Community Service Nurses' Experiences at a Public Hospital in Tshwane District, South Africa

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Abstract

The South African Nursing Council (SANC), in Regulation R765 of 2007, requires every newly qualified professional nurse trained in South Africa to perform remunerated community service in a public hospital for a period of one year before registration as a nurse. However, most newly qualified professional nurses placed in a certain public hospital in Tshwane district as community service nurses request to be transferred to other hospitals before the end of their placement term. The study adopted interpretative phenomenological analysis (IPA), which aimed at gaining an in-depth understanding of community service nurses' experiences at a public hospital in Tshwane district, South Africa. Data were collected using in-depth interviews with 11 purposively selected community service nurses. Data were analysed using Smith's IPA framework. Three themes emerged from the data analysis: (1) limited material resources and a shortage of health care personnel; (2) poor interpersonal relationships; and (3) a lack of professional support during the placement of community service nurses at the public hospital under study. The findings imply a lack of hospital readiness and preparedness to offer a conducive environment for community service nurses to gain the required clinical experience and skills. This has a negative impact on the nursing profession, nursing education, and patient care. Recommendations are put forward focusing on the responsibilities of the Health Ministry and the SANC, mentorship, and the transformation of nursing curricula to be contextually relevant to the country's health care systems and resources.

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Introduction

This article reports on a study conducted regarding community service nurses' experiences at a public hospital in Tshwane district, South Africa. Community nursing service is a programme in which new graduate nurses are expected to serve in public health care facilities before registering as professional nurses (Nursing Act 33 of 2005, R765; see SANC 2007). Community service nurses are an important category of nurses for the provision of health care in the community (Smith, Sim, and Halcomb 2019, 482). The purpose of community service is to ensure successful completion of the requirements of professional training. It also equips community service nurses with clinical experience and skills, and provides support to underserved and marginalised communities through the provision of quality health care services with skilled personnel.

Nolte et al. (2017, 4373) have highlighted that community service nurses are placed in public establishments in the absence of their mentors. Working without mentors can be a challenging experience for community service nurses (Hofler and Thomas 2016, 134). They need to enhance their clinical skills and knowledge to ensure quality health care provision. The challenge is exacerbated by the circumstances they find themselves in. Contributing factors, such as a shortage of material and human resources and negative attitudes on the part of experienced nurses and other health care professionals, have been noted (Manyisa and Van Aswegen 2017, 36; Moyimane, Matlala, and Kekana 2017, 6). Community service nurses are generally overwhelmed by the workload. Their workload may also be related to a failure to delegate tasks to junior nurses, because older junior nurses tend to undermine the community service nurses.

Community service nurses are expected to carry out their roles and responsibilities to a high standard despite the work-related stress they experience. In addition, there are challenges that prevent community service nurses from developing coping strategies and acquiring professional and practice obligations upon completion of their placements (Jacobs 2016, 63). Transition into the working environment might be hindered due to the increased number of patients with complex conditions, lack of mentorship, and performance anxiety (Hofler and Thomas 2016, 133). Barksby, Butcher, and Whysall (2015, 22) concur with these findings by highlighting that community service nurses are unable to manage their time to ensure the effective provision of health care.

Problem Statement

The South African Nursing Council (SANC) (2007) has stipulated that newly qualified professional nurses should perform remunerated community service for one full year to qualify for registration as nurses (General, Psychiatric, and Community) and for Midwifery. However, while one of the researchers, who is a lecturer at a nursing college in Gauteng, accompanied students on their clinical exposure at one public hospital in Tshwane district, the problem that this study focused on was identified. The researcher

realised that most of the nurses allocated to the community service programme at this public hospital did not complete their placements. Some became frustrated and considered leaving the nursing profession. This is cause for concern, as community service nurses are expected to complete their placements within a year in the institution where they are placed. A failure to complete, or the prolonging of community service, may delay the registration of these nurses. This will definitely exacerbate the shortage of registered nurses in South Africa.

