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The experiences of nurses regarding current in-service training programmes at a public hospital in the Western Cape

by

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DECLARATION

I, Vyjayanthimala van Heerden, hereby declare that the contents of this thesis represent my own unaided work, and that the thesis has not previously been submitted for academic examination towards any qualification. Furthermore, it represents my own opinions and not necessarily those of the Cape Peninsula University of Technology

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ABSTRACT

In-service training (IST) is essential in every hospital to address changes in healthcare. It also provides the platform to share new information, new techniques and ultimately improve nursing care. Hence this study was designed to explore the experiences of nurses regarding current in-service training programmes at a public hospital in the Western Cape. The objectives of the study were to explore and describe their experiences of IST programmes and to develop recommendations in support of IST for nurses. The research followed a qualitative approach with an explorative, descriptive and contextual design. The population in the study were nurses working on day duty, who were permanently employed at the selected public hospital. Purposive sampling was used to select participants. Nurses comprising all categories (71 participants) were included in the study. Data was collected via focus-group interviews. Trustworthiness in this study was maintained through confirmability, dependability, transferability and credibility. Results revealed that IST was like a refresher course, as it served as a reminder of what participants had learned and kept them updated. Participants declared that current IST was very applicable and practical. Despite some challenges, like staff shortages, time constraints and workload issues, the participants described their experiences regarding the current in-service training programmes positively. Participants also mentioned gaining and being empowered with knowledge, skills, experience and information, thereby assisting with better quality nursing care to patients with fewer risks of medical hazards or litigation.

The major recommendations were that management should support in-service training programmes. A special training committee/task team, comprising of management and nurses, should be established to take control and to ensure that IST takes place at the health facility. An in-depth training needs analysis needs to be done by this task team/committee in order to meet the IST needs of the nurses. Communication strategies have to be improved when advertising these programmes, in order to allow more nurses to attend. The study emphasised that IST is a much needed and important aspect for nurses in practice are not receiving the desired attention.

Keywords: In-Service Training, Nurses; Training; Continuing Professional Development

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- All participants

DEDICATION

This research was done for all the nurses employed in this public facility and is dedicated to all the participants who contributed to change the way forward.

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CLARIFICATION OF BASIC TERMS AND CONCEPTS

In-Service Training (IST)

IST refers to regular educational sessions, geared at the constant development of staff, while they are on duty, executing their allocated nursing duties. Parallel terms used is “staff in service”, “on the job training” or just “in-service”. It narrates to staff’s achievement and updating of competencies (Jooste, 2018:216).

Categories of nurses

Categories of nurses from senior to junior are the registered professional nurse, the registered staff nurse, and the registered auxiliary nurse.

A professional nurse is a person who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (SANC, Nursing Act No. 33 of 2005: Section 30).

A staff nurse is a person educated to practise basic nursing in the manner and to the level prescribed (SANC, Nursing Act No. 33 of 2005: Section 30).

An auxiliary nurse is a person educated to provide elementary nursing care in the manner and to the level prescribed (SANC, Nursing Act No. 33 of 2005: Section 30).

Training

Training implies an effort at changing or modifying knowledge, skills and behaviour as a means to achieve organizational objectives, hence refining competencies necessary in the workplace (Muller, Bezuidenhout and Jooste, 2019:352).

Training needs

Training needs are the information or skill areas of an individual or group that necessitate additional development in order to expand productivity. By using different techniques, priority training could be determined by doing a group or individual training analysis of needs (Muller et al., 2019:367).

LIST OF ABBREVIATIONS

CEO	Chief Executive Officer
CIM	Clinical Incident Management
CPD	Continuing Professional Development
CPE	Continuing Professional Education
CPR	Cardiopulmonary Resuscitation
CSP	Community Service Professional
EAP	Employee Assistance Programme
ICN	International Council of Nurses
IST	In-Service Training
PA	Public address
SANC	South African Nursing Council
SPMS	Staff Performance Management System
FGI	Focus Group Interview

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

All nurses, despite their years of experience, need ongoing staff development to maintain and improve performance in the workplace (Jooste, 2018:253). Staff development is an orderly method of education and training aiming at progress in skills and knowledge. One similar concept is in-service training (IST) (Jooste, 2018:183). In-service training (IST) programmes are important and valuable in empowering nurses with knowledge and skills. They also assist nurses to contribute to and enable the realisation of the institution's organisational goals. The functions that nurses perform daily in their workplaces should be reinforced by appropriate education and training programmes. No nurse can perform his/her duties without the appropriate training (Jooste, 2018:254).

IST encourages nurses to train while on duty, hence the workplace can become an active learning environment. Nursing and midwifery are a science and an art, demanding both academic and applied training to become knowledgeable, competent and safe practitioners (Geyer, Armstrong, Bhengu, Kotze, Nkonzo-Mtembu, Ricks, Stellenberg, van Rooyen, and Vasuthevan, 2015:25). The intention of IST is to contribute to the enhancement of nursing competence and performance, by preparing nurses to successfully implement their activities. IST could improve their confidence, allow for professional growth, and keep them abreast of advances in nursing (Booyens & Bezuidenhout, 2014:262). The availability of IST provides a focus on improved standards of care and personal and professional development of staff. Most of all, it will protect them against litigation (Jooste, 2018:255). Advances in technology provide a further impetus for continuous IST (Booyens & Bezuidenhout, 2014:262). Information technology-driven machines are connected to the patient and give results quicker. Hence, keeping abreast of new developments, particularly regarding new technology in nursing practice, is critical to delivering the best care possible (Booyens & Bezuidenhout, 2014:262). Jooste (2018: 250) agrees with Booyens and Bezuidenhout, that nurses can only remain competent by taking responsibility and being accountable for their own development (Booyens & Bezuidenhout, 2014:262).

IST offers an opportunity for development, hence attendance at and participation in these programmes is crucial. However, at the public hospital in the current study, attendance and participation in these programmes are lacking. Hence, the researcher deemed it important to explore and describe the experiences of nurses regarding current IST

programmes at a public hospital in the Western Cape in order to develop recommendations for the in-service training unit.

1.2 BACKGROUND

In South Africa, nursing is governed by a professional body, namely, the South African Nursing Council (SANC). The Nursing Act 33 of 2005 and subsequent regulations form the basis of the monitoring framework for the nursing profession in South Africa (Muller and Becker, 2016:500). One function of the SANC is to establish and uphold nursing standards (SANC, 2015:10). Within this mandate, the SANC has established a framework called Continuing Professional Development (CPD). This framework is for nurses and midwives registered with the Council (SANC, 2015:10). The current emphasis on CPD is imperative for continuous improvement of nurses' knowledge and skills. CPD has the potential to assist in refining and cultivating quality patient care. The SANC is in the process of finalising the guidelines for CPD. CPD contribute to professional growth documented through knowledge and skills acquired (Booyens, Jooste, and Sibiya, 2015:230). Although this is a national imperative, every healthcare institution still needs to focus on its own in-service training programmes.

According to Jooste (2018:259), whether it is in-service training, orientation, preceptor-ship or mentorship, planning for the development of all nurses, must focus on the training needs of nurses. It is important to implement these strategies to address these needs and to evaluate whether the nurse's development was adequate. This needs assessment is done continuously. Personnel instruction and education is a vital part of the daily activities of nurses (Jooste, 2018:357).

The most effective and economical way to approach the presentation of IST programmes, is to have a centralised department or section whose main function is the planning and presentation of IST programmes for the different categories of healthcare personnel. However, this approach does not always achieve the desired results, as the IST needs of healthcare personnel working in different units vary to a very large degree, owing to the specialised nature of medical care. A decentralised approach would therefore seem more appropriate but could be costly. A combined approach is recommended (Jooste 2018:185).

A unit for IST exists in this public hospital in the Western Cape. IST programmes are developed monthly, using quality assurance measurement outputs and relevant meeting inputs. In our weekly meetings, feedback on the experiences and incidents that occurred help to determine the training needs of all the categories of nurses. This process includes assessment of the training needs, priority planning, implementing, and evaluating outcomes. Once the programme has been approved by the head of nursing, it is

distributed to all wards/departments on a monthly basis. Currently, at this public hospital, IST programmes are held for an hour from 10:00–11:00 on Tuesdays, Wednesdays and Thursdays. All categories of nurses may attend. As a reminder, the public address system (PA) in the hospital is used to remind nurses of the upcoming training. Not all topics are presented to all categories of nurses. This is based on their scope of practice according to R2598 of 1984 (SANC. 1984, Regulation 2598). This framework is provided by the SANC with an emphasis on staying within the scope of practice to protect the public (Act No. 33 of 2005). The SANC proposes CPD for all practising nurses. However, it has not yet been finalised. CPD assists professionals to update and document their professional skills and knowledge (Booyens, Jooste and Sibiya, 2019:230). IST will become a priority in all health institutions, because of CPD. Development of practitioners in the form of IST and CPD is essential to support the practitioner in their journey of lifelong learning and form an integral part of performance appraisal (Muller & Becker, 2016:537). The researcher therefore deemed it important to explore and describe the experiences of nurses regarding the current in-service training programmes at a public hospital in the Western Cape.

1.3 PROBLEM STATEMENT

Ongoing in-service training programmes are essential for all nurses in order to render quality nursing care. By attending and participating in IST, nurses will be able to stay abreast of new developments in nursing, as they would be updating their skills and knowledge to deliver appropriate and competent care to all patients and clients. The reputation of an organisation can be enhanced and productivity improved by the provision of effective and stimulating IST programmes to its staff (Booyens & Bezuidenhout, 2018:258). Hence, the standards of education, practice and care requires consistent monitoring and evaluation (Human and Mogotlane, 2017:123). The importance of an in-service training programme is to develop nurses both personally and professionally (Booyens et al., 2015:230).

Over the last decade, the in-service training unit at this public hospital has offered various IST programmes addressing nursing care and important issues relevant to changing healthcare settings. Literature indicate that in-service trainers should not ignore the fact that sharing knowledge with nurses who are not ready to learn, will not benefit the individual, or the organisation (Abruzzese, 1996:284). Nel, van Dyk, Haasbroek, Schultz, Sono, and Werner (2005:451), concur that adults should engage in self-directed learning and must have a positive attitude towards learning. Poggenpoel, Labuschagne, Muller, Nolte, Potgieter, Potgieter and Powell (1985:49), propose that in-service training committees should involve nurse managers, professional nurses and teachers in nursing to ensure more effective and successful training programme planning. This committee should ensure that programmes are offered in a cost- and human-constrained

environment and therefore creative initiatives have to be implemented to make the programme more relevant to the current healthcare needs in health services (Poggenpoel et al., 1985:49). In-service trainers can employ a wider range of approaches to determine training needs. Questionnaires can be placed in a suggestion box by all stakeholders to generate needs analysis for training. Nurses could be encouraged to attend and participate in these programmes by offering some means of a reward (Poggenpoel et al., 1985:49). Quality patient care and cost-effectiveness should be associated with training. Further research on this aspect is of major importance. Different approaches and procedures can be integrated effectively into programmes to make learning opportunities more attractive (Poggenpoel et al., 1985:49).

Involvement and participation as adult learners, mean that nurses should not just attend training, but should actively contribute and participate for optimal leaning to take place. Poggenpoel et al., (1985:49-55) conducted a study amongst nurses regarding ITS attendance and revealed a high workload and unsuitable times as common hindrances for non-attendance and that these factors should be considered when planning in-service training programmes.

For the theoretical departure of the study, Poggenpoel et al., (1985:51) suggest nine recommendations in the planning, implementation and evaluation of IST programmes. These recommendations were explored and applied in this study for IST programmes that could be used in both public and private hospitals. From the research problem, the following research question emerged. ''What are the experience of nurses on the current in-service training programmes offered at a public hospital in the Western Cape?''

1.4 RATIONALE FOR THE STUDY

Advances in medical research and technology demands participation in IST programmes to equip nurses to perform their duties in an effective and responsible manner. Hence it is important that all categories of nurses are most likely to benefit from attending continuous IST programmes. This will keep them abreast of changes that are taking place in healthcare regarding technology and treatment. By allowing nurses to develop themselves, can increase the performance of nurses, which hold advantages for both the patient and the organisation. The organisation will be able to reach their goal of rendering quality care for all patients and clients, who in turn will leave the health services highly satisfied. Nurse Managers should ensure that quality care be given to all patients in healthcare facilities.

Training of personnel is an effective tool for development within organisations. It is a vital method by which human resources enhance competencies. Employers have an important role in the growth and development of an organisation. Empowering its employees

through in-service training, leads to the development and success of an organisation. In-service education of nursing personnel is highly significant and very effective in increasing the quality of hospital services (Jooste, 2018:273). The researcher is hopeful that the results of this study will clearly indicate the experiences of nurses regarding current IST programmes and assist in developing recommendations for the training unit at a public hospital in the Western Cape.

1.5 PURPOSE

The purpose of this study was to explore and describe the experiences of nurses regarding current IST and to develop recommendations for the in-service training unit at a public hospital in the Western Cape.

1.6 OBJECTIVES OF THE STUDY

This study aimed to:

- Explore and describe the experiences of nurses regarding current in-service training programmes offered at a public hospital in the Western Cape and
- To develop recommendations for the in-service training unit at a public hospital in the Western Cape.

1.7 THEORETICAL DEPARTURE

In-service training must be planned to be effective to skill the nurse to meet personal and professional goals. It should be focused on the identified training needs; therefore, it cannot be done randomly. The following nine recommendations, according to Poggenpoel et al., (1985:49), will be used as a framework in this study.

1. In-service trainers can plan more effective in-service training programmes with the assistance of in-service training committees consisting of nursing managers, professional nurses and teachers in nursing.
2. In-service trainers can utilise a broader spectrum of methods to assess the needs for in-service training programmes. Examples are questionnaires for nurses, employers, patients and members of the community, and the use of a suggestion box.
3. Re-iterate to nurses of the importance of participating in IST for their own personal and professional growth. Recognition for participation in IST can be discussed. Reward nurses for participation in in-service training programmes. Involve nurses to determine the format of rewards. Nurses should value in service training

because it could lead to having the necessary knowledge and growing professionally.

4. Attention can be given to correlating effective in-service training programmes with quality patient care and cost effectiveness in a specific healthcare system. It is important that it should be brought to nurses' attention that quality care can bring about cost effectiveness and that cost effectiveness cannot be seen as an isolated factor.
5. The blackboard, which is used mostly by in-service trainers, is not the most effective teaching aid. Alternative aids can be integrated effectively into in-service training programmes to create learning opportunities.
6. Attendance at in-service training programmes and group discussions does not indicate optimal involvement by nurses. Nurses as adult learners should be able to see, hear, speak and do for optimal learning to take place. It is unsatisfactory that nurses are of the opinion that they participate in in-service training programmes merely by attending.
7. Attention can be given to the fact that nurses' high workloads could possibly interfere with their attendance at in-service training programmes. It is important that these factors be considered when planning in-service training programmes for nurses to be able to attend
8. In-service trainers mostly use formal lectures as a method of teaching. Formal lectures are not the most effective way of adult teaching, as they do not encourage optimal participation in the learning process. It is critically important to consider the preferences of nurses in the methods of training to ensure involvement in their own development. Methods such as self-experience exercises, simulation and even role play could be used more often.
9. Feedback is needed from nurses attending in-service training programmes to eliminate negative factors involving training (Poggenpoel et al., 1985:49).

