# THE EXPERIENCES OF REGISTERED NURSES' OF THEIR WORK ENVIRONMENT IN A CRITICAL CARE UNIT

BY

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## ABSTRACT

Critical care nursing is a vital and significant part of health care provision to critically ill patients. It is a specialty area of nursing that requires registered nurses who are highly motivated, knowledgeable and skilled to provide optimal care to critically ill patients. These patients are nursed in a complex environment consisting of specialised equipment (such as ventilators, defibrillators, intravenous pumps, and cardiac monitors) that is not found in any other field of nursing. Collegial support and an adequate registered nurse: patient ratio is vital in critical care units in order to provide optimal quality care to critically ill patients. However, an understaffed work environment, the demands of critical care nursing and other work-related problems, such as conflict with physicians, inadequate remuneration packages and an increased workload can cause serious distress and dissatisfaction amongst registered nurses in this specific environment (Carayon & Gürses, 2005:287).

 The objectives of this study therefore are to explore and describe the experiences of registered nurses of their work environment in a critical care unit and to make recommendations that will assist registered nurses working in a critical care unit. A qualitative, explorative, descriptive and contextual research design will be utilised. Data will be collected by means of semi-structured interviews and analysed according to the framework provided by Tesch (in Cresswell, 2003:192). Purposive sampling will be used to select a sample of registered nurses working in a critical care environment.  Guba's model (in Krefting, 1991) will be utilised to verify data and to ensure trustworthiness of the study.

 Ethical considerations will be adhered to throughout the study. Once data has been analysed, recommendations will be made that will assist registered nurses working in a critical care unit.

**Keywords**

Critical care nursing

Critical care nurse

Critical care unit

Registered nurse

Experience

Work Environment

Experienced registered nurse

# TABLE OF CONTENTS

**CHAPTER ONE**
**OVERVIEW OF THE STUDY**

**CHAPTER THREE**

**DATA ANALYSIS AND DISCUSSIONS**

LIST OF TABLES

# CHAPTER ONE
# OVERVIEW OF THE STUDY

## 1.1 INTRODUCTION

Critical care nursing is a vital and important part of healthcare provision to seriously ill patients, which occurs in an environment where the technology to keep patients alive is ever-increasing, sophisticated and expensive (Jastremski, 2000:723). If walking into any critical care environment one will find blinking monitors, ventilators, intravenous pumps, and noise from equipment, bright lights and a variety of multi-disciplinary healthcare team members discussing the condition of a critically ill patient. These patients include those who are physiologically unstable with an increased risk for mortality and morbidity, but who are more likely to survive if they are given specialised care (Bucher & Melander, 1999:39). The provision of care to critically ill patients depends on the collaboration of a multi-disciplinary healthcare team (doctors, registered nurses, pharmacists, physiotherapists and dieticians) and an approach based on expert knowledge and skill. However, as indicated by Hudak & Gallo (1994:112), it is the registered nurse who is in constant attendance to provide optimal care to critically ill patients. Considering the high technological environment in which critically ill patients are nursed, it became important to explore and describe the experiences of registered nurses of their work environment in a critical care unit.

The roots of critical care nursing emerged after the 1950s when Florence Nightingale, during the Crimean war, identified the need to provide one-to-one nursing care to patients who were critically ill. Critical care units were subsequently established but as advances have been made in medicine and technology, patient care has become much more complex than before. It is against this background that the specialty of critical care nursing has emerged (Bucher & Melander, 1999:39).

The critical care unit is complex in the sense that it consists of specialized equipment (defibrillators, cardiac monitors, intravenous pumps and specialized

emergency trolleys, etc). Critical care nurses are required to possess the expertise to understand the working principles of this equipment and, based on data revealed on these monitors, critical care nurses need to make decisions quickly, accurately and often independently based on the condition of the patient (Moore & Woodrow, 2004:7). According to Bucher & Melander (1999:47) the critical care unit is an unpredictable environment in which the patient's condition may deteriorate at any time; and the registered nurse working in this environment has a continual fear of not being able to respond appropriately to a patient's haemodynamic instability. Therefore registered nurses working in a critical care environment must have advanced knowledge, clinical skills and experience in order to provide optimal patient care. However, if registered nurses do not possess the necessary clinical skills and knowledge in caring for these specific patients, the critical care environment can become very stressful.

According to Scribante & Bhagwanjee (2007:68), nurses who work in critical care units should have in- depth knowledge of the pathophysiology of critically ill patients and have the ability and knowledge to use high technology equipment correctly. Scribante & Bhagwanjee (2007:68) further explain that "nurses should be given, and should accept, responsibility and accountability for all actions undertaken"; but if they are accountable they would accept the need to agree to three preconditions, namely, ability, responsibility and authority. However, not all nurses who work in critical care units hold an additional qualification in critical care nursing. Some are experienced registered nurses and some are less experienced in the critical care unit. Currey, Browne & Botti (2006:1085) indicated that less experienced registered nurses were frightened to make decisions because if anything went wrong with the patient they would be held responsible. If a nurse made an error, for example, by giving the incorrect medication, that caused deterioration or the death of the patient he or she might end up in a court of law being accused of negligence or malpractice (Nursing Act, no. 33 of 2005, section 47). In South Africa nurses are registered with the South African Nursing Council, an institution commissioned by government through the Nursing Act no. 50 of 1978 to regulate nursing practice. In this Act certain rules and regulations are set

out, which serve as guidelines on how nurses should conduct themselves in clinical practice, such as the Scope of Practice, accountability for acts and omissions and professional and ethical codes of conduct. Physicians' orders or institutional policies do not exclude registered nurses from being accountable for their actions and judgments made. Being accountable for their decisions or actions taken increases nurses' anxiety about decision-making, because nurses working in critical care units regularly face the necessity of making clinical and ethical decisions. The registered nurse has a further role of being the patient's advocate and should therefore intervene when the basic values, rights and beliefs of the patient are at risk of being compromised. However, ethical decision- making requires nurses to identify and to evaluate alternative actions and consequences in order to determine what they ought to do. In their study on ethical decision-making and stress Erlen & Sereika (1997:958) found that it was the less experienced nurses who experienced more anxiety when it came to decision-making because they lacked the necessary expertise and confidence in caring for critically ill patients. The research findings cited would seem to suggest that less experienced nurses need guidance and accompaniment by experienced colleagues until they are competent in making independent decisions related to patient care in the critical care unit.

Owing to the shortage of nursing staff in critical care units in South Africa, the accompaniment of less experienced critical care nurses is not always possible. Shortage of staff is a major problem in South African hospitals which is mainly due to the large number of nurses who have left the country to work in other countries for better working conditions as well as better remuneration packages than they receive in South Africa (Mathiva, 2002:3; Ventner, 2005:1). According to the Democratic Nursing Organisation of South Africa (DENOSA), the exact number of nurses who have left the country is not known. In their study done in 2004-2005, Scribante & Bhagwanjee (2007:1315) indicated that there was a major shortage of nursing staff in South African public and private hospitals. The study indicated that there was a national deficit of 7920 critical care nurses in South Africa. However, this indication is not always true as it is known (but not documented) that a

substantial percentage of critical care nurses often practise in other areas such as nursing management and education (Scribante & Bhagwanjee, 2007:1316). The authors further indicated that there should be at least an average of three registered nurses allocated per critically ill patient; but this is not always possible. The private sector and only two of the nine provinces (Gauteng and Western Cape) in the public sector make use of agency workers to meet the demand for a registered nurse to patient ratio of 1:1(Scribante & Bhagwanjee, 2007:1316).

According to Gillespie (2006:38), compared with worldwide norms Western Cape critical care units have a deficit of 74% registered nurses in the public sector and 82% in the private sector, an actual shortage of 3010 registered nurses for both sectors. Gillespie's conclusion was that the current supply of registered nurses did not meet the demands of the critical care units in the Western Cape. The study was only contained to the Western Cape and statistics from the other provinces was not available.

The registered-nurse-to-patient ratio in critical care units in South African hospitals does not compare with the worldwide norms as set out for a critical care unit. According to the World Federation of Critical Care Nurses (WFCCN), (2005), it is the right of every patient admitted to a critical care unit to be cared for by a registered nurse. In addition, the patient should be treated by a registered nurse with an additional qualification in critical care nursing. Unconscious and ventilated patients should have a minimum ratio of one registered nurse to one patient. Some patients receiving complex therapies in certain critical care environments may require more than one nurse to one patient. High dependency patients in critical care units require a registered nurse to patient ratio of 1:2. Where necessary, extra registered nurses may provide additional assistance, co-ordination, contingency (for late admission or staff reporting sick), education, supervision and support to a sub-set of patients and nurses in a critical care unit (World Federation of Critical Care Nurses, 2005).

However, owing to staff shortages, it is not always possible to follow the prescribed registered- nurse- to- patient ratios in South African hospital critical care units. The nurses in public hospital critical care units in South Africa are not confined to one patient only in rendering care, but take care of two to three critically ill patients at a time. These shortages of staff increase the workload for the remaining critical care nurse and may also contribute to the known stressors of working in a critical care environment. According to Alameddine, Dainty, Deber, & Sibbald (2008:2), the stressors that the nurse has to deal with in a critical care unit include environmental, psychological and interpersonal stressors.

Critical care nurses are exposed to the same environmental stimuli as critically ill patients and their family members, which may have a negative impact on the physical and psychological well-being of the critical care nurse. The constant noise of people rushing about, telephones ringing and alarms sounding are all part of the critical care environment and can contribute to sensory overload for the patient and staff working in this environment. Critical care nurses can become annoyed and impatient with the continuous alarming in the unit, especially when they are busy with another patient and there is no one else to attend to the alarm. Alarm suspension in a critical care unit is not advisable due to the unpredictability of most patients' condition. The critical care nurse may at times whilst on duty not even know what the weather for the specific day is because of the lack of exposure to natural light and sound. In some critical care units nurses are not allowed to leave the unit during lunch or tea times in case they might be needed during a crisis situation. Registered nurses become discontented with their work environment and their dissatisfaction becomes evident in the form of sickness and absenteeism (Moore & Woodrow, 2004:24).

The critical care nurse is challenged to create a safe and therapeutic environment for the critically ill patients in this unfamiliar critical care environment where the patients are confined to a hospital bed due to intravenous lines, catheters and drains, thus limiting their movement severely. The patient has only the ceiling, hospital staff and equipment to look at, which can also have an impact on their

physiological recovery. Thus it becomes the critical care nurse's responsibility to control environmental stimuli in the unit by turning lights down, minimising noise level, and explaining sounds, alarms and procedures carefully to patients and their family members. By doing this the nurse also aids in orientating the patient and family members to the critical care environment (Bucher & Melander, 1999:54).

According to Urden, Stacy & Lough (2006:72), patient-centred care includes family-centred care and a critical care environment that is able to accommodate the needs of the family of the critically ill patient. These family members are fearful of losing their loved ones and the critical care nurse has to demonstrate an ability to help, advise and support. The patient's family has specific informational needs that must be met.  Family members often enquire about pathophysiology of the disease, treatment options and prognosis of the patient. It is important that the registered nurse describe the patient's condition in terminology that the family can understand. The technology and equipment used in a critical care environment must also be explained to the family and if possible even before the family visits the patient. The registered nurse also has to assess the family's ability to cope and to determine whether a family member needs the assistance of another healthcare team member such as a social worker, psychologist or pastor to render further emotional support. It is expected of the nurse to provide this comprehensive care in order to make the critical care unit a warm and caring environment, which maximises patient care outcomes and establishes an excellent standard of professional practice (Bucher & Melander, 1999: 54).

However, the critical care nurse may also experience the same challenges as other people do in their personal life, for example, interpersonal conflict, family crises or problems with children or a spouse that can increase their stress levels even more. Conflict with doctors or fellow colleagues may also have an effect on registered nurses working in the critical care environment. For example, doctors tend to blame nurses if a patient's condition deteriorates, which might cause the nurse to feel distressed, vulnerable and hurt and they are equally harsh towards nurses who wake them at night unnecessarily to answer questions they feel the

nurses could have answered for themselves.  These aspects that the critical care nurses' daily experience are some of the challenges mentioned which led to the problem formulation.

## 1.2 PROBLEM FORMULATION

In an Eastern Cape critical care unit where the researcher is employed, nurses deal with hemodynamically unstable, post-operative patients most of the time and they often have to make decisions regarding the treatment modalities to be implemented for these patients. The critical care unit is a specialised unit consisting of six beds where cardiothoracic surgery is done on a daily basis, on at least one to two patients per day.  These patients are admitted from the operating theatre with multiple intravenous infusions, arterial lines, a central line in situ and are often connected to a mechanical ventilator. Their condition can deteriorate rapidly and patients often present with complications such as hypotension, arrhythmias, decreased urinary output and the likelihood of a cardiac tamponade, all of which could be life- threatening to the patient if not managed promptly. When nursing these post-operative patients the registered nurse responsible for this patient is always faced with patient-care-related questions such as, whether she should give a crystalloid or colloid in the case of hypotension or increase the inotropic therapy.  What would happen if she overloaded the patient with fluid;   or whether she should phone the doctor or not.  What if the doctor thinks she woke him/her up for no good reason at 3 a.m. in the morning for a problem a registered nurse could have solved.

During a 12- hour night duty shift there is no doctor present in the unit and should any immediate crisis intervention be needed, decision-making relies on the registered nurse on duty. The doctors need to be phoned if medical treatment is required and the registered nurse has to act on telephonic prescriptions given by these doctors because most of them are not immediately available to attend to the patient. At times, because of the shortage of staff and few registered nurses who have an additional qualification in critical care nursing, patient care depends on an experienced registered nurse, a less experienced critical care registered nurse, an

enrolled nurse and an auxiliary nurse.  If the registered nurse does not possess adequate knowledge and expertise in order to make complex decisions regarding patient care, these situations can become very stressful.

A visit by the Accreditation body regarding quality improvement to the institution where the study will be conducted found an inadequate registered-nurse-to-patient ratio in this unit compared with worldwide norms (COHSASA facilitator report, visit 1-13, 2007:1). Institutional statistics obtained from the healthcare institution where the researcher is employed, showed that only 37% of registered nurses working in the unit held an additional qualification in critical care nursing of whom only 18% were involved in patient care. The other 18% were involved in administrative duties and the remaining 63% of the total number of registered nurses in the unit were experienced critical care nurses without an additional qualification in critical care nursing (Institutional statistics: 2009).

According to unit management many written communications have been submitted to the directors of the hospital to address the issue off staff shortages and based on their dissatisfaction, qualified registered nurses were employed in the unit, but they were not experienced in the critical care environment and it would take these nurses some time (six months to one year) to adapt to the routine of the critical care environment.

In their study Scribante & Bhagwanjee (2007:1315) conclude by saying that critical care nursing in South Africa face the challenge of an acute shortage of trained and experienced nurses. South African nurses are tired, often not healthy and affected by discontent and low morale. These problems need to be addressed because public hospital critical care units cannot afford any further loss of their experienced and trained staff.

Inadequate staffing, challenging decision- making regarding treatment modalities, advanced knowledge and clinical skills needed to use high technology equipment, sensory overload, lack of collegial support, patient and family support that need to

be given, inadequate financial remuneration, impact of institutional policies and ethical dilemmas, can have an effect on how the critical care nurse experiences her/his environment.

The above mentioned factors give rise to the following **research questions:**
1. How do registered nurses in a critical care unit experience their work environment?
2. What recommendations can be made to assist registered nurses working in a critical care unit?

## 1.3 RESEARCH OBJECTIVES:
With the research questions in mind, the objectives of the study are the following:

**Primary objective:**
To explore and describe the experiences of registered nurses of their work environment in a critical care unit.

**Secondary objective:**
 To make recommendations that will assist registered nurses working in a critical care unit.
            .
## 1.4 CONCEPT CLARIFICATION
The relevant concepts to this study can be defined for clarification as follows:

**Critical care nursing**
Critical care nursing is a specialized area of nursing that involves caring for patients who are suffering from a life- threatening illness or injury or potentially life-threatening illness or injury (Bucher & Melander, 1999: 39).

**Critical care nurse**

A critical care nurse is a registered nurse who has adequate knowledge, clinical skills and competence to meet the needs of the critically ill patients without direct supervision (RCN, 2003:93 as cited in Moore & Woodrow (2004:7). In South Africa the critical care nurse's qualification must be registered with South African Nursing Council (SANC) as an additional qualification in critical care nursing.

**Critical Care Unit/ Intensive care unit**

A critical care unit is also referred to as an intensive care unit (ICU). A critical care unit is a specialised section of a hospital containing the equipment, medical and nursing staff and monitoring devices necessary to provide intensive care (Intensive care unit, 2008). The research study will be conducted in an adult critical care unit.

**Registered nurse**

A registered nurse refers to a person who is qualified and competent to practice comprehensive nursing independently in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice. In terms of section 16 of the Nursing Act No.50 of 1978, such a person must be registered with the South African Nursing Council (SANC) as a practitioner in at least one of the following categories: "nurse" or "midwife" (Nursing Act no.50 of 1978). In the research study registered nurses working in a critical care unit will be the participants in the study.

**Experience**

Experience refers to the things that have happened to one that influence the way one thinks and behaves (Hornby, 2005:512). In this study experience refers to the feelings, perception, fears and attitudes experienced by registered nurses while working in a critical care environment.

**Work Environment**

An environment refers to the surroundings, conditions or circumstances in a place that affect the behaviour and development of people or something (Hornby, 2005:490). In this study work environment refers to the critical care environment, namely, the conditions and surroundings in a critical care unit that have an effect on registered nurses working in this environment.

**Experienced registered nurse**

For the purpose of this study experienced registered nurses refers to nurses who obtained knowledge and skills from previous clinical practice in caring for critically ill patients. Experience enhanced registered nurses abilities to identify and to act on signs and symptoms that show haemodynamic instability in critically ill patients and it increased nurse's decision-making confidence (Currey et al. 2006:1082). In South Africa experienced registered nurses in the critical care unit do not have an additional qualification in critical care nursing.

## 1.5 RESEARCH DESIGN AND METHODS

A brief overview of the research design and methods will be provided.

### 1.5.1 Research design

Research design refers to a plan for conducting research. It is implemented to find answers to the researches focused questions (Mouton, 2001:55).

A qualitative research approach will be used following an explorative, descriptive, and contextual research design.

### 1.5.1.1 Qualitative research

According to de Vos, Strydom, Fouche & Delport (2002:79), qualitative research is aimed at understanding the meaning, experiences and perceptions people attach to their everyday lives. This method is concerned with studying human experiences from the viewpoint of the research participants. The qualitative researcher is interested in meaning - how people make sense of their lives, experiences and their structures of the world. In the research study an attempt will

be made to understand the experiences and the meaning registered nurses attach to working in a critical care environment.

### 1.5.1.2    Explorative research

Bless & Higson-Smith (as cited in de Vos et al., 2002:109) state that explorative research is conducted to gain insight into a situation, phenomenon, community or individual. Explorative research is conducted when inadequate information about the phenomenon is available. This research study is concerned with exploring the experiences of registered nurses working in a critical care unit in order to gain insight into their experiences. The understanding of registered nurses experiences may lead to recommendations that might assist registered nurses working in a critical care unit.

### 1.5.1.3    Descriptive research

Descriptive research endeavors to give a complete and accurate description of the phenomena, and experiences of the participants as possible. It presents a picture of the specific details of a situation, social setting or relationship (Neuman, 2000:22). A detailed description of registered nurses' experiences of their work environment in a critical care unit will be given.

### 1.5.1.4    Contextual research

According to Holloway & Wheeler (2002:34), context includes the environment and the conditions in which the study takes place as well as the attitudes of the participants that permeate the setting. The research study will be conducted amongst registered nurses in the critical care unit consisting of six beds of a public hospital in the Nelson Mandela Metropole, which is in an urban area. The experiences of these registered nurses are specific to the context, because it is a specialised unit that is different from the rest of the hospital units.

### 1.5.2  Research methods

The research method refers to the sampling techniques (criteria for inclusion of participants) data-collection method an instrument and data analysis.

### 1.5.2.1   Target population

According to Brink, van der Walt & van Rensburg (2006:123), a *target population* is the entire group of persons that is of interest to the researcher, which in other words, meets the criteria for the focus of study. The population for the research study will be 15 registered nurses who work in a critical care unit in a public hospital in the Nelson Mandela Metropole.

### 1.5.2.2   Sampling methods

A purposive sampling technique will be employed which, according to Burns & Groves (1997:306), involves the conscious selection, of participants or elements that are typical or representative. In other words participants have the specific characteristics of the phenomenon (or topic) being studied. A detailed description of sample procedure and inclusion criteria of participants will be discussed in chapter two.

### 1.5.2.3   Data collection method

Participants of the research study will be approached individually. During this contact session the objectives of the study will be explained and also their willingness to participate in the research determined. Participants will be informed of their rights to refuse to participate, and /or withdraw from participation at any stage during the research study. If participants decide to participate voluntarily in the research they will be requested to sign a consent form. An appointment will be made for semi-structured interviews to be conducted at a venue and time suitable for the participant and the researcher.

Data will be collected by means of semi-structured interviews. For the purpose of this study the opening **question** will be "**Tell me about your experiences of working in the critical care unit".** A sub question that would also be asked is: **How would you like to be assisted while working in this environment?** The researcher will use an audiotape-recorder to capture the interviews which will be transcribed verbatim.  Field notes will also be taken down immediately after the

interview to ensure that the non-verbal responses of the participant are captured and to jot down her impressions of the interview (emotions, preconceptions, expectations and prejudices). Field notes will be jotted down on a small, unobtrusive notepad to be used for cross-referencing with the tape-recorded interviews.

### 1.5.2.4 Data analysis

Neuman (2000:305) defines data analysis as a search for patterns in data – recurrent behaviours, objects or a body of knowledge. The first aspect of data analysis will follow immediately after the interview. Data collected will be transcribed verbatim and analyzed thematically. The steps proposed by Tesch (in Cresswell, 2003:192) will be used to analyze data. These steps will be comprehensively discussed in chapter two.

