2   CONTEXT

2.1   INTRODUCTION

In Chapter 1, an orientation to the study was provided. Chapter 2 discusses the national-, policy-, professional- and organisational contexts in which this study was conducted. I will discuss constructivism as a philosophical paradigm and as a theory of learning, linking it to the person-centered approach. Lastly, the Person-centered Practice Framework, which served as the theoretical framework in this study, will be discussed.

2.2   MOTIVATION FOR WRITING THE CHAPTER AND SEQUENCE OF DISCUSSION

Plowright (2011:246) argues that discussing context is significant in any study and constructivist studies especially give considerable recognition to the context (Ochieng 2009:16). An introduction to the context was provided in Section 1.7. I start by discussing and reflecting on the South African national- and policy contexts, the professional context of the South African nursing profession and the organisational context of the tertiary hospital involved in this study. The importance of discussing the context in this study is further motivated for in Bratt's (2013:104) article, "*Nurse residency program: Best practices for optimizing organizational success"* where the author states that context should always be considered when developing a nurse residency programme as it leads to the successful implementation thereof. Providing in-depth details on the context assisted me in providing vital background information that acts as a measure to enhance the credibility of the study by making the reader aware of my, and the stakeholders', reasoning processes in the development of the Person-centered Nurse Residency Programme. The context further allowed me to reflect on the professional practice environment and share my own personal perspective, which assisted me in clarifying the limitations of the study (see Section 7.7). The fifth context in Plowright's *Frameworks for an Integrated Methodology* (2011:246), the theoretical context, was shaped by the literature review in Chapter 3. The interpretive description approach supports the discussion of a phenomenon by placing it in its context, together with all factors that influence it, without aiming to explain why it occurs (Teodoro, Rebouças, Thorne, Souza, Brito & Alencar 2018:3; Thorne 2016:117) as it enhances the credibility of the study (Thorne 2016:117).

The sequence in which the additional contextual aspects are discussed is led by my chosen paradigm, constructivism. I regarded constructivism as the umbrella under which the rest of the context could be described. Constructivism has a dual meaning and both meanings have relevance in this study. Constructivism was initially defined as a philosophical paradigm in Guba and Lincoln (1994:109) and was later applied as a theory of learning in the educational context, where it describes how learners construct knowledge (Hershberg 2014:182). As this study is grounded in the educational context and the nursing context, I will discuss constructivism as it pertains thereto. Constructivist learning

strategies encourage self-directed learning, which correlates with the principles of person-centered education (see Section 2.8.3). This approach to education originally developed from the person-centered approach as initially developed and applied in the field of psychology and the care context (see Section 2.8.2). In the context of care, the Person-centered Practice Framework (see Figure 2.3) was developed to guide healthcare practitioners in the use of a person-centered approach in practice (see Section 2.9.1) and was therefore used as the theoretical framework underpinning this study. A schematic representation of the context and additional contextual aspects as I regarded it in this study is provided in Figure 2.1.
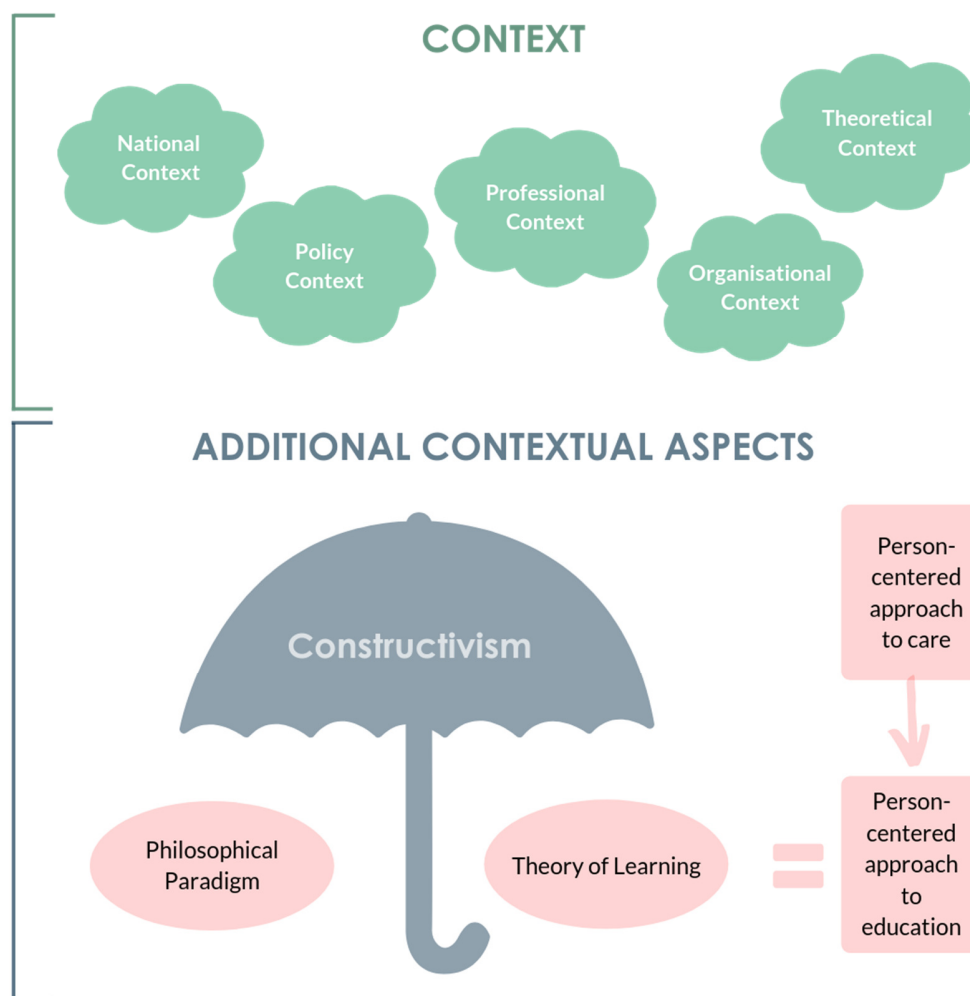
CONTEXT

National Context

Policy Context

Professional Context

Organisational Context

Theoretical Context

ADDITIONAL CONTEXTUAL ASPECTS

Constructivism

Philosophical Paradigm

Theory of Learning

Person-centered approach to care

=

Person-centered approach to education

Figure 2.1: Schematic representation of the context and additional contextual aspects in this study

Figure 2.1 provides a schematic representation of the context and additional contextual aspects relevant to this study. The overall contexts are presented as clouds, each representing a context that will be discussed. Constructivism was regarded as an umbrella overarching its two distinct applications as: (1) a philosophical paradigm; and (2) a theory of

learning. Constructivism as a theory of learning was shown to be "equal to" the person-centered approach to education, which initially developed from the original person-centered approach to care.

2.3   NATIONAL CONTEXT

South Africa is located on the continent of Africa and covers 1 214 470 square kilometres of land and 4,620 square kilometres of water, making it the 25th largest nation in the world with a total area of 1,219,090 square kilometres. South Africa became an independent state in 1910, after acquiring its independence from the United Kingdom (UK) (Worldatlas 2018:online) and subsequently became a Republic on 31 May 1961 (South African History Online 2017a:online). On 1 February 2019 at 14:34 the live population in South Africa was reported to be 57,790,885 and made up 0.75% of the global population (Worldometer 2019:online). Nine provinces exist within South Africa namely: Gauteng, Limpopo, Mpumalanga, Western Cape, Northern Cape, Eastern Cape, Free State, Kwazulu-Natal and the North West province, each with its own Premier, provincial members of executive councils and legislature. South Africa has three official capital cities namely: Pretoria, which is the administrative capital, Bloemfontein, the judicial capital and Cape Town, the legislative capital (South African Government [n.d.]:online). Gauteng, the province in which this study was conducted, is the smallest of the South African provinces with a size of 18 178 square kilometres but holds the biggest share of the South African population. According to the information on the South African Government website accessed on 1 February 2019, the statistics showed that Gauteng makes up 25.5% of the South African population, which was at that time equal to 14,717,000 individuals. The date on which these statistics were last updated is however not known. Gauteng is the centre of economy of South Africa and produces more than 34.8% of the country's gross domestic products (South African Government [n.d.]:online).

South Africa was initially ruled by the National Party, who came into power in 1948 and who was responsible for instituting the Apartheid policy. Apartheid brought separation between racial groups and brought about inequality among South Africans (South African History 2017b:online). The first democratic elections took place in 1994 in which the African National Congress, under the leadership of the late Nelson Mandela, became the ruling party (South African History Online 2017d:online). A new South African Constitution was adopted on 8 May 1996, which led to the implementation of an extensive Bill of Rights, advocating anti-Apartheid movements (South African History Online 2017c:online). Today, South Africa is known as the "*Rainbow Nation*" due to the great diversity of cultures that constitute our 11 official languages (Show Me 2009:online)**.** The official languages are Afrikaans, English, Zulu, Xhosa, Ndebele, Northern Sotho, Sotho, Swazi, Tsonga, Tswana and Venda (South African Government [n.d.]:online). The language most often spoken is Zulu and thereafter Xhosa, although the most widely spoken language is considered to be English, which is spoken throughout South Africa by the majority of people (Alexander 2018:online). South Africa proudly delivered the first cardiac surgeon to perform a heart transplant in 1967 in Cape Town, Professor Chris Barnard (South African History Online 2016:online), and is the only country in the world that had two residents from one street,

Vilakhazi street in Soweto, to become Nobel peace prize winners. The recipients were the late ex-President Nelson Mandela and Archbishop Desmond Tutu (Court & McCarthy 2015:online).