Wenger, cited in Steyn (2011:227), agrees with Poggenpoel et al., (1985:48) that competence may develop when people attend IST on a regular basis. Proficiencies might increase when attendance to conferences or other related training could be encouraged for the staff (Steyn, 2011:227). Professionals may identify their shortcomings through such training sessions and communicate their new-found insights with colleagues on their return to the institution. By doing this, these staff members try to change how the institution defines competence and they use their experiences to share and empower their less competent and inexperienced colleagues to become competent (Steyn, 2011:227). IST programmes could assist all nurses to become and remain competent, if the above recommendations are considered when planning in-service training programmes.

1.8 LITERATURE REVIEW

Research shows that an organisation's output is positively correlated to the amount of training its employees receive. This training includes IST (Booyens & Bezuidenhout, 2014:258). Changes are happening in all aspects for health care, whether legislation or technology, continuous in-service training are the only resolution to modify practices on based on emerging knowledge (Jooste, 2018:273).

International studies concluded on the importance of in-service training and authors concur that the outcome of IST improves the quality of nursing care. However, only a few studies have been conducted on in-service training in South Africa with the focus on psychiatric nurses. An in-depth review of the literature regarding IST is discussed in Chapter 2.

1.9 METHODOLOGY

According to Holloway and Gavin (2017:43), research methodology refers to a framework of principles upon which methods and procedures are based. In other words, a methodology is a systematic way to solve the research problem.

1.9.1 RESEARCH DESIGN

A research design is a framework for the collection and analysis of data to answer a research question and objectives, thereby offering a coherent justification for the choice of data sources, collection methods and analysis techniques (Saunders, Lewis and Thornhill, 2019:815). The researcher explored a deeper meaning and an understanding of human experiences within a qualitative approach. A descriptive, explorative and contextual qualitative design was applied in order to explore and describe the experiences of nurses regarding current IST programmes at a public hospital in the Western Cape. Chapter 3 provides an in-depth discussion of the design and methodology applied in this study.

9.2 DATA-COLLECTION METHOD

Qualitative data was collected by means of focus-group interviews. Qualitative data was collected via face-to-face focus-group interviews with semi-structured questions. The participants were 71 nurses of different categories. These included 23 registered professional nurses, 24 staff and 24 auxiliary nurses.

1.9.3 RESEARCH SETTING

The research setting is the physical location in which data collection takes place (Brink, Van der Walt and van Rensburg, 2018:116). This research study was conducted in the Western Cape Province in South Africa. The site was a public hospital with a bed capacity of 344 and a nursing component of 316 nurses, comprised of different categories. Categories included registered professional nurses, staff, and auxiliary nurses. These nurses worked different shifts. Shifts were done in four groups, where group 1 worked, for example, Mondays and Tuesdays and at the weekend during the day, and group 2 worked the same nights on night duty. Groups 3 and 4 worked Wednesdays and Thursdays on day and night duty. The groups alternate working days or nights over a two-week period, and this pattern is repeated at this public hospital

1.9.4 STUDY POPULATION

A study population is defined as the entire group of people of interest to the researcher, and who meet the criteria as stipulated by the researcher (Brink et al., 2018:132). Saunders et al., (2019:294) call a population a full set of cases or elements from which the sample is taken. The population in this study was the 316 different category nurses working at this public hospital in the Western Cape Recruitment included all the categories of nurses working on day duty and available at the time of data collection.

1.9.5 SAMPLING

A sample is a fraction of a whole or a subsection chosen by the researcher (Leedy and Ormrod, 2019:171). Of the population that a researcher chooses for research, ‘sampling’ refers to the process of selecting the sample from the population in order to obtain information regarding a phenomenon in a way that represents the study population (Brink et al., 2018:115). According to Jooste (2018:335), sampling is the process whereby the participants are selected from the target population to ensure that the selected participants are representative of the total population. The sample for this study, was selected from the accessible population of the different categories of nurse’s working day duty at this public hospital in the Western Cape. The sample was really representing the population and the researcher used the results to make generalisations about the whole population (De Vos, Strydom, Fouché and Delport, 2011:232). Purposive sampling involves choosing participants for a particular purpose (Leedy & Ormrod, 2019:177). De Vos et al., (2011:232) note purposive sampling is also called judgemental sampling. Based entirely on the judgement of the researcher, the sample is composed of elements that contain the characteristics most representative of the population that serve the purpose of the study best.

1.9.6 RECRUITMENT

Recruitment from the entire population included all the categories of nurses who were on day duty and available at the time of data collection. Inclusion criteria prescribed at least two years of working experience for all participants, as this timeframe would have allowed participants some attendance in IST programmes. The number of nurses on day duty was 190, consisting of 72 professional nurses, 48 staff nurses and 70 auxiliary nurses. Of the permanent staff in the two shifts, there were 36 professional nurses, 24 staff nurses and 35 auxiliary nurses. The researcher recruited 23 registered professional nurses, 24 staff nurses and 24 auxiliary nurses, who were on day duty and who voluntarily signed consent to participate in this study. In total, the participants were 71. Nurses on night duty were excluded from this study.

Inclusion criteria:

- All three categories of nurses with at least two years of working experience in the public hospital
- Working day duty
- Registered with the South African Nursing Council in one of the nurse categories

Exclusion criteria:

- Working night duty
- Nurses working through nursing agencies
- Student nurses

1.10 DATA ANALYSIS

Thematic content analysis with coding was applied. The researcher engaged immediately with the recordings by listening to them numerous times. Qualitative data collected in natural location are liable to be rich in contextual detail (Saunders et al., 2019:639). Listening included contextual information such as the words participants spoke, their tone of voice, laughter, and how one participant might have verbalised supporting the view of another. This was further supported by the field notes provided by the moderator that included actions and mannerisms while she was observing participants during the interviews. Recordings were transcribed and reproduced verbatim in a Microsoft Word document. The researcher compared all information gathered by member checking to ensure that all recorded data corresponded with what the participants said. Participants were given a code name per nursing category, for example, (P) for professional nurses, (S) for staff nurses and (A) for auxiliary nurses. Coding and thematic content analysis were employed to analyse and interpret the results. The researcher undertook the coding and saw themes emerge. These themes were divided into themes and subthemes. These themes and subthemes were reported in the analysis process (Saunders et al., 2019:655). Refer to Chapter 3 for an in-depth discussion of the data-analysis process.

1.11 RIGOUR IN QUALITATIVE RESEARCH

According to Saunders et al., (2019:218) validation is the process of verifying research data, analysis and interpretation to establish their validity, credibility, and authenticity. Two techniques to establish the quality of research are triangulation and participant or member validation. Criteria are needed to assess or evaluate the quality of research. For quantitative research, the terms 'validity' and 'reliability' are critical. Qualitative researchers regard this as inappropriate in establishing the "truth value" of a qualitative research study and indicate credibility as the most important criterion (De Vos et al., 2011:419). Saunders et al., (2019:216) concur with qualitative researchers who have pointed to other forms of generalisability that demonstrate the quality and value of qualitative research. There is a difference in the methods to establish rigour between qualitative and quantitative research. In qualitative research, trustworthiness is established through consistency, dependability, conformability, audibility, recurrent patterning, credibility, and transferability**.** Credibility, transferability, dependability, and conformability are discussed in detail in Chapter 3.

1.12 ETHICAL CONSIDERATIONS

Research approval was obtained from the Research Ethics Committees of the Faculty of Health and Wellness Sciences at the Cape Peninsula University of Technology (CPUT), reference number CPUT/HW-REC 2017/H (Appendix E). Permission was also obtained from the Chief Executive Officer (CEO) of the public hospital (Appendix D). Ethical principles such as informed consent, privacy, confidentiality, beneficence, non-maleficence, autonomy, justice, and veracity were applied and discussed in detail in Chapter 3.

1.13 STRUCTURE OF THE PROPOSAL

The layout of the study is as follows:

Chapter 1

This chapter provides the introduction to the study, rationale for the study, background to the research problem, research question, purpose, and objectives of the study. The chapter furthermore briefly introduces the research design, method, and rigour in qualitative research, as well as ethical considerations.

Chapter 2

This chapter provides an overview of the existing literature regarding IST and the impact it has on quality care and prevention of negative incidents.

Chapter 3

This chapter outlines the research methodology, population, sampling techniques and method of data collection. Rigour in qualitative research is highlighted.

Chapter 4

In this chapter, the results are discussed.

Chapter 5

This chapter analyses and interprets the results.

Chapter 6

This chapter describes the conclusions and recommendations emerging from the study. Its limitations are also highlighted.

1.14 SUMMARY

This chapter provided an overview of the study. It also included the research problem and reasons for the study. It described the purpose, objectives, terminology and theoretical framework of the study. This was followed by a brief discussion on the research design, methodology, and ethical principles applicable to the study and data analysis. The chapter concluded with an outline of the chapters to follow in the study.

The next chapter presents a review of the literature pertinent to the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter the literature relevant to this study will be explored and discussed.

According to Leedy and Ormrod (2019:74), a literature review is where the researcher evaluates, organises and synthesises what other researchers have done. In a literature review you gather the perceptions and research results into a cohesive whole. Leedy and Ormrod suggest that the researcher, while doing a literature review, should identify themes with a common thread throughout the literature and show how perspectives to the topic have changed over time. Furthermore, the researcher has to compare and contrast varying theoretical perspectives and findings on the topic and describe general trends in the research findings.

After establishing the problem, the researcher has to do a literature survey connected with the problem. Collection of research publications: books, journal articles and other documents related to the defined problem is done. It is vital to establish whether the defined problem has already been solved, the status of the problem, techniques that are useful to investigate the problem, and other related details (Easterby-Smith, Thorpe, Jackson and Jasperson, 2018:20). The researcher searched journals for relevant articles on the research topic, as well as current books and the Internet, using, among others, Google Scholar.

A review of the literature in the area of one's research is the first step before planning a study and determining the methodology to be used (Easterby-Smith et al., 2018:20). The literature review helped the researcher to obtain information, clarify concepts, and identify trends that could influence the results of the topic under study objectives (Jooste, 2018:273). Through a literature survey, one can collect relevant information about the problem, similar problems and clarity ideas. Formulate the current problem in a clear-cut way. A review on past work helps the researcher to establish the outcome of investigations where similar problems were solved. It can help the investigator to design relevant methodology for the present work. Vital links could be explored in respect of trends and phases in the chosen topic, and familiarisation with characteristic precepts, concepts and interpretations is facilitated (Easterby-Smith et al., 2018:20).

This chapter includes a literature review regarding IST, but limited literature was found closely linked to the experiences of nurses regarding IST. However, any related studies were reviewed for the current study.

International, national and provincial studies are few and mostly outdated. No study was found which focused purely on the experiences of nurses regarding IST in a public hospital. The studies done share similar key concepts.

In-service training comprises of activities that uphold and intensify employees' ability and knowledge in performing the tasks assigned to them, thereby contributing to the organisation in achieving its goals and objectives (Jooste, 2018:273). In-service training is a set of organised and designed educational activities to improve employees' performance in the workplace, thereby increasing the productivity and quality of services provided (Jooste, 2018:273).

2.2 GLOBAL PERSPECTIVE

The literature search revealed the terms 'IST', 'in-service education' and 'continuous education' are used interchangeably.

Globally, all professionals have recognised the phenomenon of continuing professional education (CPE) as a primary method to enhance basic professional education regularly. Globalisation, technological advances, consumerism, and climate change have challenged the healthcare environment to ensure that practice and services are contemporary. As nurses constitute the largest group of healthcare professionals globally, they are required to participate in CPE to develop skills and competencies, and remain current in their practice. The only way they could stay competent and skilful, is by investing in continuous learning and education. CPE attendance was highest when the topics reflected the needs of the nurses. (Chong, Francis, Cooper and Abdullah, 2013:1). The International Council of Nurses (ICN) Code of Ethics for Nurses (2012:3), advocates that "all nurses should take responsibility and be accountable for the way in which they practise their profession. Nurses and the profession determine and implement acceptable standards of clinical practice, management, research and education (Muller & Becker, 2016:118).

2.3 INTERNATIONALLY

Internationally, research regarding IST has been conducted in various countries. Bloor McHugh, Pearson and Wain (2004:39), studied the effect of training courses on

psychiatric nurses in Russia to advance management of violence and aggression. Attention was given to how nurses questioned existing practices and design new ones. Nurses were acknowledged for their role they played in bringing about organisational transformation in ancient practices. They were also commended for introducing contemporary methods of treatment and training (Bloor et al., 2004:39).

A study by Willets and Leff (2003:237-243), explored the proficiency of a staff training programme for the upgrading of the knowledge and skills of psychiatric nurses. The impact of the programme was examined to explore the range and use of management strategies by nurses. The main conclusion was that the training programme was effective in increasing the knowledge and skills of psychiatric nurses. Other studies (Lam, Kuipers, and Leff, 1993:233-237; Gournay, 2000:243-249; Munro et al., 2006) found that in-service training increases the knowledge and skills of staff members and should be used in a variety of psychiatric nursing hospitals.

In another study by Willets and Leff (2003:237), in-service training was found to increase the psychiatric nurse's knowledge and skills with regard to the management of psychiatric patients. Keltner, Bostrom and McGuinness (2011:117), state that the psychiatric nurse uses both verbal and non-verbal communication skills as a primary therapeutic agent, compared with the procedures and physical interventions used by the medical-surgical nurse. Psychiatric nurses thus need continuous in-service training in order to update their knowledge on treatment procedures and to ensure consistent, quality patient care in the demanding psychiatric nursing field (Bloor et al., 2004:39-41). IST assist psychiatric nurses to share what they know in the form of information and skills to provide quality services to patients and their families. The outcome of their skills contribute to a decrease in injuries (Kneisl & Trigoboff, 2009:22).

Needham, Abderhalden, Halfens, Dassen, Haug, and Fischer (2005:649-655), explored the result of a training course in aggression management of psychiatric nurses. What were their perceptions or views of aggression and whether they were able to cope with aggressive patients? The study concluded that due to the development in the training programme, their perceptions of patients' aggression empowered and equipped them to be effective in handling and understanding the aggression of these patients. The consequences and positive outcomes endorses the importance of in-service training for psychiatric nurses (Needham et al., 2005).

