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WORK RELATED STRESS AMONGST NURSE MANAGERS IN A RURAL DISTRICT HOSPITAL IN LIMPOPO PROVINCE

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A dissertation submitted in partial fulfilment of the requirements for the degree MNurs (Nursing Management)

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ABSTRACT

BACKGROUND

Work related stress is a globally discussed and known phenomenon in countries irrespective of their stage of economic development. The nature of work related stress is harmful and uneconomic as it hampers productivity in the provision of quality services in organisations and give rise to undesirable socio-economic effects. Work related stress is a mismatch that occurs between an individual and the work environment, wherein the higher the imbalance between the external demands and an individual's abilities. Nursing is noted for producing relatively high levels of stress due to the pressure-full and demanding nature of the job. Within nursing, nurse managers are noted to be specifically vulnerable to experiencing higher stress levels due to the stressful situations they are constantly facing, the higher the level of stress that will be experienced. Work related stress may have negative consequences for nurse managers such as lack of concern for themselves or their work and a negative self-image

AIM AND OBJECTIVE

The aim of this study was to explore and describe the perceptions of nurse managers in a rural public hospital regarding work related stress.

METHOD

The study was explorative and descriptive qualitative in nature. Semi-structured interviews were conducted with 33 nurse managers working at the designated hospital. By using content analysis five themes were identified: 1) Causes of work related stress, 2) Signs and symptoms of work related stress, 3) Consequences of work related stress, 4) Current strategies to cope with work related stress, 5) Recommended strategies to cope with work related stress.

FINDINGS

Nurse managers in the rural district hospital are aware of the nature of work related stress in their work, the causes and contributory factors, and several strategies they deem important to assist in the management of work related stress were recommended.

CONCLUSION

Nurse managers in a rural district hospital are exposed to high levels of work related stress due to the nature of their job and poor working conditions in the hospital. Recommendations to assist in the management of work related stress were made.

KEYWORDS: work related stress, nurse managers, rural areas, district hospital

DECLARATION

I, Mamere Prescilla Shiviti, declare that the dissertation titled

Work related stress amongst nurse managers in a rural district hospital in Limpopo Province

is my original work and it has not been submitted before for any degree or examination at any other University or institution, I further declare that all the sources that have been used or quoted have been acknowledged by means of approved Harvard referencing (2006).

Signed at Trichardtsdal on this 17th day of February 2020.

Signature MP Shiviti

DEDICATION

I dedicate this study to the people who added value to my study by supporting me throughout my career path.

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CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

Work related stress (WRS) is a globally discussed and known phenomenon in countries irrespective of their stage of economic development. Studies on WRS have been documented in Europe and most African countries (Salilih & Abajobir 2014; Mucci, Gorgi, Cupelli, Gioffre, Rosati, Tomei et al. 2015; Gam, Naidoo & Puckree 2015). Of note is how underdeveloped, developed and developing countries seem to agree on the harmful and uneconomic nature of WRS by hampering productivity in the provision of quality services in organisations, giving rise to undesirable socio-economic effects (Zoni & Lucchini 2012; Kinnunen-Amoroso & Liira 2014; Gam et al. 2015).

The European Union, in 2004, defined the concept WRS as a "state, which is accompanied by physical, psychological or social complaints or dysfunctions and which results from individuals feeling unable to bridge a gap with the requirements or expectations placed on them". WRS is therefore, a mismatch that occurs between an individual and the work environment, wherein the higher the imbalance between the external demands and an individual's abilities, the higher the level of stress that will be experienced (Li, Ai, Gao, Zhou, Liu, & Zhang 2017).

In health care professions, work related stressors may be divided into three categories, namely, intrapersonal, interpersonal, and stressors of the working environment or organizational stressors. Intrapersonal stressors include inability to manage work related duties at times as well as inadequate preparation of staff for demanding nursing tasks. Interpersonal stressors reflect relationships with the multi-disciplinary team, other managerial staff and co-workers (Banovcinova & Baskova 2014). Work related stress is one type of stress that is caused and or exacerbated by work and its environment (Health and Safety Authority 2011).

The main factors identifiable with WRS are work organization and processes, working conditions and environment (exposure to noise, etc.), communication about job expectations, for example, and subjective factors (Zoni & Lucchini 2012). The intrinsic characteristics of the job itself, job benefits, career prospects, and resources (Leka & Houndmont 2010; Yeboah, Ansong, Antwi & Gyebil 2014) are also vital workplace environment stressors. The amount of satisfaction, job control as well as the levels of commitment derived in their work may add to the

WRS people experience in the workplace (Johnson, Cooper, Cartwright, Donald, Taylor & Millet 2005; Jordan, Khubchandani & Wiblishauser 2016).

In modern industrial systems, WRS constitutes a source of problems in organisations due to the vast consequential socio-economic costs thereof. These costs may be manifested in absenteeism, labour turnover; loss of productivity, job dissatisfaction and disability pension costs to the organizations and to society (Mucci et al. 2014, Agai-Demjaha 2015). Studies found that health costs tend to be higher amongst those who have high stress levels (Mucci et al. 2015). The same accounts for the very high percentage of lost working days (Kinnunen-Amoroso & Liira 2014, Mucci et al. 2014 Agai-Demjaha 2015). The relationship between WRS and the resulting biological damage has been recognized in many European countries such as Italy and the United Kingdom (Mucci et al. 2014).

Stress-related disorders are common and are estimated to cause half of all absences at work. In the European Union–Occupational Safety Health Authority 2013 poll and other European studies, more than half of workers in the European Union reported WRS as a common issue (Marcatto, Collauti, Filon, Luis, Di Blas, Cavallero et al. 2016). WRS can negatively influence the psychological and physical health and well-being of workers (Johnson et al. 2005; Moustaka & Constantinidis 2010; Marcatto et al. 2016), with resultant deterioration of performance and efficiency (Banovcinova & Baskova 2014). Negative health outcomes, and destructive behaviours (Johnson et al. 2005; Govender, Mutunzi & Okonta 2012) and consequent mortalities may ensue (Eskandari & Gorgi 2018).

Any profession is capable of causing WRS (Agai-Demjana, Bislimovska & Mijakoski 2015), and each has unique stressors depending on the type of profession or specialty field (Opie, Dollard, Lenthall, Wakerman, Dunn & Knight 2010; Dagget, Molla & Belachew 2016). Studies cite health professions as producing high levels of WRS, as the responsibility of caring for people carries with it greater stress than looking after things and objects (Yeboah et al. 2014; Naik 2015).

Nursing is noted for producing relatively high levels of stress due to the pressure-full and demanding nature of the job (Johansson, Sandahl & Hasson 2013, Li et al. 2017). Taking long shifts, watching patients die in one's care being in great pain (Dagget et al. 2016; Li et al. 2017), working in bad and often daring environments particularly in rural hospitals (Opie et al. 2010) are common in nursing. Within nursing, nurse managers are noted to be specifically vulnerable

to experiencing higher stress levels due to the stressful situations they are constantly facing (Naik 2015, Miyata, Arai & Suga 2015). Cases of extreme nursing staff shortages, the complicated nature of nurse managers' responsibilities and demanding time schedules (Johansson, Sandahl & Hasson 2013) are common including rural and remote areas (Opie et al. 2010), making the situation even worse.

Nurse managers are pivotal key role players in the healthcare work environment (Miyata, Arai & Suga 2015; Sonia & Cummings 2017), such that it will be difficult to render quality healthcare services without these professionals (Schub & Karakshian 2017). WRS may have negative consequences for nurse managers such as lack of concern for themselves or their work and a negative self-image (Ugwu, Frondu & Umeano 2011). WRS can thus render nurse managers to become insensitive to others (colleagues, subordinates and patients), and to become increasingly aggressive and unwilling to help. Negative attitudes and behaviour of nurse managers towards staff (Naik 2015), may spark low morale, dissatisfaction and decreased work performance (Miyata et al. 2017) impacting patient health outcomes (Rajagopaul & Motaung 2013; Van Bogaert, Adriessens, Dilles, Martens, van Rompaey & Timmermans 2014). If not addressed, WRS amongst these healthcare professionals may increase staff turnover and patient mortality, especially those working in rural areas (Opie, Dollard, Wakerman, Dollard, MacLeod & Knight 2011, Lori, Livingstone, Rominski, Nakua & Agyei-Balfour 2018).

Studies examining WRS in rural and remote areas found that a majority of people working in those areas suffer from chronic WRS (Opie et al. 2010), due to challenges of working in those areas (Opie et al. 2011; Macleod et al. 2016). Rural healthcare notably differs from healthcare in cities (Opie et al. 2011), making rural nursing less appealing. Rural and remote nurses operate in unusually dangerous situations to offer healthcare services with safety concerns (Opie et al. 2010, Opie et al. 2011). Complaints of continuous replacement of nurse managers in rural and remote areas are documented (Opie et al. 2010, Opie et al. 2011, Bragg & Bonner 2014).

In South Africa, only 18% of nurses are serving in rural areas and 40% of the posts are vacant (Lourens 2014). Of these, only 12% are retained while caring for 85% uninsured population (Jenkins, Gunst, Blitz & Coetzee 2015. This would suggest a nurse manager shortage as well. This would be common to provinces with largely rural areas. Studies in rural and remote nursing suggest that rural nurses face similar outcomes as their metropolitan counterparts, although the experience is unique in the rural context (Opie et al. 2011, Bragg & Bonner 2014)

1.2 PROBLEM STATEMENT

The researcher observed that the nurse managers working in a rural district hospital in Limpopo province were prone to develop work related stress due to the demands of their work environment. The demands included being responsible and accountable on a 24-hour basis for the nursing care rendered, addressing staff and patients complaints, shortages of human and material resources, financial constraints, and the high turnover of nurses and nurse managers. In the midst of staff shortage, it was expected of nurse managers to assist in the wards in addition to existing job responsibilities. Nurse managers were chronically fatigued, they absented themselves from work thereby adding to the WRS of those remaining behind, as those nurses have to perform the absent nurse managers' duties in addition to their own. This in turn, contributes to poor relationships between nurse managers and the rest of the nursing staff.

According to several studies, nurse managers find the 24-hour responsibility for the operational, fiscal and performance accountability stressful; hence these managers were predisposed to WRS (Rajagopaul & Motaung 2013; Naik 2015). Absenteeism amongst nurses and nurse managers was indicated as a result of difficult working conditions in rural healthcare facilities (Opie et al. (2010). The European Foundation for the Improvement of Living and Working Conditions (2007 cited in Salilih & Abajobir 2014) found that WRS can result in work absences, higher turnover, early retirement, lower productivity, and lower quality of services or products. They further indicated that WRS affects quality of life and work, including overall well-being and social relationships. Due to all the negative outcomes of WRS, the researcher deemed it important to explore how nurse managers in the rural district hospital experience WRS as little is known how and when these managers experience WRS. The knowledge gained from the study will assist in planning strategies towards minimising nurse managers WRS in rural district hospitals.

1.3 SIGNIFICANCE OF THE STUDY

Nurse managers who know and understand work related stress and its influence on their role, may adopt healthy coping mechanisms. This in turn would assist nurse managers to develop intervention strategies to manage stressful situations they face on a daily basis. This study might empower nurse managers to get acquainted with WRS, the prevention and management thereof, making nurse leadership an attractive goal (Schub & Karakashian 2017).

The study would benefit the rest of the staff by creating an awareness of WRS for early identification, prevention and management (Govender et al. 2012) to prevent possible complications. The findings may further be utilised to influence management decisions in organisations to develop innovative strategies that uplift morale, instil job commitment and staff satisfaction (Eskandari & Gorgi 2018). The results from the study will add to the body of knowledge in nursing research and may serve as the basis of future research studies on WRS in nurse managers or nurses in general.

1.4 AIM OF THE STUDY

The aim of this study was to explore and describe the perceptions of nurse managers in a rural public hospital regarding WRS.

1.5 CONCEPT CLARIFICATION

Key concepts used in this study were the following:

Nurse managers

The term includes “frontline managers or charge nurses because they are managing the activities of the unit” (Naik 2015:7) and are categorised under the operational level of management (Muller, Bezuidenhout & Jooste 2008). Booyens (2000) recognises both senior and professional nurses in supervising nursing service in units as first level managers. In the study, a nurse manager shall refer to members of first level management including professional nurses who, by virtue of placement, are responsible at operational level and in the frontline as in charge of nursing units.

Rural district hospital

A hospital can also be described in terms of rurality of its location and the type of services provided (Cullinan 2006). A rural area is defined in terms of location, availability of amenities and infrastructure (Gaede & Versteeg 2011). The South African Department of Health (2002) recognises district hospitals as hospitals that provide first level generalist services per referral from community healthcare centres or clinics. For the purpose of this study, a rural district hospital refers to a hospital in a rural area in Limpopo that receives referrals from and provides generalist support to clinics and communities in rural areas.

Work related stress

Work related stress was defined in a Ghanaian study as the harmful physical and emotional response which occurred when the requirements of the job do not match the capabilities, resources, or needs of the worker (Yeboah et al. 2014). The phrase WRS is used in this study to denote stress caused or exacerbated by work, that constitutes an ill-fitting match between the task and the individual's abilities. WRS is an inevitable psychological hazard that is prevalent in the healthcare industry. It occurs in instances where needs, resources and capabilities of an individual are misaligned to job requirements (Naik 2015). For the purpose of this study, the definition of WRS by Naik (2015) will be accepted.

1.6 RESEARCH QUESTION

The research study was guided by the following question:

What are the perceptions of nurse managers in a rural district hospital in Limpopo regarding WRS?

1.7 PHILOSOPHICAL ASSUMPTIONS

The paradigm applied in this study is the constructivist paradigm which supports the idea that the nature of being in the world of humans is self-interpreting. This means that an individual is the only one who can describe the nature of the world around them. This further indicates that there is unity between a person and their social environment, and that phenomena can be studied through the way people see and experience life (Weaver & Olson 2006).

1.7.1 Ontological assumptions

The researcher within the constructivist paradigm believes that there are many truths about a phenomenon and these truths lie in how individuals interact with and interpret the social world around them (Houghton, Hunter & Meskell 2012). Individuals seek understanding of the world in which they live and work. In this case, the researcher sought to understand how nurse managers, within the particular rural district hospital where they work, perceive WRS. Since this reality is "socially and experientially based" (Houghton et al. 2012:36), the truth lies in the interaction with the participants in how they perceive WRS. Since reality is different for each individual (Houghton et al. 2012), the researcher interviewed the nurse managers to get

individual perspectives with regard to WRS. The mutual recognition and interpretation of the phenomenon of interest (WRS), by and between the researcher and the participants (nurse managers) is of vital importance in understanding their reality with regard to WRS (Weaver & Olson 2006).

1.7.2 Epistemological assumptions

Since “phenomena are studied through the eyes of people in their lived situations” (Weaver & Olson 2006:461), the researcher recognised subjectivity and interacted with the participants in order to understand what participants were saying from their view point. The goal was to rely as much as possible on the nurse managers’ perceptions of the situation, which are often negotiated socially (Creswell 2014); hence the interactive process. The findings are the result of this interactive process (Polit & Beck 2017) between the researcher and nurse managers under study. The researcher got the knowledge from nurse managers regarding their perspective of WRS in their workplace, where they manage employees and patient care.

1.7.3 Methodological assumptions

Data was collected through semi-structured interviews conducted with individual nurse managers who work in the selected rural district hospital in Limpopo province. The researcher used an interview guide to interview the participants. The researcher listened to and made notes allowing participants to narrate in order to establish the meaning of the phenomenon (WRS) from the views of the participants (Creswell 2014).

1.8 DELINEATION

The study focused on exploring and describing the perceptions of nurse managers in one rural public district hospital with regards to WRS.

1.9 RESEARCH DESIGN

An explorative and descriptive qualitative design was used in this research study (Brink, van der Walt & van Rensburg 2014). The aim was “to observe, describe and document aspects of a situation as it naturally occurs” (Polit & Beck 2017:206). The researcher explored the perceptions of nurse managers with regard to WRS as it occurred in the natural hospital environment where the participants are working.

1.10 METHODS

The methods used in the study will be discussed in in detail in Chapter 3.

1.11 TRUSTWORTHINESS

To ensure trustworthiness of the data, the researcher adhered to the following criteria as proposed by Lincoln and Guba (1985) in Polit and Beck (2017): credibility, dependability, confirmability, transferability, and authenticity.

1.11.1 Credibility

Credibility establishes whether or not the research findings is a correct interpretation of the information (perception of WRS) originally provided by the participants (Anney 2014, Polit & Beck 2017). To ensure the data and interpretations of the findings were derived from the data, the researcher followed the advice of Anney (2014) and kept a reflexive journal to reflect on everything that happened during data collection and discussed the analysis process with her supervisor.

1.11.2 Dependability

By providing a thick description of all procedures followed during selection of participants, data collection and analysis, and interpretation of the data, the researcher was able to attend to the dependability of the data. The researcher followed Naik's (2015) example of using two devices to record the interviews to guard against loss of information and furthermore, to discuss the data analysis and interpretation of the data with her supervisor, and requested a peer (independent coder) to participate in the data analysis.