An independent coder will be used to verify themes and sub-themes. After data analysis the independent coder and researcher will meet to have consensus discussions regarding themes and sub-themes identified. Once the data analysis has been completed, recommendations will be made to assist registered nurses in the critical care work environment. A literature control will be implemented to contextualize findings derived from themes with existing literature.

### 1.6 PILOT STUDY

A pilot study is a small- scale study conducted prior to the main study on a limited number of participants to investigate the feasibility of the research study and to detect any possible shortcomings in the data collection instrument (Brink et al., 2006:166).The researcher will conduct one interview, which will be transcribed to determine if any themes can be identified. If the questions posed to the participant are clear and elicit the required response, the interviewing technique will be used with other participants.

## 1.7 TRUSTWORTHINESS OF THE STUDY

Guba's model of trustworthiness as described in Krefting (1991:215-222) will be implemented to ensure trustworthiness. Guba's model is based on the identification of four aspects of trustworthiness which will be comprehensively discussed in chapter two.

### 1.7.1  Truth Value

Truth-value asks whether the researcher has established confidence in the truth of the findings for the participants, and the context in which the study was undertaken.  In qualitative research truth-value is usually obtained from the discovery of human experiences as they are lived and perceived by informants (Krefting, 1991:215). Truth value is established by the strategy of credibility (See Chapter 2 for discussion).

### 1.7.2  Applicability

Applicability refers to the degree to which the findings and conclusions of a research study can be applied to other contexts and settings or with other groups. Applicability is the ability to generalize from the findings to larger populations (Krefting, 1991:216). It is important for researchers to provide dense background information about the participants and the research context and setting to allow others to assess how transferable the findings are (Krefting, 1991:220). (See Chapter 2 for discussion).

### 1.7.3  Consistency

Consistency refers to whether the findings would be consistent if the study were replicated with the same subjects or in a similar context. Consistency is established through the strategy of dependability (Krefting,1991:216). The measures that will be used to ensure dependability in the study include dense description of research method, dependability audit, coding, triangulation and peer examination. (See Chapter 2 for discussion).

### 1.7.4 Neutrality

Neutrality refers to the extent to which the findings of the study are free from bias. Confirmability, which is a strategy used to achieve neutrality, is established by keeping a confirmability audit, triangulation and reflexivity (Krefting, 1991:217-221). (See Chapter 2 for discussion).

## 1.8 ETHICAL CONSIDERATIONS

Research ethics provide researchers with a code of moral guidelines on how to conduct research in a morally acceptable way (Struwig & Stead, 2001:66).The researcher will ensure that ethical and legal considerations are adhered to throughout the study. These aspects are the right to privacy, confidentiality and anonymity, the right to informed consent, no deception of participants and debriefing. A detailed description of these will be provided in chapter two.

 Before conducting the research study permission will be obtained from the following relevant authorities:
- The Advanced Degrees Committee.
- Faculty of Health Sciences Research, Technology and Innovation Committee.
- The education and training coordinator of the Complex Hospitals of the Nelson Mandela Metropole (see Annexure B).
- Medical Superintendent of the hospital where the research will be conducted( see Annexure B).
- Individual participants (see Annexure C).

## 1.9 DISSEMINATION OF RESULTS

The research findings will primarily be presented in the form of a treatise. Research findings will be communicated to audiences who will benefit from the findings and which will include nurses, other health professionals and policy makers. The results can be disseminated through:
- written reports
- in-service training and

- newsletters.

The researcher will write a report on the findings and copies will be given to the appropriate healthcare authorities. Recommendations made from research findings will be photocopied and distributed amongst registered nurses who work in a critical care environment. In-service education will also be given to registered nurses in the unit regarding the findings of the research study and recommendations made. An article for publication in a peer-reviewed journal will also be prepared.

## 1.10 CHAPTER DIVISION

The chapters will be divided as follows:

| | |
|---|---|
| Chapter 1 | Overview of the study |
| Chapter 2 | Research design and methods |
| Chapter 3 | Data analysis and discussions |
| Chapter 4 | Recommendations, Limitations and Conclusions |

## 1.11 SUMMARY OF CHAPTER

In this chapter the area to be researched, which is the experience of registered nurses of a critical care environment is stated. Data will be collected by means of semi-structured interviews and ethical principles will be adhered to throughout the study. Once data has been analyzed recommendations will be made that will assist registered nurses working in a critical unit.

# CHAPTER TWO
# RESEARCH DESIGN AND METHODS

## 2.1 INTRODUCTION

In the previous chapter a brief overview of the research study was given. The research problem and the objectives were stated. In chapter two the research design, research method, data collection method, data analysis and discussions will be described.

## 2.2 RESEARCH DESIGN AND METHODS

An overview of the research design and methods as applied during this study will be discussed.

### 2.2.1 Research design

Research design refers to the researchers overall plan for obtaining answers to the research questions and include strategies and procedures that need to be implemented (Holloway & Wheeler, 2002:35). The strategies that the researcher needs to focus on includes sampling, data collection methods, data analysis as well as writing up of the research study (Cresswell, 2003:183).The research design of the study was qualitative, explorative, descriptive and contextual in nature.

The research design is discussed as follow:

### 2.2.1.1 Qualitative research

Qualitative research focus on the qualitative aspects of meaning, experience and understanding and qualitative researchers study human experiences from the viewpoint of the participants in the context in which the action takes place (Brink et al., 2006:113). By using qualitative research the researcher bracketed out any preconceived ideas and opinions that she might had about the phenomenon under study. In the research study an attempt was made to understand the experiences

and the meaning registered nurses attach to working in a critical care environment.

Cresswell (2003:181-183) discuss the characteristics of a qualitative approach as follows:

- Qualitative researchers focus on the emic perspective meaning the views of the participants involved in the research, their perceptions, meanings and interpretations are valued. The researcher should make an attempt to discover and understand the participants' perspectives.

- The qualitative researcher is the primary instrument for data collection and analysis. Qualitative research is an interactive process between the researcher and the participants. Data are mediated through this human instrument rather than questionnaires and inventories.

- The process of qualitative research is inductive in that the researcher tries to make inferences from the information described by the participant of his/her experiences. The researcher uses reasoning to try to make sense of the phenomenon under study.

- Research takes place in the natural setting of participants so that participants' views are not isolated from their context. The researcher often goes to the site of the participants to conduct the research. This enable the researcher to develop a level of detail about the individual or place and to be involved in actual experiences of the participant.

- The relationship between the researcher and participant is close and based on a position of equality as human beings. The researcher adopts a non-judgemental stance towards the thoughts and words of the participants.

**2.2.1.2 Explorative research**

Exploratory research is conducted to gain new insight, discover new ideas and /or increase knowledge about a phenomenon (Struwig & Stead, 2001:7; Neuman, 2006). Explorative researchers are creative, open minded and flexible; adopt an investigative stance and explore all sources of information. In the research study an attempt was made to gain insight into registered nurses experiences of their work environment in a critical care unit. Semi-structured interviews were conducted with participants and knowledge and insight were obtained into registered nurses experiences. The insight obtained led to recommendations made that might assist registered nurses working in a critical care unit.

**2.2.1.3 Descriptive research**

Descriptive research involves detailed portrayals of the participants' experiences, their feelings and the meaning of their actions (Holloway & Wheeler, 2002:13). Description develops from the data and the context of the research study. Thick description was given about the setting, characteristics of the research population as well as problems encountered and the process followed by the researcher. The description is detailed enough for another researcher to duplicate the process. A description of a specific group of people and their experiences, namely registered nurses experiences of their work environment in a critical care unit were described.

**2.2.1.4 Contextual research**

According to Babbie & Mouton (2001:272) the aim of contextual research is to describe and understand events within the natural context in which they occur. Neuman (2006:158) states that qualitative researchers emphasized the social context for understanding the participants' world. They hold that the meaning of a social action or statement depends on the context in which it appears. The study was conducted amongst registered nurses in a critical care unit of a public hospital in the Nelson Mandela Metropole, which is an urban area. The critical care unit consists of six beds. The most common surgical procedures done

in this unit are coronary artery bypass grafting, valvular repair or replacement and congenital heart disease surgery. The experiences of these registered nurses are specific to the context, as it is a specialized unit that is different to the rest of the hospital units.

This unit form part of the public hospitals in the Nelson Mandela Metropole Complex and should a critical care bed be needed for a patient from the other hospitals in the complex such a patient get transferred to the specialized unit. Permanent registered nurses are employed in this unit and they are working day and night shifts consecutively. The registered nurses in this unit represent all cultural groups: black, white and coloured and they work in collaboration with a multi-disciplinary health care team.

## 2.2.2 Research methods

Research methods are techniques used by researchers to structure a study and to gather and analyze information relevant to the research question (Wellman, Kruger & Mitchell, 2005:167). The research method therefore includes the target population, sampling techniques (criteria for inclusion of participants) data collection and data analysis.

## 2.2.2.1 Target population

The *target population i*s a specic group of people whom the researcher wants to do a research study on (Neuman, 2006:224). The population of the research study comprise of *15 registered nurses* who work in a critical care unit in a public hospital in the Nelson Mandela Metropole.  It was established that five of these registered nurses have an additional qualification in critical care nursing and the remaining ten registered nurses have experience of working in a critical care unit without an additional qualification in critical care nursing.

**2.2.2.2 Sampling method**

A non probability, purposive sampling procedure was used in selecting participants for this study. According to Burns & Grove (1997:306) purposive sampling involves the conscious selection, of participants or elements that are typical or representative, in other words participants that have the specific characteristics of the phenomenon (or topic) being studied. A specific sampling size could not be determined at the onset of the study, so the researcher had to sample continuously until data saturation occurred and no new themes emerged from the interviews (Seidman as cited in (de Vos et al., 2002:300). After seven participants had been interviewed data saturation occurred and interviewing was stopped. The *criteria* for inclusion in the study were as follows:

- Registered nurses (with or without an additional qualification in critical care nursing) working in a critical care unit in a public hospital in the Nelson Mandela Metropole,
- Registered nurses who had more than one year's experience of working in the critical care unit in order to give a rich description of their experiences.

**2.2.2.3 Data collection method**

Data was collected by means of semi-structured interviews. With semi-structured interviews, interviewers are generally required to ask a number of specific questions, but additional probes to clarify issues are used. Questions were focused to ensure that the interviewees gave specific information required for the purpose of the study (de Vos et al., 2002:303). Questions were neutral rather than value laden or leading. Open-ended questions were asked, which allowed participants to express themselves freely. The opening **question** that was asked was "**Tell me about your experiences of working in the critical care unit".** A sub question that was also asked was: **How would you like to be assisted while working in this environment?**

The data collection process continued until data was saturated and no new themes emerged. This was evident after seven interviews were done.

The researcher as the main instrument of data collection abided to characteristics of qualitative research in conducting the research interview (Holloway & Wheeler, 2002:10) and these characteristics were applied as follows:

The researcher was honest and open about the research study, participants felt that researcher could be trusted and they gave a rich description of their experiences of the critical care work environment. The researcher took a non-judgmental stance so that the participants could share their true feelings and experiences of their work environment. She made participants aware that there is no right or wrong answers to questions posed.

The researcher made sure that the views and the meaning that registered nurses attach to their work environment were understood from their (the participant's) perspective. Semi-structured interviews were conducted with registered nurses working in this environment. Member checking were done with participants in order to ensure that data collected and interpreted was the participant's viewpoints and not the researcher's.

Interviews were conducted in the natural setting of the participants so that the participants' views were not isolated from their context. Interviews were conducted at a comfortable venue close to the critical care unit where the study was conducted at a time suitable for the participant and the researcher. This enabled the researcher to develop a detailed understanding of registered nurses experiences of their work environment.

The researcher was familiar with the context in which the study took place. She has been working in a critical care environment for the past six years. By being familiar with the environment it enhanced the researcher's awareness, knowledge and sensitivity to many of the experiences registered nurses shared as related to their work environment. However, the researcher guarded against being biased in how she interpreted the data as member checking was done and a personal journal was kept to note own feelings and perceptions during the interview process.

Data were collected according to the steps as set out by Wellman, Kruger & Mitchell (2005:167). These steps are discussed as follows:

**a) Preparing for the interview**

The first step in preparing for the interview involved the following:

- The researcher identified the research problem.
- The researcher made sure she understood what information was needed from participants.
- She identified those who would be able to provide information (target population and sample).

The researcher approached participants individually to establish their willingness to participate in the study. During this contact session the objectives of the study, why the participants were chosen, the method of data collection (which were interviews), how long the interviews will last, the use of a recording device, who would have access to information obtained (researcher, independent coder and supervisor) and what will be done with the research findings were all explained to the potential participant. Participants were informed of their right to refuse to participate and/or withdraw from participation at any stage during the research study. An informed consent form was given to each participant to sign if they were willing to participate in the research study. An appointment was made for an interview at a venue and time suitable for the participant and the researcher.

**b) Conducting the interview**

Interviews were conducted at a venue that was suitable for both the participant and the researcher during the off-duty time of the participants. Interviews lasted between one to one and a half hours. There were no disturbances during interviewing. It was during this stage (the interviewing process) that the researcher builds rapport and established a trust relationship with participants by once again informing participants of the objectives of the study and ensured their anonymity and the confidentiality of research findings. The researcher built rapport by putting the participant's at ease. She started the interview with some

general talk before the opening question was raised.  The opening question of research study was**: "Tell me about your experiences of working in the critical care unit. "** A sub question that was also asked was: **"How would you like to be assisted while working in this environment."** The researcher also used the following communicating techniques as laid out by Cresswell (2003:186-187) that demonstrated that she was listening carefully:

- verbal cues, for example mm…mm, uhm…, to show interest.
- Clarifying questions, for example "Are you saying that …?"
- neutral phrases, such as:  "could you elaborate on that …" was also used to provide feedback about the interview progress.

The researcher left it entirely to the participant's to provide answers to questions as she did not want to be biased and lead participant in what to say.


During the interview the researcher guided the interview to the topics related to the study by using questions that aid in clarifying data. These were:

- Introductory question:  this is the initial question posed by the researcher to the participant (See chapter 2.2.2.3).
- Follow up questions:  used to ensure that the participants answers are extended and clarified.
- Probing questions:  used by researchers to pursue answers without stating dimension to be taken into account.
- Specifying questions:   used to get precise descriptions of statements used.
- Direct questions:  used much later in the interview if information has been spontaneously shared.
- Interpreting questions:  rephrasing of what the participant has said to ensure clarification of data obtained.
- Silence:  used to allow the participant time to associate and reflect on data shared and can be broken down with new information (Kvale, 1996:133; de Vos et al., 2002: 293).

An audiotape recorder was used to capture the interviews, in order to ensure that the participants' responses were transcribed verbatim and no information was lost.

## c) Terminating the interview

The interviewer signaled before the time that the interview was coming to an end instead of ending abruptly. Each interview was terminated once the participant had nothing more to add, and the researcher had gained clarity on all that the participant had to share. A summary was given of all the areas that had been covered in the interview to ensure that what the researcher understood of the data was the actual viewpoint of the participant. The participants were also informed that a follow-up interview might be needed if data lack some clarity and to discuss research findings before finalization of the end results for the sake of member checking. Participants were also asked how the interview went for them and if there were any suggestions that could assist researcher in preparation for the next interview. Participants were thanked for their time and willingness to take part in the study and for information shared. Debriefing was not needed at the end of the sessions as participants were not distressed after the interview but the researchers number was given to interviewees should they have needed any support.

## d) Post interview

Immediately after the interview field notes were taken of the interview. By doing that, it minimized loss of data as revealed during the interview. Field notes are a written account of the things the researcher hears, sees, experiences and thinks about in the course of interviewing (Wellman et al., 2005:199).

## 2.2.3 Field notes on the interview

A separate personal journal was kept by the researcher to jot down her own feelings, impressions and reactions experienced while in the field. Direct observational notes that cannot be captured on the tape-recorder for example nervousness, anger, and frustration observed from participants were documented. Notes on the physical setting, time of day and date were also jotted down as this could have an influence on the interview, but the researcher made no assumptions without member checking. Notes were jotted down on a small,

unobtrusive notepad which was used for cross referencing with the tape recorded interviews. The types of field notes are discussed as follows:

*Five types of field notes are described by Neuman (1997: 364), which include:*
*Jotted notes*

Jotted notes are short, temporary memory triggers such as words, phrases, or drawings taken inconspicuously on a notepad. They are incorporated into direct observation notes but are never substituted for them (Neuman, 1997:364).

*Direct observational notes*

These notes are a detailed description of what the researcher heard and saw during the interview. They are an exact recording of the particular words, phrases or actions of participants and do not contain any interpretations. The notes should be ordered chronologically with the date, time and place on each entry (Neuman, 1997:364). All the interviews were done during the day between 10:30am and 12:00 pm.  When participants saw the reality of  the tape re-cording they seemed a bit nervous and had to be reassured about their anonymity and that no names would appear on the tapes, that the tapes would be kept in a safe place and then destroyed after finalization of the study. Two of the interviewees spoke non–stop and the interviewer did not have to use a lot of probes for clarity. The researcher noted that participants appeared to more relax after the tape recorder was switch off.

*Researcher inference notes*

The researcher should listen without applying analytical categories*;* he/she compares what is heard to what was heard at other times and to what others say; then the researcher applies his/her own interpretation to infer or figure out what it means. A researcher should keep inferred meaning separate from direct observation because the meaning of actions is not always self-evident (Neuman, 1997:364). Researcher's interpretations should be verified with member-checking.

The researcher made sure that any data or observation she interpreted was clarified with the participant as their viewpoint and their experience and not just the meaning the researcher put to it.

*Analytical notes*

Field researchers keep methodological ideas in analytical notes to record their plans, tactics, ethical and procedural decisions, and self critiques of tactics. Researchers suggest links between ideas, proposing conjectures, and developing new concepts (Neuman, 1997:364). In order to gain understanding into the experiences of registered nurses of their critical care environment semi-structured interviews were the main form of data collection. Some of the interviews went haltingly at the beginning and the researcher had to use probes in order for data to be clarified; but as the interview progressed participants became more relaxed and communication became easier. Most of the field notes were taken after the interview as the researcher kept more eye contact than persistent writing.

*Personal notes*

Personal notes are a record of the researchers own feelings and reactions experienced while in the field. These notes should also be recorded separately when compiling field notes (Neuman, 1997:364). As participants shared their experiences the researcher felt delighted by the saturation of data.

## 2.3 Data analysis

Neuman (1997: 426) defines data analysis as a search for patterns in data – recurrent behaviours, objects or a body of knowledge. The first aspect of data analysis followed immediately after the interview. Data collected were transcribed verbatim and analyzed. The tapes and the transcriptions were coded so that no names appeared on them. An independent coder was used to verify themes and sub-themes. The independent coder and the researcher coded the data individually.

For the purpose of this study the researcher followed the steps proposed by Tesch (in Cresswell, 2003:192) to analyze data. These steps are as follows:

- The researcher read through all the transcribed data to gain an overall meaning of information. Ideas as they came to mind were jotted down in the margin.
- This was done again with all the transcripts, to obtain clarity of the underlying meaning of the transcribed data.
- A list was made of all the possible themes identified and abbreviated codes were formed.
- With the coded themes as a preliminary focus, the researcher went back to the data. Each interview was studied and the coded themes noted in the margin. A few extra themes emerged and were added to the initial list.
- Similar topics were clustered together to form main and sub-themes. By counting the number of references to the coded themes, the researcher could distinguish which were the most important themes and which could be seen as left overs.

After data analysis the independent coder and researcher met to have consensus discussions regarding themes and sub-themes identified.  A discussion with the independent coder revealed similar themes to those identified by the researcher. A literature control was implemented to contextualize findings derived from themes with existing literature. Once the data analysis had been completed, recommendations were made to assist registered nurses working in the critical care unit. Audio tapes, transcribed interviews and field notes are locked away in a safe place which will be destroyed on completion of the study. Only the researcher, supervisors and independent coder had access to the information obtained during the data collection phase of the study.

## 2.4 PILOT STUDY

A pilot study was done to identify possible defects within the planned research study and investigate the feasibility of the study (De Vos et al., 2002:211). A pilot study was conducted before commencement of the major study.  The first

interview conducted was used as a pilot study and presented to the research supervisors to review the interviewing technique as well as the research questions used by the researcher to identify correctness of the method used and to suggest amendments as necessary. The pilot study was conducted in a comfortable room that was accessible for both the participant and the researcher. There were no interruptions during interview. The introductory question as set out in chapter 2.2.3 was asked as the opening question followed by the sub question as required. The participant was very relaxed and probing questions was also needed at times to gain clarity on experiences. The pilot study conformed to the necessary requirements and was included as part of the main study.

## 2.5 TRUSTWORTHINESS OF THE STUDY

Guba's model of trustworthiness as described in Krefting (1991:215-222) was implemented to ensure trustworthiness. Guba's model is based on the identification of four aspects of trustworthiness:

### 2.5.1 Truth Value

Truth-value asks whether the researcher has established confidence in the truth of the findings for the participants, and the context in which the study was undertaken.  In qualitative research truth-value is usually obtained from the discovery of human experiences as they are lived and perceived by informants (Krefting, 1991:215). Truth value is established by the strategy of credibility. Techniques to ensure credibility include prolonged engagement, reflexivity, triangulation, member checking, peer examination, interviewing technique, authority of the researcher and structural coherence (See application of strategies in table 2.1).

a) Prolonged engagement

Prolonged engagement means spending enough time with participants to learn about their environment and to build rapport because participants can only be understood when the researcher has invested enough time in the setting. This may result in their volunteering to participate in the study much easily, and sharing

information that may enrich the research findings (Krefting, 1991:217). The researcher is familiar with a critical care environment as she has been working in a critical care environment for the past six years.

b) Reflexivity

Reflexivity refers to a measure used to guard against the researchers over involvement with the participants that may result in an inability to interpret findings appropriately (Krefting, 1991:218). Researchers must be able to critically reflect on their own preconceptions, and monitor their relationships with the participants and their own reactions to participants' accounts and actions. Researchers are part of the phenomenon being studied and must reflect on their own actions, feelings and conflicts experienced during the research. Field notes were made during and immediately after the interview that reflected the researcher's thoughts, feelings and ideas generated while in contact with participants.

c) Triangulation

Triangulation is the process by which the phenomenon or topic under study is examined from different perspectives and methods. Thereby the findings of one type of method can be checked out by reference of another. This is a way of establishing whether there is generalisability in the research (Holloway & Wheeler, 2002:260). Kraft & Breitmayer (in Krefting, 1991:219) differentiates against several types of triangulation and will be discussed below:

Triangulation of data methods:

Researchers use one or more methods in one study to answer a similar question for example, interviews and observation (Krefting, 1991:219). Information gathered from interviews and field notes in the study were verified through literature control obtained from books, journals, articles and previous research studies.