Nurses confirmed that participation and involvement in in-service training courses had altered their knowledge, understanding and functional skills. They have sufficient knowledge and experience; however, training courses are repeated too often. Careful attention should therefore be paid to nurses' educational needs in determining the contents of in-service training courses. Suitable times and venues, and encouraging

nurses to participate in in-service training, were also essential (Sajjadnia, Sadeghi, Kavosi, Zamani and Ravangard 2015).

A study by Alshuwairek (2016), aimed to investigate the effectiveness of training programmes on employee performance in Saudi Arabia's private sector companies and recommended that training and development of all staff should be vigorously pursued and made compulsory. Listed benefits of training were that they improved employee morale, gave job security and promoted job satisfaction. The more satisfied employees are, the greater their morale and the more they will contribute to organisational success. Employee absenteeism and turnover will also be mitigated. Less supervision will be required as well-trained employees will be well acquainted with the job. Fewer accidents and errors are likely to occur if employees have the knowledge and skills required for a particular job. The more highly trained employees are, the fewer the chances of their committing accidents at work and the more proficient they become. Employees thus become more eligible for promotion as they are an asset to the organisation. Training improves both efficiency and productivity. Well-trained employees show both quantity and quality in their performance. There is less waste of time, money and resources if employees are properly trained.

Chaghari, Ebadi, Ameryoun and Safari (2016), in their study to determine and describe the manner of IST of nursing staff, devised a model they called “empowering education”. This model was devised to identify the most effective way of transferring necessary knowledge and skills to nursing staff in the workplace. They contended that nursing IST should be practice-oriented and self-directed, IST should facilitate the job function of the nurse, and be participative and self-directed (Chaghari et al., 2016).

Clinical education is an important part of nursing education. Jasemi, Whitehead, Habibzadeh, Zabihi and Rezaie (2018), recognised challenges and acknowledge the difficulties in clinical nurse education. Their study concluded that lessons should have clear goals, educational standards should be measured, and educators should have good communication skills (Jasemi et al., 2018).

Farzi, Shahriari and Farzi (2018), explored the challenges of clinical education in nursing and strategies to improve it. They concluded that the clinical educator is one of the main instruments of education. The clinical educator needs to pay attention to effective clinical education principles to ensure transfer of learning. This implies employing experienced clinical educators. Other findings related to improving the clinical education of nurses included enhancing the learning environment, developing the relationship between faculty and practice, participation of clinical nurses in clinical education, paying attention to initial staff commencement of service behaviour, and orientation at the beginning of training (Farzi et al., 2018).

2.4 NATIONALLY

Nationally, limited studies have been conducted. According to Jooste (2018:249), the purpose of nurses' training programmes is to allow the organisation to demonstrate commitment to training and educating its healthcare professionals. It also encourages them to realise the requirement to advance their own and other individuals' performance. These training programmes support the development of employees in order to improve their functioning and healthcare organisations as a whole. According to Jooste (2018:217), human assets, as opposed to some other resources, can increase in value owing to training, development and experience that enable the acquisition of skills and abilities.

Poggenpoel et al., (1985) developed nine recommendations for effective IST that can be used as a frame of reference by trainers when planning IST. IST in nursing is seen as a necessary component to help the professional nurse to keep up to date with the most recent developments in nursing and to be able to manage the demands of nursing practice. Poggenpoel et al., (1985:49) identified the following recommendations for effective IST.

- Trainers can plan more effective IST programmes with the assistance of IST committees.
- Nurses should be considered as adult learners, and active participation in the learning process should be encouraged.
- The appropriate strategies should be employed to encourage active participation in training programmes.
- Poggenpoel et al., (1985:51) also suggested that nurses should be rewarded when participating actively in IST, instead of gaining only enrichment. IST should be correlated with quality patient care and cost effectiveness.
- The blackboard should be integrated with other teaching aids to ensure more effective teaching, such as simulation, where nurses are totally involved in the learning (Jooste b 2018:187).
- Nurses' high workloads should be taken into consideration, as they could interfere with attendance. IST should therefore be planned in such a way that nurses are able to attend.
- Negative factors involving IST, such as a monotonous voice or dull presentation, should be minimised by creating opportunities for feedback from participants about the way IST is conducted. This study concluded that IST improves the quality of nursing care (Poggenpoel et al., 1985: 51).

Letlape, Koen, Coetzee and Koen (2014), in their study, explored and described the needs and benefits of IST for psychiatric nurses and develop recommendations. Changes

in healthcare delivery compel endless in-service training of psychiatric nurses to survive and adapt to their practice with current knowledge. This research results proved IST is essential and beneficial. Issues that interfere with attendance at IST programmes need to be considered when planning its implementation. Some of these could be staff shortages or impractical timing of IST sessions (Letlape et al., 2014).

Burton and Ormrod (2011), stated that there is an association relationally between psychiatric nurses, multi-disciplinary team members and teaching and learning. Trust and support is fostered based on the psychiatric nurses' knowledge and skills. They concluded that IST is necessary and beneficial in updating nurses' knowledge of new developments. Benefits were personal career advantages, such as empowerment to render quality care and encourage further studies. Socially, work relationships improved, leading to nurses' motivation, a therapeutic environment, mutual respect, and an ability to work independently. Physically, in-service education boosted their confidence and they became more productive at work (Burton & Ormrod, 2011:161). Similarly, Erasmus Loedolff, Mda and Nel (2009:235), agree that the relationship between superiors and subordinates improved because of continuous IST.

2.5 SELF-DIRECTEDNESS

Literature disclose that adults are self-directed and motivated by their personal goals (Knowles, 1980, cited in Muller & Becker, 2016:504). They want to make their own decisions and take control of their own life, interactive and self-guided. Adult learners come prepared and inspired to learn when they have established a need to obtain new knowledge and skills (Knowles, 1980, cited in Muller & Becker, 2016:504). Nurse educators should apply the principles of adult learning when presenting programmes. This includes using their experience and building on what they know, whether it is a task, problem or life orientation. Nurses need to be encouraged to recognise the gaps in their knowledge and to utilise the resources available that will assist them to attain their goals (Letlape et al., 2014).

The healthcare practitioner has a person responsibility to keep up to date with the latest knowledge, technology and methods of treatment (Muller & Becker 2016:522). Ridge (2008:28, cited in Booyens & Bezuidenhout, 2014:216), describes rapid changes in medicine, treatment modalities and medical technology that happen on a daily basis. Hence, it is essential that nurses and healthcare personnel undergo professional development and education on a continuous basis in order to stay abreast of new developments. Khomeiran, Yekta, Kiger and Ahmad (2006:69), identified the following factors that influence healthcare workers' further development. Personal characteristics of practitioners influence their readiness to participate in learning activities, for example

curiosity, readiness to know more about work-related issues, and willingness to ask questions. Motivation to learn more emerges when nurses and other healthcare personnel enter the workforce as qualified professionals and accept responsibility and accountability for patient care. Satisfaction of patients with the care rendered appears to play an important role in motivating healthcare workers to develop themselves in order to render better patient care (Khomeiran et al., 2006:69).

Jooste (2018:256), claims the importance of nurses' development in healthcare units cannot be underestimated. Healthcare managers are responsible for giving their members opportunities for continuing learning. She states that in nursing development, the emphasis is on translating knowledge, principles, skills and theory into clinical practice, aimed at producing quality client care. Booyens & Bezuidenhout (2018:258), rapports a relationship between the quality of patient care and the knowledge and skills of nurses providing this care. Nursing managers who invest in ongoing IST are rewarded with better patient care, because nurses will become more motivated to perform to the best of their ability. Nurses are with patients for 24 hours a day and need to keep abreast of clinical skills and competencies. The purpose of on-the-job training is to ensure nurses are skilled and knowledgeable, and that they remain current with changes implemented (Jooste 2018:217).

It is the responsibility of in-service trainers to determine what adult learners know and how ready they are to receive and to share knowledge and experiences (Abruzzese, 1996:284). Nel et al., (2005) agree, stating that adults prefer to plan their own learning projects and to adopt a self-directed approach towards learning. Advertising well in advance is vital for maximum attendance at IST programmes. Emails, posters on notice boards and reminders regarding IST programmes should be communicated at all meetings, prior to hosting them. Circulating eye-catching flyers at least two weeks in advance could also assist in advertising programmes. Put up notices in high-traffic areas, such as in rest rooms, on bulletin boards and in staff lounges. Ensure adequate seating and sufficient copies of hand-outs on nurses' arrival (Abruzzese, 1996:284).

Muchinsky, Schreuder and Kriek (2003), commend that in-service training keep nurses knowledgeable and prepare them to perform to the best of their abilities (Muchinsky et al., 2003:167). In-service training is defined by Muller (2009:351), as the informal training of nurses to advance their professional knowledge, skills and attitudes according to the demands of the nursing unit and, according to Abruzzese (1996:3), is the key to quality nursing care. The aim of in-service training, according to Muller (2009:351), is to enable effective functioning of nurses within a team context in a unit, to rectify shortcomings in nurses' knowledge, skills and attitudes, to prepare nurses for changes implemented by the nursing service, and to manage risks before complications arise. According to Booyens & Bezuidenhout (2014), the link of quality patient care and the competencies of nurses cannot be separated. IST is an investment and the reward is better patient care

as the nurses become more motivated to perform to the best of their ability (Erasmus et al., 2009:3; Booyens & Bezuidenhout, 2014:384).

Harrington (1989:28-31), investigated in-service training in a private general hospital. His findings disclosed a decrease emphasis on professional development and in-service training of nurses, although IST is of extreme importance. Delport, Greenfield and Carolus (1989:26-27), also investigated in-service training, and concluded that in-service training improves the quality of nursing care.

A study by Nel (1986), explored the impact of in-service training on the quality of psychiatric nursing care for mentally retarded patients. The findings stated that the involvement of management and staff to determine training needs, presentation and resources. In-service training programme success is boosted when involving external and experienced presenters.

Muller (2009:351) confirmed a list with personal learning need assessment should be done. In-service training should be task- and results-oriented. Van Dyk, Nel, van Zyl Loedolff and Haasbroek (2001), determined that the emphasis on IST should be to improve specific skills and abilities needed to perform the job and contributing to the improvement of the quality of psychiatric nursing care (Van Dyk et al., 2001:3). The involvement of competent trainers will have an impact on how the psychiatric nurses experience in-service training (Norushe et al., 2004:70). The findings of this research concluded that in-service training should be presented by all categories of nurses and that IST has advantages for all aspects in the life of nurses. Challenges need to be addressed.

Chaghari et al., (2016) did a study in hospitals in Tehran where they endeavoured to propose a contemporary ideal model attempted to introduce a relevant and effective model for IST, applying self-directed, practical learning, based on andragogic needs. Several strategies were adopted to achieve empowering education, including the fostering of searching skills, clinical performance monitoring, motivational factors, participation in design and implementation, and a problem-solving approach to better IST. The study concluded that nurses play an indispensable role in improving the quality of inpatient care and noted the importance of enhancing the effectiveness of in-service training of nurses (Chaghari et al., 2016). According to Knowles et al., (1998, cited in Brooker, Waugh, van Rooyen and Jordaan, 2016:79) argue that adult learns best when involve or active in the learning process.

Another study by Chaghari, Saffari, Ebadi and Ameryoun (2017), concluded that education plays an important role in achieving organisational goals through a combination of organisational and workforce interests. Nowadays, training is an essential factor contributing to greater efficiency of staff and organisations. In fact, it is a vital investment

that will lead to internal promotion, staff development and success of organisational plans. Training is an investment in achieving productivity and employee retention through providing career development and job satisfaction in the long run. Training programmes are essential for the survival and viability of any organisation. In-service training serves to update staff's occupational knowledge and professional skills, and improve best practices for fulfilling various tasks and responsibilities. Active participation of nurses in in-service training can lead to effective learning and development in their field of work (Chaghari et al., 2017).

Amerioun, Ebadi and Sanaienasab (2012:19), suggest a proper educational needs assessment with careful attention paid to nurses' educational needs as the basis for determining the contents of in-service training courses. They further note the importance of determining a suitable time and place for providing training courses, encouraging nurses' participation in in-service training courses, and providing careful and continuous manager supervision of employees to attend such courses. Amerioun et al., (2012) further suggest that using a proper and continuous system for monitoring and evaluating the quality of in-service training courses should be provided for nurses.

2.6 PROVINCIALLY

Provincially, the literature review did not indicate any studies linked to the researcher's investigation into the experiences of nurses regarding in-service training, but in the study of Lagrimas-Botha (2015), a section was devoted to understanding in-service training's impact as support for orientation.

Lagrimas-Botha (2015:22), wanted to determine what support systems and possible gaps that existed in the introduction and overview of Community Service Professional (CSP) nurses at two sub-structure health facilities in the Western Cape. Within this study, CSP nurses were questioned on IST and how this contributed as a support structure for orientation. The results indicated that some CSPs were cognisant of an in-service training programme. Communication of the training programme, immense workloads, less time allocated, patient care priorities, and their exclusion as CSP nurses, were some reasons noted as positive or negative. Makhakhe (2010), agrees that in-service training is essential in updating and educating staff on current job requirements. The constant and rapid rate of changes in the nursing and health care environment emphasise the importance of and need for in-service education. Because of excessive workloads and staff shortages, new graduates often find themselves in charge of a ward and thus unable to focus on their learning needs and objectives.

According to Roji and Jooste (2020), nurses need a workplace that promotes empowerment, managers who are supportive of them and who applaud the contribution of nurses in the delivery of care to their clients. Nurses received some suggestions about job possibilities, but perceived an absence of or little involvement in discussions about further training and education, and career management. Sufficient human resources within the organisation are essential, as their availability at all times contributes to the accomplishment of assigned tasks.

2.7 SUMMARY

This chapter outlined the current literature available regarding IST.

Literature relevant to IST was identified and discussed globally, internationally, nationally and provincially. Little of the literature reviewed was pertinent to the researcher's study, but many factors and concepts mentioned were relevant. The studies on IST clearly mentioned the impact it has on quality care and prevention of negative incidents.

The following chapter discusses the research methodology and design.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research methodology used to explore the experiences of nurses regarding IST in a public hospital in the Western Cape. The objectives, research design, description of the population, sample, data-collection tools, and process followed for data collection. Information on the data analysis and ethical concerns are also discussed in this chapter.

Methodology describes the interconnectedness and interrelatedness of the study's purpose, questions and methods. These components need to form a harmonious unit rather than disjointed parts (Creswell & Poth, 2018:225). According to Jooste (2018:342), data-collection methods serve to gather information and to ascertain people's opinions and reactions. Data-collection methods must fit the research approach and objectives of the study. The research method used to collect data for this study was focus- group interviews. A discussion of qualitative research follows.

