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SUPPORT NEEDS OF ENROLLED NURSES WORKING IN AN INTENSIVE CARE UNIT

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DECLARATION

I, **Thulile Patience Kubheka**,

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declare that:

"SUPPORT NEEDS OF ENROLLED NURSES WORKING IN AN INTENSIVE CARE UNIT"

is my own unaided work and has not been previously submitted by me or anyone at any other university. All efforts to acknowledge sources used in this study were taken.

______________________________ ______________________

Signed **Date**

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ABSTRACT

TITLE: SUPPORT NEEDS OF THE ENROLLED NURSES WORKING IN AN INTENSIVE CARE UNIT

INTRODUCTION

In South Africa, the Department of Health stipulates that "providing quality care to patients requires training skilled health workers and establishing a culture that values lifelong learning and recognises its important role in improving quality". For several years, professional nurses have been a scarce resource in South Africa and many countries, hospitals are faced with an escalating critical shortage of trained intensive care professional nurses. In many cases currently, hospitals utilize enrolled nurses in the intensive care environment. These enrolled nurses are faced with the challenge and demands of having to work, function and cope in the intensive care units, despite their limited scope of practice. To address the shortage of professional nurses in the intensive care units, enrolled nurses have been deployed to work in the intensive care environment.

AIM

The aim of the study was to explore and describe the support needs of enrolled nurses working in an intensive care unit of a selected private hospital in Tshwane, Gauteng Province, South Africa.

METHODOLOGY

In this study, the population included enrolled nurses working in the intensive care unit of the selected private hospital in Tshwane. the researcher selected only enrolled nurses who had worked in intensive care unit for at least six months in order to explore and describe the support needs of enrolled nurses working in the intensive care unit of the selected hospital. in this study, data was collected by means of a focus group, an appreciative inquiry interview approach was used. The researcher wished to explore and describe the participants' support needs when working in the intensive care unit.

FINDINGS

Five themes were identified from the participants' peak experiences, namely professionalism, support, knowledge, procedures and equipment. Three themes emerged in wishes, namely belonging to a team, professional development, and gaining more knowledge.

KEY WORDS

Enrolled nurses, Intensive Care Unit, Support needs

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LIST OF ABBREVIATIONS / ACRONYMS

AI	Appreciative Inquiery
CEO	Chief excecutive officer
ICU	Intensive care unit
EN	Enrolled nurses
SN	Support needs
SANC	South African Nursing Council

CHAPTER 1

ORIENTATION OF THE STUDY

1.1 INTRODUCTION

Quality health care provision is the right of patients everywhere. In South Africa, the Department of Health (DOH 2007:15) stipulates that "providing quality care to patients requires training skilled health workers and establishing a culture that values lifelong learning and recognises its important role in improving quality". In addition, the South African Nursing Council (SANC) regulates and sets standards for the education and training of nurses and approves such programmes that meet the requirements of the *Nursing Act, 33 of 2005*.

Intensive care units (ICUs) are specialised units that should be staffed with ICU-trained professional nurses. It is essential for ICU nurses to have skills, knowledge and experience of the ICU environment. The South African nursing workforce primarily comprises professional nurses (PNs) and enrolled nurses (ENs), who have different educational preparation and scope of practice (scope of practice R2598). Enrolled nurses (ENs) work under the supervision and delegation of professional nurses (PNs).

For several years, PNs have been a scarce resource in South Africa and many countries, and hospitals are faced with an escalating critical shortage of trained ICU professional nurses (Pretorius & Klopper 2012:67; Iglehart 2013:1935). In 2014, 12 9033 PNs were registered with the South African Nursing Council (SANC Statistics 2014:2-3). These PNs are shared between all healthcare facilities as well as companies, and some are not involved in bedside nursing.

Globally, nurse managers are faced with the challenge of ensuring and sustaining the nursing workforce with adequate numbers of nurses in order to maintain high-quality nursing care delivery (Newton, Pillay & Higginbottom 2012:541). In many cases then, hospitals utilize ENs in the ICU environment. These ENs are faced with the challenge and demands of having to work, function and cope in ICU, despite their limited scope of practice. In 2012, the nursing council in New Zealand countered the problem by stating that even though the scope of practice of ENs had

broadened, they still had to work under the direct supervision of PNs. The aim was to provide more support to PNs (Nursing Council of New Zealand 2012:5).

Currently, most African countries have severe shortages of nurses. The main reasons for the shortage are attrition, poor retention of nurses with skills and expertise, and nurses leaving for better salaries (George, Quinlan, Reardon & Aquilera 2012:6; Littlejohn, Campbell, Collins-McNeil & Khayile 2012:24). The severe shortage of nurses impacts directly on the quality of patient care and aggravates the burden of maintaining quality care without the necessary human resources. George et al (2012:2) found that SA is facing the same challenges as other African countries, due to the shortage of PNs. Littlejohn, Campbell, Collins-McNeil and Khayile (2012:26) point out that although each country is different, ultimately they have similar healthcare challenges due to severe nurse shortages.

1.2 BACKGROUND TO THE STUDY

To address the shortage of PNs in the ICU, ENs have been deployed to work in the environment. The ENs' scope of practice only allows them to execute a nursing care plan, which includes monitoring of vital signs and observation of reaction to medication; promote health and family planning by means of information to individuals and groups; promote hygiene needs and psychical needs, comfort needs; reassure the patient; promote basic needs, and prepare for and assist with surgical procedures (Scope of practice R2598). The nursing environment, however, demands nurses to deliver holistic patient care, which includes mechanical ventilation, monitors and haemodialysis machine monitoring, and other speciality skills and knowledge.

The researcher is a qualified PN, with a Bachelor's degree in Nursing Science and an additional qualification in Intensive Care Nursing Science. She has been working in ICUs since 2011 and currently works as a PN in an ICU of a private hospital group in Tshwane.
The researcher's experience and observations as an ICU trained PN working in a specific ICU motivated her to explore the support needs of ENs working in an ICU. Based on the findings, the researcher wished to suggest strategies to address support needed for ENs, in collaboration with other PNs and nurse educators. The aim was to ensure quality care for ICU patients and adequate support for EN's.

1.3 STATEMENT OF THE PROBLEM

The shortage of professional nurses presents serious challenges to the ICU environment, where previously only PNs worked. Hospitals are now compelled to make use of ENs to meet the high demand of critically ill patients managed in the ICU. The problem is that the ENs' scope of practice

is limited and does not prepare them for the advanced healthcare environment of ICU (Matlakala, Bezuidenhout & Botha 2014:5).

In terms of the scope of practice R2598 the EN's scope of practice is to practice under the direct supervision and delegation of a professional nurse (PN), in rendering of basic nursing care. In the ICU, however, the EN is expected to render advanced care in a technologically advanced environment to critically ill patients. The environment contributes to ENs' functioning outside their scope of practice. Iglehart (2013:1393) emphasises that, as stipulated by law, nurse practitioners, including ENs, must work as part of patient care teams, and must adhere to their scope of practice as stipulated by governing bodies.

Unlike PNs, such as ICU trained/experienced professional nurses, ENs are not trained to function independently (Pretorius & Klopper 2012:69). Furthermore, ENs are dependent on PNs to educate and train them with regard to ICU specific skills and knowledge. This situation increases the burden and stress on PNs working in ICU, as they have to supervise and support the ENs as well as manage critically ill patients of their own. Due to ENs' limited knowledge, skills and scope of practice, then, PNs have to do some of the ENs' duties. This could lead to a situation where the lack of appropriate skilled nurses in the ICU environment decreases the standard of care. General errors and mistakes can occur as a result of work overload. Currently many ICU trained PNs resign and leave to work in other healthcare settings due to stress and work overload. This increases the shortage of professional ICU nurses, leading to the use of more and more ENs to fill the gaps and meet patient demands in the ICU environment.

1.4 AIM OF THE STUDY

The aim of the study was to explore and describe the support needs of ENs working in an ICU of a selected private hospital in Tshwane, Gauteng Province, South Africa.

1.5 RESEARCH QUESTION

In order to achieve the aim, the study wished to answer the following question:

What are the support needs of the enrolled nurses working in an ICU of a selected private hospital in Tshwane?

1.6 FRAME OF REFERENCE FOR THE STUDY

The frame of reference for the study consisted of the role of the researcher, the setting, the paradigm, theoretical framework, and assumptions.

1.6.1 ROLE OF THE RESEARCHER

The role of the researcher as a primary research instrument is vital in qualitative research and the researcher should be involved in a sustained and intensive experience with the participants (Creswell 2014:188). The researcher is a qualified PN working as a PN in an ICU of a private hospital in Tshwane, therefore gaining access was not a problem and she was able to establish rapport and spend time with the participants. In this study, the researcher drew upon her own experience as a resource.

1.6.2 SETTING

A setting refers to the "physical site or location used to conduct a study and in which data collection takes place" (Polit & Beck 2017:744; Burns & Grove 2009:35).The study was conducted in a selected 360-bed private hospital in Tshwane. The hospital houses general, medical, surgical, orthopaedic, paediatric, oncology and obstetric wards as well as several theatres. In addition, the hospital has three high care units (adult, paediatric and neonatal) as well as cardiology, cardiothoracic, general and neonatal ICU units. Table 1.1 presents the permanent staff allocation for the adult ICU in the selected hospital according to the hospital's statistics for 2017.

Table 1.1 Permanent staff allocation of the adult ICU, 2017

Intensive care unit	Professional nurses	Enrolled nurses
Cardiology and cardiothoracic	28	8
Multi ICU (general ICU)	26	7
Total	**54**	**15**

Source: Hospital statistics (selected private hospital in Tshwane)

1.6.3 PARADIGM

Polit and Beck (2017:12) describe a paradigm as a world-view or "a way of looking at natural phenomena that encompasses a set of philosophical assumptions and that guides one's approach to inquiry". Polit and Beck (2017:15) add that paradigms are lenses helping to sharpen the researcher's focus on a phenomenon. The researcher followed the constructivist or naturalistic paradigm. This paradigm is considered suitable for qualitative studies because the "social constructivist believes that individuals seek understanding of the world in which they live and work" (Creswell 2014:8). Grove, Burns and Gray (2013:24) state that qualitative research "evolves from

the behavioural and social sciences as a method of understanding the unique, dynamic, holistic nature of human beings”. Accordingly, the researcher selected this paradigm because the participant ENs also worked and lived in the environment where the study took place and had a better understanding of the phenomenon under study.

The constructivist paradigm assumes that for knowledge to be maximised, there must be a minimum distance between the researcher and the participants, since subjective interactions are the primary way to access phenomena of interest (Polit & Beck 2017:12).The researcher conducted direct interviews with the participants and remained in the field until saturation of data to maximise knowledge and minimise the distance between the researcher and the participants. The findings of constructive inquiry are the product of the interaction between researcher and participants because the focus is on understanding participants’ experience as it is lived by them. This is achieved through careful collection and analysis of qualitative material that is narrative and subjective (Polit & Beck 2017:11). The results of the study, then, were the products of the interactions between the researcher and the participants.

Constructivist researchers tend to “emphasise the dynamic, holistic and individual aspects of human life and attempt to capture those aspects in full within the context of those who experience them” (Polit & Beck 2017:11). The researcher therefore conducted a focus group interview with the participants to gain insight into and understand their support needs as they worked in ICU and knew where they needed support. *Collins English Dictionary* (2009:1549) defines *support* as “(v) to give aid or courage to; to give strength to; (n) the act of supporting”. A *need* is defined as “what is required; a requirement; the fact or an instance of feeling the lack of something” (*Collins English Dictionary* 2009:1044). The researcher wished to gain insight into the support needs of ENs and suggest strategies to address a support programme to equip ENs working in the ICU.

1.6.4 THEORETICAL FRAMEWORK

A framework is “an abstract, logical structure of meaning” (Grove, Burns & Gray 2013:24; Burns & Grove 2009:153). The conceptual or theoretical framework of a study is “a structure of concepts and/or theories pulled together as a map for the study that provides a rationale for the development of a research question or hypothesis” (LoBiondo-Wood & Haber 2010:57). In this study, the researcher used Appreciative Inquiry (AI) as the theoretical framework. Preskill and Catsambas (2006:1) describe Appreciative Inquiry as “a group (collaborative) process searching into identifying and developing the best of ‘what is’ within an organisation in order to produce improved opportunities” (see chapter 2 for full discussion).

1.6.5 Assumptions

Assumptions are "principles that are accepted as true based on logic or reason, without proof" (Polit & Beck 2017:720). In this study, the researcher believed that the participants (ENs) were unique and holistic human beings who could function effectively in an ICU if their support needs were recognised and met. Moreover, a support programme would promote learning and motivate the participants and ENs to provide quality nursing care.

1.7 RESEARCH DESIGN

Polit and Beck (2017:743) describe a research design as "the overall plan for addressing a research question, including the specifications for enhancing the integrity of the study". In this study, the researcher used a qualitative, exploratory and descriptive research design in order to explore and describe the participants' support needs.

1.7.1 Qualitative

Qualitative research is the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design (Polit & Beck 2017:741). Qualitative research is "a systematic, subjective methodological approach used to describe life experiences and give them meaning" (Grove, Burns & Gray 2013:551).

The researcher considered this design appropriate because the aim of qualitative research is to understand human experiences and needs from the totality of their life ways, bearing in mind the dynamic interplay of these life ways (Burns & Grove 2009:22). Qualitative research involves an in-depth examination of the qualities, characteristics or properties of a phenomenon to better understand or explain it (Botma, Greeff, Mulaudzi & Wright 2015:182).

1.7.2 Exploratory

Exploratory research investigates the full nature of the phenomenon, the manner in which it is manifested, and other factors related to it (Polit & Beck 2017:728). An exploratory approach was considered appropriate to explore and understand the participants' perceptions and experiences.

1.7.3 Descriptive

The main objective of descriptive research is to "accurately portray all of the characteristics of persons, situations, or groups, and the frequency with which certain phenomena occur" (Polit & Beck 2017:726). Descriptive research is the exploration and description of phenomena in real-life

situations, and provides an accurate account of characteristics of particular individuals, situations, or groups (Burns & Grove 2009:45). A descriptive design enables researchers to describe variables in order to answer research questions with no attempt at establishing a cause-effect relationship (Brink, van der Walt & van Rensburg 2012:102).

Exploratory-descriptive qualitative research is conducted to address an issue or problem in need of a solution and/or deeper understanding (Grove, Burns & Gray 2013:27). Descriptive study designs are used to gain more information about the characteristics within a particular field of study (EN support needs), with the purpose of providing a picture of situations as they naturally occur (Grove, Burns & Gray 2013:28).

1.8 RESEARCH METHODOLOGY

Research methodology is the plan for conducting the specific steps of a study (Burns & Grove 2009:719). Burns and Grove (2009:25) add that qualitative research methodology is both flexible and evolving as the researcher explores the depth, richness and complexity of the information (data). Research methods are "the systems the researchers use to structure a study and to collect and examine information relevant to the research question" (Polit & Beck 2017:743). The methodology includes the population, sampling and sample, data collection and data-collection techniques, data analysis, and trustworthiness (Burns & Grove 2016:529).

1.8.1 POPULATION

A population is "the entire aggregate of cases in which a researcher is interested" (Polit & Beck 2017:249). A population is the bigger group from which the sampling elements are drawn, and to which researchers want to generalise the findings (Terre'Blanche, Durrheim & Painter 2014:133; Bless, Higson-Smith & Sithole 2013:162). In this study, the population included all ENs working in the ICU of the selected private hospital in Tshwane.

To be included in the study, the ENs had to:

- ✓ Work in one of the ICUs in the selected hospital in Tshwane.
- ✓ Have at least six months' working experience in ICU.
- ✓ Be registered with the South African Nursing Council (SANC).

All ENs who did not work in the ICU or had less than six months' working experience in ICU were excluded from the study.

