1-year period.
   f. If the proposal has been amended, a new approval should be sought from the Department of Health
   g. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated

Head of Department



Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street, Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.
Website: http/www.limpopo.gov.za

ANNEXURE E: CAPRICORN DISTRICT PERMISSION

LIMPOPO

PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

CAPRICORN DISTRICT

REF : S.5/3/1/2

ENQ : Hlatshwayo MM / Makgaloa MO

TEL : 015 290 9154/9096

FROM : DISTRICT EXECUTIVE MANAGER

TO : Thembi Julia motsepe

EMAIL : Motsepethembi@gmail.com

SUBJECT : PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES OF STRATEGIES TO IMPROVE NURSES WORKING CONDITIONS IN THE FOLLOWING CLINICS: MAKANYE, DIANA, KROMHOEK, MANKWENG, MOROTSE-THAMAGANE AND SADU ON NOVEMBER 2019.

The above matter refers:-

1. Permission to conduct research is hereby granted.
2. Kindly be informed that :
   - In the course of your practical training here should be no action that disrupts the services.
   - Kindly note that the Department can withdraw the approval at any time.
3. Your cooperation will be highly appreciated.

pp DISTRICT EXECUTIVE MANAGER

03/10/2019

DATE

Private Bag x9530, Polokwane, 0700, 34 Hans Van Rensberg ST, Polokwane 0700
Tel: (015) 290 9000, Fax: (015) 291 3260/1568 Website: http/www.limpopo.gov.za

ANNEXURE F: WATERBERG DISTRICT APPROVAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
WATERBERG DISTRICT

REF: 4/3/3.
ENQ: NKGODI D.R (PA TO THE DISTRICT EXECUTIVE MANAGER)
DATE: 22/10/2019.

TEL NO: 014. 718 0623 / 082 344 0227.
E-MAIL: David.Nkgodi@dhsd.limpopo.gov.za

TO: THEMBI JULIA MOTSEPE.

RE: PERMISSION TO CONDUCT RESEARCH: YOURSELF.

The above bear's reference:-

1. The office of the District Executive Manager, hereby confirms receipt of your request to research on strategies to improve nurses working conditions in selected public clinics of the Limpopo Province, South Africa.
2. Permission is hereby granted as per approval by the HOD.
3. You are further requested to notify this office on when you are going to start with the research and make sure that there is no action that disturbs service delivery.

Your support and cooperation in terms of the above will be highly appreciated.

DISTRICT EXECUTIVE MANAGER
WATERBERG DISTRICT

25/10/2019
DATE

ANNEXURE G: SEKHUKHUNE DISTRICT PERMISSION

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

SEKHUKHUNE DISTRICT

Ref: 5/3/1
Enq: Mashiane PN
Tel: 0156332352 / 078 126 5414
E-mail: Philistus.Mashiane@dhsd.limpopo.gov.za

Date: 06 November 2019

To: **Motsepe TJ**
University of Limpopo
Deparment of Research Administration and Development

From: Human Resource Utilization and Capacity Development.

Subject: Approval for permission to collect data: Yourself

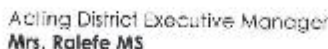
1. The above matter bears reference.

2. Based on the approval granted by the Head of Department of Health, Limpopo Province regarding your request to conduct research in our institution, the Acting District Executive Manager for Sekhukhune is hereby permitting you to visit the institution as indicated in your application letter for collection of data.

3. Also take note that the approval for the research is valid for a period of 1 year and should it happen that after the specified period you are not satisfied with your findings and wish to continue, another request from you should be send to us so that approval is sought on your behalf.
4. Be informed that the collected findings from our facilities should be kept confidential and should not be made available for public use in any way by you or the Research Ethics Committee under which you are registered.

5. **During assumption of data collection, you will present yourself and your scope of work and schedule to the Sub-district Manager or the Operational Manager on how you will be visiting the facilities.**

5. Hope the matter is found to be clear and understandable.



06/11/2019

Acting District Executive Manager
Mrs. Ralefe MS

Date

Private Bag X04, Chuenespoort 0745 Tel: (015) 633 2300,
Fax: (015)6336487 Website:www.limpopo.gov.za

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ANNEXURE H: LEKHURENG CLINIC PERMISSION

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Department of health

Waterberg district

REF: 14/04/20

ENQ: MANOKO M.S (OPERATIONAL MANAGER)

DATE: 14/04/2020.

TEL NO: 079 519 7960/015 483 3904

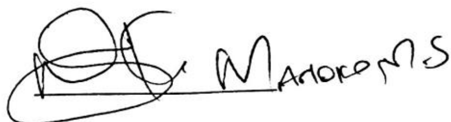
TO: T.J MOTSEPE

RE: PERMISSION TO CONDUCT RESEARCH: YOURSELF.