Schooling in South Africa starts at grade 0 and goes up to grade 12. School is, however, only compulsory from the age of seven when children usually start grade 1, to the age of 15, when they are in grade 9. Grades are divided into primary- secondary- and higher education levels, followed by university (Expatica 2018:online). The education system comprises of public schools funded by the government, public schools funded by governing bodies and parents (previously known as "*Model C*" schools during the Apartheid era), private, independent schools and international schools. South Africa has approximately 30,000 schools, with 26,000 of them being publicly subsidised. Most private, independent schools are in the Gauteng- and Western Cape provinces. The majority of parents in South Africa are responsible for paying for their child's education, but poverty-stricken families have these fees paid by the government (Expatica 2018:online). Government funded public schools are the worst-performing schools despite large amounts of money being invested in the South African public education system. The country's school system performs worse than poorer neighbouring countries. The World Economic Forum 2016-2017 Global Competitiveness Report ranked South Africa's primary education system as 126th out of 138 countries; the quality of higher education and training 134th out of 138 countries; and in the category for quality of higher education maths and science, we ranked last (Schwab 2017:325). Causes for such poor performance have been linked to the high incidence of incompetent teachers as reported by Statistics South Africa's 2013 general household survey (as cited in Mbiza 2018:online). According to Mbiza (2018:online), the South African educational system is: *"A system that often produces clueless learners".* The World Economic Forum 2017-2018 Global Competitiveness Report did show a slight increase in each category (Schwab 2018:269), but South Africa has much work ahead of it.

According to the article: "*How dropout rates are diminishing education as a human right*" in News24 on 21 March 2018, a major cause of high dropout rates of pupils in South African schools is noted to be poor socio-economic factors that force school-goers to seek employment as they must help to support their families. Other causes include drug dependency and teenage pregnancies. Grade 12 pass rates look promising, reporting numbers as high as 75.1% in 2017, but when taking into account the number of these grade 12's that started Grade 1 in 2006, being 1 155 629 pupils, statistics by Africa Check indicated that only 34.7% of them obtained a grade 12 pass in 2017. Another controversial issue reigning in the South African educational school system is the high incidence of pupils being "put-through" their grades by the school, despite not meeting the minimum requirements of that specific grade (Carroll 2018:online). The figures by Africa Check give a good indication of the number of pupils that have left the school system, negatively impacting the socio-economic status of South Africa as it exacerbates the high unemployment rates that already exist (Expatica 2018:online).

2.3.1   Impact of the national context

The potential impact of the national context on this study may purely be set on the perception of inequality that may still exist due to racial discrimination. Although the Apartheid era has long passed, racism is still a reality in South Africa and articles such as: "*Racism: The demon that won't be exorcised*" (Shongwe 2017:online) and "*South Africa's racist schools: An opportunity for a deeper reflection on race*" (Diko 2017:online) proves this to be true. The latter article indicates that racism is a problem even among the younger generation of South Africa. The lack of respect brought on by racism negatively impacts South Africans' treatment of each other and the same applies in the healthcare context. How nurses treat each other may negatively impact their perceptions of each other and may be contributory factors to challenges frequently reported on in nursing articles and literature, such as bullying (Colduvell 2017:online; American Nurse Today 2016:online) and horisontal violence (Taylor 2016:8). Racism doesn't have a significant impact on the findings of this study as it didn't aim to describe the lived experiences of the participants, such as in the case of a phenomenological study (Polit & Beck 2017:465). It is however still worth mentioning as participants in the focus group meeting did report being ill-treated by their seniors (see Annexure D5). Although the concept "racism" wasn't mentioned, I acknowledge its potential contribution to how nurses treat each other.

Although the implementation of the Person-centered Nurse Residency Programme did not form part of this study, it should be mentioned that racism may also have a direct impact on the implementation of person-centered practices in the clinical environment. Respect for persons is an underlying value of person-centeredness (Zucconi 2016:16; McCormack & McCance 2010:1) and therefore person-centered practice cannot be implemented if racism exists. Although there is no way to directly address or control this aspect, I, together with all the facilitators involved in this study, set an example of person-centeredness by applying the approach and its core values as described in McCormack and McCance (2010:1) throughout the study. This was executed by conducting a beliefs and values clarification before the focus group meeting and workshop commenced (see Section 4.3.3.1, Section 4.4.1.7) and by ensuring that the workshop participants specifically had a good understanding of what person-centeredness means (see Section 4.4.1.7). Person-centered practices were also enforced by applying the ethical principles of self-determination and respect as set out in Section 1.13.2. By role-modelling person-centeredness we hoped to instill these practices and values on some of the participants involved in this study.

The poor educational system and high dropout rates illustrated in the previous section have a significant impact on the potential for increasing the number of healthcare professionals in South Africa. With grade 12 being a minimum requirement for tertiary qualifications, and therefore also entry into nursing schools, the possibility of increasing the intake in nursing schools also remain limited. From the few grade 12 learners that successfully pass their final school year, there are limited numbers that have the potential to complete their tertiary education due to them being pushed through the schooling system without meeting the minimum requirements. These findings emphasise the importance

of providing sufficient support to the NQPNs that are currently in the system in order to retain them for the profession. Limited potential for their replacement with future generations exist if the educational system remains unchanged.

2.4   POLICY CONTEXT

The South African healthcare system consists of the public health sector and the private health sector. The public health sector serviced mainly the black community, was severely underfunded and had inadequately distributed resources during the Apartheid years. The National Health Act, 2003 (Act No 61 of 2003:58) in conjunction with other acts and policies attempted to address the poorly distributed resources by introducing regulatory authorities for different health professions that are responsible for the implementation of remunerated community service (see Section 1.2) and for regulating educational institutions responsible for training healthcare practitioners. Despite attempts to address these issues to bring about better resource distribution, the problem has not been resolved according to McIntyre and Ataguba's (2017:12-14) diagnostic report on access to quality healthcare. South Africa still has a severe shortage of qualified healthcare professionals as evidenced in Section 1.1. Further adding to these challenges, is the reported shortage of public sector beds and the fact that it is still the most used sector by the largest part of the population (McIntyre & Ataguba 2017:11;46). This is confirmed by the reported 71.2% of the South African population making use of public sector healthcare (Statistics South Africa 2017:3).

In the Constitution of South Africa, the Second Amendment Act, No. 3 of 2003, sanctions the provision of quality care by stating that all persons have the right to receive healthcare that is caring, does not inflict harm and is as effective as possible. In addition, hereto, the White Paper on Transforming Public Service Delivery commonly referred to as the Batho Pele White Paper No. 1459 of 1997 was published by the Department of Public Service and Administration of South Africa. The White Paper describes the eight Batho Pele Principles that are aligned with the constitution and act as the policy and legislative framework that guides the way in which public services are delivered. The concept "*Batho Pele*" finds its origins in the Sotho language and can be translated to "*people first*" (Batho Pele White Paper No. 1459 of 1997:[4]). The mission of Batho Pele reads: "*The creation of a people-centred and a people-driven public service that is characterized by equity, quality, timeousness and a strong code of ethics*". The eight Batho Pele Principles consists of the following elements: "*consultation, service standards, access, courtesy, information, openness and transparency, redress and value for money*" (Batho Pele White Paper No. 1459 of 1997:[20]). It encompasses how to act in front of others, acknowledgment of the rights, needs and vulnerability of others and helping others, thereby enabling them to add value to their own lives. The Batho Pele Principles require respect for others' personhood for it to be enforced successfully and it portrays the values preserved in the Bill of Rights (Batho Pele Handbook [n.d.]:25). It ultimately also agrees with the core values of the person-centered approach described in Section 2.8.2.

2.4.1 Impact of the policy context

The already existing critical shortage of nurse practitioners (see Section 1.1), especially those with specialised skills, makes it difficult to develop and implement nurse residency programmes on the same basis as it is done internationally by making use of a multitude of formally appointed staff portraying roles as mentors, preceptors, residency coordinators etc. (see Section 3.5.1). Public healthcare institutions also do not have the financial means to appoint additional formally trained support staff due to vacancies that were frozen in 2018 in the Gauteng province as a result of over expenditure of budgets (Bloom 2018:online). The impact of the shortage of human resources is further exacerbated by the fact that patient care has become more complex and nurses must care for patients with higher acuities, leading to even less time being available to provide support to NQPNs (see Section 1.1).

The above facts resulted in the decision not to develop a Person-centered Nurse Residency Programme that will require an array of support staff such as mentors, preceptors, residency coordinators etc., but to rather use a single support structure, referred to as a "facilitator" (see Section 1.8.4). Hospitals do formally appoint facilitators, or clinical facilitators, as they are generally referred to that are responsible for training and supporting not just NQPNs, but all other nursing staff. Clinical facilitators are not based in hospital wards but work from private offices within the healthcare institution. The number of clinical facilitators is generally limited, depending on the size of the hospital. In order to act in the role of a facilitator, one should be competent (Condrey 2015:468; Kinnair 2015:4; Andrews, Brewer; Buchan, Denne; Hammond; Hardy, Jacobs, McKenzie & West 2010:253) and considered an expert (Kramer *et al.* 2011b:475) in their field. When referring to Benner's *Novice to Expert Theory* (see Section 3.3.1) and looking at what it requires to be considered an "*expert*", one cannot avoid the fact that nurses that fall into this category are limited as many pursue careers internationally. Proof of this is presented in articles such as: "*The real cost of the skills shortage in South Africa health sector*" by Africa Health (2016:online) and "*A cry for help from the nursing sector*" (Becker 2017:online).

The placement of NQPNs in different types of healthcare facilities during remunerated community service as discussed in Section 1.2, might affect the type of needs and challenges experienced by these NQPNs. I, together with the workshop participants, however, still aimed to develop the nurse residency programme in such a way that it can be easily adopted and adapted to suit any type of facility in which it is implemented. Despite the roll-out of the Batho Pele Principles, patient satisfaction levels with public healthcare institutions indicated that the biggest areas of concern were that patients reported being treated with a lack of dignity and respect and that their privacy was not respected during consultations. Staff were also accused of not keeping the information confidential and showing judgemental behaviour towards patients, especially when forming part of patient groups with stigmatised illnesses such as the Human Immunodeficiency Virus**.** Behaviour such as this has been linked to staff having low morale and feeling unmotivated because of "*top-down*" approaches being used when implementing policies that directly affect them, causing them to feel excluded and unempowered (McIntyre & Ataguba 2017:21). A study by James and Miza (2015:8;9) investigated

nurses' perspectives of the Batho Pele Principles where they reported that implementation of the principles in the South African context remains problematic. This view was due to the poor planning that was done prior to the implementation of the Principles, as the lack of resources were not taken into consideration. Additionally, nurse managers were shown to take sides with patients, leaving staff feeling unsupported and were seen to lack leadership skills, thereby negatively impacting on the implementation of the Batho Pele Principles. Doctors were also found to be uninterested in implementing the Batho Pele Principles. The authors suggested that policies should be revised, and new strategies should be developed to encourage ownership and implementation into practice which supports McIntyre and Ataguba's (2017:2) feelings on the negative impact of *"top-down"* approaches. Problems such as these are indicative of a problematic workplace culture (Manley, Solman & Jackson 2013a:146) and motivated me to use a *"bottom-up"* person-centered approach to develop the nurse residency programme.