1.8.2 SAMPLING AND SAMPLE

A sample refers to a subset of a population (individuals, elements or objects) or a group selected to act as representatives of the population as a whole (Polit & Beck 2017:250). Sampling is the process of selecting participants, events, behaviours, or other elements that represent the population being studied (Grove, Burns & Gray 2013:357). Terre'Blanche, Durrheim & Painter (2014:133) define sampling as the method of choosing cases (participants) to be observed. The researcher used purposive or judgemental sampling to select participants who met the inclusion criteria. In purposive sampling, the researcher deliberately selects certain participants, elements, events, or incidents to include in the study (Grove, Burns & Gray 2013:365). (Terre'Blanche, Durrheim & Painter (2014:139) point out that in purposive sampling, sampling depends not only on the availability and willingness of participants to participate, but also on selecting cases that are typical of the population needed. The researcher chose purposive sampling because the participants involved in the topic under study would be able to make a valuable contribution to addressing the research question accordingly. The researcher selected only ENs who had worked in ICU for at least six months in order to explore and describe the support needs of ENs working in the ICU of the selected hospital. A sample of eight (8) ENs participated in the study.

1.8.3 DATA COLLECTION

Data collection is the process of collecting information (data) related to the research question in a systematic way to address a research problem (Polit & Beck 2017:725). Qualitative researchers collect their data in a real-world, naturalistic setting (Polit & Beck 2012:506). In this study, data was collected by means of a focus group, appreciative inquiry (AI) interview. The researcher wished to explore and describe the participants' support needs. The researcher, in collaboration with the supervisor, developed a semi-structured AI interview guide, using the AI 5-D cycle (see Annexure C for copy of interview guide).

The interview was conducted in a private room outside the ICU in the selected hospital and took approximately ±45 minutes. The interview was audio-taped with permission of the participants and the researcher took field notes during the interview. Following data collection, the researcher organised the data by transcribing the tape-recorded interview verbatim, and keeping the transcription as well as the field notes taken during the interview in folders. The researcher kept all the data collected in a safe place. Only she and the supervisor had access to.

1.8.4 DATA ANALYSIS

Data analysis is the systematic organization and synthesis of data to establish order, structure and meaning to qualitative data collected (Polit & Beck 2017:725; Botma et al 2010:220). Data analysis started during data collection and continued until the end of the study.

Data analysis entails categorising, ordering, manipulating, summarising and describing the data in meaningful terms (Brink, Van der Walt & van Rensburg 2012:170). Qualitative data analysis is a rigorous and logical process by which data are given meaning (Grove, Burns & Grey 2013:493). Grove, Burns & Grey (2013:279) emphasise that becoming familiar with the data involves reading the data over and over again, recalling the transcript, observation and experiences, and listening to the tape recording until becoming absorbed with the data. The researcher used Tesch's eight-step method (Creswell 2014:198) to analyse the data:

- ✓ Read through all the data carefully in order to get a sense of the whole.
- ✓ Read through the transcript again to get the underlying meaning. Write thoughts down in the margins.
- ✓ Make a list of all the topics from the data. Cluster similar topics together and form these topics into themes.
- ✓ Abbreviate the themes as codes next to appropriate segments of the text.
- ✓ Find the most descriptive wording for the themes and turn them into categories.
- ✓ Reduce the total list of categories by grouping or clustering topics that relate to each other.
- ✓ Make a final decision on the abbreviation for each category and then arrange the codes alphabetically.
- ✓ Assemble the data for each category in one place and perform preliminary analysis.

The researcher's supervisor, who is an experienced researcher, will confirm the findings of the study.

1.9 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness is "the degree of confidence that qualitative researchers have in their data, using the strategies of credibility, dependability, confirmability, transferability and authenticity" (Polit & Beck 2017:747). Qualitative validity refers to using procedures to ensure that the results or findings of a study are correct (Brink, van der Walt & van Rensburg 2015:171; Creswell 2014:201). In this study, the researcher used Lincoln and Guba's (1994) framework to ensure trustworthiness (Polit & Beck 2012:559):

- ✓ **Credibility:** The investigation must be done in a way that the participants will believe the study results and the truth of the data and interpretation thereof (Brink, van der Walt & van Rensburg 2015:172). The researcher ensured credibility of the results by the following:

- *Prolonged engagement*. The researcher remained in the data-collection process until data saturation was reached. This enabled her to establish rapport and trust and acquire information-rich data.
- *Member checking*. After data analysis the researcher went back to the participants to correct any errors and provide additional information and interpretation of data. These member checks allowed the researcher to amend the findings, where necessary.
- *Data saturation*. Data collection was prolonged to ensure internal validity of the study results. Data collection was done until data saturation was reached and no new information emerged.

✓ **Dependability:** Dependability refers to whether the findings can be applied to a similar context, setting and other participants, and produce similar findings (Brink, van der Walt & van Rensburg 2015:172). The researcher ensured dependability by means of an auditor who examined the documentation and the process of the investigation. In addition, the researcher conducted a pilot study prior to the main study to ensure dependability. The researcher provided feedback to the participants to confirm the interpretation of the data.

✓ **Confirmability:** Confirmability refers to the potential for congruency of data in terms of accuracy, relevance or meaning, and that the data was provided by the participants (Brink, van der Walt & van Rensburg 2015:173). Confirmability ensures that information provided by participants is not driven by the researcher's perceptions or misconceptions; the data must represent the voices of the participants. The researcher kept comprehensive field notes during data collection. Audio-taping ensured the participants' actual information. A co-coder was used to confirm/verify the study results and indicate whether the researcher correctly interpreted the collected data.

✓ **Transferability:** Transferability refers to the possibility that the findings of a study will have the same meaning in a different context with other participants (Brink, van der Walt & van Rensburg 2015:173). In this study, purposive sampling was used to maximise the information collected about the phenomenon. Prolonged engagement until data saturation when no new themes emerged ensured thick and rich data. A full description of the whole research process was provided.

✓ **Authenticity:** Authenticity means that the findings reflect the participants' experiences and feelings as lived in a fair and faithful manner, and the researcher must develop an

increased sensitivity to the issues discussed (Brink, van der Walt & van Rensburg 2015:172-173). Prolonged engagement allowed trust and good rapport between the researcher and the participants, which led to useful and accurate information.

1.10 SIGNIFICANCE OF THE STUDY

A research study should be significant to the nursing profession and contribute to the body of knowledge (Brink et al 2006:61). South Africa is facing an escalating use of ENs in the ICU due to serious shortages of PNs. Knowing the support needs of ENs working in the ICU should allow the researcher, in collaboration with other PNs and nurse educators, to suggest strategies to support ENs in the ICU. The aim of the suggested strategies was to address the identified support needs of ENs working in ICU. Meeting these needs should equip the participants and other ENs with specific knowledge and skills that enable them to render limited but quality care to patients in the ICU. This, in turn, would lessen the stress and burden of the PNs and gradually improve overall job satisfaction and quality care in the ICU. It should be borne in mind that the ENs would still have to work under the direct supervision of the PNs even if they are more skilled and knowledgeable. The findings and strategies should lay the foundation for future research in other contexts.

1.11 LIMITATIONS OF THE STUDY

The study was restricted to one selected private hospital and to ENs working in ICU. Hence the support needs of other ENs in other settings might differ, therefore the suggested strategies cannot be generalised to other clinical settings.

1.12 ETHICAL CONSIDERATIONS

Ethics deals with matters of right and wrong. When humans are used as study participants, care must be taken in ensuring that their rights are protected (Polit & Beck 2017:727). Accordingly, the researcher obtained permission to conduct the study, obtained informed consent from the participants, and observed the ethical principles of beneficence, respect for human dignity, and justice (Polit & Beck 2012:137).

- **Permission**

  The researcher obtained written permission from the University of Pretoria, Ethics Committee and the selected hospital to conduct the study (see Annexure A). The researcher also obtained permission from the Chief Executive Officer and the Matron of the hospital. Permission was also obtained from the ICU unit manager before commencing the focus group interview.

- **Informed consent**

  Informed consent involved informing the participants of the purpose of the study; type of data to be collected; data-collection procedures; nature of their commitment; confidentiality, voluntary consent and participation; the right to withdraw and withhold information, and the researcher's contact information (Polit & Beck 2017:731). The participants signed informed consent forms before participating (Polit & Beck 2017:143).

- **Beneficence**

  Beneficence requires researchers to minimise harm and to maximise benefits. Research should be intended to produce benefits for participants themselves or for other individuals or society as a whole (Polit & Beck 2017:139). The principle of beneficence includes the right to freedom from harm and discomfort and the right to protection from exploitation. In this study there were no physical, social, emotional or psychological risks. In order to prevent any feelings of uneasiness or discomfort due to a group session, the researcher explained the study, method of data collection and the participants' freedom to express themselves. In addition, the researcher ensured that the interview was conducted at the stipulated time. The participants' permission was also obtained to audio-tape the interview.

  Participants must not be exploited for personal gain, experience negative feelings, or be exposed to harm (Polit & Beck 2017:139). In this study, the researcher ensured that the participants did not feel that they were exploited by her, because she was their senior manager. Accordingly, the researcher made sure that all the steps of the study were followed as prescribed. Moreover, another researcher assisted with the data collection and the researcher was an observer and took field notes. The participants were assured that any information they provided would not be used against them in any form or way.

- **Respect for human dignity**

  Respect for human dignity includes the right to self-determination and the right to full disclosure. The right to self-determination means that research participants "should be

treated as autonomous agents, capable of controlling their actions" (Polit & Beck 2017:140). This implies that individuals have the right to decide whether to participate in a research study or not, without any risk or penalty or prejudicial treatment (Brink, van der Walt & van Rensburg 2012:35). The researcher gave the participants full information about the study so that they could decide whether or not to participate. The right to full disclosure requires that participants "have adequate information about the research, comprehend that information, and have the ability to consent to or decline participation voluntarily" (Polit & Beck 2017:140). The researcher informed the participants of the purpose, objectives and significance of the study; how and where data would be collected and that they could withdraw from the study at any stage should they wish to do so. The right to self-determination is based on the principle of respect for persons, which states that an individual has the right to decide whether or not to participate in a study, without the risk of penalty or prejudicial treatment (Burns & Grove 2009:188; Polit & Beck 2017:140).

- **Justice**

The principle of justice includes the right to fair treatment and the right to privacy (Polit & Beck 2017:141). The right to fair treatment is based on the ethical principle of justice. This principle holds that each person should be treated fairly and should receive what he or she is due or owed (Burns & Grove 2009:188). In this study the participants' selection was fair as they were selected for reasons directly related to the problem being studied.

The right to privacy meant that the participants had the right to anonymity and to assume the data collected would be kept confidential (Polit & Beck, 2017:141). The researcher ensured that the interview was conducted in a private room to ensure the participants' privacy of the participants and that they could not be overheard by others. The participants' anonymity was assured by not using their names. Furthermore, the audiotape was only reviewed by the researcher and the supervisor and was kept with the transcript under lock and key. Only the researcher and supervisor had access to the information.

1.13 DEFINITIONS OF KEY TERMS

In this study, the following key terms were used as defined below.

- **Intensive care unit (ICU).** An intensive care unit (ICU) refers to a highly sophisticated, modern and technologically advanced area in a hospital where patients receive invasive as well as non-invasive nursing interventions under the best possible conditions (Urden, stacy & lough 2013:2). patients who experience actual or potential life-threatening health problems and who need continuous, advanced monitoring and supervision, complex assessment, invasive and non-invasive interventions as well as intensive and vigilant nursing care are admitted to these areas (Urden, stacy & lough 2013:2). In this study, the icu referred to the area in the hospital with critically ill patients who were nursed on monitors and ventilators to prolong life and promote healing.

- **Enrolled nurses (ENs).** The South African Nursing Council (scope of practice R2598) defines an enrolled nurse (EN) as a person who has obtained a two-year certificate from an accredited training facility and is registered with the South African Nursing Council under Regulation 786, with the subfield for promotive, preventative, curative health and developmental services. The enrolled nurse's functions are to work under the direct supervision of a professional nurse (PN). For the purpose of this study, an EN was a person registered with the SANC as an enrolled nurse and employed in the ICU in the selected hospital.

- **Support needs**. Support refers to any activity that helps or contributes to fulfilling a need, or effort to assist, or to give moral or psychological support, aid or courage. Johnston, Kanitsaki & Curie (2007:49) Define support needs as "clinical teaching availability and approachability, ability to ask questions, motivation to engage in best practices, compassionate shadowing, timely constructive feedback, reassurance, back-up support and debriefing opportunities". In this study, Johnston, Kanitsaki and Curies (2007) definition was applied.

1.14 OUTLINE OF THE STUDY

The study consists of five chapters. Figure 1.1 illustrates the layout of the study.

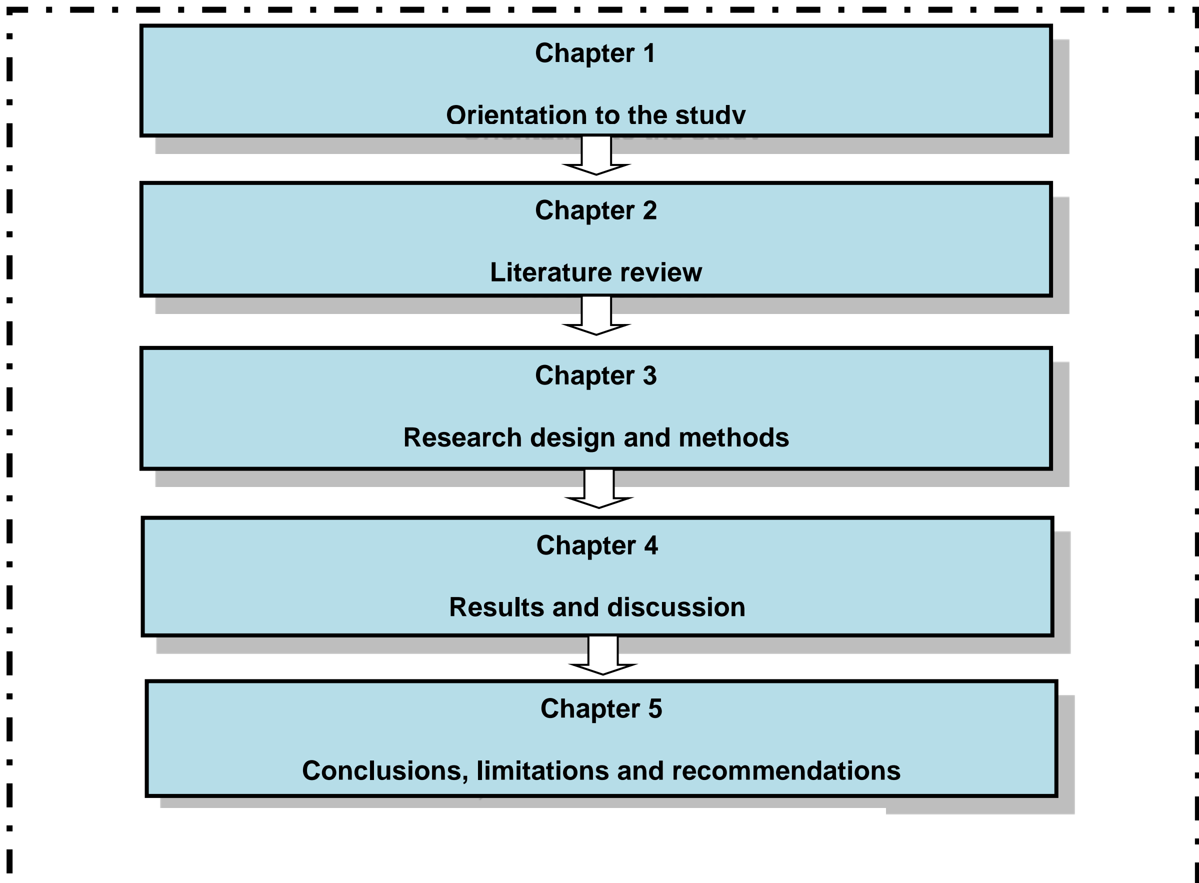

Figure 1.1: Layout of the study.

1.15 CONCLUSION

This chapter described the problem statement, purpose of the study, research design and methodology, significance, limitations and ethical considerations of the study. Key terms were defined and the layout of the study was presented.