1.11.3 Confirmability

To ensure confirmability the researcher was reflective and maintained a sense of openness to the study and unfolding findings. The researcher was objective in that the data resembled and represented the information the nurse managers had provided. The participants' voices were reflected and the conditions for the study were not made up nor consisted of assumptions and views on the part of the researcher (Polit & Beck 2017). Specific strategies used included:

- The use of audio recording to listen to the interviews so as to ensure understanding of the content by the researcher
- Reciprocal use of field notes to confirm data from the audio recordings

1.11.4 Transferability

Lincoln and Guba in Polit and Beck (2017) noted that it is the researcher's responsibility to ensure that the findings of the study can be applicable in other settings by providing adequate descriptive data so as to enable other researchers to evaluate the applicability of the data to other contexts. However, since only one hospital was used in the study, findings should be assessed cautiously regarding its applicability to other settings.

1.11.5 Authenticity

To authenticate the findings of the study (Polit & Beck 2017) the researcher was able to portray the realities of the participants by conveying a feeling of how events took place to enable the reader to understand the perceptions of the nurse managers the way they were presented by the nurse managers. This involved quoting of texts and phrases used by the nurse managers to bring out the original meaning as was intended by the latter.

1.12 ETHICAL CONSIDERATIONS

In qualitative research, the researcher is considered to be the research instrument. Therefore, researchers should be cognizant about ethical considerations and know how to address any ethical concern while carrying out the research. The researcher focused on the following ethical principles to ensure the best interest of the participants was taken into account.

1.12.1 Respect for persons

Nurse managers are autonomous beings, that is, they have got the right of self-determination. This entailed the right to can withdraw participation at any given time or stage of the study. The duty of the researcher here was to uphold those rights by refraining from exerting any form of force or pressure forcing the nurse managers, aimed at securing their participation in the study due to perceived threats (Brink et al. 2012), even incentives may not be withdrawn. The researcher was not allowed to punish the participant for not taking part in the study. Informed consent will be sought for the participants to agree in writing after giving full explanations of the implications of the study. The researcher was legally obliged to and would provide the

participating nurse managers with accurate up to date information about the study, what it entails in terms of the purpose and implications thereof as well as their rights as participants. The researcher obtained the participants' consent in writing, which did not afford the researcher the right to intrude in the lives of the participants. Respect for the participants' values was still binding on the researcher (Bryman, Bell, Hirschson, dos Santos, du Toit & Masenge 2011).

This principle includes the rights to self-determination and to full disclosure. Meaning people should be treated as autonomous beings; being capable of controlling their own actions (Polit & Beck 2017). The participating nurse managers were not coerced into taking part in the study and their participation was based on their own decisions. This study involved no monetary incentives.

The right to full disclosure involves people's right to make to make informed choices regarding whether or not to participate in the study, which then requires full disclosure by the researcher (Polit & Beck 2017). The researcher explained to the nurse managers what the study entailed, the researcher's responsibilities, their rights as participants, as well as the likely risks and benefits involved when participating.

1.12.2 Beneficence

The researcher was careful to promote the good and reduce the risk of harm to the participants as an obligation. This was done by providing information about the study to the participants Care was also taken by refraining from harming the nurse managers by exposing their names to public scrutiny. Care was taken to reduce risks and to work towards benefiting the participants in every way possible (Tappen 2016).

The point of departure was to refrain from inflicting harm, physical or emotional and the benefits of the enquiry on the participating managers should outweigh the unintended disadvantage (Towesly-Cook & Young 2013). The researcher took necessary measures to protect the participants from harm that might be suffered as a result of participation in the study (Brink et al. 2014).This included submitting the study to the relevant authority for permission to conduct the study and obtaining approval from the relevant research ethics committee (See Annexures A and C).

1.12.3 Justice

The principle of justice includes participants' rights to fair treatment and to privacy (Polit & Beck 2017). The researcher ensured that participant selection was done according to the given requirements and not vulnerability. In this study, participants were nursing managers who have worked in the designated rural hospital for twelve months or more. By right to privacy it was meant that the study should not be more intrusive than it should be. The study only commenced after written consent was obtained from participants. Full disclosure was ensured by providing information about the nature of the study and what the researcher expected from the participants during the study.

1.13 CHAPTER OVERVIEW

Chapter1 provided the introduction of the topic and background of the research problem, statement of the problem and the significance of the study. The aim of the study as well as the research questions was indicated. Then followed the clarification of key concepts used in the study as well a discussion on the ethical considerations applied in the study. Chapter 1 ended with an outline of the scope and delimitation of the study.

In Chapter 2 the topic will be re-introduced and the research question along with the research design will be presented. Then a description of the participants, sampling procedures and data collection instruments shall follow. Thereafter, data collection procedures, description of the researcher and the procedures followed to increase trustworthiness of the findings will be discussed. Finally, the data collection procedures will be discussed.

Chapter 3 will start by describing the method followed to analyse data, followed by presenting the emergent themes that address the participants' perceptions of work related stress in the work environment, consequences of WRS for them ,their staff as well as their families, training and coping strategies adopted. The results were intended to address the question guiding the inquiry.

Chapter 4 will further address the results of this study. The participants' experiences and perceptions on work related stress will be discussed at length, how and causes WRS in their work. The emergent themes of the study will be discussed in detail. The chapter will conclude

by presenting the implications of the study, limitations as well as recommendations for future research on work related stress.

CHAPTER 2 RESEARCH METHODOLOGY

2.1 INTRODUCTION

The previous chapter provided a short description and introduction of the study. This chapter presents the research design and research methods in detail. The chapter discusses the qualitative, explorative and descriptive nature of the study. It also describes the population, setting, sampling and sample size, data collection procedures and data analysis. Measures taken to ensure the rigour of the research, and the ethical considerations taken into account during the research process, are also discussed.

2.2 RESEARCH DESIGN

Brink et al. (2012) and Polit and Beck (2017) define a research design as an amalgamated plan applied to address a research question. The study adopted a qualitative, exploratory and descriptive design to answer this question: “What are the perceptions of nurse managers in a rural district hospital in Limpopo regarding WRS?

2.2.1 Qualitative research

The aim of a qualitative study is to understand the phenomenon under study from the insiders’ perspective. The participants’ voices need to be heard, and the phenomenon needs to be investigated from various participants’ perspectives. Qualitative research explains phenomena through gathering non-numerical data (Brink et al. 2012; Grove et al. 2013). Using a qualitative approach, the researcher was able to explore and describe the perceptions of nurse managers in a rural district hospital in Limpopo regarding WRS. The context allowed the researcher to appreciate the nurse managers’ perceptions regarding WRS.

2.2.2 Exploratory research

Explorative studies aim at investigating phenomena where there is limited information about the topic. Usually such a design contains a limited sample and focuses on one or two variables, which is very useful when the researcher wants to gather information on a variable that is very difficult to measure. The intention of an exploratory study is not to generalise the findings; instead, the goal is to increase the body of knowledge in a certain discipline (Grove et al. 2013).

In this study, the researcher aimed to explore the perceptions of nurse managers in a rural district hospital in Limpopo regarding WRS.

2.2.3 Descriptive research

Descriptive research is employed when very little is known about the research problem and where more information is required of certain situations as they occur naturally (Brink et al. 2012). The main aim of descriptive research is to deliver a detailed description of the phenomenon under study (Brink et al. 2012) and it was considered appropriate for this study because the study intended to describe in detail the perceptions of nurse managers in a rural district hospital in Limpopo regarding WRS.

2.3 RESEARCH METHODS

2.3.1 Context

The study has been conducted in a designated rural district hospital in Limpopo province. It is a 208 bedded hospital with 34 nurse managers responsible for supervision and management of ten nursing units and six clinics. Both in-patient and outpatient nursing units have been included. The nursing units consist of three combined general wards (paediatric, male and female wards) and a maternity ward, which is made up of four sub units namely: antenatal unit; nursery; labour and postnatal wards. The researcher also included outpatient clinics supervised and run by nurse managers who met the inclusion criteria. The clinics covered in the study were: the general, eye, tuberculosis, gateway, and reproductive clinics.

2.3.2 Population

The population in the study included 34 nurse managers working at the designated district hospital. The researcher described the word ‘population’ in terms of a whole group of individuals with common characteristics (Polit & Beck 2017). The group of nurse managers as a whole was the focus group of interest around which the researcher revolved the study. These nurse managers are responsible for managing and or supervising one or more nursing units including the clinics outlined above.

2.3.3 Selection of participants

Purposive sampling and specifically, total population sampling (Etikan, Musa & Alkassim 2016) was used. It is deemed appropriate when the population is small to include the entire population

that meet the inclusion criteria. Nurse managers who had served for at least one year or longer as a nurse manager within the designated district hospital, regardless of age and who were willing to participate were included in the study. The sample size depended on the best opportunity to reach data saturation; when sufficient depth of data had been obtained (Fusch & Ness 2015); meaning the exact number of participants was not and could not be known beforehand.

2.3.4 Data collection

Being the acting nurse manager in the selected hospital for the study, the researcher gained access by seeking permission in writing to gain entry (Polit &Beck 2017) into the hospital premises by approaching the provincial department of health and the head of the institution (chief executive officer). The chief executive officer then called a meeting with the executive council of the hospital wherein managers were informed and briefly orientated about the study. Information to assist the hospital managers in arriving at the decision to allow the study to be conducted (Polit & Beck 2017) was imparted through doing a presentation whereby the researcher briefly outlined the title and nature of the study as well the implications thereof for the institution and service delivery as a whole. This was done to gain confidence and trust as well as build a rapport with the gate keepers (Polit & Beck 2017). The presentation was in the form of a report outlining the nature of the study; how it will be conducted; whether or not there will be service interruptions as well as proposed time frames to enable decision making.

The researcher obtained participants based on the knowledge of the population and phenomenon under study (Dlamini 2015). The following criteria specified the inclusion characteristics of the research population (Polit & Beck 2017):

1) The participants had to be nurse managers at the designated hospital
2) Had to be in the nurse manager role for at least 12 months

Nurse managers were invited to a meeting through arrangement with the sectional heads of the designated hospital. The researcher presented an outline of the title, the nature of the study, the population as well as the implication thereof to participants, the institution and nursing practice in general, all the information required to enable informed consent (Towesly-Cook & Young 2013) as well as the procedures to be followed as well as tools to be used, voice recorder and consent forms, in the language they understood. In short, the researcher provided sufficient

information regarding the nature and purpose of the study, to enable the participants the ability to make an informed decision (Bryman et al. 2011).

For those who were willing to participate in the study, the researcher arranged dates and times suitable to them for interviews. The researcher ensured that data collection did not interrupt the duties of the participants in the following ways:

1) The most conveniently available participant (Polit & Beck 2017) was engaged at convenient agreed upon times.
2) The researcher used free times when units were not busy and after hours when the participants were off duty as per prior arrangement and as per the granted approval.
3) A venue that suited the participant, depending on the business of their respective stations or units was arranged.

Preparation phase

The researcher asked to meet with the nurse managers (prospective candidates) in the respective units where they are stationed, at a convenient time where she agreed with each willing candidate on suitable times for conducting the respective interviews. The researcher provided sufficient information regarding the nature and purpose of the study, to enable the participants the ability to make an informed decision (Bryman et al. 2011) to participate in the study. If the participant was not available as agreed, some future convenient date would be agreed upon for the interview. The researcher had explained to the nurse managers on an individual basis that participation was voluntary and that if they did not want to participate it would not influence their functionality and management role in anyway.

The interview guide

An interview guide with semi-structured open-ended questions was compiled for use in the interviews. The interview guide was to serve as a road map to guide the interview and the open ended questions were intended for use in obtaining as much formation as possible (Dlamini 2015) in exploring the phenomenon under study, and to ensure which areas to cover in the line of questions (Polit & Beck 2017). The interview guide consisted of a set of five open-ended questions which were formulated with reviewing literature on similar issues, with the aim at addressing the objectives of the study. The interview guide included possible probing questions to facilitate soliciting of more in-depth information on the research phenomenon (Polit & Beck

2017; Dlamini 2015) by the interviewer. Probing is done solely to obtain in depth information about the phenomenon studied. The interview guide is contained in Annexure B.

Research assistants

Four research assistants were employed to assist in data collection on behalf of the researcher. This was done in order to enhance objectivity and avoid subjectivity on the part of the researcher (Polit & Beck 2017), who happens to be working at the same designated hospital at which the study was conducted. It was also done to protect prospective participants from being coerced to participate due to the researcher being in a higher nursing management position than the rest of the nurse managers. The researcher orientated the research assistants in compliance with the training requirement cited in De Vos, Strydom, Fouché and Delport (2005) and Polit and Beck (2017) to ensure that the interviewers were capable of conducting the interviews. The training and orientation covered information on the nature of the study; orientation on the interview guide as to what type of information is required to address the research objectives as well as the line of questions and probes, staring with simple introductory part intended to establish a rapport with interviewees (Polit & Beck 2017). Interview tips and information on the pitfalls to avoid (De Vos et al. 2005) were shared and discussed and this included a reminder on using English as the language for conducting the interviews.

The interview phase

Data was collected by conducting face to face semi-structured interviews with each willing participant. An interview guide was utilised to guide the research assistants in collecting data**.** The researcher, the assistant as well as the participant met at the organised venue. The interviews were conducted in a convenient space in the nurse manager's office and or the respective nurse managers' offices, whichever was conveniently subject to prior arrangement with the participant. The interviews were conducted in English, as it is the standard medium of instruction used amongst staff for nursing services and management in the district hospital. Interviews lasted for approximately one hour and were recorded using a voice recorder, with the expressed permission of each participant. Deliberate probing, clarifying as well as summarising techniques were used in order to increase clarity in the responses (Moyimane, Matlala & Kekana 2017). The research assistants also compiled field notes, and the process proceeded until the same information was being yielded by the participants. The researcher was not present during the interviews to allow the participants to express themselves freely.

Pilot interview

A pilot interview was conducted with at least five nurse managers who also complied with the inclusion criteria of working in the hospital for at least one year. This was done to ensure the research assistants were comfortable with the research questions and were able to follow up with probing where necessary and as required (De Vos et al. 2005). The data collected with these interviews were included in the data analysis process as the inclusion criteria were satisfied during sampling.

Post interview phase

Each participant was thanked for participating in the study and informed that they may be contacted further to clarify any issues arising out of and following the interview. The participants were asked whether they had anything they would like to add to what was said in the interview and to ask questions as was needed.

Data organisation

The recorded interviews were transcribed verbatim by the researcher. The transcripts were compared with the recorded interviews to ensure the transcripts were correct. The field notes were also read. To ensure the privacy of participants was protected the researcher stored the transcribed interviews in a password protected file on her computer.

2.3.5 Data analysis

Content analysis was used to analyse the data. According to Erlingsson and Brysiewicz (2017) content analysis is about systematically transforming a “large amount of text into a highly organised and concise summary of key results”. The following steps were followed: 1) read and re-read the interviews to get a sense of the whole - to understand what the participants were talking about; 2) divided up the text into smaller parts into meaning units; 3) condensed the meaning units further; 4) labelled the condensed meaning units by formulating codes; and 5) grouped the codes into categories. As content analysis is a reflective process, the researcher continuously reflected on the initial data analysis to see the bigger picture and the patterns in the codes and organise the codes into categories. A detailed discussion on analysis of the data will be presented in Chapter 3.

2.4 SUMMARY

The chapter begins with a description of the research design, followed by explanation of the context in which the study took place as well as the criteria complied with in selecting the participants. The data collection methods are explored from preparation, implementation as well as post implementation phases. The chapter ends by explaining how the data collected data were organised leading to analysis.

CHAPTER 3 DATA ANALYSIS AND FINDINGS

3.1 INTRODUCTION

The chapter starts with a brief outline of the demographic characteristics of the participants. The methods used and the process followed by the researcher to analyse the data are described in detail. This is followed by a presentation on the identified themes, the findings of the study as well as a discussion on the findings.

3.2 DEMOGRAPHIC INFORMATION OF PARTICIPANTS

The target population were nurse managers working in different units in a rural district hospital in Limpopo. A total of 33 participants were interviewed for the study of which four were males. This is because nursing posts in this hospital are mostly populated by females. All the participants were Black South Africans who were willing to participate in the study. Three nurse managers who were meeting the set criteria were not willing to participate in the study, while one nurse manager could not take part due to being on night duty. The participants were functional and experienced in different units and wards in the hospital. Only six of the participants were holding a qualification nursing management. Table 3.1 summarises the participants' demographic data.