The above bear's reference:-

1. The office of the clinic operational manager (Lekhureng clinic), hereby confirms receipt of your request to research strategies to improve nurses working conditions in selected public clinics of the Limpopo, South Africa.
2. Permission is hereby granted by Lekhureng clinic as per approval by the HOD.
3. You are further requested to notify this office on when you going to start with the research and make sure that there is no action that disturbs service delivery.

Your support and cooperation in terms of the above will be highly appreciated.



2020/04/14

Clinic Operational manager.　　　　　Date

Waterberg District.

ANNEXURE I: STERKWATER CLINIC APPROVAL

LIMPOPO

PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

WATERBERG DISTRICT

REF: 14/04/2020

ENQ: DOLO M.E

DATE: 10/04/2020

TEL: 0154130908

TO: MOTSEPE T J

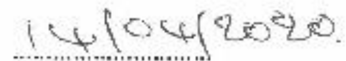
RE: PERMISSION TO CONDUCT RESEARCH

The above bear's reference:-

1. The office of the operational manager of sterkwater clinic, hereby confirms receipt of your request to research strategies to improve nurses' working conditions in selected public clinic of the Limpopo province, South Africa
2. Permission to conduct the research at sterkwater clinic is hereby granted as per approval by the provincial and district offices
3. You are further requested to notify this office on when you are going to start with the research and make sure that there is no action that disturbs the service delivery.

Your support and cooperation in terms of the above will be highly appreciated

Clinic Operational Manager



DATE

ANNEXURE J: MPHANAMA CLINIC APPROVAL

LIMPOPO

PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF

HEALTH

REF: 21/04/2020

ENQ: MPHANAMA CLINIC

TO: MOTSEPE TJ

RE: PERMISSION TO CONDUCT RESEARCH AT MPHANAMA CLINIC

STUDY TOPIC: STRATEGIES TO IMPROVE NURSES WORKING CONDITIONS AT SELECTED PUBLIC CLINICS.

1. The local area manager and the clinic operational manager of Mphanama clinic grant the permission to conduct the study
2. The permission is granted as per the provincial and district approvals
3. This permission is only valid for as long as the provincial approval is valid
4. In the course of the conducting of the research there should be no action that disrupt the routine service

Yours cooperation will be highly appreciated

Clinic operational manager's signature: Mothale M.M

Contacts: 013 265 8901

Date: 21 April 2020

ANNEXURE K: PROBEERING CLINIC PERMISSION

LIMPOPO

PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

SEKHUKHUNE DISTRICT

REF: 28/04/2020

ENQ: PROBEERING CLINIC

TO: MOTSEPE TJ

RE: PERMISSION TO CONDUCT RESEARCH AT PROBEERING CLINIC

STUDY TOPIC: STRATEGIES TO IMPROVE NURSES WORKING CONDITIONS AT SELECTED PUBLIC CLINICS.

1. The local area manager and the clinic operational manager of Probeering clinic grant the permission to conduct the study
2. The permission is granted as per the provincial and district approvals
3. This permission is only valid for as long as the provincial approval is valid
4. In the course of the conducting of the research there should be no action that disrupt the routine service

Yours cooperation will be highly appreciated

Clinic operational manager ...SEBOPA M.A...

Clinic operational manager's signature: ...MSebopa...

Contacts ...0793330600...

Date ...28/04/2020...

ANNEXURE L: LANGUAGE EDITOR CERTIFICATE

S E Matthis B A (Hons)

1 Oden Place
Douglasdale, 2191

Cell: 0837817646

email:suematthis@gmail.com

12 July 2020

TO WHOM IT MAY CONCERN

This serves as confirmation that I have proofread and language edited the dissertation:

STRATEGIES TO IMPROVE NURSES' WORKING CONDITIONS IN SELECTED PUBLIC CLINICS OF THE LIMPOPO PROVINCE, SOUTH AFRICA.

by

THEMBI JULIA MOTSEPE

S E Matthis

ANNEXURE M: TRANSCRIPTS

TRANSCRIPT OF SEMI-STRUCTURED INTERVIEW 2

Mashabela clinic

Date: 31 June 2019

Researcher = R Participant = P

Introduction: Good morning, my name is Motsepe Thembi, a nursing master's student from the University of Limpopo. I am here today to collect data for my research study; the title of the study is Strategies to Improve Nurses' Working conditions in selected public clinics of the Limpopo Province, South Africa. The study is conducted to get information that will help in improving nurses' working conditions. The interview will take about 30 minutes; in that interview, there will be demographic data and interview guides. With me, I have the consent form for you to sign which will serve as an agreement for you to participate. You are allowed to withdraw during the interview if you feel the need to withdraw. I also have a tape recorder with me, I will be recording our interview, it will help me during the transcription of our interview. Can you please sign the consent form?