Chapter 2 discusses the literature review conducted for the study, the method used to conduct the research study, and more detail information about the support needs.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 described the problem, purpose, research design and methodology of the study. The shortage of professional nurses presents serious challenges to the ICU environment, where previously only PN.s worked. Hospitals are now compelled to make use of ENs to meet the high demand of critically ill patients managed in the ICU. The problem is that the ENs' scope of practice is limited and does not prepare them for the advanced healthcare environment of ICU (Matlakala, Bezuidenhout & Botha 2014:5). The aim of the study was to explore and describe the support needs of ENs working in an ICU of a selected private hospital in Tshwane, Gauteng Province, South Africa.

This chapter discusses the literature review conducted for the study. A literature review involves researching, reading and understanding literature relevant to the study (Brink, van der Walt & van Rensburg 2006:55). The literature review covered Maslow's hierarchy of needs; support needs, and Appreciative Inquiry (AI), including its history, 5-D cycle, assumptions, and principles, and criticism of AI.

2.2 MASLOW'S HIERARCHY OF NEEDS

Maslow developed a hierarchy of five basic needs of individuals in the belief that for individuals to have a complete life, all their needs must be met. Maslow published his theory in 1943, and during the 1950s it was widely used. Maslow believed that all individuals have the same five basic needs, namely physiological, safety, social, esteem and self-actualisation needs (Cao, Jiang, Oh, Li, Liao & Chen 2013:171). Physiological needs refer to food, water, warmth and rest; safety needs refer to security and safety; social or belonging and love needs refer to interpersonal relationships and friends; esteem needs refer to prestige and feelings of accomplishment, and self-actualization

needs refer to achieving an individuals' full potential, including creative activities (Cao et al 2013:171). However, the levels are not the same; some are higher and some come before the others. Moreover, people always want more, and what they want depends on what they already have, so people are driven or motivated by their needs. Maslow's hierarchy of needs can be divided into deficiency and growth needs. The first four levels are also known as deficiency needs and the fifth level as growth or being needs (Cao et al 2013:171).

2.2.1 Physiological needs

Physiological needs are biological requirements for human survival, including air, food, water, shelter, warmth, clothing and rest or sleep (Cao et al 2013:171). Physiological needs are the most important because people cannot live or function without them.

2.2.2 Safety needs

Safety needs refer to protection, security, order and stability (Cao et al 2013:117). In an organisation, then, it is the employer's duty to ensure employees' safety. In a study on supervision, support and mentoring interventions of health practitioners in rural and remote areas, Moran, Coyl, Pope, Boxall, Carrow and Young (2014:2) found that in order to retain rural health care practitioners it was necessary to ensure continuous education and professional development to meet their needs. When employees are happy with their work environment and their support needs are met, they do not easily leave but continue to grow in the same organisation.

2.2.3 Social needs

Social needs refer to feelings of belonging (belongingness) and love. Belonging is considered a form of support or help, being accepted by people (Schader & Kentucky, 2016:2). This form of support is provided in friendship, trust, acceptance and interpersonal relationships. Social support is providing love, receiving love and having a sense of belonging (Cao et al 2013:172). Social support is very important in the workplace as people need to have a sense of belonging in an organization, to feel part of the team, and to engage in the activities that are done in the organisation by other people. Feeling supported gives people motivation (Cao et al 2013:172).

2.2.4 Esteem needs

Maslow divided esteem needs into two categories: self-esteem (dignity, achievement, mastery, and independence) and desire for reputation or respect from others (Cao et al 2013:172). Employees have a right to respect at work and to develop in their work in order to become better employees, with adequate skills and knowledge. In addition, employees who receive support from their employers are happy, show less stress and remain in the same job for a long time (Moran et al 2014:4). When people are happy with themselves and what they have achieved, it has a positive effect and outcome in the workplace.

2.2.5 Self-actualisation

Self-actualisation refers to realising people's personal potential, dreams and self-fulfilment, and personal growth (Cao et al 2013:172). Maslow believed that self-actualisation meant becoming everything people were capable of becoming. People who achieved this were more likely to be happy with things around them and had less stress. Furthermore, such people are more likely to assist and support others in the workplace and guide them.

2.3 DEFINITION OF SUPPORT NEEDS

There is no consensus on a definition of support needs. Tompson, Bradley, Bbuntinx, Schalock, Shogren, Snell, Wehneyer, Borthwick-Duffy, Coulter, Craig, Gonez, Lachapelle, Luchasson, Reeve, Spreat, Tasse, Verdugo and Yeager (2009:135) define support needs as the psychological structures intended to outline and increase the necessary support for the normal functioning of individuals and their accomplishment. In a study on workplace support, Unger (1999: 184) referred to support needs as any form of help needed by an individual in the community or in the working environment. In this study, support needs referred to any form of assistance or support in the working environment (ICU) given to the ENs by the PNs and/or any member of the multi-disciplinary team.

2.4 OVERVIEW OF SUPPORT NEEDS

Support is a broad and complex concept, and there are several types of support needs. In the hospital setting, nurses are responsible for taking care of other people's needs while they themselves have their own needs that should be met.

In a study on staff nurses' perception of stressors and support needs, Hartrick and Hills (1993: 30) found that the participants identified different sources of support needs in the workplace. Support needs are specific to a certain problem, as they are dynamic in nature. Broadbent, Moxham, Sander, Walker and Dwyer (2014:407) examined preceptors' perspectives on supporting Bachelor of Nursing students within the clinical environment and found that the participants emphasised RNs' duty to professionally support others in the workplace. Support in the workplace decreases workers' anxiety and stress making it easier for them to function better even in stressful situations (Broadbent et al 2014:406).

ICU is the most stressful environment to work in and staff members require support. Support in such an environment needs to be valued and understood, as it keeps the place running and prevents complications. Morelli, Lee, Arnn and Zaki (2015:2) point out that support needed may be emotional, physical, social and instrumental.

People who are on instrumental support benefit more if the person providing support portrays empathy and understanding about the support they are providing (Morelli et al 2015:3). People who provide support to individuals are not the same. Some people are good at providing emotional support while others are good with spiritual support. Most people rely on their usual daily support system network when they are dealing with difficult situations and illnesses (Levine, Vong & Yoo 2015:1). Furthermore, when people are in pain and are diagnosed with life-threatening illness, most of them isolate themselves from society. Getting social support assists them to cope better with their life-threatening illness (Levine,Vong & Yoo 2015:1). Spiritual support in the hospital setting was found beneficial to patients diagnosed with life-threatening illness, as it restored hope and the will to live. Spiritual support was the most important support for patients diagnosed with cancer, combined with other forms of support as well (Levine, Vong & Yoo 2015:6).

A study on the provision of spiritual support to patients with advanced cancer by religious communities and associations with medical care at the end of life found that provision of spiritual care to terminally ill patients was associated with better patient quality of life (Balboni, Balboni, Enzinger, Gallivan, Paulk, Wright, Steinhauser, VanderWeele & Prigerson 2013:1109). Spiritual

care from the medical team is usually absent, due to various factors, including practical barriers such as insufficient resources (eg, chaplaincy staff, practitioner training, and time) and concerns about offending patients (Balboni et al 2013:1109). Religious communities are the key providers of spiritual support. Balboni et al (2013:1113) found that spiritual care is a key factor influencing patients' decision making with regard to their medical condition, especially if the spiritual care was provided by the religious community rather than the medical team.

Support can have a positive or negative effect on an individual, depending on the provider's intentions in providing support. Support can also have a positive or negative effect on the organisation. Poor relationships between the employee and the employer can have a negative effect on both employer and the organisation (Shoss, Eisenberger, Restubog & Zagenczyk, 2013:158). Employees sometimes blame the organization, however, especially if things are not going according to plan. It is important that employer and employees work together to ensure that things work according to plan and eliminate problems.

Support in the working environment was developed to prevent work-related stress that could lead to future stress-related illnesses and to promote healthy, productive employees to develop growth in the workplace (Shoss et al 2013:158). Support differs extensively and support given by peers was found to be most valued in the workplace (Hartrick & Hills 1993: 24; Boyle, Topping, Jindal-Snape & Norwich 2011:4). Scholtz, Nel, Poggenpoel & Myburgh (2015:1) found that ICU nurses were required to meet the psychological, spiritual and physical needs of their patients. ICU nurses were required to provide situational support to families when needed in case of an emergency or the loss of loved ones (Scholtz et al 2015:7).) Nurses could not function independently and provide care to critically ill patients on their own; they needed a multidisciplinary team to function fully (Scholtz et al 2015:7).

2.5 TYPES OF SUPPORT NEEDS

There are various types of support needs. In the workplace, Unger (1999: 184) identified the following support needs: employee training, employee benefits, career advancement and workplace culture. This section briefly discusses social, emotional, informational, instrumental, invisible, visible, practical, spiritual, tangible, professional, and training and educational needs, and mentoring.

2.5.1 Social

Social needs refer to love, acceptance and belonging and create social value and opportunities for people to have active and effective roles in society, and include family, friendship and interpersonal relationships (Schader & Kentucky 2016:2). Social support is a way of reducing stress and producing positive health effects (Schader & Kentudcy 2016:2). At the same time, some people may not want to provide or receive support from others. Social support needs include emotional, instrumental and informational support (Schader & Kentucky, 2016:4). Cameron and Gignac (2007:5) found that caregivers experienced four social support needs, namely informational, emotional, instrumental and appraisal. Social support acts as a buffer to stressors (Faw 2016:1).

2.5.2 Emotional

Emotional support refers to listening to or giving each other an ear, and inspiring each other's behaviour and being considerate to other people with words and actions (Schader & Kentucky 2016:2). Emotional support strengthens the individual's emotions and eases concerns leading to positive self-image and increases the individual's self-esteem. The provider of support tries to ease and improve the recipient's mood or emotional state, thereby minimising stressful events and improving the recipient's mood and self-esteem (Howland & Simpson 2014:117).

2.5.3 Instrumental

Instrumental support refers to assisting with the routine or procedure to be done, by supplying necessary or relevant equipment (Schader & Kentucky 2016:4). In a hospital setting, it means helping someone with the equipment to be used during a procedure.

2.5.4 Informational

Informational support means providing information to increase individuals' knowledge, and guidance to help solve the problem at hand, or to gain more information about an aspect that is of concern (Schader & Kentucky 2016:4). Informational support includes learning; demonstration and in-service training whereby employees are given more information so as to ensure smooth working and minimise problems (Gaeeni, Farahani, Seyedfatemi & Mohammadi 2015:9). Nurses provide informational support on a daily basis to caregivers and family members of patients. In a study on

informational support to family members of ICU patients, the participants revealed that it helped the family to better adapt to the stressful situation (Gaeeni et al 2015:9).

2.5.5 Invisible

Invisible support is mostly used to reduce stressful events or tension and improve the person's mood, yet is not considered a form of support (Howland & Simpson 2014:117; Glanz & Rimer 2015:185). Invisible support is almost similar to emotional support as they both help to improve the recipient's mood. It is said to be invisible support because it is not measured or seen, and its evidence is only recognised by the change in people's behaviour (Howland & Simpson 2014:117).

2.5.6 Visible

Visible support is support that is seen and valued as support (Howland & Simpson 2014:117; Glanz & Rimer 2015:185). Both supporter and recipient are aware of what is happening, and about themselves.

2.5.7 Practical

Practical support is easier to provide if people are close to each other and help each other, and understand each other's problems (Morelli et al 2015:1). Practical support is more related to clinical supervision. Clinical supervision is the support provided by the professional nurse to the enrolled nurse in the hospital or health facility with the aim of developing competent and independent practitioners. Practical support is about giving support to an individual that is performing a certain procedure or task. Practical support involves willingness to give advice or assist a person in need of help (Howland & Simpson, 2014:117).

2.5.8 Spiritual

Spiritual support is a type of care or counselling that offers spiritual and emotional support to people in need or going through difficult times (Levine, Vong & Yoo 2015:5). Spiritual support is also related to emotional support as deals with the person's emotions. It can assist people to find hope in difficult times, find strength when they have lost hope, and to trust and believe in times of hopelessness. Spiritual care from the medical team is usually absent, due to various factors,

including practical barriers such as insufficient resources (eg, chaplaincy staff, practitioner training, and time) and concerns about offending patients (Balboni et al 2013:1109). Religious communities are the key providers of spiritual support. Spiritual support is a very sensitive issue due to cultural diversity and practices.

2.5.9 Tangible

Tangible support is given by means of providing physical things to an individual. This is done by giving an individual equipment to work; for example, preparing the CVP trolley for the doctor (Wright 2012:488). This type of support is relevant in the hospital setting, where core workers help one another in order to get the work or the procedure done. It is mainly the work of the responsibility of the PNs to provide more tangible support to ENs and other healthcare practitioners.

2.5.10 Professional

Professional support is support provided to professionals, by means of certain methods and teamwork opportunities (Moran et al 2014:5). Employers use this form of support as a form of developing employees, such as in-service training or continuous professional development. Any method used to support staff enhances their functioning and increases their skill and competence. Professional support includes teaching staff members, organising and doing simulations, and supporting the work to be done at the patient’s side in order to ease the work load and meet patient needs.

2.5.11 Training and educational

Training and educational support is provided in skills and education programmes (Moran et al 2014:5). Organisational support focuses on the needs of the organisation, the staff, and the clients. Needs are continuously assessed and continuously provided (Hartrick & Hills: 25). Organisations provide training and educational support as a form of equipping staff to become better practitioners. Training and educational support also involves clinical learning opportunities, which refer to a range of learning experiences available in the health care system to acquire clinical skills and knowledge. Blom (2013:28) found that in the practical area not enough was done to prepare students for clinical exposure and even after graduation they need clinical accompaniment and mentoring by senior staff to equip and enable them to function as independent practitioners. Universities and colleges are part of the education and training and learning support, system that

are also educating and equipping the students and the health care professionals, in becoming a more skilled and knowledgeable staff within the health organisation.

2.5.12 Mentoring

Mentoring is a professional relationship in which an experienced person (the mentor) assists another person (the mentee) in developing skills and knowledge that will enhance professional and personal growth. Mentoring provides support by guiding, discussing and accompanying students and junior members (Moran et al 2014:22). Many organisations provide mentoring programmes in which senior and experienced employees mentor junior staff.

Blom (2013:25) found that mentees found it beneficial to be mentored by practitioners of the same qualification. Baras, Lischynski, Scotland,Tan and Tarmohamed, (2013:1) point out that the student or mentee receiving support gets the benefit of practising the required skills with the expert. Moreover, the skills and knowledge learned during mentoring are what the person will use in practice. Mentorship plays an important role in the development of novice practitioners into expert professionals.

2.6 ADVANTAGES OF SUPPORT IN THE WORKPLACE

Support in the workplace is important. Faw (2016:4) found that staff members who received support after a stressful event in the workplace showed decreased stress levels after receiving support. When employees receive support in the workplace, they are able to provide high quality care and cope well with stressful working conditions (Unger.1999: 180). Shoss, Senberger, Restubog and Zagenczyk (2013:158) found that supervision played a major role in the direction, valuing and training of employees in the workplace. During clinical practice, students acquired more skill and knowledge to assist them to become better and competent practitioners (Blom 2013:5).

In a study on sport employees' job satisfaction, Melton and Cunningham (2014:25) found that despite the lack of training policies, the participants were satisfied, happy and committed to doing their job because of the support they received. Employers and organisations that are more flexible with employees bring about change and job satisfaction in their employees (Kossek & Tompson 2015:4). Workers were happy and satisfied when they knew the aspects of the work. Support provided by co-workers was found to provide a safe environment for other workers and a sense of identity (Melton & Cunningham 2014:29).

In a study on learning and teaching in clinical practice, the participant professional nurses enjoyed seeing change in the students' performance, as they became more confident and showed professional development (Broadbent et al 2014:407).

A way to assess support needs of staff members in a positive manner is to utilize the appreciative inquiry process. An overview of the Appreciative inquiry process will be discussed in the next section.