Triangulation of data sources:

Triangulation is based on the importance of variety in time, space and person in observation and interviewing. Researchers use multiple data sources and obtain their information from different groups, settings or at different times (Krefting, 1991:219). Interviews were done with several participants until data was saturated at a venue and time that was suitable for the participant. Literature was also obtained from books, journals, articles and previous research studies.

<u>Investigator triangulation:</u>

Investigator triangulation refers to a situation where more than one expert researcher is involved in the study (Krefting, 1991:219). This method of triangulation was not used in the research study.

d) Interviewing technique

Two open ended questions were asked. Seven interviews were done when data was saturated and no further themes emerged from the interviews. Various communicating techniques were used during the interview, for example probing, non-verbal expressions, restating and summarizing in order to enhanced the credibility of the study. By doing that the researcher ensured that the participants recognize the meaning that they themselves gave to a situation or condition and the truth of the findings in their own social context.

e) Member checking

The researcher's findings should be compatible with the perceptions of the people under study (Holloway & Wheeler, 2002:255). Throughout the interview the researcher summarized, repeated and rephrased the words of the participants to ensure that what she understood was what the participant experienced. The participants were asked if the researcher's interpretation was a true representation of their perspective. After data analysis the researcher made an appointment with the participants separately to ensure that the findings correlate with their perspective and that the interpretation thereof was not the perspective of the researcher. The main reasons for member checking are the feedback of participants, the reaction to the data and findings and participants' response to the

researcher's interpretation of the data (Holloway & Wheeler, 2002:257). The participants ensured that the findings were their point of view. A literature control was also effective in ensuring that the data obtained is within the context of existing literature.

f) Peer examination

Peer examination involves the discussion of research findings with study supervisors who are competent in qualitative methods or who are seen as experts in the phenomenon investigated (Krefting, 1991:219). Utilization of an independent coder to verify themes and sub-themes and consensus discussions that was held with supervisors about research findings form part of peer examination. The experts might detect bias or inappropriate subjectivity and try alternative explanations to the researchers own propositions and warn them against the attempt to fit in interpretations and explanations that cannot be substantiated by data.

g) Structural coherence

According to Guba (in Krefting, 1991:220) structural coherence ensures that there are no unexplained inconsistencies between the data and its interpretations. In qualitative research a range of experiences is sought and therefore data does not have to be consistent, but should be credible if described and interpret correctly.

The way the researcher integrates the masses of loosely collected data into a logical, holistic picture influences structural coherence. This was ensured by correct use of data collection and analysis to prevent distorted findings.

h) Unique authority of researcher

Miles & Huberman (in Krefting, 1991:11) explain unique authority of researcher as viewing the researcher as an instrument tool, using the following identified characteristics to assess trustworthiness of the linear instrument:

    - The degree of familiarity with the phenomenon and the setting under study
    (The researcher works in the critical care environment for the past six years).

- Good investigative skills, which are developed through literature review, course work, and experience in qualitative methods (the researcher undertook a course in research methodology and the researcher's supervisors has extensive experience in supervising qualitative research).

### 2.5.2 Applicability

Applicability refers to the degree to which the findings and conclusions of a research study can be applied to other contexts and settings or with other groups. Applicability is the ability to generalize from the findings to larger populations (Krefting, 1991:216). However, qualitative research is conducted in naturalistic settings and the transferability of data to other settings may be problematic. It is important of researchers to provide dense background information about the participants and the research context and setting to allow others to assess how transferable the findings are (Krefting.1991:220). The strategy used to establish applicability is transferability. Transferability is obtained by using a purposive sample and dense descriptions of the participants and the research context and settings (See application of strategies in table 2.1).

a) Purposive sample

Purposive sampling was used. Sampling ensures that the results of the research are a representative of the group from which the sample was drawn. Sampling was criterion-based, with inclusion criteria as set by researcher.

b) Dense description

A detailed description of the design and methods, literature control, transcribed interviews and field notes are provided in order to allow others to assess how transferable the findings are (Krefting, 1991:220). (See application of strategy in table 2.1).

### 2.5.3 Consistency

Consistency refers to whether the findings would be consistent if the study were replicated with the same subjects or in a similar context. Consistency is

established through the strategy of dependability (Krefting, 1991:216). The measures that will be used to ensure dependability in the study include dense description of research method, coding, triangulation and peer examination.

c) Peer examination

A pilot study was conducted and discussed with supervisor to establish the correctness of the interviewing technique and if the interviewing technique conformed to the necessary requirements to be used with all participants. An independent coder was used to assist in verifying themes derived from interviews. Data was independently coded and subsequently subjected to have consensus discussions with the supervisor on the themes and sub themes identified to be presented as research findings (See application of strategies in table 2.1).

## 2.5.4  Neutrality

This refers to the extent to which the findings of the study are free from bias. Confirmability is a strategy used to achieve neutrality. This is established by triangulation and reflexivity (Krefting, 1991:217-221). All strategies have been discussed before. Data was tape-recorded and field notes were taken to record thoughts, feelings and reactions. Field notes were written immediately after each interview. (See application of strategies in table 2.1).

**TABLE 2.1: STRATEGIES TO ENSURE TRUSTWORTHINESS**

| STRATEGY | CRITERIA | APPLICATION |
|---|---|---|
| Credibility | Prolonged and varied field experience | The researcher is working in a critical care unit for the past six years and has experience of a critical care environment. The researcher conducted semi-structured interviews; participants shared information easily. |
|  | Reflexivity | Researcher made use of a field journal to describe own behavior, thoughts, feelings and ideas.  Field notes were taken during and after each interview. |

| | Member checking | During interview summarization, repeating and paraphrasing of participants' words were done. Follow up visit to ensure credibility of findings. Literature control was also effective in ensuring that data was within the context of existing literature. |
|---|---|---|
| | Peer examination | The researcher discussed the findings of the study with an independent coder and the research supervisors who have experience in the field of study to ensure correctness of the findings. |
| | Interviewing technique | Open-ended questions were used. Researcher used various interviewing techniques, e.g. probing, verbal and non verbal expressions, rephrazing and summarizing. |
| | Structural coherence | During the interviewing process questions were rephrazed, repeated if necessary and expanded to gain clarity of the participant's response. All data obtained was analysed, described and interpreted correctly. |
| | Authority of the researcher | The researcher has experience of a critical care environment for the past six years. The researcher also undertook courses in research methodology. The researchers' supervisors have extensive experience in supervising qualitative research. |
| Transferability | Nominated sample | Purposive sampling was used. It was also criterion based. Registered nurses who are working in a critical care unit (with/without an additional qualification) in critical care nursing and who had more than one years' experience of working in the critical care unit. |

| | Dense description of research methods | Research methods and research design were described in detail. |
|---|---|---|
| | Peer examination | Independent checking and supervision with independent coder and supervisors was done. Consensus discussion between the researcher and independent coder was reached on themes and subthemes derived from interview findings. |
| Confirmability | Triangulation of data methods and data resources | The researchers' analysis and interpretation of the findings were supported by literature control obtained from journals, articles, books and previous research studies. |
| | Reflexivity | See previous discussion (page 35). |

## 2.6 ETHICAL CONSIDERATIONS

The ethics of research concerns what is right and what is wrong in the conduct of research (Brink et al, 2006:33). The researcher made sure that ethical and legal considerations were adhered to throughout the study. These aspects were:

- the right to **privacy;**
- **confidentiality** and **anonymity;**
- the right to **informed consent;**
- **no deception** of participants and
- **debriefing**

### 2.6.1 The right to privacy

According to (Brink et al, 2006:33), researchers should ensure that their research is not more intrusive than it needs to be and that the participants' privacy is maintained throughout the study. The researcher should not collect more data than is absolutely necessary for achieving the objectives of the study. Participants

have the right to expect that any data collected during the course of a study will be kept in strict confidence and that anonymity will be ensured. Anonymity was insured by not naming audio-tapes but by coding them.

### 2.6.2 Anonymity and confidentiality

Anonymity refers to the act of keeping the individuals nameless in relation to their participation in the study (Brink et al., 2006:47). Not even the researcher could link a participant with the data obtained. Anonymity was ensured by using numbers during interviews and no names were mentioned. Confidentiality refers to the researcher's responsibility to protect all data gathered from being revealed or made available to parties other than those involved in the research, unless the researcher has been given permission to do so. The participants were assured that the information gathered from each individual was kept confidential and no names will be attached to it. Audio tapes, transcribed interviews and field notes were locked away in a safe place then destroyed on completion of the final study. Only the researcher, supervisors and independent coder had access to the information obtained. The participants were informed before they consent to participate in the study that the researcher is going to make the findings known in the research report.

### 2.6.3 Informed consent

The researcher gave participants accurate and complete information about the research study before they consent to participation. The information included the objectives of the research, method of research –procedures used, duration of the study, type of participation expected of participants, possible advantages and disadvantages to the participants, the credibility of the researcher as well as how the results will be used and published(Williams et al. as cited in de Vos et al., (2002:65). Participants have the right to decide voluntarily whether or not to participate in the study. They will also be informed about the right to terminate their participation at any point without the risk of incurring any penalties. In this study participants were asked to sign a consent form in which they gave voluntary consent to participate in the study (see Annexure B).

Letters was written to the relevant authorities in order to conduct research study. (see annexure A). Permission was obtained from the following authorities:

- Advanced Degrees Committee.
- Faculty of Health Sciences Research, Technology and Innovation Committee.
- The education and training coordinator of the Complex Hospitals of the Nelson Mandela Metropole (see Annexure B).
- Medical Superintendent of the hospital where the research will be conducted (see Annexure B).
- Individual participants (see Annexure C).

## 2.6.4 No deception of participants

Struwig & Stead (2001:69) states that deception involves withholding information, or offering incorrect information in order to ensure participation of participants when they would otherwise possibly have refused it. In the study the information pertaining to the study namely, how information will be obtained, the objectives of the study, the people who will have access to the information obtained and how data will be used and published were explained. All questions asked by participants were answered.

## 2.6.5 Debriefing

The interview could reveal sensitive issues for the participants that they might have difficulty in dealing with afterwards (Struwig & Stead, 2001: 69). During debriefing sessions, participants get the opportunity after the study to work through their experience and its aftermath, which is one way in which the researcher can assist respondents and minimize harm. Thus, problems generated by the research experience can be corrected. No participants needed debriefing at the termination of interviewing but the telephone number of the researcher was provided if participants might have needed any support.

## 2.7 SUMMARY OF CHAPTER

In this chapter a detailed description of the research design and methods were discussed. The data collection method by means of semi- structured interviews was discussed, as well as a detailed description of the data analysis method. Measures of ensuring trustworthiness were described and lastly ethical considerations that need to be adhered to were discussed. In the next chapter data analysis and discussions will be described.

# CHAPTER THREE
# DATA ANALYSIS AND DISCUSSIONS

## 3.1 Introduction

This chapter deals with the analysis and discussion of data collected by means of semi-structured interviews. Themes identified during data analysis will be discussed and supported by relevant quotations from transcribed interviews. Each theme will be discussed in the context of existing literature.

## 3.2 Identified Themes

One main theme and four sub-themes were identified after consensus discussion between the independent coder and researcher. The identified themes will be presented in the table 3.1 below.

**Table 3.1 Identified themes related to the experiences of registered nurses of their work environment in a critical care unit.**

| Main Theme | Sub- theme One |
| --- | --- |
| **1. Registered nurses experience the critical care environment as enjoyable yet challenging and stressful** | **1.1 Registered nurses perceive staff shortage as a contributing factor to stress in the critical care unit,** as reflected by the following: <br> 1.1.1 Inadequate registered nurse: patient ratio. <br> 1.1.2 Decreased quality of nursing care due to lack of staff. <br> 1.1.3 Insufficient skill mix allocated on a shift. <br> **Sub- theme Two** <br> **1.2 Registered nurses perceive relationship conflict in the unit as a** |

| | |
|---|---|
| | **stressor or challenge.** |
| | 1.2.1 Registered nurses experience mixed feelings about relationship conflict with colleagues. |
| | 1.2.2 Registered nurses experience conflict with doctors due to their attitude and unavailability. |
| | |
| | **Sub- theme Three** |
| | **1.3. Perceived lack of effective management skills leads to dissatisfaction of registered nurses**. |
| | This is evident from the following: |
| | 1.3.1 Ineffective communication skills by management. |
| | 1.3.2. Favouritism by management. |
| | 1.3.3 Resistance to change from management and staff. |
| | 1.3.4 Perceived need for more staff meetings. |
| | 1.3.5 The need for more support from management. |
| | |
| | **Sub- theme Four** |
| | **1.4 Registered nurses experience a need for staff development.** |
| | 1.4.1 Registered nurses experience a need for regular in-service training. |
| | 1.4.2 Registered nurses experience a need for newly employed staff to receive adequate orientation and |

| | preceptorship. |
|---|---|

Before discussion of the research results the following demographic information needs to be shared, which the researcher thinks would be valuable in understanding the research findings.

The participants in the research study comprised of seven registered nurses working in a critical care unit of a public hospital in the Nelson Mandela Metropole. All participants are female and their age group ranged between 24-49 years. Only one of the participants had an additional qualification in critical care nursing and the other six participants were experienced registered nurses without an additional qualification in critical care nursing. The period of working in the critical care unit range between a period of one to 30 years. The research study took place in a six-bed critical care unit in a public hospital in the Nelson Mandela Metropole.

The researcher, with six years of experience in critical care nursing, was delighted by the similarity of stories told by participants. The researcher had gone into the study with an open and objective mind (Holloway & Wheeler, 2002:115) and noted that experiences linked to the physical environment (monitors, equipment, alarms, complexity of patients conditions etc.) were not core factors experienced by participants. Instead, it was more negative experiences surrounding this environment that were reported. Exploring previous studies done regarding the same topic, it was evident that 15 years ago, it had been documented that registered nurses had negative experiences about surroundings of the critical care environment in South Africa (Pike, 1993; Pope, 1996; Odendaal & Nel, 2005; Scribante & Bhagwanjee, 2007). However, according to Woodrow (2000:490) stress is commonly used to describe negative feelings; but it can be an enjoyable and rewarding environment as well. What can be a stressful experience for one person can be a challenge for another. Woodrow (2000:490) further comments that unrecognised distress can progress causing multiple problems such as staff conflict, low morale, absenteeism and inefficient quality of work. Critical care researchers, decision-makers and critical care societies are becoming increasingly

involved in addressing the existing challenges to the physical, emotional and professional environment of critical care nurses and are expanding the critical care professionals' knowledge about how to create attractive and rewarding critical care environments (Alameddine et al., 2008:4). Therefore recommendations on how to assist registered nurses in a critical care environment will be made and discussed in chapter four.  The discussion of the identified themes will follow.

**3.3 Discussion of research results.**

The identified theme and sub-themes will now be discussed.

### 3.3.1. Registered nurses experience the critical care environment as enjoyable yet challenging and stressful.

All the interviewees described the critical care unit as an enjoyable but also challenging and stressful place to work in. Participants felt that the critical care unit has a fast  pace and the nurse had to be alert and quick to act since the fast paced situations and rapid decision-making place enormous stress on the nurses who choose to work in this environment. Bucher & Melander (1999:45) state that the critical care unit provides nurses with a double – edged sword, meaning that it is an exciting, challenging and rewarding place, but it is also a tension- filled and stressful place to work. The findings of a study conducted by Odendaal & Nel (2005:95) regarding support to critical care personnel found that nursing critically ill patients *per se* was not stressful, as the group said they had chosen to do it, and they enjoyed the challenge it posed. It is the environment around this specific discipline of nursing that creates a stressful setting as a result of staff shortages, negative attitudes, and an insurmountable workload. The same experiences were shared by participants in the current research study; as illustrated by the quotes below.

*"To this specific environment, I think I enjoy this environment. I'll start when I was a student. I liked the ICU set-up and the fast pace and I decided I'm going to work in the ICU [critical care unit] as soon as I finished my four years' course, I was in the ICU…I'm working in the ICU for seven years now...and I enjoy it…")*

*"…stresvol omgewing maar dit gee jou tevredenheid…"("…stressful environment but it gives you satisfaction…")*

*"My experience of working in the critical care environment is mix, mix in the sense that uhm…it is very nice to work in the critical care environment, at the same time it can be very stressful…there are days that you feel you are very much under pressure, because you are working with a multidisciplinary team, there are doctors', there are superiors, there are juniors, there are visitors, there are relatives…so in that way at times you feel you are not coping…it is nice on the other hand because at the end of the day after nursing a very critically ill patient you feel that the patient had become better…so in that way I would say I have both positive and negative experiences".*

Some participants experience the critical care environment as being satisfying.

*"…tevredevol maar stresvol, partykeer voel ek die einde van die dag moet aanbreek…"("…satisfying but stressful, sometimes I feel that the day must come to an end…")*

*"My ondervinding in die ICU is n baie tevrede ondervinding , ek geniet dit baie , ek geniet die tipe werk…maar partykere is dit n bietjie stresvol en uhm…en partykeer voel ek dit kan n beter omgewing wees as almal moet doen wat hulle moet doen en ons as n familie saamwerk…"(My experience in the ICU is a very satisfying experience, I enjoy it a lot, I enjoy the type of work…but sometimes it is a bit stressful and uhm…sometimes I feel it can be a better environment if everybody do what they must do and if we can work as a family….).*

That the critical care environment is challenging and stressful is further supported by literature. According to Basset & Makin (2000:217), nursing and particularly high-dependency nursing is a difficult and challenging job, but the nurses working in critical care units are committed and challenged to protect, maintain and restore

the health of critically ill patients and support the patients' loved ones through the acute phase of illness (Bucher & Melander, 1999:39).

**3.3.2 Registered nurses perceive staff shortage as a contributing factor to stress in the critical care unit.**

Staff shortages seem to be a major contributing factor to stress for registered nurses in this particular critical care unit, which led to feelings of unhappiness. All participants were of the opinion that even though the unit was only a six-bed unit, the acuity level of some patients required more than one registered nurse to care for that patient. One participant mentioned that "agency workers" should be used to solve the problem of staff shortages.

*"People cannot go to in-service training because there is a shortage of staff as per norm…but another thing they can change in this unit is make use of moonlighting, [agency workers] where the staff can work when there is a shortage of staff…than they get paid for that extra work…"*

Some participants mentioned that nurses are not allowed to leave the unit during lunch-time in case they might be needed for an emergency. Only one registered nurse with an enrolled or auxiliary nurse is left behind in the unit when the other staff are going on lunch. Nobody can go off sick because there is not sufficient staff to replace them.

*"I understand we don't have an hours lunch, but you'll find you spend your whole 12 hours indoors you cannot go anywhere to see anyone… a patient may come while other people [registered nurses] are on lunch…you'll find that those who are inside the unit they actually short [too few] too handle a fresh case [post operative patient that is admitted]. In most cases there is only one registered nurse and one enrolled/auxiliary nurse inside the unit than you have to go help even if you on lunch".*

*"Newly appointed sisters [registered nurses] must learn quickly…they cannot even be accompanied by older sisters because of the shortage of staff."*

*"Wanneer die pasient kompliseer of wanneer die pasient baie siek is  dan het jy ekstra hande nodig…jy moet baie tyd  met die pasient spandeer maar jy het ekstra hulp ook nodig, want dit vat partykeer nie net een of twee verpleegsters om n  kritieke pasient wat van teater af kom uit te sorteer nie. So ek voel partykeer is die hande min en dit maak die stress ook meer. Partykeer gee die dokters die voorskrifte vinnig en jy moet dit vinnig kan uitvoer sodat die pasient se toestand kan verbeter"(When the patient complicate or when the patient is very sick than you need extra hands…you need to spend a lot of time to sort out one patient, but you need extra assistance as well, because it does not take just one or two sisters[registered nurses] to sort out a critically ill patient coming from theatre. So I feel sometimes is the hands too few and it increase the stress levels. Sometimes the doctors give the orders quickly and you must act quickly on that orders so that the patient's condition can improve).*

A study conducted by Odendaal & Nel (2005:96) indicated that participants found the critical care environment to be stressful due to an increased workload caused by a shortage of nursing staff. The shortage of qualified ICU nurses meant that help was seldom available and that a nurse was often forced to look after two or more critically ill patients at the same time. According to Caryon & Gürses (2005:287) research had shown that workload was one of the most important job stressors among ICU nurses and the most widely used measure to assess workload was the nurse-to-patient ratio. A study conducted by Aiken, Clarke, Sloane, Sochalski & Silber (2002:1992) indicated that nurses in hospitals with inadequate staff were more likely to experience job-related burnout and dissatisfaction with their jobs compared to nurses who worked in hospitals with adequate nursing staff. Larkin (2007:162) & Aiken et al.(2002:1992) are of the opinion that increased workloads, inadequate staffing levels, job burnout and dissatisfaction are common reasons why nurses quit their jobs. Staffing and scheduling problems; not having sufficient time to complete nursing tasks and not

having sufficient time to provide emotional support to patients are all work related problems experienced by participants of this study.