2.5   PROFESSIONAL CONTEXT

South Africa first started training nurses in 1899 and was the first country in the world to regulate and register its nurses. Numerous programmes have been developed since that time as the needs for quality and safe healthcare increased with the first nursing degree programme being introduced at the University of Pretoria in 1955 (Bezuidenhout, Human & Lekhuleni 2013:3). South African nurses are categorised on three different levels namely professional nurses, enrolled nurses and enrolled nursing assistants. Professional nurses, who are the most qualified, obtain their qualifications over a period of four years in which the SANC requires a minimum of 4000 hours of supervised experience (SANC1985:3). In South Africa, professional nurses can obtain their qualification through different routes and institutions. Firstly, according to Regulation 683 (SANC 1989), enrolled nurses can complete a bridging course at a nursing college where they can obtain a diploma in the discipline of general nursing. Nurses qualifying under Regulation 683 do not have to complete a period of remunerated community service (see Section 1.2). Alternatively, according to Regulation 425 (SANC 1985), a comprehensive training programme where a qualification is obtained in general- community- and psychiatric nursing as well as midwifery, can be completed at either a university to obtain a degree or at a college affiliated with a university, to obtain a diploma.

The DoH has announced major policy- and legislation changes in nursing education that involves a new scope of practice and specifically defined competencies. Public colleges offering nursing were obliged to undergo accreditation with the Higher Education Quality Committee to become higher education institutions, but most institutions were unable to meet the minimum requirements. Those not meeting the minimum requirements were unable to offer nursing since 2016. In addition, hereto, the proposed new curriculum submitted by the SANC was rejected by the Higher Education Quality Committee. As of 2019, the current nursing programmes were supposed to be completely phased out, but there has been a massive delay in the implementation of new legislation and the start of new nursing programmes. With most professional nurses (80%) being trained by public colleges, the new legislation hinders the production of

professional nurses significantly, further intensifying the already existing. Doctor Sue Armstrong from the University of Witwatersrand, in an interview with the *Mail & Guardian* on 13 May 2016, commented on the current status of nursing in South Africa, stating that: "*The country is heading for a disaster*" (Oxford 2016:online).

The researcher's background and experience also form part of the professional context according to Plowright (2011:22). Interpretive description supports this view as it places the researcher within the context and uses his/her epistemological positioning as a motivation for how the research is conducted and the nature of the research products (Thorne 2016:79). I am a former professional nurse holding a Bachelor of Nursing Science degree, with an advanced University diploma in Health Services Management and Health Sciences Education. I completed a year-long course in accident-and-emergency nursing and obtained a Master of Nursing Science degree with a specialisation in medical-surgical nursing. During my basic training, I worked in the public sector for most of the time but being a bursary holder from a private hospital group, I also worked some hours in the private sector. In 2005, at the time of my graduation, I did not take part in remunerated community service as it was not implemented or a requirement then from the Department of Health. Remunerated community service was only implemented in 2008.

I was, however, also a Newly Qualified Professional Nurse just like the current NQPNs in remunerated community service and started working in the Accident and Emergency unit in a private hospital in Pretoria, Gauteng, immediately after graduating. I worked in the corporate arena as a Key Accounts Manager in the medical industry for eight (8) years after leaving nursing but still worked numerous shifts on an overtime basis as a professional nurse at the same hospital and in the same Accident and Emergency unit. The reason being, I believed, that no employment position is permanent, and that future circumstance may lead me back to practising as a full-time professional nurse. Should this happen, I would be prepared and competent to re-enter practice. The long distances travelled as a Key Accounts Manager and my ambition to further myself professionally led me to apply for a position as a National Operational Manager at a nursing agency where I have been working since October 2017. The nursing agency has branches in Gauteng, Limpopo and Cape Town and places temporary nursing staff at various private healthcare institutions as per their requirements. In addition to this leg of the agency, short upskilling programmes for all nurse categories are also offered at the agency. This coincides with my view and passion for investing in the education and upskilling of nurses, especially in current times where a lack of competency reigns high.

2.5.1 Impact of the professional context

Training of professional nurses under different regulations contributes to the difference in levels of competency and preparedness of NQPNs. It was found by Johnston (2009:online) that degree-prepared nurses are more comprehensively trained in physical science, social science, research, leadership and management, community and public health nursing and the humanities which improve professional development and lead to them having a better

understanding of numerous social, cultural, economic and political issues that affect patients and healthcare. Roets, Botma and Grobler (2016:429) further found that degree-prepared nurses are more likely to undertake further studies and therefore stresses the importance of increasing the number of degree-prepared nurses to further develop the field of nursing. The difference in the preparedness of professional nurses has a major impact on the content of the nurse residency programme and emphasises the importance of establishing the needs of NQPNs before developing the nurse residency programme. Although the Person-centered Nurse Residency Programme is developed for NQPNs trained under Regulation 425 that are currently in their remunerated community service year, many other NQPNs under Regulation 683 also join the public health sector upon qualifying. For these nurses, completing the Person-centered Nurse Residency Programme with the community service nurses may also be beneficial as it will assist in levelling the competency among various qualifications, support their transition from student nurse to professional nurse and facilitate their integration into clinical practice.

What motivated my interest in this specific research topic came from two viewpoints: firstly, by reflecting on my own experience of *"reality shock"* and the level of support I received as a NQPN; and secondly, by reflecting on my experience as a senior professional nurse working with NQPNs. This was further exacerbated by the fact that I stepped directly into a high-paced, specialised unit with no prior experience in a normal ward in the role of a professional nurse. The same applies to so many other cases of NQPNs entering their remunerated community service year. Upon reflection, as a NQPN, I was filled with insecurities. When I joined the organisation, there were no formal mentors, preceptors or formal support programmes. The organisation made provision for one Clinical Facilitator to be at the disposal of the entire hospital's staff. New employees were orientated over a two-day period in the hospital boardroom explaining mostly policies around aspects such as ordering blood from the blood bank, activation of the resuscitation team and ordering medication from the pharmacy. The orientation was not ward specific and only consisted of general information. I perceived this new work environment as unfamiliar and unsupportive and had a strong desire to be part of a team that would take the time to induct and teach me what I still lacked in experience. My discernment of the situation led to my reconsidering the career choice I made as well as my chosen specialty. As I slowly started to grow more assertive - around my eighth to twelve months of practice - I eventually started to settle into and better understood the *"way of working"* in the unit. That was when my demeanor changed to that of a more confident team member. My journey led me to deliberate the need for, extent and value of a nurse residency programme, and how much more I could have contributed as a NQPN to my team and ward through an institutionalised transition-to-practice programme.

A second motivating factor was my personal experience as a senior professional nurse working with NQPNs, of which some qualified under R425 and therefore already completed remunerated community service. Some bias may have existed with regard to this as some aspects of their perceived incompetence may have been due to the distinct differences between the public sector, in which remunerated community service is completed, and the private sector,

in which they were now working. Examples include the different names used for medications in the public- and the private sector, or the different ways of executing certain procedures. However, even when eliminating these factors, some fundamental knowledge was still lacking in these nurses. From the perspective of a senior professional nurse, it was evident that they still required support, although they were technically in their second year after graduation. What was also prominent in my time as an NQPN and as a senior professional nurse was the personal attributes of senior professional nurses to which I, and the NQPNs after me, were drawn. Newly Qualified Professional Nurses seemed to choose seniors that were experts in the field and that were approachable and were willing to teach. These practices carried on during my time as a senior professional nurse as many NQPNs and junior nurses verbalised that they preferred working with me as I was approachable and willing to teach, which facilitated learning. This was a direct result of my passion for education.

In my current role as a National Operational Manager I, at times, assist with the routine screening procedures and interviews of nurses wanting to join the nursing agency, many of which are professional nurses that just completed their remunerated community service. During these interviews, competency and critical thinking skills are tested and are found lacking, which proved to me that there is still a need to increase the competence of NQPNs. This is exacerbated by the number of incidents I receive from healthcare institutions in which the agency nurses work, specifically involving recently qualified professional nurses. Most incidents are related to incompetence which leads to negligence and poor-quality care being rendered.

Lastly, my master's degree dissertation was a quantitative study where I made use of an interview schedule with closed-ended questions and one open-ended question that was analysed quantitatively. I was, therefore, a novice to qualitative research design when I started my PhD. For this readon I made use of expert facilitators and co-facilitators to run the focus group meeting (see Section 4.3.3.1) and the workshop (see Section 4.4.1.3). This assisted in ensuring the credibility of the study's findings as the researcher's skills play a significant role therein (Steward 2010:293). Making use of expert facilitation to enhance the quality of the study findings are supported in Thorne (2016:147).

2.6   ORGANISATIONAL CONTEXT

A tertiary hospital in Gauteng was used as a point of entry for this study. Data was collected from across Gauteng, but I worked in close collaboration with the tertiary hospital as the Person-centered Nurse Residency Programme would be developed for the tertiary hospital context. A tertiary hospital, according to the National Health Act, 2003 (Act No 61 of 2003) is defined as a hospital that provides specialist level services, sub-specialties, intensive care services under supervision of a specialist or specialist intensivist, may provide training for healthcare providers, receives referrals from regional hospitals not limited to provincial boundaries and has 400-800 beds.