2.7 HISTORY OF APPRECIATIVE INQUIRY

Appreciative Inquiry (AI) was developed in the 1980's by David Cooperrider and Diana Whitney, doctoral students at Case Western Reserve University, Cleveland, Ohio, as a tool for organisational change which challenged the problem-solving approach mainly used at the time (Kessler 2013:1). Cooperrider and Whitney wanted to focus on what people appreciated about a situation and discover how they could have more of what they appreciated. They interviewed people to discover the possibilities that were in people's minds that could solve the issue at hand (Kessler 2013:1). Cooperrider collaborated with his advisor, Dr Suresh Srivastva, and was involved with a group working with the Cleveland Clinic in a diagnosis or analysis of "what is wrong with the human side of the organisation?" Later Cooperrider, Whitney and Stavros refined it and it was then adopted in different organisations and contexts (Reed 2007:4). AI is based on action research, organisational learning and organisational change (Reed 2007:4).

AI assumes that organisations are centres of vital connection and life-giving actions that are capable of harnessing the power of connections of strength (Coghlan & Brydon-Miller, 2014:3). The methods used by AI are less formal, participants are encouraged to tell stories and get involved in conversations, rather than semi-structured interviews. AI creates a high-energy environment that fosters positive dialogue, collaboration and increased engagement. It facilitates discovering past and current capacities such as achievements, assets, unfamiliar possibilities, improvements, strengths, opportunities, and possible expectations (Mohr, Smith & Watkins 2003:3). AI requires searching for what is considered necessary by the organisation or programme (Stevenson 2011:7). In this study the researcher used Appreciative Inquiry (AI) to evaluate the participants' support needs.

2.8 DEFINITION OF APPRECIATIVE ENQUIRY

Appreciative Inquiry is a method of studying and changing social systems (organisations, groups and communities) that advocates collective inquiry into “what is” in order to imagine “what could be”, followed by collective design of a desired future state that is compelling and does not require the use of incentives (Kessler 2013:1).

Appreciative inquiry is a form of organisational study that chooses to understand, find and examine the life-giving forces of any human system’s existence and its positive core (Coghlan & Brydon-Miller 2014:3). Preskill and Catsambas (2006:1) define AI as “a group (collaborative) process searching into identifying and developing the best of what is within an organisation in order to produce and improve opportunities”. Reed (2007:2) views AI as a major approach to perceptions and focuses on the discovery of ideas that people respect about their actions. Watkins and Stavros (2009:4) define ap-pre-ci-ate as “(1) to recognise and like a favourable critical judgement or opinion; to perceive those things that give life (health, vitality, excellence) to living systems; (2) to feel or express gratitude; (3) to increase value; (4) to be fully aware of; realize fully (value, prize, esteem and honour). In-quire means “(1) to explore and discover; (2) to question; (3) to be open to seeing new potentials and possibilities”. Havens, Wood and Leeman (2006:463) describe AI as a philosophy and methodology for promoting positive organisational change through creating meaningful dialogue, inspiring hope and inviting action. Serrat (2008:1) describes AI as the process of facilitating positive change in organisations. Every organisation has something that works well. AI is therefore a generative approach to organisational development. AI is a group process that is used to positively challenge the existing assumptions of an organisation by asking questions about the strengths and successes of an organisation or a component of the organisation with the purpose of developing and implementing an improvement plan for it (Preskill & Catsambas 2006:1; Havens, Wood & Leeman 2006:463; Stevenson 2011:7).

2.9 APPRECIATIVE INQUIRY AS THEORETICAL FRAMEWORK

A framework is “an abstract, logical structure of meaning” (Grove, Burns & Gray 2013:116). The study framework is referred to as the conceptual framework and guides the development of the study. According to Serrat (2008:2), the process of AI utilises a 5-D Cycle, namely the ***Defining/Definition*** (the affirmative topic), ***Discovery***, ***Dream***, ***Design*** and ***Delivery*** phases. In this study, the researcher used the 5-D cycle of AI as the theoretical framework. This involved asking positive questions to the participants in order to craft and implement action plans

(recommendations) for excellence (Reed 2007: 2; Mohr, Smith & Watkins 2003:3). Figure 2.1 illustrates the 5-D cycle of AI.

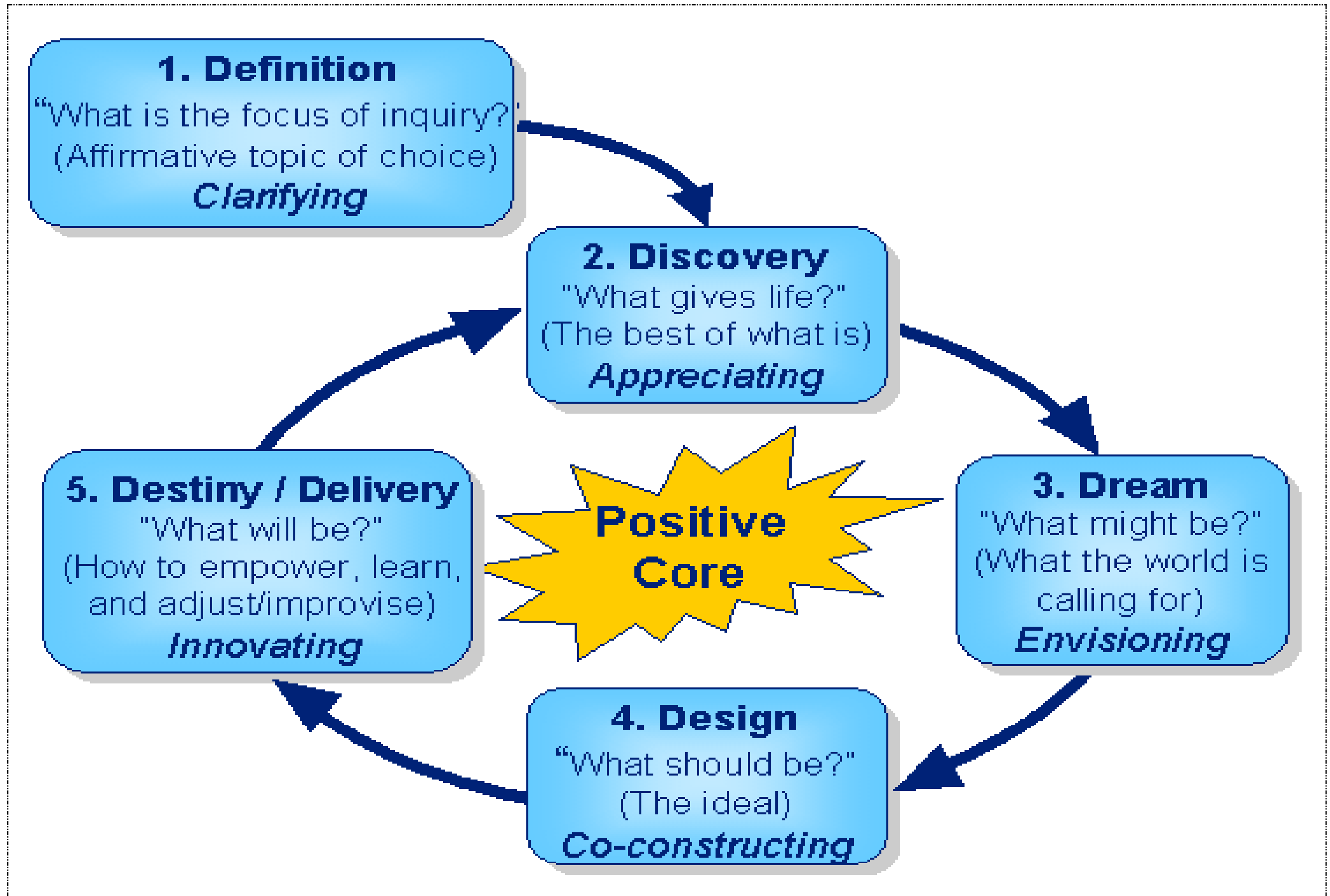

Figure 2.1 5-D Cycle of AI

Source: Serrat (2008:2)

2.9.1 Defining/Definition

During the defining phase the researcher defines (clarifies) the topic of inquiry for the study. In this study the topic of inquiry was to explore the support needs of the participants (ENs working in an ICU in the selected private hospital in Tshwane). During this phase the researcher also developed the interview schedule for the AI focus group (see Annexure A for the AI interview guide).

2.9.2 Discovery

The purpose of the discovery phase is to discover what people call their best experiences and what makes them the best in relation to the topic of the study (Coghlan & Brydon-Miller 2014:5). During the discovery phase, people talk to one another about when the organisation is functioning

at its best. AI interviews are designed to bring to light to organisations' positive capacity in order to discover and make explicit "*what works*" (Havens, Wood & Leeman 2006:465). The participants reflect on and discuss the best of the object of inquiry. Sometimes it is an inquiry into the "life-giving properties" of the organisation. Watkins and Kelly (2010:21) describe the discovery phase as conducting an inquiry into the topic and assembling the stories and key ideas that come out of the inquiry.

During the **discovery** phase, the participants had the opportunity to reflect on the "*best of what is*" in terms of the support they received from PNs and other health care practitioners in the ICU. The participants reflected on what support they received and what they valued as most important to them. This was important to know in order to build those aspects into the support programme for ENs working in ICU. The participants were encouraged to speak freely about and share their best positive experiences regarding to support in the ICU.

2.9.3 Dream

The **dream** phase is about creating options for the future and positive aspects that were generated during discovery (Coghlan & Brydon-Miller 2014:6). During the dream phase participants are encouraged to envision the organisation through the peak moments identified in the discovery phase as the norm rather than an exception (Serrat 2008:2). Participants look at the stories generated during the AI interviews and identify the key positive attributes and skills the stories reflect. The positive attributes and skills are presented to the participants, who are asked to expand on the positive core and articulate dreams and desires (Havens, Wood & Leeman 2006:465).

Mohr, Smith and Watkins (2001:10) emphasise that in this phase, based on the information obtained from appreciative interviews, participants envision themselves and their organisation functioning at their best. Reed (2007:28) adds that valuing the different contributions made and the use of positive encouraging language is critical for the success of the dream phase.

During the **dream** phase in this study, the participants had the opportunity to dream and envision "*what could be*" the ideal ICU environment for them to work in, and their "wishes" for the ideal support needed to gain knowledge and the required skills.

2.9.4 Design

In the **design** phase, participants develop ideas about the organisation's socio-technical architecture infused with what has been discovered (Watkins & Kelly 2010:21). Participants have the opportunity to look at the processes and structures that need to be in place for the dream to become a reality. Design elements can include changes to structures, policies and procedures, meetings, measurement tools, scheduling processes, communication links and more (Havens et al 2006:465). Coghlan and Brydon-Miller (2014:7) state that the design phase "translates future images into intentional actions". During the design phase, participants look at the processes and structures that need to be in place for the dreams to become a reality. Moreover, participants must work together in planning and prioritising what they say is their best of what is.

During the **design** phase the participants had the opportunity to give inputs and make recommendations for "*what should be*" the ideal support required for ENs working in ICU.

2.9.5 Delivery

Delivery is about putting all the dreams and the design into action (Reed 2007:33). The **delivery** phase is about the implementation of the co-constructed action plan: what activities will be done, by whom and when, in order for the plans to be realised (Reed 2007:33). Participants in the delivery phase focus on sustaining the AI's positive approach to improvement and organisational development. With ongoing focus on seeking the positive, participants build relationships, continue to redesign structures and sustain processes based on the organisations best attributes (George, Quinlan, Reardon & Aguilera 2002:38; Havens, Wood & Leeman 2006:465).

During the delivery phase the researcher had the opportunity to present the recommendations and suggested strategies for optimal support and development for ENs working in ICU.

2.10 ASSUMPTIONS

An assumption is "a basic principle that is believed to be true based on logic or reason without proof or verification" (Polit & Beck 2017:9). Reed (2007:10) points out that AI has specific assumptions. Table 2.1 lists the assumptions of AI and their application to the study.

Table 2.1 Assumptions of Appreciative Inquiry (AI)

Assumptions	Application to study
✓ In every society, organisation or group, something works	✓ The researcher believes that there are positive aspects of support that will be identified by participants (EN) working in ICU. The participants will work together to express their support needs in an ICU.
✓ What we focus on becomes our reality	✓ The researcher is of the opinion that if one focuses on the positive aspects of support of EN and works towards improvement, optimal support will become a reality. The participants are encouraged to focus on their support needs in ICU so that a sense of responsibility rather than limitations will be maintained.
✓ Reality is created in the moment, and there are multiple realities	✓ The researcher believes that all stakeholder (unit managers, PNs, clinical facilitators) involved in the ICU can give valuable inputs for support of ENs working in the ICU. ENs are involved with the reality as they live it.
✓ The act of asking questions of an organisation or group influences the group in some way	✓ The researcher believes by asking positive questions relating to the support needs of ENs working in ICU stakeholders will become more positive towards ENs and will collaborate to work towards supporting ENs. Asking positive questions helps to engage participants in the conversation and suggest possible solutions.

Assumptions	Application to study
✓ People have more confidence and comfort to journey to the future (the unknown) when they carry parts of the past (the known) forward with them.	✓ The researcher believes that for the participants (EN) to move towards achieving their goals they need to know where they come from and what their current goals and ambitions are.
✓ If we carry parts of the past forward, they should be what is best about the past.	✓ The researcher believes that if the participants have some positive experiences, it will be easier to build more positive aspects and provide direction.
✓ It is important to value differences.	✓ The researcher believes that as different people express different views and opinions, it helps to build the organisation and achieve solutions. As such, every view and opinion needs to be respected and valued.
✓ The language we use creates our reality.	✓ The researcher believes that the participants have the same goals and ambitions, which creates a common goal and leads to achieving their dreams, which is having their support needs met in the ICU.

Adapted from: Yoder (2005:48); Reed (2007:10-12)

2.11 PRINCIPLES OF APPRECIATIVE ENQUIRY

AI is a transformative approach for initiating shared leadership and organizational learning based on eight principles: constructionist, simultaneity, poetic, positive, anticipatory, enactment, wholeness and free choice (Kessler 2013:2). The researcher used the constructionist, simultaneity, poetic, anticipatory and positivist principles in this study.

2.11.1 Constructionist principle

The constructionist principle proposes that what people believe to be true determines what they do, and thoughts and actions emerge out of relationships (Kessler 2013:2). Watkins and Stavros (2008:8) emphasise that the constructionist principle is an understanding and acceptance of the social constructionist stance towards reality and social knowledge. What we believe to be real in the world is created through social discourse; through the conversations, we have with each other that lead to agreement about how we will see the world, and how we will accept reality. hence the constructionist theory pays attention to its processes, like telling different stories about the past, present and future and the way people think and act (Coghlan & Brydon-Miller 2000:3).

2.11.2 Simultaneity principle

The simultaneity principle holds that research and organisational change are simultaneous moments. This principle proposes that people inquire into human systems and change them (Kessler 2013:2)

According to Watkins and Kelly (2010:15), this principle works in harmony with the constructionist principle. It recognises that inquiry and change are not separate moments but are simultaneous. The things that people think and talk about, the things that people discover and learn, and the things that inform dialogue and inspire images of the future are implicit in the very questions they ask. As people analyse a phenomenon they also change due to interactions (Reed 2007:10).

2.11.3 Poetic principle

According to Watkins and Kelly (2010:14), the poetic principle acknowledges that human organisations are open books. An organisation's story is constantly being co-authored by the people within the organisation as well by those outside who interact with it. The poetic principle provides an opportunity for dialogue to enhance value and elevate team spirit and work .It brings to life the stories that empower positive relationships (Reed 2007:9).

2.11.4 Anticipatory principle

The anticipatory principle holds that what people do today is guided by their image of the future (Kessler 2013:2). Positive images lead to positive actions. Behaviour and decisions about actions

are based not only on what individuals were born with or learned from the environment, but also on what they anticipate, think or imagine will happen in the future (Watkins & Kelly 2010:259). This principle suggests that the way people think about their future determines the way they will move towards the future (Reed 2007:9).

2.11.5 Positive principle

The positive principle states that the momentum for change requires positive thinking and social bonding qualities like hope, inspiration and joy in creating with one another (Watkins & Kelly 2010:16). Kessler (2013:2) adds that the positive principle proposes that momentum and sustainable change require positive affect and social bonding.