### 3.3.2.1 Inadequate registered nurse: patient ratio

Participants felt that the registered nurse: patient ratio in the critical care unit did not compare with worldwide norms. Enrolled nurses and auxiliary nurses are allocated on a shift with registered nurses to maintain a ratio of 1:1 in the critical care unit which is not acceptable because enrolled and auxiliary nurses do not have the same knowledge base as registered nurses and their scope of practice is limited. This places additional responsibility on the registered nurse to supervise the enrolled and auxiliary nurse, which increases the workload of the registered nurse more. According to (Caryon & Gürses, 2005:286) workload is one of the identified stressors of a critical care environment due to inadequate staffing. It is evident from the quotes that participants are actually requesting a 1:1 registered-nurse-to-patient ratio in order to relieve the pressure experience of working with a ratio of less than 1:1 registered-nurse-to-patient in a critical care unit. This is evident from the following quotes.

*"Partykeer voel ek as ons maar net meer hande gehad het dan sou dit die werk soveel ligter gemaak het."(Sometimes I feel if we just could have had more hands it would have made the work so much easier)*

*"Almal strewe na die 1:1 ratio maar dit is nie moontlik nie. As dit maar moontlik gewees het…"(Everybody is striving to the 1:1 ratio but it is not possible. If it just could have been possible…)*

*"Well, we just read an article the other day that say that if it is an unstable ventilated patient than the ratio should be 1:1.5 registered nurse to patient and at the moment we not even 1:1 let alone 1:1.5. I don't know when we will get to 1.5."*

*"Laat ek eerlik wees. Die geregistreerde verpleegster sal daardie werk kan doen as sy na een pasient kan kyk. En ons het nie n 1:1 of n 1:1.5 ratio nie. As…as…dit*

*ooit gebeur dat dit so gedoen kan word dan het ons nie staf- en assistent verpleegsters nodig in die eenheid nie. En as ons n 1:1 ratio het sal die werkslading op elke suster se skouers ligter wees, want een suster kyk na een pasient."(Let me be honest. The registered nurse will be able to do that job if she was only looking after one patient. We do not have a 1:1 or 1:1.5 ratio. If …if…it will ever happen than we don't need enrolled and auxillary nurses in the unit. And if we would have a 1:1ratio the workload of each sister will be decreased, because one sister will look after one patient)*

The nursing shortage is currently the key point of discussion in nursing and probably also in healthcare delivery in general (Finkelman, 2006:368). A global shortage of registered nurses has been reported internationally and confirmed in South Africa by the National Audit of Critical Care services (Gillespie, 2005:50). A study conducted by Scribante & Bhagwanjee in 2004-2005 regarding the nursing profile in critical care units in South Africa indicated that there was a major shortage of nursing staff in public and private hospitals critical care units (Scribante & Bhagwanjee, 2007:1315). The study indicated that there was a national deficit of 7920 critical care nurses in South Africa. According to Gillespie (2005:56) and given the demand of critical care services in the Western Cape it will take 9 years to train 300 critical care nurses annually to reach the deficit target of 2711 registered nurses. Gillespie was of the opinion that the current supply of nurses did not meet the needs of the critical care units in the Western Cape. No statistics of shortages of critical care nurses in the Eastern Cape are available.

The World Federation of Critical Care Nurses (WFCCN) states that in a critical care unit one qualified registered nurse should look after one critically ill patient and for an unstable patient more than one registered nurse is required (WFCCN, 2005). The South African Association of Anaesthetists (SAAA) makes the same recommendations as to the ideal staffing of critical care and high-care areas in South African critical care units. The SAAA make the recommendation that the ideal staffing for haemodynamic unstable patients should be a registered nurse to patient ratio of 1.5:1; for patients who just need ventilatory support it can be a 1:1

registered nurse to patient ratio; and for high-dependancy patients it can be a ratio of 1:2 registered nurse to patient (South African Society of Anaesthetist, 2006: 7.2 Pike (1993:24) was of the opinion that neither the anaesthetists nor the nurse administrators take cognisance of the variations of workload which appear with different categories of patients. Inadequate staffing is an identified stressor in a critical care unit (Alameddine et al., 2008:2) and needs to be addressed.

3.3.2.2 <u>Decreased quality of nursing care due to lack of staff</u>
Participants have described themselves as experiencing guilt from their inability to meet the patient needs effectively as staff shortages increased while patient acuity continued to be high and it seemed that they did not have enough time to take care of all the patients' needs. Participants' felt that there is a lot of activities that critically ill patients need, for example, hourly observations, basic hygienic care, pressure care, medication to be given etc. and they do not have enough time to render all these activities within a specific time frame. According to Adams & Bond as cited (in Currey et al., 2006:1082) nurses experience a high level of stress when they perceive that insufficient time and staffing mix impedes the delivery of quality nursing care. Staffing mix refers to the ratio of caregivers of varying levels of skill, trained in a specialist area, experienced and less experienced within a clinical unit.

*" Ons is besig om te doen wat ons kan…partykeer is dit nie alles gedoen; observasies, rug en drukdeel versorging, suiging van pasient, beraming van pasient, medikasie toediening op die tyd wat dit gedoen moet word nie maar ons streef om dit te doen binne n sekere tyd en partykeer is dit n bietjie moeilik…"(We are busy doing what we can…sometimes everything is not done; observations, pressure care, suctioning of the patient, assessment of the patient, treatment at the time that it is supposed to be done but we strive to do it within a certain time but sometimes it is a bit difficult…).*

*"Miskien is daar twee nuwe susters met een ouer suster…ek dink dit is min…ek dink dit is onregverdig, want daar is vars ope hart gevalle, daar is gevalle wat baie*

*meer aandag nodig het…partykeer kompliseer die pasient op dag 2 of 3, daai is gevalle wat meer aandag nodig het, klomp ander dinge is in die eenheid, want meeste van die tyd is daar ses pasiente…"(May be there are two new sisters with with one older sister…I think it is few; think it is unfair because there are fresh open heart cases, there are cases that need more attention…sometimes the patient complicates on day 2 and 3, that is, patients that need more attention, many other things is in the unit, because most of the time there are six patients in the unit").*

Registered nurses felt that they were still trying to render the quality care that was needed for patients but it was not always possible due to the insufficient staffing levels. If there is not enough staff and everybody is not working in collaboration registered nurses are feeling the pressure. Collaboration is a key factor in the delivery of quality care to the patient (AACN, 2005; Binnekade, Vroom, de Mol, de Haan, 2003:190).). However, at times nurses experience a lack in collaboration, which increases the pressure experienced by nurses.

*" Ek voel daar word nog kwaliteit verpleging gegee…is net wanneer die hande min is wanneer almal nie as n span saamwerk om die min hande te kan opmaak nie…dit lyk asof ons n bietjie swaarder trek."(I think quality care is still given …is just when the hands are few that we are not working as a team together to make up for the few hands…it seems that we are pulling a bit heavier).*

*" n pasient wat onstabiel is na teater, party pasiente bloei, party is asidoties en daar is ander pasiente ook wat jou aandag nodig het…want ons werk nie 1:1 meeste van die tyd nie. As almal net hul deel kan doen, dan sal die druk nie so swaar wees nie."(A patient who is unstable after theatre, some are bleeding, some are acidotic and there are also other patients who need your attention…because we are most of the time not a 1:1ratio. If everybody can just do their part, then we wont feel the pressure)*

A study conducted by Matshikwe (2001:55) supports the fact that a shortage of staff lowers the standards of nursing care in the critical care unit. Gillies (1982), as cited in Matshikwe (2001:55), has emphasised that understaffing of a critical care unit impairs the quality of nursing care because overworked staff cannot perform essential tasks and therapeutic interventions. A survey done by the American Association of Critical Care Nurses (AACN) in 2006 regarding critical care work environments indicated that increased safety and improved outcomes for patients relied on meeting healthy work environment standards which included collaboration and adequate staffing (Ulrich, Lavandero, Hart, Woods, Legget & Taylor, 2007:75). The shortage of sufficient specialized nurses in the critical care units seriously threatens the quality of care rendered to these patients (Binnekade et al., 2003:190). According to Donchin et al. (1995) as cited in Caryon & Gürses (2005:285) critically ill patients need on average 178 activities per day and 1% of these activities include medical errors due to staff shortages, thus increases the registered nurses tension to work with insufficient staff.

### 3.3.2.3 Insufficient skill mix allocated on a shift

Skill mix is the method used to ensure that the appropriate qualified staff – qualifications and quantity are available to provide the care that is needed for patients to meet their needs and thus provide quality and safe care (Elliot, Aitken, Chaboyer, 2007:20). The overall experience of the participants was that they did not prefer being on a shift where there were two newly employed registered nurses (because of their inexperience) and only one experienced registered nurse allocated on a shift. Experienced registered nurses and registered nurses with an additional qualification in critical care nursing were of the opinion that newly employed registered nurses did not know the routine of the ward as such and that these registered nurses needed a lot of guidance. Experienced registered nurses expressed mistrust about the capabilities of newly employed [less experienced] registered nurses as well as the concern that they still needed to be guided in caring for the patient and in the ward routine.

*" In times of emergencies you need a sister who can brainstorm with you as to what the best treatment of the patient might be and unfortunately you cannot depend on the newer sisters to do that."*

*"Sommige dae geniet ek dit verskriklik baie om in die ICU te werk maar daar kom ook dae dat ek voel ek wil nie met sekere persone werk nie. Dit is moeilik as hulle twee onervare susters op jou skof sit…ooh…(lag)…jy weet jy is nou in die knyp nou…lag."(Sometimes I really enjoy working in the ICU but there are also days that I feel I don't want to work with certain nurses. It is difficult if they put two inexperienced sisters on your shift…oh…(laugh)…you know that now you are in trouble."*

*"Hulle (die nuwe susters) is heeltemal onervare en party leer stadig."(They(new sisters) are totally inexperienced and some of them are learning slowly…)"*

Participants felt that newly employed registered nurses need guidance in order to obtain confidence.

*"There are a lot of new appointees that are not critical care experienced and critical care trained, they still need a lot of guidance and they still need to work with an experienced or an critical care trained sister to gain that confidence in the critical care unit and I feel they were thrown in the deep, because they are sometimes on with just one critical care trained or experienced sister and the rest are inexperienced sisters".*

*"Partykeer is dit een ou sister met twee nuwe sisters en n assistant verpleegster… want as daar n krisis is moet jy vinnig kan werk, jy moet vinnig dink…jy weet nie of hulle in staat sal wees nie…"(Sometimes it is one older sister with two new sisters(less experienced) and an auxiliary nurse…if there is a crisis you need to work fast, you need to think quick… you don't know if they[less experienced nurses] will be able to).*

Dealing with a nurse who is inexperienced and uncertain of the equipment and the routine of the unit can add stress to the critical care nurses' already busy day (Bucher & Melander, 1999:45). To determine the skilll mix it is important to identify the type of care that is needed and who is qualified and competent to provide that care. A central principle for workforce requirements as indicated by the WFCCN is a congruence between the needs of the patient and the skills, knowledge and attributes of the nurse caring for the patient (WFCCN, 2008).

Studies by Zondagh and the British Association of Critical Care Nurses (BACCN), as cited in Gillespie (2005:51) found that the safety and the quality of patient care was directly related to the number and skill mix of direct care nursing staff, and several international studies have found that insufficient skill mix results in increased errors and patient risk. If there is an insufficient skill mix in a critical care unit it can add to the already experienced stressors of the critical care environment. Morrison, Beckman, Durie (2001:120) states that patient errors are more likely to occur when there are a combination of less experienced staff, shortage of staff, poor supervision and a lack of support staff. This could be a reason why experienced registered nurses prefer not to have more than two less experienced registered nurses on a shift. Larkin (2007:162) states that experienced nurses bring skill to the bedside that are not easily learned from a text book and often not taught in a classroom and they know how to provide compassionate care, prevent safety risks, and anticipate patients and family members needs to ensure that each patient receive the highest quality care.

### 3.3.3 Registered nurses perceive relationship conflict in the unit as a stressor or challenge

Conflict arises when individuals or groups experience differences in views, goals or facts that place them at opposite poles. It involves areas of differing expertise, practice or authority. The participants in the study have experienced conflict with colleagues and doctors. According to (Booyens, 1998:146) stress resulting from interpersonal factors, for example, interdisciplinary conflicts and conflict with supporting services are a common source of discontent, which were experienced

by participants in the research study. The components of relationship conflict as derived from data will be discussed as follow:

### 3.3.3.1 Registered nurses' experience mixed feelings about relationship conflict with colleagues

The experiences of participants related to the relationship conflict of staff in the unit are mixed. Some participants experienced a team spirit and that they could count on one another to help and support whereas others experienced the fact that some registered nurses were not collaborating within the team. One participant was talking non-stop, the words just flowing from her mouth and she was tapping with her fingers on the table the whole time when the topic of conflict came up. Different types of conflict were identified and will be discussed accordingly (Finkelman, 2006:820).

Perceived conflict involves awareness that conflict exists at a particular time. It may not be discussed but only felt (Finkelman, 2006: 82). These type of conflict can create feelings of tension, anger and anxiety and are evident in the following quote.

*"At present I'm a… like my manager said, I am a team leader and according to the off duties I am 2$^{nd}$ in charge…but I'm not so sure now because there is…umm…another sister that is also supposed to be unit manager, so there is a lot of confusion going on. So I feel there is a lot of conflict about this 2$^{nd}$ in charge."*

*"They feel somebody must be ICU-trained to be like 2$^{nd}$ in charge in the ICU, but it is not me who put me there…it was my unit manager and discussion with my area manager and chief…umh…"*

*Felt conflict* occurs when the individuals begin to have feelings about the conflict, such as anxiety and anger (Finkelman, 2006:820). The participants reported that they were feeling angry when they heard about the gossiping. Felt conflict is evident in the following quote:

*"There is a lot of gossiping going on in the unit …instead of saying to me 'you did not do 1, 2 and 3' …why tell it to someone else and that some one come tell me …*

*This creates a feeling of anger…I get so angry and cheeky…"[participant tapping with her fingers on the table].*

A participant mentioned that there was a good relationship amongst the staff and the way she avoided conflict was by the following:

*"I've got very good relationships with my colleagues. I know where everybody's touchy places is so I don't touch there…that's my motto…laugh… "*

*"I don't irritate anybody…I hope not…I'm not a person that will argue with other people."*

*"I don't say I avoid the conflict; I just think I don't cause conflict."*

Finkelman (2006:82) describes the above conflict as *latent conflict*. This stage involves the assumption of conflict since the interviewee is aware of conflict in the unit but she avoids conflict by not touching on sensitive places that might predispose a colleague to conflict and increase tension. Finkelman (2006:82) is of the opinion that if avoidance is used it may prevent the conflict from moving to the next stage. Strack van Schjindel & Burchadi (2007: 238) state that an avoidant attitude towards conflicts will not lead to any result and also the relationship will not benefit.

A study done by Odendaal & Nel (2005:98) supports the issue of conflict amongst staff in critical care units. However, the authors indicate that conflict is not necessarily detrimental, as it can improve team effectiveness although not all types of conflict have a positive outcome. It appears that much of the stress in critical care units causes dysfunctional relationship conflict. Relationship conflicts

are based on interpersonal incompatibilities and tension and animosity towards others are always dysfunctional. Relationship conflict increases personality clashes and decreases mutual understanding, thereby impeding completion of tasks. But conflict among members about task content can be beneficial; for task conflict stimulates discussion, promotes critical thinking; and improves team decision-making ( Booyens, 1998: 530).

3.3.3.2 <u>Registered nurses experience conflict with doctors due to their attitudes and unavailability.</u>

Registered nurses' experience of conflict with doctors due to their attitudes and unavailability will be discussed under different sections as follows:

a) <u>Doctors' attitudes</u>

Participants experienced doctors' attitudes as unacceptable in the unit. They (the nurses) are trying their best to render proper care but the way they are approached and treated when a patient's condition deteriorates is uncalled for. Nurses are blamed when a patient's condition deteriorates which makes the nurse feel incompetent. The participants shared with the researcher that nursing staff had resigned due to this issue.

 *"There are also some problems with the doctors …some doctors that need some attitude adjustments."*

*"Well, with the attitude of the doctors is that…that may be the patient went into cardiac arrest or something than it is the nurses' fault because the nurses did not manage the patient correctly…or the nurses always get the blame for  any incident  that happen in this unit."*

*"…jy word van die slegte geskel partykeer…maar daar het baie klagtes gekom omtrent dit en die dokter het n groot poging aangewend om die dokter se houding te verander." (you get scolded from the ugliest sometimes, but many complaints were raised and the doctor did try to change her attitude.).*

*"As mens eerlik moet wees, baie het bedank uit die eenheid oor die dokter se temperament."(To be quite honest many nurses resigned out of the unit because of the doctor's temperament.)*

*"Hulle wou nie naby die dokter kom of saalrondtes met die dokter doen nie. Jy het partykeer nie eers lus gehad om werk toe te gaan nie…maar dit het tot n einde gekom…rerig dit het tot n einde gekom."(They (nurses) did not want to come close or do rounds with the doctor. Sometimes you did not even feel to come to work…but all came to an end…really it came to an end)*

A survey done by the American Association of Critical Care Nurses (AACN), Garnett Healthcare Group and Bernard Hodes Group in 2006 regarding the status of critical care work environments indicated that a majority (64%) of respondents reported experiencing verbal and physical abuse and much of the verbal abuse reported came from physicians, patients, patients' families and significant others (Critical Care Nurses' Work Environments, 2008). A study conducted by Rosenstein (2002:26) indicated that daily interactions between nurses and doctors strongly influence nurses' morale. However, 96% of the nurses had witnessed or experienced disruptive doctors' behaviours including yelling or raising the voice, disrespect towards nurses, berating colleagues and use of abusive language. The survey found 344 nurses who knew of other nurses who had left the hospital due to disruptive behaviour by doctors. According to Pike (1993:24) the relationship between unit doctors and nurses was seen as unsatisfactory in instances where it was reported that doctors either had mixed attitudes towards the nurses or that they treated them badly. Pike was of the opinion that the nurses only had themselves to blame if they allowed themselves to be treated as the doctors' "lowly handmaiden" and not as a competent and professional member of the unit team (Pike, 1993:24). Pope (1996:53) also reported registered nurses' experience of doctors as unsatisfactory. The respondents in the study conducted by Odendaal & Nel (2005) were of the opinion that doctors should attend their (the nurses') debriefing sessions as doctors tended  to regard them(nurses) as incompetent

and to blame them when patients condition deteriorated. Doctors attitudes certainly did instill fear by registered nurses as it was evident that some registered nurse did not want to go on a doctors ward round and some nurses did resign.

b) Doctors' unavailability

Participants indicated that doctors were not available when they were needed in the unit. This causes the critical care environment to more stressful because nurses' decision-making is limited and there are only a few critical care trained nurses in the unit. Participants are of the opinion that the doctors should also take responsibility for the care of the patients but doctors need to be phoned whenever there is a crisis. Participants experience the unavailability of doctors for immediate crisis interventions as stressful.

*"If you need a doctor for a crisis in the ICU you need the doctor now, not 5-10 minutes or half an hour later."*

*"I wouldn't know then what to do if I don't find a doctor? It differ from one situation to another and it make me scared because there might be an emergency, a very serious emergency that actually need a doctor's attention and you can't find them."*

*"I see why others call this doctor even though this doctor is not on call, because the other doctors they seem not to be available which is what I hate…"*

*"Ons het n dokter 24hr nodig op die premises…iemand wat hier slaap."(We need a doctor 24hrs on the premises …somebody who sleep here).*

The absence of a medical doctor in the critical care unit poses a challenge to some registered nurses and a stressor to others in clinical decision-making. Decision- making responsibility can cause the nurse to stress. Scribante & Bhagwanjee (2007:1317) also states that it is crucial for nurses in a critical care situation to make accurate clinical judgments and to act on them. Participants in

the study conducted by (Curry et al., 2006:1085) in managing haemodynamic unstable patients, indicated that experienced registered nurses felt challenged and stimulated in making decisions for haemodynamic unstable patients. These nurses described how they felt pleased and proud when they met challenges associated with detecting, and responding to episodes of haemodynamic instability and post-operative complications. Pope (1996:54) indicated that nurses felt pressurized into making decisions that fell outside their scope of practice if the doctor was not available. The researcher is of the opinion that it depends on the registered nurse's knowledge and clinical skill and competence on what her response of decision-making will be, as her scope of practice is limited and she /he can be held responsible for the judgment she/he makes.

The South African Society of Anaesthesiologists (2006: 7.1) recommends that a critical care unit which consists of haemodynamically unstable critically ill patients requires a full-time medical doctor. A registrar or equivalent doctor should be available on the premises 24 hours a day and should be immediately available if necessary. A consultant should be available twenty-four hours and should be physically present within 30 minutes if necessary. The medical doctors scope of practice differ from that of the  nurses that is why nurses feel more comfortable when a doctor is around in a crisis situation. The following case study reflects a registered nurses situation after decision-making when a doctor was not available.

 "From past experience, the nurse knows how late night calls to this physician often result in verbal outbursts and demeaning slurs, no matter how valid the inquiry.  Needing to act but not wanting another harassing encounter with the physician, the nurse makes a judgment of the appropriate dose and administers the insulin.  Two hours later, she finds the patient completely unresponsive.  To treat the critically low blood sugar level, she administers concentrated injections of glucose and calls for additional emergency help.  Despite all attempts to restore the patient's brain to consciousness, he never awakens and his brain never functioned normally again (AACN, 2005). It is case studies like these that alert nurses not to make decisions that fall outside their scope of practice. The nurse

will be held responsible for actions taken and judgements made. Because of this reasons doctors' unavailability can cause nurses to stress.