3.2 QUALITATIVE RESEARCH

There are two well-known and recognised approaches to research, namely, qualitative and quantitative paradigms. Each differs incisively from the other. A mixed-method approach can be adopted by the researcher when needed to reach the objectives of the study (De Vos et al., 2011:63). Each approach has its own purposes, methods of conducting the enquiry, strategies for collecting and analysing the data, and criteria for judging quality. Both methods have distinctive properties and data-collection methods. Qualitative research refers to research that elicits participants' accounts of meaning, experience or perceptions. It involves identifying participants' beliefs and values that underlie the phenomena. (De Vos et al., 2011:65). The aim of the qualitative researcher is to elicit the lived experience of the sample identified for the study. Leedy and Ormrod (2019:418), define qualitative research as yielding information that cannot be reduced easily to numbers. It typically involves an in-depth examination of a complex phenomenon, while quantitative research yields information that is inherently numerical, or can be reduced easily to numbers.

The researcher's overall methodological approach to this research study was qualitative. This approach was chosen to explore and describe the experiences of nurses regarding IST at a public hospital in the Western Cape Province. A qualitative method using focus-group interviews was considered the best method for exploring, describing, contextualising and gaining in-depth insight into the participants' experiences (Leedy & Ormrod, 2019:245). This method brought deep meaning to the study, as small groups of different categories of nurses were the participants in these focus-group discussions. These groups of nurses are expected to attend IST on a regular basis at this public hospital in the Western Cape.

The researcher explored how these participants make sense of their own world and how they interpret and understand it. This qualitative approach provided rich data as it explored the insights, perceptions and views of nurses who had attended IST programmes. Nurses were allowed to express their personal experiences and views openly, and together constructed meaning and provided rich insights to this study. Each participant was allowed a fair opportunity by an experienced interviewer in the presence of a moderator. Furthermore, the researcher hoped that ideas and suggestions of how to offer IST could lead to valuable recommendations to improve IST programmes in the workplace.

The researcher reflected on her position as researcher, and applied bracketing throughout the research process. The researcher was aware that personal participation and perceptions might influence the responses of participants, and ultimately, the results of the study, hence bracketing was applied (refer to Section 3.5 for an in-depth discussion on bracketing). The researcher used a constructivist paradigm, as the participants' lived experiences regarding in-service training programmes were explored. Constructivism is discussed below.

3.3 CONSTRUCTIVISM

Leedy and Ormrod (2019:9), say that absolute truths are somewhere out there in the world and the realities that researchers identify are nothing more than human creation that can be helpful in finding subjective meanings within the data collected. Constructivism not only acknowledges that researchers bring certain biases to their research endeavours, but also try to be as upfront as possible about these biases. Constructivists enquire on the views, understandings and cultural practices of individuals and groups (Leedy & Ormrod, 2019:9). According to De Vos et al., (2011:7), constructivism is where participants become active and involved in all the phases of the process and indeed become partners in the total endeavour. Participants seek understanding of the world in which they live and work. Constructivism can be regarded

as a radical departure from tight control of the researcher, to full empowerment of the participants. This can enhance the outcome of the study and the results are more accurate where participants are involved throughout.

With this qualitative approach, the researcher uncovered factors and gained a deeper understanding in answering the objectives of this study. The focus-group interviews consisted of participants who expressed their own knowledge, experience, perceptions and views on IST. Interacting within the group and through their individual input, they jointly constructed meaning of the phenomenon under study. New information, perceptions, preferences and underlying needs were discovered as these nurses displayed their levels of satisfaction and concerns about their contextual experiences. Their personal thoughts and feelings were further enriched by co-participants, and together they socially constructed real meaning and in-depth understanding of their individual and combined levels of satisfaction with IST. These participants (who were all different categories of nurses), enjoyed getting together, interacting with one another, and sharing their experiences and what they knew of IST at the hospital. They were able to use information shared in the discussions to add to their own world view (De Vos et al., 2011:7).

In qualitative research, constructivism means every individual nurse in this study came with rich knowledge and personal experience into the study, and by sharing it with others, constructed new knowledge. Participants shared their different involvements, practices and skills, and in doing that, they learned from one another's experiences. They were all open to adapt, which ensured that learning took place. During the focus-group interviews, it was clear that all participants knew their environment well and could tap into one another's valuable experience. Each category of nurse could be linked to their own knowledge or level of intelligence, relying on their experience and that of their colleagues. The emphasis was on interaction within the group and how participants jointly constructed meaning (Leedy & Ormrod, 2019:245). This concurs with Saunders et al., (2019:803), who note that the focus is on enabling and recording interactive discussions between participants in order for participants to construct meaning together in a group. This was evident in the focus-group discussions.

3.4 THE RESEARCHER'S ROLE

The researcher has presented IST for 16 years and has been in nursing for 30 years, hence she is familiar with the environment of a hospital, nursing and where these nurses find themselves. As a nurse, she can identify with her participants and with IST within a hospital context. In choosing a qualitative approach for this study, the researcher aimed to gain an in-depth understanding of the experiences of nurses regarding IST

programmes at this public hospital in the Western Cape. The researcher is the clinical educator involved in structuring these programmes, and from the start of this research study was aware that her position, participation and perceptions might influence the process of the research from beginning to end. The researcher, being cognisant of this, put her knowledge and experiences aside and recruited a neutral, experienced interviewer, a labour relations officer, to do all the focus-group interviews for the study. This labour relations officer is often involved in recruitment and selection interviews. This ensured that confidentiality and trustworthiness were maintained throughout the study.

The researcher hoped that the results of this study would assist her to enhance the presentation of IST at her workplace. Collective understanding and experiences were shared by different categories of nurses within their areas of interest and work. The researcher was able to explore and describe the experiences, perceptions and views of these nurses contextually, as she understood their context. During the focus groups, participants could speak freely in the absence of the researcher. This process is called bracketing, discussed in the next section.

3.5 BRACKETING

According to Creswell and Poth (2018:78), bracketing occurs when the researcher sets aside her experiences, as much as possible, to obtain a fresh perspective on the phenomenon under study. The researcher needs to set aside her pre-understanding and should act non-judgementally and without any bias. Chan, Fung and Chien (2013:167), recommend four approaches for bracketing guided by reflexivity. This involves mental assessment and preparation before deciding on the research paradigm, deciding the scope of the literature review according to the prevailing gate-keeping policy, and planning for data collection, using semi-structured interviews. They conclude that bracketing personal experiences may be difficult for the researcher to implement because interpretation of the data always incorporates the assumptions that the researcher brings to the topic and might have the potential for lasting effects on the study. However, right from the start of this study, the researcher abstained from the recruiting process. She secured the services of an independent, neutral person, with many years of experience of interviewing, to conduct the focus groups. The researcher explained what the research was about, waited a while for questions or clarifications, and then left the interview venue. Throughout the research process, the researcher reflected on her role and possible bias that might occur, hence she was able to bracket herself out continuously. According to Brink et al., (2018:105), bracketing involves researchers' identifying and setting aside any preconceived beliefs and opinions they might hold about the phenomenon under study. The researcher identified what she expected to discover and deliberately put her ideas

aside, thus ‘bracketing out’ any preconceived ideas so that she could consider every viable perspective.

3.6 RESEARCH DESIGN

A research design refers to the entire process of research, from conceptualizing a problem to writing the narrative, not simply the methods such as data collection, analysis and report writing (Bogdan & Taylor, 1975, cited in Creswell & Poth, 2018:327). A research design describes the procedures for conducting the study, including when, from whom, and under what conditions the data will be obtained and analyzed for required information. The research design selected is determined by the amount of information available at the start of the research project. The researcher chose an exploratory, descriptive, contextual design (Jooste, 2018:332).

A qualitative explorative, descriptive and contextual design was chosen as the researcher required an in-depth understanding of the experiences and views expressed by the participants. By choosing this design, the researcher was able to meet the purpose of the study to explore the experiences of nurses regarding IST with deeper, more comprehensive insight (Jooste, 2018:332).

3.6.1 EXPLORATORY RESEARCH

Qualitative research is aimed at exploring what is not known. In this research, the researcher used exploratory research to try and find out the participant’s understanding of their perception of factors that may influence their behaviours regarding attending IST programmes at a public hospital in the Western Cape (Green & Thorogood, 2018:18). Ambiguous thoughts in the mind of the researcher contributed to an exploratory, descriptive, contextual design (Jooste, 2018:332).

A qualitative explorative, descriptive and contextual design was chosen as the researcher required an in-depth understanding of the experiences and views of the participants. By choosing this design, the researcher was able to meet the purpose of the study to explore the experiences of nurses regarding IST with deeper, more comprehensive insight (Jooste, 2018:332).

3.6.2 DESCRIPTIVE RESEARCH

Descriptive research is done to gain an accurate profile of events, persons or situations, by paying careful attention to detail from collection to analysis of data. The research questions in descriptive research are likely to begin with ‘what’ and ‘how’, as was the case in this study. What are the experiences of nurses regarding IST and how can IST be improved? Descriptive research may be an extension of a piece of exploratory research as the forerunner to a piece of explanatory research (Saunders et al., 2019:187). They might blend in practice, but descriptive research presents a picture of the specific details of a situation, social setting or relationship. Descriptive studies are used to describe the behaviour of a sample population. The three main purposes of descriptive research are describing, explaining and validating the findings. In this study, participants were expected to verbalise their experience of IST programmes in their current workplace and how they had reacted or not reacted or responded to these programmes (Saunders et al., 2019:636). Brink et al., (2018:107) refer to descriptive research as attempting to describe the lived experiences in the life of an individual, meaning what is happening and important in these experiences. Furthermore, the researcher is interested in ascertaining what alterations are needed from the participant’s perspective to change practice.

3.6.3 CONTEXUAL DESIGN

The researcher used a contextual design to explore and describe the data within the context of the participants’ environment where they practise as nurses and how they experience these in-service training programmes (Bryman & Bell, 2014:178). This concurs with Creswell and Poth (2018:316), who stated that the context has to be a particular set of conditions within which the strategies occur, specific in nature, and close to the actions and interactions. Extensive field data is utilised as the foundation for understanding users’ needs, tasks, intents and processes to design products and systems that meet both user and business needs. Contextual designs serve as a guide to analyse and present data, drive ideation from data, design specific product solutions, and discuss those solutions with customers. In this study, customers were the three different categories of nurses. The contextual design was used because the researcher wanted to understand and describe the real experiences of the participants in the context of their natural environment, which in this study, was a public hospital (Saunders et al., 2019:636). The researcher chose this design to contextualise and obtain a deeper understanding of the experiences of the nurses in the context of their work about IST.

3.7 RESEARCH SETTING

The research setting is the physical location in which data collection takes place (Brink et al., 2018:116). The setting where data was collected in this study was a public hospital in the Western Cape in South Africa. The site is a public hospital with a bed capacity of 344 and a nursing component of 318 nurses, made up of different categories. Categories included registered professional, staff, and auxiliary nurses. These nurses worked different shifts. Shifts are done in four groups, where group 1 works, for example, Mondays, Tuesdays and weekends during the day, and group 2 works the same nights on night duty. Groups 3 and 4 worked Wednesdays and Thursdays, day and night duty. This pattern is repeated per week and continues over a fixed period, until vacation or different types of absenteeism occur.

3.8 POPULATION AND SAMPLING

3.8.1 POPULATION

The population is defined as the entire group of people of interest to the researcher and who meet the criteria as stipulated by the researcher (Brink et al., 2018:132). Saunders et al., (2019:294) describe a population as “a full set of cases or elements from which the sample is taken”. The population in this study consisted of different categories of nurses permanently employed at a public hospital in the Western Cape, working day duty. Recruitment from the entire population included all the categories of nurses who were on day duty and available at the time of data collection. The number of nurses on day duty was 190. This included 72 professional nurses, 48 staff nurses and 70 auxiliary nurses. Of the permanent staff on the two shifts, there were 36 professional nurses, 24 staff nurses and 35 auxiliary nurses. The researcher recruited 23 registered nurses, 24 enrolled nurses and 24 auxiliary nurses who were on day duty to participate in this study. The nurses on long-term night duty are not involved in in-service training and therefore were excluded from this study. See Table 3.1 The table indicates the categories of nurses, the interview dates and the number of participants in the study.

Table 3.1 Study population

Categories of nurses	Focus-group interview date	Number of participants
Registered professional nurses	26 February 2019	8
	27 February 2019	8
	12 March 2019	7

Registered staff nurses	26 February 2019	9
	27 February 2019	9
	12 March 2019	6
Registered auxiliary nurses	26 February 2019	10
	27 February 2019	10
	12 March 2019	4

3.8.2 SAMPLING

The sample for this study was selected from the accessible population of the different categories of nurses working on day duty at a public hospital in the Western Cape.

"A sample is a part or fraction of a whole or a subset of a larger set selected by the researcher" (Brink et al., 2018:115). In respect of the population chosen for research, 'sampling' refers to the process of selecting the sample from the population in order to obtain information regarding a phenomenon in a way that represents the study population (Brink et al., 2018:115). According to Jooste (2018:335), sampling is the process whereby the subjects or participants are selected from the target population to ensure that the selected subjects or participants are representative of the total population. Leedy and Ormrod (2019:171) concur, stating that a subset of the population is used to gather data. The results of the representative sample were used to make generalisations about the population (Leedy & Ormrod, 2019:171).

Different sample designs are used which fall into two major categories, namely, probability and non-probability sampling (Leedy & Ormrod, 2019:172). For this study, non-probability sampling was used. Three common forms of non-probability sampling are convenience, quota and purposive sampling. Purposive sampling involves choosing participants for a particular purpose (Leedy & Ormrod, 2019:177). Purposive sampling was appropriate and used as pre-specified groups, divided into the different categories, were purposely selected from the population. This is the primary sampling strategy used in qualitative research. It means that the researcher selects individuals and sites for the study because they can purposefully give an in-depth understanding and share their individual experiences of IST to support the phenomenon under study (Creswell & Poth, 2018:326).

De Vos et al., (2011:232) say purposive sampling is also known as judgemental sampling. Purposive sampling is grounded on the judgement of the researcher, in that a sample is

characteristically representing the entire population. Focus groups can either be homogeneous, comprising people who share a common characteristic, such as a certain professional role, or heterogeneous, that is, people with diverse characteristics. The category chosen was homogeneous sampling as it focuses on one particular subgroup in which all the sample members are similar, such as a particular occupation or level in an organisation's hierarchy. In this study, the entire sample of the population selected were nurses, hence they were a homogeneous group, who all were expected to participate in their different categories as nurses in IST.