No study had ever been conducted to explore the experiences of community service nurses in this particular hospital. The researchers thus decided to investigate the hindrances that inhibited the completion of the community service nurses' placements. The researchers identified the following question: What are the experiences of community service nurses placed at a particular public hospital in Tshwane district?

Purpose and Objective of the Study

The purpose of the study was to gain an in-depth understanding of community service nurses' experiences at a public hospital in Tshwane district, South Africa.

The objective of the study was to explore and interpret the community service nurses' experiences of providing health care services at a public hospital in Tshwane district.

Research Design and Methods

Design

Interpretative phenomenological analysis (IPA) was utilised. In an IPA design, the focus is not only on the researcher understanding participants' lived experiences, but also on how participants interpret their experiences. This was necessary to understand how the community service nurses interpret their own experiences.

Contextual Details

The study was conducted at a public hospital in Tshwane district, Gauteng province, South Africa. This district hospital has 551 beds and serves 32 surrounding clinics from the provinces of Gauteng and North-West. The hospital is a clinical site for several public nursing colleges and universities within Gauteng.

Population and Sample

The total target population was 23 community service nurses allocated to the selected hospital. Criterion purposive sampling was used to select the sample based on the following criteria: being a community service nurse who had qualified within one year according to the SANC (2007) as a nurse (General, Psychiatric, and Community) and

midwife. The nurses had to be allocated to the hospital for at least six months. The total sample size was 11 community service nurses after data saturation.

Data Gathering Procedures

Data collection took place from August to September 2014. Individual appointments for interviews were scheduled with community service nurses who were willing to participate. The in-depth interviews were conducted at times and venues that were convenient for the participants. The interviews were conducted based on an interview guide, which had been designed in line with IPA principles (Smith, Flower, and Larkin 2009, 79). Probes and prompts were used to encourage the participants to provide more information or clarification. Each interview was audio-recorded with the participant's permission. Field notes were taken to capture aspects which could not be audio-recorded. Each interview lasted between 45 minutes to an hour. Data collection and analysis were done concurrently. The interviews were stopped when data saturation was reached. Data saturation was reached with the ninth participant; however, the interviews continued until the eleventh participant, to verify that no new information emerged from the responses.

Data Analysis

The interviews were transcribed verbatim. The data analysis was done independently by two researchers (NLN and AHM) using the IPA framework for data analysis. The researchers individually read and re-read each transcript to achieve self-immersion in the data. This was followed by reading each transcript while highlighting key statements which described participants' experiences. The statements were then coded according to their similarities. This process led to the formulation of superordinate themes.

Themes were compiled in tables for each transcript until the researchers reached consensus. The tables from each researcher were then compared for each transcript. One of the researchers consolidated all the tables into a single master table of superordinate themes, sub-themes, and excerpts from participants, indicating where the themes could be found in the transcript.

Measures to Ensure Trustworthiness

Trustworthiness in this study was ensured through prolonged engagement at the study site. Triangulation was achieved through the use of in-depth interviews and observations. Peer debriefing of the independent researcher within the field was carried out and member checking was done with two participants (P2 and P11) before finally writing up the results. Three randomly selected participants (P1, P5, and P9) were requested to go through their transcripts to check if the transcripts were a true reflection of the interviews, and all of them were satisfied.

Ethical Considerations

Ethical clearance to conduct the study was sought from the University of South Africa, Health Studies Higher Degrees Committee (ethical clearance certificate HSHDC/282/2013). Permission was received from the Department of Health and the Tshwane Research Ethics Committee. The chief executive officer of the hospital under study approved the request to access the site, prior to the commencement of data collection.

The researcher emphasised the ethical aspects to all participants, such as confidentiality, respect, voluntary participation, the right to participate, and the right to withdraw. Participants were also informed that should they experience emotional trauma or discomfort due to participation in the interviews, they would be referred for counselling by a pre-arranged psychologist free of charge. Informed consent was obtained from each participant.

Results

The results are presented based on the demographic characteristics of the participants and the themes which reflect the experiences of the participants.

Demographic Characteristics

The demographic characteristics of all participants are displayed in Table 1 below. The letter "P" is used in the table and also in the results to represent a participant.