The tertiary hospital in this study has a bed occupancy of 832 beds, 53 ICU beds, 21 High Care beds, 61 Observation areas and 108 beds in the Oncology Complex. It also has 21 Operating theatres of which 19 are active. Although the tertiary hospital is not a clinical component training hospital for nursing students, it offers practical learning opportunities to various undergraduate health science students and nursing students of the University of Pretoria, Tshwane University of Technology, various nursing colleges in Gauteng province including SG Lourens and for post-graduate nursing students from various universities (The Hospital 2014:online). In a personal conversation between myself and a Clinical Facilitator from the tertiary hospital on April 2016, she stated that each year, sixty (60) to eighty (80) NQPNs are allocated in the hospital to complete their remunerated community service.

2.7   PARADIGM

The research paradigm is explained as the lens through which the researcher sees the world or the set of beliefs that directs the study (Polit & Beck 2017:9; Killiam 2013:5). Four different worldviews are acknowledged by Guba and Lincoln (1994:109) namely positivist, post-positivist, constructivist and the critical paradigm. A fifth paradigm, the participatory paradigm, was subsequently added by Heron and Reason (1997:278). Constructivism underpins qualitative research (Nieuwenhuis 2014:51) and therefore also interpretive description. I considered constructivism as a suitable paradigm as I wanted to explore the needs of NQPNs as perceived by different levels of stakeholders. I constructed meaning from my own perspective and understanding of the data (see Section 4.3.3.2, Section 4.3.3.3) and from the literature that I consulted in Chapter 3. From this, I compiled datasheets for the workshop (see Annexures F6.1, F6.2, F6.3, F6.4) where I collaborated with different levels of stakeholders for participatory data analysis (see Section 4.4). The use of constructivism in interpretive research is supported in St. George (2010:1626) as well as in educational research (Johnson & Onwuegbuzie 2004 as cited in Kalolo 2015:151). A historical overview of constructivism will now be presented.

2.7.1   Historical overview

Constructivism, which is also referred to as naturalism (Polit & Beck 2017:10) or interpretivism (Mack 2010:7) developed from postmodernism. A definite origin of constructivism can't be identified in the literature and therefore I will rather describe it at the hand of its philosophical contributors.

As illustrated in Figure 2.1, constructivism is regarded as an overarching umbrella of its application as a philosophical paradigm and a theory of learning. As a philosophical paradigm, constructivism first was noted in the late 18th century in work by German philosopher, Immanuel Kant (1724-1804) (Duignan & Bird 2018:online). Kant believed that a person mentally constructs knowledge through experience. The experience is then processed, meaning is connected to it and knowledge (reality) is created (Mertens & Wilson 2012:134). Kant had a strong influence on Edmund Husserl's thoughts on phenomenology and Wilhelm Dilthey's thoughts on hermeneutics, which led to the development of the constructivist

paradigm (Mertens 2015:15). Another prominent name in constructivist literature and one that is also linked to the coining of the concept *"constructivist"* (Warrick [n.d.]:4) is Giambattista Vico (1688-1744), an Italian philosopher of cultural history and law (Chaix-Ruy 2018:online). Vico was well known for his slogan "*The human mind can only know what the human mind has*" (Von Glasersfeld 1989 as cited in Warrick [n.d.]:4).

The philosophical paradigm of constructivism was later applied to the educational context as a theory of learning (Lohmeier 2018:384) in which a central focus is placed on active learning and the learner forming understanding by reflecting on personal experience and linking new knowledge to existing knowledge (Bada 2015:66). The fathers of constructivism in the educational context are Russian psychologist Lev Vygotsky (1896-1934) (Encyclopaedia Britannica 2018a:online), American philosopher John Dewey (1859-1952) (Gouinlock 2018:online) and Swiss psychologist, Jean Piaget (1896-1980) (Encyclopaedia Britannica 2018b:online), each of which had a different perspective about how knowledge is constructed.

Vygotsky's theory states that children construct knowledge through social interaction with persons that are more advanced in age and development, such as adults, even before cognitive development takes place. The role that culture plays in cognitive development was also emphasised by Vygotsky. The concept *"scaffolding"* is used in his research to refer to the level of support provided by the adult and how it is adjusted according to the child's abilities. His theory has also been extended and applied to teachers and learners, among others (Psychology Notes HQ 2018:online). Vygotsky influenced Piaget, who refers to knowledge construction as part of two processes namely, *"assimilation"* and *"accommodation"*. "*Assimilation*" refers to the integration of new knowledge together with old knowledge without altering the already existing knowledge. If learners, however, find old knowledge to be incorrect, it can be replaced with new knowledge, which is referred to by Piaget as "*accommodation*" (Bada 2015:67; Kibler 2011:online). Dewey's theory rejects the notion that experience is purely subjective seeing as nature changes constantly and because the human mind forms part of nature. Dewey's contribution to education, therefore, suggests that learning should take place in real-life environments and that learners should be given opportunities to think critically and display their knowledge through collaboration and originality (Gouinlock 2018:online).

2.7.2   Assumptions

The philosophical assumptions of a paradigm direct how the researcher thinks and acts (Mertens 2015:8). Assumptions are defined in Polit and Beck (2017:720) as: *"a principle that is accepted as being true based on logic or reason, without proof"*. I considered constructivism as a research paradigm and integrated its application as a theory of learning in the formulation of my axiological-, ontological-, epistemological- and methodological assumptions.

2.7.2.1   Axiological assumptions

Axiology is referred to as the *"philosophy of values"* and "*ethics*" and involves aspects such as truth, efficacy, righteousness, beauty, right conduct and responsibility (Mertens & Wilson 2012:135; Hiles 2008:52). According to Polit and Beck (2017:10) the paradigm used by the researcher determines if the study is value-laden or not. Constructivist researchers report on the value-laden nature of their study (Chilisa 2012:33) as well as their bias (Christie & Fleischer 2015:33; Chilisa 2012:33) without attempting to control and disregard it (Christie & Fleischer 2015:33). Bias is described in Polit and Beck (2017:161) as an influence that causes a misrepresentation or error and threatens the credibility of the study. Qualitative researchers traditionally use strategies such as triangulation and reflexivity to address bias (Polit & Beck 2017:162;164) and in interpretive description specifically, this is done by stating the researcher's epistemological stance (Thorne 2016:80) (see Section 2.5). These strategies and how I applied it in this study are discussed in-depth and in accordance with the interpretive description approach in Section 4.5.

I acknowledged my bias as part of the impact of the professional context on this study in Section 2.5.1. In constructivism, values are subjective and based on the view of the researcher (Polit & Beck 2017:10; Howell 2013:90) and can therefore, be applied extensively throughout the study (Poni 2014:410). In this study, I held the core values of person-centeredness namely: respect, reciprocity, mutuality and self-determination (Titchen, Cardiff & Biong 2017b:43). I infused my person-centered values throughout the study as described in Section 2.8. However, Bryman (2016:386) warns researchers against applying values in such a manner that it distorts the study outcomes and conduct of the study. To prevent this, and by using a person-centered approach, I gave rise to the subjective values of the participants in the study by conducting a beliefs and values clarification prior to the focus-group meeting (see Section 4.3.3) and the workshop (see Section 4.4.1.7). In doing so, shared beliefs and values could be established, which did not have any negative impact on the outcomes and conduct of the study.

I noted my ethical considerations which I upheld in Section 1.13. The **axiological assumptions** of this study are:

- Mutual respect should exist between all individuals.
- Research should be done while showing respect for the comfort and ethical rights of participants (Thorne 2016:85).
- There is a shared trust and understanding between the researcher and stakeholders.
- Each individual functions autonomously.
- Beliefs and values are subjective.
- The researcher is reflexive and articulates her own beliefs and values of person-centeredness and acts on a moral intent of doing good.

2.7.2.2 Ontological assumptions

Ontology refers to what the nature of reality is (Polit & Beck 2017:10; Scotland 2012:9; Bakker 2010:630; Bourgeault, Dingwall & De Vries 2010:128) and can be either objective, such as in the positivist paradigm or subjective which is the case in the constructivist paradigm (Polit & Beck 2017:11). Constructivists are critical about reality and how the world is interpreted (Howell 2013:91). Reality is context specific (Polit & Beck 2017:11) and constructed mentally and socially by each person through their experiences and by reflecting on those experiences (Adom, Yeboah & Ankrah 2016:2; Motschnig-Pitrik & Rohlíková 2013:45). Reality is therefore "*created*", rather than "*discovered*" (Nieuwenhuis 2014:54). Because each person constructs his own reality and because people change, an absolute truth is impossible to determine (Polit & Beck 2017:10; Howell 2013:88; Mack 2010:8) which classifies constructivist ontology as being "*relative*" (Howell 2013:88). A close relationship between the researcher and the participants enables the researcher to understand how the study participants have constructed their reality (Nieuwenhuis 2014:55).

The **ontological assumptions** for this study are:

- Newly Qualified Professional Nurses face reality shock and go through a transition period during which they need support in order to transition from student nurse to professional nurse and to integrate into clinical practice.
- The needs and challenges of NQPNs as experienced by themselves and as perceived by senior professional nurses, clinical facilitators, managers and educators are mentally and socially constructed and based on their subjective experiences.
- Multiple realities exist and both individual and shared perspectives are equally important.
- Data collected does not reflect an exact representation of the phenomena, but an interpretation thereof as constructed by the researcher and the participants.
- The needs of NQPNs, senior professional nurses, clinical facilitators, managers and educators in South Africa are context specific and thus require a context-specific, Person-centered Nurse Residency Programme.
- The researcher and participants flourished during and after completion of the study.