The researcher communicated the inclusion and exclusion criteria in the meetings and to the staff of the hospital. The sample size was 71 nurses, representative of all three categories. The researcher excluded herself from the selection and recruitment process to avoid the possibility of bias. It was also communicated to all the operational managers and shift leaders not to select attendees, but to allow all staff the opportunity to voluntarily agree to participate in the study. The advantage of purposive sampling is that the data collected is based on the rich knowledge and experience that these participants bring to the phenomenon under study (Jooste, 2018:338).

3.8.2.1 Inclusion criteria

- All three categories of nurses with at least two years of working experience in the public hospital
- Working day duty
- Registered with the South African Nursing Council in one of the nurse categories

3.8.2.2 Exclusion criteria

- Working night duty
- Nurses working through nursing agencies
- Student nurses

3.9 RECRUITMENT OF PARTICIPANTS

Recruitment started after ethics approval was obtained from the Cape Peninsula University of Technology, Faculty of Health and Wellness Sciences Research Ethics Committee (Appendix E). The researcher was granted permission by the CEO of the hospital (Appendix D) and introduced the study during the nurse manager and staff meetings. The information shared was what the study was about and the objectives to be achieved. The CEO, head of nursing, operational managers and nurses supported the study and expressed interest in the outcomes of the study. Bracketing was applied by all nurse managers being informed not to select staff to participate in the study. They could

share what the study was about, but needed to allow staff to volunteer to participate. Nurse Managers agreed not to influence those who wished to participate, but would release nurses who wanted to participate for an hour or two on the dates that data collection would take place. This was done to ensure all nurses had an equal opportunity to participate voluntarily in the study. Dates and times of interviews were communicated in meetings, as well as on notice boards in the hospital. Flyers with all information were distributed to different wards, the purpose of which was to inform and remind all nurses of the study and its purpose. On the morning of the set dates, the researcher reminded the staff via the hospital's public address system.

Prior to the commencement of the data-collection process, each participant received a detailed information letter about the study. Attached to the information letter, was a consent form (Appendix A), which had to be signed by all participants prior to participating in the focus groups. Participants also had to give written permission on the same consent form.

Night duty staff were not considered, as discussed in the exclusion criteria. In-service training is not formally structured for night duty staff and if any programme is offered, it is less detailed than programmes offered during the day. This is because of fewer staff on duty during the night shift. Hence, night duty staff cannot be removed from patient care activities for long periods of time to do IST.

3.10 METHODS OF DATA COLLECTION

Methods are techniques and procedures used to obtain and analyse research data, including questionnaires, observation, and interviews (Saunders et al., 2019:808). For this research study, data was collected by means of focus-group interviews, using an interview guide (Appendix C). Saunders et al., (2019:803) define a focus-group interview as a group interview composed of a small number of participants in which the topic is defined clearly and precisely and there is a focus on enabling and recording interactive discussions among participants. Each focus-group interview had a duration of 30–45 minutes. In qualitative research, data can be collected using individual or group interviews. Group interviews are also known as focus-group interviews. These methods are best for describing, contextualising, interpreting and gaining in-depth insight into a specific phenomenon. This was the rationale for choosing this method in order to gain insight into and understanding of the experiences of nurses regarding IST.

3.10.1 FOCUS-GROUP INTERVIEWS

Interviews are one method to gather data. Each participant was allowed a fair opportunity to talk with an experienced interviewer in the presence of a moderator.

3.10.1.1 Advantages of focus-group interviews

Advantages of focus groups are that data can be collected over a shorter period of time, as participants can be interviewed in groups. A focus group could consist of 5–10 members at a time. The participants share their thoughts, generate new ideas ad this can influence and enrich the data and even cause some members to change their views (Brink et al., 2020:144). The dynamics of a group could lead to more innovative and creative ways for the researcher to explore the topic in greater detail. The technique allows the researcher to develop an understanding of why people feel the way they do. Focus groups allow for probing. Hence, participants could be challenged or forced to think about others' view and possibly revise their own. Only a few general questions can be used as a guide, and this allows the group latitude for discussions. A moderator should always be present, as the moderator plays an important role in ensuring fairness prevails within the group setting and that all participants have an equal chance of voicing their opinions (Holloway & Galvin, 2017:60).

3.10.1.2 Disadvantages of focus group interviews

Disadvantages of focus groups are that they could be difficult to organise and it is sometimes problematic to get groups of people together at the same time. Securing agreement to participate and persuading participants to turn up are major challenges. Transcribing can be complicated, as people can talk 'over' one another, and one needs to note what was said, who said it, and how it was framed (Leedy & Ormrod, 2019:245). Participants could be uncomfortable to share views, but the interviewer were skilled to facilitate, as he was doing interview often.

3.10.1.3 Interview schedule

An interview guide (Appendix C) was formulated to ensure consistency and the same sequence of the questions during the interviews. Probing and summarising were also used where needed.

The following questions were asked:

How do you experience IST programmes at this public hospital?

How could we improve these programmes?

Probing questions (starting with why do you think – /tell me more –) were asked when necessary, if participants did not relay their experiences sufficiently.

Do you have anything else you want to add?

3.10.1.4 Probing

Probing questions are questions used to explore further responses that are of significance to the research topic. They may be worded like open questions, but request a particular focus or direction (Saunders et al., 2019:812). Probing involves the use of specific words or interviewing techniques to clarify or the elaboration of a person's response to a question. Probing assist participants to complete incomplete or irrelevant answers in a survey (Saunders et al., 2019:812). Qualitative studies using semi-structured focus-group interviews with general questions, would occasionally need probing to gather more information should a deeper meaning of the phenomenon be required. Probing helps to dig much deeper than the surface and allows participants to verbalise personal opinions, feelings, and experiences and as a group, construct meaning (Saunders et al., 2019:459). Probing questions are typically open ended, meaning there is more than just one response. Most probing questions begin with 'what', 'why', or 'how'. If you want the person you're asking to expand on their response, the use of the word 'exactly', or the phrase 'can you explain further', should get you there (Saunders et al., 2019:459).

Probing questions formed part of the interview guide. These were included in this guide to elicit the desired information (See Appendix C). An interview schedule was applied to all the groups. The moderator was a silent observer to ensure fairness within the group. The interviewer was expected to guide the discussions, asking the same questions in the same order, as per interview schedule (Appendix C). The interviewer was guided using the two general questions in the same sequence throughout all nine focus groups. Probing was used by the interviewer, encouraging participation by calling participants by their coded names when he saw that some were quiet and did not participate actively.

3.11 THE FACILITATOR/INTERVIEWER AND MODERATOR ROLE

3.11.1 THE FACILITATOR/INTERVIEWER ROLE

Focus group interviews were scheduled and communicated to all nursing staff at the hospital. Present at each interview were the moderator and the interviewer. De Vos et al., (2011:367) note a group facilitator is a moderator. In focus groups, the group facilitator

should be an experienced person with the necessary communication and group facilitation skills. This includes being friendly, having a sense of humour, being a good listener and participants feeling comfortable with him or her. In conducting a focus group, according to De Vos et al., (2011:317), the facilitator should be relaxed, in control, friendly, and should encourage participants to talk. Before conducting the focus-group interview, the facilitator needs to prepare him or herself mentally and be familiar with questioning, and at the same time able to listen and think. A warm and friendly environment puts participants at ease. It is also important that the interviewer provides ground rules, including an introduction and instructions regarding the study and its objectives. The interviewer was skilled and unassuming, and gave brief comments on the study. He was expected to guide the discussions, asking the same questions in the same order, as per the interview schedule (Appendix C) (Bryman & Bell, 2014:232). He is a senior staff member at the public hospital, but not involved with IST. Seating arrangements and the order in which to speak were not important, but each participant, before speaking, was requested to give their code name, for example, P5. This was emphasised by the facilitator. He also paid attention to the group dynamics. However, the moderator, whose role will now be discussed, was experienced enough to observe and intervene when required.

3.11.2 THE MODERATOR ROLE

The moderator was a silent observer to ensure fairness within the group and was present with all focus groups during the data-collection process. The moderator also observed nuances like body language and mannerisms, which could also enrich the data (Holloway & Galvin, 2017:60). The moderator was an expert nurse educator who was not employed at this public hospital. Field notes are defined (De Vos et al., 2011:372) as written explanation of the things you hear, see, experience and think during or reflection after the data collection process. She did not participate in the interviews at all, but made field notes on the non-verbal responses, mannerisms and posture of the nurses. Field notes included non-verbal behaviour such as eye contact, posture, gestures between group members, laughing, etc. (De Vos et al., 2011:372). Her role was to ensure a fair and equal process for participants and preventing the interviewer from leading any participant in answering the questions or completing the answers on their behalf. The moderator fulfilled her role in a professional manner, as required.

3.12 PROCESS OF DATA COLLECTION

Data was collected during February and March 2019. The dates were communicated for 26–27 February and 12 March in order to accommodate the two shifts for the nursing staff

on day duty. The venue and time for each interview were organised by the researcher, communicated at every meeting, and further reinforced by a flyer up to the completion of the focus-group interviews. The venue was the North Block Boardroom, where only the interviewer, moderator and participants were present. On the morning when the interviews had to take place, the researcher requested the switchboard operator to broadcast the sessions on the public address system of the hospital. Nurses per category met at the North Block Boardroom. On entering the boardroom, they could take a seat. Once they were seated, the researcher greeted them and explained the purpose and objectives of the study to every focus group. The researcher introduced the moderator and interviewer, and explained their roles and functions to the group. She explained the study and allowed the group to ask questions for clarification if needed. She also explained voluntary participation, informed consent, and interview commencement, and that participants could leave at any time without fear of reprisal. Written consent (see Appendix A) was obtained on the day of the interview from those participants who voluntarily signed consent and willingly agreed to participate. Participants were also asked to sign permission to be recorded, after which the researcher excused herself by leaving the boardroom, to prevent any intimidation or bias, as discussed in bracketing (refer to Section 3.5).

The interviewer explained that an Olympus digital voice recorder would be used to record the focus-group interviews. None of the participants objected to being recorded. He also explained the use of various codes by each participant per category, which were already displayed on the table in the boardroom. The professional nurses' code names were P1, P2, etc., for the number of participants. Registered staff nurses' code names were S1, S2, etc., and registered auxiliary nurses were A1, A2, etc. This was to protect the identity of participants. This process was repeated with each focus group. Each focus-group recording contains the exact words and expressions of all participants. These verbatim transcriptions include questions, answers, clarifications, and even non-verbal expressions such as laughter occurring during interviews. Each interview was planned for 60 minutes, but lasted between 30 and 45 minutes. This gave the participants and the interviewer enough time to share all experiences and suggestions. Interviews were conducted in English, as that is the language used in the workplace. It was also one of the inclusive criteria, namely, that participants should respond in English. All participants expressed their views clearly in English. The interviewer thanked all participants at the end of every focus group for participating in the study.

3.13 DATA SATURATION

Creswell and Poth (2018:318), describe data saturation as the point at which the researcher no longer finds new information that adds to the understanding of the research

question. Saunders et al., (2019:801) agree, asserting that data saturation is a stage when any additional data collected provides few, if any, new insights. Saturation of data occurs when additional sampling provides no new information, and when themes elicited become redundant and repetitive. Data saturation is reached when there is enough information to replicate the study, when the ability to obtain additional new information has been attained, and when further coding is no longer feasible. Failure to reach data saturation has an impact on the quality of the research conducted and hampers trustworthiness in qualitative research (Creswell & Poth, 2018:318).

Data saturation was reached when the moderator and interviewer indicated that no new data had emerged from the final focus-group interviews. Sufficient information had been gathered that could be used to replicate the study (Creswell & Poth, 2018). The researcher confirmed data saturation by immediately listening to the recordings of the focus-group interviews and becoming aware that after the nine focus-group interviews, no additional new information emerged. Saturation of data was reached and no further focus group interviews were planned.

3.14 DATA PROTECTION AND MANAGEMENT

It is important to ensure that all data collected is completely anonymous and that any 'key' to identify data subjects is not retained by those who control the data. The principle of data protection is that the data subject is not, or no longer, identifiable. There are various techniques to anonymise personal data, such as removing data subjects' names and other personal identifiers from documents and records, especially in reporting and video recordings (Saunders et al., 2019:278).

Data management is a requirement for managing data in an ethical and legally compliant way. This can be formalised in a data-management plan which outlines how data will be collected, organised, managed, stored securely, and backed up. Files should be properly labelled and securely stored. This includes all original data, in whatever format, and all transcriptions should be stored in a restricted, secure and safe place. Data held externally, as in using USB mass storage devices, is stored under the same conditions and password protected. The data collected and transcribed in this study was stored on a USB device and was password protected. Only the two supervisors and the researcher had access to the data. On completion of this study, all data will be stored in a locked, secure safe in the nursing department at the university where the researcher was a registered master's candidate at the time of data collection. The data will be kept for a period of five years. Only the researcher and her two supervisors will have access to the data while writing for academic journal publication. After five years, the data will be destroyed with due care, paper shredded (not simply discarded in a bin), and digital data

will be permanently deleted. At the end of each focus-group discussion, the interviewer explained this to all the groups. The management of data as noted above demonstrates how ethical concerns and principles will be adhered to throughout the study, as well as beyond the study, while the work is published.

However, the researcher plans to give feedback of the results to all stakeholders, including the research participants, at the public hospital via staff and management meetings.

3.15 MEMBER CHECKING

According to Leedy and Ormrod (2019:241), member checking is when the researcher asks participants to review interview transcripts in order to double check their accuracy or seek participant feedback and possible validation regarding findings. Saunders et al., (2019:808) refer to this as member validation. This is a process allowing participants to comment on what they have said and to correct data if they do not agree. Hence, data could be validated in this way. Member checking provides an opportunity for members to understand and verify what the researcher intended to do with the data collected. It gives them the opportunity to correct errors and challenge what could be perceived as misrepresentation. Member checking provides the opportunity to volunteer additional information which may be stimulated by the playing back of the recordings to some participants. In this way, the researcher could check with the participants whether what is reported on the recording, is in fact what they have said. This would provide participants with the opportunity to assess the accuracy of the data and preliminary results (Leedy & Ormrod, 2019:241). This can be done by various categories of staff requested by the researcher to listen to the recordings, thus ensuring that transcripts and interpretations did not misrepresent their views and opinions.

3.16 DATA ANALYSIS

Qualitative data analysis is interrelated and interactive in nature, as the process of analysis and interpretation already starts with data collection and moves back and forth. Qualitative data is derived from verbal and written words (Saunders et al., 2019:636). Qualitative data analysis involves organising what you have seen, heard and read, so that you can make sense of the data collected. The researcher can now categorise the data collected and search for patterns in them. Data analysis is done simultaneously with data collection (Jooste, 2018:29). Saunders et al., (2019:796), define analysis as the skill to classify data, and to explain or simplify the nature of the different parts and to link it as a whole.