Table 1: Demographic characteristics of the participants

Participant	Age	Gender	Ward	Unit rotation	RPL[*]
P1	30–39	Female	Paediatric	1	No
P2	30–39	Male	Psychiatric	1	No
P3	20–29	Female	Psychiatric	1	No
P4	40–49	Female	Intensive care	2	Yes
P5	30–39	Male	Maternity	1	No
P6	20–29	Female	Medical	1	No
P7	20–29	Female	Paediatric	1	No
P8	20–29	Female	Theatre	1	No
P9	20–29	Female	Casualty	1	No
P10	20–29	Female	Out-patient	1	No
P11	20–29	Female	Sub-acute	1	No

 * Recognition of prior learning

Out of eleven participants, two were males and nine were females, mainly because the nursing profession is dominated by females. The age of the participants ranged between 20 and 49 years. The younger participants were new to the nursing profession and the older participant was considered for the training based on RPL. Two males and one female were in the age range of 30 to 39 years and one female was in the age range of 40 to 49 years. The rest of the participants were between 20 and 29 years. The participants were placed in different units within the hospital, and were awarded an opportunity to rotate across the units.

Super-ordinates, Themes, and Sub-themes

The data analysis process of the community service nurses' experiences in a public hospital in Tshwane district led to the emergence of three superordinate themes, as illustrated in Table 2. The key findings and extracts from the participants are discussed in the subsections that follow.

Table 2: Super-ordinates, themes, and sub-themes for the results

Super-ordinates	Themes	Sub-themes
Limited resources	Lack of material resources Shortage of human resources	Shortage of medical equipment and pharmaceutical supplies Increased staff turnover Increased workload
Poor interpersonal relationships	Disrespect Negative attitudes	Insubordination Hostile environment
Lack of professional support	Lack of supervision Lack of guidance and induction	Limited competence Unsafe practices Frustration Feeling valueless

Limited Resources

This theme relates to the resources required to enhance clinical experiences for community service nurses (Moyimane, Matlala, and Kekana 2017, 6). Resources identified by the participants as being lacking were material and human.

Lack of Material Resources

All participants alluded to the fact that the lack of material resources and pharmaceuticals in the hospital was a major challenge during their placement.

> We do not have delivery packs in maternity. Instead, we use stitch and per vaginal pack to conduct the deliveries and use scalpel blades to cut the umbilical cord. Sometimes we borrow suturing material for suturing episiotom[ies] from the neighbouring hospitals. There are also no medicines in the wards. (P2)

Shortage of Human Resources

Participants reiterated that there was a shortage of human resources in the hospital. This finding is similar to that of Sinha and Sigamani (2016, 3). The shortage of personnel led to community service nurses having to work in their respective units without the supervision of senior, experienced professional nurses.

> Sometimes there are only two nurses on duty in a unit, expected to render health care services and also non-nursing duties to more than 50 patients. We even work overtime without receiving an allowance. (P3)

The shortage of staff is worsened by increased staff turnover (Sinha and Sigamani 2016, 4). Participants mentioned that several staff members had resigned. This finding is supported by Oshodi et al. (2019, 881), who reported that participants experienced difficulties when rendering nursing care in the wards.

> Every month, there is a farewell function of staff members including community service nurses who are resigning. Last month one of us left and went to Thailand. This worsened the shortage situation. (P9)

The shortage of staff led to community service nurses being placed in charge of the wards. Community service nurses do not have the requisite experience, leading to the potential of substandard care being provided to patients (Mbombi et al. 2018, 3). Lack of experience in this category has implications for the provision of health care and workload (Smith, Sim, and Halcomb 2019, 487). The community service nurses reported that they felt misplaced, as they were just allocated for the sake of mitigating the shortage rather than to enhance their clinical experience and skills.

> I have been in a sub-acute unit since my placement. This ward is not suitable for gaining experience, as I am not learning new skills. I feel I need to be placed in very busy units so that I can experience the different challenges of the nursing profession. (P11)

Poor Interpersonal Relationships

Several studies have reported the theme of interpersonal relationships as a challenge amongst health care professionals. The difficulties encountered include disrespect, poor communication, and negative attitudes, resulting in strained interpersonal relationships.

