A BEST PRACTICE GUIDELINE FOR A HEALTHY WORK ENVIRONMENT FOR PROFESSIONAL NURSES WORKING IN THE SOUTH AFRICAN MILITARY HEALTH SERVICE

By

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DECLARATION

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TO WHOM IT MAY CONCERN

I hereby confirm that I have professionally proofread and edited the thesis (Abstract, Chapters 1-6 and list of references) for the degree of Doctor of Philosophy in Nursing, titled:

A Best Practice Guideline for a Healthy Work Environment for Professional Nurses Working in the South African Military Health Service.

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Sincerely

N.J.STEAR

DEDICATION

This thesis is dedicated to my late grandmother and mother, Dr Epainette Mamotseki Tamari Mbeki for the good values she instilled in me, for being my role model and my rock, for her unconditional love, support, encouragement and for believing in me against all odds. Thank you, mama, for all you have been to me, for making me, for being my pillar of strength and for having touched my life. You will always be very close to my heart, you are the love of my life. To my son Amandla for his unconditional love and support and for believing in me. You infused me with enormous strength to press forward my son each time you said ‘you make me proud all the time mommy’ and ‘I love you lots mommy’. Thank you for being such a considerate, understanding, loving and appreciative child, I love you.

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ABSTRACT

Governments, internationally and nationally, are becoming aware of the importance of healthy work environments within their health departments, environments that are caring and supportive to health professionals. This awareness is brought about by the mounting evidence that healthy work environments are critical to recruiting and retaining health professionals. On the other hand, unhealthy work environments can contribute to medical errors, ineffective delivery of care, and conflict and stress among health professionals in the clinical setting and faculty shortage that can compromise academic excellence in the academic setting. The professional nurses working in the South African Military Health Service (SAMHS), a branch of the South African National Defence Force (SANDF) could experience the military environment as unhealthy because it is rigid and controlled. The hierarchical rank structure could deprive them of their autonomy as the decision-making powers are directly proportional to the rank. Stressful conditions could be experienced when these professional nurses are taken away from the well equipped hospital environment to the deployment areas away from home. There was, however, no evidence found on the work environment of professional nurses in the SAMHS during literature review. The aim of the study is therefore to explore and describe the experiences of professional nurses working in the SAMHS and their understanding of a healthy work environment and the scope and nature of a best practice guideline, then to integrate the evidence generated to the evidence emanating from the critical appraisal of the existing best practice guidelines from other health settings in order to develop a best practice guideline for a healthy work environment for nurses in the SAMHS.

The study adopted a qualitative, exploratory, descriptive and contextual research design. The research study was made up of three phases. In Phase 1, semi-structured interviews were conducted with professional nurses to collect information on their experiences of working in the SAMHS and their understanding of evidence-based best practice guidelines. The interviews were transcribed by an independent transcriptionist and data analyzed using the eight steps of data analysis as suggested by Tesch. Themes were identified and grouped together to form new categories. The process of coding was supported by an independent coder. Lincoln and Guba’s model of

trustworthiness consisting of credibility, transferability, dependability and confirmability was used to ensure the validity of the study.

An integrative literature review was conducted where the existing evidence-based best practice guidelines for healthy work environment for nurses were searched for, appraised, had data extracted and were synthesized in Phase 2. In Phase 3, evidence generated in Phase 1 and Phase 2 was triangulated, forming recommendations that were utilized to develop a best practice draft guideline for a healthy work environment for professional nurses working in the SAMHS. The draft guideline was sent to five expert reviewers for their comments and recommendations. These were considered in the development of the final guideline.

The final guideline consists of several recommendations in four themes: the need for effective leadership to create an empowering environment; effective communication amongst members of the health team; a culture that supports team work, and; the need for an environment that promotes professional autonomy. Further recommendations were made to address factors that impact negatively on enhancement of a healthy work environment. The guideline is intended for use by SAMHS' leadership, at Levels 2, the strategic level, Level 3, the formation level and Level 4, the unit level (hospitals, sickbays and clinics and nursing college) and all professional nurses working in all the military health institutions of the SAMHS, including the military clinics, sickbays and hospitals irrespective of positions. However, the guideline may also be adapted by nursing institutions outside the military such as public and private hospitals and clinics where they find it applicable.

Results of this study will be disseminated through conferences, journals, and executive summaries will be written for policy makers.

KEY WORDS:

Healthy work environment; professional nurses; best practice guideline; South African Military Health Service.

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ANA	American Nurses Association
AACCN	American Association of Critical Care Nurses
AGREE	Appraisal of Guidelines for Research and Evaluation
AMHF	Area Military Health Formation (Headquarters for health care clinics)
AMHU	Area Military Health Unit
AMHU EC	Area Military Health Unit Eastern Cape
AMHU FS	Area Military Health Unit Free State
AMHU GP	Area Military Health Unit Gauteng
AMHU NC	Area Military Health Unit Northern Cape
AMHU NW	Area Military Health Unit North West
AMHU WC	Area Military Health Unit Western Cape
BPG	Best Practice Guideline
CO	Candidate Officer
DOD	Department of Defence
EBP	Evidence-Based Practice
HRH SA	Human Resources for Health South Africa
HWAC	Health Workforce Advisory Committee
HWE	Healthy Work Environment
IAM	Institute of Aviation Medicine
ICN	International Council of Nurses
IMM	Institute of Maritime Medicine
JBI	Joanna Briggs Institute
MMC	Military Medical Clinic
MMHF	Mobile Military Health Formation (Headquarters for deploying forces)
MHTF	Military Health Training Formation (Headquarters for training)

MHF	Military Health Formation (Headquarters for logistical services)
NICE	National Institute for Health and Clinical Excellence
NOIC	Nursing Officer In Charge
PICO	Population, Context, Intervention, Outcome
PN	Professional Nurse
RNAO	Registered Nurses of Ontario
SAMA	South African Military Academy
SAMHS	South African Military Health Service
SAMHSA	South African Military Health Service Substance Abuse
SANDF	South African National Defence Force
SWP	Standard Working Procedure
TMHF	Tertiary Military Health Formation (Headquarters for hospitals and Institutes for aviation and maritime medicine)
TTGSB	Thaba Tshwane General Support Base
WHAA	Workplace Health Association Australia
WHO	World Health Organization

CHAPTER ONE

ORIENTATION AND OVERVIEW OF THE STUDY

In this chapter, the reader is orientated to the background of the study, the statement of the research problem, the aim and objectives, research questions, concepts and the theoretical frame the study is based on. The research methodology is also briefly described.

1.1 INTRODUCTION AND BACKGROUND

Governments, internationally and nationally, are becoming aware of the importance of healthy work environments that are caring and supportive of health professionals within their respective health departments. This awareness is the effect of the mounting evidence that healthy work environments are imperative to enhance recruitment and retention of health professionals and maintain an organisation's financial viability (Voller, Hill, Roberts, Dambaugh & Brenner, 2009:21). The Registered Professional Nurses Association of Ontario (2008:13) defines a healthy work environment as "a practice setting that maximises the health and well-being of professional nurses, quality patient/client outcomes, organisational performance and societal outcomes. Miracle (2008) defines the healthy working environment as that which is "conducive to healing, as well as to the safety and well-being of patients." Miracle further states that a healthy work environment is necessary for professional nurses as well. Miracle (2008) also spells out the necessary components for a healthy environment as follows: 1) Effective leadership must be present where leadership growth is fostered in its staff; 2) Communication is critical; 3) Professional nurses participate in decision-making processes concerning patient care and their work environment; 4) Adequate staffing; and 5) Recognition of the efforts and achievements of the staff (Miracle, Dimensions of Critical Care Nursing, 2008: 42-43). Shirey (2006) supports the definitions above when she further adds that healthy work environments are "supportive of the whole human being, are patient-focused, and are joyful workplaces". Research shows that the creation of healthy work environments is imperative in both the clinical and academic settings to promote safe patient care,

enhance staff recruitment and retention, and maintain an organization's financial viability (American Association of Critical Care Professional Nurses, 2005: 5).

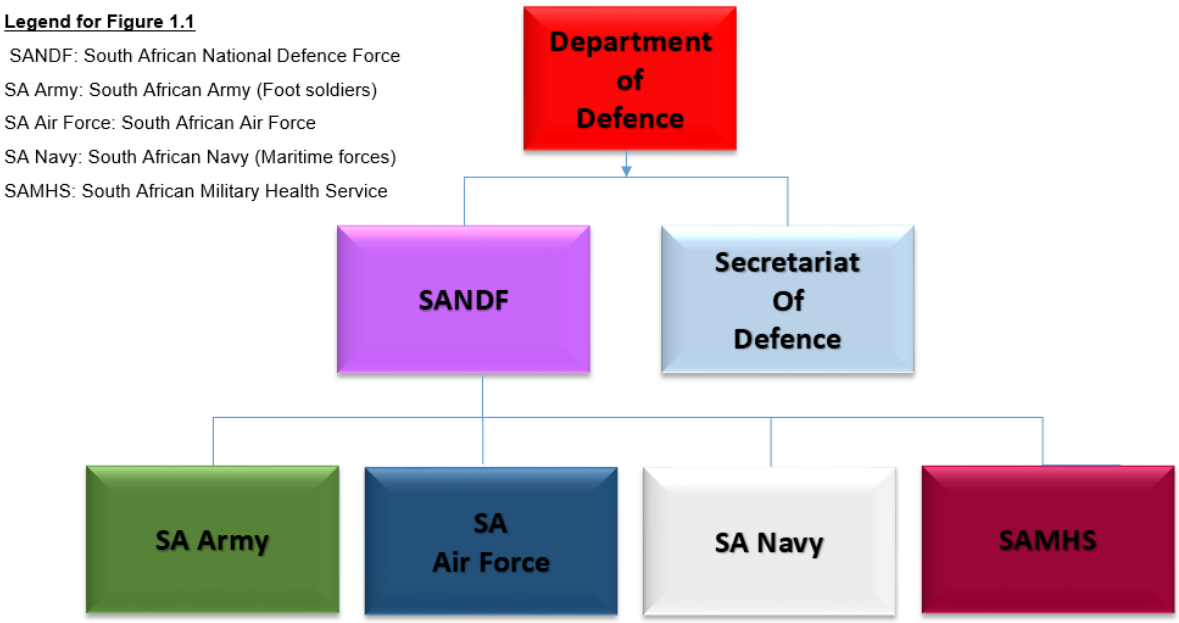
On the other hand, Rankin (2011:12) purports that unhealthy work environments can contribute to medical errors, ineffective delivery of care, and can cause conflict and stress among health professionals in the clinical setting, and faculty shortage that can compromise academic excellence in the academic setting. Shirey (2006:256), in her study, reiterates that "Because stress-related illness contributes to rising healthcare costs and disability, creating a healthy work environment is a priority for maintaining an adequate nurse workforce." However, there are few guidelines available on how to create and sustain the critical elements of a healthy work environment (Shirey, 2006:256). A National Human Resource Plan for Health in South Africa (2006:13) indicates that the new focus in South Africa is on creating work environments that will maximise the potential for health work force to deliver quality health services. According to The Human Resources for Health South Africa Strategy, (HRH SA, 2011:9), the improvement of the health status of the population is at times hampered by poor working environments, skill gaps and the use of inappropriate policy tools that often fail to provide best incentives or optimize performance of the health work force. The aim of the HRH SA strategic framework is, therefore, to ensure a health care environment where the health workforce is valued and supported and has the opportunity to develop while providing high quality care (HRH SA, 2011:9). The HRH SA strategy is a national strategy and therefore its objectives are binding to all health departments nationally.

The South African National Defence Force (SANDF), which falls under the Department of Defence (DOD), has a duty to provide health services to its employees and this is done through its arm of service, the South African Military Health Service (SAMHS). The consumers of these health services are the members of all arms of services of the SANDF, the Army, and Air-force, the Navy, the SAMHS, the military veterans and their respective dependents. The health needs of the President, former presidents, deputy presidents and ministers of the Republic of South Africa, ministers and Heads of States from countries outside South Africa are also catered for by the SAMHS. The SAMHS, as a health department is therefore guided by the strategic objectives of the HRH SA. If the standard of their health services is to be at par with or above those of

other health providers, public and private, matters of healthy work environments are to be monitored and facilitated. The SAMHS is, however, different from other health providers because the military environment is unique.

Figure 1.1 depicts the structure of the Department of Defence (DOD) under which the South African National Defence Force (SANDF) falls and all the Arms of Services the SANDF is made up of; The South African (SA) Army (SA Army), SA Air Force, SA Navy and SA Military Health (SAMHS) Service. (Adapted from the DOD Macro Organisational Structure: DOD Executive Authority's Overarching Strategic Statement, 2012:6)

Figure 1.1: Department of Defence Structure/Organogram

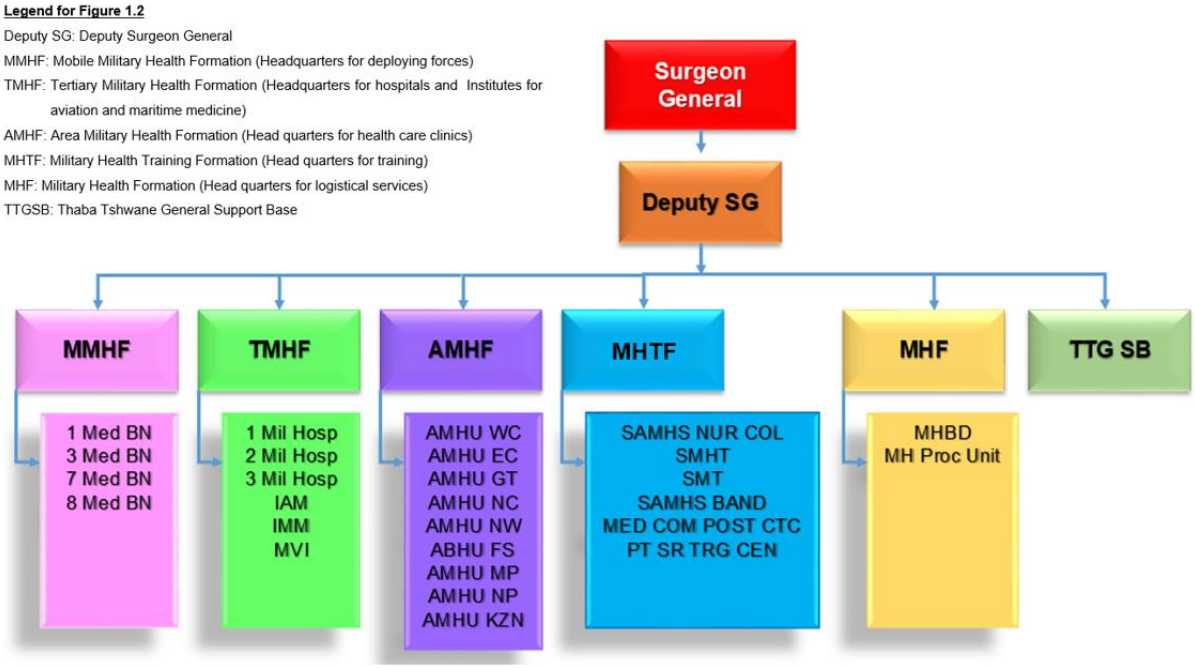


The SAMHS is the arm of service of the SANDF that provides health services to soldiers, military veterans and their dependants. It is divided into its Headquarters, military hospitals, sickbays, clinics and training units. The military hospitals are managed by an institution called the Tertiary Military Health Formation (TMHF). Falling under Tertiary Formation are also the Institutes of Aviation Medicine (IAM) and Maritime Medicine IMM). The sickbays and health care clinics are Primary health care centres and these are managed by the Area Military Health Formation (AMHF). The Area Military Health Formation has sub-units in all nine provinces and these are called Area Military Health Units (AMHU). The training units fall under the Military Heath

Training Formation (MHTF). Within the MHTF is the SAMHS Nursing College where military professional nurses are educated, trained and developed. There is an additional Formation, the Mobile Military Health Formation which is responsible for both the internal and external deployment of SAMHS members. These institutions are specifically mentioned because that is where the health-care-professionals, including professional nurses, reside. The rest of the Formations give logistical support to all SAMHS units mentioned above.

Figure 1.2 depicts the Structure of the South African Military Health Service (SAMHS**)** (Adapted from SAMHS Type Formations with associated Units in South African Defence Review, 1998:91)

Figure 1.2: SAMHS Structure or Organogram



The DOD's environment, as a military environment, is unique in many ways. It is a closed system, that is, a system that is not open to the outside. It is a system where soldiers operate within a strict military code of conduct and this environment becomes a controlled environment where one's life and well-being depend on following orders and the support of fellow comrades. The SANDF, like any other conventional force, is a corporate organisation, authoritarian, rigidly hierarchical, with a set of rules and regulations, allowing little room for initiative and freedom of action (Heinecken, 2005:

84). The SAMHS as an arm of service of the DOD has the same structures as those of the SANDF and the set rules and regulations are no different.

The SAMHS, as a health care provider in the military, sources its health professionals from outside the DOD and from those trained within the military. These health professionals provide health services to the patients in military hospitals and health care clinics; education services in institutions within the military to the members of the DOD and also health support to soldiers on deployment inside and outside the Republic of South Africa. The health professionals who come from outside the DOD get exposed to the military culture and experience the unique military environment for the first time when appointed, while those trained within assimilate the military culture during training. The health professionals from outside the DOD definitely experience the military environment differently.

Professional nurses form an important component of health professionals which ensure that the health system achieves the goals of providing access to health services, high quality patient care and a sustainable and affordable health care system. A sufficient supply of professional nurses is central to sustain these goals. Achievement of healthy work environments for professional nurses is equally critical to the safety, recruitment and retention of these professional nurses (Registered Professional Nurses' Association of Ontario (RNAO), 2008:13). The military professional nurses play an important supportive role to the success of the health system within the SANDF. The environment they operate in makes them different from other professional nurses because of its uniqueness. These professional nurses do not only provide patient care in military hospitals and clinics, but also have to sustain the health of deployed soldiers in a variety of contingencies (Lyons, 2002:1). They provide health care in an austere environment, with limited logistical and collegial resources and this demands a certain level of versatility and autonomy slightly above that of other professional nurses. During wartime, military professional nurses work in hostile or unsafe and dangerous environments, often under enemy fire. They are expected to process large numbers of patients though the field hospitals and resources are limited. In a foreign land, these professional nurses also have to care for members of the indigenous population (Wynd, 2006:6). Working in this unsafe and dangerous environment during wartime can be emotionally and psychologically

challenging and demands high levels of resilience. The very nature of military deployment distinguishes the military nurse from professional nurses in the civilian sector (Lyons, 2002:1).

The other aspect that makes the military nursing environment unique is the rank structure, this being the hierarchical order of military importance arranged by rank, gender imbalances and categorization of information. The hierarchical nature of the military rank structure tends toward the rigid and therefore may stifle autonomy. When professional nurses first enter the military, they attain the lowest officer rank and this may restrict decision-making and autonomy. The military is dominantly male and the majority in power positions is also male and there is a relationship between power and autonomy (Lyons, 2002:4-5). The categorization of information ranges from restricted to top secret, and can also be restrictive to nurse practice. These factors could create an unhealthy work environment for professional nurses as they are limiting to nurses' own initiative.

As previously mentioned, the military is a closed community. The members of the military have closely knit relations as they mostly live within the same environments. The epidemic of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) which has touched the military community and the hospitalization of HIV/AIDS patients in military hospitals, has expanded professional nurses' contact with this population. The report by the Surgeon General of the DOD admits to 8.5% prevalence of HIV/AIDS in the SANDF (DOD Corporate Communication, 2013). According to the South African National Defence Force's (SANDF) own estimates, a quarter of its body of soldiers is HIV positive, and many have already died (Heinecken, 2009:61).

As professional nurses are in the front line at their work environments, it is they who can best provide evidence that will inform the development of an evidence-based best practice guideline to facilitate a healthy work environment for them; hence their experiences of working in the SAMHS will be explored. Rankin (2011:12) states that to learn what professional nurses in the facility or organisation view as healthy will assist the administrator in creating and maintaining an environment to meet their needs. She further says that otherwise policies and systems implemented to create a

healthy work environment will ultimately result in dissatisfaction and frustration by both professional nurses and administrators. Evidence to determine how the professional nurses' experience working in the SAMHS needs to be established.

Evidence is the clear up-to-date rationale generated from research upon which decisions are based (Aveyard & Sharp, 2009:4). The advantage of evidence-based research is that it is the empirical knowledge generated from the synthesis of quality findings that best addresses a practice problem (Burns & Grove, 2011:5). Once evidence from research has been acquired it can be used to make decisions in practice.

Evidence-Based-Practice (EBP) is defined by Sigma Theta Tau International (2008) cited in Polit and Beck (2012:25), as the process of shared decision-making between practitioner, patient, and others significant to them, based on research evidence, the patient's experiences and preferences, clinical expertise or know-how, and other available robust sources of information.. This knowledge (evidence) can only address the practice problem in the form of guidelines. If the evidence that will emanate from this integration is found to be relevant, it will form the basis for the development of the evidence-based best practice guideline for a healthy work environment for professional nurses working in the SAMHS.

Evidence-based best practice guidelines are rigorous, explicit clinical guidelines developed by a team or panel of expert clinicians (physicians, nurse, pharmacists, and other health professionals); researchers and other consumers, policy makers, and economists to assist in bridging practice and research (Burns & Grove, 2011:26). Polit and Beck (2012:31) state that evidence–based best practice guidelines represent an effort to distill a large body of evidence into manageable form. They further say that guidelines give specific recommendations for evidence-based decision-making, intend to influence what clinicians do, are necessity-driven and their development involves the consensus of a group of researchers, experts and clinicians (Polit & Beck, 2012:31).

There are several tools for appraising the quality of the clinical practice guidelines. The Appraisal of Guidelines Research and Evaluation (AGREE) instrument is widely used

to evaluate the applicability of a guideline to practice (LoBiondo-Wood & Haber, 2010:214). The AGREE guideline assesses:

- The scope and purpose of the guideline
- Stakeholder involvement
- Rigour of the guideline development
- Clarity and presentation of the guideline
- Applicability of the guideline to practice and
- Demonstrated editorial independence of the developers (LoBiondo-Wood & Haber, 2010:214)

All the elements suggested by this tool were taken into consideration in the development of the best practice guideline in this research study.

1.2 PROBLEM STATEMENT

The professional nurses working in the SAMHS are a mix of those recruited from outside the military lines already trained and those trained within the military. Those professional nurses from outside the military get exposed to the military environment for the first time when they are appointed. The military nursing environment is unique because it is controlled, that is, soldiers operate under strict military rules and the environment is also rigid because of the hierarchical nature of the military rank structure. The rank structure is linked to authority and decision making. When professional nurses from outside initially enter the military they attain the lowest officer rank and this also applies to those who are trained within the military. This environment therefore limits the involvement of the professional nurse in decision-making and innovation with regard to patient care decisions and this may stifle their autonomy. The nursing environment in the military is also not stable; it changes constantly from hospitals and clinics to deployments outside the familiar environment to austere environments with limited logistical and collegial resources and this demands a certain level of versatility and autonomy slightly above that of other professional nurses. When nurses are deployed to isolated areas during wartime, they work in hostile and unsafe environments and they are expected to function autonomously and may not be able to do so due to lack of acquired competence. These conditions could be emotionally

and psychologically challenging and distinguish the military nurse from professional nurses in the civilian sector. Since the military culture has a bearing on how professional nurses practise their profession, the military environment may be experienced as unhealthy by some professional nurses. The researcher, a member of the SAMHS who has worked in different nursing positions for nineteen years, wants to explore how professional nurses working in the SAMHS experience their work environment and based on the evidence generated from the interviews of professional nurses develop a best practice guideline that will assist in facilitating a healthy work environment for the professional nurses.

1.3 RESEARCH QUESTIONS

The research questions for the study are as follows:

- How do professional nurses experience working in the SAMHS?
- What factors do professional nurses working in the SAMHS think would facilitate a healthy work environment?
- What factors do professional nurses think would hinder the attainment of a healthy work environment for professional nurses working in the SAMHS?
- What is the professional nurses' understanding of a best practice guideline?
- What would be the scope and nature of a best practice guideline for a healthy work environment faccording to the professional nurses in the SAMHS?

1.4 RESEARCH AIM

The aim of the study was to develop the best practice guidelines for healthy work environments in the military context based on the results from the qualitative exploration of professional nurses' experiences and expectations and analysis of the exixsting guidelines.

1.5 RESEARCH OBJECTIVES

The research objectives for this study are:

- To explore and describe experiences of professional nurses working in the SAMHS;

- To explore, describe and appraise existing best practice guidelines related to a healthy work environment for nurses;
- To develop a best practice guideline for a healthy work environment for nurses in the SAMHS.

1.6 CONCEPT CLARIFICATION

The following concepts are clarified to understand how they are applied in the research study:

1.6.1 Healthy work environments for professional nurses are defined by the Registered Professional Nurses' Association of Ontario (RNAO) (2008:14) as practice settings that maximise the health and well-being of the nurse, quality patient/client outcomes, organisational performance and social outcomes. In this study health work environments in the SAMHS will be explored.

1.6.2 Professional nurse means a person who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (Department of Health, Nursing Strategy for South Africa, 2008:5). In this study this person will be practicing in the health care institutions of the SAMHS.

1.6.3 Best practice guidelines are defined by LoBiondo-Wood and Haber (2010:213) as systematically developed statements or recommendations based on best evidence that serve as a guide for practitioners and assist in linking practice and research. This research study will focus on the Evidence-Based Best practice Guideline for a Healthy work environment in SAMHS.

1.6.4 Evidence-based practice is defined by Polit and Beck (2008:3) as the use of the best clinical evidence in making patient care decisions, and such evidence typically comes from research conducted by professional nurses and other health care professionals.

1.6.5 **SAMHS** is an abbreviation for the **South African Military Health Service,** a branch of the South African National Defence Force responsible for provision of health services, the training and deployment of all health personnel within the force. It is a within this arm of service that professional nurses work in the South African National Defence Force.

1.6.6 **Military environment:** In this study the military environment is the culture that soldiers are educated and live in, and people and institutions with whom soldiers interact. The military environment will include military health institutions, bases and the whole military community setting.

1.7 THEORETICAL FRAMEWORK

Figure 1.3 depicts the JBI Model.

Figure 1.3: JBI model (Pearson, Field & Jordan, 2007:17)

1.8 RESEARCH DESIGN

The research design guides the researcher in planning and implementing the study so that the study outcome is achieved (Burns & Grove, 2009:232). According to Babbie and Mouton (2008:107) a research design is a set of guidelines and instructions to be followed in addressing the research problem. Qualitative research is an umbrella term for a number of diverse approaches which seek to understand by means of exploration, human experience, perceptions, motivations, intentions and behaviour.

The researcher of this study chose to adopt a qualitative approach as the purpose of the study was to create knowledge regarding a particular human experience. The aim of this study was to explore and describe how the professional nurses experienced working in the South African Military Health Service; therefore the researcher used a qualitative, exploratory, descriptive, and contextual approach.

The research study was conducted in a three-phased approach, and the design and methods for the different phases will be discussed comprehensively in Chapter Two.

1.8.1 Phase 1

Phase 1 of the study will comprise a qualitative, explorative, descriptive and contextual design.

1.8.1.1 Qualitative research design

The qualitative approach is used to answer questions about the complex nature of phenomena, with the purpose of describing and understanding the phenomena from the participants' point of view (Leedy & Ormond (2005) in de Vos, Strydom, Fouche and Delport, 2011:64). The study will be qualitative because it is concerned with describing and making sense of and interpreting the experiences of professional nurses working in the SAMHS.

1.8.1.2 Exploratory research design

Exploratory qualitative research is designed to shed light on various ways in which a phenomenon is manifested and on underlying processes. It investigates the full nature of the phenomenon, the manner in which it is manifested, and the other factors to which it is related (Poilt & Beck, 2012:18). This study will be exploratory because there is little known about how professional nurses experience working in the SAMHS. The exploratory-design has been chosen because the area under study is not well developed and therefore no sound theories have as yet been put forward.

1.8.1.3 Descriptive research design

Creswell (2007:245) describes description as “stating the facts about the case as recorded by the investigator. Rubin and Babbie (2006) in de Vos et al (2011:96), propound that in qualitative studies, description is more likely to refer to a more intensive examination of phenomena and their deeper meanings, thus leading to a thicker description. The study will be descriptive because the researcher will describe how professional nurses experience working in the SAMHS and their understanding of a healthy work environment.

1.8.1.4 Contextual research design

Contextual studies describe and understand events within the concrete, natural context in which they occur (Babbie & Mouton, 2011:272). Babbie and Mouton (2011:2720), purport that it is only if one understands events against the background of the whole context and how such a context confers meaning to the events concerned, that one can truly claim to understand the events. This study will be contextual as it will be conducted in the natural settings of the participants, at the daily workplaces of the professional nurses, the hospitals and health care clinics in the SAMHS.

1.8.1.5 Research Method

Research methods are the techniques researchers use to structure a study and to gather and analyze information relevant to the research question (Polit & Beck, 2012:12). A research population is identified, which in this study are professional nurses working at SAMHS. A non-probability purposive sampling strategy was used to select the appropriate sample as per inclusion and exclusion criteria.

In this research a pilot study, which is a small-scale version or trial run designed to test the methods to be used in a larger, more rigorous study, also called a feasibility study (Polit & Beck, 2008:213), was conducted in the same manner as the main study. After permission to do research was obtained, individual interviews were conducted on three purposefully selected professional nurses from the three military hospitals and health care clinics. Data was collected through recording of interviews by means

of an audio recorder and a use of an interview protocol. The data collected was analysed using Tesch's method which identifies themes in the data and allows a structured organisation of data to take place (Creswell, 2014:198). An independent coder was also utilized to ensure reliability.

1.8.2 Phase 2

Phase 2 will comprise an integrative literature review of evidence-based existing healthy work environment best practice guidelines. In this phase all existing best practice guidelines for a healthy work environment for nurses will be critically appraised and the evidence extracted will be combined with the evidence generated in Phase 2 to develop the best practice guideline.

1.8.3 Phase 3

In Phase 3, after Phases 1 and 2 of the research process have been completed, where data collected was analyzed, interpreted and synthesised, data was used to develop a Best practice Guideline.

The guideline development process entailed identification and refining of the subject area; convening and running of a multidisciplinary guideline development group; identification and assessing of the evidence; translating evidence into a clinical practice guideline and reviewing and updating guidelines. The quality of the guideline development process is important and was therefore followed meticulously as the process influences the credibility of the guideline as well as its validity

The research design and methods for the different phases will be discussed in detail in Chapter Two.

1.9 TRUSTWORTHINESS

According to Lincoln and Guba (1985) as cited in Babbie and Mouton (2011:276), the key criterion or principle of good qualitative research is found in the notion of trustworthiness, which is neutrality of its findings or decisions. Trustworthiness, according to Babbie and Mouton (2011:276), is about the researcher persuading his

or her audience that the findings of a research study are worth paying attention to. There are four notions that operationalise the concept of trustworthiness in a qualitative research: credibility, transferability, dependability, and confirmability (Babbie & Mouton, 2011:276-278). These notions will be observed in this research study. Trustworthiness will be discussed in detail in Chapter Two.

1.10 ETHICAL CONSIDERATIONS

When humans are used as study participants, as they usually are in nursing research, care must be exercised in ensuring that the rights of those humans are protected (Polit & Beck, 2008:167). Researchers face ethical situations in almost every step of the research process, from selecting participants to reporting findings at the conclusion of the study (Houser, 2008:53). Ethical considerations, as propounded by researchers such as Polit and Beck (2008:170), are imperative to protect the rights of participants and to ensure that researchers minimize harm and maximise benefits. The following ethical considerations will be observed in this study: Harm to respondents; Informed consent; No deception of respondents; No violation of privacy; Actions and competence of the researcher and Plagiarism.

After permission to do research in the SAMHS has been granted by the Department of Defence, and the proposal approved by the Nelson Mandela Metropolitan University Ethics Committee, reference number H13-HEA-NUR-020, and the research committees of Nelson Mandela Metropolitan University, professional nurses will be invited in writing through their immediate supervisors to participate in the study. Those willing to participate will be issued with informed consent forms so that they give informed consent to willingly participate in the research study. Ethical considerations will be discussed in detail in Chapter Two.

1.11 CHAPTER HEADINGS

The research study will be divided into six chapters as follows:

Chapter 1: Orientation and overview of the study

In this chapter, the researcher will orientate the reader on the problem statement, research design and method and theoretical framework of the study.

Chapter 2: Research design and method

In Chapter Two the design and method applied to this study including all the three phases, will be discussed in detail.

Chapter 3: Discussion of qualitative findings (Phase One)

The data collected by means of interviewing professional nurses will be analyzed and discussed.

Chapter 4: Integrative literature review report (Phase Two)

Data emanating from the synthesis of the critically appraised existing evidence-based best practice guidelines for healthy work environment for nurses is discussed in this chapter.

Chapter 5: Best practice guideline (Phase Three)

Data generated in Phases 1 and 2 was integrated and a best practice guideline is developed and presented in this chapter.

Chapter 6: Conclusions, limitations and recommendations

Concluding remarks, limitations and recommendations with regard to nursing practice, nursing education and nursing research are indicated in this chapter.

1.12 SUMMARY OF THE CHAPTER

In this chapter an overview of the study has been done by giving a background to the study, as well as discussion of the problem statement. The aim of the research, the research question and research objectives are also highlighted. The theoretical framework and concepts used in the study are outlined and the research design and method used briefly discussed. The ethical considerations and trustworthiness are also highlighted. The methodology which is the research design and method used in the study including the different phases will be discussed in detail in Chapter Two.

CHAPTER TWO

RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

Chapter One presented an overview and the introduction to the research study to orientate the reader. A description of the research problem and the conceptual framework was provided and research questions and objectives were introduced. The research design and method were briefly described. In this chapter the purpose of the study, as well as the research design and methods, are discussed. A description of the research strategy, the data-collection process and the sampling method, data analysis and ethical considerations, as well as trustworthiness, will be dealt with in greater detail.

2.2 RESEARCH AIM

The aim of the study was to develop the best practice guidelines for healthy work environments in the military context based on the results from the qualitative exploration of professional nurses' experiences and expectations and analysis of the exixsting guidelines.

2.3 RESEARCH OBJECTIVES

The research objectives for this study were:

- To explore and describe experiences of professional nurses working in the SAMHS;
- To explore, describe and appraise existing best practice guidelines related to a healthy work environment for nurses;
- To develop a best practice guideline for a healthy work environment for nurses in the SAMHS.

In the paragraphs below the research design and method to achieve the objectives of the study mentioned above, will be outlined.

2.4 RESEARCH DESIGN AND METHOD

A research design is a plan or blueprint of how you intend conducting the research (Babbie & Mouton, 2011:74). The purpose of a design is to maximize control over factors that can interfere with validity of the study findings (Burns & Grove, 2011:253). According to Burns and Grove (2011:253), the control provided by the design ensures that the study results accurately reflect reality.

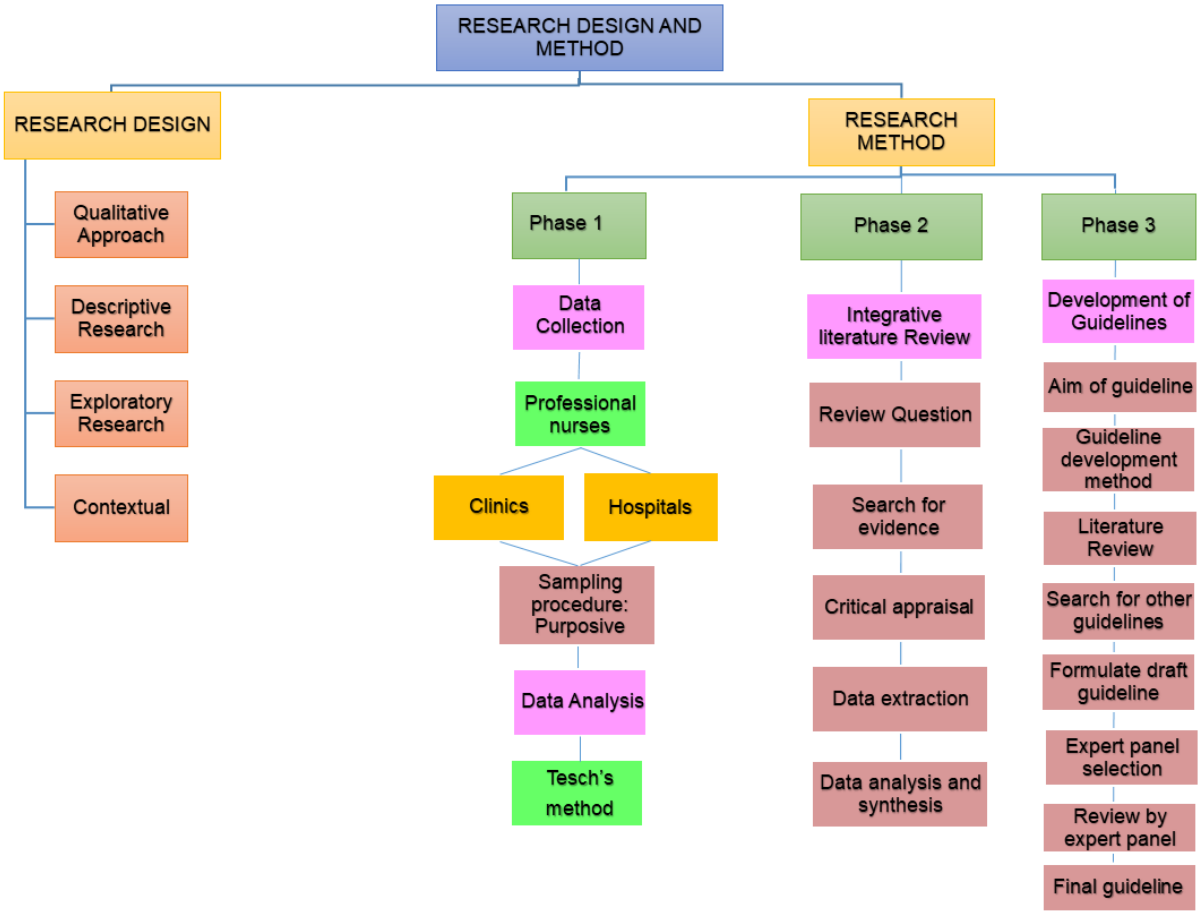
Creswell (2014:6) propounds that the choice of a design by the researcher is influenced by the worldview they espouse. Research in nursing has mainly been organized within two broad paradigms or world views, namely, positivism and constructivism (Polit & Beck, 2012:11). The Positivist paradigm assumes that there is reality out there which must be studied in order to know it. The positivists believe that nature is an ordered and regular phenomenon which depends on human observation and are inclined towards quantitative research design (Polit & Beck, 2012:12).

The researcher in this study holds the Constructivist worldview which believes that "individuals seek understanding of the world in which they live and work. This worldview also believes that individuals develop subjective meanings of their experiences, meanings directed toward certain objects or things." The goal of the research in the constructivist worldview is to rely as much as possible on the participants' views of the situation being studied (Creswell, 2014:8). The researcher's choice of the design was decided upon after looking at the purpose of the research and the Constructivist worldview typically seen as an approach to qualitative research.

The research methods are techniques researchers use to structure a study and to gather and to analyze information relevant to the research question (Polit & Beck, 2012:14). According to Munhall (2007:99), the philosophical underpinnings of qualitative research methods reflect beliefs, values and assumptions about the nature of human beings, the nature of environment and the interaction between the two. In constructivist research the inquiry takes place in the field, i.e. in naturalistic settings, over an extended time, the collection of data and its analysis progress concurrently (Polit & Beck, 2012:15).

Figure 2.1 below depicts the research design and method for this study in a form of a diagram.

Figure 2.1: Summary of the Research Design and Method



2.4.1 Research design

Polit and Beck (2012:58) define the research design as the overall plan for obtaining answers to the research questions and for handling some of the difficulties encountered during the research process. There is a wide variety of research designs but it is important for the researcher to choose a design that is suitable for the topic and will enable them to have their research questions answered. According to Polit and Beck (2012), in designing the study researchers select a specific design and identify strategies to minimize bias. They further say that research designs indicate how often data will be collected, what types of comparisons will be made, and where the study will take place. The research design is the architectural backbone of the study (Polit & Beck, 2012:58).

The broad methodological approach adopted in this study is a qualitative research approach which was exploratory, contextual and descriptive in nature. This approach aimed at gaining insight into how professional nurses experienced working at SAMHS and into their understanding of a healthy work environment. The research design and methods used in this study will be discussed in detail in this chapter.

2.4.1.1 Qualitative research design

Qualitative research is described by Burns and Grove as a systematic, subjective approach used to describe life experiences and give them meaning (Burns & Grove, 2011:73). It is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem (Creswell, 2014:4). According to Creswell (2014), the process of research involves emerging questions and procedures, data typically collected in the participant's setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data (Creswell, 2014:4). Leedy and Ormond (2005) in de Vos, Strydom, Fouche & Delport, (2011:64) propound that qualitative research is used to answer questions about the complex nature of phenomena, with the purpose of describing and understanding the phenomena from the participants' point of view (de Vos, Strydom, Fouche & Delport, (2011:64). Polit and Beck (2008:219) further state that qualitative research is holistic, that is, concerned with humans and their environment in all of their complexities. It is based on the premise that knowledge about humans is not possible without describing human experience as it is lived and as the actors themselves define it. The research design was appropriate for the study because it was concerned with exploring and describing, making sense of, and interpreting how professional nurses experienced working in the SAMHS, their understanding of a healthy work environment and best practice guidelines.

2.4.1.2 Exploratory research design

Exploratory qualitative research is designed to shed light on various ways in which a phenomenon is manifested and on underlying processes. It investigates the full nature of the phenomenon, the manner in which it is manifested, and the other factors to which it is related (Poilt & Beck, 2012:18). Exploratory studies are essential whenever

a researcher is breaking new ground, and they can almost always yield new insights into a topic for research (Babbie & Mouton, 2011:80). After doing an extensive literature search, no studies conducted in this area in the DOD were found. Generally, exploratory research designs are employed in situations where very little is known about the topic. According to Polit and Beck, (2012:18) qualitative methods are especially useful for exploring the full nature of a little-understood phenomenon. This study explored how professional nurses experienced working in the SAMHS and their understanding of a healthy work environment and best practice guidelines. The exploratory design was chosen because the area under study was not well developed and therefore no sound theories had been put forward.

2.4.1.3 Descriptive research design

Descriptive research is the exploration and description of phenomena in real-life situations. It provides an account of characteristics of particular individuals, situations, or groups (Burns & Grove, 2011:34). Through descriptive studies, researchers discover new meaning, describe what exists, and determine the frequency with which something occurs (Burns & Grove, 2011:35).

Polit and Beck (2012:226) propound that the purpose of descriptive studies is to observe, to describe, and document aspects of a situation as it naturally occurs and sometimes to serve as a starting point for theory development. Creswell (2007:245) describes description as “stating the facts about the case as recorded by the investigator.” According to Rubin and Babbie (2006) in de Vos et al. (2011:96), in qualitative studies, description is more likely to refer to a more intensive examination of phenomena and their deeper meanings, thus leading to thicker description. Speziale and Carpenter (2007:82) add that the aim of describing is to communicate and bring to written and verbal description distinct, critical elements of the phenomenon. They contend that description is based on a classification or grouping of the phenomenon. In descriptive research, the researcher hopes to generalise from studied cases to those that were not part of the research study. Simple describing, if performed well, is a major contribution to knowledge building that requires a great amount of knowledge and skill. These researchers propound that description is an integral part of intuiting and analysing (Speziale & Carpenter, 2007:82). The study described how professional

nurses experienced working in the SAMHS and their understanding of a healthy work environment and best practice guidelines.

2.4.1.4 Contextual research design

Contextual studies describe and understand events within the concrete, natural context in which they occur (Babbie & Mouton, 2011:272). It is concerned with identifying what exists in the social world and the way it manifests itself (Ritchie, Lewis, Nicholls & Ormston, 2014:31). Babbie and Mouton (2011:272), purport that it is only if one understands events against the background of the whole context and how such a context confers meaning to the events concerned, that one can truly claim to understand the events. This study was contextual as it was conducted in the natural settings of the participants.

The study was conducted in the three South African military hospitals as follows:

- 1 Military Hospital in Pretoria, Gauteng Province
- 2 Military hospital in Cape Town, Western Cape Province
- 3 Military hospital, Free State Province

And in the health care clinics as follows:

- Area Military Health Unit Gauteng
- Area Military Health Unit Western Cape
- Area Military Health Unit Eastern Cape
- Area Military Health Unit Free State
- Area Military Health Unit North West
- Area Military Health Unit Northern Cape

These institutions fall under the South African Military Health Service, a branch of the SANDF. The hospitals are situated in Pretoria, in the Gauteng Province, Cape Town, in the Western Cape Province and Bloemfontein in the Free State Province.

The hospital in Pretoria, 1 Military hospital, is a referral hospital for all defence force health institutions in all the provinces in South Africa, as well as for the African

continent. It also provides tertiary services to members of the DOD and military veterans and their dependants in Gauteng, Kwa-Zulu Natal, Mpumalanga and Limpopo provinces and government officials. The hospital in Cape Town, 2 Military hospital, looks after the Western Cape and Northern Cape provinces and the hospital in Bloemfontein, 3 Military hospital, caters for the Free State, North West, Northern Cape and the Eastern Cape provinces.

The primary health care clinics, as well as health care centres, which are bigger than the clinics, are situated in all nine provinces to cater for members and their dependents. All these primary health care settings fall under the Area Military Health Units which serve as headquarters, and are divided into Sickbays and Military Medical Clinics (MMCs). There are varying numbers of Sickbays and MMCs under each Area Military Health Unit in the different provinces. This study was conducted in the different military hospitals and military primary health care institutions, the natural settings of participants.

Participants were purposely selected from the three military hospitals and the plan was to purposely select participants from a sickbay from each province but due to vastness of the country, only six provinces could be covered: Gauteng, Western Cape, Free State, North West, Eastern Cape, Northern Cape. The selection process was done through the gatekeepers, the unit managers. The pilot study was conducted in the hospital and two sickbays in the Gauteng Province. Table 2.1 depicts type and number of military facilities per provinces where interviews were conducted.

2.4.2 Research method

Research methods are the techniques researchers use to structure a study and to gather and analyze information relevant to the research question (Polit & Beck, 2012:12). The research process was carried out in three phases: Phase 1 comprised the sampling procedure and a description of the participants' entry to the site, the data collection process and data analysis. In Phase 2, an integrative literature review for existing best practice guidelines was conducted and critically appraised. From the literature, data was extracted and synthesised, leading to Phase 3 which consisted of

the development of a best practice guideline for a healthy work environment for nurses working in the SAMHS, by integrating the data analysed in Phase 1 and Phase 2.

Table 2.1 below outlines the phases employed in this study.

Table 2.1: The structure of the study according to the phases

Phases	Objectives	Methods
Phase 1	• To explore and describe experiences of professional nurses working in the SAMHS; • To explore and describe the understanding of professional nurses of a healthy work environment; • To explore and describe the understanding of professional nurses of a best practice guideline.	Individual semi-structured interviews were conducted with professional nurses using an interview guide and recorded with an audio tape. Data was transcribed, coded and analyzed using Tesch's method.
Phase 2	To explore, describe, appraise, extract and synthesise the existing evidence-based best practice guidelines related to a healthy work environment for nurses	Integrative literature review of the existing evidence-based best practice guidelines for a healthy work environment for nurses
Phase 3	To develop an evidence-based best practice guideline for a healthy work environment for professional nurses working in the SAMHS	Development of an evidence-based best practice guideline for a healthy work environment for professional nurses working in the SAMHS

2.4.2.1 Phase 1

Phase 1 of the study comprised the sampling procedure and a description of the participants, entry to site, the data collection process and data analysis.