P: Ok

R: Thank you, for signing the consent form. Now we are going to start with the demographic data. What is your age?

P: I am 25 years' old

R: What is your gender?

P: I am female

R: What qualifications are you holding?

P: I have a B. Tech Nursing Science qualification

R: And how long is your experience in that field?

P: I would say that I have two years' experience, including community service

R: What postgraduate qualification do you have?

P: I do not have it yet, am planning to have one though.

R: Which district are you serving?

P: I am in Sekhukhune District

R: Thank you, we are done with the demographic data. Now we are going to start with the interview guide. What is your experience of the working conditions in your clinic with regard to resources?

P: Our working condition regarding resources I would say that our facility have resources but they are not enough, because like in case of maternity we don't have CTG machine, we don't have suctioning machines that are working properly and most of the time we don't have oxygen machine; and with the paperwork, we sometimes out of the paperwork, we sometimes out of the printers, the toners so we can't do the paperwork properly

R: And what is the staffing arrangement in your clinic?

P: Our staffing. We have enough staff that is balancing because like we have two we are out of two groups like we have the other group and the second group.

R: And how many professional nurses do you have in each group?

P: We have, all in all we have eight professional nurses and then we also have two ENs and then we have three ENAs, so like, we work other ones we are three professional nurses and the other group has four, and the other professional nurse is the operational manager

R: What is the physical appearance of the facility?

P: The physical appearance of the facility, it's limited, I would say it's limited because like we are nine professional nurses and then we all do not have consultation rooms, we only have two consultation rooms that are in use, the other two serves for other purposes, and then again the filing room, and then again our filing room is limited and we have a lot of patients and then the files are like are over-packed like the space is just limited

R: What is the workload in your clinic?

P: The workload is too much because we have a lot of patients but since well we have like nine professional nurses because we meet, we meet during the week like I would say we meet, we are combined, we are all combined, three days in the week so we are managing well but though we have lot of work to do is a packed clinic but we are managing so far

R: What is the arrangement of the working shifts?

P: The working shifts its hectic because we work ten days in and then four days off and it's very hectic eh it's very hectic because is a very long shift and then we, we get tired but we are just managing otherwise we are working, our clinic operates from 07h00 to 16h30

R: And how is the remuneration?

P: According to me I feel like we are being underpaid as nurses because we do a lot of work we really put too much effort to our work and then we get paid little, I feel like we get paid little so we just hope in the future that they will revise our remuneration so that we can be satisfied

R: Ok, when you are saying you are doing a lot of work, are you saying you are doing more than you are expected to do or you are doing what you are expected to do?

P: I would say we go extra miles sometimes because um like um for example in the pharmacy we do not have eh pharmacy assistant but we do take care of our pharmacy, stock taking and we do we report the treatment we order we do a lot of stuff you know and then again sometimes during the weekend we do not have data a capturer we do not have a clerk and then we do all that by ourselves

R: What are the main challenges that your clinic encounters?

P: In our clinic, I would say, our challenge is it’s our shifts, really our shifts to me are not making sense because ten days is very hectic so we get tired we always tired so and I do not think we will be more productive if like we work ten days at least if we can revise the shifts and then yeah…

R: How do those mentioned challenges affect patient care?

P: They affect them because um in terms of our productivity patient care is affected in a bad because there is no way a tired nurse can render effective, productive and comprehensive service, so patients do not a get good quality care like the assessment and history taking will be limited

R: How do those challenges affect nurses?

P: It affects us negatively as we are physically, emotionally and mentally drained by these long shifts, too much workload

R: What do you think the district, provincial and national levels of management can do to solve your challenges?

P: I think our managers should just understand the negative impact of this type of shift and announce the relevant and suitable shifts for us, and only the district level needs to approve the shifts and as for provincial and national level I do not think there is anything they can help us with.

R: Thank you. That was my last question of the interview. Now I will summarise our interview. And you will add or subtract information if there is any need to. You said your facility has resources but they are not enough, the stuff is balancing with eight professional nurses, two ENs and three ENAs, consultation rooms are not enough and the filing room is small, the workload is too much, you are working hectic and long shifts and you are being paid little and you are not satisfied. Your facility's main challenge is the shifts; they deprive patients of comprehensive patient care and drain nurses physically, emotionally, and mentally. The district-level management can help by approving relevant shifts. You do not think there is anything the provincial and national management levels can help you with. Is there anything more you would like to say?

P: No. You have said it all.

R: Thank you for your time and participation.