Table 3.1 Demographic characteristics of participants

PARTICIPANT	**P1**	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**P8**	**P9**	**P10**
Population group & Gender	A F	A F	A F	A F	A F	A F	A F	A F	A F	A M
Age in years	57	51	53	56	59	55	57	38	56	57
Years in management position	01	21	5	12	22	8	5	2	19	5
Nursing qualifications	G	ADM	M	M HM	D	M HM	M	M	M	G
PARTICIPANT	**P11**	**P12**	**P13**	**P14**	**P15**	**P16**	**P17**	**P18**	**P19**	**P20**
Population group & Gender	A F	A M	A F	A F	A F	A F	A M	A M	A F	A F
Age in years	56	53	54	53	58	51	57	37	49	57
Years in management position	3	6	20	5	12	5	5	3	5	5
Nursing qualifications	M	G	ADM	M	ADM	M	M	D HM	M	M
PARTICIPANT	**P21**	**P22**	**P23**	**P24**	**P25**	**P26**	**P27**	**P28**	**P29**	**P30**
Population groups & Gender	A F	A F	A M	A F	A F	A F	A F	A F	A F	A F
Age in years	59	51	57	49	55	51	53	55	61	57
Years in management position	21	5	21	5	5	5	5	15	9	11
Nursing qualifications	D HM	M	GO	M HM	M	M O	M	D HM	M	M
PARTICIPANT	**P31**	**P32**	**P33**							
Population group & Gender	A F	A F	A F							
Age in years	54	54	59							
Years in management position	3	20	20							
Nursing qualifications	D HM	M	MP							

Race: A = African

Gender: F = Female; M = Male

Nursing qualifications G = General Nurse; D = Degree; ADM = Advanced Diploma Midwifery; GO = Ophthalmology; M = Midwife; MP = Midwife & Paediatrics; HM = Management

3.3 DATA ANALYSIS

The thirty-three participant interviews were recorded with the consent of the participants and field notes were written. The researcher transcribed these recorded interviews verbatim. Once transcribed, the researcher analysed the transcripts using content analysis as described by Erlingsson and Brysiewicz (2017). The following steps were followed: 1) read and re-read the interviews to get a sense of the whole - to understand what the participants were talking about; 2) divided up the text into smaller parts - codes; 3) condensed the codes further by formulating sub-categories; and 5) grouped the sub-categories into categories and ultimately themes. Seventeen categories and five themes were identified. The researcher requested an experienced qualitative researcher to analyse the data independently. She and the researcher then discussed their findings and reached consensus about the final analysis. A summary of this is indicated in Table 3.2.

Table 3.2 Themes, categories and sub-categories

Themes	Categories	Sub-Categories
1. Causes of WRS	a. Interpersonal relationships	• Poor communication amongst nurse managers • Insubordination • Favouritism by higher level managers • Verbal abuse by community, patients and patients' relatives
	b. Limited resources	• Shortage of staff • Shortage of equipment, drugs and materials • Budgetary constraints
	c. Work conditions	• Long work hours • Facing death of patients • Unpaid overtime • Non nursing duties • Workload • Lack of higher level managerial support • Lack of staff commitment
2. Signs and symptoms of WRS	a. Physical signs and symptoms	• Headaches • Fatigue • Backache • Chronic conditions • Insomnia

	b. Psychological signs and symptoms	• Depression • Being discouraged • Feeling overwhelmed and not able to cope
	c. Behavioural signs and symptoms	• Poor work performance • Absenteeism and sick leave • Irritability • Problems with interpersonal relationships • Aggression
3. Consequences of WRS	a. The individual nurse manager	• Family disorganization • Displacement of emotions • Social withdrawal • Self-care neglect • Chronic conditions and other ailments
	b. The organization	• Poor work performance • Increased staff turnover
	c. On patients	• Negative patient outcomes and prolonged hospital stay
4. Current strategies to cope with WRS	a. Humour	• Joking and laughing
	b. Religion	• Faith • Prayer
	c. Socializing	• Social activities away from work • Social media • Engaging in conversation • Collegial support • Withdrawing from work and others
5. Strategies recommended by participants to manage WRS	a. Managerial support	• Staff meetings • Mentoring and coaching • Participative management style
	b. Creating a positive practice environment	• Filling of posts • Social activities and recreation at work • Address concerns about infrastructure
	c. Stress management	• Training/information sessions on managing or reducing work related stressors • Increase employee assistance program • Promote self-care
	d. Work/family life balance	• Family responsibilities • Safeguard against taking work home

3.4 FINDINGS AND DISCUSSION

The themes and their respective corresponding categories are presented and supported with appropriate verbatim quotations. A number, instead of participants' names is used to ensure confidentiality is maintained. This number is indicated in brackets after the quote. Each category is presented and followed by a discussion.

3.4.1 Theme 1: Causes of work related stress

In the study nurse managers described the challenges of facing WRS emanating from interpersonal relationships with staff and patients' relatives in the work situation; lack of resources to use in the performance of their duties as well as work conditions to which the participants are exposed.

Category a: Interpersonal relationships

In this study, the nurse managers complained about poor interpersonal relationships as a cause of their WRS. According to Banovcinova and Baskova (2014) one of the work related stressors in healthcare professions is interpersonal relationships, which reflect in relationships with the multi-disciplinary team, other managerial staff and co-workers.

Poor communication amongst nurse managers

It was found that nurse managers were concerned that the poor or lack of communication amongst themselves, in itself, contributed a lot to their stress in the work environment. Identifiable with stress is, amongst other major factors, communication about "forthcoming change" (Zoni & Lucchini 2012:44) in the work situation. These are reflected in the following quote:

*"…because you'll find that this one reported to this one, and then this one does not give information to this one."(*P7)

The same goes for communication which is given in a wrong way as one participant put it:

"*For example, we are expected to report...in the time register, if you're sick or on annual leave you should write if annual or sick leave. But the message was from above-down, saying give that person a leave. We expect a person to report to the immediate to the immediate supervisor, then up. But this was up-down". (P20)*

Nurse managers fail to give or share information, which then frustrates colleagues. Poor and unclear communication sends conflicting messages to the listeners and confuses them promoting stress.

"I can cause the situation as a manager or maybe supervisor…the communication that I'm using...if my communication is not clear...they [nurses] can revolt."(P4) and cause the manager some stress.

''They do something…without consulting the others - they take decisions on their own without consultation. Yes."(P9)

The poor communication often results in conflict between staff and the nurse managers

"You give the other one some hours…they refuse because … it seems we don't agree on one thing my seniors, myself and other junior staff". (P19)

Hence labelling of poor communication amongst these managers is perceived as *"the main factor that…contribute…" (P9)* to the WRS.

The European framework, a document which created awareness on the causes of WRS cited the vitality of communication to prevent uncertainties (Zoni & Lucchini 2012) regarding work processes, oncoming change and so on. The findings in the study support the terms outlined in the European document on WRS. The participants are exposed to suffer stress as and when decisions are taken, changes to known procedures are taken, made and implemented- all these made without being duly communicated to them. WRS ensuing due to poor communication may be prevented. The framework in its directive concerning work conditions, further legislated against psychosocial risks at work. The directive contains specific provisions placing a duty on employers to inform and consult employees on matters of concern. This study supports the directive as information is imparted through communication, consultation is indicated to let people know and have inputs before certain decisions are taken and or change is affected. The study therefore hereby emphasizes that poor communication and lack of consultation are serious psychosocial risks that should be discouraged at all costs, to protect employees against WRS.

Insubordination

In the study, employees display unacceptable behaviour towards the nurse managers, they are then forced to intervene and when they do, the relationships with subordinates become unbearable because of the resultant conflict, which then becomes stress.

"And then if you tried to intervene…there'll no longer be the relationship between the manager and the employee…sometime you will be forced to be harsh on that individual…That in itself can cause stress..." (P10)

One participant was concerned that upon taking corrective action on the particular employee conflict ensued thereby leading to further tension in between, stressing the participant further. Blair and Littlewood in Moustaka, Theodoros and Constantinidis (2010) describe work relationships as sources of stress. The researchers reiterated work relationships as potential sources of stress with conflict with staff being one of the sources of stress in that field. Similarly, the nurse manager may tend to suffer even more stress as the individual nurse withdraws support from the manager.

Another participant explained it further:
"Staff also undermine the nurse manager "...some will tell the old thing [referring to things the manager did in the past] what you have done …" (P17)

This behaviour may be identified with negativity in the work environment which nurse managers in the study by Shirey (2009) preferred to walk away from. This study therefore supports the findings of Moustaka et al. (2010) that conflict in work relationships may affect support by staff and other co-workers thereby contributing to nurse manager WRS. The study also identifies with the findings of Thabane (2015) who cited interpersonal conflict, a common work stressor at work, as a possible recipe for tension and hostility, contributing to even more stress in the working environment.

Favouritism by higher level managers

Higher level managers dictate to unit managers what to do, particularly if it applies to their favourites. Some of the nurse managers in the hospital find operating or functioning in such an atmosphere stressful. Senior managers allocate less appealing tasks to the least favoured. The favourites include nurse managers as well but the participants feel colleagues are recognized not because of hard work but rather due to favouritism. As long as one is not their favourite they will not be recognised for any good they do. Due regard is given to people who do not deserve it. Two participants noted:

"The managers have got favouritism. If they favour a person, even if she comes late… I don't know how to explain it… Even if she has done wrong, it means somebody else has done wrong." (P20)

"And also the favouritism when it comes to development of employees like when you know very well that you are due to studies. You were supposed to go to school to further your studies or to advance in a specialised area that you are interested. You may find that during training committee you are overlooked and they end up sending someone who is junior that you. (P18)

The European directive on psychosocial risks at work makes provisions for discrimination in the work environment. All forms of discrimination, direct or indirect on all grounds (Zoni & Lucchini 2012), which would include favouritism are indicated. This study supports the European directive against favouritism as a form of discrimination against other employees [nurse managers] who are the least favoured, protecting them against consequent WRS. The least favoured participants will be stressed and anxious when on duty as their cause will always be treated differently.

Verbal abuse by community, patients and patients' relatives

The community, patients and their relatives add to the WRS nurse managers are facing through bullying and verbal abuse. Participants report being blamed for patients who died in their care, due to lack of understanding of the circumstances leading to the death of the patient. The nurse mangers and nurses working in the designated hospital are victimised for similar circumstances and live in constant fear for their lives from the angry community. This is how one participant described it:

"They come being high and furious…they will say you are the one who killed my brother, you are the one who killed my sister."(P19)"

A participant shared that the community is generally aggressive when seeking to consult late in the day and after hours as they do not want to await their turn.

"…the CLO, he must tell the community to come to the hospital as early as possible not to come after hours… They come here we see that having some plastics full of groceries and these people they shout at us...If they don't see the doctor…they just expect to see a doctor. So they will shout the nurse…" P16)

Communities do not heed information imparted through health education during pregnancy, only to allot blame to nurses and their managers for the consequences of their actions. The participant shared how she was stressed already from having to deal with an unfortunate incident with a maternity case, only to be subjected to a lot more stress later, as quoted:

"They don't adhere to the treatment and the way they should take their treatment. Sometimes the woman don't go to the clinic for bookings, for antenatal clinic but at the end of the day when things go wrong they come back to us. It stress when you talk to people about his/her life but he don't listen, he don't take care of it but at the end of the day I'm one who is going to be questioned and answer form my seniors, from everywhere and from the community" (P19)

Govender et al. (2012) noted that stress at the workplace also include factors such as demands from patients. Nurse managers in the study found themselves defenceless and at the mercy of the community, patients and their relatives; a situation that may be aligned with the findings of Olender (2013) on workplace bullying. The researchers described bullying in the workplace as "these negative behaviours are intentional, occur over a prolonged period of time and are targeted at individuals who are unable to defend themselves" (Olender 2013:35). Nurse managers in the study by Govender et al. (2012) were also exposed to verbal abuse by members of the community served by the hospital, and specifically patients and their relatives. These negative behaviour and incidences increased the participant nurse managers' vulnerability to WRS.

Category b: Limited resources

The majority of the participants reported shortage of human and material resources. The shortage included different categories of staff (members of the multi-disciplinary team and support staff), equipment as well as funds for procurement of material and remuneration of staff for services rendered in overtime work. Nurse managers were not happy to operate in this situation, and the participants perceived the situation in the hospital as a major contributory factor to nurse managers' work related stress.

Shortage of staff

The study revealed an extreme shortage of staff in all directorates particularly those directly linked to patient care. This is how the participants put it:

"Starting from human resources management there is a vacancy rate of the hospital in general which is above 50%. We are running short of nurses in different wards."(P21)

"…it's 70% vacancy, the posts are not filled in laundry, cleaning services is the same."(P5)

Shortage of resources is one of the vital stressors in the work environment (Leka & Houndmont 2010; Yeboa et al. 2014). In one Ethiopian study it was found that having less than required staff to cover patient care in the units was frequently a stressful condition. The researchers also noted that inadequate staffing to ensure patient coverage in nursing units "is perceived as the most stressful event by the staff nurses" (Dagget et al. 2016:6). Similarly, nurse managers in the current study perceived the staff shortages [not for nursing only] as very stressful.

Shortage of equipment, drugs and material

Participants reported a general lack of equipment as endangering patients' lives. The units have to borrow from one another when patients have to be monitored and at times it creates an ethical dilemma, as to who amongst, the patients is to be prioritised.

"When the patient sometimes needs Oxygen…we are running about searching for the Oxygen…" (P11)

"You find that you are having only one BP machine. It's not working so you must also borrow it from the other ward, whereas they are still using it. So they must borrow you whereas going to-…they're just going up and down with one equipment."(32)"

"…what we are using in the ward, no treatment, sometimes they say there is no treatment, is finished in Dispensary."(P3)

In one Canadian study researchers noted that modern nurse managers are required to put more "emphasis on reducing costs and increasing productivity." (Sonia, Cummings, Care & Jenkins 2017). This finding is similar to the situation the nurse managers in the study are facing, namely gross shortages of medical supplies and equipment adversely affected health workers, particularly doctors and nurses who become emotionally drained, stressed and detached, impacting on the quality of healthcare services in the country (Rachiotis, Kourousis, Kamilaraki, Symvolakia, Dunias & Hadjichristodoulou 2014). The Ghanaian Times reported alarming shortages of equipment such as a CT SCAN, the machine reportedly not working, for days, in an academic hospital. The situation was made worse, by politics that feature in healthcare affairs in the spirit of saving money, as the author noted. The managers of the hospital were concerned because of the situation, the clinicians particularly doctors and nurses were noted to be suffering stress and burnout due to the shortage (Ghanaian Chronicle 2011). Consistent with all these is the finding that nurse managers in the study are persistently stressed and frustrated

by shortage of drugs, equipment and other material required in delivery of healthcare services, as quoted:

"Shortage of equipment also is a challenge for us like a C-PAP machine, equipment you find that they are not there when you have a distressed patient you don't know what to do. Some find that you are running short of BP machines now you have to run from one ward to another borrowing" (P21).

At the time of the study, the nurse managers indicated that there was a gross shortage of equipment and supplies due to budget cuts which negatively affects procurement of new supplies as well as servicing and repairing processes. In the designated hospital, nurse managers take the fall for the shortages as they are responsible for facilitating procurement processes, they fall victim to stress and burn out when they order equipment but the exercise is not bearing fruit:

"This is very much difficult… because even there is equipment that is in shortage and I have tried to order but I don't reach and it's still a stress" (P5).

Because of these shortages the quality of healthcare services is affected (Rachiotis et al. 2014) impacting on patient outcomes (Govender et al. 2012; Hall et al. 2016).

Budgetary constraints

Participants mention low budget as causing them stress as one nurse manager put it:

"You are given a small budget of which is very much frustrating. You don't know what you must prioritise in the first place…" (P21). It prevented them from buying important equipment as indicated: *"…you find that you have been given R200 000 to buy equipment and that R200 000 can't even buy one big equipment like ultrasound… and more than 200 patients that you see per month that need ultrasound…" (P5)*

Insufficient budget is an important stressor for nurse managers and budget cuts grossly negatively affects other possible stressors such as staffing (Schub & Karakshian 2017) and procurement of goods and equipment for healthcare service delivery. Naik (2015) noted the stress that nurse managers face by the continuous struggle of meeting financial targets. This is consistent with the finding that nurse managers in the designated hospital find themselves dealing with a budget crisis, which they perceive as highly stressful. In one Greek study, researchers found that budget cuts in two public hospitals led to shortage of medical supplies

and equipment, which was highly associated with high stress levels amongst health workers, doctors and nurses being the most highly affected by burnout from the austerity related shortages, which impacted on the quality of health care in the country (Rachiotis et al. 2014This is consistent with the findings revealed by the study whereby the hospital suffers annual budget cuts and related austerities, making it difficult for nurse managers and other clinicians to procure equipment and supplies.

Furthermore, the nurse managers are frustrated and concerned by the procurement processes that ought to be followed and the bureaucracy of government tenders involved therein, as quoted:

"…and the bureaucracy that we have even if there is money somewhere you need to buy equipment only to find that you just don't go from one shop to another like when you are at your home and it end up causing as if you are incompatible meanwhile you can do. For instance I might be able to buy equipment even knowing where I can get the equipment but because there are systems that we are supposed to undergo even the supply chain system you find that you are unable. I'll just quote things like baumanometer where you that I can use this type of baumanometer that can last me for five years then you are supposed to buy because there is a specific tender and that tender you get a thing that is not going last you for 18 months. It's really stressful' (P5).

Nurse managers are the ones who suffer the consequences manifested in perceived WRS and burnout, as one participant put it:

"You are given a small budget of which is very much frustrating. You don't know what you must prioritise in the first place to say I must buy this and leave this while all of them are needed" (P21).

All these frustrations and concerns point to the high levels of WRS and burnout on health workers inclusive of nurse managers in these countries discussed above resulting from financial austerities. It is noted with concern that the nurse managers in the public sector have little or no say in decision-making to intervene or relieve the situation as decisions are taken somewhere for them to implement (Mosadeghrad 2013), which only adds to the already heightened perceived WRS levels.