2.4.2.1.1 Research population

According to Polit and Beck (2012:306), a population is the entire aggregation of cases in which the researcher is interested, while LoBiondo-Wood and Haber (2010:221) define it as “a well-defined set that has certain specified properties.” A research population was identified, which in this study, comprised professional nurses working in the SAMHS.

2.4.2.1.2 Research sampling

A sample is a subset of the population from which the researcher collects the data (Polit & Beck, 2012:59). Sampling is the process of selecting representative units of a population for study in a research investigation (LoBiondo-Wood & Haber, 2010:221). A non-probability purposive sampling strategy was used to select the appropriate sample as per inclusion and exclusion criteria. In this way the researcher was able to choose research subjects that were regarded as representative of the population.

According to Polit and Beck (2012:275), in non-probability sampling, elements are selected by non-random methods and purposive sampling strategy is one of the types of non-probability sampling where the researcher’s knowledge about the population is used to select the sample (Polit & Beck, 2012:279). Gray, Grove and Sutherland (2017:352) commend that many qualitative researchers use purposive or purposeful sampling methods to select the specific participants, events, or situations that they believe would provide with rich data needed to gain insights and discover new meaning in the area of study. The researcher chose the professional nurses from the military hospitals and clinics based on the knowledge the research had of the population. LoBiondo-Wood and Haber (2010:228) allude to the fact that purposive sampling is an increasingly common strategy in which the researcher’s knowledge of the population and its elements is used to handpick the cases to be included in the sample. They assert that the researcher who uses a purposive sample assumes that errors of judgement in over representing or under representing elements of the population in the sample will tend to balance out (LoBiondo-Wood & Haber, 2010:229). The same assumption was held by the researcher in this study.

The research population in this study comprised professional nurses working in all the three South African Military Health Service hospitals and clinics in six provinces. The participants were therefore diverse in terms of hospitals and clinics they worked in at SAMHS. They were also diverse in terms of military experience and exposure to military culture. LoBiondo and Haber propound that the researcher needs to identify population descriptors that form the basis for the inclusion (eligibility) or exclusion (delimitations) criteria that are used to select the sample from the array of all possible units (2010:222). The inclusion criteria for participation in the study were as follows:

- Must be a professional nurse who is currently registered with the South African Nursing Council as a practising member;
- Must be a soldier in full-time employment of the SANDF;
- Must be working in a health institution within the Department of Defence;
- Must have worked with military patients for at least nine months;
- May be a representative of any of the race groups in South Africa;
- All interviews were to be conducted in English;
- Both genders were to be included.

Sixteen participants were selected purposively from eleven military health facilities in six different provinces, that is, the three military hospitals, 1 Military hospital in Pretoria, Gauteng Province; 2 Military hospital in Cape Town, Western Cape Province and 3 Military hospital in Bloemfontein, Free State Province, as well as from the clinics, also called sickbays, in the six provinces. The gatekeepers were the unit managers of the respective participants in both the military hospitals and the military clinics.

Table 2.2 depicts the military health facilities where participants were sampled.

Table 2.2: Spread of participants per facility per province

Province	Type of health facility	Number of health facilities per province	Number of participants
Gauteng	Hospital	1	2
	AMHU GP sickbays	2	3
Free State	Hospital	1	1
	AMHU FS sickbays	1	1
Western Cape	Hospital	1	2
	AMHU WC sickbays	2	4
Eastern Cape	AMHU Military Medical Clinic	1	1
North West	AMHU NW sickbay	1	1
Northern Cape	AMHU NC sickbay	1	1
6	3 hospitals & 8 sickbays	11	16 5 from hospitals and 11 from clinics

Regarding sample size, Polit and Beck (2012:521) propound that there are no fixed rules for sample size in qualitative research. They assert that the sample size should be based on informational needs; hence a guiding principle in sampling is data saturation. They continue to state that the key issue is to generate enough in-depth data that can illuminate the patterns, categories, and dimensions of the phenomenon understudy. In this study, 16 interviews were conducted, and the researcher believed that the data collected would suffice.

2.4.2.1.3 Entry to site

Creswell (2014:188) states that 'it is important to gain access to research or archival sites by seeking the approval of gatekeepers, individuals at the site who provide access to the site and allow or permit the research to be done. Polit and Beck (2008:70) describe gaining entry as typically involving negotiations with gatekeepers who have the authority to permit entry into their world. According to Polit and Beck (2012:184), because establishing trust is a central issue, gaining entree requires

strong interpersonal skills, as well as familiarity with site's customs and language. They contend that gaining entree may be an ongoing process of establishing relationships and rapport with gatekeepers and others at the site, including the prospective informants (Polit & Beck, 2012:184). Gatekeepers might be especially cooperative if they are persuaded that there will be direct benefits to them or their constituents.

The gatekeepers, in this research study, who were directly in charge of the military hospitals and clinics, and who could give the researcher access to research participants, included the Department of Defence Intelligence and SAMHS Surgeon General, represented by the 1 Military Hospital Research Committee. The Officers Commanding of the different military hospitals and clinics and the Nurse Managers, who are directly in charge of different clinics and hospitals in different provinces, also formed part of gatekeepers.

The study was first approved by the Faculty Research Technology Innovation (FRTI) Committee at Nelson University before permission was sought to conduct the study in the hospitals and clinics of the Department of Defence (see Annexure I. Permission to do research in the military hospitals and clinics was sought through the Department of Defence Intelligence, which controls incoming and outgoing information in the defence force (see Annexure F), and the 1 Military Hospital Research Committee, which sanctions research studies, conducted in the SAMHS on behalf of the Surgeon General (see Annexure G) Communication with gatekeepers was done in writing (see Annexure E). After the permission to do research had been obtained from the above authorities, the Officers Commanding of each military hospital and clinics were then contacted by the researcher in writing regarding gaining their permission to undertake the research study in their units (see Annexure E). Correspondence to the Officers Commanding included the aims and objectives of the study, the consent form, letters of approval from Nelson Mandela University' FRTI committee, the 1 Military Hospital Research Committee and the permission letter to conduct the study from the Department of Defence Intelligence. The Officers Commanding informed the nursing managers who were better positioned to grant access to the participants at their respective units. The participants were the professional nurses working in hospitals, clinics and sickbays of the South African Military Health Services. These nurses were

required to respond to questions that sought to establish how they experienced working in the SAMHS.

The participants were first contacted through their immediate supervisors, the nursing managers, who indicated to them that there would be a research study of this nature conducted by the researcher.

A letter addressed to participants describing the purpose and objectives of the research and extending an invitation to participate in the study was sent for circulation to the hospitals and clinics (Annexure A) through the nursing managers. The researcher indicated that only participants who were willing to participate would be interviewed and requested the nurse managers' assistance in relaying information about the study and the invitation to participate to the different units in the hospital and clinics via the organisational channels of communication. Positive responses were received within a few days through the nurse managers.

After getting the feedback about those who were willing to participate from the nurse managers, the professional nurses were contacted telephonically by the researcher, because of the vastness of the research sites, to ensure that they met the criteria, as well as to answer any questions they had pertaining to the study and explain further about the research. The researcher explained to the participants about voluntary participation, informed consent, the goals of the study, and the research methods that would be employed. Consent forms (see Annexure A) were sent through to each prospective participant for reading. The forms were to be signed in the presence of the researcher before the interview. The researcher then proceeded to set up individual appointments at dates and times that were suitable to participants for the semi-structured individual interviews. The negotiations for the dates and times were such that there were no disruptions to their work.

On the day of the interview, the researcher repeated the information that was given to the participant telephonically about the purpose of the study, and two consent forms were signed before the interview could start, one form being kept by the participant and the other by the researcher. The researcher saw it fit to emphasise that participation was voluntary and that participants should not feel obliged or coerced to

participate; as well as that there would be no consequences in their workplace if they decided to withdraw from participating. All interviews were conducted in English at venues in the military hospitals and clinics where professional nurses worked after the consent forms were signed by the participants.

2.4.2.1.4 Data collection methods

According to Polit and Beck (2008), the phenomenon in which researchers are interested must ultimately be captured and translated into data that can be analyzed (Polit & Beck, 2008:367). Burns and Grove (2017:493) describe data collection as a process of selecting subjects and gathering data from. Marshall and Rossman (2016) in Gray, Grove and Sutherland (2017:256), purport that the researcher as a whole person is completely involved in the data collection process, perceiving, reacting, interacting, reflecting, and attaching meaning and recording interviews. Phase one of the study employed semi-structured individual interviews which were arranged with military hospitals and clinics ahead of time.

Semi-structured interviews

Interviews are a method of data collection where a data collector asks subjects to respond to a set of open-ended or closed-ended questions (LoBiondo-Wood & Haber, 2012:275). They involve verbal communication during which the subject provides information to the researcher (Gray, Grove & Sutherland, 2017:403). Interviewing is a flexible technique that can allow researchers to explore greater depth of meaning than they can obtain with other techniques (Gray, Grove & Sutherland, 2017:403). Semi-structured interviews are conducted when the researcher wants to be sure that a specific set of topics is covered in qualitative interviews. They know what they want to ask but cannot predict what the answers will be (Poilt & Beck, 2012:537).

The researcher prepares an interview schedule or a topic guide with a list of questions covering the area of interest in advance (Polit & Beck, 2008:394). The questions should be phrased so that the participant responds comprehensively to all topics on the interview schedule so as to provide rich information. The researcher's role is to encourage the participants to talk freely in their own words. This technique ensures that researchers obtain all the information required, and it gives people the freedom to provide as many illustrations and explanations as they wish (Poilt & Beck, 2012:537).

Data from professional nurses was collected by the researcher through semi-structured interviews. Each interviewee was asked one main question that is in the interview schedule with five sub-questions, as follows:

- "Tell me how you experience working in the SAMHS as a professional nurse."
    - What is your understanding of a healthy work environment for professional nurses?
    - What factors do you think would facilitate a healthy work environment for professional nurses working in the SAMHS?
    - What factors do you think would hinder the attainment of a healthy work environment for professional nurses?
    - What is your understanding of a best practice guideline?
    - What would be the scope and nature of a best practice guideline for a healthy work environment for professional nurses in the SAMHS?

Recording of information

Permission was requested from the participants to use an audio recorder in order to record the interviews; this was done prior to starting each interview. This was necessary to enable the researcher to record the exact words of the interview, inclusive of questions, so that she did not forget important answers and words. The participants were assured that their names would not be used when addressing them during the recording in order to ensure anonymity.

Data was gathered until saturation stage was reached and feedback was received from a total of sixteen participants (5 professional nurses from the military hospitals and 11 from the military clinics). Data saturation is defined by Gray et al. (2017:254) as a point at which the new data begins to be redundant with what has already been found and no new themes can be identified. Each interview progressed at a rate determined by the participants and on average lasted approximately thirty minutes. Field notes were written after all interviews and interviewer's thoughts were recorded as part of the notes taken. They included everything the researcher observed during the interview, the researcher's reactions, the content, metacommunication and the context (Gray et al., 2017:257). The researcher was the main instrument during the data collection process.

After the sessions the researcher thanked the participants for their participation and explained how the information that they shared would be analysed to contribute towards the research, adding that copies of the research study would be made available to their hospitals and clinics.

2.4.2.1.5 Data analysis

Morse and Field (1995) in Polit and Beck (2012:556) define data analysis as a ‘’process of fitting data together, of making the invisible obvious, of linking and attributing consequences to antecedents. It is a process of conjecture and verification, of correction and modification, of suggestion and defence.” Data analysis usually follows data collection but in qualitative research data analysis occurs simultaneously with data collection (Streubert & Carpenter, 2011:44-46).

The data captured on audio-tapes during interviews was transcribed verbatim and field notes typed out by the researcher and a professional transcriptionist. The advantage of a researcher transcribing the recordings is that they immediately get immersed in the data (Gray, Grove & Sutherland, 2017:208). Polit and Beck, (2012:557) state that “verbatim transcription of the tapes is a critical step in preparing for data analysis, and researchers need to ensure that transcriptions are accurate and that they validly reflect the interview experience.” After the data was organized and prepared, the researcher read and looked at all data and this provided the researcher with “a general sense of the information and an opportunity to reflect on its overall meaning” (Creswell, 2014:196). The coding process then started using Tesch’s method which identified themes in the data and allowed a structured organization of data to take place (Creswell, 2009:192). Coding is the process of organizing the data by bracketing chunks and writing a word representing a category in the margins (Rossman & Rallis,2012, in Creswell, 2014:198).

Tesch, in Creswell (2014:198) suggests the following steps in analysing data:

1) Get a sense of the whole. Read through all of the transcriptions carefully. Jot down some ideas as they come to mind.
2) Pick one interview – the most interesting, the shortest, the one on the top of the pile, go through it, asking you “What is this about?” Do not think about the

substance of the “substance of the information, but rather its underlying meanings. Write thoughts in the margin.

3) When you have completed this task for several informants, make a list of all topics, unique topics and leftovers.
4) Now take this list and go back to your data. Abbreviate the topics as codes and write the codes next to the appropriate segments of the text. Try out this preliminary organizing scheme to see whether new categories and codes emerge.
5) Find the most descriptive wording for your topics and turn them into categories. Work towards reducing your total list of categories by grouping topics that relate to one another. Perhaps draw lines between your categories to show interrelationships.
6) Make a final decision on the abbreviation for each category and alphabetise these codes.
7) Assemble the data material belonging to each category in one place and perform a preliminary analysis.
8) If necessary recode your existing data.

Coding allowed insight into the data which might not have been obvious at first glance by examination; analysis and sorting into categories (De Vos in De Vos et al., 2011:345) Themes and sub-themes were identified. Once the initial coding was done by the researcher, the independent coder who is an expert in qualitative research from the Nelson Mandela University analysed the raw data independently for the emergence of any themes that were prevalent amongst those interviewed and then consensus was reached in a consensus discussion at the university about identified themes to ensure trustworthiness. These themes were used to provide the story told by the participants and to form the basis for the recommendations which could be made.

Positioning myself

The researcher is a former member of the South African National Defence force. She worked for the South African Military Health Service for 19 and half years in different positions, from a registered nurse in a primary health care setting to a Senior Nursing manager of a military hospital and lastly an Officer Commanding/Principal of SAMHS

Nursing College**.** The exposure of the researcher to the research environment could tend to influence the research findings towards her own pre-convinced ideas if these ideas are not handled carefully. Having been aware of the emotional attachment to the research environment, the researcher tried to be cautious by bracketing out her own preconceived ideas and by being intuitive when dealing with participants and their responses.

Bracketing

The researcher brackets out the world and pre-suppositions, in an effort to confront the data in pure form. Bracketing refers to suspending or laying aside what the researcher knows about the experience being studied (Burns & Grove, 2011:96). Bracketing is related to "Commitment to reflexivity." The researcher, who is herself a nurse and was a manager and a soldier at SAMHS tried to be as neutral as possible by basing her report on what unfolded from the study, not on preconceived ideas. The use of audio recording and a private transcriptionist, the involvement of an independent coder and the consensus discussion helped the researcher to set aside personal perspectives.

Intuiting

Intuition is an insight into or understanding of a situation or event as a whole that usually cannot be logically explained (Gray, Grove & Sutherland, 2017:5). It occurs when the researcher remains open to the meanings attributed to the phenomenon by those who have experienced it (Polit & Beck, 2008:228). In this study, the researcher had an advantage of having been a member of the SANDF and having worked at SAMHS in managerial positions. This helped the researcher to understand meanings behind the responses of the participants.

2.4.2.1.6 Pilot study

A pilot study is a small-scale version or trial run designed to test the methods to be used in a larger, more rigorous study. A pilot study is also called a feasibility study (Polit & Beck, 2008:213). In this research, the pilot study was conducted in the same manner as the main study. Individual interviews were conducted on three purposively

selected professional nurses from one military hospital and two health care clinics in Gauteng, after permission to do research was obtained from the Defence Force and the university and consent was signed by the participants. Data was collected through recording of interviews by means of an audio recorder and an interview protocol. In this pilot study, the data collected was analysed using Tesch's method which identified themes in the data and allowed a structured organization of data to take place (Creswell, 2009:192).

2.4.2.2 Phase 2

Phase 2 comprised an integrative literature review of evidence-based existing healthy work environment best practice guidelines.

Recent evidence-based practice initiatives have increased the need for and the production of all types of reviews of the literature (integrative reviews, systematic reviews, meta-analyses, and qualitative reviews). The integrative review method is the only approach that allows for the combination of diverse methodologies (for example, experimental and non-experimental research), and has the potential to play a greater role in evidence-based practice for nursing by informing research, practice, and policy initiatives (Whittemore & Knafl, 2005: 546). An integrative literature review is a specific review method that summarises past empirical or theoretical literature to provide a more comprehensive understanding of a particular phenomenon or healthcare problem. It is the broadest category of review that allows for the inclusion of diverse methodologies (Whittemore & Knafl, 2005:547). It sifts and sorts research studies and the data until the highest quality of evidence is used to arrive at the conclusions. It can include both quantitative and qualitative research and critically appraises literature but without a statistical analysis (LoBiondo-Wood & Haber, 2010:212). Polit and Beck (2012:31) propound that integrative reviews of qualitative studies often take the form of meta-syntheses, which are rich resources for Evidence-Based Practice (Beck, 2009, in Polit & Beck, 2012:30). They describe a meta-synthesis as involving integrating qualitative research findings on a specific topic.

In this research study, the evidence-based approach (Polit & Beck, 2012) to the integrative review process was followed; it comprised five steps (1) The review

question; (2) Search for evidence; (3) Critical appraisal; (4) Data extraction; (5) Data analysis and synthesis. The steps in the evidence-based approach will be discussed.

In Step 1 the research problem was identified by means of a review question following the acronym PICO.

- **P** – (Population or participants) = Health care professionals including nurses
- **I** – (Intervention) = Healthy work environment
- **C** – (Context) = Comprehensive military health care settings (hospitals and clinics)
- **O** – (Outcome) = Enhanced work environment for health care professionals (nurses).

The review question which was formulated to search for the relevant literature was as follows:

What existing evidence-based best practice guidelines are available for a healthy work environment for health care professionals? The question was extended to include all health care professionals because of scarcity of healthy work environment best practice guidelines from different organisations.

In Step 2 the search for the best practice guidelines was as follows:

- Electronic databases were searched to identify and become familiar with relevant keywords contained in the titles, abstracts and subject descriptors.
- All databases, including electronic, hand-searched journals and books were searched using the identified key words.
- Reference lists and bibliographies of all papers were searched for additional studies.
- Various books and articles on healthy work environments for healthcare professionals' evidence-based practice were consulted. A wide variety of electronic data bases, including MEDLINE (via PubMed), Google Scholar, and CINAHL via EBSCO host, were searched.

In Step 3, the best practice guidelines were critically appraised to determine their merit and readiness for use in practice. In order to select a suitable guideline, the Appraisal of Guidelines for Research and Evaluation 11 (AGREE II) instrument was used. AGREE II instrument is designed to assess guidelines developed by local, regional, national or international groups or affiliated governmental organisations (Brouwers, 2009) cited in Polit and Beck (2012:42). This instrument assesses the methodological rigour and transparency with which a guideline is developed. It assesses: the scope and purpose of the guideline, stakeholder involvement, rigour of the guideline development, clarity and presentation of the guideline, and editorial independence of the developers (LoBiondo-Wood & Haber, 2010:214).

The AGREE II consists of 23 key items organised within six domains followed by two global rating items ("Overall Assessment"). Each domain captures a unique dimension of guideline quality. The domains will be highlighted.

Domain 1: Scope and Purpose – is concerned with the overall aim of the guideline, the specific health questions, and the target population (items 1–3).

Domain 2: Stakeholder Involvement – focuses on the extent to which the guideline was developed by the appropriate stakeholders and represents the views of its intended users (items 4–6).

Domain 3: Rigour of Development – relates to the process used to gather and synthesise the evidence, the methods to formulate the recommendations, and to update them (items 7–14).

Domain 4: Clarity of Presentation – deals with the language, structure, and format of the guideline (items 15–17).

Domain 5: Applicability – pertains to the likely barriers and facilitators to implementation, strategies to improve uptake, and resource implications of applying the guideline (items 18–21).

Domain 6: Editorial Independence – is concerned with the formulation of recommendations not being unduly biased with competing interests (items 22–23).

Overall assessment – includes the rating of the overall quality of the guideline and whether the guideline would be recommended for use in practice. An independent guideline reviewer, together with the researcher, critically appraised the identified guidelines, and had consensus discussions to ensure trustworthiness.

In Step 4, data was extracted from the best practice guidelines and is the next step after critical appraisal. The data extraction particularly focused on the objective of the guideline, the target population of the guideline, the guideline development group, systematic methods that were used to search for evidence, the criteria for selecting evidence and the methods for formulating the recommendations.

In Step 5, the data extracted from the guidelines was synthesised and categorized into themes as recommendations that addressed healthy work environments for nurses or health care professionals. The main findings of each guideline were summarised in a table format, stating the name of the guidelines, author's publication details, and the main recommendations. The process of guidelines search, appraisal, data extraction and data synthesis concluded Phase 2 of the data collection process.

The results of the integrative literature review formed the basis for Phase 3 in the research process.

2.4.2.3 Phase 3

When Phases 1 and 2 of the research process had been completed, the data from Phases 1 and 2 were synthesised to develop an evidence-based best practice guideline for a healthy work environment for professional nurses working in the SAMHS. An eight–step approach recommended by the National Institute for Health and Clinical Excellence (NICE) Clinical Guidelines Advisory Committee (http://www.nice.org.uk) was applied to develop the best practice guideline in this research study. The eight steps to guideline development were the following:

1. Identify the aims/purpose of the guideline

The aims and/or purpose and components of the guidelines should be defined. The purpose of the guideline formulated in this research study was:

- to provide recommendations to facilitate a healthy work environment for professional nurses working in the SAMHS, based on the best available evidence.

2. Choice of guideline development method

Numerous methods for guideline development exist, but for this research study a combination of two methods was found to be appropriate for a healthy work environment for nurses. These were:

- evidence-linked guideline development;
- formal consensus approaches.

In this research study, it was decided to combine the evidence-linked method with the formal consensus method. Five expert reviewers reviewed the draft guideline.

3. Literature review

It is recommended that the literature required for the review question to be answered be searched for, critically appraised, data extracted, analysed and synthesised before the guideline is developed. A narrative literature review regarding the topic was initially undertaken, thereafter an integrative literature review was conducted on existing best practice guidelines for healthy work environments for nurses. The literature was appraised, data extracted, analysed and synthesised to form recommendations for the development of the guideline.

4. Search for other clinical guidelines

For the scope of this study, best practice guidelines were searched for using an integrative review approach. A search to identify existing guidelines on a healthy work environment for nurses was conducted. The guidelines were then critically appraised, using the AGREE II tool.

5. Formulate draft guideline

A draft guideline for a healthy work environment for nurses was formulated by integrating the qualitative findings emanating from semi-structured interviews

conducted with professional nurses working in the SAMHS, in Phase 1 of the study with the findings of the integrative literature conducted in Phase 2. The elements of the AGREE II appraisal tool were utilised to develop the guideline.

6. Expert selection

To ensure validity of the best practice guideline in this study, six senior professional nurses, five of whom are holding PhD qualifications and the other a PhD candidate, were selected. The members were from appropriate disciplines in the Nursing Science Department at Nelson Mandela University and Military Nursing Department of the South African Military Service.

7. Review of guideline by experts

The draft evidence-based best practice guideline was sent to the experts to review, comment or make recommendations. The researcher included a reviewer assessment sheet to review the guideline based on the AGREE II tool. The assessment sheet outlined the important components to be included in a guideline.

8. Final revised evidence informed best practice guideline

The draft evidence-based best practice guideline was revised and adjusted incorporating the comments received from the expert reviewers.

Phase 3 and the development of a draft guideline and the final best practice guideline for a healthy work environment for nurses will be discussed in Chapter Five.

2.5 MEASURES TO ENSURE TRUSTWORTHINESS AND AUTHENTICITY OF THE STUDY

According to Lincoln and Guba (1985) as cited in Babbie and Mouton (2011:276), the key criterion or principle of good qualitative research is found in the notion of trustworthiness, which is neutrality of its findings or decisions. Trustworthiness, according to Babbie and Mouton (2011:276), is about the researcher persuading his or her audience that the findings of a research study are worth paying attention to. There are four notions that operationalize the concept of trustworthiness in a

qualitative research: credibility, transferability, dependability, and confirmability (Babbie & Mouton, 2011:276-278).

2.5.1 Credibility

Credibility is viewed by Lincoln and Guba (1985) in Polit and Beck (2012:584) as an overriding goal of qualitative research. Credibility refers to confidence in the truth of the data and interpretations of them. Researchers must strive to establish confidence in the truth of the findings for the particular participants and contexts in the research (Polit & Beck, 2012:585). Lincoln and Guba (1985) according to Polit and Beck (2008:585) pointed out that credibility involves two aspects: first, carrying out the study that enhances the believability of the findings, and second, taking steps to demonstrate credibility to external readers. Sufficient evidence is necessary to determine credibility for the themes identified in the inquiry. In this study credibility was achieved through the following: prolonged engagement, which is, staying in the field until data saturation occurs (Babbie & Mouton, 2011:277), reflexivity which is the process of reflecting critically on the self and of analysing and making note of personal values that could affect data collection and interpretation (Polit & Beck, 2012:179), member checking, peer examination, interview technique using a schedule enhanced credibility, as all participants were exposed to the same questions, establishing authority of the researcher, structural coherence and referential adequacy or dense description of the research design and method. Data analysis was done with the aid of a professional transcriptionist and an independent coder. Themes were discussed and confirmed in a consensus discussion.

2.5.2 Transferability

Transferability refers to the degree to which the findings can be applied to other contexts, settings or with other groups; it is the ability to generalize from the findings to larger populations. Polit and Beck (2012: 539) allude to this fact when they talk about the potential for extrapolation, that is, the extent to which findings can be transferred to or have applicability in other settings or groups. The strategy that was utilized in this study was transferability and this was achieved by the following: nominated sample being a non-probability sampling used in purposive sampling where

supervisors were used to help identify informants representative of the phenomenon under study, for example, one or two long time members of the management cadre in all settings to identify persons who are typical of the membership, a purposive sample, and the dense description of methodology, meaning a complete description of the exact methods of data gathering, analysis and interpretation in qualitative research (Babbie & Mouton, 2011:277).

Lincoln and Guba (1985), cited in Polit and Beck (2012:585), assert that the investigator's responsibility is to provide sufficient descriptive data so that consumers can evaluate the applicability of the data to other contexts. About a purposive sampling, Lincoln and Guba further say that, in contrast to random sampling, qualitative research seeks to maximize the range of specific information that can be obtained from and about that context, by purposely selecting locations and informants that differ from one another (Babbie & Mouton, 2011:277).

2.5.3 Dependability

Dependability, according to Lincoln and Guba (1985), cited in Polit and Beck (2012: 585), refers to the stability (reliability) of data over time and conditions. It considers the consistency of the data as to whether the findings would be consistent. According to Babbie and Mouton (2011:278), an inquiry must provide its audience that if it were to be repeated with the same or similar respondents in the same context, its findings would be similar. In this study dependability was achieved through the following: dependability/inquiry audit, dense description of methodology, peer examination, code re-code procedure between researcher and independent coder.

Guba used the term auditable to describe the situation in which another researcher can clearly follow the decision trail by the investigator in the study. Lincoln and Guba, cited in Babbie and Mouton (2011:278), suggest that a single audit of the research can enhance both dependability and confirmability of the project.

2.5.4 Confirmability

Confirmability refers to the objectivity or neutrality of the data, that is, the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning (Polit & Beck, 2012:585). It talks to the degree to which the findings are a function solely of the informants or participants and conditions of the research and not of other biases, motivations and perspectives.

Lincoln and Guba in Babbie and Mouton (2011:278) referred to the confirmability audit trail; that is, an adequate trail should be left to enable the auditor to determine if conclusions, interpretations and recommendations can be traced back to their sources and if they are supported by the inquiry. They viewed neutrality not as researcher objectivity but as data and interpretational conformability and described the audit strategy as the major technique for establishing conformability. It is dependent on participants and experts agreeing with the researcher's interpretation and refers to the degree of agreement between two or more people about accuracy, meaning and relevance of data. In this study, neutrality was determined by the audit trail which was operationalized by validity checks, note taking, verbatim transcription and member checking.

2.6 ETHICAL CONSIDERATIONS

After permission to do research in the SAMHS was granted by the Department of Defence, and the proposal approved by the Nelson Mandela University Ethics Committee and the research committees, professional nurses were invited in writing through their immediate supervisors to participate in the study. Those willing to participate were issued with informed consent forms so that they could give informed consent to willingly participate in the research study.

When humans are used as study participants, as they usually are in nursing research, care must be exercised in ensuring that the rights of those humans are protected (Polit & Beck, 2008:167). Researchers face ethical situations in almost every step of the research process, from selecting participants to reporting findings at the conclusion of the study (Houser, 2008:53). Ethical considerations that will be discussed below are

therefore imperative to protect the rights of participants and to ensure that researchers minimize harm and maximize benefits.

2.6.1 Harm to respondents

Researchers have an obligation to avoid, prevent, or minimize harm in studies with humans. Participants must not be subjected to unnecessary risks of harm or discomfort, and their participation in research must be essential to achieving scientifically and societally important aims that could not otherwise be realized (Polit & Beck, 2012:152-153).

The researcher, who herself is a nurse, ensured that no form of physical or emotional discomfort befell the research participant during the interview. The participants were thoroughly informed beforehand of the potential impact of the investigation, so that they could withdraw from participating if they so wished. The researcher tried to identify vulnerable participants before so that they could be eliminated (Polit & Beck, 2008:170). Participants were informed that, should they need counselling due to painful memories evoked during the research process, a counsellor would be provided. The researcher would have made arrangements with a counsellor in the employ of the SAMHS to be available if it should have been prove necessary.

2.6.2 Informed consent

One particularly important procedure for safeguarding participants and protecting their right to self-determination involves obtaining their informed consent. Informed consent means that participants have adequate information about the research, are able to comprehend that information, and have the ability to consent to decline participation voluntarily (Polit & Beck, 2012:157).

The researcher gave appropriate adequate information to potential participants on the interview schedule on the goal of the investigation, the procedures which would be followed during the investigation, the possible advantages and disadvantages, including dangers to which they might be exposed to, if any, so that they (participants) would be fully informed about the investigation so as to make a voluntary, well thought

out decision about the participation in the project. Participants were given enough time to ask questions about the research project and it was explained to them that they should not base their decision on fear of the rank of the researcher as she was the Principal of a Military Nursing College. The participants were further expected to sign the consent form, giving the researcher permission to interview them and stating that they were willingly participating in the research study. It was assumed that consent was given once a nurse working in one of the settings participated in the answering of questions in the interview schedule.

2.6.3 No deception of respondents

Deception involves deliberately withholding information about the study or providing participants with false information (Polit & Beck, 2012:154). Full disclosure, or reporting as much information as is known at the time, is crucial so that the participant may make an informed decision whether or not to participate. The subject needs to know if the procedure used in the study is not necessary for their care and that it may have outcomes that are questionable or not completely understood (Houser, 2008:63). Babbie and Mouton (2011:530) state that researchers shall never deceive research participants with regard to significant aspects that could affect their willingness to participate, such as physical risks, discomfort, or unpleasant emotional experiences

The researcher ensured that no deception of the participants took place. To ensure this, an attempt was made not to disguise the real goal of the study, to hide the real function of the actions of the participants or to hide the experiences that participants would go through by participating in the study. Every aspect was explained honestly in writing to the participants except for those incidents that the researcher was not aware of (Babbie & Mouton, 2011:530).

2.6.4 No violation of privacy

Most research with humans involves intruding into personal lives. Researchers should ensure that their research is not more intrusive than it needs to be and that participants' privacy is maintained continuously (Polit & Beck, 2012:156). In this study, a sensitive issue, namely how professional nurses experience working in the SAMHS, was

addressed. It was the responsibility of the researcher to ensure that no violation of the privacy of the participant took place. Confidentiality was adhered to at all times. Information pertaining to the study was given anonymously. No information pertaining to the identity of participants was requested. The researcher ensured that there was no link with the data obtained and any particular participant.

2.6.5 Actions and competence of the researcher

The researcher is competent in conducting interviews. She was the Principal of a military nursing college for 5 years and in senior nursing management in health care clinics and a military hospital for 14 years, where she constantly interviewed members of staff and students as part of her functions. She was aware of ethical considerations in research, as she had conducted other studies before. She ensured that she did not carry her values and biases over to the study.

2.6.6 Plagiarism

Plagiarism is a form of misconduct which involves the appropriation of someone's ideas, results, or words without giving due credit, including information obtained through confidential review of research proposals or manuscripts (Polit & Beck, 2012:169). The researcher acted with integrity and ensured that all information used, for which she is not the originator, was referenced correctly. A plagiarism check mechanism was utilized.

2.7 SUMMARY OF THE CHAPTER

In this chapter the purpose of the study, as well as the research design and methods, were discussed. A description of the research strategy, the data-collection process and the sampling method, data analysis and ethical considerations, as well as trustworthiness, were dealt with in greater detail. Chapter Three will discuss the qualitative results of Phase 1.

CHAPTER THREE

DISCUSSION OF QUALITATIVE FINDINGS (PHASE ONE)

3.1 INTRODUCTION

In this chapter, themes and sub-themes that emerged from the analysis of data that was collected by means of semi-structured interviews are discussed. These themes emerged from responses given by participants to a number of questions that were asked from them in relation to their experiences in working as professional nurses at the South African Military Health Service (SAMHS). The results of reflective and field notes made by the researcher during the interviews were added to the data collected by means of audio recording using audio memos.

3.2 DISCUSSION OF RESULTS

In this section the researcher will present every theme and sub-theme that emerged from the data collected from professional nurses working in the SAMHS as depicted in Table 3.1, and these will be supported by the appropriate verbatim quotations from the transcribed data and compared with the literature reviewed. Three (3) themes and thirteen sub-themes relating to how professional nurses experienced working in the SAMHS were identified subsequent to analysis of data and these are depicted in table 3.1.

Table 3.1: Themes and sub-themes

THEMES	SUB-THEMES
1. Professional Nurses highlight various challenges associated with the culture and traditions of the military	1.1. Newly appointed professional nurses experience problems of adjusting to military culture due to inadequate induction
	1.2. The military rank structure interferes with the autonomy of the professional nurse
	1.3. Professional nurses experience conflict between their dual roles as soldier and professional nurse
	1.4. Lack of professionals' development and delays in promotions lead to problems of command and control for professional nurses
2. Professional nurses identified factors contributing towards a healthy work environment	2.1 Nurses experience a range of emotions, both positive and negative, in adjusting to the SAMHS that suggest the importance of ensuring a healthy work environment
	2.2 Effective communication and support within the multi-disciplinary team and management contribute to a healthy work environment
	2.3 Adequate resources are necessary in creating a healthy work environment
	2.4 Professional development opportunities lead to competent and confident professional nurses, increasing team cohesion
3. Professional nurses make recommendations for Best practice Guidelines within the military setting	**3.1. Multidisciplinary Team:** Professional nurses have communicated the need for clear expectations and role clarification for all role players within the multi-disciplinary team
	3.2. Patient and families support: Best practice guidelines need to clearly define the patient care approach: The need to treat clients with best-care practices that support respect and dignity of PATIENTS and their families and management diseases
	3.3. Management and structure: BPGs should serve to give guidance for team support by management so that professional nurses are provided with a sense of competence and confidence in practice

3.2.1 Theme 1: professional nurses highlight various challenges associated with the culture and traditions of the military

Figure 3.1: A diagrammatic presentation of Theme 1 and its 4 sub-themes

What emerged from the interviews of this study was that professional nurses in the military hospitals and clinics experienced various challenges associated with adjusting to the culture and traditions of the military. Encapsulated within their challenges are the following four sub-themes:

1. Newly appointed professional nurses experience problems of adjusting to military culture due to inadequate induction.
2. The military rank structure interferes with the autonomy of the professional nurse.
3. Professional nurses experience conflict between their dual roles as soldier and nurse.

4. Lack of professionals' development and delays in promotion lead to problems of command and control for professional nurses.

Overall in theme one, professional nurses working in the SAMHS, both those who trained within the military and those who joined the military already trained as professional nurses, expressed experiencing challenges associated with the culture and traditions of the military. All militaries, including the South African National Defence Force (SANDF), are large organizations with established history, with own cultures, language and ways of conducting business. Developing culture and traditions is one of the pragmatic ways of breeding ethics and moral standards in the military. These moral issues are profoundly linked to the military's way of life and ethos, which include discipline and esprit de corps. Discipline provides a platform for practising ethical values and follows accepted norms and moral standards. The creation and pursuit of culture establish common values and a sense of ownership amongst the troops (Mahalingam, 2013:2).

For mutual understanding and appreciation of theme one, military culture and traditions will first be defined and briefly discussed.

The South African Military Dictionary cited in Vrey, Esterhuyse and Mandrup, (2013:232), describes culture as "the accumulated total of a social group's knowledge, skills, beliefs, traditions and artefacts, usually related to a period in time." Vrey et al (2013:232) note that these patterns of culture are learned and not transmitted genetically. They highlight that this definition provides some insight into the ingredients of culture; on the one hand, from artefacts and concepts rooted in belief or value systems and the general meaning of life; on the other hand, to behaviours as the outcomes of these beliefs, values and opinions about life. Further implied in this definition of culture is the notion that culture can be acquired or developed. From an institutional perspective, culture underpins the degree of cohesiveness and predictability that characterises all social institutions (Vrey et al., 2013:232).

Van der Waag (2013:12) best describes military culture as the sum of the intellectual, professional, and traditional values of an officer corps. According to Van der Waag, military culture plays a central role in how that officer corps assesses the external

environment and how it analyses the possible response that it might make to the threat. Military culture therefore is a crucial indicator of how armed forces think, how they prepare for war, and how those wars are fought. Murray (1999) in van der Waag (2013:12), adds that military culture is representing the ethos and professional attributes, both in terms of experience and intellectual study that contribute to a common core understanding of the nature of war within military organizations. The underlying purpose of evolving a certain culture in the military units is to build character in the troops so as to be able to achieve combat effectiveness. It binds soldiers, their leadership and provides a sense of purpose and worth. In order for such bonding to be effective, it must evolve based on shared ethical values (van der Waag, 2013:12).

Fundamentally, military culture is an amalgamation of values, customs, traditions and their philosophical underpinnings that, over time, has created a shared institutional ethos. From military culture springs a common framework for those in uniform and common expectations regarding standards of behaviour, discipline, teamwork, loyalty, selfless duty, and the customs that support those elements (Centre for Strategic and International Studies, 2000:xviii in Vrey et al., 2013:234).

Military customs, culture and traditions are, therefore, practices and methods of functioning or doing things that have been developed and refined over a period of time and are followed in a military unit. These methods need to be congruent with the philosophy and belief of the specific group of troops. They are experiences which have been practised and gone through under trying conditions, and have been found useful. Military culture is unique and none of the military practices are found in the civilian institutions (Mahalingam, 2013:97).

On the uniqueness of the military culture, a retired General of the SANDF, in a conversation with the researcher, stated that “military culture is anchored on discipline, which is the backbone of the military.” In comparing the military and the civilian organizations he emphasized that in the military there is one commander who issues and enforces orders and the disciplined soldiers observe, execute and own the instruction, contrary to the civilians where there are intellectual debates and negotiations. The General said that in the military, consultations are done at the planning level, but once an instruction has been issued, it means a decision has been

taken then the decision is enforced. Commanders must internalise, believe in and own the order so that they are able to instruct the junior ranks. Questions from lower ranks are only for clarity not to negotiate orders; orders are enforced to strengthen discipline. To the General, this, in short, made the military culture unique. It is based on a war situation where there is a danger of loss of life and therefore there must be strict discipline.

Hudson-Burns (2015:1) alludes to the fact that the military structure functions differently from that of civilian employers and this can cause miscommunication for both parties. She asserts that the military has a hierarchical structure and has exact rules of conduct, defined roles, rank and status. Across units of the military there is consistency in doing things as opposed to civilian organizations. The military members share a bond in beliefs, traditions, and values and the importance of structure (Hudson- Burns, 2015:1).

During the interviews it became evident that although all the professional nurses experienced challenges, those who trained within the military, however, experienced different challenges to those experienced by nurses who joined the SAMHS already trained. These differences one could attribute to the uniqueness of the military culture articulated above, whose assimilation is linked to the length of stay, work and experience in the military. For civilians with little or no personal exposure to the military culture, the military might seem overwhelming and incomprehensible. This assertion is captured in the quote by a professional nurse, trained within the military, empathising with nurses who came from outside the military. One of the professional nurses said:

> *"functionally I believe it's basically the same but military wise remember civilians they have civilian culture and tradition but we in the military we have our own tradition and culture; there are rules that we follow that are different to civilians so the attitude between the two, to me it's I can see that there is a difference between the two, between a person that who trained outside and a person who grew up in the military, did all the military courses and all that, that's when now in the discipline and attitude, you can see the difference "Sounding concerned. (Int 03)*

Few outside the military understand the culture, the values, or the people who make up the military. It is necessary, therefore, that those who come to serve in the military for the first time are assisted to have a general understanding of the institution in order

for them to be able to work efficiently with the armed forces. This unique culture is inculcated through induction, training and practice, over a period of time. The Longman Dictionary defines induction as an initiation or preparatory training before embarking on a longer programme and lastly, a formal introduction for new employees (Longman Dictionary, 1984:805). Induction, in a military sense, is used to introduce new recruits to the military environment and this precedes the basic military training which lasts longer than the induction training. It enables the new recruits to adjust to the military culture. Adjusting means to adapt or conform oneself to new circumstances. The military traditions, over a period of time, enable soldiers of all formations to see logic of doing the right things on their own without being watched or through the threat of punishment. Discipline and obeying orders become a way of life in a military unit (SAMHSA, 2010:10)

3.2.1.1 Sub-theme 1.1: Newly appointed professional nurses experience problems of adjusting to military culture due to inadequate induction training

What emerged out of the interviews was that the newly employed professional nurses, from outside the military, struggled to adapt to the military environment because of the inadequate military induction training they received on joining the defence force. It was evident that they were overwhelmed by the many challenges they encountered and seemed as if they underestimated or hardly expected challenges that could be posed by their new environment.

In the SAMHS, all newly employed members from outside the defence force undergo two weeks' induction training. This initial training is meant to prepare them for military practices expected of officers in uniform; for example, how to wear the uniform properly, and different types of military ranks, drilling and salutation. The newly employed nurses expressed dissatisfaction with the short period given to the induction training they received when they joined the SAMHS. They found two weeks' induction training not to be enough to enable them to assimilate the military culture yet they were expected to wear uniform and be able to do things soldiers in uniform do. They attributed their lack of knowledge of the military practices to inadequate induction training. This feeling of inadequate induction was expressed by professional nurses

from outside the military and by the newly qualified military professional nurses. They verbalized, for example, their embarrassment and frustration caused by their inability to salute in front of juniors. One professional nurse's frustrations are captured in the following quote:

> *"When I got here, I did not know about the military, I was just a professional nurse, but I was only trained for two weeks, induction. I was taught to drill and how to salute but I was not competent. I did not know who to salute and who should salute me.....it was a bit frustrating, some of my seniors would reprimand me for not saluting....juniors would laugh at me...., the clinical part of it.....is exactly the same.....the different part is the way they run their things.....the regulations.....discipline, uniforms and the rules.....the way they do things.....you are not supposed to do stuff.....you know how military things are. They are completely different and even when you do orderings." (Int 06)*

The Substance Abuse and Mental Health Administration, SAMHSA white paper (2010:10) states that the military culture is ingrained in military personnel from the start of their careers, and that everyone begins life in the military, whether active or reserve component, with some type of initial training. Regardless of how someone enters the service, service members spend their time at initial training immersed in the military lifestyle and culture. They learn about the history of their service, military customs and courtesies, proper wear of the uniform, military bearing, military values and ethics, and other information that is critical to their success in the service, including how to listen to and follow orders and how to function within the military chain of command. Initial training teaches discipline, focus, and control (SAMHSA, 2010:10).

The military professional nurses claimed to have observed how their colleagues from outside struggled to adjust to the military culture although functionally they were doing well. One professional nurse confirmed this observation when she said:

> *"Yes people from outside struggle to adjust militarily and that must be attended to so that these people are helped to adjust fast."(Int 04)*

Vrey et al., (2013:234), contend that, learning how things are done in a military organisation involves the inculcation of individual military members into a very particular military culture. The military is in many ways a total institution, and military culture is similarly a total concept. Military culture should thus be understood as involving both input and output. This basically means that the members of the military

have to be encultured in a particular way so that they portray a behaviour that underpins a unique organisational culture. The culture of a particular military is therefore rooted in the ideas and behaviour of its people.

A newly qualified professional nurse who trained in the military also complained about not being shown how to do things in the ward and verbalised the need for in-service training, an indictment of inadequate orientation. The professional nurse said:

> *"When I came here, they threw me at the deep end. For instance, with fire-drill stuff we never check the cylinders because we were never shown how to do it. During training, they do not concentrate on procedures like wound care because it's ENs (Enrolled nurses) work, in-service training on those things should be done because of shortage of staff we have to do ENs work." (Int 07)*

Mabaso (2012:41), when addressing reasons for the lack of effective induction programme, states that employees who are transferred or promoted within the organization are not subjected to induction programmes. Both statements are an indictment to induction for newly employed professional nurses at SAMHS and confirm Mabaso's finding. According to Uma (2013:137), training is given on four basic grounds: Firstly, to familiarize new candidates who join an organization with the organizational mission, vision, rules and regulations and the working conditions. Training is also given to the existing employees to refresh and enhance their knowledge. If any updating and amendments take place in technology, training is given to help employees cope with changes and lastly, when an employee is promoted or transferred training is given to prepare the employee for the new position or work place.

The study conducted in India on effective induction of employees and satisfaction (Nandi, 2015:39), revealed that the various induction activities conducted by the organizations have a positive effect on the employee's performance and satisfaction. In this study it was confirmed that there was a strong relationship between the effectiveness of an induction programme and the employee performance and satisfaction. Therefore, it is important for every organization to have an effective induction programme for the new employees as it greatly affects their performance and satisfaction, and in turn the overall performance of the organization as a whole.

Despite the fact that the induction period was perceived to be short and not comprehensive enough to prepare the nurses from outside adequately, these nurses stayed long without further military training and this protracted and exacerbated their frustration. A professional nurse who worked at one of the military hospitals lamented that:

> *"I have worked for seven years but I have not gone for military training."(Int 09)*

> *"I am one of those officers who are failing to discipline juniors because I am not sure if I am right and whether I would get support because I don't have the knowledge."(Int 11)*

The uniqueness of military culture warrants that all individuals who join the military are trained immediately after putting on uniform to enable them to operate effectively and efficiently within the institution. One of the professional nurses said:

> *"I feel that when they recruit people from outside, they should start by giving them basic training so that they know what is expected of them. For example you juniors you don't know how to discipline them, even their language..."(Int 07)*

Inadequate training makes people incompetent and incompetence impacts negatively on individual confidence and the image of an institution. Research has proven that staff retention is improved when workers undergo appropriate induction training on beginning a new job. Therefore, all organisations (from the multinational to the local convenience shop) should have well structured and thought out induction programmes in place (Byrne, 2010:28). It also indicates that a poor induction has a significant negative impact upon new employees' perceptions of their skills and ability to meet expectations, how they feel about their job and their relationship with their fellow workers and employer. Poor induction practices can see an employee taking longer to settle and adjust to the organisation's way of life. Far more problematic than that, it can see them make unnecessary errors, under perform and become stressed as they are unclear as to what they should be achieving. This leads to unhappiness, low levels of job satisfaction and an increase in the amount of time management now spent on handling poor performance issues. Unsurprisingly a high percentage of those not effectively inducted into their new role and organisation leave within the first six months. To achieve effectiveness the induction needs to be comprehensive, systematic, relevant and clear. Failure to induct a new recruit effectively and the cost

of *not* training will become considerably higher than the cost of training (Byrne, 2010:28-42).