**3.3.4 Perceived lack of effective management skills leads to dissatisfaction of registered nurses.**

According to participants of this study management skills in this critical care unit are ineffective which leads to dissatisfaction amongst staff. Yoder-Wise (2003:24) state that effective nurse leaders realise that the most effective and visible way to influence people is to lead by example. Leading by example, or acting as a role model occurs when a role is performed in a manner that colleagues want to emulate or follow, and is demonstrated by actions, style, values and behaviours. It is associated with positive traits and characteristics such as showing support and a willingness to listen to others. However, participants in this study seemed not to have experienced effective leadership abilities from management in their unit and these are reflected upon as follows:

3.3.4.1 <u>Ineffective communication skills by management.</u>

Participants experienced management to lack effective communicative skills. The manner in which registered nurses are approached is unacceptable and workshops are needed in order for managers to learn how to communicate with personnel in the unit. Participants in the study conducted by Linton & Farrell in (2009: in press) stated that communication was an important characteristic of effective leadership in the critical care unit and that nurse leaders (which is management in the current research study) should have the personal quality of approachability. This leadership skill was experienced as not being effective by participants in the critical care unit in the current study and is evident from the following quotes:

> *"Communication is impaired in that your off duties get changed without an explanation."*

*"Our supervisors they uhm… don't have a good approach when they have something to say to their sub ordinates or to the various sub-categories…you will find out they have a very good point that they want to make , but instead of calling you aside they make a drama out of it in front of everyone."*

*"Attitudes of supervisors…they are years in this place but I think workshops are needed to teach them how to run[manage] a place. It is not actually on how to manage stock that will tell you how to manage a place [unit, people] properly."*

*"Taking into account the feelings of those at work, because some of us are stressed when you leave home, but you'll find your workplace as your home to be… so you don't need an attitude from management"*

Communication plays an important role in all managerial functions since it provides the information necessary for work performance; but also the way the communication takes place determines the relationship among employees, their attitudes, the working climate, morale, motivation and performance (Strack van Schijndel & Burchard, 2007:234). Yoder-Wise (2003:20) states that the role of listening is important for the leader to ensure that all sides are heard before a decision are made which is critical to effective communication. According to participants in the study conducted by Linton & Farrell (2009: in press), it is necessary for the leader to act as a role model by showing appropriate behaviour and effective communication in order to get staff to respect him/her. The AACN has identified leadership development as a critical factor in creating excellent work environments that are not unnecessarily stressful. In a survey done by the AACN in 2006 respondents were of the opinion that better leadership skills (communication skills) would certainly be a reason for them to reconsider if they had planned to leave their current job positions. According to (Odendaal & Nel, 2003:100) the unit manager should be equipped and able to create an atmosphere where proper trust, interpersonal skills and communication skills are promoted. Kelly-Heidenthal as cited (in Linton & Farrel, 2009:in press) states that factors influencing communication include emotions, perceptions, values,

education and the goals of those involved in the communication process. The critical care nurse has a responsibility to take care of critically ill patients in a complex environment and is required to communicate effectively with his/her colleagues, patients and supervisors in order to render optimal care; but ineffective communication with management can impair nurses' ability to render this care in the critical care environment and it can have detrimental effects for both patient and nurse. Close communication between nursing staff and physician leaders creates an environment for good collaborative communication associated with positive patient, nurse and physician outcomes but also enhances professional relationships, enhanced learning, increases nurse satisfaction and decreases job stress (Strack van Schijndel, & Burchardi, 2007:234).

### 3.3.4.2 Favouritism by management

Some participants experienced management as having favourites amongst the staff which made them feel frustrated and annoyed with the manager because all nurses are part of the collaborative team.

 *"People feel that they, uhm,…may be because I'm not ICU trained, they feel there is a lot of favouritism going on because I had been chosen to be 2$^{nd}$ in charge and I'm not ICU trained. So I feel there is a lot of conflict about this second in charge in the ICU."*

 *"The other thing I experienced is a shortage of staff…but there are a lot of favouritism going around because two of the members working in the unit, one is a sessional worker and the other one is a part time worker but the part- time worker is a registered nurse with many years of experience but she cannot be put on a stream to cover night shift when there is a shortage. At the moment she is treated as if she is an enrolled nurse although she is earning the salary of a registered nurse."*

*"The supervisors, ah… they got their good and bad side I must say, you know, one  thing we cannot run away from …there is a group of people standing there*

*who is always favourites…certain people get more preference than other people …why it is like that I don't know…"*

Favouritism in the workplace is essentially a manifestation of bad management. When there is a favoured member of staff, feelings of frustration, resentment and annoyance are involved which makes it very hard to be rational. (How to address favouritism, 2008). After a thorough literature search topics related to favouritism in the workplace could not be found.

### 3.3.4.3 Resistance to change from management and staff

Participants felt that change was good and doing something different would be a challenge. Most participants were unhappy with the duty schedules and they felt that it needed to be addressed. According to participants in this study, they experienced the night duty shift as tiring and the quick onset from change from night to day duty as unfavourable. Some participants experienced that registered nurses especially those who had been working in the unit for more than 10 years were resistant to change and what they had done for years they wanted to continue doing. They were comfortable in their ways and did not want to change.

*"Actually for me I don't think there is a short staff…because I think they just need to change their off duties. The problem in this unit is the off duties."*

*"Some nurses resigned due to off duties and others ask for a transfer to other departments."*

*"I cannot take this night duty any more…"*

*"They stagnant to change …I tried out new off duties but they just don't want to change."*

*"'You cannot work more than two days in this place…you tired emotional, physical, and spiritual…two days is enough."*

One interviewee described the environment as boring because older sisters who were working in this environment were reluctant to change.

*"There is no social activity…"*

*"When I suggested something it was said we are doing this for so many years…"*

According to (Finkelman, 2006:46) change implies that people have to give up something or make some adaptation, which may be stressful. Most people do not like disequilibrium as it makes them feel uncomfortable. Resistance to change is an effect of habit and inertia and managers and other staff often feel that the way things have always been done is acceptable. Staff or managers may fear the unknown and the loss of predictability. Finkelman (2006:46) indicates that loss plays a role in resistance to change. The examples of loss that staff may experience are their old ways of doing things, job responsibilities, and that power and authority over others may change or be lost with reorganisation. Finkelman (2006:46) is of the opinion that staff should grieve over these losses and move on.

3.3.4.4 <u>Perceived need for more staff meetings.</u>
On the question how nurses would like to be supported in the critical care unit, almost all participants replied by saying more staff meetings should be held to discuss differences that might be present between staff and managers in the unit, to vent feelings and to brainstorm the events of the week.

*" If we can at least hold meetings may be twice a month or almost every week just to brainstorm the events or the weeks experiences…because if we wait until late it can dent the relationship of colleagues…I don't know is it due to the unavailability of time or whatever but we need to have more ward meetings to iron out our differences before a problem cross us everything is sorted out."*

*" Yah …I think management must have more meetings, not only meetings when there is a problem in the unit , like on a weekly basis…you have to have meetings with the staff and talk about their feelings…what they feel is needed in the unit and what can be changed and so on."*

*"I think there must be meetings, even if it is not weekly, may be monthly…between the doctors, the staff and also managers…so we can clear our differences and voice our concerns, because we are here for the patients."*

Regular staff meetings contribute greatly to the staff feeling that they belong and that their views are valid and worthwhile (Basset & Makin, 2000:220). Changes to practice or policy can be brought about effectively by a joint staff and management approach, deciding what is best for all members of the team and ultimately the patient. Staff meetings give nursing staff the opportunity to discuss matters related to the unit such as clinical, managerial and personnel topics. Non-patient related problems can also be discussed and nurses can be given the opportunity to discuss possible changes within the unit. Meetings must be on a two- way feed back ideas and suggestions should be put forward to enhance patient care and to discuss any problems in the unit. Notes of the meeting should be taken for those who are unable to attend. Odendaal & Nel (2005:100) indicate that if conflict arises within the team a facilitative session should be held as soon as possible in order to resolve the situation. Team briefings which provide direct information and reaction, prevent misunderstanding, help nurses to accept changes and to increase their commitment in the ward should take place on a regular basis and should not take too long otherwise they create resistance. A unit manager or an independent facilitator can be available to ensure the necessary balance between an open but focused discussion and a successful decision (Strack van Schijndel & Burchardi, 2007:234). Hyde (2007:144) who implemented a brief meeting in their unit for about five minutes before each shift starts, was of the opinion that not everybody was always available for staff meetings and staff did not take ownership of the unit properly. There was resistance at the beginning but the meeting had a positive outcome as empty beds, procedures, staffing issues and

quality outcomes of the unit were discussed. According to Hyde about four weeks after implementation of the meeting the staff experienced a significant improvement on core measures and quality outcomes in the unit.

### 3.3.4.5 <u>The need for more support from management</u>

Participants experienced management as lacking compassion towards their needs and felt that debriefing sessions should be held in order for them to vent their feelings.

*"When I came back on duty unit management never asked me how is your child? What did you do, management never show any compassion which irritates me…the first thing I was told is, sister, do you know that your leave is exhausted…"*

*"If you are a manager you should manage your colleagues, do not treat me as an object… I've got feelings…)*

*"When you have a problem you go to your' manager because you want to be off or you want to take half a day…but that will be a problem for management, cant' give you off because of the staff shortage…but management don't' see your problem, she only see the shortage of staff…so you don't have a choice, you have to decide…so you go off sick".*

According to Boyle, Bott, Hansen, Woods & Taunton,1999; Basset & Makin, 2000) the managerial style that is adopted in the critical care unit can have a great effect on the morale and retention of staff. Daly et al., as cited in Linton & Farrel (2009:in press), leadership is associated with positive traits and characteristics such as showing support and a willingness to listen to others. Managers must allow time for staff needs and keep in regular contact with registered nurses so they are aware of what is happening in the unit on a daily basis. Leadership by example in the critical care unit is important as it creates and maintains an environment that is supportive and rewarding for nurses (Yoder-Wise, 2003:24). Sullivan & Dekker

(2001:24) are of the opinion that true leadership benefits the followers (in this study registered nurses) not the leader. Odendaal & Nel (2005:98) indicate that participants in their study remarked that debriefing sessions should be held from time to time to discuss emotions experienced in the critical care unit. Participants in this study also felt that in every hospital there should be a qualified person; (counsellor) who could be called upon when a stressful situation occurred. This person should be familiar with the stressors associated within the critical care environment and should be trusted by the nurses in the unit.

**3.3.5 Registered nurses experience a need for staff development.**

Participants expressed the need to develop themselves and that continuous education was needed to update their knowledge in caring for critically ill patients. According to Finkelman (2006:396) nurses must be lifelong learners in today's changing health environment, as new science, technology, treatment and management methods are constantly changing.

3.3.5.1Registered nurses experience a need for regular in-service training

Participants felt that in-service training was important to update their knowledge base; but because of shortage of staff they could not attend in-service courses at all times. In-service training should be given as an enhancer of knowledge but it is not always possible.

 *"Another thing, there should be a workshop so that we can be reminded what we were taught at school…also some in-service training when it is not busy…we can choose a topic and a certain doctor or may be amongst us can present the topic to keep us updated."*

*"My enigste problem nog …ons het nou kort n aritmiee lesing gehad wat ek nie bygewoon het nie …ek kan gewone aritmiee identifiseer maar nie gekompliseerde aritmiee nie dan het jy iemand nodig vir wie jy kan vra veral op nagdiens . Ek het altyd die vrees wat as iemand n aritmiee kry en ek bel die dokter en gee n*

*verkeerde aritmiee, want alle aritmiee word nie dieselfde behandel nie." My only problem is… we had a lecture on arrhythmias the other day which I could not attend…I know how to identify simple arrhythmias but not complicated ones. I have a fear what if the patient present with an arrhythmia and I phoned the doctor and identify the wrong arrhythmia, because all arrhythmias are not treated the same…"*

*"I think the most important thing…continuous in-service training you know …like not necessarily ICU orientated like even motivational, emotional support…because we deal with, uhm,… critical conditions."*

Continuing education is essential for maintaining competency and for individual personal growth. Continuing education features systematic professional learning experiences designed to augment the knowledge, skills and attitudes of nurses and therefore enriches the nurses' contributions. Nurses have a responsibility to maintain an up-to date knowledge base from which they can administer nursing care effectively (Critical Care Environments, 2008). Nurses who do not possess the knowledge and skill needed in a critical care environment can find this environment very stressful because they have to make decisions independently at times. According to Scribante & Bhagwanjee (2007:1317) various recent studies have shown that the knowledge of critical care nurses in South African in a number of  clinical areas is lower than the acceptable standards. Finkelman (2006:399), states that  in-service education is provided in the work setting for the purpose of assisting staff members in performing their assigned functions in that particular institution.

Pulcini, Crofts, Campbell & Davey (2007:155) were of the opinion that education strategies aim to increase knowledge, change behaviour (meaning transfer the knowledge gained to implement it in the workplace) and it aim to improve patient care. A study conducted by these authors indicated that both restrictive, educational and multifaceted interventions proved useful to curb the problem of

resistance of antibacterials. A study conducted by Warren, Zack, Mayfield, Chen, Prentice, Fraser & Kollef (2004:1613) that aim in reducing the incidence of central venous catheter-associated bloodstream infection in the medical critical care unit indicated that a small educational programme and in-service training at staff meetings on the correct practices for the prevention of bloodstream- associated infections had positive outcomes in the reduction of bloodstream infections. The education programme consisted of 45-minute lectures, posters and fact sheets. An education module was also administered to all nurses working in the unit. According to Basset & Makin (2000:228), if nurses is updating themselves by attending courses then the care they give when they return is more likely to be based on the latest research-based and the nurses is more confident in rendering that care.

3.3.5.2 <u>Registered nurses experience a need for newly employed staff to receive adequate orientation and preceptorship in the unit.</u>

Participants experienced the fact that because of the uniqueness of a critical care environment appropriate orientation and accompaniment were needed to familiarise new registered nurses with the requirements of a critical care environment.

*"Jy moet eers gelei word… ek voel wanneer jy in n ICU kom werk moet jy eers vir so n week op n kursus gaan…om jou die basis te leer…dit is n ventilator, so lyk n sinus ritme , sodat jy nie instap en nou word jy sommer gebombadeer met n ventilator nie …jy weet partykeer nie eers hoe word die pype gekonnekteer nie…en die dag wanneer daar n noodgeval is en hulle se stoot die ventilator in dan vind jy uit …ek weet nie hoe om die pype te konnekteer nie, jy weet so dit sal jou meer geruster laat voel." (You must first be accompanied… I feel that when you come to work in the ICU, you must first go for a week on a course…to teach you the basics… this is a ventilator, this is how a sinus rhythm looks like, so that you don't get in the ICU and get 'bombarded" with a ventilator…at times you don't even know how to connect the pipes…and the day when there is an emergency*

*and they say push in the ventilator, then you will find out that I don't know how to connect the pipes, you know, so it will make you feel more at peace).*

According to Finkelman (2006:355), orientation is a key tool for getting staff ready to do the job they were trained for and for the retention of staff. Orientation should be provided for new employees as well as when employees face changes in their roles, responsibilities and practice settings. According to Basset & Makin (2000:221), the period just after obtaining a formal qualification can be one of the most stressful episodes in a nurse's career. Other nurses may see that one is a registered nurse and make assumptions as to one's knowledge base, capabilities and skill levels. Guidelines drawn up by the United Kingdom Central Council for Nurses, Midwives and Health Visitors as cited in (Basset & Makin, 2000:222), state that every newly qualified nurse should have a designated person to guide and assist the newly qualified member of staff. The newly qualified nurse can gain a great deal from a period of preceptorship. If newly qualified nurses have someone whom they can trust, to whom they can talk freely and who can show them around and introduce them to others, they will feel better able to cope with the new role and all it entails.

## 3.6 SUMMARY OF CHAPTER
In this chapter a discussion of the research findings was presented. Themes and sub-themes were verified and discussed within the context of existing literature. The research findings revealed that nurses enjoyed working in the critical care environment but issues surrounding this environment caused registered nurses to either experience the critical care environment as challenging or stressful In the next chapter recommendations based on identified themes will be discussed.

# CHAPTER FOUR
# RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

## 4.1 INTRODUCTION

In chapter three data was analysed and themes related to the experiences of registered nurses of their work environment in a critical care unit were discussed. These themes will serve as a baseline for recommendations to be made that will assist registered nurses working in a critical care environment. In chapter four therefore, recommendations, limitations, as well as conclusions of the study will be discussed.

The objectives of the study were:
- to explore and describe the experiences of registered nurses of their work environment in a critical care unit and
- to make recommendations that will assist registered nurses working in a critical care unit.

In the opinion of the researcher both objectives were obtained on completion of the study. This chapter provides recommendations that will assist registered nurses working in a critical unit. A brief summary of the research findings will be provided before recommendations will be discussed.

## 4.2 FINDINGS OF THE STUDY

One main theme and four sub-themes emerged from the collected and analyzed data.

**Main theme**
- Registered nurses experience the critical care environment as enjoyable yet challenging and stressful.

**Sub-themes**

- Registered nurses perceive staff shortage as a contributing factor to stress in the critical care unit.
- Registered nurses perceive relationship conflict in the unit as a stressor or challenge.
- Perceived lack of effective management skills leads to dissatisfaction of registered nurses.
- Registered nurses experience a need for staff development.

Before recommendations are discussed the following need to be noted.

Alameddine et al. (2008:4) in their study indicated that critical care units specialize in helping sick people recover; and it is therefore not surprising that some critical care units are taking the lead in improving their work environments. Critical care associations and societies have identified improving critical care work environments as a top priority and have carried out and published a number of studies (AACN Standards, 2005; Alameddine et al., 2008:4; Strack van Schijndel & Burchadi, 2007:235) that aim at identifying the essential elements that would make such an environment attractive and rewarding. However, the significant achievements in critical care work environments have not yet diffused to all hospitals and change does not come easily in complex environments such as the critical care unit (Alameddine et al., 2008:4). Critical care leaders therefore, have an opportunity, indeed an obligation, to study and implement changes that would improve the work environments of critical care units. The AACN have identified six essential, evidence- based and relationship- centred, standards for establishing and sustaining a healthy work environment, including skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition and authentic leadership (AACN, 2005) and these standards should be applied in every critical care unit.

Recommendations related to the identified themes as summarized in chapter 4.2 will now be discussed.  First the main theme will be discussed, namely:

**4.3 Recommendations to assist registered nurses in the alleviation of stress in the critical care environment.**

Stress is an interactive process involving both negative events and reactions to these events.  Stressors in the workplace needs to be addressed and;

- To enable registered nurses to address stress/stressors in the workplace stress management should be taught which should include education programmes that will assist registered nurses in teamwork and communication skills (Alameddine, 2008:4). Workshops that include self-knowledge, self awareness and discovering one's strengths and weaknesses should be attended by critical care nurses.

- Individual-centered interventions that would assist registered nurses in assertiveness training, time management, interpersonal and social skills, and relaxation and meditation techniques should also be considered as a formalized programme in the critical care unit and should be given by professional educators.

- Support groups that will identify needs, provide support and encourage teamwork amongst staff should be implemented. The group should have a particular approach to the way in which frustrations are ventilated; it should provide support for lifestyle changes; emotional support to enable nurses to cope with stress (Booyens, 1998:151). By doing this they will develop self awareness and also acknowledge personal responsibility. Regular staff meetings should be held with an independent facilitator who can offer an effective way of sharing knowledge and skills and providing a structure for team-building (Odendaal & Nel, 2005:100).

- Team briefings should be implemented as they are a very valuable tool for communication of non-patient-related problems. They provide direct information and reaction; prevent misunderstandings; help people to accept changes and increase their commitment and control over themselves. Team briefings must not take too long before the next session otherwise

they can create resistance.  Briefings can have a particularly team-building quality (Strack van Schijndel & Burchadi, 2007:237).

## 4.4 Recommendations that will assist with shortages of staff in the critical care unit.

The AACN (2005) has identified appropriate staffing as one of the six essential standards to establish and sustain healthy work environments in critical care units. Sufficient staffing is a priority in order to maintain patient safety and the well being of the critical care nurse (Carayon & Gürses, 2005:286). The recommended staffing in a critical care unit is a 1:1 ratio of registered -nurse - to -critically ill patient.

- The healthcare organizations should have staffing policies in place that are solidly grounded in ethical principles and support the professional obligation of nurses to provide high quality care (AACN, 2005).
- The unit manager in the critical care unit should have formal processes in place that keep a record of all incidents in the unit that happened due to staff shortages and the effects they had on patient care and the nursing staff.
- Healthcare authorities should be made aware of staff shortage problems and the formal processes of which records were kept for example when patient needs and nurse competencies were mismatched and how often contingency plans were implemented or cancelled due to staff shortages. These records must be kept and discussed with management.
- Adequately trained registered nurses should be employed to reduce stress and assist in the provision of a more predictable work environment (WFCCN, 2008).
- Sufficient staff should be available in order for quick staffing adjustments to be made in the scheduling system in cases of unforeseen absenteeism, illnesses and other emergencies. An adequate registered nurse-to-patient ratio will ensure the fair distribution of work-load and responsibilities and will lead to improve quality of patient care (WFCCN, 2008).

- Proper duty scheduling of staff is important to provide the correct mix of staff and sufficient numbers of staff in order to provide adequate nursing care for patients. Nursing staff are not freely interchangeable because all nurses do not have the same level of knowledge and clinical skill. Therefore, it should not be expected of a less experienced registered nurse to function at the same high level of efficiency as the more experienced or trained registered nurse (Booyens, 1998:345).

- Each shift should have a designated trained nurse in charge to manage and lead the unit.

- Adequate support staff, within the critical unit should be provided to assist with administrative duties; to assist with manual handling of heavy patients, cleaning and domestic duty in order to allow nursing staff to focus on direct nursing care and associated professional requirements (WFCCN, 2008).

- Less experienced registered nurses need guidance and assistance from experienced and trained registered nurses in order for them to gain the knowledge and clinical skills required in a critical care unit because these nurses need to be retained in the critical care unit; otherwise the unfamiliar environment may cause them to stress and may lead to resignation which critical care environments cannot afford.

- The healthcare organization should adopt technologies (monitors, equipment) that will increase the effectiveness of nursing care delivery. Nurses should engage in the selection, adaptation, and evaluation of these technologies (AACN, 2005).