Nurse-to-nurse disrespect at bedside is still a challenge in health care workplaces, and can lead to unpleasant provocations and confrontations (Grissinger 2017, 75). Participants voiced feeling valueless during their placements. They reported being disrespected and bullied by other categories of health professionals. This mostly took the form of disrespect for community service nurses on the part of senior nursing staff members, including managers. Most (seven) of the participants raised concerns about how senior nurses and managers communicated with community service nurses.

> The communication is very bad amongst us. We are shouted at and disgraced by ward managers and other senior professional nurses in front of the patients. (P6)

Disrespect towards community service nurses is also found among junior nurses (in terms of qualification) in the form of insubordination. This threatens patient safety, as it hinders collegiality and cooperation and ruins the spirit of teamwork (Oshodi et al. 2019, 884).

> Enrolled and assistant nurses refuse delegation from us (community service nurses). Such behaviour made us feel belittled and disrespected by the subordinates in the unit, and eventually had a negative effect on our rendering of health care services. (P7)

Participants indicated that they have experienced an element of negative attitudes from hospital managers and senior and experienced nurses.

> The manager always tells us that she is the boss and that we (community service nurses) are just mere junior nurses who cannot tell her anything. This attitude makes us behave like just visitors without any say. (P6)

Participants have also acknowledged negative attitudes from medical personnel.

> The doctor will choose the older nurses and say, "I do not want this sister; she is the new one. I don't want this one (community service nurse); let the other sister come. Where is sister so-and-so?" (P7)

Participants mentioned that negative attitudes and disrespect portrayed openly by staff members also trickled down to the level of the patients.

> One day I wanted to insert a drip on a patient. The patient told me that I should call the real sister to assist him as he is not a teaching tool for "comserve", which is how the permanent hospital staff members refer to us [community service nurses]. (P11)

In spite of the community service nurses being faced with such a hostile environment, participants mentioned that there are no support structures available.

Lack of Professional Support

This theme relates to the professional support required to assist community service nurses to acquire the relevant clinical experience and skills. Managers and supervisors were perceived as unable to provide the necessary support to the nurses (Mammbona and Mavhandu-Mudzusi 2018, 143). Conversely, supportive mentors were associated with a smooth and positive transition in a Canadian study conducted by Regan et al. (2017, 250). Participants described professional support as encompassing activities such as supervision, guidance, and debriefing.

Lack of Supervision

Regarding this theme, Govender, Brysiewicz, and Bhengu (2015, 7) received positive responses from the participants in their study, who stated that they were satisfied with the support and mentoring that they received from their seniors. However, in this study, participants were concerned about the lack of supervision from some of the professional nurses in the hospital under study.

> The person who was supposed to be supervising me would just leave me to work without supervision. It is difficult to work without supervision because what we have learned in class is completely not the same as what is happening in the real clinical situation. (P8)

Lack of Guidance and Induction

Most (eight) of the participants reported a lack of guidance and induction from the experienced nurses in the hospital under study. This theme has been reported by a substantial number of studies on nursing personnel (Regan et al. 2017, 252).

> There are no formal induction programmes. We just find ourselves allocated to a specific ward and expected to function as a professional nurse with all the responsibilities. (P6)

Participants further mentioned that the lack of a formal induction programme, coupled with exposure to unsafe practices, was professionally dangerous. Despite these challenges, participants had no one to turn to for debriefing or counselling.

> Since my community service placement, I have not heard of any support programme that one can consult for debriefing sessions, because I sometimes feel so frustrated, but there is no one to talk to. (P10)

Discussion

The study investigated a largely ignored component of the provision of quality health care services, namely the experiences of community service nurses in public hospitals. This review provided a critical blending of literature relating to the experiences of community service nurses regarding the provision of health care services. The study objective was to explore the experiences of community service nurses at a public hospital in Tshwane district in South Africa. The findings suggest that the community service nurses were failing to gain the required clinical experience and skills due to the limited availability of resources. It seems that the shortage of resources has a negative impact on their acquisition of clinical experience and skills. This echoes the findings of Mammbona and Mavhandu-Mudzusi (2018, 145).