3.2.1.2 Sub-theme 1.2: The military rank structure interferes with the autonomy of the professional nurse

The participants agreed on how the rank structure in the military interfered with how they performed their nursing duties. They claimed that professional nurses were disadvantaged and disempowered by the lower military rank of a captain they possessed, because ranks are linked to authority and status in the military. The higher the rank, the more the respect and authority one commands. It is these power imbalances that cause some senior officers to interfere with how professional nurses do their work. They articulated how their right to practise nursing freely according to their scope of practice was interfered with by soldiers with higher ranks, using their authority and status to instruct them as to what to do. Some professional nurses had this to say:

> *"Sometimes in the military people who are senior will come and tell you what to do in your area of work though they do not know your area of work..."(Int 01)*

> *"The rank structure hinders when your superiors come to the sickbay and tell you what to do and expect you not to talk back."(Int 02)*

> *"Decisions a lower rank makes are ignored, and that is a problem in the clinics; the professional opinion is not considered if it is from a lower rank."(Int 04)*

The chain of command in the military is based on the rank of the individual and the authority to issue orders revolves around the rank structure. Orders are issued from top of the chain of command to the lowest ranking members and according to the military culture, lower ranks comply and complain later. Once an order is issued the decision is considered to be final (SAMHSA, 2010:8).

The rank structure in the military is seen to enforce discipline and limits confusion when orders have to be issued. Each military unit from the largest to the smallest has a very clear chain of command based solely on the rank of the individual. There is one assigned officer in charge, the commander and or a non-commissioned officer at each level who bears all responsibility of the unit. Ranks change when an individual

gets promoted up the chain of command after he or she has met certain benchmarks, including time in service, time at current rank, and military education requirements. With each promotion through the ranks comes additional responsibilities and greater pay. Additional responsibilities include oversight of a greater number of lower ranking service members and more equipment. As an individual is promoted through the military ranks, he or she assumes additional responsibility for more personnel, equipment, resources and missions (SAMHSA, 2010:8).

The researcher based on her experience in the military and the civilian world, made an observation that the military rank is afforded a superior status to that of an academic qualification in the military. As a consequence to this attitude, the professionals are not allowed the autonomy to practise. All these practices are unheard of in the civilian world, hence newly employed members from outside the military experience difficulty in adjusting to the military culture.

The legitimacy of the chain of command is one of the most important characteristics of the military culture. Maintaining the integrity of the chain of command is critical to the effective functioning and mission success of a military unit. It is also designed to identify clear lines of authority and responsibility and to eliminate any confusion in the decision-making process. Living and working within constraints of the unit chain of command dictate how an individual functions within the organization, as well as how the unit functions as a whole (SAMHSA, 2010:9). When the professional nurses were asked whether there were any military practices that impacted negatively on their work, some professional nurses had this to say:

> *"Yes, sometimes I would be told that senior ranks had to be seen before junior ranks and wives of Generals would demand to be seen before junior ranks, although they found other patients already there." (Int 06)*

> *"In the military people who are senior will come and tell you what to do in your area of work though they do not know your work."(Int 01)*

The military rank structure is consistent through all services of the national defence force, the army, air force, navy and the military health service. This means, therefore, that a senior officer in one service is recognized as such in all services; hence senior officers demand the respect attached to their ranks wherever they go within the

military. It is the practices linked to the rank structure that professional nurses in general find to be interfering with the autonomy of their nursing practice. While it is expected of professional nurses to be independent practitioners who take decisions about the care of their patients, the military puts a rank before the profession. The professional nurses themselves have an understanding that they are a "soldier first," then a nurse. The rank imposition over the nursing qualification seems not to optimise the practice of nursing by nurses. The professional nurses had this to say:

> *"I think the rank thing affects a lot of how nurses do their work...because as a professional nurse you are supposed to be in charge of what you are doing...like if you are working in the ward, it is your ward and anyone who comes to your ward is a visitor but here because of ranks, a captain becomes a junior so you are instructed by someone from outside who is not even in charge of what you doing." (Int 06)*

> *"It's this whole military, like I said before, the rank structure where people then use their ranks when they come in to the sickbay it can make you really to maybe really hate your job because you feel you know they will just come tell you what to do, to say whatever they want to say and you can't talk back or you can't say something where like in our sickbay we do have the rights of nurses, so nurses also have rights, we have the rights of the patient and we have the rights of the nurses, so I feel that if the rights of the nurses is there to protect the nurse, that she can work and do her job properly, without them hindering us like I said." (Int 02)*

> *"you hear that Colonel so and so cancelled your order; you find that the Colonel does not even understand why you want and what you are doing with this; it affects how the nurse performs and even standards; if you are affected psychologically you can't be productive or do the work the way you want."(Int 06)*

They felt so strongly against the rank interference so much that they verbalised that they were affected psychologically and could not be productive. This one nurse complained that:

> *"It affects how nurses perform and even standards...If you are affected psychologically you can't be productive or the work the way you want to do it and the other thing because you are a soldier now under the army it is like they possess you." (Int 02)*

> *"The other thing in the military environment we experience a lot where people with a higher rank really bully you if you have a lower rank than them; if one is a colonel and you are Lieutenant or Captain they can be so rude and want to bully you; they must be told that when they put their foot in the sickbay they must forget about the rank, they are a patient. In that regard in the military environment we experience problems."(Int 06)*

While professional nurses are expected to exercise a certain degree of autonomy with regard to how they practise their nursing care, the military rank stifles this independence. Lewis and Sole (2006:1) define autonomy in nursing as 'the freedom to make discretionary and binding decisions consistent with one's scope of practice'. The 'discretionary and binding decisions' mean that the nurse has control over the knowledge needed to make the decision. The nurse does not need to turn to others in order to know or understand. Instead, training and education of the nurse has provided him or her with the requisite information and understanding to make the decision (Lewis & Soule, 2006:1).

Discretionary and binding decisions mean, therefore, that no one above the nurse needs to give approval or permission for the nurse to take action on an assessment or observation (Lewis & Soule, 2006:1). Postulating on the assertions by Lewis and Soule (2006:1) one could conclude that the military rank imposition seems to be in contravention of the autonomy nurses gained through their education and training and could cause conflict and miscommunication between parties concerned. This is demonstrated in the following quote from a professional nurse working at the clinic:

> *"We had a few problems like we had problems with the nursing college; actually where the students come to sick report; most of us know that most of the students act because they don't want to work; where you as a professional nurse now you see those students, you consult the student, you write medication for the student, you treat the student and you feel that it is not necessary to book the student off but then the student goes to the nursing college and where Colonel, then takes the student's, she really made the students to disregard us because she felt that the student needs to be booked off while we can see the student don't need to be booked off;. It happened twice that the Col interfered, but I think she now understands students because she was new and you know the students; students are manipulative and things like that." (Int 03)*

Nurses interpreted the demand by senior officers to be accorded first preference and sometimes overrule their decisions, as interference. They complained that the military rank structure showed no respect for the nursing profession and therefore felt that their contribution was not recognized nor was it appreciated. These nurses felt disempowered by their junior ranks and subsequently unable to practise nursing fairly and freely. One professional who seemed to be very frustrated with how the use of rank interfered with the professional nurses' autonomy in nurse practice, suggested

that it would be much better if they practised in civilian uniform as nobody would know what rank they were. The professional nurse had this to say:

> *"They must look at that nurses who are consulting are out of uniform because the rank structure interferes with the nurses' work..." Sounding frustrated (Int 05)*

In her study, Lyons (2002) pointed out that, when compared to civilian nurses, military nurses have perceived themselves as having little autonomy, yet when deployed, military nurses must function with greater autonomy than most of their civilian counterparts. Military nurses have limited opportunity for involvement in decision-making and innovation with regard to patient care decisions. The hierarchical nature of the military rank structure tends toward the rigid and therefore, may stifle autonomy. Staff nurses initially entering the military attain the lowest officer rank and thus have restricted decision-making authority and limited autonomy (Lyons, 2002:6). This source was used because of its significance and that there was limited literature on military nursing.

3.2.1.3 Sub-theme 1.3: Professional nurses experience conflict between their dual roles as soldier and nurse

Professional nurses in the military, those who trained in the military and those who joined the military already trained were unanimous in expressing the conflict they experienced due to their dual roles as soldiers and nurses. They felt that their dual roles interfered with their nursing practice and family lives. While they would be busy performing their nursing function, the military function would need them elsewhere. One of the professional nurses expressed the frustration as follows:

> *"But here because you are a soldier, they can take you to anywhere...while you are still busy with nursing work, here comes a signal, they want you elsewhere, and if they want nurses even if you are the only one on duty, you will be forced to go...so I can say as a nurse you have no control...nothing is planned...now your work performance is affected, your family is affected."(Int 06)*

In contrast to their civilian counterparts, military health care providers must often engage patients in many different contexts and roles. In a study conducted by Johnson, Bacho, Heim and Ralph (2006) it was revealed that in the military, multiple relationships are more common for several reasons. Firstly, the health care provider

and the patient are often the members of a small close-knit community. Secondly, the health care providers can also be consultants to military commanders, as well as providers to individual patients. Thirdly, patients are frequently superior in rank and position to the health care provider and lastly patients can become comrades and comrades can become commanders (Johnson et al., 2006:312).

Johnson et al. (2006:312) further identified features of military practice settings that frequently raised multiple role concerns for health care workers. They purport that as a commissioned officer, the health care provider's first obligation is the military mission. According to them, the nurses in the military hold multiple roles with every patient, because every nurse is both a licensed practitioner and a commissioned officer, they therefore automatically occupy at least two specific roles with each patient. These nurses do not enjoy the luxury of serving exclusively the patient or the organization but must balance those obligations, even when they conflict.

As military nurses practise in isolated environments, in sickbays, military clinics and in deployment areas, they often have no choice about either commencing a clinical relationship with a friend, colleague or supervisor or terminating this relationship when other military roles begin to interfere. Shifts between clinical and administrative roles cannot be predicted. It is professional nurses who participate in the health assessments of soldiers which determine their fitness for duty, fitness for deployment outside South Africa and whether they pass the security clearance or not. The nurses make these decisions sometimes on subordinates they previously rendered an unfavourable administrative decision. Therefore, military nurses hold significant power over all aspects of a patient's life in contrast to the powers of civilian nurses.

In smaller military units where these nurses practise, personal contact with their patients is ensured. In units that frequently drill or deploy, nurses may share dining areas, working spaces and even sleeping quarters with current patients. Nurses also experienced conflict when it came to treating patients who at the same time were superior ranks at work and sometimes in charge of their units. As soldiers exist in a closed community setting, they often have to treat neighbours who also become colleagues when they put on the military cap. Each of these cases involves a potentially uncomfortable dual role and there exists in each case the potential for

misunderstanding or distress on the part of the patient and or health care provider. In this study by Johnson et al. (2006:312) on multiple role dilemmas for military mental health care providers, it was also revealed that 17% of all ethically troubling incidents involved blurred, dual or conflicting relationships with patients and multiple roles were the second mostly frequently cited ethical dilemma among practitioners.

Nurses also experienced dual roles when they were required to perform nursing functions as well as military functions. The professional nurses expressed that their dual role functions left them feeling overworked, as they were sometimes expected to work as nurses during the day and do regimental duties at night. A professional nurse complained and said:

> *"In the military we are expected to do military duties; we are doing regimental duties, where you look after the buildings and answer phones at night whereas we also work as nurses during the day. It is tiring."(Int 01)*

Professional nurses, who trained at SAMHS, felt that the military was not consistent in how they treated nurses in their dual roles, as soldiers first and then nurses. They generally felt that their unique role as nurses was not appreciated. Some participants articulated this position as follows:

> *"The nurses are not considered when it comes to privileges. They must look at how they treat nurses; they always tell you that you are a soldier first but comes December, the memo comes out, everybody gets holidays but nurses are working, but then there is a parade they need nurses." (Int 05)*

> *"The other thing that I think has to be considered as a factor that will contribute to a healthy work environment in the military, is that as a nurse, you are a nurse on one hand, and a soldier …and when you are supposed to get benefits, for putting on uniform, you don't get whatever they are getting, while you are expecting that you will get something, as an incentive that you are in two uniforms, as a soldier and you are a nurse but it doesn't come that way; when there are benefits for the nurses, you don't get those benefits, they say you are a soldier first and when you are supposed to get the benefits of a soldier, they say it's not for medics."(Int 05)*

The professional nurses indicated that the superior position assumed by or accorded the military duties over the nursing duties disadvantaged their practice of nursing. They expressed how they were not able to update their nursing skills because of the regimental duties that took precedence. A nurse trained within the defence force expressed a lot of frustration with them doing regimental duties as this interfered with

their nursing overtime they use to update their nursing skills and knowledge. Some professional nurses articulated this as follows:

> *"They expect of you also to do military duties. We are treated very unfairly because we have to fill in documents and indicate when you are available, so you give the dates when you are available; we also are doing overtime at general outpatients department to update yourself, so with the month that you are working at GOPD you tell them, 'I am working this month at GOPD' so that they can know that they must not put you on for regimental duties, but then it happens that they still put you on for regimental duties. It can happen that on the same day you are allocated for regimental duties and you are on for general outpatients department and they never listen to you and they will tell you, 'you must find somebody to do your duties', that is how it ends up that we pay people money to do duties for us because you can't do it, but the military people in charge of us are not professionals; the colonel in charge of our Gauteng is not a professional, she is a soldier, so she does not understand professional things; the RSM is also a soldier and it just goes on his path that is how it is supposed to go um ya." (Int 02)*

> *"What I believe with the military culture that I have known since I joined the defence force, I understand that what the defence force wants military wise comes first and then everything else can follow, so if now I am busy with my work and I received a call from my commander to say, 'stop I need you for deployment, for this and that', then it means you must stop what you are doing and be ready for that, so I should be ready for what the military wants me to do at all times." (Int 03)*

SAMHS allocates professional nurses in "common posts", posts which could be occupied by any other soldier irrespective of the profession. These professional nurses do not work as nurses although they are expected to keep abreast with latest developments in their profession. Dual role conflict arises when they are not afforded the opportunity to update themselves. The professional nurse assigned to this type of post had this to say:

> *"The only challenge that I see is when a professional nurse is not working as a professional nurse in the hospital but as a professional nurse in a non-nursing post, because we do have other areas where professional nurses work but then their job description is not entirely as a professional nurse, because, I feel as a professional nurse where I am working I still need to keep on par with what is currently happening in my profession but then at the same time there is a need for me to be where I am and so the only challenge with that in particular is the experience because I feel really from time to time I need to be given chance to go and make like being in the hospital or in the sickbay just for a few hours and just to keep it up with current happenings."(Int 03)*

Professional nurses expressed frustration from the perception that their professional role was of secondary importance to the military role. The supervision by the military

officers who are not nurses seemed to bring about conflict between the two roles. One professional had this to say: nurse

> *"We are treated unfairly because the person in charge of the unit is not a professional, she is a soldier; the Regimental Sergeant Major (RSM) is not a professional and so they do not understand professional things." (Int 02)*

The study conducted at the South African Military Academy (SAMA) looked at the interplay of the military and academic cultures at the SAMA. Findings from this study confirmed the existence of conflict between the academic and military culture. They showed that this conflict has historical origins. It was further shown that part of the conflict arose from the tendency of the military culture to impose itself over the academic culture (Jacobs, 2014:82). The dual roles within the military are as a result of academic qualifications on one hand, whereas professionals have to fulfil their professional roles, and military expectations as per military culture, on the other; for example, a medical officer is still expected to do regimental duties as does the nursing officer and many other professionals. The health professionals still must work a number of hours required by their different professions and these hours do not count for regimental duties. A soldier who is not a health professional only does regimental duties. This information is based on the researcher's nineteen years of experience in the military.

3.2.1.4 Sub-theme 1.4: Lack of professional development and delays in military promotion lead to problems of command and control

There was a general feeling by nurses who participated in this study that nurses outside the defence force were more abreast with the latest nursing knowledge, skills and developments compared to those in the defence force. They attributed their knowledge deficit of latest practices in nursing and latest technology to lack of development opportunities. They indicated that they noticed differences between them and their colleagues from the department of health and private sector, when they worked in hospitals outside the defence force during their spare time. Those who studied nursing degrees at universities discovered how far behind they were when they participated in class and their colleagues were far ahead of them with latest information in nursing. These were the instances they cited to have shared light to

them as to how inferior their knowledge was to that of their colleagues. This lack of exposure and lack of further education made some nurses to feel redundant and bored. They felt they needed to explore. One participant had this to say:

> *"In general my experience working here, I can say I do have a good experience, but I also notice that there is not much training in personnel development going on. When I interact with other nurses from other environments, there is a lot of new information and new updates but that is not happening with us, that is my concern. Career development is lacking compared to other nurses I communicate with...." (Int 04)*

> *"I feel I miss out a lot from outside because nurses outside are more exposed to other things that are not in the military as the military is a closed environment whereas if you work outside it's different." (Int 09)*

> *"For me working in the SAMHS, first all because I studied here, so as a young professional nurse, it felt so much comfortable for the first three years because this is the only environment that I knew and I think towards the fourth year I felt a bit frustrated because I could not explore, go out and just feel how it is and also to get exposure; it started on the fourth year, I felt bored and redundant because I did not feel the challenge..... After you have seen the outside world then you realize what you are missing..." (Int 09)*

These nurses complained that they were not afforded opportunities to develop themselves further, both in the nursing profession and in the military. They felt that the superiors were only concerned with the work done, not their development. A professional nurse who trained in the defence force related how she struggled to be nominated for a four-year nursing course when she was still an enrolled nurse. She expressed that the nurse manager was not concerned with her professional growth but wanted to keep her in the ward because she was a good nurse. Participants expressed lack of development opportunities in the following manner:

> *"Nurses are treated very unfairly. Matrons do not want to give you an opportunity to do courses, both functional and military courses."(Int 02)*

> *"They do not want you to do the courses because they want you to stay behind and do the work."(Int 09)*

> *"I am a Candidate Officer (CO) because I have not done a military course and this poses a problem because in the defence force they only understand ranks."(Int 07)*

The rank is very important in the military. It is linked to the level of responsibility given to a soldier, the command authority bestowed upon the individual soldier and the level of respect accorded him or her. All these aspects influence the command and control authority of any soldier. Most frustrations expressed by the professional nurses who trained within the defence force were related to military rank promotion. Th*ese* nurses raised serious concerns with delays in getting their military rank promotions after completing their nursing studies. They indicated that being without a military rank that befitted their professional status was the most traumatic experience as they were not accorded the acknowledgement officers received. They asserted that working without a military rank interfered with their command and control function because professional nurses were expected to supervise nursing students and oversee the nursing facility. This lack of power and control seemed to be their source of frustration. The professional nurses expressed their frustrations of not having an appropriate military rank as follows:

> *"Working as a nurse in the ward I am working in has been a bit hectic because ok I have the professional rank which is RN but due to my Candidate Officer (CO) rank I have been dealing with lots of difficulties regarding command and control. I don't have a struggle with anything professionally; it is only the military rank structure that is bothering me." (Int 07)*

> *"In the work environment other soldiers do not understand the structure of nurses, so in the military a CO is a student, but you are a registered nurse. I had plenty of times when I had to explain myself; sometimes it happens that I am alone at the sickbay and I am in charge but I am CO. When there is a problem, the person in charge at reception is a Staff Sergeant, she will tell them to go to the CO. That is when I have to explain myself that I am a registered nurse."(Int 04)*

In the SAMHS, soldiers who receive professional education inside and outside the defence force become commissioned officers and they receive military ranks after completing their studies and military courses. This enables them to exercise their command and control authority as officers and professionals. Because of the status accorded the military rank, the professional nurses who practise with a rank of a candidate officer (CO) do not command the recognition and respect they deserve because there is no status accorded a rank of CO. The nurse in one of the clinics complained that because she had not been given a chance to do the military course that would qualify her for a promotion, she had stayed without a rank for four years and this frustrated her. She said that what rescued her from being disregarded by

soldiers, although she oversaw the facility, was wearing of the civilian nurse's uniform. The professional nurse expressed her frustration emanating from not having a suitable military rank as follows:

> *"Because I am a CO I have to explain myself that I am a registered nurse...but it is unfair that everybody is having a higher rank, but I am in-charge... everywhere is written CO, even with students they don't understand that a sister is a CO. But luckily there came a breakthrough and they allowed us to wear this blue uniform where you can put your designations on and they can see that you are qualified, although there are times where you must deal with your CO situation, in the hospital and everywhere; that is the frustration I have."(Int 07)*

Merchant (2010: 28) emphasizes the importance of personnel development and professional growth amongst employees as factors that increase staff retention and satisfaction. According to him, training allows the employee to develop and acquire knowledge, skills and abilities required to enhance his/her current job and prepares him/her for future job opportunities. As we approach the 21st Century, it is essential that organizations place a high value on career development. This will allow employees to fulfil their career needs, and organizations will benefit by retaining a greater number of their competent and qualified employees (Merchant, 2010:28).

Summary to Theme 1

Theme one addressed the challenges associated with adjusting to military culture and traditions as experienced by professional nurses working in the SAMHS. What emerged from the interviews was that the newly appointed professional nurses from outside the military struggled to adjust to military culture, citing the inadequate two weeks' induction training they received on entry into the defence force as the cause. Some expressed lack of support and hostility from members who were already in the military. According to these nurses, senior officers expected them to be competent in performing military activities such as saluting, expected of members in uniform, after receiving the two weeks' training. The lack of knowledge of military traditions embarrassed them in front of their juniors when they made mistakes. They complained that they were not able to contribute towards enforcing military discipline because of lack of confidence. The newly appointed professional nurses also pointed out that they did not attend military courses for many years after the initial training.

Although some professional nurses who trained in the defence force expressed positive sentiments about being members of the defence force, they however complained of delays in getting military ranks and promotions, because they were not given opportunities to attend military courses. Professional nurses whose health status changed while already in the employ of the defence force complained of not being afforded development opportunities. Delays in getting military rank promotions interfered with their command and control function, as the military rank is more important than their professional ranks.

The use of rank by senior officers interfered with the autonomy of nurses to practise their profession. This was a complaint from most of the participants. They indicated that they preferred to be out of military uniform while on duty as their lower ranks disempowered them.

The dual roles of being a nurse and a soldier were said to be conflicting as the military rank took precedence. Regimental duties interfered with nurses' time to do overtime to update their nursing knowledge. The question of non-nursing military members overseeing nurses seemed to cause problems as these members prioritised the military duties over nurses' needs for development.

What emerged out of theme one are the following issues:

- The induction training provided at SAMHS to newly-employed professional nurses from outside the defence did not prepare them to adjust to military culture and traditions. These professional nurses do not get support from the senior officers; instead they get reprimanded for not being competent in performing their military exercises. The induction training was not followed immediately by military courses. Newly appointed professionals stayed for many years without attending military courses. According to the professional nurses who participated in this study, the lack of knowledge of military culture delayed their adjustment to the military. The newly qualified professional nurses from the SAMHS complained about not getting support, guidance and in-service training from management when placed for the first time; instead they

got criticised. They were also not given the opportunity to practise as professional nurses.

- Management did not provide professional development opportunities to professional nurses, for both nursing and military development. Failure to attend military courses delayed military rank promotions for professional nurses and this in turn interfered with their ability to exercise the authority that goes with their professional qualifications. Lack of professional development made the professional nurses to feel that they were less knowledgeable than their counterparts outside the defence force.

- The use of rank by senior military officers interfered with the autonomy of professional nurses to practise nursing. Some suggested that professional nurses in military clinics should not wear military ranks so that they were not intimidated by the ranks of their patients.

- Professional nurses at SAMHS have dual roles, those of being commissioned officers and being professional nurses. The professional nurses sometimes experienced dual role conflict when military activities are given first preference over their professional activities. They cited regimental duties as interfering with their ability to do overtime in hospitals, to update their nursing knowledge and skills, as their source of role conflict. The interference by senior officers with their professional decisions also seemed to bring about dual role conflict.

3.2.2 Theme 2: Professional nurses identify factors that enhance and/or hinder a healthy work environment for nurses

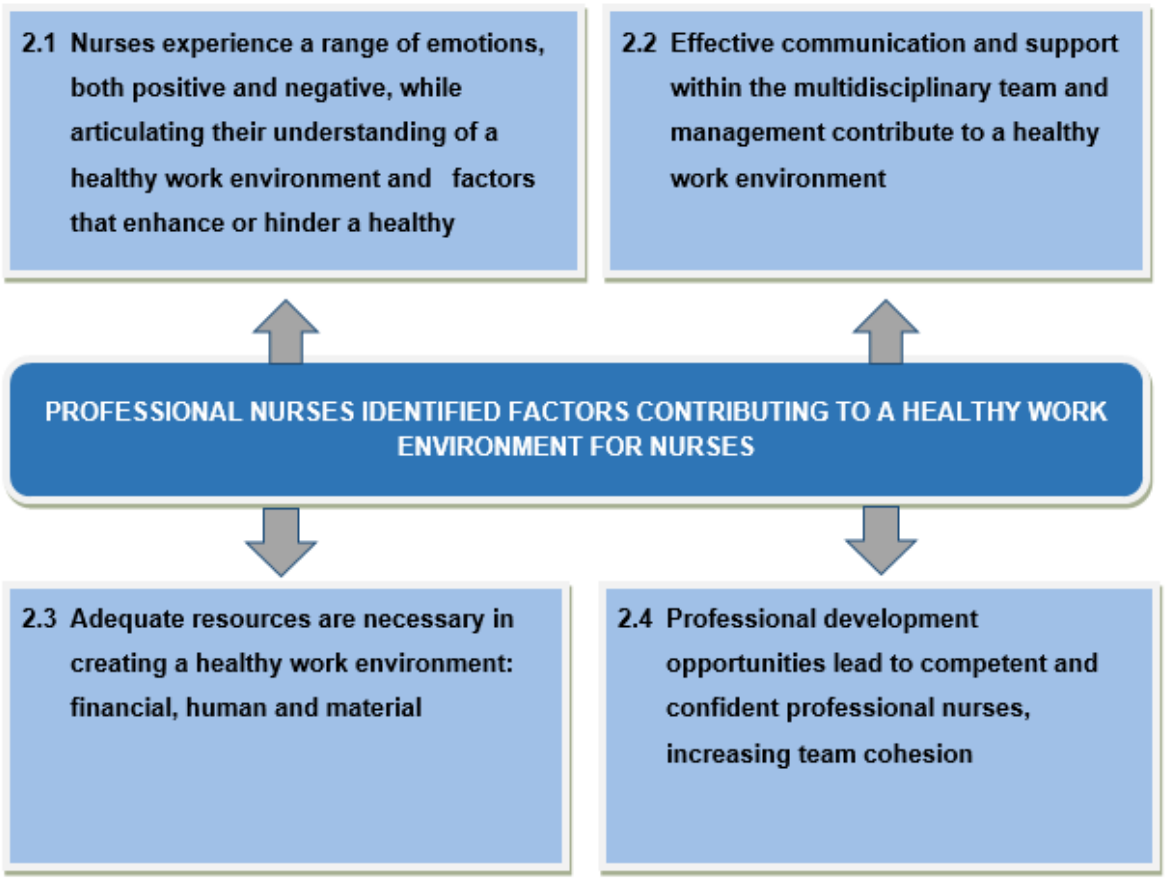


Figure 3.2: A diagrammatic presentation of Theme 2 and its 4 sub-themes

Theme 2 emanates from the responses of the professional nurses when addressing their understanding of what a healthy work environment for nurses was. The factors they asserted enhanced or hindered a healthy work environment in the SAMHS were expressed in four (4) different sub-themes.

A range of both positive and negative emotions emerged as they articulated what they felt as being factors that enhance or hinder the attainment of a healthy work environment for nurses within the SAMHS.

A healthy work environment is defined by the professional Nurses Association of Ontario (RNAO) as 'a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes, organizational performance and societal

outcomes' (RNAO, 2006:13). According to the American Nurses Association (ANA), a healthy work environment is one that is safe, empowering, and satisfying. Parallel to the World Health Organization (WHO)'s definition of health, it is not merely the absence of real and perceived threats to health, but a place of "physical, mental, and social well-being," supporting optimal health and safety. A culture of safety is paramount, in which all leaders, managers, health care workers, and ancillary staff have a responsibility as part of the patient-centred team to perform with a sense of professionalism, accountability, transparency, involvement, efficiency, and effectiveness. All must be mindful of the health and safety for both the patient and the health care worker in any setting providing health care, providing a sense of safety, respect, and empowerment to and for all persons (American Nurses Association).

In this theme it became evident that professional nurses working in the SAMHS were aware of what a healthy work environment entailed and the factors that enhanced or hindered a healthy work environment for nurses in the military; however they differed in their interpretations. Some professional nurses associated a healthy work environment with adequate resources, financial, human and material resources while some with relational issues such as team cohesion, effective communication, support, professional growth and development, respect and appreciation and a few with physical safety. Professional nurses expressed themselves as follows:

> *"I understand a healthy work environment to be an environment that is safe, physically safe to have all those things in place, infection-control, the fire drills and welcoming environment, where they welcome you." (Int 07)*

> *"I think it is an environment where an employer and an employee work together as a team and achieve a goal of the organisation. I think that is it according to my understanding." (Int 01)*

> *"A healthy work environment for me is like whereby you work everything is there all the multi-professional people, you don't have to run around; you must know where to go; you must know if I need somebody I must know who to contact and if a patient is like in a condition where you feel that this patient needs to go x-rays and then is no doctor that must write the x-rays and stuff like that you must know what to do." (Int 06)*

> *"A healthy work environment for me is firstly that you are free to do your work and where nobody interferes; and then secondly I feel the conditions where you work in are healthy, because like right now the conditions that we working in the sickbay is totally unhealthy;' the other thing is that the building is very small, and there is*

not enough space for the patients to sit, and then for us the toilets is outside.,. There is no equipment."(Int 02)

The quote above emphasises the status of what a healthy work environment is and factors that hinder the existence of a healthy work environment citing conditions, equipment and facilities as constituting a healthy work environment. Professional nurses further defined a healthy work environment as that where there are enough resources, as well as expectations that are clearly spelt out.

"In my own words a healthy working environment, will be an environment where there is enough I would say resources; when it comes to personnel it is a bit of a challenge that you find that there is a shortage of personnel and the people that are there are doing more so it does affect the work environment because there I have seen a lot of my colleagues and people after me who they train and then after a few years they are gone and then it takes time to fill in those gaps so it does affect the work environments." (Int 12)

"I believe it's an environment whereby I understand what is expected of me and I'm capable to produce and meet objectives of what is expected. Personally I should be happy about what I am supposed to do and what I'm doing there and I should be able to meet the objectives so that the organisation will also be happy with what I am producing for them then both of us; it means that we are in agreement both be happy, without too much differences or hick-ups." (Int 04)

The sub-themes of Theme 2 where nurses articulated how they conceptualized a healthy environment work will be discussed.

3.2.2.1 Sub-theme 2.1: Nurses experience a range of emotions, both positive and negative, while articulating their understanding of a healthy work environment and factors that either enhance or hinder a healthy work environment for nurses.

During data collection professional nurses revealed positive and negative emotions when articulating their understanding of a healthy work environment and factors that either enhanced or hindered a healthy work environment in the SAMHS. These emotions demonstrated the physical, social, emotional and psychological aspects that contributed to either enhancing or inhibiting the creation of a healthy environment for nurses in this organization and exposed how professional nurses experienced working in the SAMHS. The periods of experience by the participants in the defence force differed and ranged from a year to twenty years. Some had received their nurse

training in the military and some joined as trained nurses, but all had experienced the SAMHS either positively or negatively.

The feelings of pride and honour, derived from being a member of the defence force were communicated by some. They assumed that they were many out there who wished they could be given the opportunity to serve in the defence force. Professional nurses who trained in the military had these positive comments about being in the military:

> *"For me eh, it is a passion to be a nurse in the military; it was an honour for my family when I became a professional nurse in the military...it feels special because eh you have two kinds of careers...a nurse and a soldier. I am very honoured to be one. We gain a lot of experience because we deploy and work in other countries and when there are disasters and strikes in South Africa, they use military nurses..." (Int 04)*

> *"I feel there are many other people who wish to be nurses in the military if they could because it is an honour to be a nurse in the military...especially when you help during floods and strikes...that part I really enjoy." (Int 02)*

One of the professional nurses who received further training after joining the military commended the military for the different development opportunities it afforded the professional nurse, from an enrolled nurse to a primary health care nurse in charge of a military clinic. The other professional nurse expressed being happy with the nursing care given to patients at SAMHS, as well as serviceable equipment. The professional nurses had this to say:

> *"Working at SAMHS has been a very good experience to me as a nurse...eh. Firstly, wearing a soldier's uniform was quite a different thing to me as a nurse from department...secondly, doing military drills was an eye opener... as I was doing basic training, I was told by instructors that ..that you are soldier first...this was funny at first but as time went on ...I got used to it...thirdly, attending military very good...I have developed a lot....I joined the military as an enrolled nurse...I was given an opportunity to do bridging, now I am a professional nurse ....I did primary health care."(Int 01)*

> *''For the 20 years I have been in the SAMHS...it was quite an experience, I have learnt a lot... "I feel we do the best care...medical wise, because we have equipment other people do not have..."(Int 04)*

According to one of the professional nurses, working hours and resources made her happy to work in a military clinic. She expressed appreciation of the fact that she was

far removed from work politics and that she could go home to her family at the end of the day. This to her made her environment favourable. This is what the professional nurse said:

> *"Working hours is favourable: having weekends at home, doing overtime at the hospital...politics at work affect you less and at the end of the day you go home to your family, something I am grateful for. We are lucky to have computers...mainframe to look for your patients, having lab results at hand, other nurses outside do not have."(Int 05)*

What also emerged from the interviews in this theme was that, although there were positive feelings about the defence force, the concerns that made their environment unhealthy, however, outweighed the positive sentiments. The professional nurses, while articulating what they understood to be a healthy work environment, they also identified factors that contributed to enhancing a healthy work environment and those that hindered the existence of this environment. The negative emotions expressed by the professional nurses were linked to lack of the factors that enhance a healthy environment which therefore hindered its existence.

The negative emotions were attributed to different factors from feeling unsupported by management, not appreciated by patients, perceived disrespect for their profession, lacking autonomy and lacking opportunities for development. Some professional nurses, therefore, experienced the environment as interfering, unappreciative and disempowering and as a result thought the military environment was not conducive for sound nursing practice. Those who trained outside the military found the military not as welcoming as the outside world. The professional nurse who trained and worked outside the military had mixed feelings about the military. The professional nurses appreciated the presence of doctors to support nurses when they were stuck although she felt the military members were not as welcoming as the patients/clients outside the defence force. They had this to say:

> *"Quite a different environment compared to outside; outside we feel you are home." (Int 01)*

> *"Here they were not more welcoming like outside. Relations with staff are different, not welcoming...coming from another province they want to first see your capabilities; expectations are not high, they do not seem to expect you to be knowledgeable because you are from another province." (Int 08)*

"Ya, I think it starts with our superiors because if our superiors can support us and listen to us when there are complaints or when we have problems then it will be better, our superiors, whew, I don't know, there is, I like you, I don't like you, situations, so if they don't like you they will never listen to you." (Int 06)

A newly qualified professional from within SAMHS supported the sentiment of the importance of an environment that is welcoming as he said:

"To be honest, the reason why I chose orthopaedic ward, I have done my conserve there so the staff that I am working with, they were welcome, they were welcoming me from com-serve so from the unit manager and all of the staff in my ward, that are working there permanently; I actually chose that Ward due to that, so I am happy on a daily basis to go to work and work with them etc um I don't have any problems with them, ya." (Int 07)

This professional nurse from outside the defence force perceived the military patients not to be appreciative when she said:

"Management of patients is also different as patients are like those in a private sector, the demand is more. They are not as appreciative even if you go out of your way." (Int 10)

Professional nurses criticized lack of opportunities to develop further a lot. They compared themselves with their colleagues outside the defence force and deduced that these colleagues were better equipped to perform their nursing functions than they were. To some nurses, it was just a feeling, that they were less exposed, while others substantiated their claims of being less knowledgeable than their colleagues in sectors outside the military. A professional nurse complained and said:

"As the military is a closed environment, when you work outside is different...I feel I miss out a lot from outside because nurses outside are more exposed to other things that are not in the military..." (Int 03)

Those nurses who trained in the military expressed having experienced a sense of comfort and contentment during the first few years as professional nurses; however, this feeling changed as they got exposed to the world outside the military. The professional nurse had this to say:

"For me working in the SAMHS, first all...because I trained here, so, as a young professional nurse, it felt so much comfortable for the first three (3) years because this is the only environment that I knew and I think towards the fourth year I felt a bit frustrated because I could not explore, go out and just feel how it is and also to get exposure; it started on the fourth year, I felt bored because I did not feel the

challenge and also after I have seen the outside world, the provincial and the private hospitals, because in the defence force we are allowed to go and "moonlight" if I can call it that way, after you have seen outside world then you realize what you are missing..." (Int 09)

Exposure to other professional nurses outside the defence force made them aware of their knowledge, experience and practice deficits or gaps:

"But I also notice that there is not much training in personnel development going on. When I interact with other nurses from other environments there is a lot of new information and new updates but that is not happening with us...that is my concern, career development is lacking compared to other nurses I communicate with..." (Int 04)

The realization of the gap in nursing knowledge between them and their colleagues outside the defence force awakened a sense of desperation to want to study further but felt that their superiors did not give them the support they needed:

"I feel that the matrons don't want to give people a chance to develop themselves or to go study further because we have a lot of disagreements regarding the study further and we really want to study further." (Int 02)

On feeling disempowered, a professional nurse had this to say:

"Decisions a lower rank makes are ignored, and that is a problem in the clinics. A professional opinion is not considered if it is from a lower rank." (Int 04)

The observation of the researcher on the response of participants to the question of their understanding of a healthy work environment was that participants aired their challenges while addressing the question. The responses were varied and wide, covering shortage of personnel, being overworked, lack of support to newly qualified professional nurses and inadequate induction to newly employed, management attitudes and policies. These were some of the comments from professional nurses:

"We need support from our management, and a high top management we need resources; they should be able to avail resources for us so that we can be able to do our work and we don't even have to hassle." (Int 09)

"Yes there are more resources in the defence-force; they do not have enough personnel though." (Int 08)

"There should be resources, enough resources, for me for me as an employee to work, it should be free of danger for me and also for my patients, I should be

protected from the patient….It is a bit of a challenge when there is shortage of personnel, if there is not enough personnel people working there do more." (Int 72)

"Personnel shortage leads to burnout, stress..." (Int 05)

"At the NOIC (Nursing Officer in Charge) you do a lot of management tasks, the community nurses fell off now they want you to do home visits but still your patients are waiting for you. You have to push, but you can make mistakes...it makes you tired, not to want to come back to work the next day because you are afraid of what is going to happen at work...we used to see 300 patients a month but now it's 1500. They added HIV clinic, and a baby clinic. They must send more personnel...we send stats every month...we can't do outreach programmes...." Sounding very emotional and frustrated. (Int 12)

The quote above demonstrated a high level of frustration and pent-up feelings. The researcher perceived this response as the use of an opportunity by the professional nurse to address her problems. The nurse addressed the issue of shortage of personnel and work overload, also complained that the patient load had increased from 300 to 1500 per month. According to her, although they sent statistics every month, more clinics were added, suggesting that management should send more personnel.

Poor communication manifests itself in many ways and the researcher propounds that the quote above demonstrates a lack of communication between management and professional nurses. In hierarchical organisations, like the defence force, there is usually a problem of downward communication which does not provide feedback. According to Hellriegel et al (2012), upward communication gives feedback on how employees perceive the instructions and employees are given a chance to voice their opinions and ideas (Hellriegel et al., 2012:450).

Hellriegel et al. (2012) suggest that effective upward communication can provide an emotional release and at the same time give employees a chance to participate, the feeling they are being listened to and a sense of personal worth. Most importantly, these writers say, employees often have excellent suggestions for improving the efficiency and effectiveness of the organisation (Hellriegel et al., 2012:451). A professional said this about communication in the military:

"To be honest....I really think communication is a problem due to the fact that we all follow channels of command." (Int 07)

In this sub-theme the participants articulated their feelings with regard to how they experienced working in the SAMHS. Although some professional nurses expressed positive feelings about military nurses, some expressed negative sentiments. They identified the factors that could enhance a healthy work environment and those that hinder it, thereby demonstrating their understanding of the concept of a healthy work environment. A lack of appreciation, recognition, respect for and a sense of belonging among professional nurses were some of the factors that were isolated as hindering the attainment of a healthy work environment. Not being placed according to levels of qualifications and experience seemed to leave professional nurses feeling disempowered and un-appreciated. Those who did not receive their military ranks after qualifying as professional nurses, cited good salaries as their only consolation. They also provided solutions to the areas they felt made their environment unhealthy.

In a study conducted by Kieft, Brouwer, Francke and Delnoij (2014), the nurses mentioned essential elements that they believe would improve patient experiences of the quality of nursing care: clinically competent nurses, collaborative working relationships, autonomous nursing practice, adequate staffing, and control over nursing practice, managerial support and patient-centred culture. They also mentioned several inhibiting factors, such as cost-effectiveness policy and transparency goals for external accountability. Nurses feel pressurised to increase productivity and report a high administrative workload. They stated that these factors will not improve patient experiences of the quality of nursing care (Kieft et al., 2014).

3.2.2.2 Sub-theme 2.2: Effective communication and support within the multidisciplinary team and management contribute to a healthy work environment.

An atmosphere where health care workers worked harmoniously in a multidisciplinary team, where there was effective communication amongst team members and between employers and employees and where management was supportive towards professional nurses, collaborating with them before taking decisions, had an open-

door policy, where there was personal development and growth, was to the majority of the participants a healthy work environment.

Participants in this study believed that effective communication within the multi-disciplinary team and management support were the key to enhancing a healthy work environment. Participants commented as follows on communication and support from the multi-disciplinary team and management:

> *"In general I think communication is the answer to solving problems. If superiors do not discuss things or consult personnel and just expect to implement, that hinders a healthy work environment." (Int 02)*

> *"Consult with people before deploying them, not say you will go. Discuss with nurses when you are going to introduce a baby clinic for instance, it is good to discuss with people and ask who is willing to go or how can we run the clinic. Communicate with staff as to why their needs are not met." (Int 06)*

Effective communication came up frequently as a factor enhancing a healthy work environment and was linked to management's need for an open-door policy and improved support. Participants advocated that where there was no open-door policy, the superiors would never know the problems of their subordinates and therefore would not be able to solve them. Effective communication is critical during countless interactions that occur among health care workers on a daily basis. Staff must know how to communicate effectively and work collaboratively in teams so that appropriate information is shared in a timely manner. Nadzam (2009) states that when effective communication is absent, patient-care and relationships are compromised (Nadzam, 2009:184–188). It became evident in this study that communication was one the problems experienced by professional nurses working in the SAMHS as outlined by one of the participants:

When asked about factors that contribute towards attaining a healthy work environment and those that hinder it, communication and support answered both questions. They asserted that in an environment that is healthy, there would be clear and open lines of communication, an open door policy, regular contact sessions between management and personnel, regular meetings, clearly defined channels of communication and policies regulating these channels, and clear roles and

expectations. The nurses believed that it was through communication that things could be improved in the SAMHS:

> *"We must have meetings every second week, that's just a small meeting to discuss issues, say this is that and that is that, what must we do, what must we not do, so communication again amongst ourselves, that can really make things better." (Int 02)*

> *"Okay if you look at it if I have to be honest sometimes we know that seniors command lower ranks, if there is no open door policy, one cannot be free to go and openly talk to them about their own problems." (Int 07)*

> *"I think the open door policy comes in, if there is none, they will never know what the problem is." (Int 02)*

The results in this study reveal that professional nurses working in the SAMHS believed that communication was important in creating cohesion between members, and support within the multi-disciplinary team and management. Being listened to by management, seemed to be central to the creation of a healthy work environment according to the participants. Listening was the single most important skill for effective communication as indicated by participants:

> *"Your superiors can hinder the healthy work environment if they do not listen to you and want you to continue with things even if they do not work." (Int 04)*

> *"To be happy in your work place, to be listened to, if patient complains the nurse's part of the story to be heard too." (Int 05)*

Nadzam, (2009:184) defines communication as "the exchange of information between two people, a group or entities." Communication encompasses verbal and written communication and more subtle forms such as body language and tone.

Communication is the only means by which people can build relationships in the workplace and elsewhere (Hellriegel, Jackson, Slocum, Staude, Amos, Klopper, Louw & Oosthuizen, 2008:339). According to these writers, it is estimated that more than 90 percent of leaders today fail to communicate with their co-workers in a manner necessary for building productive relationships based on mutual trust and respect. The participants had this to say about failure to communicate:

> *"If superiors do not discuss things or consult with personnel and just expect people to implement, that hinders a healthy work environment, and also communication between the management and the other colleagues that I am working with, so those can be things that I can see that would hinder a good working environment." (Int 05)*

Related to communication in organizations, Hellriegel et al. (2008), point out that, hierarchical organizations have more levels of authority and greater differences in status among their members. They further state that when status and authority levels differ, communication problems are likely to occur. Even when communicating with others at the same level of authority, status can interfere with the process (Hellriegel et al., 2008:338).

The defence force, as a hierarchical organization, could easily fall prey to the problems of poor communication, but Hellriegel et al. (2008:340), suggest that people can overcome barriers to effective communication if they are aware that barriers exist, and cause serious organizational problems. However, they must be willing to overcome the communication barriers (Hellriegel et al., 2008:340). The American Association of Critical Care Nurses (AACCN's) healthy work environment standards identify six characteristics that foster healthy work environments as: skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition and authentic leadership. Five of them directly involve communication (Longo, 2013). In a study conducted by Longo (2013) the practising professional nurses identified communication as being critical for both patient and nurse satisfaction. The professional nurses made suggestions on how to increase communication or change a current process of communication as a way of providing evidence of importance of this particular standard of the healthy work environment.

Effective communication between nurses and other caregivers is critical to patient safety, yet numerous challenges contribute to poor communication and an unhealthy reliance on individual action (Nadzam, 2009:184). Effective communication is an essential component of the nursing role and when problems arise in the communication process, the patient is at risk. Four core skills are necessary for effective communication to occur: understanding communication from another's perspective, listening, emotional intelligence, and conflict management. When a nurse neglects to listen to another member of the care team or to the patient, vital information

can be lost and the safety of the patient can be jeopardized. An article by Jasmine (2009) cited in AORN Journal (2012) addresses many of these same communication skills and, in addition, addresses the important skill of "exploring" to develop effective communication. Jasmine states, "It takes more than good listening skills to be able to understand. Exploring is another essential skill and it largely involves the use of effective questioning (AORN Journal, 2012).

Regarding support from the multidisciplinary team and management one participant expressed this expectation as follows:

> *"Lack of support from the multidisciplinary team, lack of support from management because of beaurocracy, lack of communication with other clinics, nobody knowing what, nobody knowing what you are going through, hinders a healthy work environment. (Int 12)*

> *"From my point of view or rather from where I am working or let me talk about myself, the things that hinder my healthy work environment will be the support from my colleagues and management as a whole, um support is important. (Int 02)*

> *"Ya I think it starts with our superiors because if our superiors can support us and listen to us when there is complaints or when we have problems then it will be better, our superiors, whew, I don't know, there is, I like you, I don't like you, situations, so if they don't like you they will never listen to you, they say you have a big mouth, you always want to talk, you always want to be negative, but I feel if they, I don't think that will change, not in the near future." (Int 03)*

Regarding support to subordinates, regardless of rank, it is the job of the man or woman in charge to ensure that his or her service members are adequately trained in their jobs, have the necessary equipment to do their jobs, are getting the necessary sleep and food to remain at peak performance, and are following rules and regulations that dictate military performance on and off duty (SAHMSA, 2010:10).