2.7.2.3 Epistemological assumptions

Epistemological assumptions refer to what can be regarded as valid knowledge (Holloway & Wheeler 2010:21) and determine how knowledge is obtained (Nieuwenhuis 2014:55). Qualitative research has epistemological roots in phenomenology (Fouché & Delport 2011:66) whereas Howell (2013:88) states that epistemology in constructivism is much the same as critical theory, except for the fact that study results are created by means of constructions of both the participant and the researcher. Knowledge is gained by empowering participants, giving them a democratic voice and allowing them to take on an active part in the study throughout all the phases (De Vos, Strydom, Fouché & Delport 2011:7;8; Glicken 2003:31 as cited in De Vos *et al.* 2011:8) which is in line with the person-centered approach used in this study. The participants were, however, not involved in determining the theme of the research, the formulation of

the research questions and development of the research protocol, which does not completely conform to the rules of the person-centered approach, but could participate in an autonomous way in the development of the Person-centered Nurse Residency Programme and co-constructing of competencies of facilitators.

The **epistemological assumptions** for this study are:

- The voice of the NQPNs, senior professional nurses, clinical facilitators, managers and educators in the person-centered approach is essential in obtaining knowledge on their needs for a Person-centered Nurse Residency Programme.

- Newly Qualified Professional Nurses build knowledge and competency over a period as they gain experience.

- Knowledge is constructed through experience and reflection.

- Newly Qualified Professional Nurses require support from competent, expert facilitators to facilitate knowledge development to become competent professional nurses as well as to facilitate their integration into clinical practice.

- The competencies of the facilitator need to be in line with the needs of the NQPNs, senior professional nurses, clinical facilitators, managers and educators.

- By supporting NQPNs in a person-centered nurse way, they adopt a person-centered approach to their own practice that leads to the rendering of quality person-centered care and the creation of a positive workplace culture.

- Learning is reciprocal, NQPNs learn from their facilitators and facilitators learn from NQPNs.

- Developing a Person-centered Nurse Residency Programme and co-constructing competencies of facilitators is a collaborative approach between the researcher and the participants where decision-making is shared.

- The interpretive description approach is grounded in the epistemological beliefs of the nursing discipline, keeps to the methodical reasoning of the nursing discipline and creates valid knowledge for its practice (Thorne 1997:172).

2.7.2.4   Methodological assumptions

Methodological assumptions establish how knowledge should be obtained (Polit & Beck 2017:10). Data collection in constructivism can make use of any type of methodology according to Scotland (2012:9), Creswell (2011:269;272) and Mastin (2008:[1]) but the methods chosen are generally affiliated with a qualitative research design (Polit & Beck 2017:10; Adom *et al.* 2016:5). In this study, data was collected using a multi-method approach by means of a focus group meeting (see Section 4.3.3.1) and two self- administered qualitative open-ended questionnaires (see Section 4.3.3.2, Section 4.3.3.3, Annexures C4, E1) with different levels of stakeholders. According to Polit and Beck (2010:10) constructivism is generally related to inductive processes, has a holistic focus on the phenomenon and makes use of small samples. In this study, I made use of both an inductive- and deductive approach in Phase 2 for participatory data analysis (see Section 4.4.1.7). Interpretive description was used to formulate, plan and implement the study to reach the specific aim and objectives.

The **methodological assumptions** for this study are:

- The study, being a qualitative study, was flexible and emergent in design.

- An inductive- and a deductive approach was used during participatory data analysis as a means to facilitate the development of the Person-centered Nurse Residency Programme and the co-construction of competencies of facilitators within a person-centered framework.

- A person-centered approach was infused during all phases of the study by giving stakeholders the opportunity to have their voices heard and to actively collaborate, be included and participate in the study.

- A "*bottom-up*" approach was used to ensure participant buy-in which may facilitate successful implementation of the Person-centered Nurse Residency Programme in future.

2.7.3   Critique of constructivism

Advantages of constructivism are discussed in the literature as it pertains to the qualitative research design, with which it is associated. Strengths of constructivism lie in the richness of the data obtained according to Nieuwenhuis (2014:60) and the consideration that is given to the context and complexity (Ochieng 2009:16). The multiple realities that exist are at the same time also an advantage (Chilisa 2012:33) as it regards the realities from different cultures as real, which is not the case in the view of the positivist paradigm where reality is external. The close interactive relationship between the researcher and participants is beneficial, which allows the researcher a better understanding of what their "*reality*" is (Robottom & Hart 1993 as cited in Baxter & Jack 2008:545).

Critique in the use of constructivism lies mainly in its use of humans as a source of obtaining information (Polit & Beck 2017:12). The authors argue that although humans are intelligent beings, they are fallible. Furthermore, what seems to be a strong critique as it is mentioned in Polit and Beck (2017:10), Nieuwenhuis (2014:60), Howell (2013:88) and Mack (2010:8) is the use of the subjective reality of multiple persons as it causes finding an "*ultimate truth*" to be impossible. The fact that researchers do not make use of scientific procedures to verify data and the inability to generalise the findings is also problematic according to Polit and Beck (2017:12), Nieuwenhuis (2014:60) and Mack (2010:8). However, Mack (2010:8) argues that the goal of constructivism is not to generalise findings, but rather to develop local theories for practice. In a dialogue between Moss, Phillips, Erickson, Floden, Lather and Schneider (2009:504), Erickson argues that quality in a study is determined by its technical execution, meaning that the researcher spent a large amount of time in the field, data was obtained through thorough sifting of data resources, data was analysed repeatedly to identify patterns, thorough reporting on the flow of the research was done and conclusions were drawn from the findings. Secondly, the study is also viewed as valid if the researcher highlights important issues pertaining to a phenomenon and not necessarily attempts to prove anything. In Floden's opinion, quality lies in clearly defining central concepts involved with articulating the aim of the study, which I have done in Section 1.8 and conclusions (see Section 7.3) as well as the fact that the study should address a policy- and practice issue (see Section

1.2, Section 1.3, Section 2.4) and the evidence of good reasoning from previous literature (see Chapter 1 and Chapter 3). Another critique by Mack (2010:9) is that constructivism tends to neglect the political and ideological influence on knowledge and reality and that researchers are not very thorough in their approach to research. I have discussed the political influence on knowledge generation in Section 2.3. Problems pertaining to the participants are the mere fact that the sample size is small (Polit & Beck 2017:12) and that the likelihood exists that many study participants may discontinue their involvement in the study, which negatively affects the outcomes of the study, or that participants may "*take over*" the study, leading to it being a time-consuming process (De Vos *et al.* 2011:8). To address this, I deliberately tried to increase the sample size by combining different methods to collect more data (see Section 4.3.3).

2.8   PERSON-CENTERED APPROACH

I infused the person-centered approach in two ways throughout this study. Firstly, as it reflects my personal beliefs and values of respect for others, it guided me in my way of working with stakeholders. Secondly, as person-centeredness is an underpinning value of practice development (Shaw 2013:78), I considered it appropriate to adopt some of the elements of practice development as described in Manley et al. (2013b:58-62) and apply it in this study. One such element is the use of the CIP principles in the methodology. The use of the CIP principles is evident during data collection where stakeholders with different levels of expertise' voices were *included* when conducting the needs assessment (see Section 4.3.2) and during data analysis where stakeholders, also with different levels of expertise, were given the opportunity to *collaborate* with me and other stakeholders, and *participate* in the development of the nurse residency programme and the co-constructing of competencies of facilitators (see Section 4.4). Using the CIP principles created a shared vision (Manley *et al.* 2013b:59) for effectively supporting NQPNs in remunerated community service among stakeholders through the development of a Person-centered Nurse Residency Programme, as well as a shared vision on the competencies required of facilitators to effectively provide support and implement the nurse residency programme.

2.8.1   Historical overview

American psychotherapist, Dr. Carl Rogers (1902-1987), together with Abraham Maslow, founded the humanistic approach to psychology, which was first referred to as non-directive therapy and later known as client-centered or person-centered therapy (New World Encyclopedia 2017:online; Kirschenbaum [n.d.]:online). Rogers started his career as a child psychologist. During his time in practice, he discovered that the use of extensive technical theories on children was impracticable. He realised that there was a need for therapy that was effective and that met the child's needs. Rogers believed the child "*knows his own way*" through therapy and that the child should determine the direction the therapy should take. The same theory proved to be true for adults later in Rogers' career (Thorne & Sanders 2012:8-10).

Due to the focus largely being on the client's experience, the use of the concept "*client-centered*" started from here-on. The central hypothesis of client-centered therapy, therefore, is that the client can recognise the source of his own discomfort and has the control to bring about changes to enhance his state of comfort. The client is recognised as the expert of his own life, which replaced the traditional belief of the psychotherapist being the expert. The role of the therapist in patient-centered therapy is only to create a facilitative atmosphere to support the patient to bring about the changes that are required (Kirschenbaum [n.d.]:online). Rogers stressed the importance of the attitude required by the therapist to facilitate successful therapy and referred to this as the core conditions of therapy. The core conditions include: accepting clients entirely for who they are (referred to as "*unconditional positive regard*"); attempting to view things from the clients' frame of reference, (referred to as "*empathy*") and realness (referred to as "*congruence")* in their relationship (The Health Foundation 2014:14; Kunze 2013:115; Miller 2012:6; Kirschenbaum [n.d.]:online).

The client-centered approach was later applied to all human relationships and other disciplines including group work, conflict management, social work, healthcare (see Section 2.8.2), the business environment (Stirk & Sanderson 2012) and education (see Section 2.8.3). These applications led to the concept being changed from a "*client-centered*" approach to a "*person-centered*" approach (Zucconi 2016:14; Kunze 2013:115; Kirschenbaum [n.d.]:online). Carl Rogers' biographer, Howard Kirschenbaum, defined person-centeredness as: *"primarily a way of being which finds its expression in attitudes and behaviour that create a growth promoting climate. It is a basic philosophy rather than a technique or method. When this philosophy is lived, it helps the person to expand the development of his own capacities. When it is lived, it also stimulates others. It empowers the individual, and when this personal power is sensed, experiences show that it tends to be used for personal and social transformation"* (Kirschenbaum & Henderson 1989:137).