## 4.5 Recommendations that will assist registered nurses with conflict handling in the critical care unit.

Knowing how to manage conflict will be of great benefit to the critical care nurse as well as improving the working environment and ability to reach patient outcomes successfully (Finkelman, 2006:93). Conflict resolution includes the use of a variety of skills and strategies. To understand a conflict one first has to know in which area the conflict has its roots, because the solution is linked to that area. Conflicts can be task/organization-, social/emotional-, identity/vision-, or

interest/goal/achievements orientated. To enable people to handle conflict in the unit conflict management skills should be taught by providing staff the opportunity to attend the following courses in order to improve their conflict management skills (Finkelman, 2006:93); namely, training in:

- interpersonal skills,
- effective communication skills,
- assertiveness,
- problem-solving skills and
- negotiation skills

The following strategies might assist staff in conflict resolution (Finkelman, 2006: 83-90).

Unit managers should identify problem behaviours, focusing on behaviors, not personalities. They should also observe non-verbal communication that indicates staff are upset (for example, sarcasm, body posture, raising voice or tone of voice, hand movements). Arguments should be avoided since people sometimes do need to vent, as long as it is done appropriately and in a private place, it may be helpful in decreasing tension. Listening to one another should be done with understanding rather than judgement. Nurses should have knowledge of appropriate channels of negotiations so as to communicate those stressors which are within their work environment. Talking about stressful situations and personal feelings can release tension for the critical nurse (Strack van Schijndel & Burchadi, 2007:237).

### 4.5.1 Recommendations that will assist registered nurses with conflicting nurse-doctor relationships.

Finkelman (2006:91) is of the opinion that conflict between nurses and doctors arise because the two professions structure their work differently. It is expected of the doctor and the nurse to gain better understanding of each profession's viewpoint and demonstrate less automatic acceptance of inappropriate behaviour. The following interventions to optimize nurse-doctor relationships should include:

- Training workshops in collaboration and communication skills, joint interdisciplinary staff meetings, coordination of care, and discussions on case scenarios relevant to the critical care unit.

- Proactive elimination by management of negative communication and behavior by establishing a zero- tolerance policy for disruptive behaviour, holding nurses and doctors accountable for their actions;

- Dissemination of the code- of conduct policies and reporting of guidelines to both nurses and doctors, and application of policies consistently and quickly; and

- Appointment of a doctor together with a nurse facilitator that will assist with the in-service training and education programs in the critical care unit, thereby ensuring nurse competencies.

Recommended strategies to deal with verbal abuse are the following:

- Encourage staff to report abuse by allowing anonymity.
- Use nurse-doctor counsel teams to act as liaisons with employees.
- Encourage staff to speak firmly and address abuse.
- Introduce staff to new doctors and encourage them to come for assistance if needed.
- Encourage nurses to improve their knowledge base and thus develop more self-confidence when engaging in a conflict situation (Finkelman 2006:91).

Recommendations that will assist with the unavailability of doctors:

- Management should have discussions with a liaison group of critical care doctors regarding the need for the availability of an appropriately skilled and qualified critical care doctor to be accessible to the unit for decision- making and advice 24 hours per day.

- Registered nurses' scope of practice and the effects that decision-making has on the nurse should be discussed with doctors.

- A sleeping room should be made available for the doctor on duty so that he\she can be easily accessible if needed.

## 4.6 Recommendations that will assist management in developing leadership skills.

The unit manager is one of the key persons responsible for creating a positive work environment and group cohesion. Cohesion is created by trusting one another (not blaming each other), and by giving constructive feedback (Alameddine et al., 2008:3). Since the managerial style that is adopted can have a great effect on the morale and retention of staff members (Basset & Makin, 2000: 220), managers can improve their managerial skills by adopting the following measures:

- The healthcare organization should provide support for and access to educational programmes to ensure that nurse leaders develop and enhance knowledge and abilities in skilled communication, effective decision-making, true collaboration, meaningful recognition, and ensuring resources to achieve appropriate staffing.
- Systems should be developed for effective two-way communications since it is essential to make time to hear what the lower level employees think and what they have to say about top-level managements' organizational measures. It is also necessary to supply personnel with sufficient up-to-date information about what is going on in the unit.
- Prompt, constructive resolution of conflicts should be promoted. Nurse managers should receive training in handling conflicts and should apply their knowledge to resolve conflicts before they become too complex  to be solved by the manager.
- Managers should become familiar with staff and their work, for example they should be more visible in the units by being more involved in ward rounds and by familiarizing themselves with the names of staff.
- The nurse manager should demonstrate good listening skills and empathy by not interrupting people, by allowing them time to talk, by acknowledging the feelings behind the words and by showing understanding about important matters as per institutional policies.

- Proper procedures should be followed regarding discipline and the handling of grievances as per institutional policies.
- Personal respect should be shown to staff members by passing information promptly to staff on matters pertaining to the unit and patient care, encouraging staff to discuss their matters or issues before giving one's own views, consulting staff on changes that need to be made before taking action, being encouraging in difficult times, and by thanking staff for their contributions (Booyens, 1998:149; Linton & Farrel, :2009).

The following standards are set for authentic leadership in order to sustain healthy work environments (AACN, 2005).

- Nurse leaders should demonstrate an understanding of the requirement of a healthy working environment by successfully engaging in the following:
-  no favoritism allowed in the critical care unit that creates animosity amongst staff members.
- Management should attempt to bring about changes in the unit for example change of duty roster to establish the effectiveness of such a change.
- Staff meetings should be held once a month in order for nurses to discuss work-related issues and in order for them to vent their feelings.
- Nurse leaders should excel at generating visible enthusiasm for achieving the standards that create and sustain healthy work environments.
- Nurse leaders should lead the design of systems necessary to effectively implement and sustain standards for healthy work environments by being a role model in skilled communication, true collaboration, effective decision-making and authentic leadership skills (AACN, 2005).

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## 4.7 Recommendations to support registered nurses for staff development.

The critical care environment is a dynamic discipline which requires continual in-service education of nurses. In-service education implies updating, training, educating and informing employees about the present requirements of the job (Booyens, 1998:384). Continuing education and staff development programmes should be promoted to maintain competency of staff. In-service education

programmes are usually directed towards bringing employees up-to-date about new diagnostic and treatment modalities, the care and operation of new equipment, the optimal use of supplies, and new institutional policy decisions. Skills taught in the basic courses should be applied in the workplace and established in actual practice. If staff is updating themselves by attending courses, then the care they give when they return is more likely to be more current and research based (Basset & Makin, 2000:228). However, registered nurses can utilize other methods to update their knowledge in the unit, if staff shortages do not allow nurses to attend seminars, workshops or conferences for example they can join journal clubs. Within the unit, in-service education can be given utilizing videos, leaflets and literature, discussions with colleagues, private reading, group work, reflective practice and observation. A critical care unit must have a dedicated clinical facilitator to provide education, training and quality improvements activities for the unit nursing staff. This person must have an additional qualification in critical care nursing (WFCCN, 2005).

## 4.8 Recommendations that will assist with the orientation of newly employed registered nurses to the critical care unit.

Newly employed registered nurses that come to work in the critical care unit need to be welcomed and policies put into place to retain these staff. Strack van Schijndel & Burchadi (2007: 237) state that the earlier you introduce "beginners", the sooner they will be fit for their job. They should be provided with a mentor who can guide, assist, teach, and apply them with information needed to be able to cope in the unit. Thereafter a period of accommodation begins during which individual communication and team briefing continues to build the connection. Regular evaluation of the employee is necessary to establish what the individual's skills and experiences are and how he/she can be integrated in the daily work. "The more the co-worker feels he fits, the more he/she likes the job and the more he/she becomes an effective worker" (Strack van Schijndel & Burchadi, 2007: 237). In the practical sense it can be assumed that if newly employed members to the critical care unit have someone whom they can trust, whom they can talk freely to and who will show them around and introduce them to others, they will

feel better able to cope with the new role and all it involves(Basset & Makin, 2000:223).

## 4.9 LIMITATIONS OF THE STUDY

Since qualitative research studies are contextual they make generalizations to other settings problematic. The study was conducted in one public hospital critical care unit only and did not include critical care nurses of the private sector. One interview had to be rescheduled due to time limitation which could have had an influence on the interviewee.

## 4.10 RECOMMENDATIONS FOR FURTHER RESEARCH

In the light of the research findings, the following recommendations for nursing practice, education and research were formulated.

### 4.10.1 Recommendations for nursing practice

- Findings of the research study and recommendations need to be made available to all staff working in a critical care unit through the dissemination of photostat copies of the findings and recommendations.
- Support groups need to be established that can assist registered nurses emotionally and spiritually in coping with the critical care unit.
- Liaison groups need to be established between nurses, doctors and managers in order to create a warm, caring environment in which holistic nursing care need to be rendered.
- Briefing sessions should be held for of about 5 - 10 minutes before each shift starts to up-date each nurse about happenings in the ward and also for relationship building.

### 4.10.2 Recommendations for nursing education

- In-service education courses for example recognition of arrhythmias and treatment thereof need to be developed to enhance the knowledge and clinical skills of nurses working in a critical care unit.

- In-service training courses need to be developed that will assist nurses and management in conflict handling, assertiveness training, decision-making skill.
- Research finding should be disseminated through in-service training and newsletters to nurses and other health professionals that could benefit from the research findings.

### 4.10.3 Recommendations for nursing research

The following recommendations are made for nursing research:

- The repetition of the study in the Nelson Mandela Metropole, using a larger sample group should be considered.
- As a public hospital critical care unit was involved in this study, future studies could also involve a private sector critical care unit.
- A quantitative study could be done with the same themes identified that can explain how registered nurses experience their work environment in a critical care unit.
- Research can be conducted including participants with only one to two years critical care experience in order to compare results with the current research study.

### 4.11 SUMMARY OF CHAPTER

In conclusion it can be said that registered nurses experience their critical care environment as stressful related to the themes identified, but they perceive it also as a challenge and they enjoy working in this environment. Recommendations made regarding the experiences of registered nurses of their work environment can assist registered nurses working in this environment and it can be utilized as an in-service training programme.

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**ANNEXURE   A**


**APPLICATION TO CONDUCT RESEARCH FROM LOCAL AUTHORITIES**

Medical Superintendent

Dear Dr Maqagi

**Re: Application to Conduct Research in the critical care unit**

I am currently engaging in a Magister Curationis degree in Advanced General Nursing Science: Critical Care Nursing at the Nelson Mandela Metropolitan University. One of the requirements for the degree is to conduct a research study. I hereby request your permission to undertake a research study regarding: "The experiences of registered nurses' of their work environment in a critical care unit."

The objectives of the study are to explore and describe the experiences of registered nurses of their work environment in a critical care unit and to make recommendations that will assist registered nurses in this work environment.

Purposive sampling technique will be employed and data will be collected by means of semi-structured interviews. Once data has been analyzed, recommendations will be made that will assist registered nurses in a critical care work environment. A copy of the research report will be made available to the unit where the research will be conducted.

The researcher will attempt to adhere to all ethical principles of research. The research study will be conducted under the supervision of Mrs. P. J. Jordan at the Nelson Mandela Metropolitan University, Department of Nursing. Should you have any queries please do not hesitate to contact me at the following numbers: 4818168(h) or 3923351(w).

Thank you for considering my request.

Yours faithfully
B. L. Adams (Registered Nurse)

Education and Training Coordinator Complex Hospitals
Walton Building
Parsons Hill
Port Elizabeth
6001

Dear   Mrs Mtshake

**Re: Application to Conduct Research in the critical care  unit**

 I am currently engaging in a Magister Curationis degree in Advanced General Nursing Science: Critical Care Nursing at the Nelson Mandela Metropolitan University. One of the requirements for the degree is to conduct a research study. I hereby request your permission to undertake a research study in one of the public hospital critical care units in the Nelson Mandela Metropole. The topic of the research study is: "The experiences of registered nurses' of their work environment in a critical care unit."

The objectives of the study are to explore and describe the experiences of registered nurses of their work environment in a critical care unit and to make recommendations that will assist registered nurses in this work environment.

 Purposive sampling technique will be employed and data will be collected by means of semi-structured interviews. Once data has been analyzed, recommendations will be made that may assist registered nurses in a critical care work environment. A copy of the research report will be made available to the unit where the research will be conducted.

The researcher will attempt to adhere to all ethical principles of research. The research study will be conducted under the supervision of Mrs. P. J. Jordan at the Nelson Mandela Metropolitan University, Department of Nursing. Should you have any queries please do not hesitate to contact me at the following numbers: 4818168(h) or 3923351(w).

Thank you for considering my request.

Yours faithfully
Mrs B. L. Adams (Registered Nurse)

Dear   Unit Manager

**<u>Re: Application to Conduct Research in the critical care  unit</u>**

 I am currently engaging in a Magister Curationis degree in Advanced General Nursing Science: Critical Care Nursing at the Nelson Mandela Metropolitan University. One of the requirements for the degree is to conduct a research study. I hereby request your permission to undertake a research study regarding: "The experiences of registered nurses' of their work environment in a critical care unit."

The objectives of the study are to explore and describe the experiences of registered nurses of their work environment in a critical care unit and to make recommendations that will assist registered nurses in this work environment.

 Purposive sampling technique will be employed and data will be collected by means of semi-structured interviews. Once data has been analyzed, recommendations will be made that may assist registered nurses in a critical care work environment. A copy of the research report will be made available to the unit where the research will be conducted.

The researcher will attempt to adhere to all ethical principles of research. The research study will be conducted under the supervision of Mrs. P. J. Jordan at the Nelson Mandela Metropolitan University, Department of Nursing. Should you have any queries please do not hesitate to contact me at the following numbers: 4818168(h) or 3923351(w).

Thank you for considering my request.

Yours faithfully
 Mrs B. L. Adams (Registered Nurse)

**ANNEXURE   B**

**PERMISSION TO CONDUCT RESEARCH FROM LOCAL HEALTH AUTHORITIES**

Province of the Eastern Cape                                        Iphondo Lwempuma-kolon

## DEPARTMENT OF HEALTH / ISEBE EZEMPILO
## PORT ELIZABETH HOSPITAL COMPLEX
### PROVINCIAL HOSPITAL / PROVINCIAL ISIBHEDLELA
Private Bag / Ingxowa Eyodwa X 0003, PORT ELIZABETH 6000

| | | | | |
|---|---|---|---|---|
| Ireferensi Ref. No. | : | | Ifoni Telephone : | (041) 392-3408 |
| Imibuzo Enquiries | : | DR W L MAQAGI | Ifaxi Facsimile : | (041) 392-3866 |
| E-Mail | : | Wandile.maqagi@impilo.ecprov.gov.za | Date : | 11 APRIL 2007 |

Ms B L Adams
50 Heathcote Road
Heath Park
PORT ELIZABETH
6020

Dear Ms Adams

### APPLICATION TO CONDUCT RESEARCH

Your letter dated 5 March 2007 refers.

Permission is hereby granted for you to conduct the research provided that ethics is observed.

Yours sincerely

DR W L MAQAGI
SENIOR MEDICAL SUPERINTENDENT
WLM/mb

EASTERN CAPE DEPARTMENT OF HEALTH

PORT ELIZABETH HOSPITAL COMPLEX

Private Bag X60572, Greenacres
PORT ELIZABETH, 6057

Tel no: 041- 391 8080          Fax no: 041- 391 8007
Email: nqabi.mtshake@impilo.ecprov.gov.za
Enquiries - Ms N.G. MTSHAKE

# MEMORANDUM

**TO**             : Ms PORTIA JORDAAN  -- NMMU

**FROM**        : Ms N.G. MTSHAKE

**DATE**         : 24 AUGUST 2007

**SUBJECT**   : PERMISSION TO CONDUCT RESEARCH
                        PROJECT

Kindly assist this office by channeling information to the following students, who requested permission to conduct research with the P.E.H.C.

This is an effort to try and speed up the response, because the letters reached this office while, I was away and they still had to go through the NURSING SERVICE MANAGER and CLINICAL GOVERNANCE HEAD.

The permission has been granted , the candidates can produce copies of this letter to the INSTITUTIONAL NURSING MANAGERS , specifying when would they wish to visit the relevant institutions.

The candidates are  -- Ms Spagadoros --- for DIABETES
                              -- B. L. Adams      -- CRITICAL CARE

Thanking you in advance

Yours in Health

N.G. MTSHAKE

ASSISTANT MANAGER – TRAINING AND DEVELOPMENT -- NURSING

## PROVINCIAL HOSPITAL, PORT ELIZABETH

| To | : | B.L. Adams |
|----|---|-----------|
| Date | : | 07 August 2007 |
| From | : | Ms. M.E. Moss |
| Fax no | : | (041) – 392 3866 |
| Phone no | : | (041) – 392 3219 |
| **Re** | : | **Application to conduct research** |

Dear Adams

I acknowledge receipt of your letter dated 02 August 2007 for the above mentioned application.

I am kindly advising you to request permission from Dr. Rank the one in charge of the Clinical Governance, Dr. Maqagi – Senior Medical Superintended of PHPE and Mrs. Morapedi – Deputy Director of Nursing.

Yours faithfully

**M.E. Moss**
**Deputy Director - Nursing**

**ANNEXURE   C**

**PARTICIPANT CONSENT FORM**

# NELSON MANDELA METROPOLITAN UNIVERSITY

## INFORMATION AND INFORMED CONSENT FORM

| | |
|---|---|
| **Title of the research project** | The experiences of registered nurses of their work environment in a  critical care unit. |
| **Reference number (for official use)** | |
| • **Principal investigator** | Mrs B. L. Adams |
| **Address**<br><br>**Postal Code** | 50 Heathcote Road<br>Heath Park,<br>Port Elizabeth<br>6020 |
| **Contact telephone number (private numbers not advisable)** | (041) 5042122 |

| **A.     DECLARATION BY OR ON BEHALF OF PARTICIPANT**<br>**(Person legally competent to give consent on behalf of the participant)** | **Initial** |
|---|---|
| I, the participant and the undersigned<br>I.D. number<br>•<br><br>Address (of participant) | |
| **A.1     I HEREBY CONFIRM AS FOLLOWS:** | |
| 1.     I, the participant, was invited to participate in the above-mentioned research project that is being<br>undertaken by<br><br>of the Department of<br>in the Faculty of<br><br>of the Nelson Mandela Metropolitan University. | |
| 2.     **The following aspects have been explained to me, the participant:**<br><br>2.1     **Objectives of the study:** To explore and describe the experiences of registered nurses  of their work environment in a critical care unit and to make recommendations that will assist registered nurses working in a critical care unit.<br><br>The information will be used to: make recommendations that will assist registered nurses working in a critical care unit | |

| | | |
|---|---|---|
| 2.2 | **Procedures**: I understand that I will partake in a semi-structured interview with the researcher. | |
| 2.3 | **Risks:** I will not be exposed to any form of risk or harm. | |
| 2.4 | **Possible benefits:** As a result of my participation in this study, the experiences of registered nurses of their work environment in a critical care unit can be explored. Recommendations that will assist registered nurses working in a critical care Unit will be made.. | |
| 2.5 | **Confidentiality:** My identity will not be revealed in any discussion, description or scientific publications by the investigators. | |
| ▪ | **Access to findings:** Any findings that derived from the research process will be made known in the research report. | |
| ▪ | **Voluntary participation/refusal/** My participation is voluntary | |
| 3. | The information above was explained to me/the participant by<br><br><br>in<br><br>I was given the opportunity to ask questions and all these questions were answered satisfactorily. | |
| 4. | No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation. | |
| 5. | Participation in this study will not result in any additional cost to myself. | |

| | |
|---|---|
| A.2 | I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT |
| | Signed/confirmed at |

## B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)

I, **Bernardene  Lucreshia Adams**

……………………………………………………………………………………………………………………………**declare that**

- **I have explained the information given in this document to**


  -      he/she was encouraged and given ample time to ask me any questions;

- **this conversation was conducted in**

  **and no translator was used -**
  **I have detached Section D and handed it to the participant**

  Signed/confirmed at

## D. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT

**Dear participant/representative of the participant**

**Thank you for your/the participant's participation in this study. Should, at any time during the study:**

- **an emergency arise as a result of the research, or**
- **you require any further information with regard to the study,**


**Kindly contact**

at telephone number

# ANNEXURE D

# TRANSCRIBED INTERVIEW

TRANSCRIBED INTERVIEWS

P – Participant
R – Researcher


R: CAN YOU TELL ME ABOUT YOUR EXPERIENCES OF WORKING IN A CRITICAL CARE ENVIRONMENT?


P: Kan ek in Afrikaans praat?
R: Ja, jy kan in Afrikaans praat.


P: Umm… dis eintlik moeilik om te kan sê waar jy moet begin met jou ondervinding, want ek het eers in hoë sorg eenheid gewerk en was 'n nuwe suster …wat ek kan sê jy was alleen gelos in die eenheid en al personneellid wat jy gehad het om jou eintlik te help was 'n assistent verpleegster. (Umm… it's actually difficult to be able to say where you should begin with your experiences because I first worked in a high care unit and was a new sister … that I can say you was left alone in the unit and the only staff member that you had to help you actually, was an auxillary nurse.)


R: Goed… vertel my slegs van die intensiewe sorg eenheid. (Fine… tell me only about the ICU)


P: In die ICU umm… het ek eers in die respiratoriese eeheid begin … geleer om met pasiënte te werk wat soort van elke dag dieselfde is … langtermyn gevalle hulle toestand verander nie veel … met die gevolg binne 'n maand of twee kan jy jou voete vinnig vind … maar jy moes oplettend wees … jy moet bereid wees om van 'n stafverpleegster te leer en van 'n assistent verpleegkundige te leer.
Van die ventilators het ek absoluut niks geweet nie … dit het gelyk soos 'n monster wat daar staan en ek het nie geweet wat om te doen nie, die mense kom na jou… assistent verpleegster … suster jy moet dit skryf en jy moet dat skryf … en ek het niks geweet wat skryf ek neer nie. (In the ICU, uhm … I began in the

respiratory unit; learned how to work with patients that were sort of the same every day … long-term cases whose condition did not change much … with the result that you could find your feet within a month or two; but you had to be observant (alert) … you had to be prepared to learn from a staff nurse [enrolled nurse] and to learn from an assistant-nurse [auxillary nurse]. About the ventilators I knew absolutely nothing … it looked like a monster standing there and I did not know what to do. People came to you, assistant-nurse … sister, you must write this and you must write that … and I did not know anything about what I was writing down).