3.2.2.3 Sub-theme 2.3: Adequate resources are necessary in creating a healthy work environment: financial, human and material

In general, the professional nurses associated a healthy work environment with adequate resources, that is, material, financial and human resources. It became evident in the interviews that participants considered availability of adequate resources

to be very important for a healthy work environment to be considered healthy, as outlined by one of the participants:

> *"We need resources; they should be able to avail resources for us so that we can be able to do our work and we don't even have to hassle.'' (Int 03)*

The resources they mentioned ranged from facilities and equipment; the personnel to do the work, to the budget that procured, maintained and repaired facilities and equipment and paid salaries of the employees. What came up frequently when participants articulated their understanding of a healthy work environment and the factors that could help create this type of an environment was that professional nurses should have adequate resources to do their work and these resources were seemingly not always available as outlined by the participants:

> *"in my own words a healthy working environment, it will be and an environment where there is enough I would say resources when it comes to personnel it is a bit of a challenge that you find that there is a shortage of personnel and the people that are there they are doing more all the time and it doesn't seem to be resolving very quickly so it does affect the work environment because, I have seen a lot of my colleagues and people after me who sometimes after their training and then after a few years then they are gone and then it takes time to fill out those gaps so it does affect the work environments." (Int 04)*

> *"The other thing is just sometimes when we don't have computers, we didn't have computers for like two years and that was bad for us; we couldn't, if you see a patient look on the system what did the patient have before, that really was hindering the healthy environment because now you get so frustrated." (Int 05)*

> *"Not enough resources, not enough budget, lack of leadership in the organisation, not getting support from my superiors, cultural diversities or differences, yes." (Int 04)*

Participants cited the shortage of personnel as a factor which caused them to be overworked because the post structure was not big enough to meet the demands of the clientele of the SANDF. They also indicated that the procurement processes for the equipment took too long. Regarding shortage of personnel, they pointed out that when members of staff go on either normal leave or sick leave or on deployment, they were not replaced and to them, this made their environment unhealthy. The facilities were fragmented and not big enough to accommodate the clients. These facilities were not user friendly and did not portray respect to the clients, according to the participants, as outlined by participants that:

"If there is not enough staff on duty you really become tired, you really become drained. In our sickbay now, we are not staffed enough because we are four sisters and there is one doctor. If the others go on leave, say more than one go on leave, then you really have that overflow of patients. Now they change the whole structure, and I feel that our superiors didn't talk enough and didn't say that this won't work and that won't work, so everything is just thrown on you, although everybody knows it's not going to work and you must just do; it really frustrates you it really." (Int 04)

"Ya I feel like I said they must at least listen to us here on the ground and all that, like now that we have to do the HIV clinic we have to do the contraceptive clinic, they want us now to do the immunisations of the babies, and that is really not going to work because there is no space for the mothers, to sit with their healthy babies with sick people that sit and cough and things like that so that I feel it is not thought through." (Int 05)

Their own environment was not conducive to serving patients as indicated by one participant:

"The condition that we work in, our environment was meant to be temporary. There is a carpet, patients vomit and bleed, and carpet cannot be cleaned. It causes sinusitis. The building is very small; the toilets are outside, we walk in the rain." (Int 04)

"when we come to work, it's not like we have to have everything, but when you come to work the resources to be able to help the patient it must be there and the help when you need help it must be available and also where you need to refer there must be a way, lines of communication to be able to refer, they must be open and there must be a way to sort out if there is a complication, and staff wise we know there is always a shortage if there is a need, if there must be some help that is needed and then that one we have to be met halfway so that we can manage to render a proper service to the patient." (Int 11)

"We don't have um the proper facilities to even give that proper client privacy if there are no facilities where you can have a separate ward because all of this you have to do in the same office, so the facilities also, if we can have proper facilities for proper training, then it gives me a healthy work environment." (Int 06)

Recent evidence indicates that work environments that provide access to information, resources, support and opportunity create an environment of more satisfied nurses, ultimately reducing turnover (Purdy et al., 2010; Hauck et al., 2011) cited in the study conducted by Breau and Rheame (2013:20).

3.2.2.4 Sub-theme 2.4: Professional development opportunities lead to competent, confident professional nurses and increase team cohesion

Professional development refers to many types of educational experiences related to an individual's work. Doctors, lawyers, educators, accountants, engineers and people in a wide variety of professions and businesses participate in professional development to learn and apply new knowledge and skills that will improve their performance on the job. Many fields require members to participate in ongoing learning approved by the profession, sometimes as a requirement for keeping their jobs. Professionals often also voluntarily seek new learning (Mizell, 2010:3). According to Mizell (2010:7), professional development is most effective when it occurs in the context of employees' daily work. Coaching, mentoring, meetings, workshops, conferences and studying or research are cited as typical modes of professional development (Mizell, 2010:9).

To the participants, development increased their knowledge, and this made them comfortable to work in a team. The participants verbalized their need for development, as well as support from the management. They perceived management as being against their further development as expressed by the participants:

> *"We need development academic wise and we need support from our management and a high top management and we need support; we need communication we need our finances to be resolved and sorted out and we need Academic qualifications that is personal development that we need although, we, I'm not saying that we should be irresponsible and not go to school, but where it is possible then we can develop further." (Int 05)*

> *"I feel that the matrons don't want to give people a chance to develop themselves or to go study further because we have a lot of disagreements regarding the study further and we really want to study further." (Int 02)*

> *"I think one of the things also maybe can help to give us this healthy work environment, skills is one of the things that can help us, we've got a lot of say um enrolled nurses and some of them we can still manage to try and send them to go and study and then we increase the number of sisters, so those people we can send them just to explore and give them more skills to function and then we got like also like a better field to work with, and we will be improving the people that we have got in the field already, let them grow in the field and then they can give back to the patients." (Int 05)*

A professional nurse who trained in the defence force sounded very frustrated when she expressed how they did not receive training or opportunities to attend seminars on chronic illnesses they dealt with at their work places. She complained that management did not give training priority although they wanted them to open new clinics that needed them to have the latest information. The professional nurse felt that if management did not empower them, they would not get the best out of their employees. She had this to say:

> *"In the DOD it is actually a shame that we are not exposed, like for instance to things like HIV and TB training, the chronic illnesses that are happening right now if I can put it that way, or basic hypertension, but you would think that they are going to expose us, to go and do courses and go to seminars, you know things like that so that they empower us; they expect us to open HIV and ARV clinics. You put your name for a course for instance, for ARV training, you are not taken, you never go on a course, but it's not like it's not going to happen, you still have patients that want to receive ARV'S but you have no training. You would think that the management would be worried about that, that there are people that need training; training should be the priority for us to be exposed and for us to be able to get information ASAP, but you don't get that so you are not going to get the best out of your employees if you don't empower them, and that is the reality um and you give more to the patients because things change, health environment changes all the time you need to work with your colleagues often it doesn't mean you are stupid but we need to work with outside environment and the defence force; we don't have that, we will need Internet, the information is changing all the time, there is like for instance things like contraceptives; there are clients that want to come to us we never went for that training for the contraceptives that you put under the skin, people are coming to us we have no knowledge then as a professional you feel so like inferior because I should be knowing this and your client is." (Int 09)*

> *"I mean I feel that the DOD is putting us like on the spot like they want this to be done but they are contradicting themselves they don't train us you know what I mean, they don't train us so we are here but they want a result. I mean we cannot be a world-class facility if we don't communicate with the world." (Int 07)*

Emphasizing the importance of staff development in increasing effectiveness in the university, Seyoum (2012:3) claims that staff development facilitates personnel and professional development for individuals and groups, enabling them to achieve their potential and contribute to the provision of excellence in teaching and research in the university (University of Cambridge, "Staff Development Policies," 2006, cited in Seyoum, 2012:3). In another contribution, Anyamele (2004) in Seyoum (2012:3) emphasizes the importance of staff development in the current changing higher education landscape. According to the report, higher education institutions are highly recommended to put in place appropriate staff development strategies to support all

staff and promote involvement in the development and implementation of university-wide policies and strategies. This is because effective staff development is essential to support new approaches to learning and teaching, and meeting the changing needs of institutions.

One participant expressed discontent with the fact that they did not visit or work together with the clinics in the communities where the families of the members of the defence force lived because they did not know how these clinics worked. She said:

> *"Firstly I said we don't get we don't get a lot of opportunities because if you study as a nursing sister or a nurse practitioner you only do the minimum work because it depends on your clientele. Um we don't really have the opportunity to go out and do research or to do in-service training with our departments and so on, like outside departments, in defence force we don't we service other members those who stay in communities, so we not working in link with the communities because I feel like if we can work in link because some of our people are in Khayelitsha and we have to know what Khayelitsha clinic is doing because the health of our members' families that stay in the household ne they don't come here, they go to the community clinics, outside so if we not one in-line then we missing." (Int 10)*

Training, physically, socially, intellectually and mentally, is essential in facilitating not only the level of productivity but also the development of personnel in any organization. However, knowledge is the ability, the skill, the understanding and the information, which every individual requires to acquire in order to be able to function effectively and perform efficiently. The effectiveness and success of an organization therefore lies with the people who form and work within the organization. It follows, therefore, that the employees in an organization should be able to perform their duties, make meaningful contributions to the success of the organizational goals and need to acquire the relevant skills and knowledge (Olaniyan & Ojo, 2008:326-331). Quality practice environments are adequately supported and funded to allow nurses to access professional development opportunities. These opportunities can include formal and continuing education, mentoring and online learning resources (Canadian Nurses Association, 2017:2).

A healthy work environment for nurses is essential for providing quality care. Strong links between the work environment and patient safety, nurse retention, and recruitment have been demonstrated in a number of studies (Braccia, 2008).

Summary to Theme 2

Theme 2 addressed the question of the understanding of a 'healthy work environment' by nurses working at SAMHS. The participants articulated their understanding of a healthy work environment and also highlighted the factors that enhanced or hindered this environment. Most participants understood a healthy work environment as the one where there were enough resources; financial, human and material; an environment where management gave support to personnel and had an open-door policy.

Effective communication between management and professional nurses and within the multidisciplinary team, and clearly defined lines of communication stood out as extremely important factors that enhanced a healthy work environment.

Shortage of personnel that led to work overload, exhaustion and burnout, as well as management's inability to listen and solve their problems, were factors that hindered the promotion of a healthy work environment. They linked the shortage of personnel to a post structure that did not match patient load. Professional nurses who trained in the defence force identified the lack of support during the transition period from being students to professional nurses as one of the factors hindering a healthy work environment, while those who were employed as professional nurses from outside cited inadequate induction as an inhibiting factor to their adjustment to the environment. Long and protracted procurement processes, whether it is for appointment of personnel or for buying of material resources, were said to be contributing to challenges they experienced as impacting on their work environments negatively.

The participants also believed that where professional nurses were provided with professional development opportunities, they would be competent and therefore practise with confidence. This would contribute towards a healthy work environment, according to them. Cohesion among team members in a multi-disciplinary team and clearly defined roles of different professionals were identified as factors that enhanced a healthy work environment

The Registered Nurses Association of Ontario (2007:13) purport that the creation of healthy work environments has become critical for the retention of nurses and quality patient care. They believe that the achievement of healthy work environments for nurses requires transformational change, with interventions that target underlying workplace and organizational factors.

3.2.3 Theme 3: Professional nurses make recommendations for a best practice guideline within a military setting

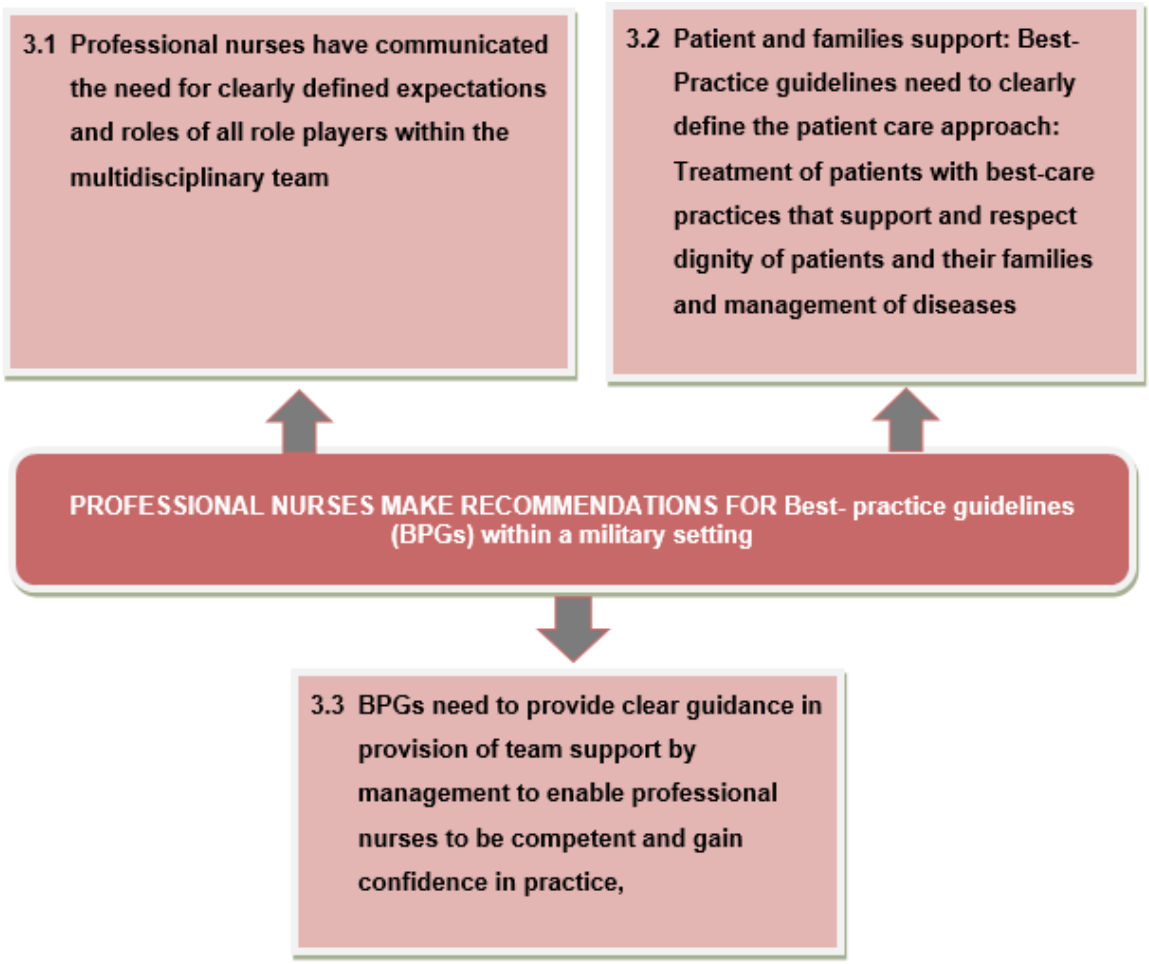


Figure 3.3: A diagrammatic presentation of theme 3 and its 3 sub-themes

A best practice guideline is defined by the Professional Nurses Association of Ontario, as systematically developed statements to assist practitioners and patient decisions about appropriate health for specific clinical circumstances (RNAO, 2007). The terms clinical practice guideline; best practice guideline and evidence-based guideline are used interchangeably in this study. Guidelines give specific recommendations for

evidence-based decision-making. Their intent is to influence what clinicians do. They attempt to address all of the issues relevant to a clinical decision, including the balancing of benefits and risks. Lastly, guidelines are developed to guide clinical practice and their development involves the consensus of a group of researchers, experts and clinicians (Polit & Beck, 2012:31).

The participants demonstrated a clear understanding of what a best practice guideline was, what its functions were and what should be contained in a best practice guideline although they articulated themselves differently as expressed by these participants:

> *"A guideline, Firstly is structural and it guides quality care together with military discipline." (Int 07)*

> *"I think a guideline will help the nurses in performing their work in a better way, um and also the procedures that must be followed, you know if they have got a certain query, that they know this is there, the steps that they have to take in getting the best out of their queries." (Int 10)*

> *"for nurses it will say this is how, and what is expected of a nurse, and this is how a nurse is supposed to do the things, for a nurse to be able to function irrespective of whether they are working in a sickbay or in a hospital or in an office because each and every field where they are there is a job description and the nursing department should be knowing that there is a nurse at this particular unit and this is what is expected of them." (Int 05)*

> *"The guideline shows you how to do your job...everything you have to do must be communicated...we need to have a standard working procedure for all nurses because if you go to other clinics there are different procedures to the ones you know." (Int 04)*

> *"In the guideline there should be working procedures, referral systems and channels of communication." (Int 06)*

> *"It addresses what is expected of a nurse, how a nurse should do things. It enables the nurse to know how to function in a clinic or hospital situation. It develops into a job description. It guides placement of nurses so that everybody knows what type of nurses should be placed where". (Int 09)*

Others felt it should address nurses' remuneration as they were both nurses and soldiers, as addressed by the participants:

> *"Remuneration should be good for them." "I think it should address professional nurses' remuneration. It should be good as they serve as nurses and soldiers." (Int 11)*

"I think the guideline should state that professional nurses should be remunerated; the remuneration of the SAMS professional nurses should be good, because they serve both as soldiers, as I have stated before, as soldiers and as nurses, when it comes to a push we have to stand on duty, for military report, for duty as military soldiers and have to look after their patients so I think to boost their morale." (Int 01)

The professional nurses, especially those who worked at clinics, displayed support and breathed a sigh of relief when they were informed that the purpose of the research study was to ultimately develop a best practice guideline for their healthy work environment. They posited that a guideline would standardize procedures, as well as give direction to them and their superiors. The participants had this to say:

"We need to have a standard working procedure for all nurses because if you go to other clinics there are different procedures. In the guideline there should be working procedures, referral systems and channels of communication." (Int 12)

"I should think a guideline will help the nurses in performing their work in a better way um and also the procedures that must be followed; you know if they have got a certain query, that they know these are the steps that they have to take in getting the best out of their queries." (Int 10)

"A best practice guideline is there to give us direction, give our superiors direction. It will tell us what to do." (Int 04)

This participant believed that a guideline helped set direction and established continuity in an organization. She felt it laid a foundation for all those who would join that organization. She said that a guideline would help new professional nurses to just follow the lead and only improve on it as new knowledge developed. She articulated this as follows:

"In a certain way a guideline I would say is something that guides you for instance if a person leaves the environment, say for example, the CoI left here and she set good guidance down on the ground and the next person who comes and takes over will just have to follow the guidelines and then she will know the results will be the same or they can be improved easily because what you are improving there is already guidance set out for her. If I find now for instance that structures was a good structure that's there, so that I am one also with good structure I also want a good results because she got good results from using that structure so now I can go and use that structure and look I can improve structure to get better results." (Int 03)

One participant expected the guideline to help the professional to be aware of what went on in different professions out there, as outlined by the participant:

"The best practice guideline, um, I'm thinking basically it should be developed into different professions in the sense, you become aware of what other people are also thinking out there". (Int 05)

One of the participants welcomed the question of the development of a guideline as articulated by the participant below:

"I feel that a guideline like this, that the Colonel is busy with, is a brilliant idea and I feel that our superiors don't get the information from the ground and then if you can collect all that information and talk to people and get it out then it will be perfect if we have a guideline." (Int 03)

With evidence-based practice evolving as the dominant theme for practice, policy, management and education, clinical practice guidelines have become critical components of long-term care. Staff are being encouraged to use the meaningful information tucked inside these guidelines (van der Horst & Scott, 2008:20*).* Although professional nurses expected guidelines to standardize nursing practice, van der Horst and Scott (2008:20) believe that guidelines and evidence should never be used to standardize or routinize care at the expense of losing resident-centred care. Evidence informed care needs to be balanced with the resident's quality of life issues. The issues that emerged from the interviews are around the multi-disciplinary team, the patients and family care approach and the support of professional nurses by management.

3.2.3.1 Sub-theme 3.1: Professional nurses have communicated the need for clear expectations and roles of all role players within the multidisciplinary team

The terms inter/multi-disciplinary refer to teams consisting exclusively of professionals from different professions or disciplines, or at least to the relationships between professionals in teams that may also include other non-professional staff (Nancarrow, Booth, Ariss, Smith, Enderby & Roots, 2013:11-19). A multi –disciplinary team care approach is a dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care. This is accomplished through interdependent collaboration, open communication and shared decision-making. This in turn generates value-added patient, organisational and staff outcomes (Nancarrow et al., 2013:11-19). Working in a multidisciplinary team

requires many skills, which involve understanding not only one's own role but also the role of other professionals (Atwal & Caldwell, 2006:359-365). In a multidisciplinary approach the patient is the main focus and is thus the responsibility of every member of the team. The multidisciplinary team has a responsibility towards one another to have open communication channels and mutual respect for different professions. Each member of the team should know his or her own abilities and limitations. To ensure holistic treatment of the complexity of the patient as a human being one should follow a multidisciplinary approach with communication as the key to optimum care (Naude &d Bruwer, 2006:8-10). The ability to work with professionals from other disciplines to deliver collaborative, patient-centred care is considered a critical element of professional practice. In this study, understanding and appreciating professional roles and responsibilities and communicating effectively emerged as two most important factors, as expressed by the professional nurses. It became apparent that the roles of professional nurses within the multidisciplinary team were not clearly communicated and that impacted negatively on the referral system of patients. They felt that a guideline would therefore give guidance in this regard as articulated by two participants:

> *"I also don't know what is the best word to describe that, like for us as nursing professionals we only do the four-year course ne and then the additional primary health course that is part-time, as you know that the doctors study for seven years, but now sometimes, if we have a problem with the patient and we refer it inside then it's almost like a problem for doctors; um we already discussed that also in various meetings that if we refer a patient to the doctor then the doctor must take over the patient, ne but sometimes the doctor will tell you, you must do this and you must do that and then refer but also in the past we also had the problem with 2 Mil hospital because the doctor at casualty, if you referred a patient to casualty, they will always ask you if there is a doctor at your premises and if you say yes, then they say 'but we don't want referral from the sister, it must be from the doctor.' I personally experience a problem with the doctor at casualty; we just want proper guidelines there." (Int 12)*

> *"The best practice guideline, um, I'm thinking basically it should be developed into different professions in the sense, you become aware of what other people are also thinking out there." (Int 05)*

There is evidence that clear understanding of professional roles and expectations and effective communication thereof had a link to positive patient and provider outcomes (Suter, Arndt, Arthur, Parboosingh, Taylor & Deutshlander, 2009:41-51). The

participants felt that when professional nurses understood exactly what they were supposed to do and this was communicated effectively, patients would not experience long waiting periods. They articulated how patients suffered or were not treated fairly because of lack of documented guidelines directing what should happen when a doctor went off duty while there were still patients who needed to be seen. The participants also indicated the importance of good relations between members of the multidisciplinary team as relations to the contrary would impact negatively on the patients. The participants articulated themselves like this:

> *"Like if I can quickly say this about our patients, because there are no guidelines, I really feel our patients are so neglected. We work from 7until 4 o'clock in General Outpatients Department; when you come there you work here finish, work there, when you get there, the patient that came at 10 o'clock in the morning there, they are still sitting there and they need a doctor to see them, and then the doctors are off-duty; and it's only nurses then you have to tell the patients to come back tomorrow or the next day but um that is, our practice at especially the hospital, it is not very good because patients suffer." (Int 02)*

> *"I have mentioned already, ya there must be teamwork; there must be good relationships and communication between the other professionals or disciplines, like between the social worker, the psychologists and doctors especially because the doctors and the sisters you know are working on this side, because if the sisters and the doctors don't understand each other then it will influence a patient at the end of the day um ja." (Int 07)*

The study conducted by Suter et al. (2009:41-51) revealed that the ability to work with professionals from other disciplines to deliver collaborative, patient-centred care is considered a critical element of professional practice requiring a specific set of competencies. Understanding and appreciating professional roles and responsibilities and communicating effectively emerged as the two perceived core competencies for patient-centred collaborative practice. For both competencies there is evidence of a link to positive patient and provider outcomes (Suter et al., 2009:41-51).

The participants expressed the need for clear direction in how members of the multidisciplinary team worked together and commended how inter-professional collaboration in health care offered rewards. They stated that members of a multidisciplinary team must be clear of where one member started and ended and had to know what was expected of each team member so as to build a stronger sense of their potential role and to improve ways to better meet the needs of clients. The

participants talked about the importance of effective communication in collaboration and knowing what was expected of them as follows:

> *"The multi-professional people are there, you do not have to run around, where you work in harmony with your colleagues, as I said ya to have good multidisciplinary relationship with the multidisciplinary team, um I mentioned good communication...." (Int 03)*

> *"If there are guidelines, I know if I am the only nurse practicing there and there is no doctor then I can refer without any problems but if there is a doctor then I feel the doctor must sort out the person; you must give the history of what you find and then the doctor must take it from there but sometimes the doctor don't want to do that, they sommer want you to refer the patient directly." (Int 03)*

> *"what is expected of me and that makes me be at ease um it also removes a room for error there, when you know what is expected of you, I mean room for errors, and um you are more confident at doing your work because you doing it not according to what you need or also your next, your colleague, you are all practising something that is uniform." (Int 09)*

Babiker et al, (2014:9-16) in their study on "working as a team" claim that there are clear expectations for each team member's functions, responsibilities and accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage of division of labour, thereby accomplishing more than the sum of its parts. About mutual trust and respect, Babiker et al. (2014:9-16) suggest that team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement. They respect and appreciate the role of each other. They also respect each other's talents and beliefs, in addition to their professional contributions. Effective teams also accept and encourage a diversity of opinions among members

According to Babiker et al. (2014:9-16), effective communication is crucial for the teamwork success. The team prioritizes and continuously refines its communication skills. It has consistent and accessible channels for complete communication used by all team members across all settings (Babiker et al., 2014:9-16).

3.2.3.2 Sub-theme 3.2: The care approach needs to be clearly defined and outlined: The best care practices that support patients and families

During the interviews it emerged that professional nurses did not have clearly defined guidelines for the management of patients. They did not know what should be prescribed by doctors and what by nurses. They complained that in some clinics nurses were allowed to manage certain conditions and prescribe to patients while other nurses in other clinics were not allowed to do so. They believed that a guideline would give direction in this regard as articulated by one of the participants:

> *"A guideline will help nurses to practise within their scope of practice. Bring in a booklet, which indicates what can be prescribed by nurses. The military restricts nurses as to what nurses can prescribe without any reason. Patients suffer because most of the time there is no doctor; nurses don't consult." (Int 04)*

Nurse practice is governed by the South African Nursing Council (SANC) regulations which dictate their scope of practice. According to the Nursing Act 33 of 2005 prescribing medication by Nurses/Midwives is intended in a Primary Health Care setup where there is a need for Nurses/Midwives to take care of this function due to circumstances as described in section 56(6)(d) of the Nursing Act. It is the view of the researcher that this function needs to be clearly communicated in the form of a guideline or a standard working procedure so that it applies to all relevant nurses across the board.

One participant indicated that management of patients was not holistic but fragmented as their families were not included. A participant addressed this and said:

> *"Patients have families when we treat the patient we don't treat the family as a totality, we just treat the mama, come the baby in, we treat the baby for an illness and that baby is in a community crèche you know and we don't' get involved in that part and stuff like that, so that kind of things." (Int 08)*

The participant, who proposed that they should work jointly with the clinics in the communities outside the defence force in the management of patients, felt that they would benefit by getting in-service training if they worked together with the other clinics. She claimed that there were medications they were not allowed to prescribe. She also raised a concern that in those other clinics, professional nurses worked together with enrolled nurses and this practice relieved professional nurses of other

duties, unlike in the defence force. She believed that a guideline line would give direction in this regard as she said:

> *"Ya we are missing out, we are having some treatments that we don't look after, so that is one of the things I preferred that we work in one line with the community clinics so that we can have some in-service training with them so that we can be like them. I can talk about our TB cases our HIV cases; we are far behind with the outside clinics so I can say it is one of the things that keep us behind because we only think about our members; we can a bitjie develop ourselves in that. One of the things and our staff-nurses also to be sent out to work with those sisters because now it seems like the sisters is a department on their own; staff nurses are a department of the own and we not like um working together. I saw in other clinics you always have a nurse, assistant nurse or a staff nurse." (Int 03)*

The participants believed that best practice guidelines would serve to optimise treatment of patients and their families. They verbalized their expectations of the best practice guideline to clearly communicate how they were supposed to treat and manage the patients and their families. They felt that they needed guidance in how to support patients and families with respect and dignity. Some of the participants had this to say:

> *"A guideline must direct us to manage patients well, communicate with patients, and win them to our side; that will decrease complaints from them. Sit down and explain, develop good relations with patients." (Int 10)*

> *"A guideline gives quality service to patients and keeps personnel happy." (Int 02)*

The failure to clearly outline the care approach for patients affected their management with respect and dignity, and this was, according to the participants, one of the reasons why patients refused to go to hospitals when they were referred to by the clinic nurses. One participant said:

> *"if we have to see our patients here and you refer the patient to the hospital the patients never want to go to the hospital because there are really treated badly at the hospital so the guideline must be there for everybody, for the doctors, for the nurses, and how to deal with the patients as well ya." (Int 08)*

Positive patient outcomes and patient centred-care are the result in a healthy work environment.

3.2.3.3 Sub-theme 3.3: Best practice guidelines provide professional nurses with a sense of competence and confidence in practice (Management team support)

It was evident in this study that some participants were not happy with the level of support they received from management. The professional nurses who trained within the defence force complained that they were not afforded opportunities to practise as professional nurses; instead they were utilized as enrolled nurses. They expressed frustration in being criticised and called “weak” by their managers. This practice according to one of the participants raised questions of trust and dented their confidence. They believed that a guideline might address their plight. The participant complained and said:

> *“To be honest, I will not mention names here, but I felt bad when the Matron came and did rounds, she said that the comservs are slow, because I trained here too, I felt they are negative to their staff, comservs must be given time to adapt. I do not know how it is done in other hospitals but comservs don’t get drug keys, they must be trusted and be given the opportunity to be professional nurses. The comservs are allocated as enrolled nurses here; when are they going to be confident? The guideline, may be, Colonel, will solve some of these challenges” (Int 07)*

One of the participants complained that, although she was placed as an officer–in-charge of the facility, she was expected by her superiors to also perform ordinary professional nurse’s duties, over and above the administrative duties. She pointed out that she did not get any incentive although this was promised to them in 2007 and nothing so far had been communicated to them with regard to the incentives. This came up as she addressed her understanding of what a guideline should contain. The participant said:

> *“I'm the NOIC (Nursing Officer In Charge) but I am also working like a sister, like the others ne, um we are doing the baby clinics and we consult patients so I see the NOIC have a lot of admin so sometimes I can't even do my admin because I have to see patients also and I am helping with the baby clinics so all the other things that the normal nurse is doing I'm also doing it's just getting more getting more, all over and above ya but when it comes to incentives they don't give me any bonus, we don't even get paid to be the NOIC, you see, so that is all over and above. They promised us now since 2007 that the NOIC's will get paid, but up until now there has been nothing.” (Int 12)*

Responding to the question on her understanding of what a guideline was, the participant below insinuated that their supervisors did not communicate with them; hence they did not know how they felt as subordinates. To this participant, communication between herself and the manager would improve productivity, therefore the guideline should address open and effective communication, education and training, problem solving. The participant had this to say:

> *"Open communication yes um I think that is key, because then my supervisor would know how I feel and at the same time she would be able to tell me what is expected of me we would have that two-way communication um also that feedback then you are able to then give each other feedback because if you are able you know to keep those lines of communication open then it is easier to instance for production purposes or for client satisfaction in my environment then you are able to talk that out that for instance what makes me happy, what is, how can I make things better in the Department, then if we have our meetings and then the other person the manager is more approachable then it's easier to, because not only other things have two wait for meetings and then you know if the person is approachable he is always around to correct things at that time when they happen then we don't have things that are piled up feelings. You only get the best out if members are around you and I think also it's important for everybody not only the managers they need to empower themselves to know what is new around because things are changing every day the environment is changing every time. We have people that have problem-solving skills all the time. Actually, education and keeping information at your disposal all the time is also a key." (Int 09)*

The quote above is an indictment on an organizational culture that is not supportive to personnel. The guideline for a healthy work environment on "Sustaining leadership" states that the need to create and sustain empowered work environments for nurses is a common theme in nursing leadership literature (RNAO, 2013:37). It further states that empowerment occurs over time, has been linked to trust and is thought to occur when an organization sincerely engages its staff with mutual interest and intention to promote growth.

Both empowerment and satisfaction are directly related to employees' circumstances in the workplace. It takes a combination of organizational conditions and leadership styles to empower staff. Social structures in the workplace influence employee attitudes and behaviour as do structural factors, such as access to information, receiving support, access to necessary resources to the job, and opportunities to learn and grow. Manojlovich (2005) cited in RNAO (2013:37) found a strong direct relationship between how nurses perceive their manager's ability to mobilize

necessary resources and their sense of empowerment. That study also showed nurses had a greater belief in their own capabilities when they had strong nursing leadership, which they did not feel if they perceived nursing leadership to be weak. They found managers who reported adequate access to information, support and resources were significantly more empowered and committed to their organizations than staff nurses. Transformational leaders empower nurses through ongoing dialogue, by sharing their vision and values, and motivating others to share them and make them a reality. Empowering leaders give purpose and meaning to work by promoting the value of nursing and creating access to formal and informal power structures, which are significant predictors of access to empowerment in the workplace (RNAO, 2013).

What also came out of the interviews on a best practice guideline was that nurses felt they were not recognised for a job well done; therefore the guideline should address recognition of professional nurses. One of the participants indicated this:

> *"Nurses are not recognised; you need to say even a thank you to like just a simple thank you for a job well done and actually incentives, to say actually you did that quite well, then you get people that are motivated then also in a department you need to recognise not only that the person is here as a worker but that those people have feelings like for instance people have families so you feel important so that the other person feels that they own this place." (Int 09)*

According to Burton (2010:3) every nurse longs to be recognized by his or her peers and nursing leaders as being valued member of the health care team. American Association of Critical care Nurses (AACN) (2005) in Burton (2010:3) proclaims that meaningful recognition is a central element of the Healthy Work Environment (HWE) and is essential to the growth and development of nurses. Inadequate recognition is often cited as the primary reason nurses leave a place of employment or the nursing profession altogether. AACN (2005) describes the nurse leader in a HWE as being a skilled communicator, a team builder, positive change agent, committed to service, results-oriented, and a role model for collaborative practice. Nurse leaders must embrace the concept of a HWE and be positioned to influence decisions that affect nursing practice and the work environment (Burton, 2010:3).

Participants expected guidelines to address all their problems pertaining to support and good relations with management. The guideline should further address the availability of crèches, because most nurses were married and female, sense of belonging, recognition of their birthdays and holding of departmental functions. Monitoring and evaluation and rotation of staff also came as aspects to be addressed in the guideline. They regarded all these needs as factors that contributed to cohesion among colleagues and to a healthy work environment. They believe that in a healthy work environment, professional nurses would give their all. Some participants articulated themselves as follows:

> *"They will get more out of them if they feel that this is also theirs, this is their environment they belong, because the thing is I would say 80% of time we spend at work, so this is your home, so if your colleagues they are cohesive they work together they, you get, let's say for instance at the end of the year they recognise things like birthdays at the end of the year you do have you know departmental functions, things like that, so that people feel more close to each other; and if you don't have that then it hinders that healthy working environment." (Int 05)*

> *"I think also it's important especially that most nurses are females the fact that they are working mothers, so you need to create that you recognise that um these are family orientated people then you have facilities to work around; also to be flexible around working hours because sometimes I feel in the DOD it's like, that doesn't happen, where as we are family we are mothers; it's like it doesn't happen so how do you expect people to give their all, their best, let's say there is a strike for instance, you can hardly expect them to go and work there if you're not going to make an environment where they have a crèche for instance and leave their children not to have those flexible hours where the work is done, then the person can go and do this that, because the reality is that they are wives they are mothers, if you have those reality kind of facilities for them, you will get a lot out of people, out of your employees." (Int 09)*

Good relations between management and staff came up when one of the participants answered the question on what needed to be contained in a best practice guideline. The participant said:

> *"I think my understanding of a best practice guideline is the good relationship with management, a good relationship of which it starts in the ward, a good relationship with the staff " (Int 10)*

> *"First like I say we must have communication; communication must be improved and we must have regular meetings, nursing sisters meetings, if we have meetings and the communication is right, then we will see the environment and from that we can improve the environment but the main thing is to assist monitoring in evaluation; evaluation is important because we can't make a decision if there*

wasn't evaluation on what we have done before. And then they have to rotate people frequently because sometimes it's good to rotate and see the other health environments what they are doing, because if you sit on the one place, you just get so common on the things." (Int 06)

Van der Horst and Scott (2008:20) purport that guidelines provide one with additional, different or better options than what one currently knows. According to them, guidelines can assist you to determine options, prevent complications, and perform techniques and necessary skills, and numerous other recommendations (van der Horst & Scott, 2008:20). Most guidelines are broad recommendations meant to assist practitioners in a variety of settings, and it is often necessary to adapt them for use in your long-term care (Graham & Harrison, 2002, cited in van der Horst & Scott, 2008:20).

Summary to Theme 3

This theme attempted to deal with the recommendations for a best practice guideline made by the professional nurses. The participants showed support for a development of a best practice guideline for a healthy work environment for nurses, as they believed that it would address their different challenges within military settings. The recommendations covered three areas as follows:

Multi-disciplinary team: The participants felt that the roles of different professionals within the multi-disciplinary team needed to be clearly defined. They believed that if they had an understanding of what it was expected of them in the team, they would work harmoniously and play their roles with confidence. The participants did not want to understand only their own roles but also those of other professionals. They indicated that they would benefit from knowing the roles of others.

Patients and families care approach: The participants felt a guideline that defined the care approach for the patients and their families was needed. They expressed the wish that such a guideline should address best care practices that supported dignity and respect of patients and their families. The participants raised concerns that the absence of such guidelines exposed patients to disrespect and they cited the long waiting periods they were subjected to only to be told to come back the following day because the medical practitioners had gone off. They also indicated that the referral

system was not clearly directed because some medical officers did not accept referrals from nursing officers. They needed a guideline to provide clear guidance in treating and managing chronic conditions and complications as this was not standardized. They indicated that there were different practices in different clinics as far as which medications should be prescribed by nursing officers. Participants felt that the guideline would position them properly within their scope of practice as the defence force restricted them to the disadvantage of the patients.

Management team support: Participants expected the guideline to promote provision of support of professional nurses by management. The type of support to be contained in the guideline included recognition of their work by means of incentives; recognitions of their birthdays and also having departmental functions; the availability of crèches at their places of work so that they were able to concentrate on their work and not worry about the safety of their children; support of newly qualified professional by means of in-service training and mentorship; good relations with management, effective communication and empowerment.

3.3 SUMMARY OF THE CHAPTER

Chapter Three discussed the results which emerged from the data collected and analysed from the semi-structured individual interviews of military professional nurses. The results were divided into three themes which comprised how professional nurses experienced working in the SAMHS, followed by their understanding of a healthy work environment and a best practice guideline, and finally their recommendations for the content of a best practice guideline for a healthy work environment for nurses. This concluded Phase 1 of the research study. The findings were compared and contrasted with the literature as a means of verifying the findings.

Chapter Four will deal with an integrative literature review of the existing best practice guidelines for a healthy work environment for health professionals. The guidelines that met the criteria will be critically appraised using AGREE II instrument (Brouwers, 2009, cited in Polit & Beck, 2012), data extracted and synthesised and triangulated with findings from Chapter Three and used to form recommendations for the development

of a best practice guideline for a healthy work environment for professional nurses working in the SAMHS. Chapter Four is Phase 2 of the study.

CHAPTER FOUR

INTEGRATIVE LITERATURE REVIEW REPORT (PHASE TWO)

4.1 INTRODUCTION

In Chapter Three the researcher discussed the findings which emanated from the semi-structured individual interviews with professional nurses where their experiences of working in the South African Military Health Service, their understanding of a healthy work environment and a best practice guideline, as well as the recommendations for the content of a best practice guideline for a healthy work environment for professional nurses working in the SAMHS, were explored and established. Literature control was done to support and contextualize the themes that emerged from the interview evidence in the existing literature. This process confirmed the validity of the findings and Phase 1 was concluded.

This chapter will commence with Phase 2 of the study which comprised an integrative literature review to explore, describe, appraise, extract and synthesise existing best practice guidelines related to a healthy work environment for nurses.

4.2 INTEGRATIVE LITERATURE REVIEW: A METHODOLOGY

Evidence-based practice relies on meticulous integration of research evidence on a topic. Systematic reviews are a pivotal component of evidence-based practice, their bottom line being a summary of what the best evidence is at the time the review was written (Polit & Beck, 2012:30). Systematic reviews that integrate evidence can take various forms and result in different products such as meta-analysis and meta-synthesis (Polit & Beck, 2012:653). Meta-analysis is a systematic review method of integrating quantitative findings statistically while a meta-synthesis involves integrating qualitative research findings on a specific topic. Reviews that critically appraise the literature in an area without statistical analysis are termed integrative literature reviews. Whittemore and Knafl (2005:546) and Onwuegbuzie and Frels (2016:29) define an integrative literature review as a specific method that summarizes past empirical or theoretical literature to provide a more comprehensive understanding of

a particular phenomenon or health problem. According to these authors, the integrative literature review is an approach that allows for the review of diverse studies using diverse methodologies including both quantitative-based and qualitative-based methodologies and has a potential to play a greater role in evidence-based practice for nursing (Whittemore & Knafl, 2005:547; Onwuegbuzie & Frels, 2016:29). Whittemore and Knafl (2005) add that properly conducted integrative literature reviews present the state of the science, contribute to theory development, and have direct applicability to practice and policy (Whittemore & Knafl, 2005:546). An integrative literature review is the broadest category of review (Whittemore, 2005, cited in LoBiondo-Wood & Haber, 2012:212). Burns and Grove (2011:24) add that an integrative literature review of research includes the identification, analysis and synthesis of research findings from independent, quantitative outcomes and qualitative literature to determine the current knowledge in a particular area. The conduct and synthesis of numerous high quality studies in a health-related area yield the best research evidence (Burns & Grove, 2011:465).

4.2.1 Best evidence in integrative literature review

Sources of best research evidence are, according to Craig and Smyth (2012:6-10), empirical studies, other forms of published evidence and available clinical expertise and resources. In this study, an integrative literature review of existing evidence-based best practice guidelines regarding a healthy work environment for health professionals was conducted. Evidence-based guidelines, like systematic reviews, represent an effort to distil a large body of evidence into a manageable form. They give specific recommendations for evidence-based decision-making and attempt to address all of the issues relevant to a clinical decision (Polit & Beck, 2012:31). Guidelines and other sources that integrate, evaluate and concisely summarise important research evidence about a clinical problem are regarded by Haynes and DiCenso, cited in Craig and Smyth (2012:64), as best research evidence. Guidelines were therefore identified as a reliable source of best research evidence. In evidence-based practice, professional organisations categorize and rate evidence. LoBiondo-Wood and Haber (2010:16) developed a hierarchical rating system that nurses use to make decisions about evidence as depicted in Figure 4.1.

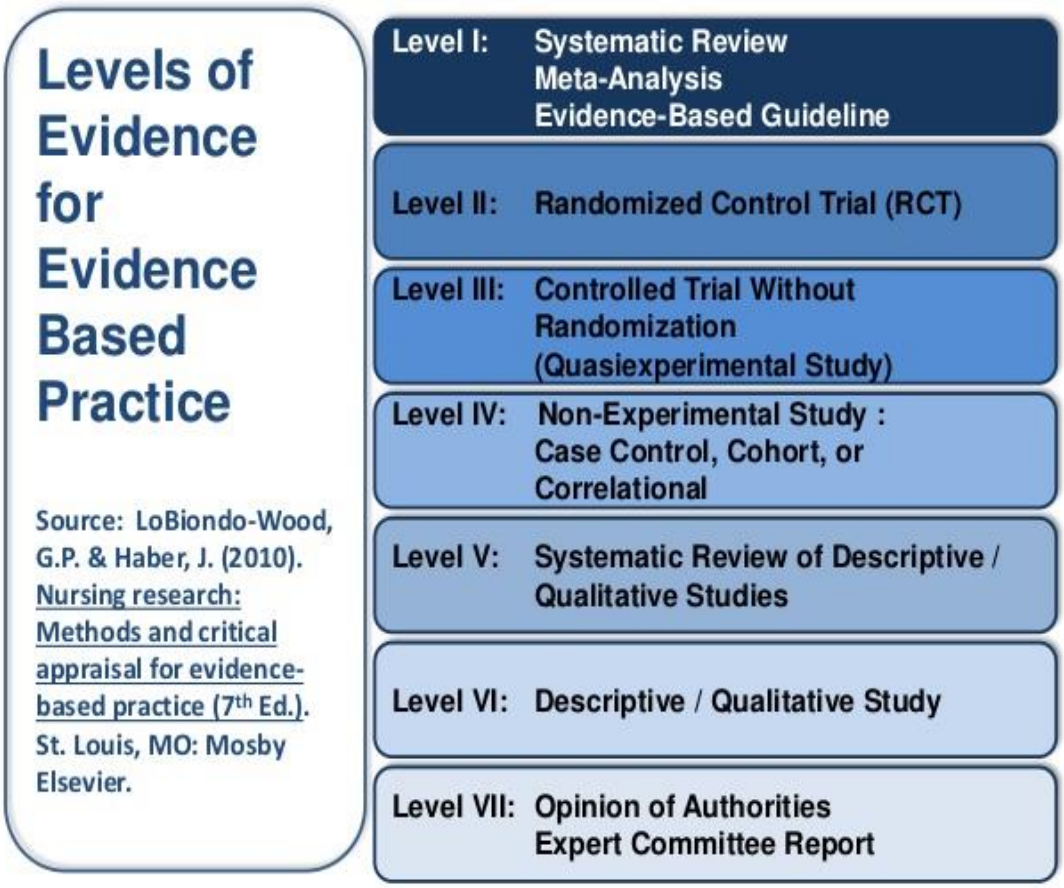


Figure 4.1: Levels of evidence hierarchy by LoBiondo-Wood and Haber (2010:16)

This rating system by LoBiondo-Wood and Haber was employed to decide on the level of evidence for the research study.

The focus of this chapter is to synthesize the existing evidence-based best practice guidelines portrayed as Level I on LoBiondo-Wood and Haber's levels of evidence hierarchy (see Figure 4.1), using the integrative literature review method. The review question, search, identification and selection of existing evidence-based best practice guidelines for a healthy work environment for health professionals, their appraisal, data extraction, analysis and synthesis, will be discussed as part of the methodology of the integrative literature review.

4.3 THE METHODOLOGY OF AN INTEGRATIVE LITERATURE REVIEW

Evidence-based practice guidelines that are formulated with rigorous methods can, according to LoBiondo-Wood and Haber (2010:401), provide a form of evidence to synthesize with empirical research. LoBiondo-Wood and Haber (2010:213) assert that although guidelines are developed by professional organizations, government agencies, institutions or convened expert panels, not all practice guidelines are well developed or built on strong evidence and like research, must be assessed before implementation. They need to be evaluated for quality, quantity and consistency (LoBiondo-Wood & Haber, 2010:213). The integrative literature review process was followed to review the guidelines. According to Whittemore and Knafl (2005:548), without explicit and systematic methods of undertaking an integrative review, the risk of error increases exponentially. They suggest five (5) stages to the integrative review process: (1) the problem identification stage (2) Literature search stage (3) Data evaluation stage (4) Data analysis stage and (5) Presentation of results. These stages equate to the steps used in the evidence- based approach as depicted in Table 4.1.

Table 4.1: Depicts the stages/steps for integrative literature review process

Stages of in the integrative review process (Whittemore & Knafl, 2005)	Steps in the evidence-based approach
1. Problem identification	1. Review question
2. Literature search	2. Search for evidence
3. Data evaluation	3. Critical appraisal
4. Data analysis	4. Data extraction
5. Presentation of results	5. Data analysis and synthesis

Sources: (Whittemore & Knafl, 2005:548; Polit & Beck, 2012).

In this study, the process of integrative literature review of the guidelines was done using the evidence-based approach, which conforms to Whittemore and Knafl (2005:548)'s approach and discussed below.