The more positive questions are asked, the faster social change is brought about and the organisation moves in the direction being considered. The positive principle recognises that sustainable change is fuelled by positive emotional energy and positive questions keep participants fully focused for longer (Reed 2007:9).

2.12 CRITIQUE OF APPRECIATIVE ENQUIRY

AI has been accused of being naive and idealistic and of focusing on positive aspects to the extent of ignoring or suppressing negative experiences (Reed 2007:23). Critics accused AI of ignoring or even denying problems. However, AI addresses issues and problems from a different and often more constructive perspective: it reframes problem statements into a focus on strengths and successes (Preskill & Catsambas 2006:6).

Appreciative inquiry was criticised for its focus on positive aspects rather than the entire problem (Coghlan & Brydon-Miller 2014:11). Focusing on the positive stories during the discovery phase invalidates the negative organizational experiences (Coghlan & Brydon-Miller 2014:11).

2.13 CONCLUSION

This chapter discussed the literature review conducted for the study. The literature review covered Maslow's hierarchy of needs, support needs, types of support needs, the history, assumptions and principles of AI, and criticism of AI. Chapter 3 discusses the research design and methodology of the study.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

Chapter 2 discussed the literature review conducted for the study on support needs of enrolled nurses (ENs) working in an ICU. Appreciative Inquiry (AI) was discussed in detail as the researcher used AI as the theoretical framework for the study. This chapter discusses the research design and methodology.

3.2 AIM OF THE STUDY

The aim of the study was to explore and describe the support needs of ENs working in an ICU of a selected private hospital in Tshwane, Gauteng Province, South Africa.

In order to achieve the aim, the study wished to answer the following question:
What are the support needs of the enrolled nurses working in an ICU ofa private hospital in Tshwane?

3.3 RESEARCH DESIGN

Creswell (2014:4) refers to a research design as a method for discovering and understanding approaches that guide the way to the research study. Polit and Beck (2017:56) describe a research design as “the overall plan for addressing a research question, including the specifications for enhancing the integrity of the study”. According to Grove, Burns and Grey (2013:195), a research design is a blueprint for conducting the study and the tool used to conduct the study in a way that is guided, planned, and implemented to achieve accurate results. Research designs help researchers minimize bias and guide the whole process of answering the research questions (Polit & Beck 2017:56; Terre’Blanche, Durrheim & Painter 2014:34; Brink, Van der Walt & Van Rensburg 2012:102).

In this study, the researcher used a qualitative, exploratory and descriptive research design in order to explore and describe the participants' support needs.

3.3.1 Qualitative

Qualitative research is the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design (Polit & Beck 2017:741). Qualitative research is "a systematic, subjective methodological approach used to describe life experiences and give them meaning" (Grove, Burns & Gray 2013:551). Terre'Blanche, Durrheim and Painter (2014:47) state that qualitative research is "naturalistic, holistic and inductive" and occurs in a natural setting with no change or manipulation of the environment. The aim of qualitative research is to study human experiences as lived by them and to make sense out of them (Grove, Burns & Grey 2013:27; Taylor, Bogdan & DeVault 2015:10). Qualitative studies involve an in-depth examination of the qualities, characteristics or properties of a phenomenon to better understand or explain them with the goal to ensure that the chosen theory matches the data, not the other way around (Botma, Greeff, Mulaudzi & Wright 2015:182;Taylor, Bogdan & DeVault 2015:9).

In qualitative studies, the participants and their environments are always viewed as one, not separate components (Taylor, Bogdan & DeVault 2015:9).Qualitative researchers investigate phenomena in a complete manner and in-depth through the collection of rich narrative material using a flexible design (Polit & Beck 2017:12).

Qualitative research has the following characteristics:

3.3.1.1 Natural setting

Qualitative researchers collect data in the field at the site where participants' experience the problem under study (Creswell 2014:185). Information is gathered by directly talking to people and seeing them behave and act in their context the researcher comes in contact with the participants directly. Accordingly, data was collected from the participants who worked in the setting of the study.

3.3.1.2 Researcher as key data-collection instrument

In qualitative research, researchers collect data themselves, as they are involved in the whole process and steps of data collection (Creswell 2014:185). In qualitative studies, researchers use their own instrument for data collection and tend not to use or rely on questionnaires or instruments developed by other researchers. In this study, data was collected by the researcher and the researcher's supervisor, who is a qualified researcher. The researcher designed and used an AI interview guide for data collection.

3.3.1.3 Complex inductive reasoning

During data analysis researchers formulate categories and themes from collected data (Creswell 2014:186). All the themes and categories identified are well analysed and more supportive information added (Creswell 2014:186). In this study, the researcher analysed the data collected, and formulated themes, categories and subcategories from the data.

3.3.1.4 Multiple sources of data

In qualitative studies, researchers collect all forms of data, and do not use one source (Creswell 2014:185). Researchers go through data analysis and develop sets of themes, categories and subcategories (Creswell 2014:185). In this study, data was collected by means of a focus group interview that was audio-taped and through observations and documents.

3.3.1.5 Researcher's focus on participants' perceptions

In qualitative studies, researchers find the participants' meaning through their responses to the phenomenon under study (Creswell 2014:186).The researcher focused on learning the participants' meanings and their subjective views, not the meaning she brought to the study. Accordingly, the researcher used a research question to gain information, and probing was done to get more information from participants to obtain rich data.

3.3.1.6 Reflexivity

The researcher reflects on the researcher's role and past experiences to assist during data analysis (Creswell 2014:186). The researcher kept a reflective journal in order to bracket out her own experience, perceptions and any preconceptions.

3.3.1.7 Holistic account

In a holistic view of social phenomena, researchers try to develop a complex picture of the problem or issue under study. This involves multiple perspectives, identifying the many factors involved in a situation, and generally sketching the larger picture that emerges (Creswell 2014:185). Researchers try to look at the research problem from all angles and for any possible problems that may occur (Creswell 2014:186). The researcher, therefore, kept in mind any possible factors that could hinder or affect the study.

3.3.2 Exploratory

Researchers use exploratory designs in areas that are unfamiliar as the initial stage of the investigation (Terre'Blanche, Durrheim & Painter 2014:44). Exploratory research investigates the full nature of the phenomenon, the manner in which it is manifested, and other related factors. This type of research is conducted for a problem that has not been clearly defined. It helps determine the best research design, data-collection method and selection of participants (Polit & Beck 2017:15).

Exploratory research is designed to increase knowledge of a field of study and not intended for generalisation to large populations (Grove, Burns & Grey 2013:694). The researcher used an AI approach to explore the participants' support needs in the ICU of the selected hospital.

3.3.3 Descriptive

The main purpose of descriptive studies is to define the phenomenon under study (Terre'Blanche, Durrheim & DeVault 2014:44). Descriptive research has the accurate portrayal of the characteristics of persons, situations, or groups, and the frequency with which certain phenomena occur as its main objective. Descriptive research explores and describes phenomena in real-life situations for the purpose of observing, describing and documenting aspects as they occur naturally in order to serve as the starting point for hypothesis generation or theory development (Polit & Beck 2017:726). In this study, the researcher used an exploratory, descriptive design in order to describe the participants' support needs.

3.4 RESEARCH METHODOLOGY

Research methodology is the plan for conducting the specific steps of a study (Burns & Grove 2009:719). Burns and Grove (2009:54) add that qualitative research methodology is both flexible and evolving as the researcher explores the depth, richness and complexity of the information

(data). Research methods are "the techniques researchers use to structure a study and to gather and analyse information relevant to the research question" (Polit & Beck 2017:743). The methodology includes the population, sampling and sample, data collection and data-collection techniques, data analysis, and trustworthiness.

3.4.1 Population

A population is the whole group that the researcher is interested in studying and meets the criteria (Polit & Beck 2017:249). A population is the bigger group from which the sampling elements are drawn, and to which researchers want to generalise their findings (Terre' Blanche, Dureim & Painter 2014:133; Bless, Higson-Smith & Sithole 2013:162). In this study, the population included all ENs working in the ICU of the selected private hospital in Tshwane.

Polit and Beck (2017:249) distinguish between the target and the accessible population. The target population is the aggregate of cases about which the researcher would like to generalise, the accessible population is the aggregate of cases that meet the inclusion criteria and are accessible as participants for a study. In this study, the target population was all the ENs working in an ICU in a selected hospital in Tshwane with a minimum working experience of six months in ICU. The researcher gained access to the population through the hospital CEO, the hospital matron and the ICU unit manager.

To be included in the study, the ENs had to

- ✓ Work in one of the ICUs in the selected hospital.
- ✓ Have at least six months' working experience in ICU.
- ✓ Be registered with the South African Nursing Council (SANC).

Exclusion criteria are features that can cause participants not to be included in the target group for the research (Grove, Burns & Grey 2013:353). Accordingly, ENs who did not work in the ICU or had less than six months' working experience in ICU were excluded.

3.4.2 Sampling and sample

A sample is a group of people or elements that are selected for the study (Grove, Burns & Grey 2013:351; Terre'Blanche, Durrheim & Painter 2014:133). Sampling is the process of selecting a part of the population to represent the total population (Polit & Beck 2017:250; Brink, Van der Walt

& Van Rensburg 2012:145). Purposeful or non-probability sampling is used in qualitative research to select study participants because they understand the research problem and phenomenon under study (Creswell 2014:225). Polit and Beck (2017:254) add that in purposive or non-probability sampling, the researcher selects participants based on personal judgement about which ones will be the most informative. Brink, Van der Walt & Van Rensburg (2012:143) state that a large sample cannot guarantee the accuracy of the study results.

The researcher used purposive sampling to select the participants for the study. The advantage of purposive sampling is that it allows the researcher to select participants that are knowledgeable about the study phenomenon (Brink, Van der Walt & Van Rensburg 2012:141). Qualitative research does not require large samples (Brink, Van der Walt & Van Rensburg 2012:143). The researcher used purposive sampling to select eight (8) ENs working in the ICU because they were seen as informative and knowledgeable about their supports needs as lived and experienced by them (Botma, Greeff, Mulaudzi & Wright 2015:201). In qualitative studies it is important that data saturation is reached (Brink, Van der Walt & Van Rensburg 2012:144). Data saturation is when no new information emerges from participants during data collection (Brink, Van der Walt & Van Rensburg 2012:144).

3.4.3 Data collection

Data collection is the process of collecting data related to the research question in a systematic way to address a research problem (Polit & Beck 2017:725). Qualitative researchers collect their data in a real-life natural setting (Polit & Beck 2017:464). In qualitative studies, data is collected by means of interviews, observations and recordings in the participants' environment where they live (Terre'Blanche, Durrheim & DeVault 2014:51).

In this study, data was collected by means of a focus group AI interview. A focus group is a group of people selected by the researcher to share their insights and personal experiences about the phenomenon under study (Powell & Single 1996:499). The main purpose of using a focus group interview is to collect rich, detailed data, and that group interaction is focused on the selected topic (Carey & Ashbury 2016:15).This method is suitable for people who have knowledge and experience of the phenomenon, and are able to share their experience with the researcher (Carey & Ashbury 2016 :16). A focus group interview makes experiences more holistic by providing beliefs, insights and attitudes about the whole behaviour and the context (Carey & Ashbury 2016:17). Focus group interviews generate rich and detailed data (Carey & Ashbury 2016:15). Participants' descriptions of their experiences can provide unique information about the meanings of their experiences and how they organize them (Carey & Ashbury 2016:17).

A disadvantage of this method, however, is that during a focus group interview, the control between the researcher and the participants is reduced; the research is conducted with the participants not on the participants (Carey & Ashbury 2016:12).

The researcher wished to explore and describe the participants' support needs. The researcher, in collaboration with the supervisor, developed a semi-structured AI interview guide, using the AI 5-D cycle to guide the interview (see Annexure C for copy of interview guide).The researcher followed the steps of AI, namely **Define** (describing the research problem); **Discover** (discover the phenomenon); **Dream** (thinking and imagining what could be); **Design** (transform ideas into actions); **Deliver/Destiny** (empowering and creating a new future). The researcher selected this method to explore and describe the participants' support needs. The focus group interview lasted approximately 70 minutes, until data saturation was reached.

During the focus group interview the participants were seated in a circle, for a more face-to-face presentation with each other and the group facilitator (Powell & Single 1996:502; Dilshad & Latif 2013:193). The researcher recorded and noted all activities during data collection. The interview took place in a private room outside the ICU of the selected private hospital for privacy purposes. A quiet setting without disruptions is an ideal setting for data collection (Polit & Beck 2017:464).

The focus group interview was audio-taped and the researcher took field notes for transcription purposes. Interviewed data must be participants' actual verbatim responses (Polit & Beck 2017:535). After data collection, all the data was reviewed by the researcher and her supervisor in preparation for data analysis. The researcher organized the data by transcribing the tape-recorded interview verbatim and keeping the transcription as well as the field notes taken during the interview in folders. The researcher kept all the data collected in a safe place to which only she and the supervisor had access.

3.4.4 Data analysis

Data analysis is the systematic organization and synthesis of data to establish order, structure and meaning to qualitative data collected (Polit & Beck 2017:725; Botma et al 2010:220).

Data analysis entails categorising, ordering, manipulating, summarising and describing the data in meaningful terms (Brink, Van der Walt & Van Rensburg 2012:170). Qualitative data analysis is a rigorous and logical process by which data are given meaning (Grove, Burns & Grey 2013:493). Grove, Burns and Grey (2013:279) emphasise that becoming familiar with the data involves reading the data over and over again, recalling the transcript, observation and experiences, and

listening to the tape recording until becoming absorbed with the data. Data analysis is a process that reduces, organizes, and gives meaning to data (Grove, Burns & Grey 2013:46; Doody, Slevin & Taggart 2013:1).The researcher involved her supervisor during data analysis for confirmation of the research findings.

According to Doody, Slevin and Taggart (2013:4), focus group data analysis entails generating rich data; familiarizing oneself with the data; writing memos; indexing; forming themes, and mapping and interpretation. Focus group analysis has strengths and weaknesses (Doody, Slevin & Taggart 2013:6). In focus group data analysis, the researcher is able to develop a high level of analysis, and get deep into the data. The process is imaginable and shows a high level of understanding (Doody, Slevin & Taggart 2013:6).However, focus group data analysis is a complex, time-consuming process, with a large volume of data collected and a potential for researcher bias (Doody, Slevin & Taggart 2013:6). Furthermore, misinterpretations may occur during group interaction, as group members may give similar answers or not participate during discussions and the modified responses of the group members may be misinterpreted (Doody, Slevin & Taggart 2013:6).

According to Doody, Slevin and Taggart (2013:4), focus group interview data analysis involves generating rich data; familiarising oneself with the data; writing memos; indexing phrases and quotes; forming themes, and mapping and relating themes.

The researcher used Tesch's eight-step method (Creswell 2014:198) to analyse the data:

- ✓ Read through all the data carefully in order to get a sense of the whole.
- ✓ Read through the transcript again to get the underlying meaning. Write thoughts down in the margins.
- ✓ Make a list of all the topics from the data. Cluster similar topics together and form these topics into themes.
- ✓ Abbreviate the themes as codes next to appropriate segments of the text.
- ✓ Find the most descriptive wording for the themes and turn them into categories.
- ✓ Reduce the total list of categories by grouping or clustering topics that relate to each other.
- ✓ Make a final decision on the abbreviation for each category and then arrange the codes alphabetically.
- ✓ Assemble the data for each category in one place and perform preliminary analysis.

3.4.5 Bracketing

Bracketing is a process of detecting and setting aside one's beliefs and thoughts about the phenomenon under the study and an ongoing process throughout the research study (Grove, Burns & Grey 2013:60; Polit & Beck, 2017:471).The researcher made sure that her beliefs and experiences did not interfere with the study, as she worked with the participants and was their leader in the workplace. In addition, the researcher's supervisor supervised the whole process of data collection.