The researcher gathered all the data collected over the timeframe of the focus-group interviews and listened to the interview recordings immediately. This activity was done repeatedly, initially for the researcher to get an overview of what the nurses said about their experiences and what they would suggest for improvement regarding IST. The researcher listened, transcribed verbatim, read, and interpreted before in-depth analysis took place. The researcher identified, monitored and recorded the findings or how themes appeared. The data was reviewed by the researcher until a common understanding was reached. Analysis of data entails contrasting and comparing the final data to determine which patterns or themes emerge (Brink et al., 2018:105). In qualitative data analysis, it is generally accepted that in order to analyse large amounts of non-standardised data, it is necessary to fragment such data by coding and reorganising it into analytical categories. It is important to maintain the integrity of the data (Saunders et al., 2019:643).

3.16.1 SIX STEPS OF THEMATIC ANALYSIS

Saunders et al., (2019: 669) explain King and Brooks' (2017), six steps for thematic analysis that are useful for qualitative data analysis. The following steps of King and Brooks (2017) were applied for the data analysis process.

3.16.1.1 Step 1

The researcher was required to familiarise herself with the data. She started becoming familiar with the data by immediately listening repeatedly to each recording, followed by transcribing it verbatim. The researcher transcribed the data herself, which allowed her to engage with the data intensively. This was followed by reading and re-reading the transcripts. The researcher could now categorise the collected data and search for patterns in them. Data analysis is done simultaneously with data collection (Jooste, 2018: 29). According to Saunders et al., (2019:796) analysis is the ability to break down data and to clarify the nature of the component parts and the relationship between them.

3.16.1.2 Step 2

Open coding is a strategy where the researcher first goes through the data with an open mind looking for various possible meanings and categories (Leedy & Ormrod, 2019:350). Open coding was used, as the researcher did not have pre-set codes, but developed and modified the codes as data was analysed. The researcher initially grouped what sounded like the same experience and ideas together. This was discussed with the research supervisors and with the participants as part of member checking. The coding was guided by words, phrases and experiences shared by the participants (Saunders et al., 2019: 669).

3.16.1.3 Step 3

The researcher searched for themes. A theme is a broad category of information incorporating several codes that appear to be related to one another and which indicate an idea that is important to the research question (Saunders et al., 2019:657). The first objective of the study explored the experience of nurses regarding IST. Participants' shared views were phrased with words of positivity and empowerment, but with some challenges, such as lack of communication. This was coded under one theme, 'experience', with subthemes. These subthemes were 'empowerment' and 'lack of communication'.

3.16.1.4 Step 4

In this step, the themes were reviewed. Some questions were asked by the supervisors in order for the researcher to understand what a theme and subtheme could look like and how the decision was reached; whether the theme was unique, or should it be moved or separated if there was any overlapping. At this point it was useful to gather all the data relevant to or associated with each theme. The data associated with each theme was colour-coded with the same colour across all the interviews (Saunders et al., 2019:669).

3.16.1.5 Step 5

In this step, the researcher needed to define and finalise all the themes and subthemes. The aim was to identify the 'essence' of what each theme entailed or what the data gathered from the participants implied regarding IST. The subthemes should interact and relate to the main theme and the themes relate to each other.

3.16.1.6 Step 6

This step concludes with the researcher compiling a research report (Saunders et al., 2019: 669).

3.17 CODING

Coding is an important means of managing data to facilitate retrieval under relevant codes. Coding is used to categorise data with similar meanings. Coding involves labelling each unit of data within a data item such as a transcript or document with a code that symbolises or summarises that extract's meaning (Saunders et al., 2019:653). Codes may be actual terms used by participants recorded in the data, while labelling is developed from the data and derived from existing theory or literature (Saunders et al., 2019:655). The researcher used coding while analysing the data. Hence the development of the themes.

3.17.1 THEMATIC ANALYSIS

According to Saunders et al., (2019:819) thematic analysis is a technique used to analyse qualitative data that involves the search for themes or patterns occurring across a data set. Thematic analysis involves a researcher's coding the qualitative data to identify themes or patterns related to the research question for further analysis. Thematic analysis offers a systematic yet flexible and accessible approach to the analysis of qualitative data. The nature and flexibility of thematic analysis mean that it is fairly straightforward to use compared with some other qualitative techniques. The procedure outlined involves various elements: becoming familiar with the data, coding the data, searching for themes and recognising relationships, refining themes, and testing propositions.

Refer to Chapter 4 for further discussion on coding and thematic analysis.

3.18 REFLEXIVITY

According to Creswell and Poth (2018:327), reflexivity is an approach to qualitative research in which the writer is conscious of the biases, values and experiences that he or she brings to the qualitative research study. In writing a reflective passage, the researcher discusses his/her experiences with the central phenomenon and then examines how these experiences may potentially shape interpretation. The researcher's background, perspective and position might affect or shape the research study. The researcher adopted reflexivity, as she reflected on her own background as a nurse for the past 30 years, and secondly her position as clinical educator for the past 16 years. The researcher was aware how these could influence the research process from her selecting the topic, choosing the methodology, analysing the data, interpreting the results, and presenting the conclusions, hence she also applied bracketing at all times(refer 3.5). The researcher achieved reflexivity, as she kept and maintained a reflective journal and always remained aware that her views were unimportant, as she did not want to influence the objectives and outcomes of the study. Reflexivity is an attitude of attending systematically to the context of knowledge construction, especially to the potential subjectivity of the researcher, at every step of the research process (Creswell & Poth, 2018:327).

Reflexivity is important, because if applied correctly, it can contribute to the accuracy of the qualitative research outcomes. Reflection enabled the researcher, within the context of her involvement with IST and as a nurse, to use the data purely to enhance trustworthiness. Reflexivity, together with the reflective journal, is just one way that qualitative research designs can address the bias that frequently permeates the socially dependent nature of qualitative research (Jooste, 2018:345).

3.19 RIGOUR IN QUALITATIVE RESEARCH

Trustworthiness was ensured by means of the criteria of credibility, transferability, dependability, and confirmability. According to Lincoln and Guba (1985), the key principle of good qualitative research is found in trustworthiness. According to Saunders et al., (2019:218) validation is the process of verifying research data, analysis and interpretation to establish their validity, credibility and authenticity. Two techniques to establish the quality of one's research are triangulation and participant or member validation.

Criteria are needed to assess or evaluate the quality of research. For quantitative research, the terms 'validity' and 'reliability' are critical. Qualitative researchers regard this as inappropriate in establishing the "truth value" of a qualitative research study and indicate credibility as the most important criterion (De Vos et al., 2011:419). Saunders et al., (2019:216) concur with qualitative researchers who have indicated other forms of generalisability that demonstrate the quality and value of qualitative research. The manner in which rigour is established in qualitative research is different from that in quantitative research. In qualitative research, trustworthiness is established through consistency, dependability, conformability, audibility, recurrent patterning, credibility, and transferability. The research proposal for the thesis was peer reviewed by four academics prior to acceptance at the university's institutional research and ethics committees. This is a rigorous review process with input from all the committee members on both the research and ethics committees. The researcher also used focus-group interviews, an acknowledged data-collection method in qualitative research. The researcher did member checking by inviting some of the participants from each category randomly to validate credibility as part of trustworthiness. This started with the researcher explaining the reason to the participants, followed by a discussion to draw conclusions.

The researcher compared her understanding of what a participant said or meant with the participant, to ensure that the researcher's interpretation was accurate. Interviewee transcripts were reviewed as a technique for improving the rigour of interview-based, qualitative research. Interview transcript review is a process whereby interviewees are provided with verbatim transcripts of their interviews for the purposes of verifying accuracy, correcting errors or inaccuracies, and providing clarification. This was done in this study, as all participants had the opportunity to view their transcripts if they wished to do so.

The concepts of credibility, transferability, dependability, and conformability are now discussed to illustrate how trustworthiness was applied and maintained throughout this study during the research process.

3.19.1 CREDIBILITY

De Vos et al., (2011:419) use the terms ‘credibility’ or ‘authenticity’. This is the alternative to ‘internal validity’, in which the goal is to demonstrate that the enquiry was conducted in such a manner that the subject has been accurately identified and described. The researcher enquires if there is a match between the research participants’ views and the researcher’s reconstruction and representation of them.

Saunders et al., (2019:217) concur that the representations of the research participants’ socially constructed realities should match what the participants intended. This correlates with the lengthy involvement required to build trust and rapport to collect sufficient data, check data, analyse data, and interpret data with participants. It is vital to ensure that the researcher’s preconceived expectations of what the research will reveal do not militate against the social constructions of the participants, by regularly recording these and challenging them during analysis of the data. Authenticity promotes fairness by representing all views in the research, raising awareness and effecting change, and it links to constructivism. The strategies for credibility applied by the researcher were prolonged engagement and persistent observation in the field.

The researcher achieved this, as she engaged with the data over a long period, during data collection and analysis. The researcher trained an independent person to do the interviews. The moderator was an external person, appointed in the interests of justice and fairness. Member checking was done, as the researcher liaised with the participants to verify the transcriptions. It was also done by talking about their understanding of their words and actions. Authenticity can be described as the meaningful descriptions which are obtained through participants’ experiences as expressed in the interviews. Each transcription was done and checked by the researcher in this study, which could be regarded as authentic and credible (Brink et al., 2018:171). Credibility cannot be attained in the absence of dependability (Polit & Beck 2017: 559).

3.19.2 TRANFERABILTY

Saunders et al., (2019:420) describe transferability as whether the findings of the research can be transferred from one specific situation to another. Saunders et al., (2019:217) note that transferability is tested when the researcher give a complete account or report of the whole research process from the problem statement to the findings to a new researcher to apply to another research setting. Transferability thus refers to the degree to which the research can be transferred to other contexts. This is defined by readers of the research. The reader notes the specific details of the research situation and methods, and compares them with a similar and more familiar situation. If the

specifics are comparable, the original research would be deemed more credible. It is essential that the original researcher supplies a highly detailed description of his or her situation and methods. Transferability essentially refers to the generalisability of the data. The depth and richness of the data allow for inductive generalisation from the sample to the population, and this is reached with data saturation (Jooste, 2018:353). Findings of research project can be used to compare own experiences in a significant way (Brink et al., 2018:171). The findings of this study will be applicable for use in the training units where IST is done at this setting and throughout other hospital settings provincially, nationally and globally.

3.19.3 DEPENDABILITY

According to Saunders et al., (2019:217), dependability in this context means the recording of all the changes to produce a reliable or dependable account of the emerging research focus that may be understood and evaluated by others. Dependability also implies that the process was logical, well documented and audited (Saunders et al., 2019:217). Shenton (2004:63) concurs with Saunders et al., (2019:217) that dependability states to how reliable or constant the outcomes or results would be if the study were duplicated in a similar context. The data presented and findings obtained should be able to stand the test of time. The dependability of the study will be enhanced by aligning the theory, methodology and analytical processes of the study. The findings of the current study will be published and presented to all relevant stakeholders. Dependability ensures the process is described in sufficient detail to facilitate another researcher to repeat the work or to replicate the study.

Dependability in qualitative research means the data and results obtained in a study are reliable and stable, and thus applicable to future similar studies. Dependability can be compared with reliability in quantitative studies. In other words, dependability can be viewed as an appraisal format to test the worth or reliability of the whole research process from beginning to end (Saunders et al., 2019:217).

3.19.4 CONFIRMABILITY

Confirmability guarantees or confirms that the findings, conclusions and recommendations are supported by the data. Saunders et al., (2019:421) concur with Polit and Beck (2018:560), that conformability check that the findings or results of a study can be approved or endorsed for its objectivity by another person. Beck (2017) stated that conformability is measured by the research findings in comparison with the data collected. In this study, conformability was achieved by associating objectives with the interview questions. Brink et al., (2018:111) concur with Polit and Beck (2017), that there

should be an internal agreement between the researcher's interpretation, actual evidence of the data and not the researcher's biases or perspectives.. Meanings emerging from the data have to be tested for their plausibility, their sturdiness, their 'confirmability', so that two independent researchers would agree about the meanings emerging from the data (Brink et al., 2018).

Within trustworthiness, confirmability should be a done to verify results. This criterion entails confidence that the research study's findings are based on the participants' narratives and words, rather than on potential researcher biases. Confirmability thus verifies that the findings are shaped by participants, rather than by a qualitative researcher (Jooste, 2018:355). This is a process to establish whether the researcher has been biased during the study, owing to the assumption that qualitative research allows the researcher to bring a unique perspective to the study. The researcher confirmed data collection with data analysis by member checking. This was done by asking a few different categories of nurses to listen to the focus-group interviews and verbatim transcripts, and to read the analysis.

3.20 ETHICAL CONSIDERATIONS

Research approval was obtained from the Research Ethics Committee of the Faculty of Health and Wellness Sciences at the Cape Peninsula University of Technology (CPUT), CPUT/HW-REC 2018/H15 (Appendix E). Permission was also obtained from the Department of Health, Western Cape, to gain entry to the public hospital. A request for a support and permission letter was submitted to the CEO and head of nursing of the public hospital, should any participant react negatively or sensitively to any of the focus-group interview questions. Permission was granted and counsellors on site at this public hospital were made available to all participants. Participants were also informed, if needed, to call the Employee Assistance Programme (EAP). Access to this supportive programme is known to all staff, as they are always informed that help is available to them in case of any challenges or issues. Participants were asked to sign written consent to be recorded and to maintain confidentiality (see information letter and consent form, Appendix A). All data were treated confidentially and anonymously through the research process.

Ethical principles applied and upheld throughout the duration of this study are discussed below.

3.20.1 INFORMED CONSENT

Together with the Informed consent form, it is vital to share the complete information and requirements to all participants of the research study. This was done for this study by means of an information letter, which contains a detail description of the study (Refer to Appendix A). A written informed consent form followed the explanation of the study and allowed participants enough time to ask questions or clarifications on any information. Afterwards they could make an informed decision to voluntary participate in the study (Leedy & Ormrod 2019:415). Consent was obtained by the researcher from the Research Ethics Committee, Faculty of Health and Wellness Sciences, Cape Peninsula University of Technology (Appendix E). Permission was also obtained from the CEO of the public hospital (Appendix D).

A detailed explanation of the research study and an informed consent form was explained to the participants. All participants gave written consent prior to the commencement of the study. They were informed that they had the right to withdraw from the study at any time, with no negative consequences. Participation in this study was completely voluntary (Appendix A). Informed consent was given when participants knew the nature of the study and they granted written permission by signing the informed consent form (Appendix A) for both participation and being recorded during the focus-group interviews (Leedy & Ormrod, 2019:112).