In step 1 (see Table 4.1), a review question was formulated using PICO acronym as detailed in Chapter Two to assist the literature search for evidence related to a healthy work environment for professional nurses. The next step, which is step two, entailed

a search for evidence in which specific inclusion and exclusion criteria were outlined in order to isolate evidence related to the review question. Once the guidelines had been retrieved, those that met the inclusion criteria were critically appraised in step three, using the AGREE II tool discussed in detail in Chapter Two. Data was then extracted from the guidelines in step four. Lastly, in step 5, the data was analysed and synthesized resulting in recommendations which were presented in this report and form the draft for the best practice guideline for a healthy work environment for nurses.

4.3.1 Step one: The review question

- The review question was formulated using the acronym PICO, which stands for P = Population or participants; I = Intervention or issue of interest; C = Context and O = Outcome. This was done to guide the literature search process. The PICO was applied to the study as follows:
- **P** – (Population or participants) = Health care professionals including nurses
- **I** – (Intervention) = Healthy work environment
- **C** – (Context) = Comprehensive health care settings (hospitals and clinics)
- **O** – (Outcome) = Enhanced work environment for health care professionals (nurses).

The review question which was formulated to search for the relevant literature was as follows:

What existing evidence-based best practice guidelines are available for a healthy work environment for nurses/health care professionals? The question was extended to include all health care professionals because of scarcity of healthy work environment best practice guidelines from different organisations.

4.3.2 Step 2: Search for evidence

Once the question was formulated, a comprehensive search for eligible evidence-based guidelines related to a healthy work environment for nurses or health care professionals commenced. Databases, keywords and the explicit and succinct inclusion and exclusion criteria were applied in order to isolate the evidence related to

the review question. A systematic search for the high-quality evidence-based best practice guidelines was conducted and the search process will be discussed. Evidence only in Level I (see Table 4.1) was searched for.

The search process started with the researcher requesting assistance from the Faculty of Health Sciences librarian at Nelson Mandela University. After the initiation of the process, the researcher together with the librarian conducted the search. The search for this topic included nursing and medical references and health-related fields. The scoping review included articles found in databases and grey literature such as unpublished theses and dissertations responding to the healthy work environment for professional nurses. The researcher concentrated only on Level I evidence-based best practice guidelines. Databases specialising in best practice guidelines (BPG) were thoroughly searched for BPGs. All words were searched under full title and with full PDF. Abstracts were read in order to obtain a preview of the contents and to make decisions on whether to use the documents. This strategy enhanced a comprehensive literature search for high quality evidence, as full text were more elaborate thus facilitated better comprehension of the topic under discussion. The electronic databases, CINAHL, Ebscohost, Biomed Central, Medline, Science direct and Pub-med, Google, Google scholar and organisation's sites like Registered Nurses Association of Ontario (RNAO) and National Institute for Health and Care Excellence (NICE) were thoroughly searched using a combination of key words: "healthy work environment for nurses,", "healthy work environment for health care professionals," healthy environment," "healthy military environment," "best practice guidelines," "professional nurses," "healthy nurses", "positive work environment", "workplace health to facilitate the search." The search terms used to search literature are reflected in Annexure M.

4.3.2.1 Selection of evidence

As part of the search planning process, the researcher decides what studies should be included in the study. Craig and Smyth (2012:191) recommend that this should be done according to rigorous inclusion and exclusion criteria so that systemic bias can be avoided. These clearly stated eligibility criteria specify which studies will be included and which will be excluded from the review. Inclusion and exclusion criteria

were used to determine relevant primary sources. The selection of the eligible evidence-based best practice guidelines to be amalgamated into the research study was guided by the following inclusion and exclusion criteria:

4.3.2.2 Inclusion criteria

On completion of the formulating of the review question, literature search and data evaluation, the researcher decided on the following inclusion criteria for this study:

- All Level I (see Table 4.1) available evidence-based best practice guidelines (BPGs) focusing on healthy work environments for nurses or health care professionals whose outcomes were enhanced work environments;
- All guidelines related to health care professionals including nurses due to scarcity guidelines;
- All the BPGs that were published in English as the researcher did not have the capability of reviewing documents in other languages due to translation costs;
- Literature published between 2003 and 2017. The researcher used this extended literature publication period due to scarcity of the BPGs on healthy work environments. The time period of publication chosen was all inclusive of old and latest literature;
- Using most updated versions of the BPGs.

4.3.3.4 Exclusion criteria

The exclusion criteria were based on the following:

- Literature on healthy work environments other than for nurses or health care professionals was excluded.
- BPGs that were duplicated because they were from different sources, as well as outdated versions of the same BPGs were excluded.

4.3.2.4 Selection process for inclusion and exclusion.

All guidelines that met the criteria for the study were retrieved and classified correctly. The exclusion was done by reading all the titles that did not respond to the review

question since these BPGs either did not address the healthy work environment for nurses or health care professionals or were not health related. Full texts of the BPGs were then excluded. Thereafter, the full texts of BPGs were obtained from the titles that were relevant. The inclusion and exclusion criteria were applied by both the researcher and the independent reviewer. Consensus following conscious deliberation was then reached between the two reviewers as to which guidelines to include or exclude from the study. The guidelines that were most applicable or those that addressed the topic under study appropriately were retained while the ones not answering the review question were discarded. More information about the data obtained from this search and the selection process will be discussed in 4.4. The entire search was recorded in the PRISMA flowchart, Figure 4.2.

4.3.3 Step 3: Critical appraisal

The third step of integrative literature review under the evidence-based approach is critical appraisal. Critical appraisal is defined as 'the process of carefully and systematically examining research to judge its trustworthiness, and its value and relevance in a particular context' (Burls, 2009, cited in Gough, Oliver & Thomas (2017:259). O'Rourke (2005) in Craig and Smyth (2012:150) further clarifies that critical appraisal is a discipline for increasing the effectiveness of a researcher's reading, by encouraging systematic assessment of reports of research evidence to see which ones can best answer clinical problems and inform "best practice."

Once the existing guidelines for a healthy work environment, that met the criteria, were found, they were retrieved and critically appraised. Several guideline appraisal instruments are available, but the one that has gained the broadest support is the Appraisal of Guidelines for Research and Evaluation (AGREE II) Instrument from the AGREE Research Trust (Brouwers, 2009, cited in Polit & Beck, 2012:42). This tool is widely used to evaluate the applicability of a guideline to practice. It assesses: the scope and purpose of the guideline, stakeholder involvement, rigour of the guideline development, clarity and presentation of the guideline, and editorial independence of the developers (LoBiondo-Wood & Haber, 2010:214). The AGREE II instrument was utilized to assess the quality and applicability of the selected evidence-based best practice guidelines to the study at hand. The AGREE II instrument (see Annexure J)

consists of twenty-three (23) items organized within six (6) main domains, followed by two (2) global rating items (Overall Assessment). Each domain captures a specific aspect of the guideline quality. It is recommended that the tool be used by at least two (2) independent appraisers to increase the reliability of the assessment (Brouwers, 2009:7, cited in Polit & Beck, 2012). The highest score that can be attained by a single item is 7 and the minimum is 1. The overall highest score for the 6 domains is 161 while the lowest is 23. The percentage per guideline was calculated by dividing the score obtained by 161and multiplied by 100. All guidelines which weighed 60% and above were regarded as rigorously developed and were therefore recommended and allowed for use in the current study. The same guidelines were appraised by the independent appraiser and all those who were affirmed by the independent appraiser were considered for use. The independent appraiser was identified by the Department of Nursing at Nelson Mandela University, a member of the department and an experienced appraiser with vast knowledge in the field of health and nursing and in appraising and reviewing guidelines. The decision to either include or exclude the guidelines was taken after the marks from the independent appraiser were collated and appraisal results finalised. It is recommended that the tool be used by at least two independent appraisers as extrapolated earlier as this will enhance the reliability of the assessment (Brouwers, 2009:6, cited in Polit & Beck, 2012).

Table 4.2: Rating scale for AGREE II according to (Brouwers, 2009:8, cited in Polit & Beck 2012)

All AGREE II items are rated on a 7 point scale (1- strongly disagree to 7- strongly.

1 Strongly disagree	2	3	4	5	6	7 Strongly agree

Score of 1**:** (Strongly disagree)**:** A score of 1 should be given when there is no information that is relevant to the AGREE II item.

Score of 7: A score of 7 should be given if the quality of reporting is exceptional and where a full criterion has been met. The findings of the critical appraisal are described in more detail in the discussion of results in section 4.4.

4.3.4 Step 4: Data extraction

Data was extracted from the best practice guidelines and is the next step after critical appraisal. The data extraction particularly focused on the objective of the guideline, the target population of the guideline, the guideline development group, systematic methods that were used to search for evidence, the criteria for selecting evidence and the methods for formulating the recommendations, and lastly the views of the funding body had not influenced the content of the guideline. As there was a lot of information with regard to healthy work environment, data extraction was guided by the major themes from the interviews in Phase 1. Data was then summarized using the different headings as stated in the AGREE appraisal tool. The AGREE II appraisal tool was used as there was no other structured data extraction tool available. Data extracted from the best practice guidelines were presented in a form designed by the researcher adapted from the AGREE II Instrument (see Table 4.4).

4.3.5 Step 5: Data analysis and synthesis

Data extracted from the best practice guidelines that met the inclusion criteria was categorized into themes. A descriptive analysis done was based on the major recommendations regarding healthy work environment for nurses or health care professionals derived from the data extraction. These analyses later formed themes that addressed healthy work environments for nurses or health care professionals. The extracted data were analysed and synthesized as recommendations which were included in a draft best practice guideline for a healthy work environment for nurses working in the SAMHS in Chapter Five of the study. The process of data analysis and synthesis was also supervised the experienced researcher. The results of the integrative literature review will be discussed in the following section, starting in paragraph 4.4.

4.4 DISCUSSION OF RESULTS OF THE INTEGRATIVE LITERATURE REVIEW

This section deliberates on the results of the integrative literature review that was conducted by the researcher**.** It constitutes themes that emerged after coding of

extracted data from the inclusive guidelines based mainly on recommendations related to enhancement of a healthy work environment for health care professionals, including nurses.

4.4.1 Description of the evidence

A total of fifteen (15) guidelines on healthy work environment for nurses or health care professionals were identified in the initial search. Of the 15 guidelines one (1) was not considered for the study (see Annexure N) as it did not meet the inclusion criteria as the population was not health care professionals or nurses, while two (2) guidelines were found not to be relevant for the study due to duplication and were therefore eliminated (see Annexure N for exclusion reasons). Twelve (12) guidelines were identified for possible inclusion in the integrative literature review. After the final critical appraisal twelve (12) guidelines were included for data extraction and synthesis in the integrative literature review and themes were subsequently formulated. **Figure 4.2** summarizes the guidelines searched and ultimately included in the Integrative literature review.

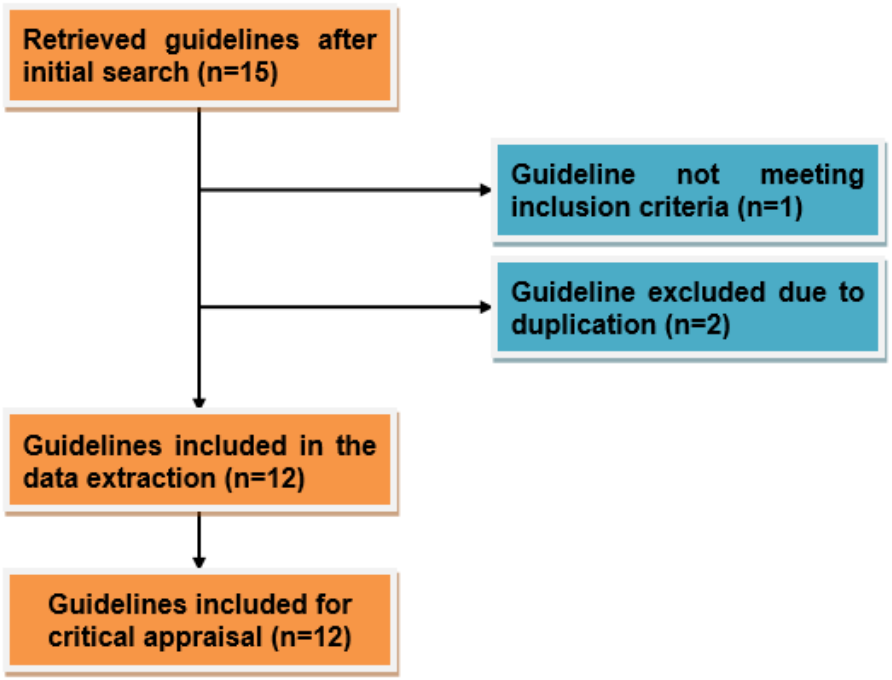


Figure 4.2: Summary of the process leading to guidelines included in the Integrative literature review

Table 4.3 outlines the guidelines excluded for appraisal.

Table 4.3: Guidelines excluded for appraisal

Serial no	Name of the guideline	Publishing organisation	Year of publication	Reasons for exclusion
1.	Preventing and managing violence in the work place	RNAO		Duplication
2.	Supporting Leaders in evidence Based Management Decision Making Towards Clinical Nursing Excellence	Sigma Theta Tau International	2011	Duplication
3.	Framework Guidelines for Addressing Workplace Violence in the Health Sector	ILO, ICN, WHO & PSI	2002	Did not meet the criteria

Below is the list of guidelines included for appraisal and a summary of the appraisal scores (Table 4.4) from the two appraisers:

Table 4.4: A list of guidelines include for appraisal and a summary of Appraisal scores of twelve guidelines from the two (2) appraisers

Serial no	Title of guideline	Total scores by researcher in %	Total scores by the independent reviewer in %	Decision Included / Excluded
1**.**	Healthy work environment: Mitigating Nurse Fatigue in Health Care (RNAO, 2011)	88% (142)	82%	Included
2.	Healthy work Environment: Embracing Cultural Diversity in Health care: developing cultural competence (RNAO, 2007)	87% (140)	99%	Included

Serial no	Title of guideline	Total scores by researcher in %	Total scores by the independent reviewer in %	Decision Included / Excluded
3.	Healthy work Environment: Best Practices for Assessment and Control of Psychological hazards (Government of Alberta, 2011)	88% (142)	82%	Included
4.	Healthy work Environment: Managing and mitigating Conflict in Health Care Teams (RNAO, 2012)	88% (142)	98%	Included
5.	National Guidelines for the promotion of Healthy work environments (HWAC, 2006)	75% (121)	83%	Included
6.	Healthy work environment: Intra-professional Collaborative Practice among Nurses(RNAO, 2016)	90% (145)	99%	Included
7.	Best practice Guidelines: Work place Health in Australia: (WHAA, 2015)	70% (113)	73%	Included
8.	Healthy Work Environment: Developing and Sustaining Effective Staffing and Workload Practices (RNAO, 2017)	88% (142)	88%	Included
9.	Healthy Work Environment: Professionalism in Nursing (RNAO, 2007)	87% (140)	86%	Included
10.	Healthy Work Environment: Developing and Sustaining Inter-Professional Health Care: Optimising patient, organizational and system outcomes (RNAO, 2013)	90% (145)	100%	Included

Serial no	Title of guideline	Total scores by researcher in %	Total scores by the independent reviewer in %	Decision Included / Excluded
11.	Healthy Work Environment: Workplace Health, Safety and Well-being of the Nurse (RNAO, 2008)	87% (140)	86%	Included
12	Healthy Work Environment: Developing and Sustaining Nursing Leadership (RNAO, 2013)	88% (142)	88%	Included

Data was extracted from the twelve (12) guidelines and is presented in Table 4.5 below.

Table 4.5: Summary of data extracted from guidelines

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
1.	Healthy work environment: Mitigating Nurse Fatigue in Health Care (RNAO, 2011)	The aim of the guideline is to provide the best available evidence to support prevention and mitigation of fatigue for nurses and other health-care professionals	1. Governments at both national and provincial levels must promote the management of fatigue in health-care work environments by providing sufficient economic and human resources within the work environment to prevent and mitigate fatigue. 2. Organizations plan, implement and evaluate staffing and workload practices that create adequate staffing to reduce workload, in order to mitigate nurse fatigue and ensure nurse and patient safety. 3. One study identified **that integral role that nurse managers play in creating and modelling the health care work environment for staff nurses** (Shirey M. 2006 in RNAO (2011:26). Further research examining **the relationship of fatigue to the leadership style** of the nurse manager is required and will benefit the development of successful approaches to address nurse fatigue. **4. Managers** and those responsible for staffing and scheduling must be educated about the importance of incorporating fatigue prevention initiatives into the organisation's daily operations. **(Linked to Theme 2, sub-theme 2.3 in Phase 1**).

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
2.	Healthy work Environment: Embracing Cultural Diversity in Health care: developing cultural competence (RNAO, 2007)	The aim of the guideline is to provide the best available evidence to support the embracing of cultural diversity in health care to create thriving work environments	**Embracing cultural diversity in the workplace:**. **Cultural competence** is a congruent set of workforce behaviours, management practices and institutional policies within a practice-setting whose underlying values are inclusivity, respect, valuing differences, equity and commitment. Cultural competence is a continuous process of effectively developing the ability to work within the cultural context of community, family and individuals. Developing cultural competence means that the health professional becomes aware of one's own cultural attributes and biases, and their impact on others. **Leadership is clearly a critical variable** to the success of any diversity initiatives. Sensitivity to diversity issues at the executive level had an effect on diversity management practices used by health institutions (P.40) **Communication** Health care professionals need to **learn appropriate communication skills across cultures to practise competently** and to discuss health related issues effectively. Language and cultural differences have been identified consistently in literature as factors that act as barriers to development of genuine relationships between clients and nurses. Communication becomes a key issue in developing collegial relations in the diverse work team. Embracing cultural diversity and developing cultural competence are key components of healthy work environments and influence all aspects of the environment including **leadership, teamwork**, and professional practice. .

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
3.	Healthy work Environment: Best Practices for Assessment and Control of Psychological hazards (Government of Alberta, 2011)	To provide evidence to deal with health organizational stress	**Causes of stress in the work place** 1.Participation and control (lack of participation in decision making, lack of control over work processes, pace, hours, methods, and the work 2. Career development, status and pay 3. Role ambiguity 4. Interpersonal relationships (unsupportive supervision, bullying, abuse, violence, isolated work, poor relationship with co-workers, etc.) 5. Organizational culture (**poor communication**, **poor leadership**, lack of behavioural rules, lack of clarity about objectives, structures and strategies) **(Linked to Themes 1, 2 and 3).** 6. Work – life balance (conflicting demands, lack of organizational policies and rules to support work-life balance **(linked to Themes 2 and 3)** 7. Lack of opportunity for advancement which can lead to frustration, anxiety and a sense of failure. **(Linked to Themes 1 and 2)** 8. Lack of fairness in terms of pay, benefits, involvement, opportunities, advancement. **Relationships** »» Poor relationships with supervisors reflecting management style and the lack of development of trust and mutual assistance. »» Poor relationships with colleagues which may lead to distrust, hostility, ambiguous loyalties and **low levels of communications**. »» Poor relationships with clients which may result from clients with high demands and low levels of appreciation. **(Linked to Theme 1**).

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
			Organizational climate »» Lack of participation in decision-making at both the organizational level and at the level of an individual's work. **(Linked to Themes 1 and 2).** »» Lack of information at the organizational level leading to a lack of clarity about the overall direction, operations and values of the organization. **(Themes 1 and 2).** »» Lack of information at the individual level that will enable a worker to perform his or her work as well as possible **(Linked to Themes 1 and 2).** **Role clarification** »» Role conflicts brought out by inconsistent expectations from supervisors or co-workers, or when materials are not available to do a job properly, yet the job needs to be done. (**Linked to Theme 2 and 3).** »» Role ambiguity when workers do not know what is expected of them, especially common when workers are not aware of the goals or objectives that must be accomplished. **(Linked to Theme 2 and 3).** **Violence in the workplace** One form of Type III events is workplace bullying. The most common examples of bullying behaviour were shouting, ordering, belittling, abusive language, spreading rumours, nasty or harmful teasing or jokes, and an oppressive workplace where there was fear of speaking up about issues of concern. **(Linked to Theme 1).** The United States Joint Commission, which accredits healthcare organizations in the United States, issued an alert about intimidating and disruptive behaviours at work:

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
			Intimidating and disruptive behaviours can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on **teamwork**, **communication,** and a collaborative work environment. To assure quality and to promote a culture of safety, Health care organizations must address the problem of behaviours that threaten the performance of the health care team. **Good interpersonal relationships** are the foundation of healthy workplaces. **Management style** can lead to behaviours such as abuse, bullying, or violence between workers. **Communication** It is essential that **management** communicate new changes and what the organization hopes to achieve through the change. Discuss the Timetable for action and the specific steps to be taken; the impact of changes on their day-to-day activities. Management to **provide training** to assist with change and alleviate concerns. Ideally, new developments should be communicated as soon as possible to minimize the negative impact of rumours. Face-to-face communication is the best option in order to allow workers the opportunity to ask questions and express their views. It is helpful to utilize a variety of communication methods (e.g. face-to-face, paper, and electronic) in order to effectively get the message out to workers. Maintain an open-door policy where workers can talk to managers about

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
			Their concerns and make suggestions for improving the change process. **(Linked to Themes 1 and 2)** **Work-Life Conflict, Including Reactions to Excessive Workload** Individuals fulfil a variety of roles throughout their lives and strive to achieve a balance between these different roles and responsibilities. Reconciling work and family commitments is an ongoing challenge for many workers particularly in the context of a changing family paradigm, management to take cognisance of work-family balance.
4.	Developing and Sustaining Inter-professional Health care: Optimizing patient, organizational and system outcomes (RNAO, 2013)	To identify best practices to enable, enhance and sustain teamwork and inter-professional collaboration for positive outcomes for patient, organization and system	Effective inter-professional **teamwork** is part of a healthy work environment. Inter-professional care is the provision of comprehensive health services to patients by multiple health care givers who work collaboratively with patients and families to deliver quality care across settings. They identify and take advantage of each professional's care expertise. Organizations and system put policies, practices and structures in place to enable all health providers to optimize their scope of practice for the benefit of patients and themselves. Novice professionals are encouraged to draw on the knowledge and support of an expert in the same profession. **Leaders of key agencies** (governments, academic institutions, regulatory bodies, professional associations and practice-based organizations) collaborate to make inter-professional care a collective strategic priority. Health care professionals must be willing to **share power** by letting others influence patients care regardless of their educational or professional preparation. This leads to all team members, including patients to feel engaged, empowered, respected and validated.

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
			Collaborative leadership, a people and relationships focused approach, is based on the premise that answers should be found in the collective. It reflects shared responsibility and accountability that addresses power and hierarchy. It promotes a collective leadership process where at different times different people assume the leadership role. It structures a learning environment that supports continuous self- development and reflection, team members learning together from each other, supports relationships that value honesty and mutual respect, fosters shared power and values diversity. **Optimising profession, role and scope:** **Team members are allowed to work to their full scope of practice**. **(Autonomy)** Practitioners must understand not only their roles but also those of other team members. They must be able to articulate their roles, knowledge and skills and use effective listening skills with other members. All practitioners must respect each other's professional culture and values. **Shared decision making** gives all team members, including patients, the opportunity to contribute their knowledge and expertise, to arrive collaboratively at an optimal goal. It requires respectful and trusting relationships among providers. For shared decision making to work, everyone must recognize and respect each other's knowledge and expertise, regardless of occupation and formal position. **Effective group function:** A health care system that supports **effective teamwork** can improve the quality of patients' care, enhance patients' safety and reduce workload issues. This is the successful interaction of an inter-professional interdependently to provide care to patients. They are expected to work collaboratively to formulate, implement and evaluate care and assess, practise and reflect on whether the group processes were effective. **Competent communication:**

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
			Openness, honesty, respect for each other's opinions and effective communication skills are part of all domains of inter-professional practice. Competent communication helps develop and sustain leadership and actively engages members of the team while demonstrating respect and professionalism.
5.	Developing and Sustaining Safe, Effective Staffing and Workload Practices (RNAO, 2017)	To assist nurses, nursing leaders, and administrators to create healthy work environments through safe, effective staffing and workload practices.	Safe, effective staffing and workload practices are critical components of a healthy work environment**.** This is essential to the ability of nurses to deliver appropriate and effective person and family centred care. Safe nursing staffing processes are conducted by **nurse leaders** with requisite knowledge, professional judgement, skills and authority in collaboration with nursing staff at the point of care (Recommendation 1.1) **Nursing leaders** make evidence-based decisions when conducting nurse staffing planning to provide sufficient numbers of nurses (Recommendation 3.0) Heavy workloads, stress and long hours can alter nurses' physical and psychological health. Overburdening existing staff with increased workloads and demands that may bring about further staff turnover must be avoided and those responsible for staffing must create and employ a clear communication strategy to address staffing needs in unplanned situations, such as pandemics and disasters. Nurses, including **charge nurses,** responsible for day-t-day staffing decisions for their unit or team must demonstrate skills and knowledge that support a comprehensive approach to staffing including patient needs, knowledge of the team, communication skills, flexibility and scopes of practice.

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
6.	Developing and Sustaining Nursing Leadership Best Practice Guideline (RNAO, 2013a)	To assist nurses and others performing both formal and informal nursing leadership roles from the point of care to the board room, across a variety of practice domains and settings, with leadership practices that create a healthy work environment	**Nursing leadership** is a vital component in the delivery of patient care. It shapes the profession, facilitates policies on mentoring and evidence-based practice and helps navigate change in challenging times. **The five practices of Transformational leaders:** ***1. Building relationships and trust*** is a critical leadership practice, the foundation on which the other practices rest. Relationships include those formed between individual nurses, on teams and in internal and external partnerships. **2. *Creating an empowering work environment*** depends on respectful, trusting relationships among people in a work setting. An empowered work environment has access to information, support, resources, and opportunities to learn and grow, in a setting that **supports professional autonomy** and strong networks of collegial support. **3. *Creating a culture that supports knowledge development and integration*** involves fostering both the development and dissemination of new knowledge and instilling a continuous-inquiry approach to practice, where knowledge is used to continuously improve clinical and organizational processes and outcomes. **4. *Leading and sustaining change*** involves the active and participative implementation of change, resulting in improved clinical and organizational processes and outcomes. **5. *Balancing the complexities of the system, managing competing values and priorities*** entails advocating for the nursing resources necessary for high-quality patient care, while recognizing the multiple demands and complex issues that shape organizational decisions. Proper use of evidence is the key.

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			6. Nurse leaders create environments where **communication is open**, and **teamwork and the contribution of others' knowledge is valued** (Ballein Search Partners, 2003, in RNAO, 2013:45). **Organizational Supports** influence whether **leadership practices** will succeed and produce a strong, visible **nursing leadership.** They include: ■ valuing nurses' critical role in providing patient/client care; ■ supplying sufficient and appropriate human and financial resources; ■ providing necessary information and decision support; and ■ creating a culture and climate conducive to effective, efficient nursing care**.** **Nurse leaders** use **transformational leadership** practices to create and sustain healthy work environments. **Health-service organizations** provide supports for effective nursing leadership. **Governments** develop policies and provide resources that support effective leadership.
7.	Healthy work environment: Workplace Health Safety and Well-being of the Nurse (RNAO, 2008).	To promote a healthy work environment for nurses by addressing factors that contribute to nurses' health, safety and well-being and to make recommendations	Workplace health and safety of the nurse is crucial if nurses are to provide the best possible care to their patients and if they are to be enticed to enter/remain in the nursing workforce. **Organizational culture and Nursing outcomes** This culture should focus on nursing outcomes such as job satisfaction, stress, burnout and autonomy. Approaches to achieve and maintain a suitable level of workplace health and safety based on prevention, identification and resolution of potential risks (both physical and psychological) are required. **Leadership and organizational** culture of the employer are crucial to the establishment of a suitable healthy and safe work

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
		that may influence the overall health and well-being of an individual nurse.	environment for health care workers. A supportive climate to nursing includes **teamwork,** a sense of personal importance and freedom to ask questions. **Nurse turnover** Nurse turnover is influenced by characteristics associated with workload, management style, empowerment and autonomy, promotion opportunities and flexible scheduling. Research has demonstrated that the more autonomy, work empowerment and resources nurses had and the stronger the leadership present at work, the more likely they were to be satisfied with current position. **Nursing leadership:** Nursing leaders play a key role in creating a positive safety climate. Nursing employers must work with governments to advocate for the appropriate human and fiscal resources required to implement and sustain safe work policies and practices. Nurses require strong leadership at every level of the health care system hierarchy, including direct supervision of nursing practice at bedside (RNAO, 2008:34). **Training and education programmes** To establish a safe environment for nurses, organizations must provide nurses with the knowledge to recognize and evaluate hazards and facilitate the development of skill sets for confronting hazardous situations. Knowledge transfer or exchange of evidence-based knowledge must be supported by user friendly materials and a communication strategy that enhances credibility of the organisation. **Personal and Professional Development work/life balance** Organizations must provide nurses with opportunities for personal, professional and spiritual development with regard to healthy work environments, professional competencies and work/life balance. (

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
8.	Healthy work environment: Intra-professional Collaborative Practice among Nurses (RNAO, 2016)	To strengthen collaborative practice among nurses in the health care organizations	Intra-professional collaborative practice occurs when multiple members of the same profession work as a team to deliver quality care. This requires the members of the team to be willing and committed to **working as teams.** They must have clear understanding of their roles and responsibilities, their scopes of practice, and communicate effectively. **The attributes of teamwork are:** mutual respect, open communication, resilience, honesty, accountability, self awareness, shared planning and emotional intelligence. For successful intra-professional collaborative practice among nurses, nurse managers need to be mentors, providing guidance and professional training according to staff needs. They must be approachable, respectful and listen actively to nurses. **Effective leadership is key** where there is power sharing between managers and nurses, nurses participating in decision making. There must be clear processes and structures in place to promote intra-professional collaboration. Rounds and team meetings form part of the processes and structures as they promote face to face interaction and collaboration. Organizations to have clear policies and strategies that **encourage teamwork**, including conflict management policies. Governments to support nursing participation in collaborative team work by developing structures and funding to enhance team development.

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
9.	Managing and mitigating conflict in health care teams (RNAO, 2012)	To foster healthy work environments for nurses and other health care professionals through managing and mitigating interpersonal conflict	Nursing is about relationships and the quality of those relationships is vital to everyday interactions and positive outcomes to patient/client care and role satisfaction as conflict is inevitable in any workplace, organizations need to have a process to manage conflict that may occur. Failure to manage conflict, a stressful work environment with its negative consequences will be created. Bullying and ostracism are associated with inter-personal conflict. Nurses do experience conflict with doctors, mangers, colleagues, patients and families and these are either relational or task conflicts**.** Lack of communication, lack of collaboration and lack of emotional intelligence can exacerbate conflict and unaddressed interpersonal conflict can interfere with the personal well-being of individuals. **Support from the employee's supervisor** is integral to management of inter-personal conflict amongst health care workers. **Organization leaders, managers, nurses and health-care teams** need to have an understanding of sources of conflict so that they are able to manage and mitigate conflict.
10.	Healthy work environments Best Practice Guidelines: Professionalism in Nursing (RNAO, 2007)		Knowledge provides the basis for professional practice (41) and, is a central aspect of professionalism (42-45). Knowledge enables professions, such as nursing, to define the nature of problems and solutions, make autonomous decisions and use discretion within their practice. There is a close relationship between professionalism, education and knowledge development. **Autonomy**: (linked to Theme 1, sub-theme 1.2) **Professionalism** includes: - Working independently and exercising decision-making within one's appropriate scope of practice.

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
			- Nurses' ability to be autonomous being supported or limited by the organization. Although autonomy cannot be 'given' by those in formal power, it can be facilitated by nurse leaders. - Nurses may experience that peers, colleagues and the administration limit their autonomy. Attitudes, values, traditions, policies and practices may restrict nurses' decision-making about their practice. When nurses analyse the reasons why their autonomy is compromised they can seek ways to remedy the situation. **Advocacy** (Linked to Theme 3, sub-theme 3.2 Definition: An advocate is a person who supports or speaks out for a cause, policy. This includes being an advocate/change agent for clients, families and communities as well as the profession. Nurses have a long tradition of patient-related advocacy. Many authors describe advocacy as implicit within the daily activities of the nurse and an essential component of practice. Nurses are well placed within health care team to act as advocates or mediators. Nurses are responsible for the majority of patient care delivery; they are positioned to have the influence on the patient care outcomes Nurses should have input into all aspects of patient care within their scope of practice including serving as patient advocates. **Collegiality and Collaboration (Linked to Theme 3, sub-theme 3.1)** Definition: A colleague is a fellow official or worker, especially in the same profession or business.

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
			Shared power and authority is vested among colleagues. Collaborate means to work jointly with, co-operate. It goes beyond individual requirements and includes other health professionals. **Professionalism** includes: Developing **collaborative partnerships** within a professional context. Acting as a mentor to nurses, nursing students and colleagues to enhance and support professional growth; Acknowledging and recognizing interdependence between care providers. Collaboration between nurses and health professionals is an important component of a nurse's professional practice which can result in positive outcomes for nurses (satisfaction) and patients Positive patterns of **communication**, **enhanced teamwork**, and feedback to staff related to voiced matters of concern all contribute to quality practice settings (in which nurses practice safely, thereby positively impacting patient care). **Ethics and values** **Professionalism** includes: Collaborating with colleagues to develop and maintain a practice environment that **supports** nurses and **respects** their ethical and professional responsibilities **(Linked to 3.1 and 2.2);** Establishing and participating in regular meetings about ethical and professional issues at the unit or organizational level; Establishing and respecting a culture at these meetings that supports enquiry, critical thinking and looking for creative solutions.

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
11.	Best practice Guidelines Workplace Health in Australia (WHAA, 2015)	The WHAA Best practice Guidelines have been developed to help organisations and providers alike understand the factors that underpin good programme outcomes with reasonable programme expenditures.	Workplace health represents “the combined efforts of employers, employees and society to improve the health and well-being of people at work. This is achieved through a combination of improving the work organisation and the working environment, promoting the active participation of employees in health activities and encouraging personal development.” **Active Support and Participation by Senior Leadership** **Senior leadership** support is critical to building and sustaining successful workplace health programmes. This goes beyond simple endorsement of programmes and involves active and visible participation. It has been WHAA’s experience that when the CEO gets behind workplace health initiatives that things really start to happen. Management-related factors have been shown to contribute more to success than the content of the (workplace health) intervention (41). **Supportive Environment and culture** How do you integrate workplace health into the “DNA” of an organisation? Through the development of a supportive environment and culture, or in other words, ‘making healthy choices the easy choices’. In addition to creating a supportive environment and culture, a variety of strategies can be utilised to remove barriers to participation and encourage employees to ‘take the health road.

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
			Health as a shared responsibility The effective delivery of workplace health programmes requires a mutually beneficial partnership between employers and employees which encourages both parties to take and accept responsibility for health in the workplace. **Engagement of key stakeholders** A healthy workplace is only attainable through the commitment and cooperation of employers, employees and employee representatives working collaboratively (43). Supportive environment and culture Innovative marketing and communication **Participatory planning and design** The first step in creating a successful workplace health programme is to understand employee and organisational needs. For employees, the benefits of participating in workplace health programmes include (but are not limited to) improved **team relationships.** Generating high levels of employee engagement and participation is essential for workplace health program success. For employers, the benefits of providing workplace health programmes include (but are not limited to): Improved productivity, increased creativity and innovation, improved employee engagement, improved staff morale, reduced sickness-related absenteeism increased attraction and retention of staff, reduced workplace injury and workers.

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
			The most successful workplace health programmes, nationally and internationally, have involved creative marketing. Marketing involves analysing what employees need, selling the value of the solutions, and motivating employees to participate in them. Having **an appealing communications strategy** is also necessary to foster and maintain employee interest and participation. There is a wide array of tactics to communicate workplace health efforts including: Communicate the aims/purpose of the programme, with an emphasis on shared responsibility; Use existing communication networks to "spread the word" (e.g. intranet, payslips, newsletters, point-of-sale, team meetings, high-traffic areas); Choose different **modes of communication** based on specific employee characteristics (e.g. podcasts for Gen Y employees); Provide **clear and frequent communication** through multiple communication channels to maximise reach to all employees.
12.	National Guidelines for Promotion of Healthy Work Environments: A Framework for Health and Disability Support Sector (HWAC, 2006)		**6 principles** of a healthy work environment: • Organisational Culture (norms , values , beliefs and behaviours) • Leadership and Decision –Making • Change Management • Information and Knowledge –Sharing • Career Development • Employee Recognition

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
			The vision of a healthy working environment underlying this advice is one in which people work in a positive environment in which they are valued and that supports them to work in an effective manner. **(Linked to Themes 1and2**). "… **the foundations of a healthy work environment are** good communication, a positive relationship with one's supervisor**,** friendly and helpful co-workers and receiving recognition. Both employees and employers benefit from these 'healthy' relationships through higher job satisfaction and commitment, reduced turnover and less absenteeism." In this context, the general attributes of healthy workplaces have been defined as including: • a strong vision • people-centred values • effective teamwork • information-based management decisions • genuine employee involvement in decision-making • open communication • support for individual learning and development **A cornerstone of the HWE philosophy is that of collaboration** and it is important to recognise that this places obligations on employees as well as those who employ them. Some strategies – such as the involvement of staff in workplace decision-making – must be initiated and driven by employers. **Good organisational practice** Participatory decision-making.

Serial no	Name of Guideline	Purpose	Summary of findings regarding healthy work environments
			Culture promotes teamwork, support, communication, innovation, inclusion, clinical effectiveness and risk management. Excellent staff orientation, training and ongoing development. Workloads, remuneration and skill mixes are optimally structured. Career growth and opportunities need to be present. Opportunity for development is described as advancement, vertical or lateral movement, paid training and on-going learning opportunities.' (Price Waterhouse Coopers, 2001, in HWAC, 2006). Organisational culture is a broad concept with many aspects. These include patterns of communication, the nature of relationships between different subgroups in the workforce, the tolerance (or otherwise) of cultural and personal diversity, and the handling of workplace errors (HWAC 2006) One of the key aspects, however, is the need for organisational culture to be based less on authoritarian hierarchies and more on "network" relationships that emphasise collaboration and teamwork (National Health Committee (2001) in HWAC, 2006:). Another key aspect of organisational culture is the concept of professional autonomy**.** Such autonomy does not mean complete independence – workers must still practise in an equal and collaborative manner with their colleagues, and recognise and operate within the overall resource constraints of their organisation. **Autonomy** has instead been defined as "the ability of clinicians to make timely decisions based on their expert judgement … because they are trusted to act ethically, with expertise and take responsibility for the results of their actions" (HWAC 2006).

4.4.2 Results

The integrative literature review results will be discussed in this section. After data was extracted from the 12 guidelines and synthesized, themes pertaining to healthy work environments for nurses or health care professionals were formed. Four themes that support the enhancement of a healthy work environment emerged from the guidelines and they included the following:

- The need for effective leadership
- Effective communication is central to enhancement of a healthy environment;
- Effective teamwork an integral part of a healthy work environment; and
- The need for professional autonomy

Table 4.6: Linking themes to Guidelines

Serial no	Themes	Names of BPGs for healthy work environments that supported individual themes
1.	**The need for effective leadership (n=11)**	1. Healthy work Environment: Embracing Cultural Diversity in Health care: developing cultural competence (RNAO, 2007) 2. Healthy work Environment: Best Practices for Assessment and Control of Psychological hazards (Government of Alberta, 2011) 3. Developing and Sustaining Inter-professional Health care: Optimizing patient, organizational and system outcomes (RNAO, 2013b) 4. Developing and Sustaining Safe, Effective Staffing and Workload Practices (RNAO, 2017) 5. Developing and Sustaining Nursing Leadership Best Practice Guideline (RNAO, 2013a) 6. Healthy work environment: Workplace Health Safety and Well-being of the Nurse (RNAO, 2008). 7. Healthy work environment: Intra-professional Collaborative Practice among Nurses (RNAO, 2016) 8. Managing and mitigating conflict in health care teams (RNAO, 2012) 9. Healthy work environments Best Practice Guidelines: Professionalism in Nursing (RNAO, 2007a)

Serial no	Themes	Names of BPGs for healthy work environments that supported individual themes
		10. Best practice Guidelines Workplace Health in Australia (WHAA, 2015) 11. National Guidelines for Promotion of Healthy Work Environments: A Framework for Health and Disability Support Sector (HWAC, 2006)
2.	**Effective communication is central to enhancement of a healthy environment (n=11)**	1. Embracing cultural diversity in health care: developing cultural competence (RNAO, 2007(b)) 2. Best practices for assessment and control of psychological hazards (Government of Alberta, 2011) 3. Developing and sustaining Inter-professional health care: Optimizing patient, organizational and system outcomes (RNAO, 2013b) 4. Developing and sustaining safe, effective staffing and workload practices (RNAO, 2017). 5. Developing and sustaining nursing leadership best practice guideline (RNAO, 2013a). 6. Workplace health, safety and well-being of the nurse (RNAO, 2008). 7. Intra-professional collaborative practice among nurses (RNAO, 2016). 8. Managing and mitigating conflict in health care teams (RNAO, 2012). 9. Best practice guidelines: professional in nursing (RNAO, 2007a). 10. Best practice guidelines: workplace health in Australia (WHAA, 2015) 11. National guidelines for promotion of healthy work environments: a framework for health and disability support sector (HWAC, 2006)
3.	**Effective teamwork an integral part of a healthy work environment (n=9)**	1. Healthy work environment: embracing cultural diversity in health care: developing cultural competence (RNAO, 2007b). 2. Healthy work environment: Best practices for assessment and control of psychological hazards (Government of Alberta, 2011). 3. Developing and sustaining inter-professional health care: optimizing patient, organizational and system outcomes (RNAO, 2013b) 4. Developing and sustaining nursing leadership best practice guideline (RNAO, 2013a)

Serial no	Themes	Names of BPGs for healthy work environments that supported individual themes
		5. Healthy work environment: workplace health, safety and well-being of the nurse (RNAO, 2008). 6. Healthy work environment: intra-professional collaborative practice among nurses (RNAO, 2016). 7. Healthy work environments best practice guidelines: professionalism in nursing (RNAO, 2007a). 8. Best practice guidelines workplace health in Australia (WHAA, 2015). 9. National guidelines for promotion of healthy work environments: a framework for health and disability support sector (HWAC, 2006).
4.	**The need for professional autonomy (n=5)**	1. Developing and sustaining intra-professional collaborative health care: optimizing patient, organizational and system outcomes (RNAO, 2016) 2. Developing and sustaining nursing leadership best practice guideline (RNAO, 2013a) 3. Healthy work environment: workplace health safety and well-being of the nurse (RNAO, 2008). 4. Healthy work environments best practice guidelines: professionalism in nursing (RNAO, 2007a) 5. National guidelines for promotion of healthy work environments: a framework for health and disability support sector (HWAC, 2006)

These themes were considered as they emerged from all the guidelines. Themes that only emerged once or twice were not considered as strong themes for discussion and were excluded from the discussion.

All twelve (12) guidelines addressed effective nursing leadership, communication, teamwork and autonomy to greater and lesser extents. Because of scarcity of best practice guidelines for healthy work environments for health care professionals, of the 12 guidelines to be synthesized, nine (9) were developed by the Registered Nurses Association of Ontario (RNAO), one (1) by the Workplace Health Association Australia (WHAA), one (1) by the Government of Alberta (Canada) and the other one by the

Health Workforce Advisory Committee of New Zealand (HWAC) respectively. The themes that emerged from the integrative literature review are discussed in the section below.

4.2.2.1 Theme 1: The need for effective nursing leadership

Of the twelve (12) best practice guidelines, eleven (11) guidelines considered nursing leadership as playing a key role in creating healthy work environments. A best practice guideline on the role of leadership in creating healthy work environments, developed by the Registered Nurses Association of Ontario (RNAO) (2013a:17) suggested that effective nursing leadership is an essential ingredient in achieving a healthy work environment and indicated that it shapes the profession, facilitates policies on mentoring and evidence practice and navigates change in challenging times. The guideline outlined the evidence-based transformational leadership practices which are fundamental for transforming nurses' work settings into healthy work environments. Creating an empowering work environment is one of the leadership practices mentioned in the guideline, a practice that depends on a respectful, trusting relationship among people in a work setting. The guideline further stated that an empowered work environment has access to information, support, resources, and opportunities to learn and grow, in a setting that supports professional autonomy and strong collegial support (RNAO, 2013a:17). Empowering leaders gives purpose and meaning to work by promoting the value of nursing and creating access to formal and informal power structures, which are significant predictors of access to empowerment in the workplace (Dubuc, 1995; Huffman, 1995; McKay, 1995; Whyte, 1995, cited in RNAO, 2013a:37). Burns (1978), cited in RNAO (2013a:27), clustered the leadership style referred to as Transformational leadership into Communication which entails listening and expectations; building interactive relationships that show respect, being friendly and supportive, participatory decision-making, and managing conflict; community which is about building a culture of belonging through relationships based on values of dignity, honesty, fairness and integrity; as well as guidance that is providing learning opportunities, role modelling, mentoring, coaching and team building. Leaders who create healthy work environments seek and acknowledge multiple perspectives, demonstrate understanding of issues, acknowledge and promote nurses' contribution, communicate successes to create confidence, have an

open-door policy and support staff (RNAO, 2013a:34-35). Visibility is also seen as important in leaders. Communication, including appreciation and recognition, enabled by respect and empathy, can optimize the visibility of nursing leadership (RNAO, 2013a:27).

The guideline on workplace health, safety and well-being of the nurse (RNAO, 2008) reiterated that nursing leaders play a key role in creating a positive safety climate. The guideline claimed that the nurse manager's leadership style has a direct impact on job satisfaction of their direct subordinates. The guideline further indicated that to achieve a goal of the safest possible care system, all leaders and practitioners must have a clear understanding of their individual and collective responsibilities to provide resources and shape the structures and values by which the system operates (Hemmingway & Smith, 1999, in RNAO, 2008:34). Nurses require strong leadership at every level of the health care system hierarchy, including direct supervision of nursing practice at the bedside (RNAO, 2008:34).

Leadership and decision-making are considered critical in the six principles of the National guidelines for promotion of healthy work environments (HWAC, 2006:9). The guideline stated that leadership focuses on people, their potential, their impact and what makes them function optimally. The guideline encouraged that leadership should continually be developed and supported at all levels (HWAC, 2006:10).

The best practice guidelines in Workplace Health in Australia (WHAA, 2015) indicated that senior leadership support is critical to building and sustaining successful workplace health programmes. This guideline further stated that this went beyond simple endorsement of programmes and involved active and visible participation.

The guideline on embracing cultural diversity stated that leadership is clearly a critical variable to the success of any diversity initiative. It further indicated that sensitivity to diversity issues at senior executive level had an effect on diversity management practices used by organizations (RNAO, 2007b:40).

The guideline on intra-professional collaborative practice (RNAO, 2016:46) stated that establishing intra-professional collaboration required strong nursing leadership at all levels of the organisation. It further asserted that the absence of strong leadership in

teams contributes to lack of shared vision among employees which hinders communication, undermines quality of care and limits capacity. Strong leadership is linked to positive job satisfaction for nurses, successful outcomes and nurses having autonomy and control over their practice (Puffield, Roche, O'Brien-Pallas, Catting, Paull & King, 2009, cited in RNAO, 2016:44). Cunnings et al (2010), St Pierre (2012) and Cilliers and Terblanche in RNAO (2016:44) recommended that government funding was needed to support organisations and individuals to develop effective management and leadership skills that enhance healthy work environments.

In the RNAO guideline on staffing and workload practices (2017: 31), Twigg et al (2011) asserted that nurse leaders' involvement in staffing process has been shown to have a positive effect in the areas of care delivery, nurse productivity and appropriate utilization of staff. Nursing leaders have therefore a professional responsibility to ensure that staffing plans include categories of nurses with knowledge and skill set to deliver safe care.