Category c: Work conditions

Nurse managers described the conditions under which they work as highly stressful. Participants described the following working conditions under which they are working:

Facing death of patients

The participants face human suffering and witnessing pain and death on a continuous basis, which leaves them feeling drained and needing help, as in the following quotes:

"And then another thing we are facing dying and death. So there are… many patients are very ill- in a terminally ill stage, at the end they end up dying." (P10)

"Some patients come with problems, some they come in with the baby dead in the uterus so you must counsel that woman and deliver the dead body. Sometimes they are rotten inside. You must take care of the baby and counselling of the patient…" (P19)

Watching patients die in one's care being in great pain (Dagget, Molla & Belachew 2016; Li, Ai, Gao, Zhou, Liu, & Zhang 2017) as well as breaking the news to the relatives (Dlamini 2015) as is the case in nursing, produces high stress levels (Johansson, Sandahl & Hasson 2013). The same may be attributed to the participants in the study, who are exposed to death and dying for extended time periods in the work environment. "Medical emergencies added to the tension of patient care… grief and loss when a patient dies, all these factors can increase a nurse's stress level…" (Dagget et al. 2016:2). Similarly nurse managers in the study, are also exposed to the same work conditions cited by the researchers in the latter study, and are therefore also exposed to very high stress levels for facing similar situations. Since working conditions are amongst the main known factors identifiable with WRS (Zoni & Lucchini 2012), it may therefore be maintained that nurse managers in the study are operating in conditions rendering them vulnerable to high work related stress levels.

Long work hours

The study revealed the managers work abnormally long hours; such that overtime funds get exhausted. The participants raised the issue in the following way:

"Another thing is that of offs [referring to off-duties]. So the way we knock off in OPD [referring to Outpatient Department] is not like in other hospitals…We end up arriving at home late and we fail to manage some of the things at home."(P16)

"In our situation, we are working over-hours [referring to very long hours] in the first place-we're, we're working over-hours. And then… you are so exhausted…" (P12)

"…sometimes you have to, to leave home for three days …" (P23)

"Nurses work long hours; 12-h shifts are common, especially in hospitals, and the job is physically taxing…" (Dagget et al. 2016:2). The same may be said about nurse managers in the study for working for very long hours, under the working conditions postulated by the researchers. The European framework has, in its directive against psychosocial risks, made provisions for regulating working times [by employers] in order to protect employees against WRS

Non nursing duties

The participants were concerned that they are compelled to do work which does not fall under their scope of practice in addition to their nursing responsibilities. This happens in most cases due to poor staffing of certain categories of personnel, and it adds to the workload and flares the already heightened levels of perceived WRS.

"Nurses end up going to fetch linen in the laundry of which is…non-nursing duties at the hospital (P21)".

"*Because most of the time we end up portaging files to different wards and portaging of files, taking of blood investigation to laboratory. We end up doing it on our own" (P16).*

Jiyane (2014) described non-nursing duties as the responsibilities carried out by nurses that fall out of their scope of practice. Performance of the non-nursing tasks "usually lead to mistakes that impact negatively on patients and their families" (Jiyane 2014:469). The nurse managers in the study perceived the non-nursing duties as adding fuel to their perceived WRS and therefore sought to be relieved. To elaborate further on non-nursing duties, "sometimes patients had unrealistic expectations of healthcare workers. A case in point was where nurses were expected to assist financially with the burial of an HIV and AIDS patient and supply food for poor affected families which were both non-health related tasks" (Kupa 2018:45). This, together with the management imposed task of being expected to provide psychological support to HIV affected patients when they themselves were not trained in the counselling field, was cited as unrelated to the participants' work and therefore caused them high WRS levels (Kupa 2018). Similarly, the participant nurse managers in the current study felt that the extra job tasks expected to be carried out are unrelated to nursing and are therefore adding to their perceived WRS levels.

Unpaid overtime

The study revealed that there is a general dissatisfaction around the issue of lack of funds for overtime payment. Nurse managers in the designated hospital found it stressful to supervise the nurses in doing overtime work when knowing that there will be no remuneration in the end as the funds have been exhausted. Participants indicated *"…for instance, now we are working…as from now…the hospital is not prepared to pay…overtime as from July meanwhile we are working overtime. They say we must work for hours [referring to remuneration by means of time-off]. They are not prepared to give…payments for the …for those extra hours been worked." (P12)*

"And then the other issue….lack of funds from the employer…you find… issues of overtimes not being paid…After they've worked they are told there's no funds, and they get demoralized, and then you as the supervisor…it becomes so stressful to make people to work while they won't get anything in the end." (P34)

In one South African comparative study of job satisfaction amongst professional nurses (Pillay 2009) it was found that professional nurses in the public sector were the most dissatisfied with their pay and the resources available to them, as compared to those in the private sector. Dlamini (2015), when investigating the psychological needs of nurses in rural areas, found dissatisfaction amongst nurses resulting from poor payment of financial rewards in the form of overtime and salaries which led to absenteeism and sick leave. Aligned with these findings, it may be deduced [as was revealed in the current study] that nurse managers who supervise disgruntled nurses, may find it stressful to demand overtime work performance and productivity from them, when they [the nurse managers] know that the there'll be no payment after the work is done. Therefore continued work under those work conditions may only increase the participants' stress levels related to their work.

Workload

The vacancy rate of the hospital itself indicates work overload to the staff that is on duty. The study revealed that the workload even exceed normal hours of work as less posts are filled, as reflected in the following quotes:

"…you find that it's two professional nurses in that unit that they are working maybe the other one is going off at one then other one is going off at seven, so you find that the workload for that one who's left behind is too much because you have to re-insert the drips; she has to give IV

medication and she is alone…is too much the pressure is too much…we just have to cope." (P11)
"Starting from human resources management there is a vacancy rate of the hospital in general which is above 50%. We are running short of nurses in different wards."(P21)

The study revealed that the workload even exceed normal hours of work as one quoted:
"…we are taking this work [administrative tasks] home because we're…we are unable to finish the work…then we just take it home."(P32).

Another participant explained *"You leave three days. You come back… the workload is… more than when you are in..." (P23)*

Studies have identified workload as a common source of WRS (Miyata, Arai & Suga 2015; Thabane 2015) and the main determinant of stress (Yeboa et al. 2014). Thabane (2015) describe workload in terms of being expected to perform many complex tasks than the individual is normally able to perform, which then contributes stress. This is corresponds with the finding revealed in this study that it is expected of the participants to render patient care and fulfil a managerial role simultaneously. In one study in Limpopo, nurse managers faced a challenge of workload created by managing primary health care units with overcrowded patients, "managers having to assist in terms of seeing clients in order to clear long queues at the expense of their supervisory functions" (Rajagopaul & Motaung 2013:61). This can be aligned with the findings revealed in this study; the participants are hands on in the sense that they are involved in doing the patient care work in addition to managerial and supervisory roles due to perceived staff and high vacancy rates. Luhalima, Mulaudzi and Phetlhu (2016) associated the high workload in rural hospitals in Limpopo, with WRS amongst nurses working in those areas. Similarly, the nurse managers working in the designated rural district hospital in the same province were having the same concern due to perceived WRS fuelled by the workload.

The nurse manager's job role is one of having tight schedules; chasing deadlines; having to make quick decisions with far reaching consequences (Schub & Karakshian 2017) and having to deliver more with less resources (Sonia & Cummings 2017). Having to deliver services and performing under pressure is one factor that causes stress (Thabane 2015; Nekoranec & Kmosena 2015).

Lack of higher level managerial support

Participants are stressed by the fact that they are not supported by senior management when they need it most, despite appeals. This concern was raised because higher level managers do not take an active supportive role; they are just distant watchers only stepping in to assist as and when necessary, as quoted:

"I've been knocking at the manager's office…writing reports which were not helpful…And when you try to bring something which…could benefit the community, you've got no support." (P23)

"…what they do when they come in they want to know what happened…relatives come from home and they want answers from me. I must answer everything but my seniors don't support me. " (P19)

In a study on psychosocial stress and its predictors among radiographers (Ugwu et al. 2016), lack of social support problems were found to be important predictors of stress at the work place. Support is vital in decision making and denotes the extent to which workers receive encouragement (Yeboah et al. 2014) from senior management and other categories of staff (Thabane 2015). Social support "…refers to a situation where there is lack of help from other team members…" (Ugwu et al. 201:13). This is reflected in the findings of this study in that higher level managers in the hospital under study are supposed to be the main team players, and so their actions [withdrawal of social support] may be a predictor of WRS the nurse managers.

Lack of staff commitment

The study reveals general lack of commitment starting with fellow managers as revealed by the following participants:

"Like when I had to look for the doctor from 19h00, from seven o'clock in the evening up to…around twenty-two hours…mind you, patients…are seated here waiting for the doctor…those who are assaulted, bleeding…all those things."(P12)

"…except for the pharmacy…, let's say I have got a patient – it's an emergency. Then I need something to carry out the duty. If I phone, they'll say this is not the day for ordering." (P20)

The lack of commitment is evident even in emergencies where medical officers fail to honour calls from the trauma and emergency unit, as quoted:

"They take to respond sometimes they'll just answer the phone they take time to come and attend to the patient and then at the end those things are stressing us..." (P11)

Health care service constitutes a highly stressful environment and the stress in this environment may cause health workers to be pessimistic, less concerned with themselves and their work (Ugwu et al. 2011), which may explain the lack of commitment amongst colleagues as perceived by nurse managers in the study. Aligned to this, it may be said that WRS amongst members of the multidisciplinary team renders nurse managers in the study even more vulnerable to WRS, not only as health care workers, but also having to work in a stressful environment with colleagues who are negative due to WRS. Work related stress is therefore a danger to everyone in the healthcare environment including the nurse managers at the designated hospital.

3.4.2 Theme 2: Signs and symptoms of WRS

Category a: Physical signs and symptoms

The study brought to light the following physical symptoms as reported by participant nurse managers.

Headaches

Participants noticed that they frequently suffer from headaches which are perceived to be a sign of their stress at work, verbalized thus:

"I become sick…headache, dizziness, and fatigue". (P20)

"Another thing like physically you end up not well like others normally experience headaches…" (P10)

Frequent headaches is one of the common signs when employees are experiencing WRS together with related symptoms such as muscular aches, cramps around the neck, and so on (Thabane 2015). Headaches, together with these other symptoms occurs as the body's physiological adaptation mechanism to prolonged exposure to WRS, which if left unmanaged, may lead to serious health problems. Symptomatic headache may manifest in different ways, either physically or physiologically (Kupa 2018) or both, which may indicate vulnerability to serious health problems like cardiovascular diseases and related conditions.

Fatigue

Most managers reported a general feeling of tiredness; they are always tired when they reach home and all they want and need is to rest. Some do not even have the energy to hug their kids at home due to exhaustion, as quoted:

"...you find that when you get home you are getting tired…you are always tired. …Tiredness is due to shortage where that you are working being two in the ward. Then you become tired physically…" (P3)

"Physically I become very tired because when you work overtime the body won't respond well. I will get tired and sometimes get sick physically." (P19)

In a South African study on stress amongst medical doctors, doctors were noted to be stressed from work related factors such as tiredness from the long working hours, responding to complaints as well as too much information management, amongst other factors (Govender et al. 2012). According to Dlamini (2015), nurses complained of tiredness from their increased workload, working for very long hours with little or no rest, and it placed them at risk of practice errors. Aligned to these findings, nurse managers in the study perceived WRS from functioning in similar stressful work conditions; wherein perceived staff shortage lead to increased work load and insufficient resting periods, consequently causing perceived stress in the work environment.

Backache

Participants also complained about backache as shown from these quotes:

"… you know stress causes backache…I'm sure I've consulted more times about backache." (P23)

"Labour ward we stand for a long time. Many of us complain about backache…" (P19)

Studies agree that physical symptoms such as physical diseases of stress is one of the signs of ineffective coping to stressors at work (Govender et al. 2012; Banovcinova & Baskova 2014). In support of these studies it is hereby reiterated that the participants in the study are still not coping effectively with the perceived work related stressor of inadequate staffing in the relevant units. Hence, the perpetual symptom of backache. In one study in Limpopo, researchers associated the high workload in rural hospitals with nurses' ill health in the form of backache, painful legs and fatigue amongst other health conditions due the stressful nature of the work

(Luhalima; Mulaudzi & Phetlhu 2016). Similarly, the nurse managers in the study were exposed to strenuous work conditions.

Chronic conditions

The participants reported physical symptoms suggestive of chronic ailments:

"Sometime you will get severe headache…many of us we complain about backache and the legs" (p19)

"I believe if another research can be done you might find that most of the ill health that nurses are having are related to Diabetes, which is psychosomatic disease, it's related to Hypertension, I might also be a sufferer, it's related to Cancer, it is a psychosomatic disease and all these diseases are caused by stress…"(P5)

Govender et al. (2012) postulated that being overwhelmed by a frustrating and demanding job may result in acute or chronic health conditions such as cardiovascular disorders. "Long term, prolonged exposure to stress has been linked to serious illnesses, including diabetes, heart disease and suppression of the immune system cells involved in fighting cancer" (Thabane 2015:56). The researcher is of the opinion that the participants in the study presented with different psychosomatic disorders in reaction to perceived work related stressors in the designated hospital, given the work conditions under which they function.

Insomnia

Participants also reported having problems with sleeping. They experienced difficulty in sleeping as they kept on thinking about the stressful cases they faced in the work situation, recalling the events of each day. Several participants had an opinion on this matter:

"During the night sometimes you don't sleep thinking about things that are happening here…You see you don't sleep you have sleepless nights. Sleepless nights become stress…" (P19)

"Or have, maybe you've had a confrontation. Even when you are at home…you cannot sleep because you, you think of the, that injury and say 'by the way, it's like this and this'. This happened to me like this and it was not supposed to be like this. Then, you think of the situation even at home." (P11)

"The sleeping pattern yes you going to have a problem with that…You find that you don't get enough sleep-you don't get enough rest."(P10)

A common finding in most studies about WRS (Govender et al. 2012; Banovcinova & Baskova 2014) is that the negative effects of stress may either be physical and physiological or psychological and emotional as in growing anxiety and tension disorders as well as inability to concentrate. Fourie (2015) found that when a person does not get enough sleep, it causes a negative change in the human biological system responsible for handling stress responses. An increase in stress can cause sleep distortions, particularly when high demands is expected of the employee the next day. Fourie's findings seem to be consistent with the experiences of the participants in this study: the nurse managers also complained about sleep interruptions when thinking about events at work, change in sleep patterns and difficulties in falling asleep. Although it is not clear as to which stage of their sleep the interruptions occur, these sleep disturbances would suggest the presence of stress in their work and work environment or rather confirm the nurse managers' perceptions of WRS in their work.

Category b: Psychological signs and symptoms

Depression

Participants verbalized feelings of sadness and low mood as psychological signs in reaction to the stressful circumstances at work, which may lead to them being diagnosed with mental disorders:

"Depression will be one of the signs. If you are stressed will be depressed. Sometimes you can think of committing suicide" (P10)

"Others end up being mentally ill, if not mentally ill, taking mental medication because it's stress goes with a person and it can affect a person anyhow." (P5)

Depression is a condition that affects the mood of an individual and is characterised by a feeling of hopelessness mixed with helplessness, and can weaken an individual by affecting their job performance (Hatzipapas 2013). Psychological reactions to WRS, according to Banovcinova and Baskova (2015) include amongst others depression and negative emotions. This may be aligned to the finding in this study, nurse managers' perceptions of potential signs of mental illness in the wake of perceived work related stressors. In Hatzipapas (2013), WRS amongst the caregivers was caused by the workload of caring for HIV infected orphans and was manifested in depressive episodes. Similarly, the nurse managers in the study are also concerned that some of them and their staff end up being depressed due to the perceived stress resulting from the high workload, caring for dying patients in the wake of gross staff resource shortage.

Being discouraged

The nurse managers felt discouraged and blamed themselves most of the time, thinking it is their fault when things do not work well for patients.

"I'm thinking that it's me who is failing to nurse the patient while it's not…because even if you coming to work, ah, you, ah, you feel like I'm not doing anything" (P11)

"You know, it become…it's like you are, you are a failure… in the eyes of the community. It's like now when they see you…" (P12)

"You end up saying I wish I could retire if it's possible…You end up saying let me pause or whatever…You don't feel active when you on duty, energetic when you are on duty. You get bored, you don't feel active at work" (P21)

Discouragement is one common psychological symptom of WRS and is usually accompanied by frustration and self-blame (Better health channel 2012). The burnout syndrome, according to Dominguez (2017) manifests itself through discouragement amongst other symptoms, and this may also negatively affect those close to them as it may affect the individual's mood and personality, as is indicated in the following quote:

"When you wake up you just think of someone who is stressing you "(P17)

Similarly, the participant nurse managers' mood may be affected, by being angry for example. That attitude may affect the subordinates who may feel discouraged to work with the manager who is in that mood. In a study exploring the challenges faced by rural area nurses, nurses found it stressful and discouraging when their financial needs in the form of salaries and overtime were not met despite their working under stressful conditions to render services (Dlamini & Visser 2017). The discouragement itself becomes a sign that the individual is experiencing WRS in their work situation

Feeling overwhelmed and not able to cope

Participants reported being overwhelmed, frustrated and not coping due to perceived stress in their work to an extent they did not know what to say or do to relieve the situation as indicated in the following quotations:

"Sometimes if the stress is too much you end up taking alcohol and you know that alcohol can lead to something else. When you are drunk you will no longer think consciously so. Sometimes you can think of committing suicide."(P10)

"You become emotionally upset…you become disturbed…" (P12)

In the study by Nekgotha (2018) one of the important psychological characteristics of stress is feeling overwhelmed. The European framework agreement in Zoni and Lucchini (2012) outlines subjective factors, amongst other factors, to be analysed in order to exclude WRS. The subjective factors include feeling overwhelmed and unable to cope, the presence of which suggest a problem of WRS. Aligning to this, the presence of these complaints in the research population may be diagnostic and suggestive of the presence of perceived work related stressors amongst the nurse managers in the study. Researchers agree that since WRS is subjective in nature and thus suggest further enquiry through the use of tools such as self-assessment questionnaires [guarding against the limitations of each and other strategies to explore the subjective experiences (Mucci et al. 2015).