3.20.2 RIGHT TO PRIVACY AND CONFIDENTIALITY

The participants knew the nature of the study and were willing to sign informed consent. The researcher also informed the participants that any data collected would not be traceable back to particular individuals, thus keeping personal data confidential and maintaining participants' rights to participate (Leedy & Ormrod, 2019:239). Code names were used to protect participants' information and personal data. No names were linked with the interviews, and the participants were informed that codes would be used in the writing up of the research report. There was no association between the data and their names. The participants' names were replaced with the code and number in the order in which they were interviewed, e.g. P1, 2, 3, for professional nurses, S1, 2, 3 for staff nurses, and A1, 2, 3 for auxiliary nurses.

Grace (2009:98), declares that privacy is a broader subject than confidentiality. Leedy and Ormrod (2019:114), agree that confidentiality is broken when private information about a person is given to another person. Under no circumstances should a report be presented in a way for others to determine how a particular participant has responded or behaved. Privacy is compromised when someone else gains access to another person's personal information (Leedy & Ormrod, 2019:114).

The consent forms (Appendix A) will be kept in a safe in the Department of Nursing at the university where the researcher was a registered master's student for five years. They will then be destroyed. Findings were reported in such a way that there was no link to the identity of the public hospital or any participant. This protection of information was assured from the start, release and publication of this research.

Participants were informed that the data collected would be kept in a safe in the Department of Nursing at the university. The researcher and her supervisors would be the only persons with access to the stored data, which would be destroyed five years after completion of the study and resultant journal publications.

3.20.3 BENEFICENCE

Beneficence means maximising good outcomes for participants and minimising harm (Saunders et al., 2019:259).

The researcher explained to the participants that there would be no harm or hurt done to them. The only intention was to explore and describe their experience of IST programmes and to develop recommendations that could lead to guidelines to assist in their training. The researcher explained to the participants that participating in this study would allow them to express their views and experiences which could contribute to the improvement of attendance at IST in this public hospital. This would contribute to their professional and personal development. While each participant had the right to access their own information, the results of the study would be available to everyone without exposing any individual's personal details. Anonymity and confidentiality would be upheld and safeguarded at all times. Hence, no participant would be harmed or was harmed in this study.

3.20.4 NON-MALEFICENCE

Saunders et al., (2019:259) states that ethics are intended to avoid poor practice, malpractice and harm. In any research, the researcher should anticipate risk and attempt to avoid the possibility of causing harm. Non-maleficence means avoiding or minimising unnecessary harm or risk. Researchers should treat participants with respect. Participants were subjected to no risks in this study, but provision was made for a counsellor on site at this public hospital, or referral to EAP, should any participant react negatively or over sensitively during the interviews. In this study, no participant reacted negatively, nor was it necessary for any referrals to a counsellor on site or EAP off site.

3.20.5 AUTONOMY

Lategan and van Zyl (2018:101), declare autonomy to be independence of individuals to self-sufficiency and self-rule for making their own free choices or interventions, without coercion or undue influence. Essential to autonomy, is the need for full information so that the choice is informed. Participants were respected to choose to take part in the study or withdraw at any stage of the study without harm. All the participants participated of their own free will. These participants also signed written consent to be recorded during the interviews for transcription purposes. This ensured the individual's right to self-determination and individual liberty (Muller & Becker, 2016:110). Every participant had the right to express his or her viewpoint and understanding. This view was respected. Participants could withdraw at any stage of the study. This means their choice or decision was respected.

3.20.6 JUSTICE

The principle of fair or equal allocation of resources is referred to as justice (Muller & Becker, 2016:111). The researcher ensured a fair and equal opportunity to all the nurses on day duty to participate in the study. No favouritism was allowed. The researcher ensured that the selection of participants was based on the requirements of the research and that all participants met the inclusion criteria. All participants were treated equally and without discrimination. All nurses in the categories on day duty, who were available, could participate. No incentives were given to participants in this study. Participants were protected in each focus-group interview by being allocated a significant anonymous identification code as noted previously. All data were handled confidentially.

3.20.7 VERACITY

This means an obligation to tell the truth and not to deceive others (Muller & Becker, 2016:111). In this study, participants were encouraged to be open and share their experiences truthfully without any negative consequences. The outcomes of this study were dependent on what was being shared. The focus groups were done by a highly skilled and trained independent person. The researcher was not involved with the focus-group interviews at all, as she is the clinical educator and involved with IST at this hospital. Hence, she bracketed herself out all the time and stayed reflective throughout the research process.

3.21 SUMMARY

This chapter focused on the research methodology and design used in the study. The research setting and sampling were described. Trustworthiness, as well as the ethical

principles that were upheld throughout this study, were discussed in detail. The next chapter (Chapter 4) discusses the findings of the focus-group interview

CHAPTER 4

RESULTS

4.1 INTRODUCTION

This chapter presents the results from the focus-group interviews (FGIs) conducted in this research study. The knowledge, experiences, and views (opinions) of the participants, based on the questions asked during the interviews, are expressed. These are presented according to themes and further divided into sub-themes. Seventy-one nurses participated in nine FGIs at a public hospital. The purpose of the study was to explore and describe the experiences of nurses regarding in-service training at a public hospital in the Western Cape and to make recommendations to improve IST programmes.

4.2 BIOGRAPHICAL DATA

In this study, participants comprised registered professional nurses, coded (P), staff nurses (S), and auxiliary nurses (A). Their biographical data were collected at the start of the FGIs. Included in this data were their age, gender (F – Female and M – Male), years of employment (Employ), area of work or department, and whether they attended IST (Y – Yes and N – No), as well as how many topics they had attended in the last six months.

Seventy-one nurses, comprising three different categories, participated in the focus-group interviews. There were 23 registered professional nurses, 24 staff nurses, and 24 auxiliary nurses. Gender comprised 67 females and 4 males. Their ages ranged from 26–59 years and length of employment from 2–39 years. Areas of work were maternity, with 25 participants. Maternity included the antenatal, postnatal, neonatal, and labour wards. Other participants included 12 from the surgical wards, 11 from the medical section, 8 from paediatrics, 3 from the emergency centre, 4 from the outpatient department, 4 from the operating theatre, 3 from the mental health section and 1 from the infection prevention and control section of the hospital. Attendance of participants at any IST programmes over the last six months also varied from 0–6 sessions, with two participants not attending any IST.

Table 4.1 Registered professional nurses – code name P

Participant	Age (years)	Gender	Employment (years)	Area of work	Attended IST	Number of topics attended in last 6 months prior to interviews
P1	57	FEMALE	6	OPD	YES	2
P2	34	FEMALE	8	MAT	YES	6
P3	52	FEMALE	31	SUR	YES	1
P4	47	FEMALE	24	MAT	YES	3
P5	38	FEMALE	9	MED	YES	3
P6	33	FEMALE	5	OT	YES	4
P7	31	MALE	4	MAT	YES	6
P8	56	FEMALE	30	MAT	YES	2
P9	26	FEMALE	4	MAT	YES	0
P10	33	FEMALE	8	PAEDS	YES	1
P11	52	FEMALE	6	OPD	YES	4
P12	51	FEMALE	33	MAT	NO	0
P13	44	MALE	9	MED	YES	2
P14	54	FEMALE	35	IPC	YES	3
P15	48	FEMALE	7	MED	YES	0
P16	59	FEMALE	37	OPD	YES	0
P17	48	FEMALE	27	EC	YES	5
P18	28	FEMALE	2	PAEDS	YES	3
P19	43	FEMALE	5	MAT	YES	4
P20	44	FEMALE	13	MAT	YES	3
P21	54	FEMALE	9	MAT	YES	4
P22	37	FEMALE	8	SUR	YES	4
P23	40	FEMALE	8	MED	YES	4

Table 4.1 displays the registered professional nurses. Gender included 21 females and 2 males. Ages ranged from 26–59 years and their years of employment varied from 2–37 years. Their area of work was 9 from maternity, including antenatal, postnatal, neonatal, and labour wards. Others were 2 from surgical, 4 from medical, and 2 from paediatric wards, 1 from the emergency centre, 3 from the outpatient department, 1 from the operating theatre, and 1 from the infection prevention and control section of the hospital. Attendance at IST over the last six months varied from 0–6 sessions, with 1 participant who indicated no attendance during the last six months.

Table 4.2 Registered staff nurses – code name S

Participant	Age (years)	Gender	Employment (years)	Area of work	Attended IST	Number of topics attended in last 6 months prior to interviews
S1	39	FEMALE	2	PAEDS	YES	3
S2	38	FEMALE	3	PAEDS	YES	2
S3	33	FEMALE	6	OT	YES	3
S4	59	FEMALE	39	SUR	YES	2
S5	45	MALE	5	EC	YES	1
S6	44	FEMALE	6	MAT	YES	4
S7	38	FEMALE	4	MAT	YES	4
S8	28	FEMALE	5	MED	YES	3
S9	44	FEMALE	3	MAT	YES	5
S10	36	FEMALE	4	OPD	NO	0
S11	40	FEMALE	4	MAT	YES	4
S12	37	FEMALE	5	SUR	YES	2
S13	32	FEMALE	3	MAT	YES	0
S14	54	FEMALE	25	MAT	YES	5
S15	38	FEMALE	6	MED	YES	2
S16	44	FEMALE	12	MED	YES	2
S17	58	FEMALE	8	MAT	YES	5
S18	34	FEMALE	3	MAT	YES	4
S19	44	MALE	9	EC	YES	0
S20	54	FEMALE	33	MAT	YES	4
S21	47	FEMALE	27	SUR	YES	2
S22	39	FEMALE	13	SUR	YES	3
S23	46	FEMALE	4	MED	YES	3
S24	43	FEMALE	8	MAT	YES	1

Table 4.2 displays the registered staff nurses. There were 24, of whom 22 were female and 2 were male. Their ages ranged from 28–59 years, and years of employment varied from 2–39 years. Their main area of work was 10 in the maternity (antenatal, postnatal, neonatal, and labour) wards. The rest of the participants were 4 from the surgical, 4 from the medical, and 2 from the paediatric wards, 2 from the emergency centre, 1 from the outpatient department, and 1 from the operating theatre. Participants attended between 0–5 IST sessions over the last six months, except for 1 participant, who indicated that she had not attended any IST sessions in the last six months

Table 4.3 Registered auxiliary nurses – code name A

Participant	Age (years)	Gender	Employment (years)	Area of work	Attended IST	Number of topics attended in last 6 months prior to interviews
A1	36	FEMALE	7	OT	YES	4
A2	30	FEMALE	3	PAEDS	YES	2
A3	57	FEMALE	9	PAEDS	YES	2
A4	35	FEMALE	5	MED	YES	3
A5	31	FEMALE	9	SUR	YES	2
A6	56	FEMALE	8	MAT	YES	3
A7	39	FEMALE	8	MAT	YES	3
A8	42	FEMALE	5	MAT	YES	1
A9	41	FEMALE	15	MH	YES	7
A10	41	FEMALE	3	SUR	YES	4
A11	53	FEMALE	2	SUR	YES	1
A12	55	FEMALE	30	MAT	YES	4
A13	41	FEMALE	4	OT	YES	1
A14	51	FEMALE	29	SUR	YES	2
A15	35	FEMALE	8	MH	YES	2
A16	38	FEMALE	7	MAT	YES	3
A17	39	FEMALE	8	MH	YES	2
A18	29	FEMALE	2	MED	YES	0
A19	33	FEMALE	8	SUR	YES	0
A20	33	FEMALE	4	PAEDS	YES	2
A21	29	FEMALE	9	PAEDS	YES	3
A22	45	FEMALE	5	MED	YES	1
A23	50	FEMALE	8	SUR	YES	5
A24	46	FEMALE	3	MAT	YES	3

As indicated in Table 4.3, the registered auxiliary nurses comprised 24 females. Their ages ranged from 29–57 years and years of employment varied from 2–30 years. Their areas of work were 6 from the maternity section, which included antenatal, postnatal, neonatal, and labour wards. There were 6 from surgical, 3 from medical, and 4 from the paediatric wards. Two worked in the operating theatre, and 3 in the mental health section. Attendance at IST over the last six months also varied from 0–5 sessions.

4.3 DATA PRESENTATION IN THEMES

Categories of nurses	Focus-group interview date	Number of participants
Registered professional nurses	26 February 2019	8
	27 February 2019	8
	12 March 2019	7
Registered staff nurses	26 February 2019	9
	27 February 2019	9
	12 March 2019	6
Registered auxiliary nurses	26 February 2019	10
	27 February 2019	10
	12 March 2019	4

Nine FGIs were conducted, comprising 23 professional, 24 staff and 24 auxiliary nurses. All focus groups were audio recorded using an Olympus digital hand recorder. Each participant was assigned a code name as follows: P1–P23 for professional nurses, S1–S24 for staff nurses, and A1–A24 for auxiliary nurses. Each participant was assigned an individual number. During data analysis, five themes emerged, and various subthemes were developed after coding. A semi-structured interview schedule (Appendix C) guided the process. Two general questions were asked of all participants in the same format and sequence, and recorded accordingly. All recorded FGIs were transcribed by the researcher. Transcriptions were verified though member checking. Coding and interpretation were done by the researcher, with the help of her supervisors. However, she also liaised with the moderator when she deemed it necessary. Thematic content analysis and coding were employed to analyse the data. The following themes were evident, and subthemes emerged in the discussions. Three themes and ten subthemes emerged (refer to Table 4.4 below.)

Table 4.4 Themes and subthemes

Themes	Subthemes
1. Experience of the planning of IST programmes	Fear of possible medico-legal risks or litigation Assessment of training needs Involvement of staff in IST programmes

2. Experience of the implementation of IST programmes	Time IST topics Knowledge and skills Staff shortages Workloads Decentralised training
3. Communication	Lack of communication and information Feedback Request for IST on night duty

4.4.1 THEME 1: EXPERIENCE OF THE PLANNING OF IST PROGRAMMES

4.4.1.1 Fear of possible medico-legal risks or litigation

Some participants stressed the point of IST being essential for the protection and safety of their patients, but leaving the ward could also cause medico-legal incidents.