On inter-professional health, the guideline indicates that leadership can facilitate a team to realise high levels of collaboration, trust and respect. This, according to Greenfield (2007) in RNAO (2013b:38-39), creates an environment in which collective learning and increased responsibility thrive. Leaders promote open dialogue and other measures for creating a more equitable workplace that include integrating training in cultural competencies and ethics to strengthen reflective, effective and respectful health care relationships (RNAO, 2007a, 2009, 2012, cited in RNAO 2013b:38-39). Leaders at the point of care and throughout the organization can accelerate adoption of a culture that supports inter-professional care and practices by acting as role models and facilitators (Donahue, 2013, in RNAO, 2013b:38). Conclusions in the literature suggest that having individual champions who are role models and demonstrate an understanding of the concepts, competency and basic skills in the areas of inter-professional care result in a positive experience for team members and patients/clients (Curtis, 2008, in RNAO, 2013b:38).

The guideline on management of conflict (RNAO, 2012:36) stated that the wise and effective leader develops a high level of intuitive and process skills in facilitating the work and interaction of others to anticipate the normally embedded elements of

conflict, the potential for the exposition of that conflict, and the early management of the conflict process as part of the ordinary and usual function of good leadership (Porter-O'Grady, 2004, in RNAO, 2012:36). Managers that are engaged in and demonstrate supportive leadership, act as role models and have clear expectations, can also be effective at preventing, mitigating and managing conflictual situations (Barrett et al., 2009, in RNAO, 2012:36). The guideline on professionalism RNAO, 2007a:40) highlights that nurse leadership is important in building and promoting collaborative relationships and team-work within the organisations when nurses demonstrate their willingness to work effectively with others. Regarding nursing leadership in preventing and mitigating nurse fatigue (RNAO, 2011:30), the guideline states that education regarding fatigue and its successful mitigation must be focused on direct care nurses, nurse managers, senior management team members who are responsible for strategic planning and day-to-day decision-making. The guideline written by the government of Alberta (2011:15) asserts that senior management should clearly indicate that management is committed to identifying and controlling psychological hazards in the workplace. All the guidelines mentioned above suggest that leadership plays a critical role in the creation of a healthy work environment.

Summary of the theme

In the discussion above, effective leadership emerged as central to achieving healthy work environments for health care professionals. The guidelines associate effective leadership with the use of transformational leadership style where an empowering environment is created by leaders. According to the guidelines, an empowering environment is based on respectful, trusting relationships among team members, access to information, support, resources and opportunities to learn and grow and the environment supports autonomy and strong networks of collegial support. The guidelines also associate effective leadership with promotion of teamwork, a culture that supports personal and professional development of team members, an environment where there is shared decision-making and effective communication.

They state that an environment that focuses on people, their potential, their impact and what makes them function optimally, is indicative of effective leadership. Sensitivity to diversity issues and management thereof, efficient staffing processes

and workload management, mentoring of staff, proper orientation, honesty and feedback are associated with transformational leadership practices which are an indication of effective leadership.

Effective leadership is, according to the guidelines, essential in creating healthy work environments. It must therefore be developed, supported and sustained as a critical first step in creating healthy work environments in health care.

4.2.2.2 Theme 2: Effective communication is central to enhancement of a healthy environment

Communication emerged as the overarching concept in eleven (11) of the twelve (12) guidelines reviewed. Sharing or communicating knowledge with colleagues, clients, family and others to continually improve care and health outcomes, came through as the major theme in all the guidelines. Communication is demonstrated as being central to organizational practices, teamwork and relationships and is referred to as the foundation of a healthy work environment Staff must know how to communicate effectively and work collaboratively in teams so that appropriate information is shared in a timely manner. When effective communication is absent, patient care is compromised. Hartung and Miller (2013), cited in the guideline on intra-professional collaborative care (RNAO, 2016:27), propounded that communication had been identified as a key determinant of successful collaboration among nurses and a vital component in workplace health. .

The guideline on inter-professional care (RNAO, 2013b) indicated that organizations can support inter-professional care through enhanced communication by establishing effective communication processes and creating a culture that promotes regular formal and informal communication among team members (RNAO, 2013b:41). Competent communication - openness, honesty, respect for each other's opinions and effective communication skills - is part of all domains of inter-professional practice (Humphreys & Pountney, 2006, in RNAO, 2013b:29). Competent communication helps develop and sustain leadership and actively engages members of the team while demonstrating respect and professionalism. Communication encompasses a wide range of strategies and purposes. The guideline on embracing cultural diversity (RNAO, 2007b), acknowledged the important role played by communication in

promoting cultural diversity. It encouraged individual health care professionals to be aware of different communication styles that influence a culture of communication in cultural diverse settings (RNAO, 2007b:33). The guideline on staffing and workload practices (RNAO, 2017:32) stated that competent, effective communication enhances working relationships and therefore the care of patients. Communication must always be a component of the staffing process. Role understanding and expectations in collaborative practices depend on effective communication,

The guidelines also emphasized the ability for cross-cultural communication in terms of both patient understanding and the capacity to work with members of inter and intra-professional teams. Communication has been found to be key in enhancing healthy work environments. The government of Alberta posits that good communication and collaborative approach are important for an effective programme and promote a healthy work environment (Government of Alberta, 2011:19). Regarding effective communication, the RNAO guideline on developing and sustaining leadership (2013a:36), purports that nurse leaders communicate effectively by communicating openly, honestly and frequently. The guideline recommends that leaders should listen interactively and demonstrate understanding of the opinions of others. The HWAC (2006:8-10), encourages an organisational culture which enables effective and open multi-level communication channels where effective feedback systems are developed. This guideline purports that the foundation of a healthy work environment is good communication (HWAC, 2006:15). Mitigating and managing conflict guideline (RNAO, 2012:40) suggests that communication gaps related to conflict exist and responsible for errors and reduced patient/client safety, dissatisfaction, reduced commitment. This guideline encourages effective communication in mitigating and management of conflict. Positive patterns of communication, enhanced teamwork, and feedback to staff related to voiced matters of concern all contribute to quality practice settings in which nurses practice safely, thereby positively impacting patient care (Mackay & Risk, 2001) in RNAO (2007a:40). The guideline further regards skilled communication as one of the aspects which are integral to successful collaboration (RNAO, 2007a:42). The Workplace Health, Safety and Well-being of the Nurse best practice guideline purports that a communication strategy is important in an organisation as it enhances knowledge transfer (RNAO, 2008:47). Knowledge transfer is described as a process by which relevant research information is made available and accessible for practice,

planning, and policy-making through interactive engagement with audiences. The guideline written by the Workplace Health Association Australia (WHAA, 2015) suggests that having an appealing communications strategy is necessary to foster and maintain employee interest and participation. (WHAA, 2015:19). The guidelines in this discussion overwhelmingly support the importance of effective communication in creating a healthy work environment for nurses/healthcare professionals.

Summary of the theme

Communication emerged as critical in creating healthy work environments as health care is about relationships and collaborative work. Communication has been projected as being the cornerstone in promoting effective leadership, building teams, promoting quality patient care, embracing cultural diversity, managing and mitigating conflict in teams, entrenching professionalism and in strengthening relations between employers, employees, clients and families. It plays a role in the professional development of health care personnel, in creating confidence in health care practitioners by acknowledging successes of their contributions and in motivating them. Communication is said to be enhancing the staffing processes and playing an important role in promoting cultural diversity. Mentoring, coaching and providing support to health care staff, clients and families can only be achieved through effective communication.

4.2.2.3 Theme 3: Effective Teamwork an integral part of a healthy work environment

The concept of teamwork emerged as one of the practices which organizations cannot function without, a product of collaboration which includes a process of interactions and relationships between health professionals working in a team environment (CHSRF, 2006a, in RNAO, 2012:42). Of the twelve (12) best practice guidelines reviewed, eleven (11) guidelines support the notion that teamwork is critical in the enhancement of a healthy work environment. The RNAO guidelines on developing and sustaining inter- professional health care (RNAO 2013b) and intra-professional collaborative care among nurses (RNAO, 2016) both asserted that teamwork is the integral part of the creation of healthy work environments. Inter-professional care is comprehensive health care services provided by multiple care givers working

collaboratively (RNAO, 2013b:24) while intra-professional collaborative care among nurses occurs when multiple members of the same profession work collaboratively to deliver quality care within and across settings (College of Nurses of Ontario, 2014, cited in RNAO, 2013b:26). The terms teamwork and collaboration are used synonymously in the literature to express relationships between members of a team. The guiding principles and assumptions for both inter-professional health care and intra-professional collaborative health practice are that effective teams produce better outcomes for patients/clients and team members. These guidelines posited that a collaborative work environment, safety and quality patient care are dependent on teamwork. The teams are not limited to health care professionals but include patients and their families. Professionals work together with patients and families in order to identify and take advantage of each professional's care expertise. Teamwork

The guideline on embracing cultural diversity (RNAO, 2007b:35) cited teamwork between employers and unions as being vital in creating work environments that support cultural competence in care delivery and staff relationships. The guideline further stated that organizations that promote collaboration and work collaboratively with each other will improve services for culturally diverse populations and contribute to a work environment that embraces diversity.

Teamwork promotes sharing of power which happens when each team member is open to letting others influence patients care regardless of their educational or professional preparation. Willingness to share power contributes to a healthy work environment where all team members, including the patient/client, feel engaged, empowered, respected and validated (RNAO, 2013b:26). Teamwork also embraces collaborative leadership, a people and relationship-focused approach based on the premise that answers should be found in the collective (the team). Working in a team allows team members to work to their full scope of practice and takes advantage of the synergies professionals working together can create. The guideline on Inter-professional health care further indicated that a health-care system that supports effective teamwork can improve the quality of patients/clients' care, enhance patients' safety, and reduce workload issues that cause burnout among professionals (RNAO, 2013b:26).

The supporting principles to team work came through as competent communication and understanding of roles by different health care professionals. On communication, the guideline on intra-professional collaborative care (RNAO, 2016:27) claimed that open, effective communication is a key competency of a culture that supports teamwork. The guideline on inter-professional health care (RNAO, 2013b: 29) stated that all professionals are to understand their roles and expertise and know the standards and boundaries of their practice so that they recognize when it is time to turn to other team members. Effective inter-professional teamwork is part of a healthy work environment (RNAO, 2013b:22). The guideline on intra-professional collaborative care among nurses, (RNAO, 2016) stated that role ambiguity can interrupt the effectiveness of a team and have negative impact on job satisfaction. Oelke et al. (2008) in RNAO (2016:27) indicated that nurses need to have and demonstrate role clarity to optimize the quality of patient care and patient safety.

According to the guideline developed by the Health Workforce Team, members are allowed to work to their full scope of practice. Practitioners must understand not only their roles but also those of other team members. They must be able to articulate their roles, knowledge and skills and use effective listening skills with other members. All practitioners must respect each other's professional culture and values. Organizations and system put policies, practices and structures in place to enable all health providers to optimize their scope of practice for the benefit of patients and themselves. Novice professionals are encouraged to draw on the knowledge and support of an expert in the same profession. Teamwork embraces collaborative leadership where there is shared accountability and power and hierarchy is addressed. All health care professionals are allowed to work to their full scope of practice. Team members are expected to work well and recognised appropriately (HWAC, 2006: 10). Safety and quality of patient care is said to be dependent on teamwork, communication, and a collaborative work environment. The guideline on intra-professional collaborative care among nurses (RNAO, 2016:35), called for governments to openly support nursing participation in collaborative team work through development of structures and processes that promote and reward collaborative practice (RNAO, 2016:26).

The key to the reduction of conflict is the development of team structures that foster collaborative relationships. Nurses and health-care teams need to be aware that

working together in a team-focused manner is the foundation for structuring positive outcomes (RNAO, 2012:42). The guideline from Alberta government (2011) views collaboration as well as good communication as important for an effective programme (Alberta, 2011:17). In the Workplace, Safety and Well-being of the Nurse guideline, it is stated that a climate that is supportive of nursing includes teamwork (RNAO, 2008:32). The RNAO's Leadership guideline (RNAO, 2013a) states that effective leaders build and promote collaborative relationships and teamwork by seeking and acknowledging broad input, recognising the legitimacy of other's interests and discuss how interests are aligned, building consensus and evaluating the effectiveness of working together (RNAO, 2013a:33). The guideline further expatiates that such a leader participates as nurse leader on inter-professional teams, advocate for patients with the professional team and works collaboratively on nursing and interprofessional teams (RNAO, 2013a:33). In defining the general attributes of healthy workplaces, HWAC (2006:4), effective teamwork was included in the attributes. The RNAO (2007a) guideline on professional supports collegiality and collaboration. It suggests that professionalism includes developing collaborative partnerships within a professional context. This guideline defines collaborate as meaning to work jointly with, c-operate. The guideline further expatiates on collaboration that 'collaboration among nurses results in accountability and increased clinical competence.' The guidelines regard teamwork as critical to enhancement of healthy work environments.

Summary of the theme

Teamwork emerged as being the integral component of a healthy work environment from the eleven guidelines reviewed. It is said to be based on competent communication and role understanding. The guidelines on healthy work environment viewed teamwork as the backbone of successful inter and intra-professional collaborative practices. It is believed to be central in building good relations and in embracing cultural diversity. The guidelines also propounded that teamwork allowed health care practitioners to exercise authority over their own areas of expertise, thus allowing them independent and interdependent decision-making. It allowed team members autonomy to work to their full scope of practice, feel empowered, respected and validated. Health care practitioners working in a team understood and appreciated not only their roles, but the roles of other team members and took advantage of the

synergy created when professionals worked together. Teamwork is said to embrace collaborative leadership, participatory decision-making and sharing of power.

4.2.2.4 Theme 4: The need for autonomy

Five (5) guidelines of the twelve (12) suggested that autonomy was an important aspect of a healthy work environment because nurses felt empowered by autonomous practice. Autonomy is defined as the freedom to act on what you know, to make independent clinical decisions and to act in the best interest of the patient. According to the guideline on professionalism (RNAO, 2007a) autonomous practice means working independently and exercising decision-making within one's scope of practice (RNAO, 2007a:34). Autonomy includes the ability to carry out the appropriate course of action within a system that has standards of practice, a code of ethics and organizational policies to advocate in the best interest of the client. In the guidelines it was indicated that autonomy includes the capacity of the nurse to determine her/his own course of action, ability to deliberate (RNAO, 2007a:34). Burgess and Purkins (2011), cited in the guideline for intra-professional collaborative care among nurses (RNAO, 2016:32), stated that collaboration fostered nurse practitioner autonomy to explore new practice approaches, cultivate new partnerships, and be responsive to clients and communities. They continued to say that nurse practitioner autonomy enabled nurses to construct innovative collaboration to advance primary health care and collaboration and autonomy have reciprocal effects.

The guideline on professionalism (RNAO, 2007a:34-35) stated that autonomy had been rated highly by nurses and was associated with a strong sense of teamwork. The guideline further said that professional autonomy was not necessarily related to organisational structure but could be indirectly affected by decentralization of organisations. Nurses' ability to be autonomous was supported or limited by the organization. Although autonomy could be 'given' by those in formal power, it could be facilitated by nurse leaders. Several papers have looked at what nurses need to be autonomous. One feature is organizational support to make discretionary and binding decisions that fall within the nurses' scope of practice (RNAO, 2007a:34).

Autonomy and input into decision-making are linked to staff and leader empowerment and positive outcomes for clients and nurses. Nurses in autonomous practices are

said to be accountable for their decisions and responsible for their own actions whether working independently or as team member. According to the guideline on professionalism (RNAO, 2007a:35), nurses might experience that peers, colleagues and the administration limited their autonomy. Attitudes, values, traditions, policies and practices might restrict nurses' decision-making about their practice. The guideline claimed that when nurses analysed the reasons why their autonomy was compromised they could seek ways to remedy the situation themselves (RNAO, 2007a:35). Because autonomy allowed nurse practitioners to act independently and interdependently in teams, it was found to be one of the components that enhanced healthy work environments. The HWAC guideline (2006:8, 14) indicates that the most fundamental principle in developing healthy workplace environments is ensuring that the culture of an organisation supports healthy working styles. The concept of professional autonomy is considered an aspect of organisational culture in this guideline. The guideline continues to say that such autonomy does not mean complete independence, but workers must still practise in an equal and collaborative manner with their colleagues and recognise and operate within the overall resource constraints of their organisation. Autonomy is defined by the guideline as the 'ability of clinicians to make timely decisions based on their expert judgement because they are trusted to act ethically, with expertise and take responsibility for the results of their actions (HWAC, 2002) cited in HWAC (2006:14-15). The guideline on Professionalism by RNAO (2007a:32) deals with accountability and links accountability to responsibility, autonomy and authority. The guideline states that responsibility and authority are both essential conditions for autonomy and accountability. It further supports autonomy and indicate that nursing departments can be held accountable over certain activities only if they have autonomy over these same activities, while practicing nurses can be held accountable if they have a certain amount of autonomy over the activities they are involved in. The RNAO (2007a:34) guideline defines autonomous practice as 'working independently and exercising decision-making within one's scope of practice. In a healthy work environment, an empowering environment that supports professional autonomy and strong networks of collegial support must be created (RNAO, 2013a:17). The guideline on Workplace health, Safety and Well-being (RNAO, 2008:21) purports that organisational well-being is measured in terms of efficiency, personal development, autonomy, goal quality, workload, leadership and work climate.

It further suggests that nurse turn-over is influenced by characteristics associated with workload, management style, empowerment and autonomy. The guidelines in this theme find it critical for nurses to have autonomy for the work environment to be deemed healthy.

Summary of the theme

Autonomy, which is freedom to make discretionary decisions about what one knows, to make independent, clinical decisions and to act in the best interest of the patient, is said to be crucial in creating a healthy work environment. Of the twelve (12) guidelines reviewed, five (5) guidelines support the notion of promotion of professional autonomy for health care professionals. Autonomy is considered by nurses to affect both job satisfaction and the delivery of effective patient care. The guidelines propound that effective leaders contributed in creating autonomous practices. Autonomy could therefore be enhanced or limited by health care leaders. Autonomy and input into decision-making are linked to staff and leader empowerment and positive outcomes for clients and nurses. Because autonomy allowed nurse practitioners to act independently and interdependently in teams, it was found to be one of the components that enhanced healthy work environments.

4.5 SUMMARY OF THE CHAPTER

This chapter provided the findings of the integrative literature review of evidence-based best practice guidelines related to the enhancement of healthy work environments for health care professionals, including nurses. The integrative literature review approach allows for the combination of diverse methodologies and has the potential to play a role in evidence-based practice for nursing. Derived from the data findings in this chapter, an evidence-based best practice guideline was developed which will be presented in Chapter Five of this study.

CHAPTER FIVE

BEST PRACTICE GUIDELINE (PHASE THREE)

5.1 INTRODUCTION

The study comprised three phases. Phase 1 of the study consisted of Chapters One, Two and Three. Chapter One discussed the overview and introduction to the study; Chapter Two dealt with the methodology where steps that underpinned this research were explicitly stated and in Chapter Three data was collected from professional nurses working in the SAMHS with regard to how they experienced working in the military. Data was analysed and themes and sub-themes that emerged were formulated. Phase 2 of the study was formed by Chapter Four where the integrative literature review of evidence-based best practice guidelines for a healthy work environment for health professionals was conducted. The findings from the integrated literature review were synthesized with the findings from qualitative research that was conducted in Phase 1 to formulate recommendations for the development of a best practice guideline for a healthy work environment for nurses in Phase 3.

Chapter Five will then triangulate the data from Phases 1 and 2 to form new themes that will contribute to the development of a best practice guideline. The steps followed in guideline development process will be discussed in this chapter although these steps were discussed comprehensively in Chapter Two. The summary of the guideline as well as comments from expert reviewers and the reviewed guideline will also be discussed.

Extensive research evidence is needed to develop sound empirical knowledge for synthesis into the best research evidence needed for practice. Research synthesis is a summary of relevant studies for a selected health care topic that is critical to the advancement of practice, research and policy (Whittemore et al., 2014, in Gray, Grove & Sutherland, 2017:454). This research evidence might be synthesised to develop guidelines, standards, protocols or policies to direct the implementation of a variety of nursing interventions (Burns & Grove, 2011:5). Evidence-based best practice guidelines are described by Gray et al. (2017:678) as rigorous, with explicit clinical guidelines developed on the basis of the best research evidence available, supported

by consensus from recognised national experts and affirmed by outcomes obtained by clinicians. In this study a qualitative research was conducted in Phase 1 and the findings thereof were synthesised with the evidence extracted from the existing evidence-based best practice guidelines (Level I evidence) obtained through a search via the integrative literature review conducted in Phase 2. This synthesis was to develop the best evidence that formed the basis for the development of the evidence-based best practice guideline for a healthy work environment for nurses. Themes were formulated from the triangulation of evidence from Phases 1 and 2.

5.2 TRIANGULATION OF QUALITATIVE FINDINGS AND THE INTEGRATIVE LITERATURE REVIEW FINDINGS

Table 5.1 below presents the findings of Phase 1 and Phase 2 that will be triangulated and form Phase 3.

Table 5.1: Triangulation of Phase 1 and Phase 2

PHASE 1: Summary of qualitative findings related to a healthy work environment for nurses		**PHASE 2:** Findings of the Integrative literature review of best practice guidelines for a healthy work environment for nurses	**PHASE 3**: Triangulation of Phases 1 & 2. Recommendations for a best practice guideline for a healthy work environment for nurses
THEMES	**SUB-THEMES**	**THEMES**	**THEMES & SUB-THEMES**
Theme 1: Professional Nurses highlight various challenges associated with the culture and traditions of the military.	1.1. Newly appointed professional nurses experience problems of adjusting to military culture due to inadequate induction. 1.2**.** The military rank structure interferes with the autonomy of the professional nurse. 1.3 Professional nurses experience conflict between their dual role as a soldier and professional nurse 1.4 Lack of professionals'	**Theme 1: The need for effective leadership applying transformational leadership practices which are:** • Creating an empowering work environment :that depends on respectful, trusting relationship among people in a work setting; access to information, support, resources, and opportunities to learn and grow; supports professional autonomy and strong collegial support. • Communication which entails listening and expectations; • Building interactive relationships that show respect, being friendly and supportive, participatory decision-making, and managing conflict; • Community which is about building a culture of belonging through relationships based on values of	**Theme 1**: The need for effective leadership to create an empowering environment: 1.1 Support to newly appointed professional nurses to adjust to military culture and traditions 1.2 Clearly defined expectations 1.3 Provision of adequate resources 1.4 Opportunities for professional development and promotion 1.5 Collegial support **Theme 2**: Effective communication amongst health care team members: 2.1 Formal and informal communication 2.2 Standardisation of working procedures

PHASE 1: Summary of qualitative findings related to a healthy work environment for nurses		**PHASE 2:** Findings of the Integrative literature review of best practice guidelines for a healthy work environment for nurses	**PHASE 3**: Triangulation of Phases 1 & 2. Recommendations for a best practice guideline for a healthy work environment for nurses
THEMES	**SUB-THEMES**	**THEMES**	**THEMES & SUB-THEMES**
	development and delays in promotion lead to problems of command and control for professional nurses	dignity, honesty, fairness and integrity; as well as • Guidance that is providing learning opportunities, role modelling, mentoring, coaching and team building; • Seeking and acknowledging multiple perspectives, demonstrating understanding of issues; • acknowledging and promoting nurses' contribution; • communicating successes to create confidence; • having an open-door policy and support staff; • accelerating adoption of a culture that supports inter-professional care and practices by acting as role models and facilitators. **Theme 2: Effective communication:** • Communication is central to organizational practices, teamwork	**Theme 3**: A culture that supports effective teamwork 3.1 Team building 3.2 Role clarification **Theme 4**: The need for an environment that promotes professional autonomy. 4.1 Abuse of military rank and recognition of functional rank 4.2 Dual role conflict **5. Recommendations** to address organisational factors that impact negatively on enhancement of a healthy work environment for nurses 5.1 Shortage of personnel and the staffing process 5.2 Acquisition of equipment and the procurement processes 5.3 Status of infra structure

PHASE 1: Summary of qualitative findings related to a healthy work environment for nurses		**PHASE 2:** Findings of the Integrative literature review of best practice guidelines for a healthy work environment for nurses	**PHASE 3**: Triangulation of Phases 1 & 2. Recommendations for a best practice guideline for a healthy work environment for nurses
THEMES	**SUB-THEMES**	**THEMES**	**THEMES & SUB-THEMES**
		and relationships and the foundation of a healthy work environment: • Sharing or communicating knowledge with colleagues, clients, families and others; • Communication a key determinant of successful collaboration among nurses and a vital component in workplace health; • Communication - openness, honesty, respect for each other's opinions and effective communication skills are part of all domains of inter-professional practice. **Theme 3: Effective teamwork is** central to inter-professional and intra-professional collaboration which lead to healthy work environments. Effective teamwork is based on:	5.4 Lack of development opportunities for sickly personnel

PHASE 1: Summary of qualitative findings related to a healthy work environment for nurses		**PHASE 2:** Findings of the Integrative literature review of best practice guidelines for a healthy work environment for nurses	**PHASE 3**: Triangulation of Phases 1 & 2. Recommendations for a best practice guideline for a healthy work environment for nurses
THEMES	**SUB-THEMES**	**THEMES**	**THEMES & SUB-THEMES**
		• Competent communication and • Role understanding • It promotes shared power • Embraces collaborative leadership; • Allows team members to work to their full scope of practice. **Theme 4: The need for autonomy** **Autonomy** is associated with a strong sense of teamwork; empowers nurses and helps them to explore new practice approaches, cultivate new partnerships, be responsive to clients and act independently and inter-dependently and is one of the components that enhance healthy work environments.	
Theme 2: Professional nurses identified factors contributing	**2.1** Nurses experience a range of emotions, both positive and negative, in adjusting to the SAMHS that suggest		

PHASE 1: Summary of qualitative findings related to a healthy work environment for nurses		**PHASE 2:** Findings of the Integrative literature review of best practice guidelines for a healthy work environment for nurses	**PHASE 3**: Triangulation of Phases 1 & 2. Recommendations for a best practice guideline for a healthy work environment for nurses
THEMES	**SUB-THEMES**	**THEMES**	**THEMES & SUB-THEMES**
towards a healthy work environment	the importance of ensuring a healthy work environment **2.2 Effective communication** and support within the multi-disciplinary team and management, contribute to a healthy work environment. **2.3 Adequate resources** are necessary in creating a healthy work environment **2.4 Professional development opportunities** lead to competent and confident professional nurses,		

PHASE 1: Summary of qualitative findings related to a healthy work environment for nurses		**PHASE 2:** Findings of the Integrative literature review of best practice guidelines for a healthy work environment for nurses	**PHASE 3**: Triangulation of Phases 1 & 2. Recommendations for a best practice guideline for a healthy work environment for nurses
THEMES	**SUB-THEMES**	**THEMES**	**THEMES & SUB-THEMES**
	increasing team cohesion.		
Theme 3: **Professional nurses make recommendations for best practice guidelines within the military setting**	**3.1 Multi-disciplinary team:** Professional nurses have communicated the need for clear expectations and role clarification for all role players within the multi-disciplinary team. **3.2 Patient and families support**: Best practice guidelines (BPGs) need to clearly define the patient care approach: the need to treat clients with best care practices that support and respect dignity of patients and their		

PHASE 1: Summary of qualitative findings related to a healthy work environment for nurses		**PHASE 2:** Findings of the Integrative literature review of best practice guidelines for a healthy work environment for nurses	**PHASE 3**: Triangulation of Phases 1 & 2. Recommendations for a best practice guideline for a healthy work environment for nurses
THEMES	**SUB-THEMES**	**THEMES**	**THEMES & SUB-THEMES**
	families and management of diseases. 3.3 Management and structure: BPGs should serve to give guidance for team support by management so that professional nurses are provided with a sense of competence and confidence in practice.		

5.3 BEST PRACTICE GUIDELINE DEVELOPMENT PROCESS

Qualitative findings regarding a healthy work environment which corresponded with evidence emanating from the integrative literature review, when triangulated, resulted in the following recommendations for an evidence-based best practice guideline for a healthy work environment:

The need for effective leadership to create an empowering environment

- Support to newly appointed professional nurses to adjust to military culture and traditions
- Clearly defined expectations for professional nurses in the SAMHS
- Provision of adequate resources complete
- Opportunities for professional development and promotion
- Collegial support

Effective communication among health care team members

- Formal and informal communication
- Standardisation of working procedure

A culture that supports team work

- Team building
- Role clarification

The need for an environment that promotes autonomy

- Abuse of military rank and recognition of functional rank
- Dual role conflict

Recommendations to address factors that impact negatively on enhancement of a healthy work environment

- Shortage of personnel and the staffing process
- Acquisition of equipment and the procurement processes

- Status of infrastructure
- Lack of development opportunities for sickly personnel

After triangulation of data from Phases 1 and 2, most findings were congruent except those that were peculiar to the defence force which included the abuse of military rank and recognition of functional rank and the lack of development opportunities for sickly personnel. The recommendations for abuse of military rank dealt with promotion of autonomy for professional nurses which was interfered with by hierarchy in the military. The boundaries between the military and nursing professional ranks were obliterated and the military rank took precedence, thereby making it difficult for professional nurses to take nursing practice decisions. The recommendations suggested that nursing leadership should restore those boundaries to allow professional nurses to practice nursing without consideration of military ranks. Regarding lack of development for professional nurses whose health status changed while already employed by the defence force, these professional nurses were to be allowed the opportunities to do military courses under different conditions than normally the case.

5.4 FORMAT OF BEST PRACTICE GUIDELINE

In the development of this guideline, the AGREE II appraisal instrument was used as a guide to the presentation of the recommendations. This instrument provides a framework to assess the quality of guidelines as well as for the development and implementation of best practice guidelines (Brouwers, 2010:1). The tool has six quality domains with 23 items for appraising guidelines and two global rating items for the overall rating. The copy of the AGREE II instrument is provided in Annexure H.

The first part of the guideline deals with the scope and purpose of the guideline and addresses the overall aim, the review question, and defines the target population. The second part of the guideline addresses stakeholder involvement which is the extent to which appropriate stakeholders participated in the development of the guideline and whether they represented the views of the intended users. The third part discusses rigour development. The fourth part handles the clarity of presentation in terms of language, format and structure. The fifth part deals with applicability of the guideline which, owing to the limited scope of this research study, was not addressed. This part

deals with while the barriers to implementation of the guideline, cost implications and strategies to improve uptake. The last part, the sixth, deals with editorial independence where any possible conflict of interest and independence of the recommendations were declared.

5.5 BEST PRACTICE GUIDELINE FOR A HEALTHY WORK ENVIRONMENT FOR NURSES WORKING IN THE SAMHS

Comments from the 5 expert reviewers are provided in this section of the study. The reviewers were from the SAMHS' department of military nursing, all holding degrees in nursing, two of which are PhDs. All military reviewers, 1-3, are managers and one of them specifically works with policy and planning and would therefore all be active participants in the implementation of the guideline. The other two reviewers are from academia, from the Nursing Science department at Nelson Mandela University and are senior professional nurses with PhDs. They are experts in guideline development. All expert reviewers consented in writing to participating in the review of the draft guideline. The draft guideline, together with the review sheet, was sent by e-mail to the respective reviewers for the assessment and comments.

5.5.1 Comments from the expert reviewers

The comments and/or recommendations from the five reviewers are presented according to the headings used in the review sheet. Based on the comments, the final guideline was adopted. The scores as rated by reviewers were calculated for each domain using the formula in the AGREE II instrument. For a better understanding of how the domain score was reached at, the first domain score will be explained in detail subsequently the other domain percentage scores will just be stated.

5.5.1.1 Scope and purpose of the best practice guideline

The first domain of the AGREE II instrument is the scope and purpose and was rated by the reviewers on a scale of 1 to 7. 1 stands for strongly disagree while 7 is strongly agree. Three items in this domain were rated and these were the aim and objectives of the guideline, the review question and the target population.

The calculations are outlined in **Table 5.1** as follows:

Table 5.1: Calculations

Reviewers	Item 1	Item 2	Item 3	Total
1	7	7	5	19
2	7	7	4	18
3	7	7	7	21
4	5	7	7	19
5	6	7	6	19
Total	32	35	29	97

Maximum possible score = 7 x 3 items x 5 reviewers = 105 and the Minimum possible score = 1 x 3 items x 5 reviewers = 15

The scaled domain percentage score will be:

$$\frac{\text{Obtained score} - \text{Minimum possible score}}{\text{Maximum possible score} - \text{Minimum possible score}} \times 100$$

$$\frac{96-15}{105-15} \times 100 = \frac{81}{90} \times 100 = .90 \times 100 = 90\%$$

When the score rating obtained is high, the consensus related to the assessed domain is great and thus can be used as a form of validation of the content of the best practice guideline.

5.5.1.2 Stakeholder involvement

Four of the five reviewers commented that the items addressing the patient's views and preferences were not properly addressed as senior military professional nurses' (managers) views were not sought and therefore not represented in this study, but rather the professional nurses who work in the hospitals and clinics. This would be a consideration for a post-doctoral study where managers would be explicitly addressed, as professional nurses were not categorized according to seniority in this study. This comment was put as limitation to the study.

5.5.1.3 Rigour of development

The fourth reviewer rated Item 9 which addresses limitations and strengths very low commenting that this item should have been included and suggested that the limitation of the variety of evidence found to be indicated in the final chapter. The limitations have been addressed in Chapter Six of the study. Generally, the five reviewers agreed and or strongly agreed with the rigour of the developed guideline, although reviewer four rated item 11, on linking of each recommendation at 4/7 which is 57%. The percentage score for the domain stood at 95.5%

5.5.1.4 Clarity and presentation

All 5 reviewers strongly agreed that the clarity and presentation of the guideline was acceptable since the recommendations were specific, unambiguous and easily identifiable, however the fourth reviewer rated item 13 on recommendations are specific and unambiguous at 4/7, which is 57%, implying that the recommendations were not specific and unambiguous. The concerns raised by the reviewer were attended to, corrected and included in amended guideline. The fifth reviewer rated items 13 and 14 at 5/7 which is 71%. The reviewer further commented on clarity of guidelines that the recommendations were to some extent vague and could be more explicit for the target population. The inputs of the fifth reviewer were considered and incorporated into the final guideline. The overall percentage allocated to the domain was 93%.

5.5.1.5 Editorial independence

Item 15, which deals with the possibility of the guideline being influenced by the funding body, seemed to have not been understood by the three members of the expert reviewers, as a result two of the reviewers commented “not applicable’’ and the other put a question mark. Only the fourth reviewer strongly agreed. Modifications on the phrasing of item 15 were made.

5.5.1.6 Other comments

General comments made by individual reviewers are as follows:

Reviewer one

The overall quality rating of the guideline is 6 and the reviewer recommends the use of the guideline. The reviewer is of the opinion that the guideline may also apply to other health care professionals although it is meant for professional nurses. The reviewer also commends the researcher and supervisors for the good work and indicates that the topic is of utmost importance to nursing and military profession. Lastly the reviewer suggested that more evidence be added to support the rationale. Based on these comments changes were made, where applicable, to strengthen the guideline.

Reviewer two

The overall quality rating of the guideline is 6 and the reviewer recommends the use of the guideline. The reviewer believes that although the guideline is contextual, it could be used in other health contexts. It is also the view of the reviewer that senior managers should have been included in the study.

Reviewer three

The overall quality rating by reviewer three is 6 and recommends the use of the guideline with modification. The reviewer is of the opinion that the views of senior military nursing managers were not sought therefore not represented. The reviewer also suggests that the study should compare the military with other civilian nursing institutions to establish whether lack of autonomy in practice applies only to the military or to the nursing profession in general**.** The reviewer's comments will form part of and is more appropriate for the recommendations for research, and are not included in the final guideline.

Reviewer four

Reviewer four allocated a global quality rating of 5 and recommends the use of the guideline with modification. The reviewer made the following comments:

Item 1 – the difference between purpose and objective unclear

Item 5 – the views of PNs only have been sought in Phase 1 of the study. Perhaps views of the nursing management could have also been sought (if this applies, this could be included as a limitation to the study in the final chapter)

Item 9 – the limitations and strengths could be included (perhaps also the variety of evidence found – limitations could be added to the final chapter)

Item 10- overall the methods for the development of the guideline were clear. Some comments/corrections were done (please see detailed comments in the BPG document)

Item 11- Although evidence was provided in the introduction and rationale, each recommendation could also be linked to the evidence (Level I for recommendations from the found BPGs and level 4 from the interviews).

All comments were given attention and incorporated into the final guideline. Overall the guideline was accepted by the reviewers and final reviewer score stood at 90%.

Reviewer five

The overall quality rating by reviewer five is 5 and recommends the use of the guideline. The reviewer raised concerns that the recommendations were to some extent vague and could be more explicit for the target population. The inputs given by the reviewer were considered and incorporated into the final guideline

5.6 THE FINAL BEST PRACTICE GUIDELINE

This section provides the reader with a summary of the evidence-based best practice guideline on a healthy work environment for professional nurses working in the SAMHS. A copy of the final guideline is available as Annexure P

5.6.1 Guideline title

A best practice guideline for a healthy work environment for professional nurses working in the SAMHS

5.6.2 Scope and purpose

The objective of the guideline, the review question and the target group are items for discussion in this section.

5.6.2.1 Guideline objective

The objective of this guideline is to provide professional nurses working in the SAMHS with best practice recommendations that will assist in the enhancement of a healthy work environment for nurses.

5.6.2.2 Review question

The review question that was formulated to search for relevant literature pertaining to a healthy work environment was:

"What existing evidence-based best practice guidelines are available for a healthy work environment for nurses/health care professionals?"

The question was extended to include all health care professionals because of scarcity of healthy work environment best practice guidelines for nurses from different organisations.

5.6.2.3 Target group

The guideline is intended for use by SAMHS' leadership, at Levels 2, the strategic level, Level 3, the formation level and Level 4, the unit level (hospitals, sickbays and clinics and nursing college) and all professional nurses working in all the military health institutions of the SAMHS, including the military clinics, sickbays and hospitals irrespective of positions. However, the guideline may also be adapted by nursing institutions outside the military such as public and private hospitals and clinics where they find it applicable.

5.6.3 Stakeholder involvement

Owing to the scope of this research study, the guideline was developed by the researcher and not by a recommended guideline development group. However, an expert reviewers were consulted to comment on the guideline construction and content. Three of the expert reviewers were senior professional nurses from academic institutions of higher learning and are knowledgeable in the formulation of best practice guidelines. The other three were from the military environment and are experts in military nursing. All the reviewers hold PhD qualifications, except for one who is a PhD candidate at a South African university and holds a position of Policy and Planning in the Directorate of Military Nursing. These senior military nurses engage with professional nurses at all levels of the SAMHS including representing nurses at strategic level. The expert reviewers were the ideal representatives to review and validate the recommendations for a healthy work environment for nurses.

The views of the professional nurses who were interviewed in Phase 1 of the study were taken into consideration in the development of the guideline. Data from the qualitative research, together with data that emanated from the integrative literature review, formed the rich basis on which the guideline was developed.

The guideline was not pilot-tested amongst the target users, namely the professional nurses working in the SAMHS, as this was not part of the scope of the study. Implementation strategies thus have still to be developed to enhance the use of this guideline in practice.

5.6.4 Rigour of development

This draft best practice guideline was developed based on the data derived from an integrative literature review. The librarian of the Faculty of Health Sciences at the Nelson Mandela University assisted with the search for relevant literature in citation databases CINAHL, Medline, Biomed Central, Academic Search Complete, Health Source: Nursing/Academic Edition and the internet search engine Google Scholar. Search terms used for identifying literature pertaining to a healthy work environment “evidence based” or “healthy work environment” or “best practice” AND (guideline OR protocol) AND (“professional nurses” OR “health-care professionals” AND (care OR

focus*) AND (military health settings) OR military hospitals, military clinics or sickbays. Guideline databases which were searched were the US National Guideline Clearinghouse, sponsored by the US Agency for Health Care Research and Quality, the Guidelines International Network (G-I-N), and the National Institute for Health and Clinical Excellence (NICE). Another strategy was to search the websites of known guideline developers (Scottish Intercollegiate Guidelines Network, Royal College of Nurses, Registered Nurses Association of Ontario, New Zealand Guidelines Group, National Health and Medical Research Council, Canadian Medical Association and the National Department of Health in South Africa). The search was limited to guidelines pertaining to healthy work environments for health-care professionals including nurses, published in English between 2003 and 2017. All guidelines relating to other disciplines other than health were excluded.

The initial search for evidence identified 15 possible guidelines for inclusion in the integrative literature review. After eliminating duplications (n=2), and studies that did not adhere to the inclusion criteria of the review (n=1), twelve (12) guidelines were included in the critical appraisal process. Following this process, which was done independently by two reviewers, the primary reviewer being the researcher, and an independent reviewer, who is an experienced reviewer from the Department of Nursing Science at the Nelson Mandela University, twelve (12) guidelines were included in the integrative literature review. The guidelines that met the criteria, after consensus between the two reviewers was reached, were critically appraised using the Appraisal of Guidelines for Research and Evaluation (AGREE II) Instrument (Brouwers, 2009:8, cited in Polit & Beck, 2012). On completion of the critical appraisal, data was extracted from the guidelines. Following data extraction, the main findings from each guideline were summarized in a table format, stating the authors, publication details and the main recommendations. These were synthesised and categorized into themes based on similarities of evidence found in different guidelines. The themes from the integrative literature review and the qualitative research findings were synthesized, based on aspects of healthy environments, to form the recommendations. The comments from the expert reviewers were incorporated in the development of the final draft of the best practice guideline for a healthy work environment for professional nurses.

5.6.5 Clarity and presentation of recommendations

The recommendations presented in this section are based on evidence generated from a qualitative research and integrative literature review with comments from reviewers incorporated. Creating healthy work environments is both an individual and collective responsibility. Successful uptake of any guideline requires a concerted effort by nurse administrators, staff and advanced practice nurses, nurses in policy, education and research, and colleagues from other disciplines (RNAO, 2013a:5). The nurse leaders referred to in the recommendations include unit managers at hospitals, sickbays and clinics, as well as the military nursing directorate. The SAMHS leadership is the whole Command Council of SAMHS under the leadership of the Surgeon General where all directorates and departments are represented from human resources, logistics to the military nursing directorate and other directorates involved in provision of patient care. Recommendations for implementation by professional nurses working in the SAMHS concerning a healthy work environment are as follows:

5.6.5.1 The need for effective leadership to create an empowering environment

It was evident from the qualitative findings in Phase 1 of the study that professional nurses working in the SAMHS needed effective leadership that would create an empowering environment to help them deal with challenges associated with the military culture and traditions they experienced; an environment that would provide them with adequate resources, give them opportunities to develop, support and mentor them. According to these findings, the professional nurses needed an empowering environment. Based on these findings and the integrative literature review, the recommendations are as follows:

5.6.5.1.1 Support to newly appointed professional nurses to adjust to the military culture and traditions

The newly appointed professional nurses attributed their problems of adjustment to inadequate induction training.

Recommendations

SAMHS' leadership, at Levels 2, the strategic level, Level 3, the formation level and Level 4, the unit level (hospitals, sickbays and clinics and nursing college) (in supporting personnel to adjust to military culture and traditions should:

- Provide a structured induction programme that will equip the newly appointed personnel with military skills used on a daily basis before they wear military uniform at entry into the military context. This induction programme should be reinforced by weekly practices for a period of up to three months until the members are competent.
- The newly appointed members should attend basic military courses that are more comprehensive within a year of appointment.
- Colleagues (other professional nurses/managers) to be assigned to coach each newly appointed professional nurse in uniform. The rank of the peer should be at the level that does not cause a power differential that may impede openness and trust by the new professional nurse.
- Newly qualified professional nurses (novice) from within the SAMHS should be orientated, mentored and coached to build trust of leadership and their own confidence.

Rationale

A structured induction programme and mentoring will assist the newly appointed professional nurses with assimilation of military skills to adjust to the military environment. Regarding the novice professional nurses trained within the SAMHS, professional nurses do not emerge from training fully prepared and completely effective. The qualitative research study in Phase 1 revealed that both newly appointed and newly qualified did not receive either adequate induction or orientation. Their development is a more involved and incremental process; therefore comprehensive orientation and mentoring programmes should be in place, monitored and evaluated. Induction is according to Fowler (1996) cited in Stirzaker (2004:3), the period between the employee's starting work and eventually becoming fully integrated and competent. Fowler continues to say that real induction takes place over several months, not days and is dependent on both the individual and the situation (Fowler, 1996).

5.6.5.1.2 Clearly defined

It is crucial that professional nurses understand what their military and professional roles are in a work environment and that the organisation's expectations are clearly spelt out to them.

Recommendations

It is the role of leadership to ensure that professional nurses understand what it is that is expected of them in any health setting by confirming that:

- Expectations are communicated verbally and in writing to professional nurses annually through duty sheets and one-on-one meetings with management
- Duties of every professional nurse are displayed, are visible and accessible
- Professional nurses know the direction the organisation plans to take
- Professional nurses are assessed on the roles they played periodically
- Communication is effective by holding individual counselling and interview sessions with professional nurses periodically.

Rationale

Understanding one's expectations allows professional nurses to work to their full scope of practice, embrace teamwork and experience professional autonomy (RNAO, 2013b:26). It promotes commitment to participating actively towards achieving goals and objectives of the organization and mitigates against conflict thus facilitating a healthy work environment.

5.6.5.1.3 Provision of adequate resources

To create a healthy work environment, nurse leaders facilitate nurses' access to appropriate resources such as the materials, finances, supplies, equipment and time necessary to fulfil their roles (RNAO, 2013b:40).

Recommendation

With regard to provision of resources, the following recommendations are made:

Nurse leaders should:

- Minimize constraints to resources
- Provide necessary budgetary support
- Establish mechanisms to monitor and achieve manageable workloads
- Respond to changing needs in technology, education and training, licensing body prescripts and national and world politics
- Provide up-to-date functioning equipment, better staffing and adequate infrastructure (RNAO, 2013b:44).

Professional nurses should identify resources needed

- Communicate the need for resources annually
- Plan and budget for the resources they are going to use annually
- Share information and resources
- Urge the logistics and human resources departments to facilitate acquisition of resources by shortening the procurement processes and communicate this process to management.

Rationale

Nurses and employers have an obligation to their clients to advocate for and contribute to quality practice environments that have the organizational structures and resources necessary to promote safety, support and respect for all persons in the practice setting. This in line with creating an empowering work environment as advocated for by the RNAO guideline on leadership(RNAO, 2013a:17). Findings in Phase 1 revealed that professional nurses expected their managers to provide them with adequate resources so that they do not have to run around when they have to do their work.

5.6.5.1.4 Opportunities for professional development and promotion

When organisations encourage life-long learning by supporting professional development and mutual sharing of knowledge, they become learning organisations. Quality practice environments are adequately supported and funded to allow nurses to access professional development opportunities. These opportunities can include formal and continuing education, attending seminars, conferences and mentoring.

Recommendations

Nurse leaders should

- Prioritise the empowerment of nurses
- Represent nurses' development needs to the organisation
- Develop policies for nurses' career advancement and professional development opportunities
- Have a career plan for individual nurses and hold career development discussions annually
- Identify learning needs of professional nurses
- Provide opportunities for professional nurses to attend promotional courses, both professional and military courses at least every three years
- Provide knowledge acquiring and transferring opportunities to professional nurses such as seminars, conferences, workshops in-service training annually and continuously
- Advocate for financial resources for nurses' professional development
- Develop a plan for professional development and succession
- Ensure that professional nurses are technology literate, for example to encourage them to attend necessary computer literacy courses. Nurses must nominate themselves for the computer courses according to their needs.
- Link professional development to upward mobility/promotional opportunities of professional nurses
- Monitor and evaluate work performance of professional nurses continuously and give feedback

Rationale

Professional development is important for equipping professional nurses with knowledge and skills as well as building their confidence in executing their nursing duties. It also affords the individual nurses with opportunities for promotions. Professional nurses revealed in the qualitative study in Phase 1 that lack of development opportunities delayed their promotion opportunities and also made them to feel inferior to their colleagues in the public and private sectors. Organisations which

do not develop their staff become redundant and yield negative patient and personnel outcomes. There is a close relationship between professionalism, education and knowledge development. Knowledge acquired through development provides basis for professional practice (RNAO, 2007a:28). The employees in an organisation to be able to perform their duties and make meaningful contributions to the success of the organisational goals need to acquire the relevant skills and knowledge (Olaniyan & Ojo, 2008:326). See comment re the references

5.6.5.1.5 Collegial support

A colleague is a fellow official or worker, especially in the same profession (RNAO, 2007a:40). Nurse leaders create conditions for nurses to access and use support, feedback and guidance from superiors, peers and subordinates (RNAO, 2013b:39). Collegial support promotes sharing of authority, trust and respect between management and workers and amongst workers. When trust links people to the organisation it encourages workers to be willing to contribute more. Communication, in particular among diverse groups, becomes a key issue in developing collegial relations in the work team (RNAO, 2007b:33).