3.5 TRUSTWORTHINES

Trustworthiness is "the degree of confidence that qualitative researchers have in their data, using the strategies of credibility, dependability, confirmability, transferability and authenticity" (Polit & Beck 2017:747). Qualitative validity refers to using procedures to ensure that the results or findings of a study are correct (Brink, Van der Walt & Van Rensburg 2012:171; Creswell 2014:201). In this study, the researcher used Lincoln and Guba's (1994) framework to ensure trustworthiness (Polit & Beck 2017:559):

- ✓ **Credibility:** The investigation must be done in a way that the participants will believe the study results and the truth of the data and interpretation thereof (Brink, Van der Walt & Van Rensburg 2012:172). The researcher ensured credibility of the results by the following:
  - *Prolonged engagement*. The researcher remained in the data-collection process until data saturation was reached. This enabled her to establish rapport and trust and acquire information-rich data.
  - *Member checking*. After data analysis the researcher went back to the participants to correct any errors and provide additional information and interpretation of data. These member checks allowed the researcher to amend the findings, where necessary.
  - *Data saturation*. Data collection was prolonged to ensure internal validity of the study results. Data collection was done until data saturation was reached and no new information emerged.

- ✓ **Dependability:** Dependability refers to whether the findings can be applied to a similar context, setting and other participants, and produce similar findings (Brink, Van der Walt & Van Rensburg 2012:172). The researcher ensured dependability by means of an auditor

who examined the documentation and the process of the investigation. The researcher provided feedback to the participants to confirm the interpretation of the data.

- ✓ **Confirmability:** Confirmability refers to the potential for congruency of data in terms of accuracy, relevance or meaning, and that the data was provided by the participants (Brink, Van der Walt & Van Rensburg 2012:173). Confirmability ensures that information provided by participants is not driven by the researcher's perceptions or misconceptions; the data must represent the voices of the participants. The researcher kept comprehensive field notes during data collection. Audio-taping ensured the participants' actual information. A co-coder was used to confirm/verify the study results and indicate whether the researcher correctly interpreted the collected data.

- ✓ **Transferability:** Transferability refers to the possibility that the findings of a study will have the same meaning in a different context with other participants (Brink, Van der Walt & Van Rensburg 2012:173). In this study, purposive sampling was used to maximise the information collected about the phenomenon. Prolonged engagement until data saturation when no new themes emerged ensured thick and rich data. A full description of the whole research process was provided.

- ✓ **Authenticity:** Authenticity means that the findings reflect the participants' experiences and feelings as lived in a fair and faithful manner, and the researcher must develop an increased sensitivity to the issues discussed (Brink, Van der Walt & Van Rensburg 2012:172-173). Prolonged engagement allowed trust and good rapport between the researcher and the participants, which led to useful and accurate information.

3.6 ETHICAL CONSIDERATIONS

Ethics deals with matters of right and wrong. When humans are used as study participants, care must be taken in ensuring that their wellbeing and rights are protected (Polit & Beck 2017:727; Terre'Blanche, Durrheim & Painter 2014:61). Accordingly, the researcher obtained permission to conduct the study, obtained informed consent from the participants, and observed the ethical principles of beneficence, respect for human dignity, and justice (Polit & Beck 2017:139; Creswell 2014:95).

- ✓ **Permission**

The researcher obtained written permission from the University of Pretoria, Ethics Committee and the selected hospital to conduct the study (see Annexure A). The researcher also obtained

permission from the Chief Executive Officer and the Matron of the hospital. Permission was also obtained from the ICU unit manager before commencing the focus group interview.

- ✓ **Informed consent**

Participants have the right to participate or not participate in a research study, without any risk, penalty or prejudicial treatment (Brink, Van der Walt & Van Rensburg 2012:35). Informed consent means that participants "have adequate information about the research, comprehend that information, and have the ability to consent to or decline participation voluntarily" (Polit & Beck 2017:140). Accordingly, the researcher explained the purpose and significance of the study to the participants. The researcher informed the participants where and at what time the study would take place; what was expected of them, and that all information discussed would be kept confidential between them and the researcher to maintain their privacy. Carey and Ashbury (2012:11) point out that it is not possible to maintain confidentiality in focus group interviews, but researchers can assure that the information discussed can be kept confidential.

The researcher also informed the participants that they had the right to withdraw from the study at any time should they wish to do so. The participants signed the informed consent form as proof of voluntary participation in the study (Creswell 2014:96).

- ✓ **Beneficence**

Beneficence requires researchers to minimise harm and to maximise benefits. Research should be intended to produce benefits for participants themselves or for other individuals or society as a whole (Polit & Beck 2017:139; Terre'Blanche, Durrheim & Painter 2014:67). The principle of beneficence includes the right to freedom from harm and discomfort and the right to protection from exploitation. In this study there were no physical, social, emotional or psychological risks. In order to prevent any feelings of uneasiness or discomfort due to a group session, the researcher explained the study, method of data collection and the participants' freedom to express themselves. In addition, the researcher ensured that the interview was conducted at the stipulated time. The participants' permission was also obtained to audio-tape the interview.

Participants must not be exploited for personal gain, experience negative feelings, or be exposed to harm (Polit & Beck 2017:139). In this study, the researcher ensured that the participants did not feel that they were exploited by her because she was their senior manager. Accordingly, the researcher made sure that all the steps of the study were followed as prescribed. Moreover, another researcher assisted with the data collection and

the researcher was an observer and took field notes. The participants were assured that any information they provided would not be used against them in any form or way.

The study was conducted in a private room for the participants' comfort and to provide privacy. During the study participants must not experience any form of negative feelings or be exposed to any harm, or feel disadvantaged (Polit & Beck 2017:139). During data collection, the focus group was conducted by the researcher's supervisor and the researcher was an observer. This was done to ensure that the participants were comfortable and did not feel exploited as the researcher is their shift leader and senior to them in the workplace. The researcher ensured that the results would not be used against them and all participants were treated the same way.

- ✓ **Respect for human dignity**

  Respect for human dignity includes the right to self-determination and the right to full disclosure. The right to self-determination means that research participants "should be treated as autonomous agents, capable of controlling their actions" (Polit & Beck 2017:140). This implies that individuals have the right to decide whether to participate in a research study or not, without any risk or penalty or prejudicial treatment (Brink, Van der Walt & Van Rensburg 2012:35). The researcher gave the participants full information about the study so that they could decide whether or not to participate. The right to full disclosure requires that participants "have adequate information about the research, comprehend that information, and have the ability to consent to or decline participation voluntarily" (Polit & Beck 2017:140). The researcher informed the participants of the purpose, objectives and significance of the study; how and where data would be collected and that they could withdraw from the study at any stage should they wish to do so. The right to self-determination is based on the principle of respect for persons, which states that an individual has the right to decide whether or not to participate in a study, without the risk of penalty or prejudicial treatment (Burns & Grove 2009:188; Polit & Beck 2017:140).

- ✓ **Justice**

  The principle of justice includes the right to fair treatment and the right to privacy (Polit & Beck 2017:141; Terre Blanche, Durrheim & Painter 2014:68). The right to fair treatment holds that each person should be treated fairly and should receive what he or she is due or owed (Burns & Grove 2009:188). In this study, the participants' selection was fair as they were purposively selected for reasons directly related to the problem being studied.

The right to privacy meant that the participants had the right to anonymity and to assume the data collected would be kept confidential (Polit & Beck 2017:141). The researcher ensured that the interview was conducted in a private room to ensure the participants' privacy and that they could not be overheard by others. The participants' anonymity was assured by not using their names. Furthermore, the audiotape was only reviewed by the researcher and the supervisor and was kept with the transcript under lock and key. Only the researcher and supervisor had access to the information. The audio tape and the transcript will be kept under lock and key for a certain period; no unauthorized person will have access to them or to the information except the researcher and her supervisor.

3.7 CONCLUSION

This chapter described the research design and methodology, including the population, sampling and sample, data collection and analysis, and ethical considerations in detail. Chapter 4 presents the data analysis and interpretation, and findings.

In this chapter the, discussion of the research methodology, data collection, data analysis, sampling, population, trustworthiness and ethical considerations were discussed in detail. The next chapter is chapter four (4). Chapter four contains detail descriptions of the study results/findings. The whole detailed information on the study findings and more on the literature about the study finding is discussed in the next chapter (chapter 4).

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION AND FINDINGS

4.1 INTRODUCTION

Chapter 3 described the research design and methodology of the study. This chapter discusses the data analysis and interpretation, and findings. The findings are discussed with reference to the literature reviewed.

4.2 THEMES, CATEGORIES AND SUB-CATEGORIES

Data was collected by means of a focus group interview (FGI). Eight enrolled nurses participated in the FGI, of whom two were permanently employed and six were working in the ICU through a nursing agency. The FGI took approximately 70 minutes and was facilitated by an external facilitator.

The researcher used Tesch's 8-step data analysis method. Eight themes were identified during data analysis, of which five related to the participants' peak experiences, namely professional conduct, support, knowledge, procedures and equipment, and three related to the participants' wishes, namely belonging to a team opportunities, and knowledge. Table 4.1 summarises the themes, categories and sub-categories.

Table 4.1 Summary of themes, categories and sub-categories

PEAK EXPERIENCES		
THEMES	**CATEGORIES**	**SUB-CATEGORIES**
Professionalism	Positive attitude	
	Patient-centred communication	Greeting
		Introduce
Support	Professional nurse	
Knowledge	Haemodynamic parameters	Report
	Diagnosis	
	Priorities care	
Procedure	Prepare for admission	
	Checking emergency trolley	
	Withdraw blood from arterial line	
	Taking a12-lead electrocardiography	
Equipment	Blood gas machine	
	Infusion pumps	
WISHES		
THEMES	**CATEGORIES**	**SUB-CATEGORIES**
Belonging to a team	Acknowledge	
	Valued	
Opportunities	Continuous professional development programme	
	Clinical facilitator	

THEMES	CATEGORIES	SUB-CATEGORIES
Knowledge	Mechanical ventilation	Principles
		Care of patient
		Weaning
	Intravenous medication	Inotropes
	Electrocardiography analysis	• Manipulation
	Arterial blood gas analysis	
	Laboratory results	
	Equipment	
	Renal dialysis	
	Chest x-ray	

The themes, categories and sub-categories are discussed next.

4.3 PARTICIPANTS' PEAK EXPERIENCES

Five themes were identified from the participants' peak experiences, namely professionalism, support, knowledge, procedures and equipment.

4.3.1 Professionalism

The participants stated that professionalism guides nurses and their practice. Professionalism requires nurses to have theoretical knowledge, practise ethically, uphold nursing values, have a positive attitude and acknowledge collaboration (Alidina 2012:132). The nursing profession is guided by the South African Nursing Council, (SANC) as the regulatory body. The SANC expects nurses to have a professional image, thinking and behaviour. Professional values in nursing practice are the beginning of the nursing profession, and used to direct nurses on how to relate to the community, society and colleagues (Cetinkaya-Uslusoy, Pasli-Gurdogan & Aydinli 2015:2). These values help nurses to have one common culture and nursing ideology and mission. Moreover, professionalism helps the nursing profession make and maintain a certain standard in nursing practice (Cetinkaya-Uslusoy, Pasli-Gurdogan & Aydinli 2015:2).

Bromley and Orchard (2016:352) emphasise that nursing codes and values go hand in hand with maintaining higher standards of ethical behaviour and can also be a legitimizing symbol in the cultural context of professionalization and neoliberalism. Furthermore, this is the way to ensure accountability and transparency and prevent misconduct in the future (Bromley & Orchard 2016:353). Nursing practice is standard throughout the world, with policies and procedures on professional conduct. Accordingly, all nursing schools are responsible for teaching professional conduct, procedures, acts and omissions before nurses start clinical nursing practice. It is very important that during service delivery nurses are aware of the scope of practice that guides their personal and professional behaviour (Cetinkaya-Uslusoy, Pasli-Gurdogan & Aydinli 2015:2). Professionalism is the most important part of nursing practice nationally in all nursing categories.

Two categories were identified in professionalism, namely positive attitude and patient-centred communication.

4.3.1.1 Positive attitude

The participants valued that they had learned to present themselves positively to other staff members and to patients. Alidina (2012:128) found that nurses who had a positive impact on patient satisfaction had the attribute of professionalism. The participants indicated that some of the registered nurses had a positive attitude toward them, and those with positive attitudes were willing to support and teach them in the ICU setting. This enabled them to acquire certain skills and competency and a positive attitude. Patients expect nurses to have a positive attitude and it is the nurses' responsibility to present themselves positively in the workplace. Positive attitude promotes teamwork and is a motivation in the working environment. All nurses are encouraged to have a positive attitude to achieve their goal, mission and vision in the workplace for the employer and other colleagues.

According to the participants,

> "The registered nurse was having a positive attitude towards me [EN]."
>
> "The registered nurse encouraged me [EN] that everything will be fine."
>
> "The registered nurse encourages me [EN] to have positive attitude towards the patient."

It is important for registered and licensed nurses to have a positive attitude about the importance of families in surgical hospital units (Blondal, Zoega, Hafstelnsdottir, Olafsdottir, Thorvardardottir, Hafstansdottir & Sransdottir 2014:358). Workplace culture between the multidisciplinary team is that they are all there for the patient and each individual plays an important role in his or her profession for the health of the patient as they do not practise the same thing. The nurse's role in the process is to assess the patient's need. The participants identified having a positive attitude as a way of achieving positive outcomes in the working environment and of keeping all employees working towards a common goal. When doing a job, that job is associated with certain knowledge or fulfilment which are all involved or part of positive job attitude (White & Bryson 2013:390).

A positive attitude is affected by a person's emotions and emotional state (Rocklage & Fazio 2016:268). Regarding positive leadership and employee well-being, the most important aspect that leaders in the workplace are responsible for is to encourage positive emotions towards one another and their followers (Kelloway, Weigand, McKee & Das 2013:108; Lehmann-Willenbrock, Chiu, Lei & Kauffeld 2017:39-78). In this study, some of the participants stated that they needed "encouragement that everything will be fine". Positive emotions in the organisation or workplace promote positive outcomes in the work being done and fewer mistakes are more likely to occur.

4.3.1.2 Patient-centred communication

Patient-centred communication is very important in professionalism and professional conduct. Patient-centred communication is a major part of nursing in the workplace, since nursing is about communication throughout the day. Patient-centred communication had two sub-categories, namely greeting and introducing. The participants stated that they valued the knowledge they had gained about professionalism, especially regarding patient-centred communication, as they knew what was expected of them and when. Coming on duty nurses greeted and introduced themselves to the patients they would be rendering service to and to their colleagues. Introducing referred to the way nurses greeted the patients verbally and told them their name and their intentions towards them for that particular shift. Greeting and introducing go hand in hand as nurses use both interchangeably throughout their practice. Regarding the importance and value of professionalism and patient-centred communication, the participants stated:

> "How to work with the patient and to introduce myself to the patient and present myself positively to the patient."

"I learned the welcoming manner of the ICU staff."

"We learned to nurse our patients with pride, considering their needs."

"To have a good relationship between the enrolled nurses and the registered nurses and not to undermine each other."

"To have a good relationship with our patients so we can know in detail what is wrong with them."

Introducing themselves to patients is important and sets the tone for the day; even greeting them with a smile says a lot to everyone in the working area. In a study on the trust status of the nurse-patient relationship with patients suffering from cancer, Ozaras and Abaan (2016:7) found that most of the participants stated that when the nurse came to their room and said good morning, it made them happy and forget about their sadness for a short while. Chen and Hsu (2015:791) emphasise that good nurses are passionate, caring and attentive and ensure patients' wellbeing. Nurses deal with patients from different cultures and cultural backgrounds, but the norm is that they are all treated the same and equally. Chen and Hsu (2015:792) found that despite the different cultural variations patients still valued and preferred person-to-person relationships with the nurses. Professionalism is something that the nurses acquire throughout their education and practice. Communication with patients makes them open up and creates a trusting patient-nurse relationship.

How patients perceive communication affects their willingness to communicate as well as their satisfaction with their care (Baker & Watson 2015:621). All the activities in the ICU setting require effective communication for effective patient care without any errors. For good communication to occur between patients, doctors and nurses requires more time, commitment, teamwork and effort (Baker & Watson, 2015:622). In the ICU setting communication is always a problem between healthcare providers and patients and patients' relatives due to the nature of the patient's condition. Communication in the ICU setting is often impaired due to patients being sedated or intubated and other barriers in the ICU environment (Banerjee, Taylor, Brett, Young & Peskett 2014:314). Lack of communication in the ICU setting leads to patients and nurses experiencing negative effects and feelings and failure to overcome these problems can cause frustration and conflict (Rodriquez, Spring & Rowe 2015:174). Patients with language barriers are less satisfied about their care than patients who are more proficient in the language (Galinato, Mantie, Shuman, Patak &Titler, 2016:7).