Category c: Behavioural signs and symptoms

Poor work performance

Participants noted deterioration in their work performance due to perceived stress as quoted:

"I feel demoralized. I'm no more a hard worker. I was a hard worker but I'm no more" (P20)

"…you don't feel active when on duty. You get bored; you don't feel active at work." (P21)

Thabane (2015) noted that boredom, performing repetitive work as well as being under pressure from meeting deadlines may directly affect employees' work performance. The researcher also postulated that lack of recognition at work in terms of not feeling valued may lead to poor productivity. Vijayan (2017) associates low work performance with workload, which also may be the effect of constraints such as pressure to meet deadlines and insufficient resources to accomplish tasks. Rajagopaul and Motaung (2013) add boredom and frustration to the emotional symptoms of stress. From these findings, it may be inferred that WRS consists of a vicious circle of one factor causing the other, one thing leading to the other- perceived workload and inadequate resources leads to working under pressure to meet deadlines which in turn increases the workload. As a result of working under pressure the participants will start showing the symptoms [bored, frustrated and unable to cope] with the workload. Workload is one of the three principal factors negatively affecting work employees' performance at work (Vijayan 2017). In Fourie's study (2015) it was confirmed that negative stress caused participants to be tired and less productive impacting on their job performance. The findings in this study are consistent with those findings in that some of the nurse managers verbalized feeling tired always when thinking

about the situation at work, as early as in in the mornings when waking up. This would mean that due to perceived stress the affected nurse managers' work performance may deteriorate.

Absenteeism and sick leave

The study revealed that absenteeism and sick leave has become a coping mechanism as managers are faced with perceived workload and stress at work. They are also not coping with absenteeism amongst subordinates who keep on consulting doctors and obtaining sick notes for sick leave just to escape the work situation and its challenges.

"Like I said that I end up being ill most of the time."(P2)

"Always nurses will be going for consultation- she'll just phone in the morning and say I'm going for consultation" (P10)

"The effect on our colleagues they take always sick leave" (P8)

Studies show that absenteeism is highly associated with WRS (Zoni & Lucchini 2012; Gam, Puckree & Naidoo 2015). A regular pattern of absence, especially on the same day weekly is a known sign suggestive of WRS (Thabane 2015). "Stress affects the quality of life and work, including overall wellbeing…in addition, stress can result in work absences, higher turnover…" (Salilih & Abajobir 2015:326). Identifying with these findings, it may be evident that participants in this study are negatively affected by perceived work related stressors consequently falling sick at regular intervals rendering the frequent sick leaves suggestive of the presence of WRS.

Irritability

The study showed that participants demonstrated impatient and often irritable due to stressful situations in their work, verifiable in the following quotes:

"When you are from a stressful environment…as I'm saying it affects your mind. Sometimes you just feel so irritable …the children are so expecting a hug from you and they're like…you're so exhausted."(P12)

"…you postpone everything …and when you find that there's going to be a demand…when they ask you, you are going to start by like being irritable not assisting…"(P10)

Thabane (2016) in her study on WRS involving post office employees, noted that prolonged stress on employees may induce such symptoms as muscle cramps, making them feel angry, irritable and frustrated, as well as having difficulty in concentrating. Similar symptoms are notable in what the participants reported as consequences of perceived WRS. Most studies

documented how prolonged WRS induces irritability and other related emotional symptoms amongst employees. (Zoni & Lucchini 2012; Banovcinova & Baskova 2014; Marcatto et al. 2016), affecting their productivity and impacting on organisational performance. Similarly, the participants also reported being irritable when they are from work due to tiredness and perceived stress at work. Irritability occurs as a product of physiological changes that disturbs the homeostatic balance in the body resulting from exposure to work related stressors (Nekgotha 2019).

Problems with interpersonal relationships

Some nurse managers noticed interpersonal conflicts that would arise amongst themselves being colleagues. They start blaming each other leading to strained relationships amongst themselves all this interpersonal relationship troubles emanating from the perceived stress. The effect of the perceived stress impacts on collegial relationships leading to tensions amongst staff and conflict all due to stress in the work and work environment.

"…*You can find yourself withdrawn, no longer speaking, joking, laughing…" (P4)*

"We blame each other, even the managers [referring to top managers] can blame us that we are not working" (P11)

Interpersonal relationship problems ensue in the midst of or presence of interpersonal stressors which also bear conflict and tension (Liu 2016). In the study involving nurse managers, consistency with the findings by Liu (2016) reveals serious interpersonal conflicts emanating from colleagues daily interactions and dependency on each other in both clinical and supervisory roles but due to the stressful nature of their work end up having conflicting ideas, values, etc. This results in serious trouble some type of interpersonal relationship which only threatens mental wellbeing of individuals impacting on their performance as it happens at work in the work environment. Kato (2014) while investigating coping with interpersonal stressors, observed that trying to wait for the right time to intervene to overcome some interpersonal relationship may be too taxing and cause mental disorders such as depression and anxiety amongst hospital nursing staff. Kato defined interpersonal stressors as "stressful episodes between two or more people that involve quarrels, arguments, negative attitudes or behaviour, an uncomfortable atmosphere during a conversation or activity, and concern about hurting others' feelings" (Kato 2014:100). The resultant mental health episodes could be associated with the 'uncomfortable atmosphere' created by prolonged exposure to the interrelationship stress, consequently exhausting the victim's adaptive resources in the meantime while waiting

for a suitable moment (Kato 2014), which may worsen the individual's WRS levels. The 'blaming each other' episodes are the effect of perceived stress and burnout amongst stressed participant nurse managers, which are then fanned by the interpersonal relationship stress to end in the worst case scenario of WRS.

Aggression

Participants observed that they are easily provoked, which is quite unusual even to themselves; they become overwhelmed, anxious and frustrated by unfavourable situations:

"May be if one has made a mistake you become emotional…and then you become angry…" (P15)

"You find that you harass people…" (P4)

"Sometimes I become angry and is not my intention, just because the woman [referring to maternity patient] is not cooperating I become angry." (P19)

WRS may have negative consequences for nurse managers such as lack of concern for themselves or their work and a negative self-image (Ugwu et al. 2011). WRS may thus render nurse managers to become insensitive to others (colleagues, subordinates and patients), and to become increasingly aggressive and unwilling to help. WRS triggers a physical and psychological response which, amongst others, raises blood pressure giving rise to negative emotions (Banovcinova & Baskova 2014; Thabane 2015) such as becoming more aggressive (Schub & Karakshian 2017) and having destructive behaviours (Govender et al. 2012). One nurse manager when frustrated by a patient said *"Sometimes you even shout at the patient…after shouting the patient, then you starts realising … I'm out of line'. Then you start to redress…" (P23).* The participant was aggressive towards the patient as he was stressed and frustrated from the fact that he lacked a suitable instrument for a simple ophthalmic procedure on the patient, which he requested for a long time but was denied.

3.4.3 Theme 3: Consequences of WRS

Category a: The individual nurse manager

In this study nurse managers experienced undesirable consequences on themselves as Ugwu, et al. (2011) indicate that WRS may have negative consequences for nurse managers such as lack of concern for themselves or their work.

Family disorganization

Participants found their family and social lives to be affected, they failed to spend quality time with families at home due to perceived stress at work, long working hours, and the staff shortages. They focused too much on work issues consequently neglecting family responsibilities. Spouses and children are noticing the change in the participants' behaviour, not spending quality time with wives and kids impacting on family life. Some verbalized ignoring and neglecting parental and marital responsibilities and roles being reversed, of which one participant was concerned that it may lead to divorce. The following quotes show just how families are being affected.

"You come back home very late, if the child has started to be delinquent, taking Marijuana [referring to substance abuse] you can't even see the child because you are very tired." (P5)

"And from my family's side …you end not being able to do whatever is expected from you as a mother…not being to get chance to be with your children, your family because if you're stressed there's no time that you can spend quality time with your family." (P2)

"*Now you are going to phone them 'hey I'm not coming back because there's a shortage I'm sacrificing until 19h00'. You see maybe you planned something that at 14h00 you are going somewhere, now your family drops because of work issues you have to satisfy the employer before you can satisfy yourself." (P12)*

"And ah sometimes you have to leave home for three days, which is not good for a family person." (P23)

In a South African study on stress amongst medical doctors working in public hospitals (Govender et al. 2012), it was noted that the type of work done by doctors carries high stress levels arising out of the long hours at work, fear of possible litigations, information overload and so on. It was also found out that the stress causes the doctors many marital problems frequently leading to divorce. Similarly, nurses work very long hours and face the same ills as doctors as they care for the same patients. Hence, nurse managers are also at risk of family disorganisation in the form of marital problems which may cost them their families, as one verbalized:

"You will find that there's no longer good relationship between you and your kids and also your wife. Sometimes it can go further to extend of family disorganisation leading to divorce, something like that." (P10)

Gordon (2017) in her study on impact of work-life challenges on fathers, noted that "work life integration…can be negative from one domain namely, the workplace might make it challenging to meet the needs of the other domain, namely family and home." (Gordon 2017: 28-29). This finding is supported in the sense that due to staffing challenges in the units nurse managers are forced to be 'hands on' and work extra-long hours to cover patient care, thereby disorganizing their families, as one participant put it:

"Now you are going to phone them 'hey I'm not coming back because there's a shortage I'm sacrificing until 19h00'. You see maybe you planned something that at 14h00 you are going somewhere, now your family issues drops because of work issues you have to sacrifice the employer before you can satisfy yourself." (P9)

Loveridge (2017) in the study on nurse manager role, found that the nurse manager role adversely affected their parental role. They ended up experiencing guilt about the long hours they work and being preoccupied when they're home with their children. A similar finding was made in the study where one participant confessed:

"There is a time when I tell myself that you know what 'all this phones must be off, this weekend I do not answer calls from anyone. This weekend I do not answer calls from 7 pm until 6 am on Monday'. I really shut down because if you don't do it will be difficult and then when I have shut down I take the phones and put the far away." (P4)

The general expectation in workplaces is usually that employees should focus on their work role more than the roles at home, and furthermore the individual may also be given with work tasks that are challenging their mental capacity (Gordon 2017), in order to accomplish these tasks the working parent may need to look at it while being with their family. Friedman (2018) examined how prioritizing work over parenting affects children through behaviour change: if the parent is overly psychologically engaged on job-related matters while in the house, the children tend to display emotional distress more often than not. This according to the researcher points to the need to spend quality time with the children at home by being there for them not just physically, but also psychologically.

Displacement of emotions

One participant indicated that *"…sometimes when you're overworked or are having stress, you'll retaliate in a wrong way, when a staff member is talking to you you'll find that you don't communicate well with her" (P33)*

Displacement is a psychological coping mechanism which involves transfer of negative emotions, such as aggression, from the original source to an easy or less threatening target. Displacing emotions is usually a common defence mechanism used to deal with unacceptable situations. Displacement may according to Mohiyeddini, Bauer and Semple (2013) allow an individual temporarily to 'cut-off' attention from a threatening stimulus, which may then help reduce perceived WRS.

Social withdrawal

Some of the participants reported self-isolation, not willing to share with their families or other people at work, for fear of causing them stress too. Also thinking it is pointless to share for they will not assist in any way since they are not in the same situation.

"Having to share with friends …it's not always helping…people who are not in the same situation doesn't always assist." (P2)

"If you were someone who is outspoken you can find yourself withdrawn, no longer speaking, joking, laughing and such things you used to do to entertain yourself you cut off" (P4)

Studies showed that psychological effects of or reaction to stress include negative emotions, and depression (Banovcinova & Baskova 2014; Marcatto, Colautti, Filon, Luis, Di Blas, Cavallero et al. 2016) amongst others, as well as social withdrawal (Khamisa, Oldenburg, Peltzer & Ilic 2015). It is identifiable with the behaviour of participants described in the quotes. It is common to find depressed people withdrawn to themselves, isolating themselves as they often feel worthless and that life is hopeless (Khamisa et al. 2015).

Self-care neglect

Some of the nurse managers neglected their health needs by not taking time to prepare nutritious food, relying on fast food, eating less as well and shy away from normal life activities, while trying to chase deadlines and covering patient care in the wards, as participants verbalized:

"…a person might find himself or herself physically not taking care of physical like not eating well not hygienically taking care of self." (P4)

"Nowadays you end up getting to Shoprite taking that food that has been cooked fast so that you can prepare meal fast and at least by 10 PM you also be sleeping."(P5)

According to Ugwu et al. (2011) stress may cause workers to have a negative self-image and lack of concern for themselves. Similarly nurse managers who are stressed at work may start showing signs of self-neglect, caring less about themselves, not eager to look after themselves by preparing well balanced meals, exercising and so on. The participants in the study went to relying on fast food outlets for supper as one participant mentioned, to try and save time in order to meet demanding time lines that may confirm stress perceptions amongst the participants. The self-care neglect on the part of the nurse managers may have negative effects on their health as was found by Hall et al. (2016) and Dlamini (2015).

Chronic conditions and other ailments

Some of the managers admitted suffering from chronic ailments as well as other conditions as quoted:

"…when I started to work I didn't have hypertension but…ultimately now, I'm having Hypertension. I'm taking treatment. Yes" (P32)

"Sometime you'll get severe headache… Many of us complain about backache and the legs. Most of the time we are complaining of headache is because we are working under stress…" (P19)

Poor and uncomfortable conditions of work may affect employees' health causing health disorders such as cardiovascular diseases (Marcatto et al. 2016). According to Thabane (2015) exposure to work related stressors for long time periods is associated with symptoms such as headaches, back pains, muscle cramps involving the shoulders, and so on. Long term, prolonged exposure to stress has also been linked to diabetes and suppression of the immune system, in particular cells involved in fighting cancer (Nekgotha 2019). The current study support these findings, as some of the participants suffer from and is on chronic treatment for hypertension, which they ascribed as a result of being exposed to WRS.

Category b: The organisation

Perceived WRS has got adverse effects on the organisation as seen in the following sub-categories:

Poor work performance

Nurse managers have low morale and feel discouraged by thoughts about work and the work situation. Some even fake sickness just to avoid the work situation. They are psychologically

traumatised and are scared that they may be attacked by angry relatives blaming them for the death of loved ones. The perceived stressful situation may negatively affect their productivity and work efficiency impacting on patient outcomes:

"Psychologically, you become tired when thinking to go to work, you become discouraged. When coming to work you are always tired no feeling to come to work."(P3)

"For me as a person I end up being demoralised and I might even get sick when at times you not really that sick just to avoid the situation you are in." (P2)

One participant admitted that she was once a hard worker but she no longer feels the same.

"I feel demoralized. I'm no more a hard worker. I was a hard worker but I'm no more a hard worker."(P20)

Salilih and Abajobir (2014) associated reduced productivity with stress. In a study by Mosadeghrad (2013), it was found that due to stress at work, nurses become less satisfied with their jobs, and then increasingly absent themselves from work due to dissatisfaction with their work. The researcher further noted that there is an association between stress and an employee's commitment towards their job, the less the commitment the more the intention to want to leave the job. Studies (for example Banovcinova & Baskova 2014) agree that stress impairs concentration at work there by rendering individuals less productive and more prone to mistakes. This is consistent with what is revealed in this study whereby nurse managers felt under pressure, demoralised, and no longer committed to continue working, thus impacting on their productivity and job efficiency.

Stressful situations emanating from boring work, being under pressure to meet deadlines, and where staff feel undervalued in so far as decision making is concerned may impact directly on their productivity (Thabane 2015). In most cases it results in absenteeism and presenteeism, which may negatively affect service delivery (George 2014) by lowering the quality of the service rendered (Salilih et al. 2014), causing clients to complain and or litigate. Presenteeism refers to when people are at work but are not productive. The employees' daily availability at work is fully appreciated; however, the presence of an employee who is not able to contribute to service delivery as required of them may be damaging to the organisation (Thabane 2015). If the nurse managers are present at work in name only and not performing in terms of their job descriptions, patient care services may collapse and litigations may ensue. Stressed

employees, on the other hand, lack concentration and are thus likely to commit errors in practice which may expose them to litigation threats (Govender et al. 2012).