Recommendations

Nurse leaders should

- Seek to understand thinking, learning and working styles of others
- Create structures and processes that enable interactions (Team building exercises at least annually, recreation activities quarterly and contact sessions weekly, at least monthly).
- Tailor leadership style to individuals and situations
- Formalise recognition for nurses who demonstrate excellence in practice with awards annually
- Identify fears of professional nurses and offer assistance to alleviate the situation by using support/debriefing spaces/ongoing and sustained assistance especially in light of the military context where unpredictable events can be called upon by the newly appointed professional nurses to act on.
- Initiate communication with colleagues

Rationale

An important component of nurses' professional practice is developing and establishing collegial working relationships (Joanna Briggs Institute, 2005) cited in RNAO (2007a:40). Collegial support proposes that colleagues support one another, and a supportive environment reduces job stress and promotes a safe, relaxed and a healthy work environment. Findings from the qualitative research study in Phase 1 revealed that professional nurses expected to be supported by their seniors at work. According to ICN (2007:29), regardless of setting, positive work environments support nurses in their professional role of caring for patients. If nurses do not have the supports they need to practice, they cannot ensure the best outcomes for patients. They may be discouraged and quit job or even the profession (ICN, 2007:29).

5.6.5.2 Effective communication amongst members of the health team

Nurse leaders create environments where communication is open, and others' knowledge is valued (RNAO, 2013:32).

5.6.5.2.1 Formal and informal communication

Nurse leaders should promote flow of information and ideas at multiple levels through formal and informal practices. In a healthy work environment, leaders communicate openly with health care workers, patients and families of patients and provide timeous feedback when such a need arises.

Recommendations

Nurse leaders should:

- Advocate for open, transparent and honest communication
- Possess communication skills and use them appropriately
- Hold formal meetings with professional nurses monthly and whenever it is needed
- Hold informal contact sessions with professional nurses weekly in order to give feedback on latest developments in the organisation and to give professional nurses the opportunity to raise their concerns and discuss solutions.

- Conduct progress interviews with nurses yearly and whenever the need arises
- Give timeous feedback all the time
- Arrange for team-building exercises at least annually
- Negotiate skillfully to help team members overcome differences in viewpoints/be a mediator
- Be able to adjust the language to the target audience, express themselves at the level that will be understood by all
- Embrace cultural diversity and any diverse opinions of nurses from different cultural backgrounds
- Recognise contributions of professional nurses by means of incentives and by creating opportunities for responsibility to widen the set skill of the professional nurse.

Professional nurses should:

- Communicate among themselves about patients' progress (Nurses' rounds and handing and taking over rounds, report-giving)
- Communicate with other care-givers
- Participate in grand rounds
- Communicate with patients about their conditions and families about progress of their loved ones.

Rationale

Healthy work environments promote effective and transparent communication between nurses and management, patients and their families, other caregivers and among nurses. Effective communication is critical to good patient outcomes and nurses' job satisfaction. It is a cornerstone of effective leadership, building teams, promoting quality patient care and critical in strengthening relations between employees and employers, clients and families (RNAO, 2013a:41; 2009:46; 2007:33; 2017:32). Effective communication emerged as one aspect professional nurses indicated as lacking in the qualitative study in Phase 1.

5.6.5.2.2 Standardisation of Standard Working Procedures

Working procedures are a written means of communication to a large number of people suitable for big and small organisations. Health organisations utilize work procedures to standardize health practices. Where these work procedures are absent, health practices are in disarray and this is an indication of poor communication. Professional nurses expressed the need for standardized work procedures at hospitals, sickbays and clinics.

Recommendations

In order to standardize work procedures nurse leaders should:

- Ensure that there is a quality assurance department that is responsible for drafting of standard-work-procedures (SWPs)
- Have a team for drafting of well researched/benchmarked SWPs for all aspects of nursing
- Draft SWPs to be workshopped with all stakeholders
- Distribute adopted SWPs to different units, to be signed for on receipt
- Monitor and evaluate the use and effectiveness of SWPs quarterly
- SWPs must be updated at least yearly
- New changes to be incorporated in the form of amendments.

Rationale

Standardized work procedures will ensure that there is uniformity in rules, procedures and practices across all military health institutions. The moderate systematic review by Cummings et al (2010) found team functions improved when leaders involved staff in developing and implementing of policies and the policies were clear and implemented consistently (RNAO, 2016:40).

5.6.5.3 A culture that supports team work

Teamwork is integral in creating healthy work environments and a backbone of inter-professional health and intra-collaborative heath practice. Nurses collaborate with various professional and non-professional health care workers (ICN, 2007:18). To

support effective team work and avoid conflict and negative consequences for the team, team members should clearly understand their roles and scope (Eager et al, 2010 in RNAO, 2016:30).

5.6.5.3.1 Team building

Factors that facilitate the establishment of teamwork are critical if quality care is to be provided (ICN, 2007:18).

Recommendations

In building teams, nurse leaders should:

- Encourage multi-disciplinary collaboration all the time
- Provide team training regarding working in teams after every six months
- Eliminate hierarchy
- Enforce a zero-tolerance policy to disruptive behaviour
- Embrace diversity in culture and views
- Be able to mitigate conflict
- Facilitate sharing of power among team members
- Encourage collaborative leadership, rotate leadership amongst members of the team at least monthly
- Allow participation of team members in decision-making
- Build trust relationships

Rationale

Teamwork is central to winning of wars by militaries and providing quality patient care by nurses in health institutions. An organizational culture that supports teamwork therefore becomes a winning organisation. Effective communication and role clarification are the guiding principles of teamwork. Literature shows that nurses who have a clear understanding of roles, responsibilities and competencies support and demonstrate willingness to work effectively with others (RNAO, 2016:29).

5.6.5.3.2 Role clarification

Understanding and appreciating professional roles and communicating effectively are central to the success of any team and is linked to quality patient care and a healthy work environment for nurses. Findings in Phase 1 revealed that professional nurses indicated that their roles were not clearly defined. The literature shows that nurses who have clear understanding of roles, responsibilities and competencies support and achieve intra-professional collaborative practice. Practice nurses need to understand clearly their full scope of practice in the setting where they work, be secure within their professional team and communicate effectively (RNAO, 2016:25).

Recommendations

In clarifying the roles, the following recommendations are made:

Nurse leaders should:

- Provide professional nurses with induction training and ensure they are aware of their role within their immediate work team or unit, and the broader organisation
- Provide clearly defined work objectives and expected outputs for professional nurses
- Ensure professional nurses possess up to date duty-sheets
- Always ensure that professional nurses are aware of additional tasks should there be any changes and make sure that they receive training for those tasks they are not confident or capable of doing
- Develop and maintain a working environment where professional nurses are consulted and can provide feedback on changes impacting on their job tasks.
- Involve the professional nurses where a change in structure or roles occurs

Rationale

Role ambiguity can interrupt the effectiveness of a team and have a negative impact on job satisfaction. Nurses need to have and demonstrate role clarity to optimize the quality of patient/client safety (Oelke et al, 2008) in RNAO (2016:29

5.6.5.4 The need for an environment that promotes professional autonomy

Autonomy is defined as freedom to act on what you know to make independent clinical decisions and act in the best interest of the patient (RNAO,2007:34). This freedom is conferred upon professional nurses as soon as they qualify and licensed as professional nurses and after obtaining other licences to practise in different disciplines in nursing based on their qualifications. Should, for whatever reason, this autonomy be frustrated, leadership should take steps to intervene in the best interest of the patient and professional nurses. This would be an effort to enhance a healthy work environment.

5.6.5.4.1 Abuse of military rank and recognition of functional rank

It became evident from the qualitative findings in Phase 1 that the use of military rank by patients and other senior officers on professional nurses at sickbays and clinics, interfered with their practice autonomy. The interference with practice autonomy of professional nurses by military senior officers emanates from the fact that these professional nurses either have junior ranks or have a candidate officer (CO) rank (which is no rank at all). Although the junior officer is a professional nurse, their functional ranks are insignificant in the military consequently their functional ranks are not recognized. The Registered Nurses Association of Ontario (RNAO, 2013b:9) recommends that organisations must acknowledge the impact of power hierarchy by identifying imbalances of power and making changes to equalize and build mutually supportive, safe inter-professional workplaces.

Recommendations

Nurse leaders are senior officers in the military. They are high ranking officials with authority and therefore are in a position to represent professional nurses' interests and concerns at the formation level and Level 2. They also develop operational policies; therefore should optimize opportunities for professional nurses' autonomy, personal and professional growth and mitigate conflict by:

- Facilitating the concurrent functional and military rank promotions of professional nurses immediately after qualifying

- Creating awareness by displaying on notice boards the significance of the professional nurse's functional rank and the status attached to it
- Facilitating a system/policy that will enable senior officers to be seen by a separate professional nurse whenever they come for consultation to mitigate conflict of power imbalances.
- Developing policies that protect the limitation of professional nurses' practice autonomy
- Ensuring that nurse leaders themselves coach, mentor, be role models and guide professional nurses
- Providing opportunities for development and knowledge
- Encouraging use of judgment, risk taking and innovation
- Developing policies and processes that enable full scope of practice
- Establishing formal and informal leadership roles at practice levels such as clinical persons. These would be senior professional nurses who are role models to professional nurses.
- Demonstrating confidence in others by delegating effectively

Professional nurses must clearly communicate and organize their work, act on nursing decisions using clinical judgement by:

- Clearly defining their own expectations for autonomous clinical practice
- Being part of clinical rounds to maximise the valuable contribution on nurses' unique perspective and perspective in the care of patients
- Acting within their scope of practice.
- Role modeling expected behaviours reinforces autonomy

Rationale

The literature reviewed in Phase 2 indicated that the autonomy of a nurse practitioner included the ability to carry out the appropriate course of action within a system that has standards of practice, code of ethics and organizational policies to advocate in the capacity of the nurse to determine her/his own course of action, ability to deliberate. Furthermore, autonomy is said to enable professional nurses to construct innovative

collaboration to advance primary health care (RNAO, 2007:34). The nurses' ability to be autonomous is supported or limited by the organisation (RNAO, 2007:34).

5.6.5.4.2 Dual role conflict

Professional nurses in the military have dual roles: a role of a nurse and that of a soldier. It was evident in qualitative findings in Phase 1 that professional nurses did not get the opportunity to work overtime at hospitals to update their knowledge and skill because the military role in the form of regimental duties overruled the nursing role. Tensions can arise if the demands of the mission or line command are at odds or in tension with the duties to attend to the health of those needing care

Recommendations

Nurse leaders in mitigating the conflict between the roles should:

- Develop a policy enlightening military leadership on the importance of nurses updating their knowledge and skill
- Hold meetings with Officers Commanding of units to communicate the need for this continuing education function annually
- Facilitate/support the system of Continuing Professional Development (CPD) points.

Rationale

The dual roles must be managed properly so that a balance is reached as these roles are part of the uniqueness of the military culture and should be congruent. The military is hierarchical and relies on formal authorities and chain of command. Decisions often have to be made quickly and decisively. This type of decision-making structure can be challenging to health care professionals who are facing ambiguous or uncharted territory that requires them to rely on their judgement, discretion, and in accordance with non-military professional. Ethical and moral issues that health care professionals in the military are usually faced with can be resolved with effective communication, training, leadership, clear rules of engagement and unit cohesion and support (Defense Health Board, 2015:ES-1).

5.6.5.5 Recommendations to address factors that impact negatively on enhancement of a healthy work environment

These recommendations are based on the factors that came up repeatedly from professional nurses in the qualitative findings in Phase 1 as inhibiting the creation of a healthy work environment. They must be viewed as addressing the need to minimize these factors from the environment to enhance a healthy work environment, not as duplications.

5.6.5.5.1 Shortage of personnel and the staffing process

Shortage of personnel seemed to be inhibiting the healthy work environment for nurses in the SAMHS as nurses in the qualitative findings expressed how they were overworked because of the long and protracted staffing process. They indicated that it took a very long time to replace members who left through natural attrition process and those who die.

Recommendations

SAMHS leadership at level 2

- Should revisit the post structure and consider restructuring to address demand and personnel ratio.

Human resources to ensure that:

- the bureaucratic processes that prolong the appointment of professional nurses are minimized
- Vacant posts created by attrition of nurses are filled within three months At Levels 3 and 4 (The formation and unit levels i.e hospitals and clinics, college).

Nurse leaders should:

- act on valid and reliable workload data (RNAO, 2013b:40)
- create a pool of reserve force nurses and make use of reserve force nurses to alleviate shortage of personnel.

Rationale

Creating a healthy working environment for nurses begins with effective and proactive staffing and workload processes that capitalize on individual and collective nurses' knowledge, experience and skills sets. Three key elements of workload planning, workload management and workload measurement are critical to successful staffing and workloads, and must be operationalized within a systems context (RNAO, 2007b:37).

5.6.5.5.2 Acquisition of equipment and the procurement processes

Not having serviceable, appropriate and adequate equipment becomes a source of frustration for nurses. Professional nurses find themselves spending a great deal of time locating equipment and arranging for its repair and maintenance, according to findings of the qualitative research study in Phase 1. Nurse leadership at SAMHS level 2 should enhance a healthy work environment by liaising with logistics department to ensure that long procurement processes are minimized.

Recommendations

Nurse leaders facilitate for:

- Logistics to minimize long procurement processes
- Maintenance and repair plans to be in place and be monitored and followed up by nurse leaders
- Equipment to be serviced as per purchase instructions
- Personnel to handle equipment with care
- Service life of equipment to be observed and procurement orders to be done in advance to replace the obsolete equipment.

Rationale

Up to date and functioning equipment contributes to good health service delivery which translates to good quality care for patients. It enhances a healthy work environment as it enables professional nurses to perform their tasks optimally. SAMHS leadership

should provide nurses with serviceable equipment to perform their job effectively and efficiently.

5.6.5.5.3 Status of infra structure

Professional nurses indicated that the buildings used for rendering of health services in sickbays and clinics were not designed for that purpose. Furthermore, the buildings were not maintained as a result they were dilapidated, not adequately ventilated and still had carpet fittings making it difficult to keep high infection control standards.

Recommendations

The SAMHS leadership at level 2 should:

- Prioritise the redesigning and refurbishing of the primary healthcare facilities according to the occupational health and safety requirements and specifications
- Ensure that the existing primary health care facilities are replaced by modern state of the art facilities
- Prioritise maintenance and repair of health facilities
- Avail financial resources for maintenance and repair of facilities
- Utilize expertise within the defence force for upgrading of facilities to curb costs.

Rationale

The status of the facilities has either a demoralizing or morale boosting effect on professional nurses and building of confidence on patients with regard to the standards of health services they are about to receive, depending on what state the facilities are. The facilities that meet high health standards equate to good quality of patient care and enhance a healthy work environment.

5.6.5.5.4 Lack of development opportunities for sickly personnel

It was evident from the qualitative findings in Phase 1 that professional nurses whose health status changed while already in the employ of the defence force were disadvantaged when it came to professional development.

Recommendations

SAMHS leadership should consider:

- Affording professional nurses who fall sick already in the employ of the defence force opportunities to attend courses and be put on light duty or
- That the professional nurses receive their rightful military promotions without considerations of military courses
- Alternatively, that the affected professional nurses wear civilian uniform to avoid humiliation associated with not having a military rank.

Rationale

The initial health status of professional nurses who fall sick when they are already members of the defence force should suffice to warrant them consideration for professional development opportunities. Should it be impossible for professional nurses to attend military courses and are therefore not eligible for military rank promotions, such nurses should wear civilian uniform to spare them frustrations of not having a rank.

5.6.6 Editorial independence

The responses from the professional nurses working in the SAMHS in the individual interviews formed the basis for the development of this evidence-based best practice guideline. The promoter and co-promoters of the study are assisting in the conception and the design of the guideline. The draft guideline was sent to the reviewers for comments and their comments will be incorporated into the development of the final guideline. No conflict of interest is applicable to the development of this guideline.

5.7 SUMMARY OF THE CHAPTER

A draft evidence-based best practice guideline was submitted to expert reviewers for their comments and recommendations. The comments were incorporated into the development of the final guideline for a healthy work environment for nurses working in the SAMHS. Chapter Six describes the conclusions, limitations and recommendations emanating from the research study.

CHAPTER SIX

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

Chapter One provided an overview of the study where the purpose of the study was stated, the research objectives and questions outlined, and the paradigmatic framework described. The research design and method were introduced, and ethical considerations clarified. In Chapter Two the research methodology was discussed in detail. Chapter Three dealt with data analysis of evidence generated through semi-structured interviews with professional nurses working in the SAMHS. Phase 1 comprised the first three chapters. Phase 2 of the study comprised Chapter Four. In this chapter, an integrative literature review was conducted where a search of existing best practice guidelines for a healthy work environment for nurses, their appraisal, data extraction, analysis and synthesis were conducted. Chapter Five dealt with the process of a best practice guideline development and the triangulation of evidence generated in Phases 1 and 2, and that chapter constitutes Phase 3 of the study. A draft best practice guideline was developed and sent to expert reviewers for their comments and recommendations. The draft best practice guideline was then modified by incorporating the comments from reviewers, a process which resulted in the final best practice guideline. Lastly Chapter Six, aims to conclude the study by addressing conclusions, limitations of the study and making recommendations.

6.1 INTRODUCTION

Evidence-based practice (EBP) is defined as the conscientious integration of best research evidence with clinical expertise and patient values and needs in the delivery of quality, cost-effective health care (Craig & Smyth, 2012; Sacket, Straus, Richardson, Rosenberg, & Haynes, 2000; cited in Gray, Grove & Sutherland, 2017:453). Polit and Beck (2012:727) further add that EBP is a problem-solving strategy that emphasises the integration of best available evidence from disciplined research with clinical expertise and patient preferences. Because the ultimate goal of nursing is to provide evidence-based care that promotes quality outcomes for patients, families, healthcare providers, and the healthcare system (Craig & Smyth, 2012; Doran, 2011; Melnyk & Fineout-Overholt, 2015, in Gray, Grove & Sutherland,

2017:11), it is important, therefore, that nurses use the best available research evidence.

The best research evidence is synthesised by reviewers that are experts into into evidence- based guidelines that provide current, comprehensive directions for using research in practice (Burns & Grove, 2011:492). LoBiondo-Wood and Haber (2010:24) define clinical guidelines as systematically developed statements or recommendations that serve as a guide for practitioners. They further state that guidelines have been developed to assist in bridging practice and research. Polit and Beck (2012:31) posit that evidence-based clinical practice guidelines represent an effort to distill a large body of evidence into manageable form. Clinical practice guidelines give specific recommendations for evidence-based decision-making. Their intent is to influence what clinicians do (Polit & Beck, 2012:31).

6.2 CONCLUSIONS OF THE STUDY

The aim of this study was to explore and describe how professional nurses experienced working in the SAMHS, their understanding of a healthy work environment and a best practice guideline, in order to develop a best practice guideline for a healthy work environment for professional nurses working in the SAMHS.

The research was driven by the observation that the rigid and authoritarian military nursing environment, where soldiers operate under strict military rules, could be experienced negatively by those professional nurses who did not train as nurses within the military lines. Professional nurses working in the SAMHS, which is an arm of service of the South African National Defence Force (SANDF), are sourced from within the military and from public and private sectors outside the military. The professional nurses from the other sectors get exposed to the military culture for the first time when they get appointed. The awareness of how the world insisted on creating healthy work environments for nurses prompted the researcher to explore how the professional nurses experienced working in the unique military environment because of the belief that it was the professional nurses themselves who could best express their experiences.

The Registered Nurses Association of Ontario (RNAO), as early as 2003, made an observation that there was a relationship between nurses' work environments, patient/client outcomes and organisational and system performance. They then commenced the development of evidence-based best practice guidelines in order to create healthy work environments for nurses. RNAO suggest that those focusing on creating healthy work environments made decisions based on the best evidence possible (RNAO, 2007:14).

Themes relating to the development of guidelines that could facilitate a healthy work environment for professional nurses were identified and these included: the need for effective leadership to create an empowering environment, effective communication amongst members of the health team, a culture that supports teamwork amongst colleagues, the need for an environment that promotes professional autonomy and recommendations to address factors that impact negatively on enhancement of a healthy work environment.

To achieve the objectives of this study, the development of a best practice guideline for a healthy work environment for nurses working in the SAMHS was done in three phases.

Phase 1 explored and described how the professional nurses experienced working in the SAMHS, their understanding of a healthy work environment and their understanding of a best practice guideline. The objectives of the study were successfully achieved through individual semi-structured interviews with professional nurses working in the hospitals and clinics of the SAMHS. An independent coder was utilised to code data to ensure trustworthiness of the research findings. The findings were extrapolated in Chapter Three.

Phase 2 aimed to explore, describe, appraise, extract and synthesise data from the existing available evidence-based best practice guidelines with regard to a healthy work environment for nurses. A systematic search of literature was conducted and found in databases and grey literature. Relevant evidence-based best practice guidelines relating to a healthy work environment for nurses were selected, critically appraised and data extracted was synthesised to develop a best practice guideline for

a healthy work environment for nurses. This marked the achievement of the fourth objective in Chapter Four and the beginning of Phase 3.

In Phase 3 triangulation of findings from Phases 1 and 2 took place and the objective of the development of a best practice guideline was realized. The draft guideline was submitted to expert reviewers together with a review sheet adapted from the AGREE II tool, for their comments. The draft guideline was then modified based on the comments and recommendations of the reviewers. Phase 3 is presented in Chapter Five. The findings of the research study revealed the need for an evidence-based best practice guideline to facilitate a healthy work environment for professional nurses working in the SAMHS since there was none found during literature review.

6.3 PARADIGMATIC PERSPECTIVE

The paradigm underpinning the research study is the Joanna Briggs Institute (JBI) Model of Evidence-Based Health Care. The JBI model articulates the following four major components of the evidence-based health care process (Pearson, Field & Jordan, 2007:17):

- Healthcare evidence generation
- Evidence synthesis
- Evidence and knowledge transfer
- Evidence utilization.

The four stages were applied in this study; however evidence and knowledge transfer, as well as evidence utilisation, were not part of this study although the evidence-based health care process makes mention of them.

Health care evidence generation

The JBI model suggests that evidence for health care is generated by research, experience and formulation of opinion; however, properly conducted research provides more reliable evidence than personal views. In this study the step of generating health care evidence commenced with the interviewing of professional nurses about their experiences of working in the SAMHS, their understanding of a

healthy work environment for nurses and their recommendations for the content of a best practice guideline for a healthy work environment for nurses. Semi-structured interviews were conducted with professional nurses working in the hospitals and clinics of the SAMHS.

Evidence synthesis

Evidence synthesis deals with the evaluation or analysis of research evidence on a specific topic to aid decision-making in the health care system. Evidence generated from the semi-structured interviews with professional nurses was analysed and utilised, together with the evidence that emanated from the integrative literature review of existing evidence-based best practice guidelines related to a healthy work environment for nurses to develop a draft best practice guideline for a healthy work environment for nurses working in the SAMHS. The draft was then presented to a expert reviewers (n=5) consisting of senior professional nurses from academia and the military. All the experts were ideal to do the reviews because of their extensive knowledge in the development of guidelines. Their comments were incorporated into the development of the final guideline for a healthy work environment for professional nurses working in the SAMHS.

Evidence and knowledge transfer

Evidence/knowledge transfer is defined as “the act of transferring knowledge to individual health professionals, health facilities and health systems globally by means of journals, other publications, electronic media, education and training and decision support systems” (Pearson et al. 2005:213). This stage is not part of this study; however, the evidence-based best practice guideline for a healthy work environment for professional nurses was developed and will be presented to the SAMHS for adoption and utilisation by the professional nurses. An article regarding this study will also be submitted for publication in a peer-reviewed journal.

Evidence utilisation/implementation

In the JBI Model reconsidered, the component of utilisation has been changed to implementation. Evidence implementation in the context of the JBI Model is defined

as a purposeful and enabling set of activities designed to engage key stakeholders with research evidence to inform decision-making and generate sustained improvement in the quality of healthcare delivery. After the adoption and use of the best practice guideline by professional nurses working in the SAMHS, its effect on their work environment will be evaluated. This stage is not part of the current study but could be considered for post-doctoral study.

6.4 LIMITATIONS

- Although the researcher had intended to conduct the study in all SAMHS health institutions in all nine provinces, it was conducted in only six provinces due to a large geographical area and financial constraints. Unavailability of professional nurses due to changing work circumstances became a big limitation, but this did not influence the data findings as conclusions could still be made.
- The study did not categorize professional nurses, thereby excluding exclusive experiences of managers as a category of professional nurses (see Chapter One: 1.6.2).
- Of the 16 interviews conducted, 2 interviews could not be transcribed due to technology failure. However, the 14 interviews provided suffice data that could provide meaningful findings
- The paucity of best practice guidelines for healthy work environments for both nurses and healthcare professionals limited the study. The field of “healthy work environment” is not widely covered; only a few organisations have written on the topic, and specifically the Registered Nurses Association of Ontario (RNAO) has written comprehensively. The few organisations found were not as comprehensive. The bulk of the evidence generated in the integrative literature review is as a result from the RNAO. Although there are research studies on positive practice environments conducted by different health care professionals in South Africa, such as Coetzee, Klopper, Elis and Aiken (2013) and Munyewende et al (2014), no BPGs related to the military context were found.
- The changes in the researcher’s social life caused movement constraints. The study took longer than anticipated because of the changed circumstances.

- There were limited databases or access with guidelines on healthy work environments for nurses/healthcare professionals although the librarians did their best to help.

6.5 RECOMMENDATIONS

Recommendations for this research study are made for practice, education and nursing research.

6.5.1 Recommendations for nursing practice

- The study revealed the need for a guideline to facilitate a healthy work environment for nurses working in the SAMHS. The implementation of the guideline could create a healthy work environment for all nurses in the SAMHS. It is recommended that the guideline be piloted in one of the military health settings, be evaluated then utilised in all units if found to be beneficial.
- Although the guideline was developed for use in the military health settings only, it can be used by the public and private sectors. Recommendations made can be incorporated in the SAMHS standard working procedures for use by SAMHS leaders, including nurse leaders and other leaders from different SAMHS' departments as they affect all SAMHS' members.
- In-service training programmes to be arranged for target users for them to familiarize themselves in preparation for implementation.
- Finally, striving for a healthy work environment for nurses should become an organisational culture of the SAMHS and should be made policy.

6.5.2 Recommendations for nursing education

- In order to entrench a culture of a healthy work environment for nurses in the SAMHS, principles for creating a healthy work environment should be part of the nursing curriculum at SAMHS Nursing College. This would create an awareness amongst student nurses as to what a healthy work environment is all about.
- Seminars, workshops and conferences on creation of healthy work environments should be held by nurses within SAMHS to create awareness.

6.5.3 Recommendations for nursing research

- A similar study could be repeated in the SAMHS using a sample that would include nurse leaders and other nurse groupings, so as to obtain a more global view of the experiences of nurses working in the SAMHS.
- A post-doctoral study should be conducted to evaluate the extent to which this best practice guideline has contributed to facilitate a healthy work environment for nurses working in the SAMHS.
- Professional nurses should conduct further research to update the SAMHS on the status of the healthy work environment for nurses on a 3-yearly basis.

6.6 SUMMARY OF THE CHAPTER

This chapter provided an overview of the whole research study and the aim and objectives were realized. The findings of the qualitative study gave a clear indication of the absence of a guideline to facilitate a healthy work environment for nurses working in the SAMHS. A rigid, authoritarian and controlled military environment was proved by the findings to be unhealthy for practice of military nursing. An evidence-based best practice guideline for a healthy work environment for nurses working in the SAMHS was developed to facilitate the creation of a healthy work environment. The conclusions and limitations of the study were communicated and recommendations for practice, education and research made.

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ANNEXURE A: LETTER TO PARTICIPANT

Telephone: 012 674 6267
Fax: 012 6746309
Enquiries: Col J.F.M. Mabona

SAMHS Nursing College
Private Bag x1022
Thaba Tshwane
0143
November 2013

Dear Participant

Participant Unique Study Nr: _____

RE: REQUEST FOR PERMISSION TO INTERVIEW PARTICIPANT

My name is Ms J.F.M. Mabona, and I am a Doctoral student at the Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth. The research I wish to conduct for my Doctoral treatise is entitled: *A best practice guideline for a healthy work environment for nurses working in the South African Military Health Service*. The project is being conducted under the supervision of Professor R.M. van Rooyen and Dr P.J. Jordan at the Department of Nursing Science at the NMMU.

I hereby seek your consent to interview you for the purposes of this study. I will be interviewing other professional nurses at your institution. The goal of the study is to determine how the professional nurses experience working in the SAMHS; their understanding of evidence based practice and best practice guidelines. The information will be used to develop a Best Practice Guideline for a Healthy Work Environment for nurses working in the SAMHS in order to enhance quality patient care and patient and nurse satisfaction.

The data will be collected by means of semi-structured interviews with each participant.

Each interview will last approximately 45-60 minutes. The questions that you will be asked are as follows:

- "Tell me about how you experience working in the SAMHS as a professional nurse/lecturer
- “What is your understanding of a healthy work environment”?
- “What factors do you think constitute a healthy work environment”?
- “What factors do you think hinder attainment of a healthy work environment”?
- “What factors do you think can assist to facilitate a healthy work environment for you and your patients”?
- “What is your understanding of a best practice guideline”?

You should not feel pressurized to participate. You may withdraw at any time. All information will be managed confidentially. However, because the choice of multi-professional team members is limited, anonymity cannot be guaranteed. Quotes from the interviews may be used in the research report or in an academic article. However, the actual names of the participants will be replaced with pseudonyms. There are no direct benefits for the participants, but the healthy work environment guideline developed from the study will be of benefit to nurses, patients and the organization.

I will receive a signed consent form from you before you can participate in the study and upon completion of the study; I undertake to provide your institution with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me at:

Cell nr:	**0737930697**	**Tel. nr:**	**0126746267**
Fax nr:	**0126746309**	**Email:**	**madi0922@yahoo.com**

INFORMATION AND INFORMED CONSENT

I hereby seek your consent to interview you for the purposes of this study. I will be interviewing professional nurses working in the SAMHS. The goal of the study is to explore and describe how these professional nurses experience working in the SAMHS and also determine their understanding of evidence based practice, a healthy work environment and best practice guidelines for nurses. The data will be collected by doing a semi-structured interview with each participant. The information will be used to develop a Best Practice Guideline for a healthy work environment for all nurses working in the SAMHS. Each interview will last approximately 45-60 minutes. You should not feel pressurized to participate. You may withdraw at any time and the information will be managed confidentially. However, because the choice of multi-professional team members is limited, anonymity cannot be guaranteed. Quotes from the interviews may be used in the research report or in an academic article. However, the actual names of the participants will be replaced with a unique study number to protect your identity. You will not be remunerated to participate in this study. There are no direct benefits for the participants, but the guideline developed from the study might be of benefit to the nurses. I will receive a signed and dated consent form from you before you can participate in the study.

INFORMED CONSENT

I hereby voluntarily consent to participate in the research study: A Best Practice Guideline for a Healthy Work Environment for Nurses working in the SAMHS.

Signed at……on……..day……of…….20……

Signature of participant:……

Print Name: _____

Thank you for your time and consideration in this matter.

Yours sincerely,
Ms J.F.M. Mabona

ANNEXURE B: LETTER TO DEFENCE INTELLIGENCE

Telephone: 012 674 6267
Fax: 012 6746309
Enquiries: Col J.F.M. Mabona

SAMHS Nursing College
Private Bag x1022
Thaba Tshwane
0143
November 2013

Chief Director Defence Counter Intelligence
Department of Defence Intelligence
Pretoria

Sir

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN THE SAMHS

I, 94068285PE Col J.F.M. Mabona am a Doctoral student at the Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth. The research I wish to conduct for my Doctoral treatise is entitled: *A best practice guideline for a healthy work environment for nurses in the South African Military Health Service*. The project is being conducted under the supervision of Professor R.M. van Rooyen and Dr P.J. Jordan at the Department of Nursing Science at the NMMU.

The goal of the study is to determine how the professional nurses experience working in the SAMHS; their understanding of evidence based practice and best practice guidelines. The information will be used to develop a Best Practice Guideline for a Healthy Work Environment for nurses working in the SAMHS.

I am hereby seeking your consent to do research in the three military hospitals, sickbays, clinics and using professional nurses as participants for this project.

I have provided you with a copy of my treatise proposal which includes copies of the consent forms to be used in the research process, as well as a copy of the approval letter which I received from the NMMU Research Ethics Committee (Human).

Upon completion of the study, I undertake to provide the Department of Defence with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me at:

Cell nr:	0737930697	**Tel. nr:**	012 6746267
Fax nr:	012 6746309	**Email:**	madi0922@yahoo.com

Thank you for your time and consideration in this matter.
Yours sincerely,

(**J.F.M. MABONA**)
OFFICER COMMANDING SAMHS NURSING COLLEGE: COL

ANNEXURE C: LETTER TO SAMHS

Telephone: 012 674 6267
Fax: 012 6746309
Enquiries: Col J.F.M. Mabona

SAMHS Nursing College
Private Bag x1022
Thaba Tshwane
0143
November 2013

Chief Director Force Preparation
SAMHS Headquarters
Kasteelpark
Pretoria

Sir

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN THE SAMHS

I, 94068285PE Col J.F.M. Mabona am a Doctoral student at the Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth. The research I wish to conduct for my Doctoral treatise is entitled: *A best practice guideline for a healthy work environment for nurses working in the South African Military Health Service*. The project is being conducted under the supervision of Professor R.M. van Rooyen and Dr P.J. Jordan at the Department of Nursing Science at the NMMU.

The goal of the study is to determine how the professional nurses experience working in the SAMHS; their understanding of evidence based practice and best practice guidelines. The information will be used to develop a Best Practice Guideline for a Healthy Work Environment for nurses working in the SAMHS.

I am hereby seeking your consent to do research in the three military hospitals using both professional nurses as participants for this project.

I have provided you with a copy of my treatise proposal which includes copies of the consent forms to be used in the research process, as well as a copy of the approval letter which I received from the NMMU Research Ethics Committee (Human).

Upon completion of the study, I undertake to provide the Department of Defence with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me at:

Cell nr: **0737930697** **Tel. nr:** **040 444 5555**
Fax nr: **012 6746267** **Email:** **madi0922@yahoo.com**

Thank you for your time and consideration in this matter.

Yours sincerely,

(**J.F.M. MABONA**)
OFFICER COMMANDING SAMHS NURSING COLLEGE: COL

ANNEXURE D: LETTER TO GENERAL OFFICERS COMMANDING MILITARY HEALTH TRAINING FORMATION

Telephone & fax: 012 3411367
E mail: madi0922@yahoo.com
Enquiries: Ms J.F.M. Mabona

504 Louis Bothahof
147 Celliers Street
Sunnyside
0002

April 2014

The GOC Military Health Training Formation
Thaba Tshwane

Dear General Joseph

RE: INTERVIEWS ON PROFESSIONAL NURSES FOR A RESEARCH STUDY

With your permission, Madam, kindly be advised of my intention to interview, after hours, a number of professional nurses within the Training Formation between 28 April 2014 and 06 May 2014.

These nurses have been identified at SAMHS Nursing College, School for Military Health and School for Military Training. Authorities from Defence Intelligence and the SAMHS Ethics Committee have already been obtained and faxed through to your office. Some of them have given an indication that they were willing to participate and after their written consent I will proceed with interviews.

Your cooperation is highly appreciated.

Yours faithfully

(J.F.M. MABONA)
PhD CANDIDATE NELSON MANDELA METROPOLITAN UNIVERSITY:MS

ANNEXURE E: LETTER TO OFFICERS COMMANDING/GATEKEEPERS

Telephone & fax: 012 3411367
E mail: madi0922@yahoo.com
Enquiries: Ms J.F.M. Mabona
504 Louis Bothahof
147 Celliers Street Sunnyside
0002

I°, May 2014

The OC Area Military Health
Unit Port Elizabeth
cc. S01 Nursing

Dear Col Phike

RE: INTERVIEWS ON PROFESSIONAL NURSES FOR A RESEARCH STUDY

With your permission, Sir, kindly be advised of my intention to interview a number of professional nurses within your different sub-units between 28 May 2014 and 05 June 2014 for the purpose of my research study. The East London Military Medical Clinic and Umtata Sickbay are preferred because of their proximity to my current residence.

Authorities from Defence Intelligence and the SAMHS Ethics Committee have already been obtained and will be faxed through to your office. These nurses will have to give an indication of their willingness to participate in the study and after their written consent interviews will be conducted

Find attached the letters from the Defence Intelligence, Ethics committee, Nelson Mandela Metropolitan University and a copy of request to the participant.

Your cooperation is always highly appreciated.

Yours faithfully */)*

"'>{-.r>--w--- -....././

(J.F.M. MABONA)
PhD CANDIDATE NELSON MANDELA METROPOLITAN UNIVERSITY:MS

ANNEXURE F: LETTER FROM DEFENCE INTELLIGENCE

A/oc Num Col. (1)

RESTRICTED

defence intelligence
Department:
Defence
REPUBLIC OF SOUTH AFRICA

DI/SDCI/R/202/3/7

Telephone: (012)3150216
Fax: (012)326-3246
Enquiries: Lt Col C.E Dumas

Defence Intelligence
Private Bag X367
Pretoria
0001
28 August 2013

AUTHORITY TO CONDUCT RESEARCH IN THE DEPARTMENT OF DEFENCE (DOD) IN FULLFILMENT OF THE REQUIREMENTS FOR THE DOCTORAL TREATISE (DOCTOR OF PHILOSOPHY IN NURSING): COL J.F.M. MABONA

1. Your request letter dd 20 August 2013 has reference.

2. Permission is hereby granted from a security perspective to Col J.F.M. Mabona to conduct research in the DOD on the topic entitled **"A Best Practice Guideline to Facilitate a Healthy Work Environment for Nurses in the South African Military Health Service (SAHMS)"**.

3. The final product of the research must be submitted to Defence Intelligence (DI), Sub-Division Counter Intelligence (SDCI) before it is released to any entity outside the DOD.

4. For your attention.

SAGD AKADEMIE: P/SAK X1022
VOORTREKKERHOOGTE 0143
205/93
12,09,13
SAMS ACADEMY: P/BAG X1022
VOORTREKKERHOOGTE 0143

(MAJ GEN T. MATLAKENG)
CHIEF DEFENCE INTELLIGENCE: LT GEN
KS/KS

DSTR

For Action

SAHMS Nursing College T T (Attention: Col J.F.M. Mabona)

Internal

File: DI/SDCI/R/202/3/7

Lefapha la Boipheelo . Umnyango wezoKuVikela . Kgoro ya Tshireletso . iSebe lezoKhuselo . Department of Defence . Muhasho wa Tshiledzo
UmNyango WezoKuVikela . Ndzawulo ya swa Vusirheleri . Lehapha la Tshireletso . Departement van Verdediging . LiTiko leTekuvikela

RESTRICTED

ANNEXURE G: LETTER FROM SAMHS ETHICS COMMITTEE

RESTRICTED

1MH/302/6

Tel: 012 314 0487
Facsimile: 012 314 0623
Enquiries: Prof / Lt Col
M.K. Baker

1 Military Hospital
Private Bag X1026
Thaba Tshwane
0143
11 October 2013

CLINICAL TRIAL APPROVAL: "A BEST PRACTICE GUIDELINE TO FACILITATE A HEALTHY WORK ENVIRONMENT FOR NURSES WORKING IN THE SOUTH AFRICAN MILITARY HEALTH SERVICE"

1. The 1 Military Hospital Research Ethics Committee (1MHREC), adhering to GCP/ICH and SA Clinical Trial guidelines, evaluated the above-mentioned protocol and additional documents.

2. The following members approved the study:

   a. Lt Col M.K. Baker: Neurologist, male, chairman 1 MHREC.
   b. Lt Col C.S.J. Duvenage: Specialist physician, female, member 1 MHREC.
   c. Lt Col D. Mahapa: Dermatologist, female, member 1 MHREC.
   d. Lt Col A.D. Moselane: Urologist, male, member 1 MHREC.
   e. Lt Col E.J. Venter: Periodontist, male, member 1 MHREC.
   f. Lt Col M.L. Kekana: Specialist physician, female, member 1 MHREC.
   g. DR T.J. Marè: Advocate, independent of the organization, male, member 1 MHREC.
   h. Mrs. C. Jackson: Layperson, independent of the organization, female, member 1 MHREC.

3. The following documents were evaluated:

   a. Study protocol titled as above.
   b. Request for permission to interview participant and Informed Consent.
   c. Confirmation of indemnity insurance cover.
   d. Feedback as requested, dated 02.10.2013.

4. The recommendations are: The study was ethically approved on 6 October 2013. The principal investigator, Col J Mabona, will be supervised by Prof R van Rooyen. Report backs are to be made to the 1MHREC six monthly, in the event of any serious adverse events and on completion or termination of the study. Should publications result from the study the relevant manuscripts will also need to be approved by Military Counter Intelligence.

5. The 1 MHREC wishes you success with the study.

M.K. Baker.

(M.K BAKER)
CHAIRMAN 1 MILITARY HOSPITAL RESEARCH ETHICS COMMITTEE:
LT COL / PROF

World Class Clinical Care
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ANNEXURE H: LETTER FROM GENERAL OFFICER COMMANDING TERTIARY MILITARY HEALTH FORMATION

RESTRICTED

Telephone: (012) 671 5012
Facsimile: (012) 671 5469
Enquiries: Brig Gen N. Badli

TMHF/R/302/6

Headquarters
Tertiary Military Health Formation
Private Bag x102
Centurion
0048

20 March 2014

Ms J.F.M. Mabona
504 Louis Bothahof
Sunnyside
0002

CLINICAL TRAIL APPROVAL: "A BEST PRACTICE GUIDELINE TO FACILITATE A HEALTHY WORK ENVIRONMENT FOR NURSES WORKING IN THE SOUTHAFRICAN MILITARY HEALTH SERVICE"

1. Letter received from you dated 14 March 2014 refers.

2. The Research Ethics Committee has already approved your research therefore permission is granted to you to gain access to 1, 2 and 3 Military Hospitals to interview nursing personnel, however service delivery must not be compromised by this.

3. Success with the study.

Kind regards

(N. BADLI)
GENERAL OFFICER COMMANDING TERTIARY MILITARY HEALTH FORMATION: BRIGADIER GENERAL

/RESEARCH MABONA

For Info

GOC 1 Mil Hosp
OC 2 Mil Hosp
OC 3 Mil Hosp

Internal

File: TMHF/R/302/6

Health Warriors Serving the Brave

RESTRICTED

ANNEXURE I: LETTER FROM FACULTY OF HEALTH SCIENCE RESEARCH, TECHNOLOGY AND INNOVATION COMMITTEE

Nelson Mandela Metropolitan University
for tomorrow

Copies to:
Supervisor: Prof RM van Rooyen
Co-supervisor/s: Dr PJ Jordan

Summerstrand South
Faculty of Health Sciences
Tel. +27 (0)41 5042121 Fax. +27 (0)41 5042854
Nouwaal.Isaacs@nmmu.ac.za

Student number: 199247900

Contact person: Ms N Isaacs

28 November 2013

Ms JFM Mabona
504 Louis Botha Hof
147 Celliers Street
Sunnyside
0132

FINAL RESEARCH/PROJECT PROPOSAL:
QUALIFICATION: **PhD (NURSING)**
TITLE: **A BEST PRACTICE GUIDELINES TO FACILITATE A HEALTHY WORK ENVIRONMENT FOR NURSES IN THE SOUTH AFRICAN MILITARY HEALTH SERVICE**

Please be advised that your final research project was approved by the Faculty Research, Technology and Innovation Committee, subject to the following amendments/recommendations being made to the satisfaction of your Promoters:

COMMENTS/RECOMMENDATIONS

1. The title could be briefer, "to facilitate" could become "for".
2. Abstract
   Page 1, the last sentence contradicts the title.
3. Research aim on page 12 does not include bullet point 4 of the research objectives on page 12.
4. Page 12
   - Add another bullet under the research questions namely; "What would be the scope and nature of a best practice guideline for…"
   - Research aims
     The comments from the nurses only would not enable the researcher to develop the guidelines.
5. Page 19
   First paragraph, "When planning a qualitative…". Replace the word population with sample.
6. Page 23
   Indicate that the last two steps within the last bullet will not be implemented (Reviewing and updating guidelines).
7. Participants and sampling
   The gate keepers would assist with the selecting of the participants. This could lead to bias.
8. Data collection
   For Phase II (page 22) after the appraisal, it was not sure how data will be extracted and synthesized. Was there a process for this? How will this step be evaluated?
9. Trustworthiness
   How does the researcher adhere to neutrality between Phases 1 and 2? Phase 1's results may contaminate the reading/analysis of Phase 2.
10. Plagiarism section
    Utilise a plagiarism check mechanism.

ANNEXURE J: COPY OF AGREE II INSTRUMENT FOR CRITICAL APPRAISAL

AGREE II GUIDELINE APPRAISAL TITLE:

DOMAIN 1: SCOPE & PURPOSE **TOTAL SCORE=**	
1. The overall objective(s) of the guideline is (are) specifically described.	
2. The health question(s) covered by the guideline is (are) specifically described	
3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.	
DOMAIN 2: STAKEHOLDER INVOLVEMENT **TOTAL SCORE=**	
4. The guideline development group includes individuals from all relevant professional groups.	
5. The views and preferences of the target population (patients, public, etc.) have been sought.	
6. The target users of the guideline are clearly defined.	
DOMAIN 3: RIGOUR OF DEVELOPMENT **TOTAL SCORE =**	
7. Systematic methods were used to search for evidence.	
8. The criteria for selecting the evidence are clearly described.	
9. The strengths and limitations of the body of evidence are clearly described.	
10. The methods for formulating the recommendations are clearly described.	
11. The health benefits, side effects, and risks have been considered in formulating the recommendations.	
12. There is an explicit link between the recommendations and the supporting evidence.	
13. The guideline has been externally reviewed by experts prior to its publication.	
14. A procedure for updating the guideline is provided.	
DOMAIN 4: CLARITY OF PRESENTATION **TOTAL SCORE =**	
15. The recommendations are specific and unambiguous.	
16. The different options for management of the condition or health issue are clearly presented.	
17. Key recommendations are easily identifiable.	
DOMAIN 5. APPLICABILITY **TOTAL SCORE=**	
18. The guideline describes facilitators and barriers to its application.	
19. The guideline provides advice and/or tools on how the recommendations can be put into practice.	
20. The potential resource implications of applying the recommendations have been considered.	
21. The guideline presents monitoring and/or auditing criteria.	
DOMAIN 6: EDITORIAL INDEPENDENCE **TOTAL SCORE =**	
22. The views of the funding body have not influenced the content of the guideline.	
23. Competing interests of guideline development group members have been recorded and addressed.	