Open communication between family members, patients and healthcare providers requires time and patience for good outcomes and meeting patients' needs (Rodriquez, Srping & Rowe 2015:176). If individuals' needs are not met, all the members of the team are at risk of developing anxiety and stress (Banerjee, Taylor, Brett, Young & Peskett, 2014:317)

4.3.2 Support

The participants' considered support one of the most important aspects while working in ICU. The participants felt supported by the professional nurses, and valued the support they received, especially when they were given a patient with challenges. Only one category emerged under support, namely professional nurse, as the participants felt that it was very important for them to have full support from the professional nurses. The participants and all ENs only work under the direct supervision of professional nurses, as stipulated by their scope of practice. The participants also appreciated the guidance, psychological and work-related support given by the professional nurses in the complex ICU setting with critically ill patients. Moreover, the participants were able to work with confidence knowing that they were fully supported.

The SANC categorises nurses into the following groups: professional nurse, enrolled nurse, nursing auxiliary, and care worker. All nursing categories have particular functions in the work setting as set and regulated by the SANC. In this study, the participants worked together with the professional nurses as they functioned under their supervision. A professional nurse is someone who is "qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice" (Nursing Act, 33 of 2005:25). Professional nurses thus do not work under any supervision, carry out doctors' orders as ordered and, in other instances, ensure that doctors' orders are carried out correctly in the manner prescribed. Professional nurses are fully responsible and accountable for all the functions and the activities that occur in the ICU setting.

According to the participants,

> "To have more support from the professional nurse and the doctors."
>
> "To work with the professional nurses who are more experienced, as most of the things we learn from them."

"To have trust and encouragement from the line manager and the ICU trained professional nurses."

In the ICU environment the professional nurse plays the most important part, as this environment requires independent practitioners and professional nurses are part of the independent practitioners. Dossey and Hess (2013:10) point out those professional nurses are instructors of the whole team in the workplace, by means of principles and modalities that are set in place as guidelines. Advanced practice (professional) nurses have various roles and teach other nurses advanced clinical skills for expected knowledge (McDonnell, Gerrish, Kirshbaum, Nolan, Todd & Guillaume 2012:369).

Professional nurses have a huge impact on practice because of their advanced knowledge which they use to solve problems and provide support to their subordinates (ENs) in extending their role (McDonnell et al 2012:379). In this study, the participants valued the support and fairness they received from the professional nurses. Professional nurses valued subordinates' loyalty, presence, and job well one (McDonnell et al 2012:684).

4.3.3 Knowledge

The participants identified knowledge as another important peak experience in the ICU. In this study, knowledge referred to the information, understanding and skills acquired through learning, experience, practice and service. The participants felt competent and confident, and valued the knowledge they had gained in the ICU environment as it enabled them to take care of the ICU patients. Three categories were identified in this theme, namely haemodynamic parameters, diagnosis, and prioritised care. These categories are discussed next.

4.3.3.1 Haemodynamic parameters

Knowledge of haemodynamic parameters meant that the participants were able to identify abnormalities in patients' haemodynamic parameters, and to report them to the shift leader early. The participants reported that they appreciated and valued the fact that they were able to detect abnormalities. Haemodynamic parameters in the ICU setting are monitored continuously with invasive or non-invasive equipment monitor and are one of the most important assessments strategies of the critical ill patient.

According to the participants,

> "As an ICU enrolled nurse, I have learned to strictly monitor the vital signs and report any abnormalities to my shift leader."
>
> "At least now I can see if something is not going well with my patient and report."
>
> "I can see the abnormalities on the arterial blood gas, and also nurse the patient on inotropes knowing that the shift leader will support and guide me all the way."

The participants identified haemodynamic parameters as important and were happy that they could identify abnormal values and report it in time. The participants believed that having this knowledge would make them safe enrolled nurses working in the ICU. A study on nurses as knowledge workers found that information is the created evidence and knowledge that makes a well-recognised relationship (Matney, Maddex & Staggers 2014:175). The information about the patient observations and their trends and whether the trends are normal or not are all part of knowledge generation (Matney, Maddex & Staggers 2014:175).

4.3.3.2 Diagnosis

The participants identified diagnosis as another peak experience while working in the ICU setting. They also realised that diagnosis in the ICU setting differs from diagnosis in the ward setting. The participants appreciated that they could understand the diagnosis of the critical ill patients and give treatment according to the patient's needs. Patient diagnosis requires knowledge, skill and competence to see a particular problem in the patient. The Nursing Act, 33 of 2005 defines diagnosis as "the identification of the nature of an illness or other problems by examination of the symptoms". Patient diagnosis allows for patients to get the proper care according to their needs. Such care requires nurses to have the skill, competence and knowledge to give the necessary care according to the identified need and diagnosis. The participants appreciated being capable of nursing and taking care of patients according to their needs, even though their scope of practice was limited.

According to the participants,

> "I wish we can have a course about the diagnostic tools (arterial blood gas machine) that are used in the ICU and the important of using them."

> "To have one programme at least once a month, for learning more basic things about the ventilator."
>
> "To have more books and pamphlets in the ICU regarding the conditions of patients."

Diagnosis is a way of identifying patients' problems, or sickness by means of signs and symptoms, diagnostics test machines or clinical signs exhibited by patients. The ICU setting has many diagnostic tests used by the nurses, and all require skill and knowledge on how to operate them. The machines and equipment used on a daily basis for the ICU patient perform the following tasks: analyse the arterial blood gas, analyse the ECG paper for abnormalities, ventilator machine values for abnormalities, monitor for any abnormal tracing of graphs, urine analysis for any abnormalities, and others. It is important for healthcare professionals to have recent up-to-date knowledge on all tasks for patient safety, and for nurse assistants to be supported, because assistants generally have a lower level of safety knowledge (Mockiene & Suominen 2016:14).

ENs are dependent on people with more experience to give them support and guidance. Professional knowledge is also transferred through social networking (Tasselli 2015:864). Sharing information within the same professional group enables the knowledge to be shared again in the future. However, sharing of knowledge depends on the group dynamics for it to be more or less supportive (Swift & Virick 2013:721). Lower positions or ranks are associated with lower responsibility, which is associated with lower knowledge as well and the need for information and learning (Mockiene & Suominen 2016:12). Tasselli (2015:842) emphasises that when co-workers work together and share knowledge and skill they fulfil the standard of practice. In the ICU setting, the participants although of lower rank were expected to function like a higher category, due to the nature of the environment in which they worked. The participants learned from other nurses who were more skilled and had knowledge and insight about the ICU setting. The participants reported that this made them feel competent and nurse with pride and they valued everything they were taught in the ICU.

4.3.3.3 Prioritised care

Prioritised care was identified as a category under knowledge. Prioritised care is considered first because the ICU has the sickest patients. Consequently, with all the treatment, interventions and procedures to be done, it is always important to decide which ones must be done first. Procedures and routines in the ICU setting get prioritised on a daily basis, depending on the patients' current

status. Prioritising care is learned and acquired over a period and requires particular skill and competence that the participants were keen to learn more about how to prioritize patient care.

According to the participants,

> "I wish I know how to prioritize the patient's problems and care, and new which one to attend to first."
>
> "As enrolled nurses not to undermine one another, to show each other how to deal with certain things."
>
> "I have learned about the critical signs in ICU that can put the patient in danger and how to overcome (prevent) them."

When working with the patient in the ICU setting, it is very important to decide what must be done first, especially if the patient is very sick and complicating. Certain things must be done first for patient safety. The multidisciplinary team also prioritises the care provided to the patient on a daily basis while working. In source-limited hospitals in Iran, Maghsoudi, Tabei, Zand, Tabatabaee and Akbarzadeh (2014:1) discovered that doctors had difficulties about which patients were more suitable for admission in the ICU setting. Some patients met the criteria for ICU, but would not benefit from the treatment that they would receive (Maghsoudi, Tabei, Zand, Tabatabaee & Akbarzadeh 2014:1).

In the ICU setting there is a daily routine of all the things that are done on a daily basis such as medication, bathing and suctioning, due to patients' different conditions. Not all these things are done at the same time, even though there is a routine that stipulates times of what must be done at which time. Consequently, the participants valued the knowledge and competency they acquired in prioritising patients' problems and care. In prioritising or organising patient care, one of the main things to remember is that during the shift, you must expect the unexpected, and further it is very important to consider the business of the unit and who can help, when you need help, and also to ask for help while it is still early, when the patient is difficult (Ouan, 2008). Kinney (2011) emphasises that critical thinking is the most important thing in ICU when prioritising care as it helps with problem solving, organising things and information and also to avoid mistakes.

Professional nurses play the most important part of transferring their knowledge to other nurses who are still learning as well as to nurses that have just qualified in order to continue the tradition of nursing. This knowledge is what gives patients quality care and hospitals good standards of care. When nurses are nursing a patient, they are not only nursing the patient but the family, hospital and the community as well, especially in the private sector. If one nurse is considered highly knowledgeable, patients who were nursed by that particular nurse are more likely to refer other patients to that hospital, as they will trust the care that they will receive. The same applies to the doctor.

4.3.4 Procedures

The participants identified procedure as another peak experience in the ICU. Four categories were identified in this theme, namely prepare for admission, check emergency trolley, draw blood from arterial line and taking a 12-lead electrocardiography. In this study, procedures referred to the things that are set in place by the hospital on how they are done step by step in order to maintain standard and consistency. Procedures also refer to the step-by-step sequence of performing an activity; e.g., levelling and zeroing the arterial and central line. When something is done step by step, it is essential to follow all the steps in order (sequentially), one after the other, without skipping the steps in between as something can go wrong.

According to the participants,

> "I have learned how to give intravenous medication."
>
> "I have learned how to draw blood from an arterial line and to measure the pressure bag to 300Kpa."
>
> "I want to learn about the interpretation of the electrocardiogram."
>
> "I want to learn about the arterial blood gas interpretation."
>
> "I wish we can attend a class where we can learn about the electrocardiogram and arterial blood gas interpretation."

In the ICU setting many procedures are done, and all require skill, knowledge and competency. The participants felt supported especially when they were doing certain procedures. They valued the fact that they were able to do procedures that were different from those done in the ward setting. Each ICU has certain procedures and protocols of the doctors that must be followed by the

nurses. The hospital as well has certain guidelines and procedure manuals on certain things that must be done. At the same time, the SANC lays down guidelines for nurses to do things in a certain way. In a study on the legal implications of ignoring hospital policies and procedures, Whyman (2015:83) states that following hospital policies and procedures is the only way to maintain stability in the workplace and prevent mistakes. All healthcare professionals are expected to be competent in certain skills, as required by their training and field of work, consequently the skills must be maintained throughout their practice on a daily basis (McLaughlin, Hockenberry, Hueckel & Docherty 2014:304).

Shannon and Kubelka (2013:222) found that most human errors occurred during stressful situations when it is difficult to remember complex tasks. For skill competency to be maintained, the organisation must have simulations and in-service training of the staff to maintain skill and knowledge at its optimal level (McLaughlin et al 2014:305). Senior staff must have straight roles and procedures to be taken by other staff to achieve a common goal and mutual understanding of all tasks that must be done (Whyman 2015:4). For employees to maintain their skill and competence, more practice is needed and continuous staff development in simulations and on-going training. Standard procedures are a means of maintaining hospital standards, and making sure that all the procedures are done as stipulated by the hospital or regulating body. All hospitals make sure that procedures are done in a correct way to promote quality patient care and consistency. Procedures are a way to prevent mistakes or misconduct which can lead to disciplinary hearing or action.

4.3.5 Equipment

Two categories were identified in the theme equipment, namely blood gas machine and infusion pumps. In this study, equipment referred to the things or items used for a specific purpose in the ICU setting. The ICU has a lot of equipment and each item has a particular purpose and therefore requires certain skills and knowledge on how to utilise or operate it. In this study the equipment were all the instruments in the ICU setting used for critically ill patients. The participants felt competent about operating some of the equipment in the ICU setting, as they knew how to use and nurse a patient on these machines.

According to the participants,

> "To have more skills about the equipment we use daily."
>
> "I want to be more exposed to the ventilator."
>
> "To have more knowledge about the emergency equipment."

All equipment in the ICU setting is very important and has a specific purpose. Some is used for diagnosing, and some for supporting the patient's life by performing a function of a certain organ that has failed temporarily. The intensive care nurse must have knowledge and skills on how the different equipment works and how to care for a critical ill patient with supportive equipment (Heydari, Vafaee-Najar & Bakhshi, 2016).. Nurses need the knowledge and skill to be able to operate all the equipment and be able to detect any problems with the patients. The participants (ENs) need the skill and knowledge to operate all the equipment as they have to work in this highly technological environment.

4.4 PARTICIPANTS' WISHES

During the focus group interview the participants expressed certain things that they wished could happen, while they were working in the ICU. Three themes emerged in wishes, namely belonging to a team, professional development, and gaining more knowledge. Each of the themes will be discussed in the section below.

4.4.1 Belonging to a team

Belonging to a team was the first theme that was identified by the participants. Two categories were identified in this theme, namely being acknowledged and valued.

The participants acknowledged working as part of the ICU team in this complex environment as challenging. Some of the participants wished they could feel part of the ICU team. The participants wished that the doctors and the other members of the ICU team would acknowledge and respect them as part of the team. At the same time, the participants acknowledged that working in the ICU was not the same as working in the wards, with the high demands and expectations in patient care. According to the participants, belonging to the team meant feeling part of the group, acknowledged, important, and an equal member of the team.

The participants valued the ICU staff knowledge and skills and wished to be able to work and function independently like them. In addition, the participants valued the opportunity of having to work in the ICU setting, and acknowledged that they still needed more support and to learn more about the ICU activities.

According to the participants,

> "I wish there could be a good relationship between the enrolled nurses and the professional nurses, not to undermine each other."
>
> "I wish all the professional nurses would support the enrolled nurses in all the measures."
>
> "I wish that the enrolled nurses could be treated the same as the professional nurses."
>
> "I wish that the doctors would also respect us (ENs)."

The ICU is about the team, as there are many health care professionals that work in this environment, and each one has their own duties. Everyone has a role to play. Umansky and Rantanen (2016:551-552) emphasise that nurses have multipurpose roles in the workplace hence it is important to work as a team. The nurse managers in the workplace ensure that there is continuation in the ethical nursing standard and competency and support the nurses (Aitamaa,Leino-Kilpi, Iltanen & Suhonem 2016:654). However, doctors frequently did not take nurses' perspective into account, which left nurses feeling less valued (Aitamaa et al 2016:652).

Belonging to a team is the most constructive way to ensure the functionality of the ICU. Problems between healthcare professionals can cause dysfunction of the whole unit (Aitamaa et al 2016:654). The participants stressed that belonging to a team was very important because their scope of practice are limited and they were dependent on the professional nurses. When people are part of the team, they feel important, protect each other, and develop a sense of trust. According to Ervin et al, (2018:469) the collective nature of team work require members to interact, collaborate and share knowledge and resources, meaning that they are dependent on one another for task accomplishment. Being part of the team and working together increases overall patient care and satisfaction and lessens stress for the healthcare professionals.

4.4.2 Professional development

Professional development was the second theme identified in the participants' wishes. Two categories were identified in this theme, namely continuous professional development and clinical facilitator.

A clinical facilitator is responsible for conducting and maintaining continuous professional development (CPD). The clinical facilitator is the person responsible for helping and supporting the students and staff, to ensure that they are competent, and become independent practitioners (Nursing Act, 2005). Continuous professional development is the range of activities that healthcare

professionals must have and maintain for certain knowledge and skill to ensure safe practice within their scope of practice (Jacknon, Manley, Martin & Wright 2015:9). The participants felt the need for more education in the form of CPD and in-service training and simulations. They believed that CPD would equip them to become better nurses who were competent and knowledgeable in the ICU setting.