R: Mmm… (Mmm…)

P: Mettertyd het personneellede wat in bevel was probeer om lesings te gee in tussentyd maar as jy ook nie vrae gevra het nie, het hulle jou nooit gehelp nie, en umm … en daar was party vloer susters wat umm… jy was een suster gewees met ses pasiënte, met net 'n algemene assistent en 'n stafverpleegkundige … soms was vyf pasiente geventileer. Soms het die vloer susters (susters in bevel) nie gekom om te kom help nie. (As time went by, staff members who were in charge tried to give lectures in between; but if you also did not ask questions, they never helped you; and, umm … there were some floor sisters who, umm … you were one sister with 6 patients, with just a general assistant and a staff nurse … sometimes 5 patients were ventilated. Sometimes the floor sisters [sisters in charge] did not come and help.)

R: Mmm…(Mmm…)

P: Ek het geleer om arteriële bloed te trek deur stafverpleegkundiges. Hulle het my geleer hoe voel jy, waar moet jy voel. Hulle het my geleer hoe suig jy 'n pasient. So die senior susters het net kom vra kan jy "cope". En jy moes maar net leer om te "cope". (Enrolled nurses showed me how to draw arterial blood.They taught me how to feel and where to feel. They taught me how you

should suction a patient.  So the senior sisters just came to ask if you could cope. And you had to just learn to cope.)

R:  So in die geval … hoe sou jy sê wat het jy nodig gehad om jou te help in die "ICU" om te "cope"?  (So in that case … how would you say what you needed to help you cope in the ICU?)

P:  Die tipe opleiding wat ek nodig gehad het, is wanner hulle jou kon "gepartner" het met iemand wat kan sê, "kyk ek werk saam met jou vandag, dit is 'n ventilator, dit is waarna jy kyk, hoe werk dit", baie keer gaan die alarm af … dan weet jy nie waarvoor gaan die alarm af nie, dan sal die assistent verpleegster sê … suster kyk of daar nie $H_2O$ in die pype is nie … die drukke is te hoog … dis hoe ek geleer het.  Daar was lesings umm… tussen in gebied … maar al die susters was nie lief om lesings te gee nie, want dan vra jy vrae wat hulle partykeer nie kon geantwoord het nie of hulle het die boekkennis maar hulle weet partykeer nie hoe om dit oor te dra nie, want jou vrae wat jy vra is baie "simple" … jy weet eenvoudige vrae en baie van hulle het in die jare … seker 10 jaar gelede 'n ICU kursus gedoen, maar as ek nou iemand spesifiek … (The type of training that I needed was that they could have partnered you with someone who could say "Look, I'll work together with you today.  This is a ventilator, this is what you must look at and this is how it works."  Often the alarm went off … then you didn't know why, or for what reason it went off.  Then the assistant would say " … Sister, look to see if there is not water ($H_2O$) in the pipes …the pressure is too high" … that's how I learned.  There were lectures, umm… offered in between times …but not all the sisters were keen to give lectures, because then you might ask questions which they could perhaps not have answered or they had the book knowledge; but they sometimes did not know how to convey it;  because your questions that you asked were very "simple" … you know, uncomplicated questions and many of them had during the years … certainly 10 years before … done an ICU course; but now if I should name someone specifically …)

R:  Moenie name noem nie … (Don't  mention names …)

P:  Okei … iemand spesifiek wat daar was het altyd probeer om die basiese goed te leer … soos byvoorbeeld wat is 'n sinus ritme, 'n sinus tagikardie, waarvoor kyk jy spesifiek … maar as daar aritmieë voorgekom het, is dit so vinnig wat dit gebeur of saam met die aritmieë is daar komplikasies , dan sal een persoon agterna miskien … as die pasient uitgesorteer is … sal een persoon jou neem en verduidelik wat het gebeur en waarop jy moet let, ensovoorts, en umm …  (Okei … somebody specific who was there, has always tried to learn the basic stuff … like, for example, what a sinus rhythm was, a sinus tachycardia, what you should look for specifically … but if arrhythmia presented it was so quick that it happens … or with the arrhythmia there is always complications, than one person would perhaps afterwards … if the patient had been sorted out … one person would take you aside and explain what had happened and what you should notice or observe and so on, and, umm … )

R:  Dink jy jy moet gelei word deur … (Do you think that you should be guided first …)

P:  Jy moet eers gelei word … ek voel dat as jy van 'n hoë sorg eenheid ingeplaas word na 'n ICU moet jy eers vir so 'n week op 'n kursus gaan … om jou die basis te leer, bv. Dit is 'n sinus ritme, so lyk 'n ventilator, sodat jy nie instap en nou word jy sommer gebombardeer met 'n ventilator nie en jy het nog nooit die ding in jou lewe gesien nie … jy weet partykeer nie eers hoe word die pype gekonnekteer nie …en die dag wanneer daar 'n noodgeval is en hulle sê stoot die ventilator in dan vind jy uit umm … ek weet nie hoe om die pype te konnekteer nie, jy weet … so dit sal jou meer geruster laat voel ook. Veral in die cardiac eenheid né …toe ek daar begin werk het, ek ondervinding gehad van respiratoriese pasiente … maar respiratoriese pasiente was gekoppel aan ventilators … en oor die algemeen as jy moes geresusiteer het, dan was dit makliker, dan was hulle alreeds geïntubeer en geventileer … so dan was dit makliker … want met "cardiac" pasiente, daardie pasiente se toestand verander in 'n ommesien en … dan vind jy uit jy weet nie hoe om basiese "airway opening" te doen nie, want jy vergeet partykeer jy moet die

nek in ekstensie sit, want alles is so deurmekaar … die pasient lê net voor jou oë dan moet jy as suster bevele gee vir mense[verpleegsters] wat onder jou werk, jy weet. (You must be guided first … I feel that if you are transferred from a High Care Unit to an ICU, you should first go on a course for about a week to be taught the basics, for example, this is a sinus rhythm, this is what a ventilator looks like, so that you don't walk in and now you just get bombarded with a ventilator and you've never seen the thing ever in your life before … you sometimes don't even know how the pipes are connected … and the day when there's an emergency and they say "push the ventilator in", then you find out, umm … I don't know how to connect the pipes, you know … so that would also help you feel calmer. Especially in the cardiac unit, eh – when I began working there I had had experience of respiratory patients … but respiratory patiens were attached to ventilators … and in general if you had to resuscitate, then it was easier, then they were already intubated and ventilated … so then it was easier … because with cardiac patients, those patients' condition changed in a split second and … then you find out you did not know how to do a basic "airway opening", because you sometimes forgot you had to put the neck in extension, because everything was so mixed up … the patient was lying there before your eyes and you as the sister had to give orders to people[nurses] who worked under you , you know.)

R: Jy dink die suster moet weet wat sy doen… (You think the sister should know what she's doing…)

P: Ek glo wat hulle moes doen … voordat hulle enige suster in die ICU sit, laat haar 'n basiese resus kursus ondergaan … om haar kennis te verfris … dit doen jy as student en op poppe gedoen …en dit is hoeveel jare gelede. In die ICU is dit baie belangrik om vinnig op te tree … dis waar ek geleer het om vinnig op te tree met 'n cardiac pasient … jy weet … daar is een suster wat my geleer het as 'n "cardiac" pasient inkom, die belangrikste is, hou die pasient pyn vry … ek het nooit regtig verstaan waarom nie … jy is te bang jy gee te klomp morfiene en dan onderdruk jy die pasient se asemhaling … maar dis nie hoe dit werk nie … daai morfien help die pasient ontspan en die hart werk dan nie so hard nie, dis hoe ek

my insig gekry het … ja ek sal nooit vergeet hoe ek in Johannesburg gaan "moonlight" het nie. Toe kyk ek na 'n "cardiac" pasient en daardie nag het ek nie een keer my oog van die "cardiac" monitor afgehaal nie, want ek was so bang netnou gebeur daar iets met die pasient en nou is dit nog 'n privaatgeval … ja … (sug) (I believe that what they should have done before they placed any sister in the ICU, they should enable her to undergo a basic "resus" course to refresh her knowledge – that you do as a student and on dolls – and that was however many years ago. In the ICU it is important to act quickly with a cardiac patient, you know … There was one sister who taught me that when a cardiac patient come in, the most important thing was to keep the patient pain-free … I never understood why … you're too afraid to give to much morphine and then you suppress the patient's breathing – but that is not how it works – that morpine helps the patient relax and then the heart doesn't work so hard; that's how I gained my insight … yes, I'll never forget how I went and "moonlighted" in Johannesburg. Then I nursed a cardiac patient and that night I didn't take my eyes off that cardiac monitor, because I was so scared that just now something would happen with the patient now it's also a private case … yes (sigh!)

R: Ja … so jy sê die toestand van die pasiente verander in 'n ommesien? (Yes … so you say the condition of the patient changes in a split second?)

P: In in ommesien … in 'n ommesien en wat jy ook moet weet as jy sien die toestand verander, dan moet jy as suster kalm wees, want umm… umm…wat gebeur die toestand is so deurmekaar en die hele situasie is so deurmekaar en elkeen skree en verskree mekaar en een persoon is kalm en jy gee jou bevele 'n bietjie stadig en jy… umm… dit gaan nie in by die een [verpleegster] wat jy wil hê nie (Pause). As jy vir die een [verpleegster] sê gee my 'n ambusak, dan gee die een 'n masker. Ek moes my self leer om kalm te kan wees, en rustig te kan wees en om die ander 'n kans te gee om ook tot bedaring te kan kom… okei. (In a split second … in a split second and what you also need to know if you see the condition changing, then you as the sister must be calm because, umm … umm, what happens is that the condition is so chaotic and the whole situation is so

confused and everyone screams and screams at one another and one person is calm and you give your orders a bit slowly and you … umm … it doesn't go into the one what you want. (Pause). If you say to the one[nurse] "Give me an ambubag, than the one gives you a mask. I had to teach myself to be able to stay calm, to be able to remain tranquil and to give the others a chance also to calm down … OK)

R: So jy sê dit help om kalm te wees? (So you're saying it helps to be calm?)

P: Ja, dit help verskriklik baie, dan luister die een ook, want as die suster eers haar kop verloor, dan kan jy maar vergeet. … ha ha ha (lag). Nog iets, die omgewing van ons eenheid of ICU verskil van ander ICU'S want op die oomblik het ons net die 6 bed en al wat ons mee te doen kry, is net ope hart gevalle… en dit is vir my baie stresvol. Want hulle glo daaraan dat die een wat die langste ondervinding het, moet met die vars gevalle werk … Dit is hoe dit eers gewerk het, en met al die nuwe gevalle het ek spesifiek genoem dat die nuwe mense[geregistreerde verpleegkundiges] nie genoeg ondervinding kry om met vars gevalle te werk nie. Met die gevolg hulle het nooit vertroue in hulself wat om te doen of hoe om op te tree in 'n situasie nie. Toe het ek genoem dat al die nuwe susters 'n geleentheid kry om met vars gevalle te werk. Dit is 'n leer situasie en jy die een met die ondervinding, staan die suster by. Jy los haar nie op haar eie nie. Jy weet, dan is dit soort van twee susters wat na een ope hart kyk, een met ondervinding, en een sonder ondervinding. Maar jy met ondervinding moet daardie persoon lei, dat jy nie 'n vrees inboesem vir 'n ope hart nie. Maar jy sê amper moenie bang wees om foute te maak nie, ek is hier om jou te help. (Yes, it helps a great deal, then the other one listens because if the sister goes and loses control, then you may as well forget … ha, ha, ha (laughs). Something else, the environment of our unit differs from other ICU's because at the moment we have only the 6-bed unit and all that we have to deal with, is just open heart cases … and that is very stressful for me; because they believe that the one who has the longest experience, must work with the fresh cases … That is how it used to work, and with all the new cases I specifially mentioned that the new people[registered

nurses] were not getting enough experience working with fresh cases[post operative patients];  with the result that they never developed confidence in themselves about what to do or how to act in a situation.  So I mentioned that all the sisters should get a chance to work with new cases.  It's a learning situation and you; the one with the experience, the sister stands at hand.  You don't leave her on her own.  You know, then it's sort of 2 sisters that look after 1 open-heart case, one with the experience and one without experience, but you with your experience have to guide that person, so that you don't instill fear of an open-heart case.  But you almost say "don't be afraid to make mistakes; I'm here to help.")

R: …so jy sê 'n nuwe suster moet begelei word…sy kan nie op haar eie werk… kan dit bewerkstellig word?  (…so you're saying that a new sister must be accompanied … she can't work on her own … can this be instituted?)

P:  En ek moet sê die situasie het baie verander, voorheen het dit my omtrent 'n jaar en half geneem voordat ek blootgestel was aan 'n ope hart geval want daardie pasiënte is geneig om umm… wat is die naam nou weer…   (And I must say the situation changed a lot.  Previously it took me about a year and a half before I was exposed to an open-heart case because those patients were inclined to … umm … what's the word again now?)

R:  Cardiac tamponade…  (Cardiac tamponade …)

P:  Cardiac tamponade te kry.  Toe ek eintlik in die ope hart begin werk, het jy drie pasiënte gehad met net een suster en 'n stafverpleegster, maar gelukkig het ek nou 'n jaar tot 'n jaar en half ondervinding gehad vanaf hoë sorg, respiratories "cardiac" en ope hart… maar na 'n tyd het hulle dit verander.  Mense [susters] eers ope hart, toe respiratories, en toe "cardiac" toe gestuur, maar met my was dit anders.  Maar nou … ons is baie kort van personeel met die gevolg enige nuwe suster moet binne twee maande 'n ope hart kan behartig.  Die leerproses is vinniger.  Jy as suster verwag ook van die een[nuwe geregistreerde verpleegkundige] om notisie te neem en belang te stel en umm …  en umm…

party van die nuwe susters wil ook nie hê 'n mens moet hulle sê nie... party voel hulle het genoeg kennis opgedoen ensovoorts. En baie is bang om met ope hart pasiënte te werk, veral baie van die ou susters wat lankal in die eeheid werk het nie geduld om nuwe susters te leer nie. Jy moet leer om arteriële bloed te neem, jy moet een leer om vital tekens te lees en hy/sy moet dit verstaan. Dit is die belangrikste. En 'n suster het my geleer jy jaag nie 'n CVP nie. Dit is iets wat ek nog steeds in my gedagtes het. Toe vra ek vir haar, my dokter sê hy wil die CVP 6-10 hê en die CVP is 3-4 … sy het my geleer as die pasient warm is en hy passeer genoeg uriene, en die bloeddruk is "fine", dan steur jy jou nie aan CVP nie. (To get a cardiac tamponade. When I actually began to work in the open-heart unit, you had 3 patients with one sister and a staff nurse, but luckily I have now had a year to a year-and-a-half of experience since the high-care, respiratory, cardiac and open-heart unit … but after a time it changed. People[ newly employed registered nurses] are sent first to open-heart, then respiratory, then to cardiac, but with me it was different. But now … we are very short-staffed with the result that any new sister has to be able to handle an open-heart. The learning process is quicker. You as sister expect one to take notice and to take an interest and, umm … and umm some feel they have acquired enough knowledge, and so on. And many are afraid to work with open hearts; especially some of the older sisters who have worked for a long time in the unit do not have the patience to teach the new sisters. You have to learn to draw arterial blood; you have to learn to read vital signs and he/she has to understand this. It's the most important. And a sister taught me not to chase a CVP. And that's something which I still have in my mind. Then I asked her, my doctor said he wants to have the CVP 6-10 and the CVP is 3-4 … she taught me that if the patient is warm and he is passing enough urine and the bloodpresure is fine, then you don't worry about a CVP.)

R: So jy sê hulle moet verstaan wat op die monitor aangaan? (So you're saying that they must understand what's going on on the monitor?)

P:  Hulle moet verstaan … en jy as suster omdat ons nie 'n dokter het wat 24 uur in die eenheid is nie is alles op die skouers van die een met die meeste ondervinding, is dit so dat jy as suster moet kan lees, want baie van die dokters kom nie in om na die pasiënte te kom kyk nie.  So jy moet vir hulle sê wat dink jy is fout.  (They must understand… and you as sister, because we don't have a doctor that is in the unit 24 hours, everything is on the shoulders of the one with the most experience; that is so that you as sister must be able to read, because many of the doctors do not come in to check the patients.  So you have to tell them what is wrong.)

R:  So jy sê die suster moet weet wat aangaan sodat hulle kan weet hoe om 'n situasie te hanteer?  (So you're saying the sister must now what's going on so that they can know how to handle a situation?)

P:  Sy moet, sy moet … dit is baie belangrik, want as 'n pasient tamponade, sê nou CVPis ewe skielik 23 en dit was altyd 10?  Die eerste ding wat jy doen jy kyk eers lê die pasient nie op CVP nie, is daar nie 'n knak nie, wat is die bloeddruk, want as bloeddruk heeltyd normaal was, en nou is dit laag, dan kyk jy na "drains", en as die "drains" nie dreineer nie, dan moet jy weet iets is fout. (She must, she must … it's very important, because if a patient tamponades, say now CVP is suddenly 23 and it was always 10?  The first thing that you do is you first look if the patient is not lying on the CVP, is there not perhaps a knick, what is the blood pressure, because if the blood pressure was always normal, and now it is low, then you check the drains, and if the drains are not draining, than you have to know something is wrong.)

R:  So jy sê die suster moet weet, sy moet die toestand ken?  (So you're saying the sister, she must know the situation?)

P:  Die suster moet weet … jy weet, daar word nie meer baie lesings gegee nie oor wat tekens en simptome is van 'n cardiac tamponade.  Dit is die eerste ding wat iemand my geleer het toe ek  in ope hart gewerk het.  As jy dit ken dan kan jy

met vertroue in die ICU werk.  (The sister must know … you know, not many lectures are given on what the signs and symptoms of a cardiac tamponade are. This is the first thing that somebody taught me when I worked in open-heart.  If you know that, you can then work in the ICU with confidence.)

R:  Jy sê dit kan nuut aangestelde geregistreerde verpleegkundiges leer deur lesings wat gegee word en daarna? (You're saying that it can teach new appointed registered nurses through lectures that are given and after that?)

P:  Dit word nie meer toegepas nie, al wat hulle die nuwe susters leer is hoe om te suig, hoe om arteriële bloed te trek, party male as jy arteriële bloed neem moet jy ook verstaan… (That are not applied any more, all that they teach the new sisters is how to suction, how to draw arterial blood; sometimes when you have to take arterial blood, you also have to understand …)

R:  Hoe dink jy wat is die rede waarom daar nie meer lesings gegee word nie? (What do you think the reason is why lectures are no longer given?)

P:  Umm … een basiese rede wat ek kan gee, die enigste tyd wat ons nie meer besig is nie is op 'n Sondag … (lag) … en miskien op 'n Maandag gedurende die dag … maar ons is so kort aan staf dat baie male is die eenheid op 'n Maandag tjok en blok vol … ons het nie meer kans vir lesings gee nie … die omset van ons pasiënte is so vinnig … baie vinnig en wat ook gebeur … ons word oorvol van die pasiënte van Livingstone en daardie pasiënte is so siek, al wat jy dink is "o jinne, kan ek net die situasie onder beheer kry, dis die belangrikste umm… wanneer jy kans kry om iemand te leer is wanneer daar 'n nuwe suster begin en daar is baie personeel aan diens dan word sy gekoppel aan een persoon … dus hoe jy deesdae kans kry om iemand te leer.  Okei so daar is definitief … ons het 'n groot tekort aan indiens opleiding in ons eenheid, dinge verander so baie in die wetenskap jy moet tred hou, jy weet, met alles. Ons 'critical care society' gee lesings so nou en dan, nou werk jy parykeer, dan kan jy ook nie daardie lesings bywoon nie. Ons tegnikus wat met die ventilators werk is altyd gretig om lesings te

gee…lag…maar haar bewoording en taal is meer tegnies as gemaklik om te verstaan … jy verstaan nie altyd wat sy wil sê nie, maar sy praat boektaal en nie so prakties nie. (Umm… one basic reason that I can give, the only time that we're not busy is on a Sunday …(laughs) …and perhaps on a Monday during the day … but we're so short of staff that often the unit is chock-a-block full … we no longer have a chance of giving lectures … the turnover is so quick … very quick and what also happens … we get overfull of patients from Livingstone and those patients are so sick, all that you think is, oh, goodness, if I can just get the situation under control, that's the most important, umm… when you get a chance to teach somebody is when a new sisters begins and there is plenty of staff on duty, then she is attached to one person … that's how you get a chance nowadays to teach someone.  OK, so there is definitely … we have a great shortage of in-service training in our unit.  Things are changing so quickly in Science that you have to keep pace, you know, with everything.  Our 'critical care society' gives lectures from time to time, and then sometimes you're working; then you also can't attend those lectures.  Our technician who works with the ventilators is always eager to give lectures … (laughs)… but her vocabulary and language are more technical than comfortable to understand … you don't always understand what she wants to say, but she talks book language and not practical language.)

R:  So jy sê dit is 'n probleem in die eenheid en indiens opleiding is belangrik? (So you're saying this is a problem in the unit and that in –service training is important?)

P:  Dit is baie belangrik … okei…umm… wat is daar nog … (It is very important … OK…umm … what is there still…)

R: Is daar enige ander gevoelens wat jy het omtrent die eenheid, wat wil jy leer, is daar enige bystand wat jy dink wat sal help om optimale verpleegsorg te kan lewer? (Are there any other experiences that you have regarding the unit, what

wou want to learn; is there any assistance which you think will help to be able to deliver optimal care?)

P: Nog iets wat ek dink… ons het vloer susters maar hulle is nie rêrig nodig in die eenheid nie… (Something else that I think … we have floor sisters but they are really not needed in the unit…)

R: Kan jy uitbrei oor wat jy bedoel met vloer susters… (Can you elaborate on what you mean by floor sisters?)