Rogers' philosophy, as well as those of Paul Tournier (1999), a psychologist from Switzerland and Martin Buber (1984), a German-Jewish religious philosopher (McCormack & McCance 2017:17; Simon [n.d.]: online) influenced the work of Professor Tom Kitwood (1937-1998), a psycho-gerontologist and psychology lecturer from Boston (McCormack & McCance 2017:17; Fox 1999:online), and second prominent figure in the history of person-centeredness. Kitwood's view of person-centeredness was based on its central concept, the "*person",* defining personhood as "*a standing or status that is bestowed upon one human being, in the context of relationship and social being. It implies recognition, respect and trust"* (Kitwood 1997:8 as cited in McCormack & McCance 2017:17*).* Kitwood's definition formed part of what was used by McCormack (2004) as cited in McCormack and McCance (2017:17) as a starting point for the four core "*modes of being*" fundamental to person-centeredness. The modes of being include: "*being in relation"*, which focuses on relationships and the development thereof through interpersonal processes, "*being in a social context",* which is a story about what people feel is important to them in their social context, "*being in place"*, which refers to the impact the physical environment has on a person and how they are emotionally connected thereto and lastly, "*being*

with self", which fosters the need to be recognised as a person. When someone feels recognised, the person bringing recognition is respected, relationships are built, and personhood is then laid open (McCormack & McCance 2017:17-19).

The person-centered approach is discussed shortly pertaining to the healthcare environment as it serves as an introduction to the underpinning theoretical framework used in this study, the Person-centered Practice Framework (see Section 2.9.1). This is followed by a discussion on person-centered education and how it has been applied in the development of curriculums.

2.8.2 Person-centered practice in healthcare

Person-centered practice has been mostly correlated to the discipline of nursing (McCormack & McCance 2017:1) and can be dated back to Florence Nightingale, where she differentiated medicine from nursing, by making the patient the focal point of treatment rather than the disease itself (Lauver et al. 2002 as cited in Morgan & Yoder 2012:7). Nightingale's portrayal of the patient at the heart of care was unmistakable in the emphasis she placed on the environment and its influence on the recovery of the patient (Thomas 2016:online; Nay & Garrat 2009:110). Person-centeredness has been applied widely in the geriatric context when referring to the original definition by McCormack, Manley and Titchen (2013:9), but since the approach has been adopted by other healthcare professions, the definition has also evolved. Person-centeredness was defined in Section 1.8.7.

2.8.2.1 Understanding the concepts

Person-centered practice in the healthcare environment is known by many names such as "*person-centered care*" (Zhao, Gao, Wang, Liu & Hao 2016:398; Lines, Lepore & Wiener 2015:561) "*patient-centered care*" (Zhao *et al.* 2016:398; Lines *et al.* 2015:561; McCormack, McCance & Maben 2013b:192; Starfield 2011:63), "*client-centered care*", "*individualised care*" (McCormack 2013b:192) "*person-focused care*" (Starfield 2011:63) and "*person directed-care*" (Lines *et al.* 2015:561) that, at times, are used interchangeably (McCormack 2013b:192). There are different views regarding the use of these concepts as synonyms. The Royal College of General Practitioners (2014:10) argues that the concept "*patient"* refers to the traditional clinician-patient relationship and that it is therefore more appropriate to use the concept *"person"*. Another argument advocating for the replacement of the concept "*patient-centered care"* with the concept "*person-centered care*" is to emphasise the fact that the patient/client is being treated holistically (The American Geriatrics Society Expert Panel on Person-Centered Care 2016:15; Zhao *et al.* 2016:401; Kirschenbaum 2015:[3]). Based on the difference between the meaning of the concept "*patient*" and "*person*" as described above, many authors agree that the concepts cannot be used as synonyms (The American Geriatrics Society Expert Panel on Person-Centered Care 2016:15; Zhao *et al.* 2016:401; Kirschenbaum 2015:[3]; Lines *et al.* 2015:561; Starfield 2011:63). Another concept prevalent in literature is that of *"people-centered care"* that is used in the WHO's Policy

Framework for People-Centered Care (2007). The concept, "*people-centered care*" refers to the importance of empowering people to be healthier and to protect their health, preventing them from becoming patients. The concept "*people-centered care*" does not just focus on patients, but also considers the needs of healthcare practitioners and healthcare institutions, empowering them to transform the healthcare system for the better (WHO 2007:5). The WHO (2007:7) states that: *"The overall vision for people-centred health is one in which individuals, families and communities are served by and are able to participate in trusted health systems that respond to their needs in humane and holistic ways..."*

I agree with many of the arguments led by the above authors including that the patient/client should be treated holistically, that the traditional clinician-patient relationship should be done away with as well as with the WHO's view where the needs of all persons need to be considered in healthcare. As far as referring to a patient as a client – it may fit in better with the person-centered approach according to some authors, but as the concept "*patient*" is such a generally used concept throughout the healthcare context and in all disciplines, this will require a lot of practice and dedication to change. I will therefore still refer to the concept "*patient*" as it is the generally used concept in practice. Due to the multiple views on the definition of person-centered care and interchangeable use of concepts in literature, I chose to use the single concept "*person-centered*" and regarded all concepts as synonymous when the literature review was conducted (Chapter 3). The concept "*person-centered*" is furthermore the concept used in the underpinning theoretical framework for this study by McCormack and McCance (2017:42), the Person-centered Practice Framework (see Figure 2.1).

2.8.2.2   Implementing person-centered care

Person-centered care has become a philosophy of healthcare systems where people are placed at the centre of the care process (McCormack & McCance 2017:1). It is an important element in redesigning the healthcare system through its direct connotation with the rendering of quality care (Institute for Healthcare Improvement [n.d.]:online; HIN [n.d.]:[2]). The evidence of its importance and proven effectiveness is evident in the various government- and healthcare organisations advocating for the implementation thereof (Australian Commission on Safety and Quality in Health Care 2011; National Health Service 2005; US Department of Health & Human Services 2008, WHO 2007; National Research Corporation Picker, 2008; Picker Institute 2004; Batho Pele White Paper No. 1459 of 1997:[20]). Because person-centered care is synonymous with quality care, it has been incorporated into nursing curricula worldwide (McCormack & McCance 2017:5-7) as well as into the curriculua of accredited international nurse residency programmes (see Section 3.5.1).

Just as the complex healthcare environment with its challenges influences the preparedness of NQPNs (see Section 1.1), it also influences the ability of healthcare practitioners to render person-centered care (Mareš 2017:2; Wolf

2012:41; Manley & McCormack 2008:12). When patients are admitted to hospitals, their values and needs are often disregarded as they form part of stringent hospital routines and protocols that are implemented with the purpose of improving patient care, but are at the same time inhibiting it (Royal College of General Practitioners 2014:19). According to Ekman, Swedberg, Taft, Lindseth, Norberg, Brink, Carlsson, Dahlin-Ivanoff, Johansson, Kjellgren, Lindén, Öhlén, Olsson, Rosén, Rydmark and Stibrant Sunerhagen (2011:250), healthcare practitioners have started applying person-centered approaches to their care practices, but they do not apply it consistently and systematically, which leads them to fall back into non-person-centered ways of working.

Different Frameworks have been developed by organisations and experts to guide healthcare practitioners in the implementation of person-centered care. Examples of these Frameworks include:

- *Person-centered Care Framework:* developed by two organisations in the United Kingdom, Skills for Health and Skills for Care, that each focusses on the development of the healthcare workforce, in collaboration with Health Education England, an organisation dedicated to the delivery of high-quality education to healthcare professionals (Skills for Health 2017:online; Health Education England [n.d.]:online; Skills for Care [n.d.]:online).
- *Conceptual Framework on Person-centered Care Implementation* developed by Santana, Manalili, Jolley, Zelinsky, Quan and Lu (2017:3) that used evidence from existing frameworks to develop a step-by-step guide for healthcare systems to implement person-centered care in practice.
- *Person-Centered Nursing Framework* developed by McCormack and McCance (2010) as cited in McCormack Manley and Titchen (2013a:10) that focusses on the delivery of person-centered care by the nursing workforce. This further developed into the…
- *...Person-centered Practice Framework* (McCormack & McCance 2017:42) which includes all healthcare practitioners and not just the nursing workforce.

2.8.2.3   Critique of person-centered care

Nolan, Davies, Brown, Keady & Nolan (2003:48:52) present a critical review of person-centered care in the elderly and motivated that the person-centered approach is too individualistic and that a relationship-centered approach to care is preferred. Relationship-centered care is based on the importance of interaction between the family, the patient, healthcare practitioners and the community exchanging information, concerns and emotions required to understand the illness. Nolan et al. (2003) may not view person-centeredness as the inclusion of others in the patient's care, but this is contradictory to the definition of person-centeredness provided by McCormack and McCance (2017:20) presented in Section 2.8 which does recognise these relationships.

A literature review by El-Alti, Sandman and Munthe (2019:56) was conducted to establish the difference and possible unison of the person-centered approach to care and personalised medicine. The authors found that both concepts are

threatened by reductionism and that they may have to be used in combination with each other in order to render holistic care. The authors also suggested that further investigation is warranted into if person-centeredness can really be considered as "*personalisation of care*". The review acknowledged the different sources of the two concepts with person-centeredness originating in the care context, and personalised medicine originating in the biomedicine context. I argue that person-centered care can stand alone, as biomedicine focusses on biology and physiology, whereas nursing sees the client as a holistic being, acknowledging it biological and physiological components but also acknowledging the spiritual component as Nightingale noted (Dossey 2010:221).

2.8.3   Person-centered practice in education

Carl Rogers believed the application of the person-centered approach in education should bring about the same results as using the person-centered approach in psychology, which ultimately led to learners being capable to educate themselves with no direct instruction from an educator (Snowman & McCown 2011:465). This led to a paradigm shift in adult learning from traditional pedagogy (teacher-directed) to andragogy (student-directed) (Zucconi 2016:12:18; Kunze 2013:117; Attard *et al*. 2010:2), which focusses on learning rather than teaching and on solutions rather than problems (Zucconi 2016:15). Like the core conditions of person-centered psychotherapy (see Section 2.8.1), Rogers identified three core conditions for the person-centered educator that facilitates person-centered education. This involved: "*realness and capacity of contact in the facilitator of learning*", which is the ability of the educator to be honest and real with the learner, share experiences and feelings, not to put on an act and to be in touch with himself/herself and others; a "*non-judgmental attitude*" that accepts, respects and trusts learners, shows real interest, care, acceptance and appreciation and listens to opinions; and "*empathetic understanding*", which is the ability to understand personal experience, feelings, thoughts and behaviours and to communicate this understanding in a clear, simple and direct manner that leads to creating a climate of facilitation in the learning environment (Zucconi 2016:15).