ANNEXURE K: LETTER TO INDEPENDENT CODER

Mr K. Topper

Faculty of Health Science
School of Clinical Care Sciences
Department of Nursing Sciences
Tel: +27 737930697
E-mail: jfmmabona@gmail.com
January 2015

Dear Mr Kegan Topper

Thanks and appreciation is extended to you for agreeing to be an independent coder for my Doctoral thesis entitled: *A Best Practice Guideline for a healthy work environment for nurses working in the South African Military Health Service*.

The aim of the research study is to explore and describe how professional nurses experienced working in the South African Military Health Service (SAMHS), their understanding of a healthy work environment and the best practice guideline. This is to help develop a best practice guideline to be used by SAMHS' leadership and professional nurses working in the SAMHS to facilitate the creation of a healthy work environment.

Data was collected by means of semi-structured interviews conducted with professional nurses working in the SAMHS. The evidence generated from the interviews will be used in the development of a best practice guideline for professional nurses working in the SAMHS. Do not hesitate to contact me should you have any queries,

Yours sincerely

JEAN FEZEKA MADI MABONA

ANNEXURE L: GUIDELINE DATABASES

Publishing organisations
RNAO
Sigma Theta Tau International
ILO, ICN, WHO & PSI
Databases
CINAHL, Ebscohost, Biomed Central, Medline, Science direct and Pub-med, Google, Google scholar

ANNEXURE M: TRANSCRIBED INTERVIEWS

Individual Interview 01
I = interviewer
P = participant

I = good afternoon thank you for the opportunity. I have already explained to you how the consent form and everything, and what I request of you is that when you give me the information you must please be as honest as possible because the main goal is to you know make it a different is by developing this guideline that we want to and develop. Okay the first question is as follows you, I request you to tell me about how you experience working in the SAMS as a professional nurse, just in general? You know, I mean you have worked you have been to different places within SAMS you did courses and you must have actually taken a lot of experienced out of this so just tell me briefly how your experience here has been working here as a professional nurse yes?

P = thank you very much. Working with SAMS in the service has been very good experience to me as a nurse, firstly to wear a soldier's uniform to me is quite was quite a a a a a different thing from what I moved Portside from the Department of health and doing military drills as a nurse was also for me a a a a a an eye opener for me. As we were as I was doing basic training our instructors told us we soldiers first then a nurse that was very fun to me in the first place but as the time went on I could read that what the instructors told me secondly, I mean thirdly going to courses, meeting different people, with different cultures it has been also a very good experience, that mixture of cultures and cultural deficit was also an eye-opener for me so in a nutshell it has been a very good experience

I = okay now there is now you have told you have just spoken about the military part of the professional part now, how have you experienced it the professional part of being in the service as a professional nurse the military function part?

P = yah it's also been a very good I have developed a lot professionally from SAMS I joined the military as a enrolled nurse within a short space of time I was given an

opportunity to study further so I studied I did a two year bridging course and I was a professional nurse right up to, I worked as a professional nurse while I was based or located in East London and worked in pharmacy I also, I was also given an opportunity again to study further to do midwifery and after that I did primary health care and I also did a dispensing course and also some short courses, functional courses, like HIV management and other courses, I also did pharmacy so it has been a very good experience, like I said I cam here a rough nurse but now I am an experienced professional nurse, now I I I I am in charge of a health clinic, I am seeing patients doing management and everything, so I feel like I have developed very much

I = there is nothing that for example interfering with your nurse practice in the military, you haven't expressed any interferences by other military people as you work as a professional nurse within the service?

P = nope, I can't say there are interferences except for few things like you know with the military it has this rank thing when a person is senior to you he will tell you what to do in your area of work so sometimes it is getting me frustrated and he is coming to tell you what to do and I think that's the thing, the only thing I think that interferes

I = ya okay now we, I, remember I said the main aim of the interview is for me at the end is to be able to develop a best practice guideline for a healthy working environment for professional nurses working in the service. So what in your understanding, what is in your understanding of a healthy working environment?

P = I think it is an environment where an employer and an employee work together as a team and achieve a goal of the organisation I think that is it according to my understanding.

I = what should be, your environment something that is abstract, to you what should be in that environment for us to be able to say it the environment is healthy, you know that healthy for you and your patient, what should be your ?

P = it should be resources, enough resources, for for for me for me as an employee to work it should be free of danger for myself and also for my patients, I should be protected from the patient, in persuit of the yes

I = medication

P = medication yes so that I can I can I can work freely, also that my patients should also be protected from me. Ya, I think I have answered

I = ya, no we, can just summarise give the factors that constitute a healthy working environment like in point form, some of them you have mentioned already, these factors now that constitute that, this working environment?

P = okay resources that I mentioned by resources I mean people on the ground won't notice equipment and facilities, competent facilities and also the budget, a very good budget because without the budget first, there is nothing. Ya

I = the resources ya you have mentioned the resources and what else comes to mind, the factors that constitute this healthy working environment, the thing you have mentioned already the thing between the employer and whatever and whatever you are dealing with?

P = teamwork between the employer and employee, working as a team. okay

I = something else? Okay. now the factors that would hinder you from obtaining a healthy working environment. And you want a healthy working environment, these factors that will make you not to be able to attain a healthy working environment?

P = not enough resources, not enough budget, lack of leadership in the organisation, not getting support from my superiors, cultural diversities or differences, yes

I = okay ya okay, now the other question is the factors now that you think can assist to attain this healthy working environment for you in a patient?

P = as I said before a good budget that is money, support from my superiors or management, team work, understanding of one another's cultures

I = right okay, ya is there anything else that you would want to add?

P= no

I = no okay. I want to develop a best practice guideline for a healthy working environment for nurses that work in the different area of the military. What is your understanding of a best practice guideline for example what is it, to you and what should be contained in a best practice guideline?

P = best practice guideline.

I = you are not writing exams so you do not have to think like (…) just say what comes to mind a guideline you can define it by telling me what should it do, one example, for you as a professional nurse in the SAMS?

P = ya I think professional nurses should be remunerated, the remuneration of the SAMS professional nurses should be good, because they serve both as soldiers as I have stated before as soldiers and as nurses, when it comes to the push we have to stand on duty, for military report for duty as military soldiers and they have to look after their patients so I think to boost their morale, remuneration should be good for them

I = what else should, the things that should be be there in the guidelines, to guide you as a professional nurse, we don't have to labour on this piece. it's fine, ya okay, thank you very much for all this information, I am going to use this information to come up with this best practice guideline that we we have to develop for the SAMS. Thank you very much

P = thank you

I = what will happen is that I think I will give a copy to, the information of, your information so that people are able to have access to the the the guidelines

ANNEXURE N: LIST OF GUIDELINES

Serial no	Name of guideline	Publishing organisation	Year published
1.	Healthy Work Environments Best Practice Guidelines: Mitigating Nurse Fatigue in Health Care	Registered Nurses' Association of Ontario (RNAO)	2011
2.	National Guidelines for the promotion of Healthy Work Environments	Health Workforce Advisory Committee of New Zealand (HWAC)	2006
3.	Healthy Work Environments Best Practice Guidelines: *Workplace Health, Safety and Well-being of the Nurse*	Registered Nurses' Association of Ontario (RNAO)	2008
4.	Healthy Work Environments Best Practice Guidelines: *Embracing Cultural Diversity in Health care: Developing cultural competence*	Registered Nurses' Association of Ontario (RNAO)	2007(b)
5.	Healthy Work Environments Best Practice Guidelines: Managing and Mitigating Conflict in Health Care Teams	Registered Nurses' Association of Ontario (RNAO)	2012
6.	Healthy Work Environments Best Practice Guidelines: Intra-professional Collaborative Practice among Nurses	Registered Nurses' Association of Ontario (RNAO)	2016
7.	Healthy Work Environments Best Practice Guidelines: Developing and Sustaining Effective Staffing and Workload Practices	Registered Nurses' Association of Ontario (RNAO)	2017

Serial no	Name of guideline	Publishing organisation	Year published
8.	Healthy Work Environments Best Practice Guidelines: Developing and Sustaining Nursing Leadership	Registered Nurses' Association of Ontario (RNAO)	2013(a)
9.	Best Practices for Assessment and Control of Psychological hazards	Government of Alberta	2011
10.	Healthy Work Environments Best Practice Guidelines: *Professionalism in Nursing*	Registered Nurses' Association of Ontario (RNAO)	2007(a)
11.	Healthy Work Environments Best Practice Guidelines: *Developing and Sustaining Inter-Professional Health Care: Optimizing patient, organisational and system outcomes*	Registered Nurses' Association of Ontario (RNAO)	2013(b)
12.	Best Practice Guidelines: Workplace Health in Australia	Workplace Health Association Australia (WHAA)	2015

ANNEXURE O: A LETTER TO INDEPENDENT GUIDELINE APPRAISER

Dear Ms Marianna Spagadoros

Thanks and appreciation is extended to you for agreeing to be an independent appraiser for my Doctoral thesis entitled: *A Best Practice Guideline for a healthy work environment for nurses working in the South African Military Health Service*.

The aim of the research study is to explore and describe how professional nurses experienced working in the South African Military Health Service (SAMHS), their understanding of a healthy work environment and the best practice guideline. This is to help develop a best practice guideline to be used by SAMHS' leadership and professional nurses working in the SAMHS to facilitate the creation of a healthy work environment.

Data was collected by means of semi-structured interviews conducted with professional nurses working in the SAMHS. The evidence generated from the interviews will be used in the development of a best practice guideline for professional nurses working in the SAMHS. Do not hesitate to contact me should you have any queries,

Yours sincerely

JEAN FEZEKA MADI MABONA

ANNEXURE P: SCORES OF THE CRITICALLY APPRAISED GUIDELINES

Serial no	Title of guideline	Total scores by researcher in %	Total scores by the independent reviewer in %	Decision Included/Excluded
1.	Healthy work environment: Mitigating Nurse Fatigue in Health Care (RNAO, 2011)	88% (142)	82%	Included
2.	Healthy work Environment: Embracing Cultural Diversity in Health care: developing cultural competence (RNAO, 2007)	87% (140)	99%	Included
3.	Healthy work Environment: Best Practices for Assessment and Control of Psychological hazards (Government of Alberta, 2011)	88% (142)	82%	Included
4.	Healthy work Environment: Managing and mitigating Conflict in Health Care Teams (RNAO, 2012)	88% (142)	98%	Included
5.	National Guidelines for the promotion of Healthy work environments (HWAC, 2006)	75% (121)	83%	Included
6.	Healthy work environment: Intra-professional Collaborative Practice among Nurses(RNAO, 2016)	90% (145)	99%	Included

Serial no	Title of guideline	Total scores by researcher in %	Total scores by the independent reviewer in %	Decision Included/Excluded
7.	Best practice Guidelines: Work place Health in Australia: (WHAA, 2015)	70% (113)	73%	Included
8.	Healthy Work Environment: Developing and Sustaining Effective Staffing and Workload Practices (RNAO, 2017)	88% (142)	88%	Included
9.	Healthy Work Environment: Professionalism in Nursing (RNAO, 2007)	87% (140)	86%	Included
10.	Healthy Work Environment: Developing and Sustaining Inter-Professional Health Care: Optimising patient, organizational and system outcomes (RNAO, 2013)	90% (145)	100%	Included
11.	Healthy Work Environment: Workplace Health, Safety and Well-being of the Nurse (RNAO, 2008)	87% (140)	86%	Included
12	Healthy Work Environment: Developing and Sustaining Nursing Leadership (RNAO, 2013)	88% (142)	88%	Included

ANNEXURE Q: LETTER TO THE EXPERT REVIEWERS

Dear……

Thanks and appreciation is extended to you for agreeing to participate in the reviewing of my Doctoral thesis best practice guideline draft entitled: *A Best Practice Guideline for a healthy work environment for nurses working in the South African Military Health Service*.

The aim of the guideline is to provide the professional nurses working in the South African Military Health Service (SAMHS), with the best practice recommendations that will assist in the enhancement of a healthy work environment for nurses This is to help develop a best practice guideline to be used by SAMHS' leadership and professional nurses working in the SAMHS to facilitate the creation of a healthy work environment.

Data was collected by means of semi-structured interviews conducted with professional nurses working in the SAMHS. The evidence generated from the interviews will be used in the development of a best practice guideline for professional nurses working in the SAMHS. Do not hesitate to contact me should you have any queries,

Yours sincerely

JEAN FEZEKA MADI MABONA

ANNEXURE R: REVIEW SHEET FOR EVIDENCE-BASED BEST PRACTICE GUIDELINE (ADAPTED FROM AGREE II INSTRUMENT)

Please tick the most relevant response in the blocks indicated below

Citation information	Evidence-based best practice guideline for a healthy work environment for professional nurses working in the South African Military Health Service. J.F.M. Mabona, D. van Rooyen, P. Jordan. Department of Nursing, Nelson Mandela University, 2017.						
Description of context	The evidence-based best practice guideline was developed for the facilitation of a healthy work environment for professional nurses working in the South African Military Heath Service (SAMHS). The guideline was based on the data derived from the integrative literature review.						
DOMAIN 1: SCOPE AND PURPOSE	**Strongly disagree ⟷ Strongly agree**						
SCORE	**1**	**2**	**3**	**4**	**5**	**6**	**7**
1. The overall objective(s) of the guideline is (are) specifically described.							
2. The health question(s) covered by the guideline is (are) specifically described							
3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.							
DOMAIN 2: STAKEHOLDER INVOLVEMENT							
4. The guideline development group includes individuals from all relevant professional groups.							
5. The views and preferences of the target population (patients, public, etc.) have been sought.							

6. The target users of the guideline are clearly defined.							
DOMAIN 3: RIGOUR OF DEVELOPMENT							
7. Systematic methods were used to search for evidence.							
8. The criteria for selecting the evidence are clearly described.							
9. The strengths and limitations of the body of evidence are clearly described.							
10. The methods for formulating the recommendations are clearly described.							
11. There is an explicit link between the recommendations and the supporting evidence.							
12. The guideline has been externally reviewed by experts prior to its publication.							
DOMAIN 4: CLARITY OF PRESENTATION							
13. The recommendations are specific and unambiguous.							
14. Key recommendations are easily identifiable.							
DOMAIN 5: EDITORIAL INDEPENDENCE							
15. The views of the funding body have not influenced the content of the guideline.							

OVERALL GUIDELINE ASSESSMENT

1. Rate the overall quality of this guideline

1 Lowest possible quality	2	3	4	5	6	7 Highest possible quality

2. I would recommend this guideline for use.

Yes	
Yes, with modification	
No	
Notes:	

ANNEXURE S: BEST PRACTICE GUIDELINE FOR A HEALTHY WORK ENVIRONMENT FOR NURSES WORKING IN THE SAMHS

BEST PRACTICE GUIDELINE FOR A HEALTHY WORK ENVIRONMENT FOR PROFESSIONAL NURSES WORKING IN THE SOUTH AFRICAN MILITARY HEALTH SERVICE

Guideline development team

Jean Fezeka Madi Mabona: MA Health and Welfare Management, BEd Nursing: Nursing Education, Nursing Management, Community Health Nursing Science and Community Mental Health Science; Diplomas: Nursing Education, Nursing Administration, Midwifery, General Nursing; Certificate: Aviation Nursing.

Dalena van Rooyen: PhD (Nursing), MCur, BA Cur Honours (Advanced General Nursing Science), B Cur, Certificates: General Management; Diplomas: Nursing Education, Intensive Care Nursing

Portia Janine Jordan: PhD (Nursing), MBA, MCur, BCur; Diplomas: Nursing Education, Nephrology Nursing

OVERVIEW OF THE BEST PRACTICE GUIDELINE DEVELOPMENT

The overview of the development of the Best Practice Guideline will be discussed.

The purpose for the Best Practice Guideline

Evidence-based best practice guidelines are specific practice recommendations that are based on a methodically rigorous review of the best evidence on a specific topic (Melnyk & Fineout-Overholt, 2011:575). The purpose for developing the Best Practice Guideline was to provide professional nurses working in the South African Military Health Service (SAMHS) with recommendations that will assist in the enhancement of a healthy work environment for nurses. This guideline endeavors to facilitate the enhancement of a healthy work environment for nurses working in the SAMHS.

Process

The development of the guideline is Phase 3 of a study aiming to facilitate a healthy work environment for nurses working in the SAMHS and a culmination of processes that occurred in Phase 1 and Phase 2. Qualitative data which emanated from the semi-structured interviews with sixteen professional nurses working in the SAMHS, conducted in Phase 1, was analyzed, and themes and sub-themes that emerged from the findings were formulated. The qualitative study conducted in Phase 1 aimed to generate the evidence-based evidence that was considered in the development of the best practice guideline.

In Phase 2, a search for evidence-based best practice guidelines related to a healthy work environment for professional nurses working in the SAMHS was conducted by means of an integrative literature review which formed the basis for the development of the best practice guideline. Preceding the integrative literature review of Level I evidence, assistance with the search was given by the librarian from the Faculty of Health Sciences at Nelson Mandela University. Although the guideline for a healthy work environment was developed for nurses, guidelines for health care professionals were included due to the scarcity of guidelines addressing nurses/nursing specifically. The researcher concentrated only on Level I evidence, according to LoBiondo-Wood & Haber's levels of evidence hierarchy (2010:16), evidence-based best practice guidelines. Databases websites of organisations that could have published these guidelines were thoroughly searched. Titles and abstracts were read to obtain a preview of the contents and to make decisions on whether to use the documents. This strategy enhanced a comprehensive literature search for high quality evidence, as full texts were more elaborate thus facilitated better comprehension of the topic under discussion. The electronic databases, CINAHL, Ebscohost, Biomed Central, Medline, Science direct and Pub-med, Google, Google scholar and organisation's sites like Registered Nurses Association of Ontario (RNAO) and National Institute for Health and Care Excellence (NICE) were thoroughly searched using a combination of key words: "healthy work environment for nurses," "healthy work environment for health care professionals," healthy environment," "healthy military environment," "best practice guidelines," "professional nurses," "healthy nurses", "positive work environment", "workplace health to facilitate the search. Following the selection of

best practice guidelines for a healthy work environment that met the inclusion criteria 12 guidelines were critically appraised by the researcher and an independent reviewer, data was extracted using a format formulated by the researcher, a table indicating the details of the publisher, the name of the guideline and main findings related to healthy work environments. Findings from the qualitative data and integrative literature review were synthesized into themes and became the basis for the extraction of the main findings in the guidelines, and recommendations that will be utilized to develop this Best Practice Guideline.

Setting

The Best Practice Guideline will be used for the enhancement of a healthy work environment for the professional nurses working in all military health settings, which are military clinics, sickbays and hospitals of the SAMHS. The guideline can be applied to other health institutions such as public and private hospitals and clinics outside the military.

Population

The recommendations from the Best Practice guideline will be used by professional nurses working in all military health settings of the SAMHS.

Triangulation of themes

Synthesis of themes from Phase 1 and Phase 2 culminated in the formulation of the recommendations that formed the basis for the development of the Best Practice Guideline for a healthy work environment for professional nurses working in the SAMHS. The following recommendations were formulated:

- The need for effective leadership to create an empowering environment
- Effective communication amongst members of the health team
- A culture that supports teamwork amongst colleagues
- The need for an environment that promotes professional autonomy
- Recommendations to address factors that impact negatively on enhancement of a healthy work environment.

1.1 Introduction

Governments, internationally and nationally, have become aware of the importance of healthy work environments, environments that are caring and supportive to health professionals within their respective health institutions. This awareness is because of the mounting evidence that healthy work environments are imperative to enhance recruitment and retention of health professionals and maintain an organization's financial viability (Vollers, Hill, Roberts, Dambaugh & Brenner, 2009:21). The Registered Professional Nurses Association of Ontario (2008:13) is an organization that has pioneered the project of the creation of healthy work environments for nurses and defines a healthy work environment as "a practice setting that maximizes the health and well-being of professional nurses, quality patient/client outcomes, organizational performance and societal outcomes." The SAMHS as a health provider for members of the defense force, in a unique military environment that is authoritarian and rigidly hierarchical, allowing little room for initiative and freedom of action (Heineken, 2005:84) has a duty to ensure that its professional nurses function in a safe and healthy work environment.

1.2 SCOPE AND PURPOSE

The objective of the guideline, the review question and the target group are items for discussion in this section.

1.2.1 Guideline's objective

The objective of this guideline is to provide professional nurses working in the SAMHS with best practice recommendations that will assist in the enhancement of a healthy work environment for nurses.

1.2.2 Review question

The review question that was formulated to search for relevant literature pertaining to a healthy work environment was:

"What existing evidence-based best practice guidelines are available for a healthy work environment for nurses/health care professionals?"

The question was extended to include all health care professionals because of scarcity of healthy work environment best practice guidelines for nurses from different organisations.

1.2.3 Target group

The guideline is intended for use by SAMHS' leadership, at Level 2, the strategic level, Level 3, the formation level and Level 4, the unit level (hospitals, sickbays and clinics and nursing college) and all professional nurses working in all the military health institutions of the SAMHS, including the military clinics, sickbays and hospitals irrespective of positions. However, the guideline may also be adapted by nursing institutions outside the military such as public and private hospitals and clinics where they find it applicable.

1.3 Stakeholder involvement

The draft guideline will be submitted to a group of five experts for review. Two of the expert reviewers are senior professional nurses from academic institutions of higher learning and are knowledgeable in the formulation of Best Practice Guidelines. The other three are from the military environment and are experts in military nursing. All the reviewers hold PhD qualifications, except for one who is a PhD candidate at a South African university and holds a position of Policy and Planning in the Directorate of Military Nursing.

1.4 Rigour of development

This draft best practice guideline has been developed based on the data derived from an integrative literature review, Level I evidence and qualitative research study findings, Level 4 evidence. The librarian of the Faculty of Health Sciences at the Nelson Mandela University assisted with the search for relevant literature in citation databases CINAHL, Medline, Biomed Central, Academic Search Complete, Health Source: Nursing/Academic Edition and the internet search engine Google Scholar. Search terms used for identifying literature pertaining to a healthy work environment "Evidence based" or "healthy work environment" or "best practice" AND (guideline OR protocol) AND ("professional nurses" OR "health-care professionals" AND (care OR

focus*) AND (military health settings) OR military hospitals, military clinics or sickbays. Guideline databases which were searched were the US National Guideline Clearinghouse, sponsored by the US Agency for Health Care Research and Quality, the Guidelines International Network (G-I-N), and the National Institute for Health and Clinical Excellence (NICE). Another strategy was to search the websites of known guideline developers, (Scottish Intercollegiate Guidelines Network, Royal College of Nurses, Registered Nurses Association of Ontario, New Zealand Guidelines Group, National Health and Medical Research Council, Canadian Medical Association and the National Department of Health in South Africa). The search was limited to guidelines pertaining to healthy work environments for health-care professionals including nurses, published in English between 2003 and 2017. All guidelines relating to other disciplines other than health were excluded.

The initial search for evidence identified 15 possible guidelines for inclusion in the integrative literature review. After eliminating duplications (n=2), and studies that did not adhere to the inclusion criteria of the review (n=1), twelve (12) guidelines were included in the critical appraisal process. Following this process, which was done independently by two reviewers, the primary reviewer being the researcher, and an independent reviewer, who is an experienced reviewer from the department of Nursing Science at the Nelson Mandela University, twelve (12) guidelines were included in the integrative literature review. The guidelines that met the criteria, after consensus between the two reviewers was reached, were critically appraised using the Appraisal of Guidelines for Research and Evaluation (AGREE II) Instrument (Brouwers, 2009:8). On completion of the critical appraisal, data was extracted from the guidelines. Following data extraction, the main findings from each guideline were summarized in a table format, stating the authors, publication details and the main recommendations. These were synthesised and categorized into themes based on similarities of evidence found in different guidelines. The themes from the integrative literature review and the qualitative research findings were synthesized, based on aspects of healthy environments, to form the recommendations. The themes are presented in a tabular form in Table 1.1.

Owing to the scope of this research study, the guideline was developed by the researcher with inputs from the promotor and the co-promotor. However, the guideline

will be submitted to the expert reviewers for their comments and the guideline will be finalised after incorporating those comments. It is recommended that the guideline be reviewed every three years, if required.

1.5 RECOMMENDATIONS

The triangulated themes and sub-themes of both qualitative data as well as the integrative literature review were used to formulate recommendations for the Best Practice Guideline. These themes and sub-themes are presented in Table 1.1

Table 1.1 Triangulated themes and sub-themes

Serial number	Themes	Sub-themes
1.	The need for effective leadership to create an empowering environment	1.1 Support to newly appointed professional nurses to adjust to military culture and traditions 1.2 Clearly defined expectations 1.3 Provision of adequate resources 1.4 Opportunities for professional development and promotion 1.5 Collegial support
2.	Effective communication among health care team members	2.1 Formal and informal communication 2.2 Standardisation of working procedures
3.	A culture that supports team work	3.1 Team building 3.2 Role clarification
4.	The need for an environment that promotes professional autonomy	4.1 Abuse of military rank and recognition of functional rank 4.2 Dual role conflict
5.	Recommendations to address factors that impact negatively on enhancement of a healthy work environment	5.1 Shortage of personnel and the staffing process 5.2 Acquisition of equipment and the procurement processes 5.3 Status of infra structure 5.4 Lack of development opportunities for sickly personnel

The themes, sub-themes with their respective recommendations and rationale will be addressed in the section below.

1.5.1 The need for effective leadership to create an empowering environment

It was evident from the qualitative findings in Phase 1 of the study that professional nurses working in the SAMHS needed effective leadership that would create an empowering environment to help them deal with challenges associated with the military culture and traditions they experienced; an environment that would provide them with adequate resources, give them opportunities to develop, support and mentor them. According to these findings the professional nurses needed an empowering environment. Based on these findings and the integrative literature review the recommendations are as follows:

1.5.1.1 Support to newly appointed professional nurses to adjust to the military culture and traditions

The newly appointed professional nurses attributed their problems of adjustment to the military health environment to inadequate induction training.

Recommendations

SAMHS' leadership, at Level 2, the strategic level, Level 3, the formation level and Level 4, the unit level (hospitals, sickbays and clinics and nursing college) in supporting personnel to adjust to military culture and traditions should:

- Provide a structured induction programme that will equip the newly appointed personnel with military skills used on daily basis before they wear military uniform. This induction programme should be reinforced by weekly practices for a period of up to three months until the members are comfortably competent.
- The newly appointed members should attend basic military courses that are more comprehensive within a year of appointment.
- Colleagues to be assigned to coach each newly appointed professional nurse in uniform. The rank of the peer should be at the level that does not cause a [power differential that may impede openness and trust by the new professional nurse.

- Newly qualified professional nurses (novice) from within the SAMHS should be orientated, mentored and coached to build trust of leadership and their own confidence.

Rationale

A structured induction programme and mentoring will assist the newly appointed professional nurses with assimilation of military skills to adjust to the military environment. Regarding the novice professional nurses trained within the SAMHS, professional nurses do not emerge from training fully prepared and completely effective. The qualitative research study in Phase 1 revealed that both newly appointed and newly qualified did not receive either adequate induction or orientation. Their development is a more involved and incremental process, therefore comprehensive orientation and mentoring programmes to be in place, monitored and evaluated. Induction is according to Fowler (1996) cited in Stirzaker (2004:3), the period between the employee's starting work and eventually becoming fully integrated and competent. Fowler continues to say that real induction takes place over several months, not days and is dependent on both the individual and the situation (Fowler (1996).

1.5.1.2 Clearly defined expectations

It is crucial that professional nurses understand what their roles are in a work environment and that the organisation's expectations are clearly spelt out to them. They indicated in the qualitative study in Phase 1 that they did not have clearly defined expectations.

Recommendations

It is the role of leadership to ensure that professional nurses understand what it is that is expected of them in any health setting by confirming that:

- Expectations are communicated verbally and in writing to professional nurses annually through duty sheets and one-on-one meetings with management
- Duties of every professional nurse are displayed, are visible and accessible
- Professional nurses know the direction the organisation plans to take
- Professional nurses are assessed on the roles they played periodically

- Communication is effective by holding individual counseling and interview sessions with professional nurses periodically

Rationale

Understanding one's expectations allows professional nurses to work to their full scope of practice, embrace teamwork and experience professional autonomy (RNAO, 2013b:26). It promotes commitment to participating actively towards achieving goals and objectives of the organisation and mitigates against conflict thus facilitating a healthy work environment.

1.5.1.3 Provision of adequate resources

To create a healthy work environment, nurse leaders facilitate nurses' access to appropriate resources such as the materials, finances, supplies, equipment and time necessary to fulfill their roles (RNAO, 2013b:40). Resources and supplies are closely related elements. However, resources are not limited to consumables as they also include aspects such as: human resources, financial resources, essential healthcare facilities all of which enable the smooth running of healthcare facilities. Many health facilities operate without sufficient essential resources and therefore there needs to be sufficient allocation in the healthcare budget in this regard (DENOSA, 2013:4).

Recommendation

With regards to provision of resources, the following recommendations are made:

Nurse leaders should

- Minimize constraints to resources
- Provide necessary budgetary support
- Establish mechanisms to monitor and achieve manageable workloads
- Respond to changing needs in technology, education and training, licensing body prescripts and national and world politics
- Provide up-to-date functioning equipment, better staffing and adequate infrastructure (RNAO, 2013b:44)

Professional nurses should

- Identify resources needed
- Communicate the need for resources annually
- Plan and budget for the resources they are going to use annually
- Share information and resources
- Urge the logistics and human resources departments to facilitate acquisition of resources by shortening the procurement processes and communicate this process to management.

Rationale

Nurses and employers have an obligation to their clients to advocate for and contribute to quality practice environments that have the organizational structures and resources necessary to promote safety, support and respect for all persons in the practice setting. This in line with creating an empowering work environment as advocated for by the RNAO guideline on leadership (RNAO, 2013a:17) Findings in Phase 1 revealed that professional nurses expected their managers to provide them with adequate resources so that they do not have to run around when they have to do their work.

1.5.1.4 Opportunities for professional development and promotion

When organisations encourage life-long learning by supporting professional development and mutual sharing of knowledge, they become learning organisations. Quality practice environments are adequately supported and funded to allow nurses to access professional development opportunities (ICN, 2007:26). These opportunities can include formal and continuing education, attending seminars, conferences and mentoring. Lack of support for professional development activities for healthcare professionals wishing to acquire training and educational opportunities discourages healthcare professionals (DENOSA, 2013:4).

Recommendations

Nurse leaders should

- Prioritise the empowerment of nurses

- Represent nurses' development needs to the organisation
- Develop policies for nurses' career advancement and professional development opportunities
- Have a career plan for individual nurses and hold career development discussions annually
- Identify learning needs of professional nurses
- Provide opportunities for professional nurses to attend promotional courses, both professional and military courses at least every three years
- Provide knowledge acquiring and transferring opportunities to professional nurses such as seminars, conferences, workshops in-service training annually and continuously
- Advocate for financial resources for nurses' professional development
- Develop a plan for professional development and succession
- Ensure that professional nurses are technology literate, for example to encourage them to attend necessary computer literacy courses. Nurses must nominate themselves for the computer courses according to their needs.
- Link professional development to upward mobility/promotional opportunities of professional nurses
- Monitor and evaluate work performance of professional nurses continuously and give feedback

Rationale

Professional development is important for equipping professional nurses with knowledge and skills as well as building their confidence in executing their nursing duties. It also affords the individual nurses with opportunities for promotions. Professional nurses revealed in the qualitative study in Phase 1 that lack of development opportunities delayed their promotion opportunities and also made them to feel inferior to their colleagues in the public and private sectors. Organisations who do not develop their staff become redundant and yield negative patient and personnel outcomes. There is a close relationship between professionalism, education and knowledge development. Knowledge acquired through development provides basis for professional practice (RNAO, 2007a:28). The employees in an organisation to be able to perform their duties and make meaningful contributions to the success of the

organisational goals need to acquire the relevant skills and knowledge (Olaniyan & Ojo, 2008:326).

1.5.1.5 Collegial support

A colleague is a fellow official or worker, especially in the same profession (RNAO, 2007a:40). Nurse leaders create conditions for nurses to access and use support, feedback and guidance from superiors, peers and subordinates (RNAO, 2013b:39). Collegial support promotes sharing of authority, trust and respect between management and workers and amongst workers. When trust links people to the organisation, it makes workers to be willing to contribute more. Communication, in particular among diverse groups, becomes a key issue in developing collegial relations in the work team (RNAO, 2007b:33).

Recommendations

Nurse leaders should

- Seek to understand thinking, learning and working styles of others
- Create structures and processes that enable interactions (Team building exercises at least annually, recreation activities quarterly and contact sessions weekly, at least monthly).
- Tailor leadership style to individuals and situations
- Formalise recognition for nurses who demonstrate excellence in practice with awards annually
- Identify fears of professional nurses and offer assistance to alleviate the situation using support/debriefing spaces/ongoing and sustained assistance especially in light of the military context where unpredictable events can be called upon by the newly appointed professional nurse to act on
- Initiate communication with colleagues

Rationale

An important component of nurses' professional practice is developing and establishing collegial working relationships (Joanna Briggs Institute, 2005) cited in RNAO (2007a:40). Collegial support proposes that colleagues support one another,

and a supportive environment reduces job stress and promotes a safe, relaxed and a healthy work environment. Findings from the qualitative research study in Phase 1 revealed that professional nurses expected to be supported by their seniors at work. According to ICN (2007:29), regardless of setting, positive work environments support nurses in their professional role of caring for patients. If nurses do not have the supports they need to practice, they cannot ensure the best outcomes for patients. They may be discouraged and quit job or even the profession (ICN, 2007:29).

1.5.2 Effective communication amongst members of the health team

Nurse leaders create environments where communication is open, and others' knowledge is valued.

1.5.2.1 Formal and informal communication

Nurse leaders should promote flow of information and ideas at multiple levels through formal and informal practices. In a healthy work environment, leaders communicate openly with health care workers, patients and families of patients and provide timeous feedback when such a need arises.

Recommendations

Nurse leaders should

- Advocate for open, transparent and honest communication
- Possess communication skills and use them appropriately
- Hold formal meetings with professional nurses monthly and whenever it is needed
- Hold informal contact sessions with professional nurses weekly in order to give feedback on latest developments in the organisation and to give professional nurses the opportunity to raise their concerns and discuss solutions.
- Conduct progress interviews with nurses yearly and whenever the need arises
- Give timeous feedback all the time
- Arrange for team-building exercises at least annually

- Negotiate skillfully to help team members overcome differences in viewpoints/be a mediator
- Be able to adjust the language to the target audience, express themselves at the level that will be understood by all
- Embrace cultural diversity and any diverse opinions of nurses from different cultural backgrounds
- Recognise contributions of professional nurses by means of incentives and by creating opportunities for responsibility to widen the skill set of the professional nurse

Professional nurses to

- Communicate among themselves about patients' progress (Nurses' rounds and handing and taking over rounds, report-giving)
- Communicate with other care-givers
- Participate in grand rounds
- Communicate with patients about their conditions and families about progress of their loved ones.

Rationale

Healthy work environments promote effective and transparent communication between nurses and management, patients and their families, other caregivers and among nurses. Effective communication is critical to good patient outcomes and nurses' job satisfaction. It is a cornerstone of effective leadership, building teams, promoting quality patient care and critical in strengthening relations between employees and employers, clients and families (RNAO, 2013a:41; 2009:46; 2007:33; 2017:32). Effective communication emerged as one aspect professional nurses indicated as lacking in the qualitative study in Phase 1.

1.5.2.2 Standardisation of Standard Working Procedures

Working procedures are a written means of communication to a large number of people suitable for big and small organisations. Health organisations utilize work procedures to standardize health practices. Where these work procedures are absent,

health practices are in disarray and this is an indication of poor communication. Professional nurses expressed the need for standardized work procedures at hospitals, sickbays and clinics.

Recommendations

Nurse leadership to standardize work procedures should

- Ensure that there is a quality assurance department that is responsible for drafting of standard-work-procedures (SWPs)
- Have a team for drafting of well-researched/benchmarked SWPs for all aspects of nursing
- Draft SWPs to be workshopped with all stakeholders, including professional nurses and managers
- Adopted SWPs to be distributed to different units and be signed for on receipt
- Monitor and evaluate the use and effectiveness of SWPs quarterly
- SWPs must be updated at least yearly
- New changes to be incorporated in the form of amendments.

Rationale

Standardized work procedures will ensure that there is uniformity in rules, procedures and practices across all military health institutions. The moderate systematic review by Cummings et al. (2010) found team functions improved when leaders involved staff in developing and implementing of policies and the policies were clear and implemented consistently (RNAO, 2016:40).

1.5.3 A culture that supports team work

Teamwork is integral in creating healthy work environments and a backbone of inter-professional health and intra-collaborative heath practice. Nurses collaborate with various professional and non- professional health care workers (ICN, 2007:18). In order to support effective team work and avoid conflict and negative consequences for the team, team members should clearly understand their roles and scope (Eager et al., 2010 in RNAO, 2016:30).

1.5.3.1 Team building

Factors that facilitate the establishment of teamwork are critical if quality care is to be provided (ICN, 2007:18).

Recommendations

In building teams, nurse leaders should:

- Encourage multi-disciplinary collaboration all the time
- Provide team training at least quarterly
- Eliminate hierarchy
- Enforce a zero-tolerance policy to disruptive behaviour
- Embrace diversity in culture and views
- Be able to mitigate conflict
- Facilitate sharing of power among team members
- Encourage collaborative leadership, rotate leadership amongst members of the team at least monthly
- Allow participation of team members in decision-making
- Build trust relationships

Rationale

Teamwork is central to winning of wars by militaries and providing quality patient care by nurses in health institutions. An organizational culture that supports teamwork therefore becomes a winning organisation. Effective communication and role clarification are the guiding principles of teamwork. Literature shows that nurses who have a clear understanding of roles, responsibilities and competencies support and demonstrate willingness to work effectively with others (RNAO, 2016:29).

1.5.3.2 Role clarification

Understanding and appreciating professional roles and communicating effectively are central to the success of any team and are linked to quality patient care and a healthy

work environment for nurses. Findings in Phase 1 revealed that professional nurses indicated that their roles were not clearly defined. The literature shows that nurses who have clear understanding of roles, responsibilities and competencies support and achieve intra-professional collaborative practice. Practice nurses need to understand clearly their full scope of practice in the setting where they work, be secure within their professional team and communicate effectively (RNAO, 2016:25).

Recommendations

In clarifying the roles, the following recommendations are made:

Nurse leaders should

- Provide professional nurses with induction training and ensure they are aware of their role within their immediate work team or unit, and the broader organisation
- Provide clearly defined work objectives and expected outputs for professional nurses
- Ensure professional nurses possess up to date duty-sheets
- Always ensure that professional nurses are aware of additional tasks should there be any changes and make sure that they receive training for those tasks they are not confident or capable of doing
- Develop and maintain a working environment where professional nurses are consulted and can provide feedback on changes impacting on their job tasks.
- Involve the professional nurses where a change in structure or roles occurs

Rationale

Role ambiguity can interrupt the effectiveness of a team and have a negative impact on job satisfaction. Nurses need to have and demonstrate role clarity to optimize the quality of patient/client safety (Oelke et al., 2008 in RNAO, 2016:29).

1.5.4 The need for an environment that promotes professional autonomy

Autonomy is defined as freedom to act on what you know to make independent clinical decisions and act in the best interest of the patient (RNAO, 2007:34). This freedom is

conferred upon professional nurses as soon as they qualify and licensed as professional nurses and after obtaining other licenses to practice in different disciplines in nursing based on their qualifications. Should, for whatever reason this autonomy be frustrated, leadership should take steps to intervene for best interest of the patient and professional. This would be an effort to enhance a healthy work environment.

1.5.4.1 Abuse of military rank and recognition of functional rank

It became evident from the qualitative findings in Phase 1 that the use of military rank by patients and other senior officers on professional nurses at sickbays and clinics, interfered with their practice autonomy. The interference with practice autonomy of professional nurses by military senior officers emanates from the fact that these professional nurses either have junior ranks or have a candidate officer (CO) rank (which is no rank at all). Although the junior officer is a professional nurse, their functional ranks are insignificant in the military consequently their functional ranks are not recognized. The Registered Nurses Association of Ontario (RNAO, 2013b:9) recommends that organisations must acknowledge the impact of power hierarchy by identifying imbalances of power and making changes to equalize and build mutually supportive, safe inter-professional workplaces.

Recommendations

Nurse leaders are senior officers in the military. They are high ranking officials with authority and therefore are in a position to represent professional nurses' interests and concerns at the Formation and Level 2. They also develop operational policies, therefore should optimize opportunities for professional nurses' autonomy, personal and professional growth and mitigate conflict by

- Facilitating the concurrent functional and military rank promotions of professional nurses immediately after qualifying
- Creating awareness by displaying on notice boards the significance of the professional nurse's functional rank and the status attached to it

- Facilitating a system/policy that will enable senior officers to be seen by a separate professional nurse whenever they come for consultation to mitigate conflict of power imbalances.
- Developing policies that protect the limitation of professional nurses' practice autonomy
- Ensuring that nurse leaders themselves coach, mentor, be role models and guide professional nurses
- Providing opportunities for development and knowledge
- Encouraging use of judgment, risk taking and innovation
- Developing policies and processes that enable full scope of practice
- Establishing formal and informal leadership roles at practice levels such as clinical persons. These would be senior professional nurses who would role model nursing practice excellently and act as preceptors to other professional nurses to strengthen their confidence.
- Demonstrating confidence in others by delegating effectively

Nurses must clearly communicate and organize their work, act on nursing decisions using clinical judgement by:

- Clearly defining their own expectations for autonomous clinical practice
- Being part of clinical rounds to maximise the valuable contribution on nurses' unique perspective and perspective in the care of patients
- Acting within their scope of practice.
- Role modeling expected behaviours reinforcing autonomy. Encourage active participation of professional nurses in decision-making, give them opportunities to assume leadership positions in the team, acknowledge and respect the decisions they make.

Rationale

The literature reviewed in Phase 2 indicated that the autonomy of a nurse practitioner included the ability to carry out the appropriate course of action within a system that has standards of practice, code of ethics and organizational policies to advocate in the capacity of the nurse to determine her/his own course of action, ability to deliberate.

Furthermore, autonomy is said to enable professional nurses to construct innovative collaboration to advance primary health care (RNAO, 2007:34). The nurses' ability to be autonomous is supported or limited by the organisation (RNAO,2007:34).

1.5.4.2 Dual role conflict

Professional nurses in the military have dual roles, a role of a nurse and that of a soldier. It was evident in qualitative findings in Phase 1 that professional nurses did not get the opportunity to work overtime at hospitals to update their knowledge and skill because the military role in the form of regimental duties overruled the nursing role. Tensions can arise if the demands of the mission or line command are at odds or in tension with the duties to attend to the health of those needing care

Recommendations

Nurse leaders in mitigating the conflict between the roles should

- Develop a policy enlightening military leadership on the importance of nurses updating their knowledge and skill
- Hold meetings with Officers Commanding of units to communicate the need for this continuing education function annually
- Formalise the system of Continuing Professional Development (CPD) points

Rationale

The dual roles must be managed properly so that a balance is reached as these roles are part of the uniqueness of the military culture and should be congruent. Military leadership is hierarchical and relies on formal authorities and chain of command. Decisions often have to be made quickly and decisively. This type of decision-making structure can be challenging to health care professionals who are facing ambiguous or uncharted territory that requires them to rely on their judgement, discretion, and in accordance with nonmilitary professional. Ethical and moral issues health care professionals in the military are usually faced with can be resolved with effective communication, training, leadership, clear rules of engagement and unit cohesion and support (Defense Health Board, 2015:ES-1).

1.5 Recommendations to address factors that impact negatively on enhancement of a healthy work environment

These recommendations are based on the factors that came up repeatedly from professional nurses in the qualitative findings in Phase 1 as inhibiting the creation of a healthy work environment. They must be viewed as addressing the need to minimize these factors from the environment to enhance a healthy work environment, not as duplications.

1.5.5.1 Shortage of personnel and the staffing process

Shortage of personnel seemed to be inhibiting the healthy work environment for nurses in the SAMHS as nurses in the qualitative findings expressed how they were overworked because of the long and protracted staffing process. They indicated that it took a very long time to replace members who left through natural attrition process and those who die.

Recommendations

Level 2, the strategic level at SAMHS

- Should revisit the post structure and consider restructuring to address demand and personnel ratio

Human resources to ensure that

- the bureaucratic processes that prolong the appointment of professional nurses are minimized
- Vacant posts created by attrition of nurses are filled within three months

At Levels 3 and 4 (The Formation and unit levels i.e hospitals and clinics, college)

Nurse leaders should

- act on valid and reliable workload data (RNAO, 2013b:40)
- create a pool of reserve force nurses
- make use of reserve force nurses to alleviate shortage of personnel

Rationale

Creating a healthy working environment for nurses begins with effective and proactive staffing and workload processes that capitalize on individual and collective nurses' knowledge, experience and skills sets. Three key elements of workload planning, workload management and workload measurement are critical to successful staffing and workloads, and must be operationalized within a systems context (RNAO, 2007b:37).

1.5.5.2 Acquisition of equipment and the procurement processes

Not having serviceable, appropriate and adequate equipment becomes a source of frustration for nurses. Professional nurses find themselves spending a great deal of time locating equipment and arranging for its repair and maintenance, according to findings of the qualitative research study in Phase 1. Nurse leadership at SAMHS level 2 should enhance a healthy work environment by liaising with logistics department to ensure that long procurement processes are minimized

Recommendations

Nurse leaders facilitate for

- Logistics in terms of acquisition of material resources to minimize long procurement processes
- Maintenance and repair plans to be in place and be monitored and followed up by nurse leaders
- Equipment to be serviced as per purchase instructions
- Personnel to handle equipment with care through education/instructions clearly displayed.
- Service life of equipment to be observed and procurement orders be done in advance to replace the obsolete equipment.

Rationale

Up to date and functioning equipment contributes to good health service delivery which translates to good quality care for patients. It enhances a healthy work environment

as it enables professional nurses to perform their tasks optimally. SAMHS leadership should provide nurses with serviceable equipment to perform their job effectively and efficiently.

1.5.5.3 Status of infra structure

Professional nurses indicated that the buildings used for rendering of health services in sickbays and clinics were not designed for that purpose. Furthermore, the buildings were not maintained as a result they were dilapidated, not adequately ventilated and still had carpet fittings making it difficult to keep high infection control standards.

Recommendations

The SAMHS leadership should

- Prioritise the redesigning and refurbishing of the primary healthcare facilities according to the occupational health and safety requirements and specifications.
- Ensure that the existing primary health care facilities are replaced by modern state of the art facilities.
- Prioritise maintenance and repair of health facilities
- Avail financial resources for maintenance and repair of facilities
- Utilize expertise within the defense force for upgrading of facilities to curb costs.

Rationale

The status of the facilities has either a demoralizing or morale boosting effect on professional nurses and building of confidence on patients with regards to the standards of health services they are about to receive, depending on what state the facilities are in . The facilities that meet high health standards equate to good quality of patient care and enhance a healthy work environment.

1.5.5.4 Lack of development opportunities for sickly personnel

It was evident from the qualitative findings in Phase 1 that professional nurses whose health status changed while already in the employ of the defense force were disadvantaged when it came to professional development.

Recommendations

SAMHS leadership should consider

- Affording professional nurses who fall sick already in the employ of the defense force opportunities to attend courses and be put on light duty or
- That the professional nurses receive their rightful military promotions without considerations of military courses
- Alternatively, that the affected professional nurses wear civilian uniform to avoid humiliation associated with not having a military rank.

Rationale

The initial health status of professional nurses who fall sick when they are already members of the defense force should suffice to warrant them consideration for professional development opportunities. Should it be impossible for professional nurses to attend military courses and therefore not eligible for military rank promotions, such nurses should wear civilian uniform to spare them frustrations of not having a rank.

1.6 Editorial independence

The responses from the professional nurses working in the SAMHS in the individual interviews formed the basis for the development of this evidence-based best practice guideline. The promoter and co-promoters of the study are assisting in the conception and the design of the guideline. The draft guideline will be sent to the reviewers for comments and their comments will be incorporated into the development of the final guideline. No conflict of interest is applicable to the development of this guideline.