The SANC requires hospitals to conduct and maintain CPD to ensure that all nurses are well skilled and knowledgeable at all times to ensure patient safety, standard of care and patient satisfaction. The participants wished that they could have a clinical facilitator who focused on them (ENs) and their development. The participants expressed the need for someone who understood their level, because most of the things they were taught in this environment were very advanced and they felt confused and did not always understand.

According to the participants,

> "I wish we could have a programme once a month to learn about the basis of the ventilator."
>
> "I wish they could train us or teach us about ICU, like an short ICU course."

Professional development is a way of ensuring that all health care practitioners are up to standard in their practice in order to minimise errors as they are dealing with human lives. Clinical facilitators are also involved in ensuring that quality care and staff development is maintained at all times. In a study on clinical supervision in a community setting, Evans and Marcroft (2015:16) emphasised that health care regulating bodies required registered staff members to undergo CPD (continuous professional development). Furthermore, clinical supervision is also responsible for CPD to ensure staff development, and promote and maintain quality health care. CPD promotes and ensures up-to-date skills and practice. Bodmer and Van het Bolscher (2016:28) found that many hospitals found regular staff training too expensive which led to a decline in staff skill and knowledge. In Rwanda, Kasine, Babenko-Mould, Cechetto and Regan (2016) found that CPD remarkably increased staff knowledge and skill.

CPD and clinical supervision improve nurses' knowledge, skill and competency, as well as overall care. Moreover, as ENs gained skill and competency during CPD, PNs workload was reduced (Bodmer & Van het Bolscher 2016:29). At all levels of nursing practice, CPD and clinical facilitation equip and enable staff to become expert in the areas they work (Bodmer & Van het Bolscher 2016:29). Most hospitals now have clinical facilitators responsible to assist permanent staff, newly

employed staff and students with the skills development and knowledge of the particular unit and the type of patients.

4.4.3 Knowledge

The participants felt that they needed to know about most equipment used daily and how they function and to analyse the readings. The participants understood that ICU was not only about nursing the patients allocated to them, but also the many machines involved that they had to be familiar with.

Matney, Maddex and Staggers (2014:175) define knowledge as information "created so that there are associations that are well recognised and formalized". Knowledge was the last theme identified in the study. Eight categories were identified in this theme, namely mechanical ventilation; intravenous medication; electrocardiography analysis; arterial blood gas analysis; laboratory blood gas analysis; laboratory results; equipment; renal analysis, and chest x-rays.

According to the participants,

> "I wish I could learn about electrocardiography interpretation."
>
> "I wish we could understand and know the blood gas interpretation."
>
> 'I wish I could learn how to prepare the emergency bed for the ICU patient, in an emergency situation."
>
> "I wish we could learn more about the emergency drugs, and their use in an emergency."

An ICU nurse must have knowledge in order to work and function in the ICU. The participants could only achieve this by gaining knowledge from experienced PNs, who were willing to guide and nurture them. Tasseli (2015:842) found that co-workers gained knowledge through interacting with other co-workers, as well as experience and ability to maintain the quality required. Nurses networked more between each other than other healthcare practitioners even though nurse managers' role was to modify the interaction between nurses and doctors to ensure active interaction (Tasselli 2015:857). A study on health care professionals' knowledge regarding patient safety found that even taking into consideration that medication continuously changed, nurses had little knowledge of administering medication (Brasaitel, Kaunonen, Martinkenas, Mockiene & Suominen 2016:2). In this study, the participants wished to have knowledge about the equipment used in the ICU. The participants also wanted to know why certain things were not done to some patients and were done to others, although the patients had the same diagnosis. This is done through knowledge transfer as PNs teach and equip those under them with the knowledge that

they have. According to Matney et al (2014:175), knowing why certain things must be done and some not done, is wisdom. In this study, the participants wished for wisdom or specific knowledge and clarity about the activities in the ICU environment.

4.5 CONCLUSION

This chapter discussed the data analysis and findings of the study. The peak experiences as well as the wishes of enrolled nurses working in the intensive care units were discussed and supported with relevant literature Chapter 5 concludes the study, briefly describes its limitations and makes recommendations for practice and further research.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter 4 provided detail information on descriptions of the study results/findings and supported with recent literature. In this chapter a summary of the study findings will be discussed as well as the recommendations for the ideal support needs for enrolled nurses working in ICU. The limitations of the study and recommendations for future research will be provided.

5.2 AIM OF THE STUDY

As an ICU trained nurse, working in the public sector and now for in the private sector, I have realised that ICU's are using enrolled nurses to cover for the staff shortage as well as for financial gain as enrolled nurses hourly rates are less than ICU trained nurses. This practice is despite the enrolled nurses limiting scope of practice as they are not capable to work and function independently in an ICU setting. Hence the aim of the study was to explore and describe the support needs of the enrolled nurses working in an intensive care units of a private hospital in Tshwane.

5.3 FINDINGS AND RECOMMENDATIONS

This section summarises the findings according to the questions in the AI interview guide. Recommendations are made based on the finding of the study.

5.3.1 Question 1: What was your best experience of being supported as an EN working in ICU?

The first question aimed to discover the participants' peak or most satisfying experience regarding being supported as an enrolled nurse working in ICU. Five main themes emerged namely: professionalism, support, knowledge, procedures and equipment. The participants verbalised they valued the registered nurses professional behaviour and learned from them as role models how to act as a professional. The two sub-categories that emerged were positive attitude and patient-centred communication. The participants appreciated those professional nurses who had a positive attitude towards them, they indicated that assisted them to realise the importance of a positive attitude towards patients, families and colleagues in the workplace. Furthermore the participants valued the professional nurses who tough and supported them on how to communicate with patients, families as well as colleagues. The enrolled nurses indicated they felt supported and empowered learning about the importance of patient-centred communication.

The participant indicated gaining knowledge as a peak experience for them as enrolled nurses working in ICU. They felt supported by those professional nurses who shared their knowledge with them and were willing to teach them relating different aspect of intensive care. They indicated the areas where they gained most knowledge was regarding hemodynamic parameters, understanding the different diagnosis of intensive care patients, how to prioritise care as well as understanding different procedures in ICU. Participants indicated they realised the importance of being knowledgeable and skilled when working in ICU, they appreciated the professional nurses who were willing to teach and support them to gain knowledge and skills on a daily basis.

5.3.1.1 Recommendations

The researcher recommends the following strategies to ensure support of enrolled nurses working in ICU:

- Ensure that each enrolled nurse works at all times under direct supervision of a professional nurse.
- Allocate EN to attend in-service training sessions to enable them to gain knowledge.
- Professional nurses should portray a positive attitude towards the enrolled nurses, and support them to become a valuable team member.
- Emphasise the importance of sharing information relating the patient with the enrolled nurse taking care of the patient.

- Demonstrate to the EN nurses' basic ICU procedures e.g. suctioning of the mechanical ventilated patient, drawing of an arterial blood gas, taking of a 12 lead ECG.
- Teach the EN basic principles of non-invasive and invasive mechanical ventilation.
- Teach the EN the basic principles of hemodynamic monitoring, inotropic support and interpretation of values
- Support the EN when nursing patients in the ICU, and do on the spot teaching as learning opportunities' emerges.

5.3.2 Question 2: What are you wishes in terms of support for EN working in ICU?

The second question explored the participants' wishes in terms of support needs for EN working in ICU. Three themes emerged nl: belonging to a team, professional development and gaining knowledge. The EN wished to gain more knowledge to enable them to care for patients in the ICU with more confidence and with the support of professional nurses. The EN wished to be acknowledged as part of the healthcare team and feel values. Furthermore they wished to have continuous professional development opportunities for them as EN specifically and wished they had a clinical facilitator to support them in clinical practice. The EN wishes to gain more knowledge relating the specific equipment used in the ICU as well as the readings and ranges of the different equipment as well as to be able to interpret the readings they recorded.

5.3.2.1 Recommendations

With regard to the wishes of EN for support in the ICU, the researcher recommends the following:

- Professional nurses working with the EN in the ICU should focus on giving positive feedback to EN for care/activities well done.
- Inform EN at all times regarding decisions made and care to be implemented for the patients they care for.
- Plan CPD sessions specifically for EN working in ICU relating there specific learning needs e.g. equipment and interpretation of values.
- Allocate a specific day for the clinical facilitator to focus only on the EN specific learning needs in the ICU.

- Create opportunities for the EN to learn more advance equipment and technology even on a basic level, as they work under direct supervision of the professional nurse.

5.4 LIMITATIONS

The study was limited to the support needs of EN working in a specific private hospitals' and cannot be generalised to all EN working in the ICU environment. The support needs identified was based on the EN specific needs as reflected during the FGI, no other members of the multi-disciplinary teams inputs were asked for this study.

5.5 FUTURE RESEARCH

The researcher recommends that further research be conducted on the following topics:

- The role and responsibilities of EN in the ICU environment.
- Development of a basic programme (short course) for EN working in ICU.
- ICU nurses` challenges working with EN in ICU.

5.7 SUMMARY

This chapter concluded the study, summarised the findings, briefly described the limitations of the study, and made recommendations to support EN working in ICU. The findings of this study should benefit EN working in ICU, to be supported to enable them to gain knowledge and enhance the care they deliver to ICU patients. When EN are supported and focus is placed on identifying and addressing their learning needs, teamwork and quality care to patients in the ICU can be enhanced. Delivering quality care to patients in the ICU is a team effort and needs team members with knowledge, skills and compassion.

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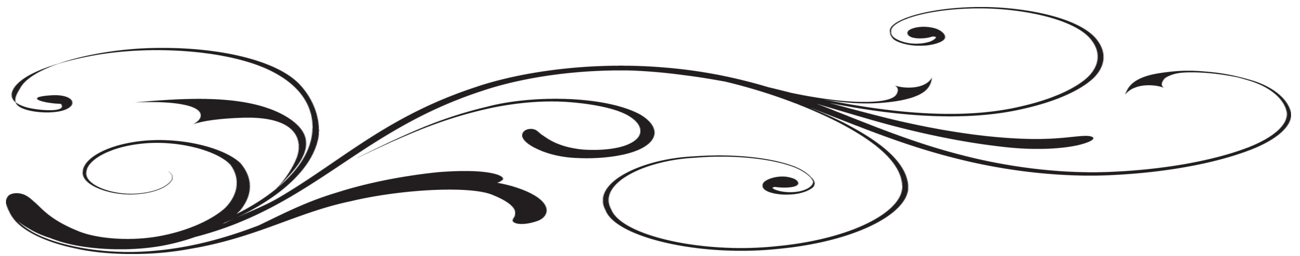
ANNEXURE A

Ethical approval



The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

28/07/2016

Approval Certificate
New Application

Ethics Reference No.: 188/2016

Title: Support needs of enrolled nurses working in an intensive care unit

Dear Miss Thulile TP Kubheka

The **New Application** as supported by documents specified in your cover letter dated 28/04/2016 for your research received on the 28/04/2016, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 28/07/2016.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year.
- Please remember to use your protocol number (**188/2016**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:

- The ethics approval is conditional on the receipt of **6 monthly written Progress Reports**, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed,PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

☎ 012 356 3084 deepeka.behari@up.ac.za http://www.up.ac.za/healthethics
✉ Private Bag X323, Arcadia, 0007 - Tswelopele Building, Level 4, Room 60, Gezina, Pretoria

ANNEXURE B

Participant information leaflet and informed consent document

Life HEALTH CARE Wilgers Hospital

Life Wilgers Hospital Proprietary Limited
Cnr Lynnwood & Simon Vermooten Roads,
Die Wilgers Ext 14, Pretoria 0081
P O Box 73928, Lynnwood Ridge, Pretoria 0041
Telephone: +27 12 807 8100
Telefax: +27 12 807 0375
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29 June 2016

PER E-MAIL

Ms T.P. Kubheka
MCur
kubhekathulilepatience@gmail.com

Dear Ms Kubheka,

REQUEST TO CONDUCT RESEARCH - (Support needs for the enrolled nurses working in the Intensive Care Unit)

We are pleased to inform you that all requirements as per Life Healthcare Clinical Trial Policy have been met and hereby approval is granted to conduct above mentioned Clinical Trial.

We trust that you will find the above in order.

Yours sincerely,

André Joseph
HOSPITAL MANAGER

A subsidiary of Life Healthcare Group Proprietary Limited
Reg. no. 2012/042191/07 Registered address Oxford Manor, 21 Chaplin Road, Illovo 2196, Private Bag X13, Northlands 2116
Directors: AP Brown, PR Engelbrecht, Dr PF Snyman, MTG Stafford, E van Dyk

ANNEXURE C

Example of a completed interview schedule

ANNEXURE D

Declaration for the editor

Annexure B: Participant information leaflet and informed consent

Participation leaflet and informed consent

Dear participant

You are invited to participate in a research study for enrolled nurses working in Intensive Care units, to explore the support needs of enrolled nurses working in Intensive care units. This information leaflet contains information that will help you understand your role in the study. If there is any need for further clarification, please feel free to contact the researcher at any time. Please note that no remuneration will be provided for participation in the research. Your participation and contribution is highly appreciated.

TITLE OF STUDY

Support needs of enrolled nurses working in an intensive care unit

1) The overall aim of the study

The overall aim of this research is to explore the support needs of enrolled nurses working in Intensive care units.

2) Explanation of procedures to be followed

You are invited to take part in a research study. Your participation will be as an enrolled nurse working in the Intensive care unit. The interview will last approximately 45 minutes. With your permission the interview will be audio taped and information transcribed. You will only be identified as a participant in the transcribed interview. No participant is expected to give their names. The transcribed interviews will be kept in a locked cupboard in the researchers' office and will be destroyed after a period of three years by deleting the electronic copy and shredding the hard copy.

3) Risk and discomfort involved

As a participant, you will experience no discomfort. There is also no risk involved in this study. However, your input into this research will require some of your time and effort.

4) Benefits of the study

Providing valuable inputs during the interview regarding the support needs enrolled nurses have when working in Intensive Care units can assist the researcher and enrolled nurses to develop strategies to address these needs and to optimally support you when you are working in the intensive care unit. in the critical care units.

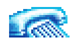
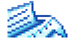
5) Voluntary participation in and withdrawal from the study

Participation occurs on a voluntary basis, and you can withdraw from the research without stating any reason should you no longer wish to take part.

6) Ethical approval

The Faculty of Health Sciences' Research Ethics Committee at the University of Pretoria, as well as Gauteng Department of Health, has given written approval for this study. Please feel free to contact Mrs Deepika Behari if you need any clarification pertaining to ethical approval inquiries.

Deepeka Behari
Level 2, Room 2-33
31 Bophelo Road, Gezina
Private Bag X323, Arcadia, 0007

 012 3541677  0866516047

deepeka.behari@up.ac.za

7) Additional information

If you have any questions about your participation in this Appreciative Inquiry process, you should contact the researcher, Ms TP Kubheka

Cell phone: 0735907898

Supervisor: Prof Isabel Coetzee

Email address: Isabel.coetzee@up.ac.za

Contact detail: (012) 354-2125 / 0711 589 045

8) Confidentiality

Your input into this research will be kept confidential; you will not need to indicate your name on the self-reported interview guide. Results will be published and presented in such a manner that you as a participant will remain anonymous.

9) Consent to participate in this study

Your participation in this research is subject to reading and accepting the above information and signing the informed consent document below.

INFORMED CONSENT

I have read the above information leaflet and fully understand what is expected of me. Its content and meaning have been explained to me. I have been given the opportunity to ask questions and received satisfactory answers. I hereby volunteer to take part in this research.

______________________________ ____________

Participant's signature **Date**

………………………..

Ms TP Kubheka

Researcher

Cell/Mobile: 073-782-3923

53 Glover Avenue
Doringkloof
0157 Centurion

17 July 2019

TO WHOM IT MAY CONCERN

I hereby certify that I have edited Thuli Kubeka's master's dissertation, **Support needs of enrolled nurses working in an intensive care unit**, for language and content.

IM Cooper

Iauma M Cooper
192-290-4