Rogers (1951) had five hypotheses with regard to person-centered education. Each is presented together with an accompanying practical explanation, also showing its relevance to the constructivist learning theory.

- "*A person cannot teach another person directly; a person can only facilitate another's learning*".
  The individual exists in a world that is constantly changing in which he/she is the center. Experience is gained from this and their reaction to the changing world is based thereon as well as their perception thereof and this determines how and what is learned.
- "*A person learns significantly only those things that are perceived as being involved in the maintenance of or enhancement of the structure of self*".
  This hypothesis states that content should be relevant for learning to take place and emphasises the importance of conducting a needs assessment (see Section 4.3).

- *"Experience which, if assimilated, would involve a change in the organization of self, tends to be resisted through denial or distortion of symbolism".*

  What is taught in theory and what the learner experiences in practice may not agree, which refers to the well-known theory-practice gap. For learning to take place the learner should be open-minded. Course content should be relevant to current circumstances in practice.

- *"The structure and organization of self-appear to become more rigid under threats and to relax its boundaries when completely free from threat".*

  An open, friendly learning environment where learners are comfortable to discuss their experiences and beliefs should be encouraged. This is especially relevant to learners holding a different understanding or different beliefs than others. Learners should not feel threatened by new information. If vulnerability is kept to a minimum, learning takes place.

- *"The educational situation which most effectively promotes significant learning is one in which: (a) threat to the self of the learner is reduced to a minimum and; (b) differentiated perception of the field is facilitated".* The educator should be willing to learn from the learners and attempt to connect the learners with the learning content through close interaction. The educator should fulfil the role of a facilitator instead of the expert who gives instructions (as cited in Zucconi 2016:16; Kirschenbaum [n.d.]:online; Smith 2012:[5]).

2.8.3.1   Understanding the concepts

The use of the person-centered approach in the context of education is referred to as person-centered education and is used interchangeably with concepts such as, "*learner-centered approach*" (Schreurs & Dumbraveanu 2014:[1]); "*person-centered learning*" or "*student-centered learning*" (Zucconi 2016:14; Zucconi 2015:60; Attard *et al.* 2010:2). I will from here on make use of the concept "*person-centered education*" as it is the concept originally used by Rogers and "*learner*" as the NQPNs is not a student in the traditional context, but an adult learner of the professional nurse role.

2.8.3.2   Implementing person-centered education

There are certain key elements required to implement person-centered education. These include a shift from passive learning to active learning, highlighting deep learning and understanding and learners taking responsibility and being accountable for learning. Active learning and the concept of person-centered education is synonymous with each other. All key elements are also linked directly to the use of active learning as a teaching strategy. Key elements of person-centered education and person-centered learning environments are illustrated in Figure 2.2.
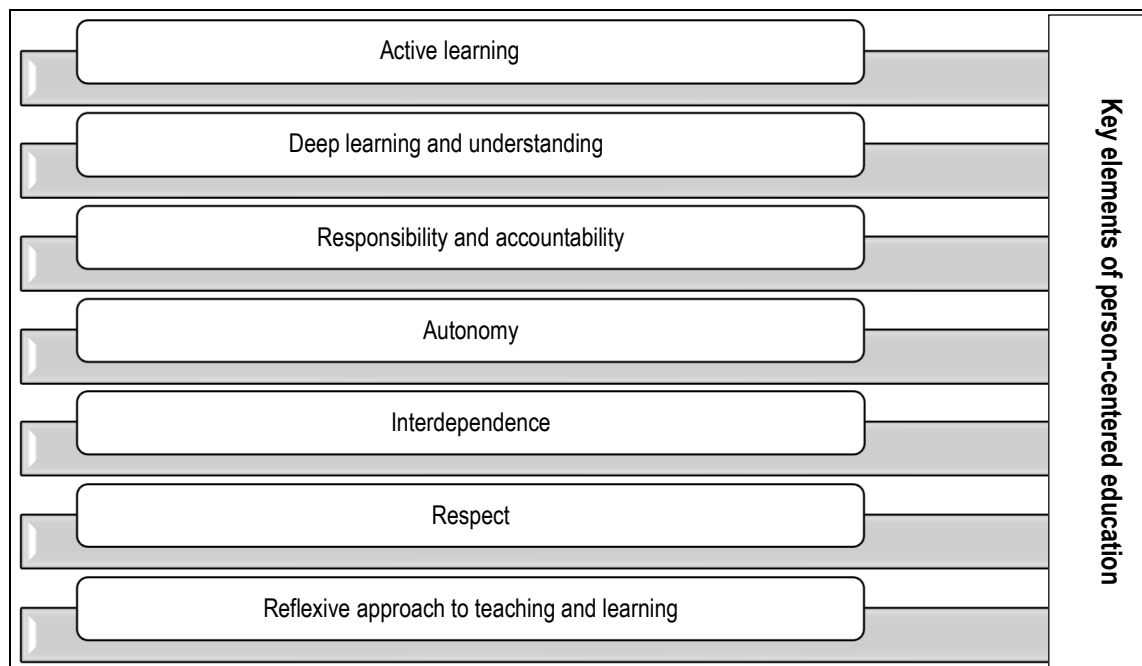
Figure 2.2: Key elements of person-centered education *Source: Adopted from Zucconi (2016:12); Disch (2012:340); Lea et al. (2003) as cited in Attard, Di Iorio, Geen & Santa (2010:2)*

Figure 2.2 illustrates the key elements of person-centered education and person-centered learning environments. Each key element is discussed shortly. For staff to flourish in the workplace, active learning is essential (Dewing 2008 as cited in McCormack *et al*. 2013b:196) and staff need to be given the opportunity to think and act creatively (McCormack et al. 2013b:196). The Center for Teaching and Learning at the University of Washington (2018:online) and the Center for Educational Innovation at the University of Minnesota (2018:online) describes active learning as different to the traditional educational approach, by letting the learner actively engage in the learning process. Dewing (2010:22) described active learning as: "*anything that involves a learner in doing things and thinking about the things they are doing*". Popular methods used to enable active learning include problem-based learning, role-playing, group work, case studies, discussions, (Attard et al. 2010:32) experiential learning (Attard et al. 2010:32; McCormack, Dewing, Breslin, Coyne-Nevin, Kennedy, Manning, Peelo-Kilroe & Tobin 2009:95), critical reflection, sharing experiences through dialogue, enabling facilitation and enabling action (McCormack *et al*. 2009:95). The use of activities such as these as an approach to learning is based on the constructivist learning theory which puts learners in charge of constructing their own knowledge (Polit & Beck 2017:10; Winterbottom 2015:[1]).

When explained in the context of practice development, Dewing (2010:23) states that active learning is more orientated towards feelings, it is creative and flexible and emphasises communication and social processes. Dewing further argues that active learning should not just form part of practice development, but also professional development in

order to take full advantage of learning in the workplace, which makes it an essential strategy to use in the transition of the NQPN from student nurse to professional nurse and to facilitate his/her integration into clinical practice. A deep approach to learning and understanding results from active learning and is characterised by the learners' intent to understand what they are learning. Previous knowledge is essentially replaced with a reconstruction of new knowledge that generates a deeper understanding and learners then develop the ability to apply critical thinking skills in different real-life contexts (Hoidn 2016:4; Winterbottom 2015:[1]; Brantmeier & Lawrence 2013:3; Attard *et al*. 2010:2). Deep learning cannot take place without a positive learning environment that facilitates learning (Winterbottom 2015:[1]). Facilitators and learners both have the responsibility of creating a person-centered learning environment filled with communal empathy, trust, respect and congruence (Zucconi 2106:12;16; Zucconi 2015:61). Learners are further expected to take responsibility and to be accountable for setting their own goals, their own professional development as well as their own skills development in various realms (Zucconi 2016:16; Zucconi 2015:61). All of the above aspects generate a sense of autonomy among learners (Winterbottom 2015:[2]) which essentially refers to them having the right to decide what they would like to learn, when they would like to learn it and how they would like to learn it (Boyadzhieva 2016:36). Lastly, person-centered education results in an interdependence between the facilitator and learner where both parties learn from each other, mutual respect exists between them and both the facilitator and learner can reflect on teaching and learning activities, allowing for changes to be made to better facilitate learning (Attard *et al.* 2010:2).

2.8.3.3   The educator as a facilitator of learning

The relationship between the educator and learner is essential in active learning and although the learner is more independent in the learning process, there is still a dependence on the educator to fulfil the role as the facilitator of learning, acting as an expert and providing support through scaffolding and feedback (Lee & Hannafin 2016:710; Vygotsky 1978 as cited in Lee & Hannafin 2016:719; Winterbottom 2015:[1]).

Educators need to be knowledgeable about how to follow a person-centered approach and should be motivated to teach in such a way (Zucconi 2016:13). The educator should show dedication and motivation to his/her role in the facilitation of learning and believe and apply democratic education that is based on values. The educator should be able to share the authority of making decisions with the learner, have the required skills and attitude to be a person-centered educator that encourages ingenuity and autonomy and be able to facilitate learners in building their personal- and social skills (Zucconi 2016:16; Zucconi 2015:60). When person-centered education is implemented, characteristics of the learner should be considered, which includes different styles of learning, different needs and interests and different backgrounds and experiences (Attard *et al.* 2010:3). This results in the personalisation of learning (Bhatti & Ahmed 2015:S12; Parsons & Beauchamp 2012:9). The use of the concept "*facilitator of learning*" instead of "*educator*" is supported in Sahu (2013:online) and Giri (2011:online) and is the term used in Rogers' (1951) five hypotheses with

regard to person-centered education (see Section 2.8.3). "*Facilitator*" is therefore the concept I chose to use in this study.