P: Ok vloersusters is die susters wat oor die eenheid is. Basies het ons drie per dag. Hulle werk nie rêrig in die eenheid nie. Hulle is in bevel…hulle kom net sien of daar probleme is wat hulle kan uitsorteer dan gaan hulle weer hul administratiewe werk doen…maar volgens my voel ek nie dit is nie nodig om drie susters te hê wat administratiewe werk doen nie…een is genoeg, ons is 'n klein eenheid…net 'n ses bed saal…en hulle hande en ondervinding het ons nodig in die eenheid, want partykeer is ons net een suster met 'n stafverpleegster en 'n assistent verpleegster tussen drie pasiënte …en ... jy weet dan is daar twee ventilators en jy as suster moet omtrent alles doen vir daardie pasient en dit is partykeer net te veel en soms verwag hulle te veel van ons as susters.  (OK. Floor sisters are the sisters that are above the unit.  Basically we have 3 per day. They don't really work in the unit.  They are in charge…they just come to see if there are problems that they can sort out and then they go back to do their administrative work …but according to me, I feel it's not necessary to have 3 sisters who do administration work.  One is enough.  We are a small unit … just a 6-bed ward – and we need their hands and experience in the unit, because sometimes there is just one sister with a staff nurse and an auxillary nurse amongst 3 patients … and you know, then there are 2 ventilatiors and you as sister must do almost everything for that patient and it is sometimes just too much and sometimes they expect too much of us as sisters.)

R: …Alles… kan jy duidelikheid gee oor wat jy bedoel met alles. (…Everything…can you clarify what you mean by everything?)

P: Ok… met alles is soos…umm… jy moet pasiënte suig, jy moet drip omruil wat leeg is, die assistent verpleegster kan jou nie help om medikasie te gee nie…soos dobutrex, dopamien, insulien meng, want hulle weet nie eers waarvoor word dit gebruik nie…dis onmoontlik vir een suster tussen drie pasiente… (OK…with everything it's like …umm…you have to "suction" the patient, change the drip that's empty, the auxillary nurse cannot help you to give medication …like dobutrex, dopamine and mix of insulin, because they don't even know what this is used for…it's impossible for one sister among 3 patients…)

R: Mmm…

P: Jy probeer somtyds om dit te kan doen… so ek voel as daar een vloer suster in die eenheid kan wees is dit darem twee susters tussen 3 pasiënte wat 'n groot hulp kan wees in die eenheid.  (You sometimes try to be able to do it … so I feel if there could be 1 floor sister in the unit, then there are at leas 2 sisters amongst 3 patients which can be a big help in the unit.)

R: Sou jy sê assistent en stafverpleegsters is nodig in die eenheid? (Would you say an auxillary and staff nurse is necessary in the unit?)

P: As ek baie eerlik moet wees …as hulle nie daar is nie dan is die eenheid in 'n warboel…lag… hulle doen die klein dinge, maar hulle doen die belangrike dinge- as die suster besig is met dokters rondtes kan hulle die observasies doen, of as daar n krisis is en die susters is besig hou hulle rekord van vitale tekens, hulle kan uriene sakke leeg maak, hulle maak pasiënte gemaklik … hulle doen klein dinge maar dit is so belangrike klein dinge. (If I were to be very honest … if there are not, then the unit is in a mess (laughs) … they do the little things; but they do the important things … if the sister is busy with doctors' rounds, they can do the observations, if there is a crisis and the sisters are busy, they keep record of vital

signs; they can empty the urine bags, they can make the patients comfortable …they do small things but they are such important things.)

R: Sou jy verkies dat daar geregistreerde of assistent en stafverpleegsters sou wees? Sou die geregistreerde verpleegster ook nie die werk kan doen van 'n assistent en stafverpleegster nie. (Would you prefer it if there would be registered nurses or auxillary and staff nurses?  Would the registered nurse not also be able to do the work of an auxillary and a staff nurse?)

P: Laat ek eerlik wees. Die geregistreerde verpleegster sal daardie werk kan doen as sy na een pasient kan kyk. En ons het nie n 1:1of 'n 1:1.5 ratio nie. As…as… dit ooit gebeur dat dit so gedoen kan word dan het ons nie staf- en assistent verpleegsters nodig in die eenheid nie. En as ons n 1:1 ratio het sal die werkslading op elke suster se skouers ligter wees, want een suster kyk na een pasient. (Let me be honest.  The registered nurse would be able to do that work if she could look after one patient.  And we don't have a 1:1 or a 1:1:5 ratio.  If … if … it ever happened that it could be done in that way, then we wouldn't need staff and auxillary nurses in the unit.  And if we have a 1:1 ratio, the workload on every sister's shoulders will be lighter, because one sister will be looking after one patient.)

R: Sê jy nou eintlik dat die ratio in die eenheid nie n 1:1 ratio is nie. (Are you actually saying that the ratio in the unit is not a 1:1 ratio?

P: Absoluut nie…nie op die oomblik nie …nie in ons eenheid nie, nie wat geregistreerde verpleegsters aanbetref nie, nou is die staf en assistent verpleegsters daar vir ekstra help om "pressure care" te gee, wanneer daar noodgevalle opduik, dan is daar nog 'n hand om te help … verstaan jy wat ek bedoel…  (Absolutely not …not at the moment …not in our unit, not as far as registered nurses are concerned.  Now the staff and auxillary nurses are there to give "pressure care" when emergency situations arise, then there's another hand to help…do you understand what I mean…)

R: Mmm… ja … so op die oomblik werk dit nie so nie.  (Mmm…yes .. so at the moment it doesn't work like that?)

P: Nee glad nie…nee… yo…lag … dit werk glad nie so nie…lag… (Not at all…no…yo!...(laughs) it doesn't work like that at all…(laughs).

R: Wat is die ratio in jou eenheid?  (What is the ratio in your unit?)

P: Ons ratio in die eenheid veral op nagdiens is een suster met drie pasiënte en soms …dan is dit een suster nè…luister nou mooi… dan het jy een vars na operatiewe geval waarna die een suster moet kyk dan het jy nog twee ander gevalle waarna sy moet kyk. Gewoonlik begin baie pasiënte probleme gee op dag twee of drie soos aritmieë, pyn, sommige kry DT'S , sommige ontwikkel ICU sindroom…hulle begin nagmerries te kry.  (Our ratio in the unit, especially on night-duty, is 1 sister to 3 patients and sometimes …then it is one sister … now listen carefully … then you have one "fresh" post operative patient which one sister has to look after and she still have two other cases that she has to take care of.  Usually many patients begin to have problems on the second or third day, like arrhythmia, pain, some get the DT's, some develop ICU syndrome…they begin to have nightmares.)

R: Ja … is daar engiets anders wat jy wil sê… (Yes…is there anything else you would like to say?)

P: O ja!  Wat die… umm… atmosfeer betref in die eenheid op die oomblik is dit nie 'n lekker atmosfeer kan 'n mens maar sê …. Vroumense is maar bitsig en vroumense is maar skerp met hulle monde … en ons het ook 'n dokter wat … umm … ok ons vorige dokters was baie kalm bedaard in enige noodsituasie … jy suster kan maar ronddraf maar hy is rustig en op sy tyd en nou het ons iemand wat ook die vroulike temperament het en yuh!.... jy word geskel van die slegte partykeer, maar daar het baie klagtes gekom omtrent dit en die dokter het 'n groot

poging aangewend om haar houding te verander en dit het … dit het nogal 'n beter uitwerking op die personeel … sug … as mens eerlik moet wees baie het bedank uit die eenheid oor die dokter se temperament … maar nou dink ek die dokter het tot die besef gekom dat sy haar houding moet verander anders gaan sy baie van die personeellede verloor. (Oh, yes! A regards the …umm…atmosphere in the unit at the moment, it's not a nice atmosphere, one could say … women are really sharp-tongued and women are harsh with their mouths and we also have a doctor …who…umm…OK, our previous doctors were very calm and composed in any emergency situation…you, the sister, could trot around but he was placid and took his time; but now we have someone with a female temperament and yah, you get scolded from the worst, but many complaints have come in about it and the doctor has made a great effort to change her attitude and it has … it has a better effect on the staff (sighs) … if a person has to be honest, many have resigned from the unit because of the doctor's temperament…but now I think the doctor has come to the realization that she has to change her attitude otherwise she's going to lose many of the staff members.)

R: Mmm… (Mmm…)

P: Die dokter se houding ek moet sê, het drasties verander… die dokter het 'n poging aangewend om meer gemoedelik te wees en meer geduldig te wees. (The doctor's attitude I must say, has change drastically…the doctor has made an attempt to be more kind and to be more patient.)

R: Hoe sou jy sê wat het die dokter se houding verander?(How would you say what made the doctor's attitude change?)

P: Wat die dokter se houding verander het … umm… daar was baie besprekinge gewees met die senior verpleegkundiges van die eenheid asook hoofverpleegkundiges van die hospitaal. Klagtes was nie net van een eenheid nie maar ook van ander sale. Baie verpleegsters was in so 'n toestand … hulle wou

nie naby die dokter kom of rondtes te doen nie. Jy het partykeer nie eens lus gehad om werk toe te gaan nie, maar dit het alles tot 'n einde gekom…rêrig dit het tot 'n einde gekom.  (What changed the doctor's attitude … umm…there were many discussions with the senior nurses from the unit as well as chief sisters of the hospital.  Complaints were not only from one unit but also from other wards. Many nurses were in such a state…they did not want to come near the doctor or do rounds with her.  You sometimes did not even feel like going to work; but it all came to an end…really, it did come to an end.)

R: Jy sê dit het tot 'n einde gekom … die dokter se  houding het verander…  You say it did come to an end…her attitude did change?)

P: Ja. (Yes.)

P: Wat die atmosfeer nou mislik maak is van 'n rassistiese aard…ons het nou meer swart verpleegsters en met die nuwe bedeling waar swartes in bevel moet wees kry jy die idée hulle wil die laaste se hê in alles … jy is te bang om jou mond oop te maak, want enigiets word as rassisties beskou … ek kan baie "nagging" wees, want ek wil hê alles moet nou klaar gedoen word…baie hou nie van my nie…hulle voel ek is te puntenerig … nè …voel jy nie ook so nie?  (What makes the atmosphere nauseating now is of a racial origin.  We now have more black nurses and with the new dispensation where black people have to be in charge, you get the idea that they want to have the last say in everything…you are too afraid to open your mouth, because everything gets regarded as racist. I can be very nagging, because I want everything to be properly completed … many don/t like me … they feel I'm too pernickety … you know … don't you fell the same?

R: …lag…voel jy dinge moet reg gedoen word, sou jy so sê (…(laughs) You feel things must be done correctly, would you say that)

P: Ja, ek wil my beste sorg lewer … as ek die pasient se vrese kan verminder of pyn kan verlig wil ek dit doen…niemand moet sê ek kan nie pynmedikasie gee

nie… dan verfies ek my in my skoene…hoe weet ek die pasient het nie pyn… ek het nog nooit 'n operasie gehad. (Yes, I want to deliver my best care…if I can reduce the patients fears or relief pain, I want to do it…nobody must say I cannot give pain medication…then I became very angry in my shoes…How do I know the patient is in pain?  I've never had an operation.)

R: Mmm…(Mmm…)

P: Soos die dokter verduidelik het, hulle rek die borskas oop … ek het die ICU kursus gedoen en gedruip maar wat my gehelp het ek het geleer wat is pyn … (As the doctor explained, they stretched the chest cavity open…and I had done the ICU course and had failed it but what helped me is that I had learnt what pain was.)

R: Mmm…(Mmm…)

P: Ek het geleer as jy die pasient iets gee vir pyn is hulle nie lastig nie. (I had learnt that if one gave the patient something for pain, then they were not a nuisance.)

R: OK… sê jy om die ICU kursus te doen …. (OK…do you say to do the ICU course…)

P: Strek tot jou voordeel … ja… baie…baie…maar jy moenie die kursus gaan doen as jy nie langer as twee jaar in die ICU werk nie… jy het nog nie genoeg ondervinding met ventilators, jy werk met dit maar verstaan dit nie. In jou 1ste jaar gaan jy nie genoeg kennis hê van ander pasiëte of ventilators nie…jy werk nie met "volume control" of ander "modes" van ventilators nie. (Is to your advantage … yes, very much so… very much … but you musn't go and do the course if you haven't been working for longer than 2 years in the ICU… you do not have enough experience with ventilators, you work with them; but you don't understand them.  In your first year, you're not going to have enough knowledge of other

patients or ventilators…you don't work with volume control or other modes of ventilators.)

R: Jy sê hulle [verpleegsters] moet eers ondervinding opdoen.  (You say they [nurses] must first obtain experiences.)

P: In ons eenheid werk jy nie met ander pasiënte nie …ons is 'n gespesialiseerde eenheid…dit raak partykeer vervelig … ons kennis is beperk tot ope hart pasiënte … (In our unit you don't work with other patients.  We are a specialized unit … it gets boring sometimes … our knowledge is limited to open-heart patients…)

R: Enigiets wat personeel daaromtrent kan doen? (Anything that staff can do about that?)

P: Ja …'n uitruiling … met Livingstone kritieke sorg…hulle verpleeg respiratories, chirurgies en kardiale gevalle. Respiratories …jy sien hoe maak pasiënt vordering. Nou en dan kry ons pasiënte probleme.(Yes…an exchange with Livingstone Critical Care…they nurse respiratory, surgical and cardiac patients. Respiratory patients … you see how patiens make progress.  Now and then our patients get problems).

R: Mmm … niks nuwe kennis wat jy opdoen … (Mmm … no new knowledge that you've acquired…)

P: Niks … en ons narkotiseurs is nie lief om lesings te gee… (Nothing…and our anaesthetists are not keen on giving lectures…)

R: Iets wat personeel kan doen om kennis te verbeter? (Something that staff can do to improve knowledge?)

P: As die dokters lesings kan aanbied …ja…(If the doctors can offer lectures, yes…)

R: Mmm … ja … is daar nog iets wat jy wil noem.(Mmm … yes…is there something else you would like to mention?)

P: Ek geniet dit om in die ICU te werk … net nie langer as twee dae … jy is moeg na twee dae… fisies, psigies en emosioneel uitgeput. (I enjoy working in the ICU…just not longer than 2 days … you're tired after 2 days…physically, psychologically and emotionally drained.)

R: Voel jy dit is die sorg wat jy lewer wat jou uitput.  (Do you feel it is the care you deliver that wears you out?)

P: Baie male is dit die familie lede wat gerus gestel moet word…die familie is geskok…as hulle die pasient op 'n ventilator sien… hulle skrik groot, en as die alarm lui…en as jy as suster nie weet hoe om op te tree …dan het familie nie vertroue in jou. Hulle is angstig as jy met die pasiënt werk. Sommige familie voel hulle weet van beter.(Many times it is the family members that have to be reassured…the family is shocked…if they see the patient on a ventilator…they get a big fright, and if the alarm rings…and if you as the sister do not know how to respond, then the family doesn't have confidence in you.  They are anxious when you nurse the patient.  Some families feel they know better.)

R: Mmm…(Mmm…)

P: Dit verg baie … as familie aan jou gewoond raak soek hulle jou persoonlik om na die pasient te kyk.  (It demands a lot…when families get used to you, they search for you personally to look after the patient.

R: So jy sê die familie waardeer dit as jy goed na die pasiënt kyk.(Would you say the family appreciate it if you take good care of the patient?)

P: Ja. Môre, oormôre is dit jou familie dan verwag jy verpleegsters moet goed kyk na jou familie. (Yes. Sooner or later it is your family, then you expect that nurses should take good care of your family.)

R: Is daar nog iets wat jy wil noem.(Is there still something you would like to mention?)

P: Sommige dae geniet ek dit verskriklik om in die ICU te werk maar daar kom ook dae dat ek voel ek wil nie met sekere persone werk nie. Dit is moeilik as hulle twee onervare susters op jou skof sit … oh …lag … jy weet jy is in die knyp nou … lag  (Some days I enjoy working in the ICU tremendously; but then days come when I feel that I don't want to work with certain people.  I'ts difficult if they place 2 inexperienced nurses on your shift…oh…laughs…you know you're in trouble water now…laughs)

R:…lag…is dit beter om met ervare susters te werk?  (…laughs…is it better to work with experienced sisters?)

P: Nee, ek sou sê een nuwe suster op jou skof is meer as genoeg wat jy kan hanteer…so umm…as hulle afdienste uitmaak moet hulle probeer om een nuwe suster te plaas, want jy moet na jou eie pasiënte kyk en ook alles dophou wat hulle[nuwe susters] doen … hulle[nuwe susters] is heeltemal onervare en party leer stadig. Jy moet leer om georganiseerd te wees … jy moet leer om bevele te gee.  (No, I would say one new sister on your shift is more than enough to handle…so, uhm … if they make out off-duties, they should try to place one new sister, because you have to look after your patients and keep an eye on everything that they[new sisters] do … they are completely inexperienced and some learn slowly.  You must learn to be organized … you have to learn to give orders.)

R:…as jy nie bevele gee nie…(…if you don't give orders…)

P: Jy sal uitvind daar is baie werk wat nie gedoen is nie. Maar jy moet nie so bevele gee dat jy op jou louere rus nie. My enigste probleem nog …ons het nou kort n aritmieë lesing gehad wat ek nie bygewoon het nie …ek kan gewone aritmieë identifiseer maar nie gekompliseerde aritmieë nie, dan het jy iemand nodig vir wie jy kan vra veral op nagdiens om saam met jou die aritmieë te identifiseer. Ek het altyd die vrees wat as die pasient 'n aritmieë kry en ek bel die dokter en gee 'n verkeerde aritmieë, want alle aritmieë word nie dieselfde behandel nie. Ons het nie 'n dokter 24hr aan diens nie. (You will find there is a lot of work that doesn't get done.  But you must not give orders in such a way that you rest in your laurds.  My only problem still … we have just recently had a lecture in arrhythmia which I didn't attend…I can identify normal arrthythmia, but not complex ones, then you need someone whom you can ask, especially on night-duty, to identify arrhythmias with you .  I always have the fear that, if a patient gets an arrhythmia and I ring the doctor and give the wrong arrhythmia, because all arrhythmias are not treated in the same way.  We don't have a doctor on duty 24 hours.)

R: Gee julself behandeling …Is dit jou vrese …is daar nie 'n dokter aan diens nie. (Giving treatment yourself … is it your fears … isn't there a doctor on duty?)

P: Ons het nie 'n dokter altyd nie … veral nie op nagdiens … op nagdiens is ons op ons eie. Ek bel vir behandeling …ek sal nie buite my "scope" werk nie …nee nooit … Basies die hele 12hr van nagdiens is ons[verpleegsters] op ons eie en as ons 'n dokter benodig moet ons bel, hulle is omtrent 10 min. van hospitaal, met die gevolg ons moet self sien en kom klaar. (We do not always have a doctor … especially on night duty … on night duty we're on our own.  I phone for treatment … I will not work beyond my scope … no, never…basically those whole 12 hours of night duty we are on our own and if we need a doctor, we have to phone. They're about 10 minutes away, with the result that we have to see to it ourselves and manage.)

R: So wat sou jy sê van jou ervaring in die eenheid? (So what would you say about your experience in the unit?)

P: Daar kort 'n dokter … permanent in die eenheid wat in 'n kamer slaap op dieselfde vloer …so as ons hom benodig is hy binne 'n minuut beskikbaar. (We're need a doctor … permanently in the unit, who can sleep in a room on the same floor … so that if we need him he is available in a minute.)

R: Het jy 'n idee hoe daardie probleem opgelos kan word? (Have you an idea of how that problem can be solved?)

P: Wel ek weet nie of die dokter in die eenheid sal wil slaap nie. Hulle[dokters] sal moet iets uitwerk. Ek dink wanneer so iets gaan gebeur is wanneer ons 'n pasient gaan verloor wat nie nodig was nie. (Well, I don't know whether a doctor would want to sleep in a unit. They[doctors] will have to work something out. I think that when such a thing is going to happen, it will be when we lose a patient, which was not necessary. )

R: Mmm…   (Mmm…)

P: Maar ek geniet dit.  (But I enjoy it.)

R: So jy is een van die verpleegsters wat die ICU geniet.  (So you're one of the nurses that enjoys the ICU?).

P: Ja.  (Yes.)

R: Hoe sou jy bygestaan wou word in die kritieke sorg eenheid?  (How would you like to be assisted in the critical care unit?)

P: Ek sou sê as jy een maal 'n maand met 'n sielkundige of 'n psigiater kan praat, want soms voel jy nie om met kollegas te praat nie … om met iemand te praat wat

net kan luister … sodat jy alles kan uitblaker wat nie teen jou sal tel nie. Vergaderings help nie.Ons het al baie vergaderings gehad. My uitgesprokenheid in 'n vergadering het al lelike nagevolge vir my gehad. Ek het nog nooit gesien een van die matrones of superintendent van die hospital kom na die eenheid om te vra hoe gaan dit nie. (I would say that if you could speak to a psychologist or psychiatrist once a month, because sometimes you don't feel you can talk to colleagues … to be able to talk to someone who can just listen … so that you can flirt out everything which will not count against you.  Meetings don't help.  We've had lots of meetings.   My outspokenness in meetings has already had ugly repercussions for me.   I have not yet ever seen one of the matrons or superintendents of the hospital coming to the unit to ask how it is going.)

R: Voel jy hulle moet meer dikwels kom en nie net wanneer daar probleme is nie. (Do you feel they should come more often and not only when there are problems?)

P: Ja. Maar elke dag is nie dieselfde. Ons het ook ons rustige dae…dit gee ons kans om asem te skep. Ons kan mekaar ook goed bystaan indien nodig … bv. Wanneer iemand familielid verloor het.  (Yes.  But every day is not the same.  We also have peacefull days … it gives us a chance to draw breath.  We can also support one another when necessary, for instance, when someone has lost a family member.)

R: Is daar nog engiets wat jy wil noem? (Is there anything else you want to mention?)

P: Nee dankie dit is al.  (No, thank you, that is all.)

R: Goed as dit al is sê ek vir jou baie dankie vir die onderhoud en indien nodig sal ek 'n afspraak maak vir 'n opvolg besoek.  (Good, if that is all, I'll say "thank you very much for the interview and if necessary I'll make an appointment for a follow up.)