Increased staff turnover

Nurse managers feel demoralised and wish to leave the institution to go and work somewhere else to escape the perceived stressful situation. Those who are older intend to go on pension earlier because of the circumstances under which they are working. Retaining staff is difficult in these circumstances, as indicated by the following quotes:

"So it means you don't have your own free days and that is the thing that makes the nurse managers when they reach 55 it becomes a maximum. Those who strengthen themselves might reach 60 or may be because of financial, look because there is no money the person will stay until 60…" (P5)

"So you have people coming in going out to other areas…you can't force them to stay." (P5)

"If nothing is not done…will apply somewhere else…go to other hospital" (P8)

Staff turnover refers to when workers leave their organisations (Mosadeghrad 2013) for one reason or another. WRS is known to be an important predictor of turnover intention in nurses (Fasbender, Van der Heijden, & Grimshaw, 2019). Mosadeghrad (2013:2) found a "strong inverse relationship between occupational stress and employees' job satisfaction". This suggests that the higher the WRS, the more employees become drained and less efficient and the more likely they are to leave the organisation.

Category c: Patients

Work related stress do no only affect the physical health of the nurse manager but also affect their decision making process that may ultimately affect patient outcomes and prolong patients' stay in hospital.

Negative patient outcomes and prolonged hospital stay

According to the nurse managers, patients are not receiving optimal care due to shortages of medicine, equipment, and staff. These conditions exacerbate the nurse managers' WRS, which could contribute to increased medical errors, adverse patient events, and low quality of care.

"… is making us stressful because some of the patients are dying because … of the treatment, which is not there…equipment which is not there in this hospital. Yes." (P31)

"…then you do things that you know that is not okay and then at the end the patient is going to develop some sepsis at the ward." (P12)

If unsafe procedures are done, it has not only legal consequences but also irreparable harms are incurred to patients, which can have dire consequences for the patients and their family, including long-term accommodation, patients suffering, additional costs, dissatisfaction with the hospitals, (and thus dissatisfaction with the whole health system) and sometimes even patients death. (Keykaleh, Safarpour, Yousefian, Faghisolouk, Mohammadi & Ghomian 2018: 2229)

Supporting the findings in Keykaleh et al. 2018, similar patient outcomes may result if the nurse managers' WRS is not reduced. Patients' health is compromised and contributes to increased patient stay days and additional costs (Keykaleh et al. 2018). Burnout may cause employees to have reduced concentration, poor judgement and affects ability to take and implement decisions leading to malpractice (Mosadeghrad 2013), and which may also result in negative patient outcomes (Govender et al. 2012).

Although the nurse managers are not responsible for staff shortages in the hospital, it increases their WRS as they feel indirectly responsible for the consequences of the staff shortages.
"…we are dealing with lack of doctors…and then due to this shortage of specialists in our hospital we take patients for X-ray we wait for doctor to come and review… patient remain so many days without proper diagnosis without proper treatment…" (P1)

Since stress and burnout could affect employees' decision making skills (Mosadeghrad 2013) and affect their ability to have compassion for others (Ugwu et al. 2011; Schub & Karakshian 2017), nurse managers may not be willing to make decisions and take the necessary measures to prevent the unfortunate situations referred to in the quotes above. This may result in situations described by Keykaleh et al 2018, whereby patients stay longer in the units incurring additional costs, which "can impose a huge economic burden on the healthcare system and society" (Keykaleh 2018: 2229) as well as general mistrust of the healthcare system by communities.

3.4.4 Theme 4: Current strategies to cope with WRS

Participants developed their own individual coping strategies to deal with the stress in their work and some mentioned the following mechanisms:

Category a: Humour

Participants resort to utilizing humour to deal with their stress, which tends to give some relief. Participants indicated that by using humour to re-structure their perceived stressful emotions they managed to calm their emotions.

Joking and laughing

The participants indicated that joking and laughing with people rather than dwelling on their stress, offered them some relief from the stressful situation, as per quote:

"Me sometimes I'm using my jokes to feel happy the whole day so that I can't see the workload." (P3)

"If I don't want to be angry when I'm on duty what I normally do I'll just speak to the patient and laugh if I have to laugh and after that I feel better…" (P11)

Studies on humour proved that humour is able to counteract the harmful emotional effects of stress (Abel 2008; Fourie 2016). People with a high sense of humour were found able to effectively handle and manage stress that comes on day to day basis better and are less anxious than the less humoured, meaning that the role reversing high stressful situation to a less stressful version is acknowledged and supported (Abel 2008).

Geldenhuys (2016) describes how humour enables people to rise above their challenges through two methods developed by Lazarus and Folkman (1984), namely, primary and secondary appraisals. By primary appraisal an individual is able to overcome stress through emotion-induced fight and flight response. By secondary appraisal, also called problem focused appraisal, the stress is mitigated by the person's belief and confidence in their ability to deal with the stressful situation, whereas re-appraisal is when the individual gains experience by the occurrence of the stressful even thereby equipping the individual with sills to face the challenge and overcomes it .Those who believe in themselves and their abilities are less likely to be bothered by stress induced emotions.

Category b: Religion

The participants verbalized finding solace in their Christianity through having faith in God and prayer sessions.

Faith

They hope and believe that attending church and continuous prayer in the wards will alleviate the stressful situations in the hospital. They start routine work in the wards with a prayer and their faith sustains them to cope with the stress of work:

"…to cope with stress is just because, we are going to church. It's just a prayer. A prayer-make, make us to cope with the stress. Yes. We are always praying when we are in the wards. We are always praying for the patient, praying for us, praying everything which can at least help us. Yes." (P31)

"...the staffs you are working with, we just comfort each other, pray a prayer…Let's just pray, may be God sometimes when the time comes God will send another staff to come." (P3)

Prayer made with faith is believed to have miraculous effects in human, and miracles may have retrospective healing properties and includes ability to heal stress, anxiety and elevate mood positively and promote mental health (Andrade & Rhadhankrishnan 2009). The study revealed that nurse managers believe in the miraculous nature of prayer, which helps them not to see and feel the stress. According to Bakibinga, Vinje and Mittelmark (2014) the faith Ugandan nurses have in God served to make them accept their situation, providing a source of meaning in life.

Prayer

Participants hold on to prayer and then proceed to work with renewed strength. Prayer is the first thing they start their day with; where they get the confidence to face yet another stressful day. When faced with challenges they rely on prayer to renew their hope and get relief, as quoted:

"And then at work we start by having a prayer session…from the prayer we'll have one to lead us with a prayer…thereafter …we start discussing the needs for that day…" (P10)

"…You just go and pray and come back and work."(p27)

In a study exploring stress "many participants reported making use of their religious beliefs and affiliations in times of overwhelmingly stressful situations" (Hatzipapas 2013:65). The

participants have reportedly used prayer and church related religious practices to fight and overcome stressful encounters, and they would obtain closure, relief and support through those endeavours. On the same note, participants in the current study are also prayer oriented. Coming from Christian backgrounds, they are more inclined to choose their religion to cope meaningfully with stress. Andrade and Rhadhankrishnan (2009) indicated in their study that participants found the reading of the Bible and leading with prayer as a way to reduce their stress.

Category c: Socializing

Some of the participants used socializing with others as one of their coping strategies. Going out with friends, attending functions and having meals together in the form of tea or lunch.

Social activities away from work

Attending social events like celebrations and other social gatherings away from the work environment help them to relax and unwind:

"Then I will concentrate on my social thing like 'mekete' [referring to celebrations], 'Kerekeng' [referring to at church]" (P5)

"…during the day in the five working days there should be a day where there is gymnasium area during the day so that all the workers will know that on this day we will reduce stress." (P17)

In a study involving care workers, participants used different kinds of activities including a sense of being creative to promote relaxation. "They expressed feeling relieved during these activities as it allowed them to process their circumstances at work. They gained a sense of rejuvenation" (Hatzipapas 2013:65).

Social media

When a manager is stressed or frustrated or come across challenges they use social media to communicate amongst themselves or to consult and assist each other to bring solutions to the perceived stressful situations. The same applies when one is left in charge as acting nurse manager, when experiencing challenges the individual will use social media to communicate the challenge to colleagues or other nurse managers they are working with to seek assistance with the perceived stressful situation, as per quotes:

"Someone don't come to you because of the system. They usually do the WhatsApp. They use the WhatsApp to communicate with the managers."(P71)

"…because your phone, your WhatsApp is open you are at work… if you have left somebody, the person that you have left because you might be leaving acting person… you are supposed to assist that person if there are challenges and you might find yourself being off... So it really takes a lot, it takes a lot" (P5)

The participants sought to utilise social media communicate with colleagues for assistance with stressful situations encountered in the working environment. However, studies are emerging to discourage the use of social media in dealing with stress and stressful situations (Linetti 2019) According to Linetti (2019) spending much time on social media tends to make one to lose self-control by relying on other people's coping behaviours. In addition, social media could interrupt sleep because of the tendency to remain glued to it and not sleep, which may ultimately affect work productivity.

Engaging in conversation

Being in the presence of people, be it patients or anyone whom they feel comfortable to converse with airing out their challenges, talking about their frustrations and sharing ideas helps them get relief form perceived.

"I keep myself talking with the patient…they give then their problem, and you his or her problem like the same to me. It feels I'm not alone." (P8)

"…actually I ventilate. I share. I share my problems …I'm one person who …I don't keep things with myself. I just share, relate it to somebody…sharing with them, it's like I'm getting a bit relieved…" (P12)

The presence of other people in a stressful situation may help by influencing how the person responds to the stressor (Thabane 2015) making the experience less stressful. Similarly having people close by, that is, patients or other people in attendance assist to mediate the stress. In Geldenhuys (2016) study, respondents suggested that the individual should talk to others about the perceived stressful situation as their presence and ideas may help mediate the situation.

Collegial support

"…even the juniors they just comfort us saying 'ay doesn't worry. We are with you…if you knock off late we'll knock off late even us'. I'll knock off with them because they say 'we cannot leave you alone-we are in the same section'." (P32)

"I'm going to share with other colleagues nurse manager to share this situation that we it can be solved." (P3)
"Ja [yes], in the workplace I do share like whenever I experience a challenge maybe, now I'm the manager there I something wrong then I usually share. And … you find that sometimes one can come with, a positive advice." (P12)

The findings in this study support findings from various studies (e.g. Fourie 2015 and Adriaenssens, Hamelink and Van Bogaert 2017). In the study by Fourie (2015), it was suggested to talk to others about the challenge one is encountering, so that others may come up with ways to mediate the stress. Adriaenssens et al. (2017) found that if first-line nurse managers perceive social support from other staff members, it contributed to lower their occupational stress levels.

Withdrawing from work and others

The stressed nurse manager withdraw from work and others by switching off their cell phones for example as a way of dealing with the stressful situation. They think and believe that by doing it, it will alleviate their stress:
"I just shut down. I mean what physically I do. There is time when I tell myself that you know what all this phones must be off, this weekend I do not answer calls from anyone. This weekend I do not answer calls from 7pm until 6am on Monday."(P5)
"…and then when I have shut down I take the phones and put the far away. Then I will concentrate on my social things like "mekete", "kerekeng" [referring to attending celebrations at her church] wherever." (P5)

In the study by Fourie (2015), participants handled stress effectively by withdrawing themselves from the company of other people.
One of the participant's indicated *"I try to keep myself busy even try to be innovative that means starting other projects make the stress much easier to cope with" (P2). "Having to share with friends the things that are happening at work… is not always helping …I try to keep myself busy even try to be innovative that means starting other projects"(P2)*

The findings of this study support those by McTiernan and McDonald (2015) who found that diverting attention away from work was the most used strategy amongst their participants.

3.4.5 Theme 5: Additional ways to manage WRS

Various ways have been recommended by the participants during the interviews to manage work related stress. Following is a discussion of the five categories identified.

Category a: Managerial support

Participants feel that support from their managers as well as senior management will make them feel better and relieve some of the stress. They feel that managers can support them by coming to the units at least twice weekly, appreciating the workload they are having, give words of comfort, and praise where they are doing good.

"I suggest that our unit manager can at least twice a week…come into our ward, check our ward, try to evaluate our work…they can see and support us. Support … means a lot to us and it shows motherhood…" (P1)

"And even managerial support, just to come to the place where we are working 'how, how are you coping today? How is the work?' Just a word of comfort." (P32)

Management support is an extension of perceived organisational support. It recognizes that mutual obligation is part of the employee contract and that there may be times when managers are required to support employees in dealing with challenges they face, even these extend beyond the workplace. It is not just about providing skills, training, job opportunities and fair pay but also about building a culture of trust and a safe psychological environment that motivates individuals and ensures their involvement and commitment. The relationship between employers and their employees is one of mutual obligation and in this context, managerial support occurs when management treats employees fairly, build trust and consult employees regarding work matters so they can build a relationship of mutual respect where employees perceive that their needs are considered and are acted on appropriately. Such support can also facilitate the communication and implementation of strategic decisions (Travaglione, Scott-Ladd, Hancock & Chang 2017)

Part of a manager's supportive role is to coach and encourage employees; acknowledge positive things about their work as well as promoting, facilitating, and aiding employee learning processes (Ellstrom 2012). In an integrative review conducted by Labrague, McEnroe-Petitte, Leocadio, Van Bogaert and Cummings (2017) on stress and ways of coping amongst nurse

managers, it was found that support by higher level management was cited as one of the top coping strategies employed to deal with stressors.

Staff meetings

The need for regular meetings with higher levels of management was indicated as a way to reduce WRS. Holding meetings as staff at the hospital does help to manage stress, but only to a certain extent. Participants had strong feelings that management from the provincial offices should also form part of these meetings to provide support and to understand their challenges. One nurse manager shared, *"I can say even, not mean the managers or CEO [referring to the chief executive officer of the hospital]; the top officials there by the province, they need to sometimes come to the hospital and sit down with the staff and ask them those questions that you are asking us so that they can know what is going on in this hospital." (P13)*

Another participant stated, *"If may be the government… must come down to come and hear the problems of …employees maybe they can come with something that may be the employees can cope with the situation…And then even the managers must call a meeting and then advise us I think people can be able to cope, yes!" (P9)*

Some of the nurse managers felt that to discuss their stressors locally will not be the answer; they expressed a need to engage with senior officials in government.

"Because we won't tell the managers our problems. At least the top officials they need to come…" (P13)

"I don't think if I'm given day to day support because what I'm looking at, the people who are supposed to give me day to day support are also having challenges, how can they support me because they are my colleagues…I'm speaking about Assistant Director Finance…" (P5)

These findings are similar to that of Munyewende, Rispel and Chirwa (2014), who indicated that primary health care nursing managers expressed a need for professional support from their supervisors on a higher level. The findings of this study is similar to that of Förster and Duchek (2017) who found that contact and exchange with colleagues is an important factor in the work environment, especially pertaining to support in fulfilling tasks.

Mentoring and coaching

There was consensus that discussing challenges with peers who could provide them with the necessary support and possible solutions in addressing these challenges will be beneficial to their well-being. Two of the participants described it in the following way:

"Oh, I can say by good communication and informing them about the challenges that we are having, like the challenge of overtime. We call them and tell them what is happening." (P20)

"If you are a manager and there's something you're not doing it well. Somebody must talk to you. Somebody must show you the way…which means if we discuss things amongst ourselves, you'll pick…we could achieve the best. I think this is the thing that could improve our situation. "(P23)

Kim, Im and Hwang (2015) indicated the important role mentoring plays in building on-going relationships between organizations and their members. They see mentoring as a way toward maintaining a long-term relationship, allowing mentees to take charge of their own development, release their potential, and achieve the results they value. It was found that in this ongoing relationship mentees appreciated especially the psychosocial support as they could share their worries and concerns with their mentors. However, this study's findings rather coincide with that of Brousseau, Cara and Blais (2019), who found that insufficient mentoring and coaching brought about a sense of discouragement and devaluation among the first line managers, leading them to quit their managerial position.

Participative management style

The study revealed that consultation of staff, good communication, as well as transparency help to reduce stressful relationships. The nurse managers feel they need to be consulted on issues that concern them. They feel a need to have an input in matters that concern them and they need to be heard when necessary. They feel they need to be consulted so as to be able to give their side of the story; top managers need to hear first-hand information from them, not from other people who are not well informed. This is shared in the following quotes:

"As a manager I think my manager … must also come up with strategies to help me or at least hear my side of the story so that the work can be easier…" (P2)

"If people know the reason why things are done they become less stressed, because they know what is happening and be honest with the resolution of the problems" (P4).

Participatory management is a management approach "designed to increase employees' opportunities to make decisions or participate in decision-making process at work" (Arapovic-Johansson et al. 2018:3). Limited opportunities for decision-making and lack of transparency as well as unrealistic demands, poor communication and effort–reward imbalance were all implicated as contributing towards occupational stress (Bhui, Dinos, Galant-Miecznikowska, de Jongh & Stansfeld 2016). It was furthermore indicated that a management style that was supportive and emphasised effective communication are appreciated by employees. Nielsen et al. (2017) found that a supportive leadership style in turn promote team spirit and staff morale leading to job satisfaction and better performance, which could reduce WRS and burnout.

Category b: Creating a positive practice environment

A positive work environment must be created to ensure work related stress is reduced or eliminated. Following is a discussion of how the participants envisioned such an environment can be created.

Filling of posts

The study revealed the need for recruitment and appointment of more staff in the institution to reduce the stress caused by the high workload due to the vacancy rate in the hospital. They indicated:

"To appoint new staff after the other one went for [referring to succession plan] to replace those who are on pension, replace staff who have resigned-in order to reduce the workload." (P30)

"The employer just has to hire more staff…so that the work should be done properly…" (P12)

In several of the studies reviewed by Labrague et al. (2019), a lack of qualified staff to meet quality patient care is one of the top stressors amongst nurse managers. McTiernan and McDonald (2014) also identified a lack of staff as a frequent stressor, and according to Munyewende et al. (2104) work pressure of nurse managers were exacerbated by staff shortages.