2.8.3.4   Advantages of person-centered education

Knowledge gained through person-centered education is comprehensive, develops the learner's personality and influences future actions. When compared to traditional education, it is seen as equally important for lifelong learning (Kunze 2013:115). Advantages of person-centered education include learners creating a more positive attitude towards learning (Disch 2012:340), enhanced critical thinking skills, better problem-solving skills and better class attendance (Disch 2012:340; Cornelius-White & Harbaugh 2010 as cited in Zucconi 2016:17). Other advantages include easier attainment of educational goals, increased learner satisfaction and self-esteem, better interpersonal relationships and increased learner retention (Cornelius-White & Harbaugh 2010 as cited in Zucconi 2016:17).

2.8.3.5   Critique of person-centered education

Critique on Rogers' work on person-centered education includes the risk that the educator may focus too much on the person-centred approach, disregarding the importance of interaction (Lee & Hannafin 2016:713; Smith 2012:[8]), which is imperative to the constructivist approach (Polit & Beck 2017:10). According to Smith (2012:[8]), when interaction is disregarded it leads to individualism, which implies that the focus shifts from a two-way relationship between the learner and the educator to a one-sided relationship. This can be addressed by ensuring that the facilitator is trained in the correct use of the person-centered approach to education and understands the importance of interaction and communication.

Another critique by Smith (2012:[6]) is that person-centered approaches may not acknowledge that "*traditional teaching*", still has a place and is a valuable form of education. The Cambridge Centre for Sixth-form Studies (2017:online) advocates for the combination of traditional methods with active learning approaches, which they refer to as "*spaced learning*". This approach acknowledges that traditional methods do have a place in the educational context but must be used correctly and appropriate to the situation in order to achieve the best outcomes. I agree with Smith's view that there is room for traditional teaching. This is highly dependent on the learner's background knowledge of the subject/discipline that is being taught as there should still be a form of foundational knowledge provided by the educator/facilitator of learning, before the learner can be expected to resume learning on his/her own. Again, the training of the facilitator is crucial to ensure that he/she understands when which methods should be used.

2.9   THEORETICAL FRAMEWORK

Qualitative research is traditionally affiliated with the use of conceptual frameworks, rather than theoretical frameworks. However, according to the view of Munhall and Chenail (2008) as cited in Grant and Osanloo (2014:21), qualitative researchers make use of theoretical frameworks that underpin their studies to develop their own theory during the data analysis phase. Although the developing theory was not the aim of this study, interpretive description acknowledges the existence of priori theory that assists in understanding a phenomenon (Thorne 2016:85). The Person-centered Practice Framework (see Figure 2.3) was chosen as the underpinning theoretical framework in this study as its validity has been tested extensively through implementation into practice and through research as reported in McCance and McCormack (2017:41). A discussion on the Person-centered Practice Framework is presented in the next section with a short description of its implementation in the healthcare setting.

2.9.1   The Person-centered Practice Framework

The Person-centered Practice Framework originated from the Person-centered Nursing Framework - a mid-range theory that was developed by McCormack and McCance (2006), which was developed further in 2010. The Person-centered Nursing Framework was originally based on McCormacks' (2003) conceptual framework focusing on person-centered care of geriatric patients and McCances' (2003) framework focusing on the patient and nurse's experience of caring in nursing (McCance & McCormack 2017:37). The Person-centered Nursing Framework reflects the standards of care with consideration for morals and therapeutic goals shown through effective interpersonal relationships (McCance & McCormack 2017:41). The Framework was later made relevant to other areas of nursing including nursing education (McCormack & McCance 2017:7) and leadership, with the development of the Person-Centred Situational Leadership Framework by Lynch, McCance, McCormack and Brown (2018:427).

The Person-centered Practice Framework guides the healthcare practitioner in working with the patient's beliefs and values, authentically engaging with a patient, being sympathetically present, sharing decision-making and providing holistic care (McCance & McCormack 2017:39). The Person-centered Practice Framework consists of four domains: "*prerequisites", "care environment", "person-centered processes"* and *"person-centered outcomes"*, each with their underlying constructs (McCance & McCormack 2017:42) (see Figure 2.3).
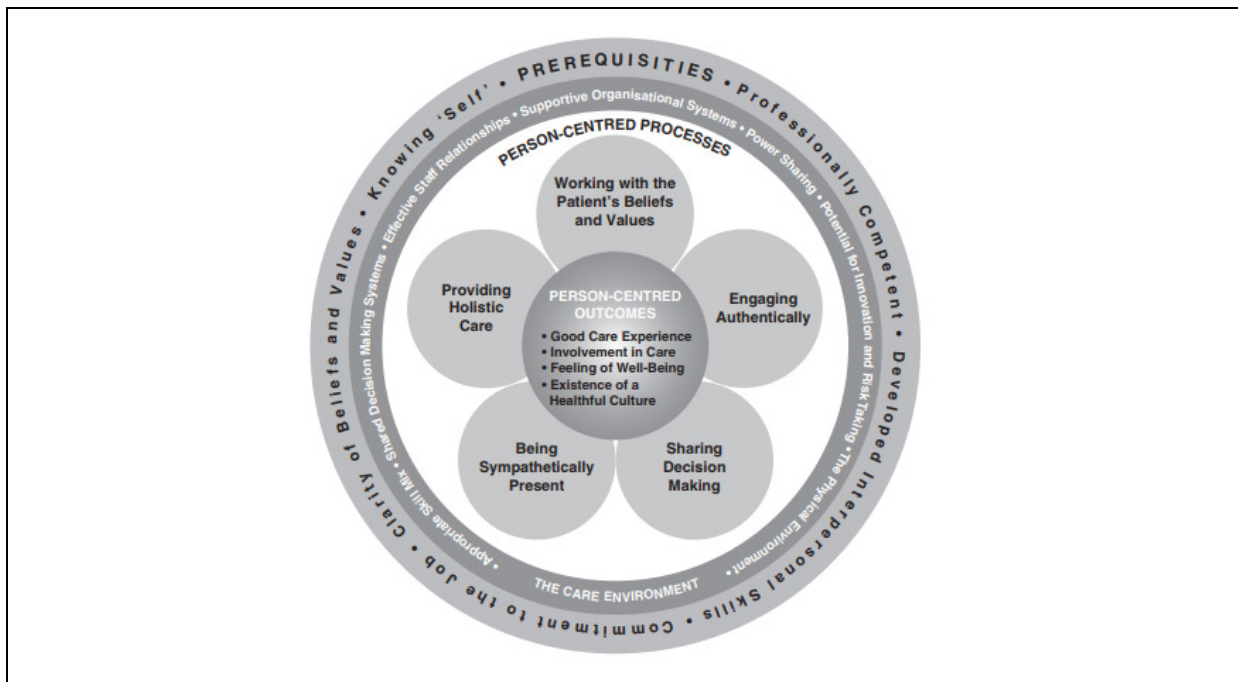
Figure 2.3: Person-centered Practice Framework *Source: Adopted from McCormack and McCance (2017:39)*

Figure 2.3 illustrates the Person-centered Practice Framework with its four relational domains: *"prerequisites", "care environment", "person-centered processes"* and *"person-centered outcomes"*. The framework suggests that positive outcomes for patients and staff require that responsibility must be taken for the prerequisites and care environment, which are essential for rendering effective care through person-centered processes (Lynch *et al.* 2018:427). The four domains are discussed shortly along with the related constructs of each.

2.9.1.1 Prerequisites

Prerequisites refer to the attributes that the healthcare practitioner should have to enable him/her to render person-centered care. Prerequisites therefore include having the required professional competence that takes a holistic approach with regard to the knowledge, skills and attitude needed, developed interpersonal skills that build positive relationships, showing commitment to the job through intentional engagement with others to provide holistic, evidence-based care, demonstrating clear beliefs and values and knowing how it influences the care provided and how it is received by the patient and knowing self which is the way in which an individual makes sense of his/her knowing, being and becoming a person-centered healthcare practitioner through critical reflection, self-awareness and engaging with others (McCance & McCormack 2017:38;41).

2.9.1.2   Care environment

The care environment refers to the context in which person-centered care is delivered and has the greatest influence on the development or restriction of person-centered care delivery. The care environment requires an appropriate skill mix among healthcare practitioners with the necessary knowledge and skills to provide quality care, facilitation of shared decision- making between the healthcare practitioner and the patient/family by using collaborative, inclusive and participative engagement, positive staff relationships, supportive organisational systems that evaluate the quality of care rendered on a constant basis, power-sharing between the healthcare practitioner and the patient, having the potential for innovation and risk-taking and a physical environment that facilitates the rendering of person-centered care (McCance & McCormack 2017:38;47; McCormack *et al.* 2013a:10; McCormack & McCance 2006:475;276).

2.9.1.3   Person-centered process

The person-centered process refers to the rendering of care through activities that implement person-centered practices and that are focused on the patient. Person-centered processes enable the healthcare practitioner to work with the patient's values and belief system, which assists the healthcare practitioner to understand how the patient understands things, be authentically engaged in relationships, have a sympathetic presence, share decision-making with patients and render holistic care (McCance & McCormack 2017:38;53; McCormack *et al.* 2013a:10; McCormack & McCance 2006:276).

2.9.1.4   Person-centered outcomes

Person-centered outcomes are in the middle of the framework and reflect the expected outcomes of person-centered practices when it is successfully implemented. This includes having a good experience of care, being involved in care, having a feeling of well-being and the existence of a healthful culture where there is shared decision-making, collaborative staff relationships, transformational leadership and supported innovative practices (McCance & McCormack 2017:38;58).

2.10 SUMMARY

Chapter 2 provided a discussion of the relevant contexts in which this study was conducted, and I illustrated its impact thereon. I then discussed constructivism as a philosophical paradigm and as a theory of learning, linking it with the person-centered approach to education. The origins of the person-centered approach were discussed as it relates to the care context as well as the Person-centered Practice Framework that acts as a guide to healthcare practitioners to implement person-centered care in practice, which also formed the underpinning theoretical framework in this study. Chapter 3 presents an overview of the literature that shapes the theoretical context of the study.