Furthermore, it is evident that medical equipment and pharmaceutical supplies are critical to providing quality nursing care. Participants were concerned about the lack of medicine to treat patients. Participants reported that they had to improvise materials to render health care services, due to a shortage of material resources. Improvising

appeared to have a negative impact on the quality of health care services provided in the hospital. This was a challenge to the community service nurses in this study, who did not know what they were supposed to do in order to render the required nursing care. It is noteworthy that Govender, Brysiewicz, and Bhengu (2015, 7) identified findings different to those of this study. These authors concluded that participants in their study reported substantial clinical preparedness for their nursing roles and rendered nursing care with confidence.

A shortage of human resources was linked to the high turnover of qualified and skilled personnel, a finding confirmed by Oshodi et al. (2019, 881). This too compromised the transference of skills from experienced nurses to community service nurses. It is evident that the shortage of human resources has been a challenge in health facilities. A study by Matlala and Lumadi (2019, 7) also supports these findings. The absence of experienced personnel left those on duty, including community service nurses, with an unbearable workload. Sinha and Sigamani (2016, 6) further asserted that attrition and emigration exacerbate the shortage of qualified health personnel, thus increasing the workload of remaining nurses. Mammbona and Mavhandu-Mudzusi (2018, 144) documented the same results in terms of human resources. The view of the researchers, based on the study findings, is that workload attributes to compromised nursing care. Malelelo-Ndou, Ramathuba, and Netshisaulu (2019, 7) further highlighted the implications of a shortage of nursing personnel as a determinant of substandard nursing care.

Apart from a shortage of resources, it appears that eventually community service nurses become lost in transition (Teoh, Pua, and Chan 2012, 146). During theoretical training, community service nurses are taught based on ideal health care facilities with the stipulated types of resources (Regan et al. 2017, 251). This curriculum prepares them to render quality nursing care services to patients. When these nurses are allocated to clinical settings, the expectation is that they will implement what they have learnt during their training. However, this seems not to be the case for the community service nurses in this study, allocated at the particular public hospital in Tshwane district in South Africa.

At health care facilities, teamwork is required for the delivery of safe patient care (Oshodi et al. 2019, 883). However, this study revealed that the community service nurses find themselves in a hostile environment. These nurses are disrespected by the hospital staff, including the junior category of nurses, such as nursing assistants, and senior staff members, including hospital managers. A study by Halcomb and Ashley (2016, 541), on satisfying aspects of work amongst Australian nurses, resulted in similar findings. In the present study, disrespect was also shown by other members of multidisciplinary teams, including medical doctors. The abuse of nurses by physicians has a long history (Siedlecki and Hixson 2015). The findings of this study confirmed the tendencies of showing uncivility towards and bullying newly qualified nurses during their placement, as well as bullying of new professional nurses by senior nurses

(Cullinan et al. 2019, 13). Systemic disrespect is a global, ingrained condition. It appears that, in the hospital under study, the undermining of community service nurses even occurred in front of patients. The patients also developed negative attitudes, and came to adopt the same mistrust of this nursing category. This type of situation further compromised the community service nurses' opportunities to gain clinical experience and skills, as some of the patients refused any assistance from them. This finding is in line with those of Kuhlmann and Jensen (2015, 30), who stated that poor inter- and intra-professional relationships might result in negative outcomes, which is costly in both human and financial terms.

Community service nurses were expected to work in nursing units without the supervision of senior, experienced professional nurses, due to a shortage of human resources in the hospital. The findings of this study are in line with those of Manyisa and Van Aswegen (2017, 36), who mentioned that a lack of resources contributes to poor health services. In the present study the shortage of staff led to community service nurses being placed in charge of wards they had never worked in. The findings are in line with those of several authors who have noted that community service nurses are used to cover for shortages in specialised units without prior allocation to that unit (Nolte et al. 2017, 4375). The practice of allocating community service nurses merely to meet the hospital's staffing needs, without first considering their learning needs, compromises the purpose of community service nursing. This practice also poses a risk to the lives of patients, as inexperienced community service nurses may not know how to act in case of sudden changes in a patient's condition (Regan et al. 2017, 251). Participants mentioned that sometimes they even work overtime and during holidays for no pay, due to the budgetary constraints of the hospital.