Social activities and recreation at work

By encouraging social activities such as birthday celebrations and allowing recreational activities at work could assist participants and staff with managing their stress. Two of the participants shared ways they believe would assist them in recharging their batteries:

"The issue of social events can…assist…nurses can… celebrate their birthdays with others in the ward, or may be organize trips to go somewhere." (P10)
"There should be…proper recreational facilities."(P21

According to Bourgault (2019) nurses have a responsibility to recharge their own batteries. It is imperative to work together to foster an environment in which there is support and encouragement to be the best that one can be. Opportunities for recreation serve a vital role in employees work life. Young (2013) found, when investigating stress in the military, that recreational activities are tailored to promote employee efficiency and job morale, a way of helping staff to feel refreshed and well geared and ready to perform. As soldiers are expected to meet demands for performance free from mistakes at any time, the employer has to see to it that their needs are met, by helping them to relax. This includes being able to relax under stressful circumstances or attend to activities which can help with relaxation (Young 2013).

Availability of equipment

The majority of nurse mangers emphasized the need of sufficient equipment to ensure quality patient care. The unavailability of equipment to render patient care contribute to their stress levels. Participants described it in the following way:
"The equipment should be bought according to the needs." (P20)
"If there is a budget I motivate for getting the equipment that we need…I take the initiative that the equipment is serviced on time or… the budget is utilized at least we have equipment to work" (P2)

The nurse managers understand there are processes in place for acquiring equipment, but voiced their frustration with these processes because their input regarding which equipment would be of a better quality is not considered.
"You buy something… and that thing is of a lower quality… the government encourage to buy cheaper things of which are not lasting" (P21).
"For instance I might be able to buy equipment even knowing where I can get the equipment but because there are systems that we are supposed to undergo even the supply chain system you find that you are unable" (P5)

The study's findings support what nurse managers indicated in a study by Udod, Cummings, Care and Jenkins (2017:33), namely "There is always a challenge for adequate resources and

that we're providing safe care" and is at the very forefront in our minds." The participants in Munyewende et al. (2014) study also identified lack of functioning equipment as a stressor that needs to be addressed to ensure an enabling practice environment.

Address concerns about infrastructure

Buildings need refurbishment and also to create more space to accommodate services rendered, with suitable infrastructure and facilities to render services in each unit. The participants found it difficult and stressful to render healthcare services in an inappropriate environment, and described it as follows:

"…you find that there, there is no even the oxygen some of the taps in the ward are not working. Some of the, the taps in the cubicle, they are not working. They are just closed. Yes. It's what, ah, ah, even some of the, ah, the toilets for the patient are, are not working for a long time. Closed. Yes. So, you find that the patient… from other cubicle moving to the other cubicle for bathrooms and so on. Yes. That is not good for, for us. It makes us stressful." (P31)

"And then secondly…old dilapidated buildings like theatre some doors are broken, you just operate while the door is wide open, you see there's no privacy. They have to build buildings for proper quality care."(P12)

The ideal hospital framework (DOH 2018) prescribes the availability of good infrastructure as well as maintenance thereof as a requirement for a hospital to maintain an ideal status. In this case infrastructure is described in terms of physical condition and space; communication; information and technology; bulk supplies as well as well managed and maintained fleet of vehicles. By physical space the framework covers the availability of well-maintained buildings well designed to suit workload and services provided in the hospital; health technology refers to furniture and other non-medical equipment whereas bulk supplies refer to piped gas supply, uninterrupted water supply and so on.

In line with person centeredness, infrastructure should be conducive to the healing process, while at the same time, remaining sustainable, flexible, energy efficient, and affordable, and within the financial and environmental constraints. The delivery of appropriate, well designed and affordable facilities in the right location facilitates the provision and access to quality health services. This can be achieved by adhering to various principles during the planning and delivery of new infrastructure and the maintenance thereof (Western Cape government health 2014:112).

In the Draft policy document (DOH 2014) it was maintained that health facilities require infrastructure in the form of staff, equipment and drugs, buildings and related supplies to operate effectively. “The make-up of a particular facility depends on the defined service to be delivered as well as services provided” (DOH 2014:5). The appropriate design, electricity, water, hygiene and sanitation and equipment requirements are some of the type of infrastructure required for a health care facility to deliver on its mandate (WHO 2008; Carr 2017; Dixit, Mandal, Pandey & Bansal 2017).

Consistent with these findings, the designated hospital in the study may be found to be lacking the relevant infrastructure that supports the services the hospital is supposed to be providing. The lack of piped oxygen supply and broken water taps contributes a stressful working environment as these are vital resources in provision of patient care, particularly during crisis situation such as disasters and other emergencies, hence the perceived WRS amongst the participants as core custodians of patient care and main healthcare planners. Inability to achieve the desirable ideal hospital status despite efforts may also contribute perceived anxiety and stress on the part of the nurse managers in the designated hospital. The poor structural design of the facility may cause WRS whereby the participants have to improvise and continuously adapt the situation in order to ensure continued rendering of healthcare services in the facility as one alluded:
“Right now, the eye clinic has got no structure… We are just being, catered in another structure which is not good… does not fit for the, the clinic.” (P23)

The Democratic nursing organisation of South Africa (DENOSA) also raised concerns on the poor state of infrastructure in provincial hospitals. It appears as if that the relevant departments seemed to wait for incidents to happen before they could plan interventions (DENOSA 2019).

Category c: Stress management
Participants were of the opinion that some form of intervention is needed to manage stress.

Training/information sessions on managing or reducing work related stressors
Participants suggested that all staff in the hospital should attend sessions on managing or reducing work related stressors as indicated by the following comments:

"I suggest short courses like if one of our unit managers or managers here can come up with idea of saying you sister or you managers, you supervisors in the hospital, let us invite each other and have a workshop or in-service training in stress related…" (P1)
"Maybe to attend the training workshop about this stress" (P3).
"I think they must in-service or give us workshop on stress related programs. They must come and render those stress related programs in our institution because you cannot just be in the institution without coming across challenges and those challenges are the stress causes. If they can come and in-service us or workshop us that can help us." (P10)
"If maybe they can come and give us a lecture…monthly or even after we are having an incident in the ward…" (P20)

Ugwu, Amazue and Onyedire (2017) indicated that a better understanding of work-related stress amongst nurses is an essential step in reducing the adverse consequences thereof. In Beh and Loo (2012) it was found that understanding the definition of stress in all its dimensions and what stress is about may help in coping with its negative effects. According to Kupa (2018), to deal with stress successfully individuals must acknowledge the existence of the stress, their personal physiological response to it, the circumstances that produce the stress response and their own personal coping mechanisms. Hence, the need for training or provision of information on managing work related stressors. Ugoda (2013) found that managers should be trained in stress management skills, and these may be imparted to the rest of the nursing staff through in service training workshops, with referrals effected where there is need for expert intervention.

Increase employee assistance

Participants in the study suggested that employee assistance services should be accessible to employees in the hospital for use in case of need. They believe that organizing of debriefing workshops and sessions by a psychologist especially after traumatic or stressful experiences at work is indicated in the circumstances.
"I think that the employee wellness program should be there…so that you can able to refer …there because when they are being counselled somewhere they will open up and say I've got this challenge. It will assist somehow." (P21)

An employee assistance programme is a programme established in the workplace that is aimed at addressing employee issues that interfere with employee productivity or job performance (Nakani 2016). It is a program that offers counselling and consultation services to employees

and their families to achieve mental health and wellbeing, as well as enhance employee productivity (Kirk & Brown 2003). Employee assistance interventions prevent employee psychosocial challenges, including WRS from becoming complicated thereby impacting on the employee's productivity at work (Nakani 2016).

Participants expressed a need to have access to a psychologist or social worker during working hours. They feel the employer should benchmark with the private sector where employees are referred for regular and periodical counselling, especially after traumatic incidents:
"…Like after disaster management…then after that they send us to psychologist for counselling and other things..." (P11)
"Let say maybe the employer…organized that if someone has stress and then you know that you are going for psychologist or social worker…like social worker they know that every week maybe a certain day is for the hospital members to consult a certain day once per week or once for some hours we know that this time is for the members…Because of the time we are here we do not have time to go outside to consult social workers because they work normal hours like us." (P15)
"May be they should organize psychologist for me maybe twice or thrice per year."

According to a survey done by Beresford, Gibson, Bayliss and Mukherjee (2016) in the UK, employers have a duty of care to their employees by providing support to staff with WRS through access to clinical psychology. Ugoda (2013) noted the need for managers to be trained for their role in referring and encouraging employees to utilise the services of the wellness program.

Promoting self-care
It is evident that the nurse managers were concerned about their own well-being and the need to find an equilibrium between their personal self and their professional self as indicated by Bressi and Vaden (2017). To promote their well-being and reduce WRS, participants indicated the importance to address work related aspects that infringe on their time for rest and relaxation. The nurse managers stated that they do not relax sufficiently when at home:
"You don't relax as much your mind is always at work… " (P21)
"And sometimes when you are home you try to relax, you see you work and you, you can see your failures. You can't see your improvements and as such, it affects." (P23)

Kelly (2019:2645) wrote that "in order to unlock more time in our schedules for rest, we must first value ourselves enough to appreciate that our time is precious and should be spent in ways that promote our long-term health." According to Dyess, Prestia and Smith (2015) it is important for nurse leaders to acquire self-care behaviours to manage stress. Shields and Stout-Schaffer (2016, cited in Dyess et al. 2015:80) indicate that self-care is inclusive of "…self-assessment, self-reflection and self-responsibility to adopt a lifestyle that supports all dimensions of well-being, including the physical, emotional, mental, and spiritual aspects of oneself as well as relationships with others and the environment, to create life balance and satisfaction." However, it is indicated in Dyess, Prestia, Marquit and Newman (2018) that arming nurse leaders with self-care practices may not be enough; the motivation needed to practice it should be embedded in the holistic culture of the organization.

Category d: Promoting work-life balance

The study revealed that nurse managers in the designated hospital are struggling to strike a balance between work and family life; they bring work home at night and think about work at home. To achieve work-life balance, nurse managers should actively engage in social roles in both their work life and nonwork life as suggested by the studies included in an integrative review conducted by Sirgy and Lee (2018) on work-life balance.

Family responsibilities

The study revealed that nurse managers find it difficult to fulfil their responsibility towards family and friends because of work. Work often prevents them from attending funerals and functions of family members. Two participants voiced the following:

"We end up arriving late at home and we fail to do…things at home. Like myself I stay at nurses home and I fail even to attend …relatives' funerals…I arrive at home during the night and the following day you find that the relatives are going to do a funeral and I fail to support…you see." (P16)

"…at home they know that you're coming back at 13h00, Now you are going to phone them 'hey I'm not coming back because there's a shortage I'm sacrificing until 19h00'. You see… maybe you planned something that at 14h00 you are going somewhere…" (P9)

Various studies (e.g. Bagherzadeh, Taghizadeh, Mohammadi, Kazemnejad, Pourreza, & Ebadi 2016; Ugwu, Amazue & Onyedire 2017) found that when workers cannot meet their family

responsibilities due to incompatible work and family demands, they may experience high levels of stress.

Safeguard against taking work home

It was revealed that due to their workload nurse managers took work home to try and catch up, thereby reducing their time to rest and exacerbating fatigue.

"You are always tired and being always tired, your phone remain open for 24 hours, seven over seven…Even when you have knocked off you get home…your phone rings…There is work related things that they…over the weekend… So it means you don't have your own free day…" (P5)

Bressi and Vaden (2017) suggest that workers employ strategies to disengage actively from work when at home or avoid bringing one's work home at night. Nurse managers should learn to set clear boundaries about work and even thoughts about work when at home. According to Kossek, Ruderman, Braddy and Hannum (2012) organizations must foster workplace cultures and structures that enable employees to exert schedule and boundary control to ensure work–life demands are aligned with personal with needs and preferences.

3.5 SUMMARY

WRS amongst nurse managers is caused by many factors and starting with relationships amongst the managers themselves proceeding to circumstances in and around the work environment in the designated rural district hospital.

The signs and symptoms of WRS included the observable signs and behaviours displayed and described by the participant managers as they experienced the perceived WRS in their work and work environment. The perceived WRS amongst nurse managers yielded many undesirable consequences which impact on many people and gives rise to a number of complicated situations at the participants work environment and home. The participants may become severely affected resulting in their being dysfunctional in almost every sphere of their lives, negatively affecting the consumers of healthcare services; the organisational image and (thereby) impacting on service outcomes. The complications of WRS amongst the participants tend to affect people close to the nurse managers socially, professionally and so on, causing a vicious circle of undesirable consequences and mishaps.

The participants indicated several ways that they currently employ to cope with the perceived WRS. The participants further came up with suggestions on how to manage WRS, in order to curb the causation of WRS and prevent the complications thereof amongst nurse managers.

CHAPTER 4 CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

4.1 INTRODUCTION

Chapter 3 presented and discussed the study findings which had been analysed into themes, categories and subcategories. These are discussed with reference to relevant literature and concluded with a summary of the discussions. Chapter 4 will further discuss the results of the study in relation to the aim and limitations thereof. The chapter will concludes with implications and recommendations for nursing management, nursing education and nursing practice as well as regarding future research into this field of study.

4.2 AIM OF THE STUDY

The aim of the study was to explore and describe the perceptions of nurse managers in a rural public hospital regarding WRS.

4.3 SUMMARY OF MAIN FINDINGS

It is evident from the findings that the nurse managers at the designated hospital experience work-related stress. Several stressors were identified. Following is a presentation of the main findings of the study:

Interpersonal relationship challenges emanating from communication barriers existing amongst nurse managers and nursing staff; verbal abuse; bullying and harassment of nurse managers by patients, patients' relatives and the community as well as the shortage of resources the form of staff; supplies and poor infrastructure. These are the main causes of WRS amongst nurse managers; which interfere with interpersonal relationships rendering the working conditions and environment highly stressful for the participants in the study. Nurse managers are dehumanised through harassment, attacks and bullying as if their rights as human beings are inferior to those of patients and communities they are serving. When such incidences occur the participants in the study found themselves defenceless and at the mercy of patients, their relatives or the communities they are serving.

The staff shortages, lack of supplies in the form of equipment and drugs as well as poor infrastructure leading to and causing long queues, extended working hours and patient deaths which could otherwise be prevented.

Management styles adopted by nurse management in the designated hospital proved to be promoting favouritism, which was also listed as a contributory factor to perceived WRS, doing more harm than good by demotivating and demoralising hardworking employees thereby adding to the existing high WRS stress levels.

The fourth main finding is a lack of training and information sessions on managing work-related stress and access to employee assistance program. This identified a lack of knowledge amongst the participants, which could delay early diagnosis of and interventions against WRS when necessary, leaving room for affected individuals to experience complications which could otherwise be prevented with early identification and management.

The fifth finding is about a lack of recreational facilities and social activities in the work environment. The designated hospital does not provide for any form of socialization and recreation, although the participants utilise recreation to escape perceived WRS.

The sixth finding concerns the need for supportive management to visit the participants' functional areas to offer support and to listen to staff concerns in the units. These visits should occur regularly and not only when there are incidents. The nurse managers also feel the need for officials from provincial department to come meet them in order to listen to and address their concerns. Decision-making must be decentralised to afford nurse managers a certain level of autonomy for decision making at their level of operation.

And lastly, the participant nurse managers seemed to agree on the need to have experts giving workshops on management of WRS. The need to have access to EAP and to have a flexible program that is adapted to allow them access to EAP services during working hours as a group or as individuals.

4.4 RECOMMENDATIONS

The following recommendations are made for nurse managers to ease their experience of and perceptions regarding WRS in order to prevent its complications and the risks associated with WRS since complete elimination thereof is not possible. The researcher makes the following recommendations for nurse managers, nurse educators and nursing practice at large.

4.4.1 Top level nursing management

- Display a more participative management style by including nurse managers in decision-making in nursing matters and all issues affecting nursing management. Joint decision making should be made a vehicle with which to encourage every nurse manager to participate in matters that concern nursing. This may improve communication and interpersonal relationships through easing of existing communication barriers amongst the nurse managers leading to elimination of perceived favouritism through practising proper communication channels.
- Institute policy and practice changes to increase the recruitment and retention of all categories of nurses to reduce stress due to staffing and workload issues.
- Build positive work environments to retain nurses in the designated hospital.
- Review financial management skills and the budgeting process to ensure proper staffing, thereby reducing the number of overtime hours worked by staff and ensuring staff do not work hours without being paid.
- Increase autonomy of nurse managers, specifically decision making authority.
- Strengthen and sustain access to psychological services that provide emotional and moral support to all staff in the designated hospital.
- Initiate training and information sessions on work-related stress and the management thereof.
- Ensure coaching and mentoring is available to nurse managers, especially the newly appointed nurse manager.
- Support a learning culture in the organisation and allow for personal growth.

4.4.2 Nurse managers:

- Develop employee wellness programs to reduce effects of WRS amongst nurses in the work environment to prevent and minimize complications.

- Ensure their own professional development with regard to leadership, financial management and interpersonal relationships.