Several studies have found that newly graduated nurses need a period of support (Halpin, Terry, and Curzio 2017). A lack of professional support and supervision has been identified by several researchers (Abiodun et al. 2019, 8). A lack of material and human resources, overcrowding of patients, and staff absenteeism in health care facilities have led to the failure to provide professional support, guidance, and mentoring to newly qualified nurses (Haley et al. 2017, 618–19). The same situation was experienced by the participants in this study, where most reported a lack of support, guidance, and induction from experienced nurses. This finding is also supported by Regan et al. (2017, 253). The result is that the competencies of the community service nurses are limited, and that they feel valueless during their placements (Netshisaulu and Maputle 2018, 5).

Community service nurses reported unsafe practices, which are directly related to the lack of material resources in the units. Most of the time experienced nurses tend to improvise to provide health care with the limited resources available. These tendencies led to compromised quality. Participants were frustrated by the unsafe practices taking place in the units, and expressed the fear of litigation or of losing their license to practice (Matlala and Lumadi 2019, 5).

Conclusion

Community service nurses are allocated to public health care facilities for the purpose of acquiring clinical experience and skills, in order to prepare them to work independently as registered nurses. However, the reality is that public health care facilities are not sufficiently resourced to offer community service nurses the required clinical experience and skills. Instead, community service nurses are exposed to the challenges of a non-accommodative, stressful, and frustrating health environment during their community service placements. It was noted that participants lacked the necessary support and supervision from experienced and senior personnel to enable them to acquire clinical experience and skills. This hindered them from rendering quality health care services.

This study brought to light that there is a need to address the current public hospital situation to embrace the learning needs of community service nurses. Furthermore, it is necessary to adapt nursing education to make it contextually relevant to the reality that nurses find when they start working in actual health care facilities.

Recommendations

To improve the situation, the South African National Department of Health, in collaboration with the SANC, should develop a policy to ensure that public hospitals are well equipped and adequately staffed to enhance community service nurses' experiential learning. The SANC needs to monitor and evaluate all hospitals to ensure that they meet the standards required for community service nurses to acquire proper clinical experience and skills, which will promote the status of the nursing profession and the quality of nursing care.

Public hospitals need to allocate preceptors or mentors to support community service nurses. To reduce costs, retired professional nurses could be used as mentors for community service nurses. In cases where this is impossible due to financial constraints, the support of community service nurses may be incorporated as part of the individual integrated performance management system. Professional support should be channelled towards performance appraisal to determine performance bonuses and promotions of health care professionals.

Community service nurses' needs for a conducive learning environment must be urgently addressed. This can be done through transforming nursing education to increase its contextual relevance, by means of a continuous partnership with local health care facilities. This will ensure that nursing education takes into account what is currently being practised, for example if a hospital is using adaptive approaches (improvising) to adjust to resource challenges. During theoretical learning and clinical demonstrations, which are usually done in the form of simulations, students should be shown instances of such improvising, to prevent them feeling shocked or frustrated

when they later encounter this in practice. This is necessary, especially in the current unstable economic climate, which affects the funding of public health care facilities.

Strengths and Limitations

The study provided a broader understanding and insight into the health care services provided in public hospitals. The use of an IPA design enabled the community service nurses to freely narrate and interpret their experiences and also make suggestions for improvement. The use of criterion purposive sampling and maximum variation—according to age, gender, and units to which participants are allocated—assisted in obtaining views from diverse participants.

The limitation of the study is that it was conducted in a single setting, namely at a public hospital in Tshwane district in Gauteng. Although the study was conducted at only one district hospital, the findings can be transferable to other public hospitals within and outside the district, as the hospitals are funded by the same Department of Health.

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