- Maintain equilibrium between their personal-self and their professional self.
- Engage in meaningful self-care activities to sustain their capacity to thrive in the work environment.
- Become knowledgeable about stress management activities such as establishing boundaries, reflecting and reorienting, employing a proactive approach to stressors, enhancing resilience, and mindfulness training. Use evidence from research to ensure they stay abreast of the latest activities to manage stress.
- Establish and maintain a support group for newly appointed nurse managers.

4.4.3 Nurse educators:

- Ensure that WRS and the management thereof are covered in the curriculum.

4.5 LIMITATIONS OF THE STUDY

As the study was conducted in one medium district hospital it would be prudent not to generalise the findings of the study.

Although English is the official language used in the designated hospital, it might have affected the ease with which the participants expressed themselves as English is not their first language.

4.6 RECOMMENDATIONS FOR FUTURE RESEARCH

A study using a larger sample from different levels of hospitals, in both rural and urban areas, could shed more light on this topic. It would also be beneficial to see if there is a difference between the levels of work-related stress as experienced by nurse managers from hospitals in the public sector compared to those from hospitals in the private sector.

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ANNEXURES

ANNEXURE A: PERMISSION TO CONDUCT THE STUDY

Omitted to ensure confidentiality is maintained

ANNEXURE B: PARTICIPANT'S INFORMATION & INFORMED CONSENT DOCUMENT

STUDY TITLE: Work related stress amongst nurse managers in a rural district hospital in Limpopo Province.

Principal Investigator: Mrs Mamere Prescilla Shiviti
Institution: Hospital X

DAYTIME AND AFTER HOURS TELEPHONE NUMBER(S): 0736806428
Daytime numbers: (015) 383-9496
Afterhours: 0736806428
DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

Dear Mr / Mrs …… date of consent to procedure :……...

1) INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about all the procedures involved.

2) THE NATURE AND PURPOSE OF THIS STUDY

You are invited to take part in a research study. The aim of this study is to explore and describe how nurse managers working in a rural district hospital perceive work related stress. By doing so we wish to learn more about work related stress amongst nurse managers in a rural district hospital.

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

This study involves an interview that will take approximately one hour of your time. Questions will be about work related stress. It will be done at a time convenient to you and when it will not intervene with your work. As I am your colleague at the district hospital, a trained research assistant will conduct the interviews. The research assistant will also take some notes during the interview. To ensure none of

the information you share is lost or misinterpreted, I ask your permission to audio record the interview. If you are not comfortable doing so, I will rely on the notes taken by the research assistant. After the interview, the researcher will listen to the recording and transcribe the interviews word-for-word.

4) RISK AND DISCOMFORT INVOLVED.

Sharing of sensitive information may cause emotional discomfort. However, should this occur, the researcher will refer you to a trained counsellor.

5) POSSIBLE BENEFITS OF THIS STUDY.

Nurse managers will know and understand work related stress and its influence on their role, will adopt healthy coping mechanisms. This in turn assists the nurse managers to develop intervention strategies to manage stressful situations they face on daily basis.

6) I may at any time withdraw from this study without any given reason as my participation is voluntary.

7) HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This Protocol was submitted to the Faculty of Health Sciences Research Ethics Committee, University of Pretoria, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been granted by that committee. The study has been structured in accordance with the Declaration of Helsinki (last update: October 2013), which deals with the recommendations guiding doctors in biomedical research involving human/subjects. A copy of the Declaration may be obtained from the investigator should you wish to review it.

8) INFORMATION

If I have any questions concerning this study, I should contact: Mrs.M.P Shiviti: tel: (015) 383 9496 or cell: 073 6806428.

9) CONFIDENTIALITY

All records obtained whilst in this study will be regarded as confidential. Findings will be published or presented in such a fashion that patients remain unidentifiable.

10) CONSENT TO PARTICIPATE IN THIS STUDY.

I have read or had read to me in a language that I understand the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given opportunity to ask questions and am satisfied that they have been answered satisfactorily. I understand that if I do not participate it will not alter my management in any way. I hereby volunteer to take part in this study.

I have received a signed copy of this informed consent agreement.

Participant name Date

Participant signature Date

Investigator's name Date

Investigator's signature Date

Witness name and signature Date

ANNEXURE C: ETHICS APPROVAL UNIVERSITY OF PRETORIA

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

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 03/20/2022.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 03/14/2020.

26 April 2019

Approval Certificate
New Application

Ethics Reference No.: 180/2019
Title: Work related stress amongst nurse managers in a rural district hospital in Limpopo Province.

Dear Mrs MP Shiviti

The **New Application** as supported by documents received between 2019-03-28 and 2019-04-24 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 2019-04-24.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year and needs to be renewed annually by 2020-04-26.
- Please remember to use your protocol number (180/2019) 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, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- 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) MPharmMed 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, Second Edition 2015 (Department of Health)

Research Ethics Committee
Room 4-60, Level 4, Tswelopele Building
University of Pretoria, Private Bag X323
Arcadia 0007, South Africa
Tel +27 (0)12 356 3084
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Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

ANNEXURE D: COPY OF TRANSCRIBED INTERVIEW

Interview number: no 31 Recording_0073

Venue: Hospital X

Date: 27/08/2019

Duration of interview: 19 minutes and 41 seconds

TRANSCRIPT OF INTERVIEW

Research assistant: Okay. Good afternoon.
Participant: Afternoon. How are you?
Research assistant: Good, and how are you?
Participant: I'm fine and you?
Research assistant: Good, good. So, I am acting as the research assistant and it's for the study: Work-related stress amongst nurse managers in rural district hospital in Limpopo province. Um, I request to audio record you during our interview. Um. Do you consent to this?
Participant: Yes.
Research assistant: Um, can you please read the line?
Participant: Okay. I, I hereby agree to be audio recorded during the interview process and to physical or telephonic follow-up by the investigators for clarity should the need, should need arise.
Research assistant: Okay, perfect. So, in case there's anything that the investigator needs to follow up on in your answers, then she will contact you or she'll talk to you face-to-face. So, during this interview, it's just five questions and then, as the investigator said, we might have follow-up questions based on what you say. Okay?
Participant: Okay.
Research assistant: Perfect. So, the first question that we are going to start with is, um, can you define in your own words what work-related stress is?
Participant: Hm. Okay. Ah, work, ah, related stress is, is just, ah, the, the, the problems that we, we meet on in, ah, in our, ah, workplaces. Yes. Problems, many problems that we are, that we are, ah, facing on during work, ah, situation. Okay. Ah, like for example when you are, when you are busy, ah, working at the, ah, when you are busy working with the patients sometimes you find that there is no, ah, there is not enough equipment for, ah, the patient for, for using. Ea. Sometimes you are compromising instead of, ah, real equipment and even sometimes there is no, ah, treatment at the, at pharmacy. It's many, yes.
Research assistant: Okay, thank you for your answer.
Participant: Yes.
Research assistant: Um, as a nurse manager, what do you regard as work-related stress?
Participant: Pardon?
Research assistant: As a nurse manager, what do you regard as work related stress?
Participant: Work-related. Hm. Ah. As a nurse manager. Ah. Sometimes if, if, if… Sometimes we…
Research assistant: That's fine.
Participant: I, I can't. I don't know what to answer, put.

Research assistant: Hm. Um. We can maybe go move on to the next question, if you?
Participant: Yes.
Research assistant: Okay. Um. So, what causes work-related stress for you as a nursing manager?
Participant: Ah. The, the causes is the shortage of, ah, human resources and even the shortage of medication and the pharmacy and also, ah, the shortage of equipment. Yes. We are not having, ah, enough equipment, ah, and also, ah, even, yeah, shortage of equipment. Yes, is the causes of, is, is what make us stressful in this working situation.
Research assistant: Okay.
Participant: Yes.
Research assistant: And with that stress, what kind of equipment do you think is causing that stress? What lack of equipment?
Participant: Ah. Sometimes you, you, you find, you find it you, you are not having, ah, even the, the, the Hb machine. You don't have. You are also borrowing and even the sometimes you find that there, there is no even the oxygen some of the taps in the ward are not working. Some of the, the taps in the cubicle, they are not working. They are just closed. Yes. It's what, ah, ah, even some of the, ah, the toilets for the patient are, are not working for a long time. Closed. Yes. So, you find that the patient, ah, from other cubicle moving to the other cubicle for bathrooms and so on. Yes. That is not good for, for us. It make us stressful. Yes.
Research assistant: Thank you. And looking at hospital management, does that ever cause you work-related stress?
Participant: No. No, they are working hand in hand. Yes.
Research assistant: Good. So, that moves on to our next question. So what does, how does work related stress you experience affect you?
Participant: Ah. If, firstly, if there is no equipment in the ward, ah, people or patients are dying. If there is lack of medics, some of their medications also, ah, ah, patients also are not, are still dying. And this, this thing is not good because the patient came here to, to be, came here to get the treatment, to get, ah, good equipment so that they may be healed too and go back home. Yes. Sad things is not, ah, is making us stressful because some of the patients are not, are not dying because there is no, the, they are not. Ah. Some of the patient are dying because of some of the treatment which is not there, some of the equipment which is not there in this hospital. Yes.
Research assistant: And then you as a person? That stress, how does that affect you? Make you feel?
Participant: It affects me psychologically. Yes. And even physic, ah, psychologically. Ea. It affect us, it affect me. Yes.
Research assistant: Okay. And when you say psychologically, what do you mean?
Participant: I, I mean that you are always…Ah, this thing may make us always to be think a lot. Think a lot about the life of the patients. Yes, because our patient really are in, ah, their life are in, in danger. Yes, because of the shortage of, ah, ah, things which we supposed to use it. Yes.
Research assistant: Okay, and then you also said that it affects you physically. How does that stress affect you physically?
Participant: Ah. Physically we, we, we don't, we don't have power when we are coming in this work because we know that, I know that, you, you know that we don't have. We are going, we

are just going to work but some of things are not there. So, physically we are not moving with power really. We are not, ah, active. Yes. We are, we are, we are always or almost losing even hope. Yes.
Research assistant: I see.
Participant: Ja, and sick. It is, it is always make us, make us tired.
Research assistant: I see. And does that stress ever affect your family life?
Participant: Yes because, ah, because this is our, ah, because we are staying here. It's our, it's our, our village. So, yes because when you are, ah, moving from work, when you are returning back to home, sometimes we are at least we are talking about the, ah, there is no… Eish. We, at work, there is, ah, some of, ah, medication are not there. Even when they are going to the clinic, they don't find it. Even if they are going to the pharmacy, the hospital, ah, they don't find it. Some of us or some of us in this village, we don't, we are not working and they don't, they don't have, ah, medic, ah, medical aid to go to, ah, private hospitals. So that is why I say, even at home, ah, at our families, this stressful, this stress, is affect them.
Research assistant: Okay.
Participant: Yes.
Research assistant: And what helps you to cope with work-related stress?
Participant: Hm. Ah, which, which help me to cope with stress is just because, ah, we at, at, ah, we, is just because we are, we are going to church. It's just a prayer. A prayer make, make us to cope with the stress. Yes. We are always praying when we are in the wards. We are always praying for the patient, praying for us, praying for every, everything which can at least help us. Yes.
Research assistant: And do you use any other strategies to cope with the stress?
Participant: No.
Research assistant: Okay. Um. So, in your work, as you're working, is there any other things that you use to help you cope with the work-related stress?
Participant: No. We don't have.
Research assistant: Okay.
Participant: Yes.
Research assistant: Have you had any training in how to cope with work-related stress?
Participant: No.
Research assistant: Okay. Do you think that you could benefit from training?
Participant: Ja, training can benefit us if is here.
Research assistant: Okay.
Participant: Yes.
Research assistant: So, currently, how do you suggest to improve the situation?
Participant: Hm. I don't know but if, ah, I think if, if, if there is, if there is money in this hospital, I suggested to, I suggest to, to, I suggested them to buy us the equipment so that this patient, ah, must, must get help. Yes, if there is money. Even the, some of the medication which are not there. If there is money, they must, ah, buy the treatment at pharmacy so that the, our patients must get it. Yes.
Research assistant: Okay. And what day-to-day support do you feel you need?
Participant: Maybe. Okay, maybe at the, if, if there, ah, our management maybe sometimes can call us the psychologist and the others just to come together at least to come to reassure

us. Maybe. Or call one by one, ah, at least to, at least, ah, to call, ah, one by one to at least to, to, to talk about them according to their, ah, their work. Yes.
Research assistant: And have you ever spoken to a psychologist?
Participant: No.
Research assistant: No? Okay.
Participant: Yes.
Research assistant: And you believe that it would help you?
Participant: Yes. Yes.
Research assistant: Um, so, moving, this is our very last question. So, what aspects in your work and your work environment help you to manage your work-related stress, now?
Participant: Now? Okay. Ah, our, our work environment?
Research assistant: Yes.
Participant: Alright. Ah. We are managing, ah, this stress now at, at, at our wards just, ah, by, by using those, some, ah, some equipment which are there, even some treatment which are there. We are, at least, ah, ah, busy using it. Ah, some of them are helping us very, a lot. Hm. And borrowing, ah, even other ward's. Some of them, sometimes they are borrowing - even at the clinics. Yes. They, the hospital sometimes borrows, ah, any other equipment, other treatment at the Hoedspruit Hospital, Hoedspruit clinic and even at other clinics. So, we are working hand-in-hand with our clinics. Yes. Ea. That is that.
Research assistant: Okay.
Participant: Hm.
Research assistant: And, in terms of hospital management, are they helping you cope with your work-related stress, in any way?
Participant: Yes, they are coming at the ward.
Research assistant: Okay.
Participant: Yes, and we are discussing, we are, they are, we are discussing with them and they know about this shortage. They know about this situation. Ea. They sometimes, we are, they come at the wards and talking about us about, about, with us about this situation. So, even the, even themselves, they know and they don't know what can I, they, they do. They, ah…ja. It's there so who, ah, borrow, ah, something outside, um, at least give us. Yes.
Research assistant: Okay. Thank you very much.
Participant: Thank you.
Research assistant: Um, so just before I close off, is there any other information that you think can help us?
Participant: No.
Research assistant: Okay, so nothing else to add?
Participant: Yes.
Research assistant: Okay, well thank you very much for your, your answers to the question and, if there is anything that the investigator wants to clarify on, then she will either phone you or call you in and talk to you about your answers or something inside your answers that she just wants to get a bit more detail about.
Participant: Alright, thank you
Research assistant: Okay, thank you very much.
Participant: Thank you very much. Thanks

ANNEXURE E: COPY OF FIELD NOTES

Interview number: 191026_0073
Venue: Hospital X
Date: 27/08/2019
Duration of interview: 19 minutes and 41 seconds

REFLECTION OF INTERVIEW

As it was the first interview that I would be conducting for the researcher, I was quite nervous about the unknown. I felt prepared, as I had been through the debriefing material beforehand, but I still felt worried that I may not be able to gain the information desired, during the interview. In my preparation, I had tried to rephrase some of the questions so that they would help obtain the same information but not involve so many academic English words. I thought this may help, especially if the interviewee was not fluent in English.

So, after we went through the formalities, the interview began. The interviewee was able to speak English but she was not fluent and struggled to form complete thoughts in response to some of the questions, in English. Some of the questions, she did not understand and I tried my best to rephrase them without losing the meaning of the question. In one case, she really did not know how to answer the question and I was at a loss of how to assist or simplify it for her. The result was I moved on to the next question, after trying only once to rephrase it. I think it was more because of nerves, from both parties involved, that I was faced with this dilemma but, afterwards, the other questions flowed better.

I used all of the prompting questions to try obtain the greatest amount of information that I could. This was needed, especially with the first question, as I found that it was understood as asking for examples of work-related stressors rather than defining the phrase. The interviewee attempted most of the questions, even with the language restrictions, and the answers were brief but I believed they did adequately answer the interview questions.

In all, I think the interview went well. Both the interviewee and myself relaxed as the interview progressed and it became a conversation rather than a formal interview.

ANNEXURE F: DECLARATION LANGUAGE EDITOR

P.O.BOX 18

MKHUHLU

1246

CELL NUMBER 0722357606

DATE: 03 JANUARY 2020

UNIVERSITY OF PRETORIA

PRIVATE BAG X323

ARCADIA

0700, SOUTH AFRICA

TO WHOM IT MAY CONCERN

Re: ENGLISH LANGUAGE EDITING ON DISSERTATION FOR THE UNIVERSITY STUDENT

Ms. Shiviti M.P Student no. **18377280** Title: Perceptions of nurse managers regarding work related stress in a rural district hospital in Limpopo province.

1. This serves to confirm that **I, Khisimusi Elson Ubisi,** am a retired teacher in English and have specialized in English as a major subject in the senior teacher's diploma (STD) and as ancillary subject in the Bachelor of Arts degree. I have a teaching experience of **27** years in the English language as subject at high school. I produced a 100% matric pass rate for English for the years **1989 to 2015**. I was a chief marker in English language for the Mpumalanga Department of Education over a two year period. Attached hereto please find copies of my certificate(s) and testimonial to that effect.

2. I hereby certify that I did English language editing on the dissertation and am satisfied that the work may be submitted for examinations as per the university requirements. Attached hereto please find copies of certificate(s) and testimonial.

3. Hope this will assist the department as may be necessary.

Yours sincerely: Ubisi K.E

Signed: .....

Date: 2020 February 03