IST is a must it is a must at any institution, also keep nurses out of the court… (P3:FG1)

… we don't want to leave the ward something might happen (P22FG3)

…I don't know if we are just protecting our patients more like that side… (P15:FG2)

…we can give that holistic save patient care… That is why in my ward is very important we have more nurses they must be alert more vigilant patient is not breathing if the patient went to the toilet… (P13:FG2)

…sometimes got new difficult to send the older staff the ones we have for long we do miss out sometimes just because you feel it's your responsibility is to cover the ward…(P20:FG3)

The IST … remind ourselves that proper way of doing things… (P22:FG3)

…older staff …we do miss out sometimes just because you feel it's your responsibility is to cover the ward… (P20:FG3)

IST is very good because it can make me to be more confident… in the ward …can see the signs of the patient who want to abscond so we are taught how to deal with the patient so you must do this and this to prevent abscondment (A11:FG2)

… if there is incidents in the ward what to do, it is good if like my colleagues say… I found out that you know all these things but you also not applying it the way you should but when you get to sit in class and then things are clear and light for you then you I've been doing things the wrong way (A19:FG2)

…when the management try to defend us, they can't because there is nothing they can use to defend us… (A22:FG3)

…worked outside my scope of practice what about every something go wrong who will cover me but that time you don't think about it you think about the work must be done …That why I say IST is very important, refresh our mind every time, don't do that, do the right thing... (A23:FG3)

…I can say I think out of every ward they must at least send one or two people to attend, it must be a must to attend the IST (A21:FG3)

…you did not even record now so it is very important to do things in a good manner when you are working (A24:FG3)

4.4.1.2 Assessment of training needs

Participants assessed their training needs as follows:

…is good basic nursing care, we all need basic nursing care, but we have different levels in the hospital… you feeling the same very inexperienced I feel the CSPN actually need a lot we need a facilitator (P17:FG3)

…you really need to focus on the level of our specialty (P21:FG3)

…that pertains to the kind of work that we also do and things that we deal with in the ward… (P9:FG2)

…they need to be that their level educational wise so that when they come and they are sisters after the four year that they done at least they have insight…(P19:FG3)

…can categories the different sections so we can understand the things they are going through… (P22:FG3)

…they can't say they are so busy they can't attend and the in service training is for ourselves, she helps us but they don't help themselves… (A23:FG3)

…. our managers in the ward they must take it seriously. If they want us to take it seriously. They must force us to go downstairs for the IST. …because our management they are not they don't care about this… (A22:FG3)

mostly private, they going to school and some of them are bridging, they never stop bridging, while we would stop bridging. They never stop, they continue (A1-FG1)

3 years ago when they were telling us about this bridging course and not being able to go, if you wanted to do something else, you cannot do something else… (A7:FG1)

I think because why the sisters when they want to learn more, they have chances to go learn A5:FG1)

they are not sending us to school… I don't think we do have that opportunities like nurses to go and study by ourselves (A9:FG1)

4.4.1.3 Involvement of staff in IST programmes

Participants revealed that they would like to be involved.

There is experienced people here, she doesn't need to hire people to come give lectures… the experienced people we have here can give IST (P1:FG1)

…get the provider of the IST to move into theatre and then also, just a suggestion that for paediatrics and neonates, get somebody in the program to have things related to paediatrics... (P3:FG1)

…information here they take that and put it on the board ask the colleagues to write down which in-service training they will they allocate themselves (P11:FG2)

… involve more people on different level, facilitator on different level I think to involve one facilitator that's involved with education… it will be too much… (P19:FG3)

… why not involve us, we want quality nurses here… focus on…specialty side and involve us … (P21:FG3)

Where specialty is concerned I think we in our department to be involve in IST, not just in our level…ask someone in the unit can you present this topic next month or next two weeks ask the person… (P17:FG3)

…our operating manager ask senior registered nurses to do in-service training, nurses also to give us in-service training teach us a lot, …also got a book in the ward sign the book if we can't attend in-service training (S4:FG1)

…the time you say let's go train, others said I didn't even go, why you must go… (S17:FG2)

Also the IST that we are attending I feel like we can most of us all included, we must all know it so we can educate it for our patient… (S24:FG3)

I am allocated to do IST with the staff because there is patients with certain diagnosis… sometimes we need read on that knowledge (P17:FG3)

Get people from outside give us IST about the IV fluids and all of that when is the drip out left or when is a drip left recordkeeping out we can do it in our sleep (A1:FG1)

get people from outside like maybe people that are orthopaedic trained to show us how to do all this stuff give us training about …so I can that is how we can improve some (A10:FG1)

4.4.2 THEME 2: EXPERIENCE OF THE IMPLEMENTATION OF IST PROGRAMMES

4.4.2.1 Time

Some participants divulged that training does not start according to the scheduled time.

…about the time you send the nurse to the IST at 9 but the IST start at 0930 because of the other people from the other wards they come so late to attend the IST (P3:FG1)

…be on time because that is the other thing the training does not start on time (P12:FG2)

Commencement of IST does not match available time in the wards

… Early mornings, we not busy early mornings in the morning we start at 8 if we can have IST (P1:FG1)

Normally that time we are very busy in the wards, so sometimes we don't have time to attend IST at that time, if they can change the times it can be better for us (S8:FG1)

…change the time most of the time is 10h00-11h00 can she go to 14h30 the ward is mostly it's very busy (A19:FG2)

Participants commented on the duration of the IST programmes:

…timeframe I think 11 let us start at 11 and lunchtime is 12 for me we don't need more than an hour for (P3:FG1)

The time and the period of the IST it's too long (S2:FG1)

I think they must change the time because that time we are busy in the ward and it's difficult to attend the IST (S8:FG1)

I also second about the time We have three days for theatre Monday, Tuesday and Thursday it's a busy day (S9:FG1)

… we are busy there in the ward then we can't come here to the IST (S7:FG1)

That thing also of the time …can better time manage, the time if we say 10 o clock it must be 10 o clock till half pass the others can also come, like not 10 until 11, then the others won't be able to come (A5:FG1)

… I think she can change the time they must change the time (A9:FG1)

4.4.2.2 IST topics

Participants' opinions about the topics offered during IST were as follows:

The person providing the training is doing all the necessary steps to keep you on par and is related into the nursing and it is nothing outside that is not related to nursing actions (P3:FG1)

…you learn a lot…she gave you a chance to ask her and she gave you an answer in a way that when you come out of the in-service training you clear… (S12:FG2)

We don't miss anything what we have been taught by the trainer… In fact …it helps me a lot…I applied the information (S17:FG2)

Topics are too general – need to include specialty/outside.

The training here focus on the adult absolutely nothing on neonates training or paediatrics (P8:FG1)

…ICU trained in a specialty department, advanced midwifery we need to balance it's not just basic nursing care… (P17:FG3)

…. give us proper IST. Get people from outside give us IST about the IV fluids and all of that when is the drip out left or when is a drip left recordkeeping out we can do it in our sleep (A1:FG1)

Topics are too long or too short:

The time and the period of the IST it's too long (S2:FG1)

…we can attend for 2 days the same thing; you come to understanding, you can manage better, they must be longer (S13:FG2)

…time is very short…. stick on a topic and make it practical for us… (A10:FG1)

For me if they can repeat this IST twice a month's (some response at the back saying JA) infection control we can attend for 3 times not just once (A12:FG2)

Topics are repeated too often:

…because we have the same old topics every year… (A1:FG1)

…recordkeeping this Thursday and next Thursday again, you won't have excitement or interest, so they must change the topics regularly as A5 said so give us the IST and give us the skills (A9:FG1)

…repeat the same thing every time the next month is record keeping and the following month its record keeping again, they can also teach like computer so we can gain skills we not gaining anything skills (A5:FG1)

Participants reflected and expressed IST to be informative and good:

I experience it as very informative because even if I send my nurses to IST they come back and do the information they gained by the IST they received (P1: FG1)

It's very informative firstly and secondly there's topics we don't sometimes that we don't even know about so we get to increase our knowledge and skills by entering IST (P17:FG3)

…I can agree with my a fellow colleagues in-service training empower you with a lot of new knowledge and it actually keeps you updated with new developments sometimes there is new developments in the our nursing career and that's very good and you learn a lot and it benefits you in the wards (S16:FG2)

In-service training is very good… You learn a lot… (S11:FG2

Most of the participants referred to IST being a refresher.

…so IST is a form of refreshment…it is form of skilling our people to get that necessary knowledge for our patients to give our patients holistic save patient care (P13:FG2)

… you know so it is a refresher for us but it has to be broaden in a way because it helps a lot (P19:FG3)

In-service training is very good and she is refreshing your brain (S15:FG2)

…it is refreshing the minds and go back in time …You learn a lot and it is good thing as I said just that update (A14:FG2)

4.4.2.3 Knowledge and skills

Other participants said they gained knowledge that they could apply practically.

I can agree with my a fellow colleagues in-service training empower you with a lot of new knowledge and it actually keeps you updated with new developments sometimes there is new developments in the our nursing career and that's very good and you learn a lot and it benefits you in the wards (S16:FG2)

IST it is really for me you do expand your knowledge and the passion and everything but we need to focus on our level of our specialty (P21:FG3)

It's good for in-service training just because we learn a lot and it make us to do the total nursing care properly to our patients…I applied the information (S17:FG2)

…all in all it's quite good…and you learn a lot and it is good thing as I said just that update (A14:FG2)

The experience here is very good because you learn a lot of things you don't know (A1:FG1)

Very informative. You learn things that you forgot, so you just refreshers your mind to better care for your patients… (A21:FG3)

It's very informative firstly and secondly there's topics we don't sometimes that we don't even know about so we get to increase our knowledge and skills (P17:FG3)

…they can also teach like computer so we can gain skills we not gaining anything skills… (A5:FG1)

…do most practical… even if the other things are not our scope of practice how to handle a patient on a blood transfusion… (A12:FG2)

The IST is good because we learn a lot …you get the skills there, (A9:FG1)

4.4.2.4 Staff shortages

Participants had the following to say regarding staff shortages:

…I am the only one the only registered nurse and the OM (P16:FG2)

…we have shortages of staff in the ICU there's only 2 so one can't go (P12:FG2)

That is why in my ward is very important we have more nurses they must be alert more vigilant patient is not breathing…. (P13:FG2)

I cannot attend in-service training I work alone to relieve me (S5:FG1)

…shortage of staff …they must try to minimize the shortage of staff and absenteeism (S17:FG2)

The other problem actually sometimes the program that is like on the IST you really want to go, but sometimes the staff shortage in the wards don't allow you to come IST (S16:FG2)

There's sometimes that our management in our ward can't send us, because there is nobody to go… (S14:FG2)

…if we could maybe have more staff on duty or more staff to be appointed then we have more time to come to IST (A1:FG1)

4.4.2.5 Workloads

Workloads in the various departments posed a major issue:

Sometimes the clinics are very busy in the morning out patients there is no time to come to come to in-service (P16:FG2)

…I agree …we become so busy in the ward (P9:FG2)

…we are very busy in the ward sometimes then we cannot attend the in-service ….. (S8:FG1)

…we are busy there in the ward then we can't come here to the IST (S7:FG1)

I think maybe if our supervisors can change the time because it's very early and at 10 o'clock we are very busy in the wards, maybe the afternoon can be used (A2:FG1)

…the nurse must go there and the others must go there and we don't have the chance…to the IST… (A5:FG1)

…sometimes we escort and then you can't leave the agent behind, (A9: FG1)

4.4.2.6 Decentralised training

Some participants requested the IST to take place at ward level.

…we don't get time to come down if we could get the same, someone to come to us and we get the IST before we start working … (P6:FG1)

…duty but I was on last year on seven months night duty there nothing on night (P12:FG2)

…do IST for night duty people also …at least we can also be on the same page like the others …at least you know something because you went to IST (A18:FG2)

I also feel that its beneficial especially for the lower categories, they also get to know the documentation, and all that things so when they come to the wards you don't expect them to know what they are doing it makes the workload little bit lighter for me as a registered nurse especially cos we don't always have time to show them (P18:FG3)

…because in my department there are people permanently night on night duty, they are missing out… (A13:FG2)

…I was on last year on seven months night duty there nothing on night (P12:FG2)

…get reallocated then we have that knowledge and that skill because we sometimes get reallocated form medical to surgical and we've been working in medical…. (P13:FG2)

…can improve in the ward what we do… (P16:FG2)

4.4.3 THEME 3: COMMUNICATION

4.4.3.1 Lack of communication and information

Participants declared not being informed of in-service training sessions/schedules, nor having received a training programme.

My experience with in-service training is we I didn't get information as supposed to … (P11:FG2)

…we don't have that list of in-service training… (P15:FG2)

…they don't tell you in time like by the time of the IST you will be called that… (P10:FG2)

…nurses have a tendency of not checking the notice board (P13:FG2)

… you don't know what they are going to talk about, you are not prepared but if they can just tell us in time (P10:FG2)

Several commented that the same nurses attend IST every time, leaving some never to receive training and consequently to remain out of date.

…everyone will get equal opportunity and will get empowered to give proper care to our patients (P11:FG2)

We must all be included not certain people must go… (S24:FG3)

Sometimes it is the same person going every week (all agreed in saying JA in the back round) … so the others don't get a chance (A21:FG3)

Every day so the manager must send the name of the person who is supposed to attend (A23:FG3)

4.4.3.2 Feedback

Participants highlighted the importance of feedback to other colleagues who did not attend:

…when that one goes to learn when she comes back she gives us feedback… (P11:FG2)

… tell the people that you work …. with there this is what you must do with this documentation… learn the stuff to teach the people that you work with also… (P20:FG3)

…people just go there and they come back and they say nothing. When we have meetings, nobody is saying anything to the ones who didn't attend the service training… (PFG1)

you are able even to help those who did not even attend the in-service training in the ward when you back in the ward you can teach the others how to do the new things that you get in the in-service training (S13:FG2)

Also the IST that we are attending I feel like we can most of us all included, we must all know it so we can educate it for our patient, I'm feeling that in this IST almost we must all be included not certain people must go because things are changing, maybe you are just doing it by your mind and you no longer know it, you forgot some of the things (S24:FG3)

never got feedback from them and what I would suggest is also that they come up with new topics for IST, like I said we don't work in the same ward every year, every day… we don't know that things, because we have the same old topics every year (A1:FG1)

…come to the nurses and ask guys what are you interested in doing this week, what IST can we do this week… (A5:FG1)

Try and listen to the nurses and ask us what is making us happy because they will never ever ask us, they just telling us what to do, they just giving orders (A10:FG1)

I am happy that we have this research because at least we express our feelings (A5:FG1)

…help with my staff morale, if they can attend it every time… (P1:FG1)

For some topics like BLS is there a certificate form of motivation…I think also as a motivation if you have regularly attended (P14:FG2)

…IST that have certificates (A7:FG1)

…is important for us because at the end of the day it will help with my staff morale, if they can attend it every time… (P1:FG1)

…most of the time when you go there, the nurses don't attend the IST, she must make sure the nurses attend, if you go there is only 2 nurses the Om (A20:FG2)

4.4.3.3 Request for IST on night duty

Some participants requested IST to take place on night duty.

…we don't get time to come down if we could get the same, someone to come to us and we get the IST before we start working … (P6:FG1)

…duty but I was on last year on seven months' night duty there nothing on night (P12:FG2)

…do IST for night duty people also …at least we can also be on the same page like the others …at least you know something because you went to IST (A18:FG2)

…because in my department there are people permanently night on night duty, they are missing out… (A13:FG2)

4.5 SUMMARY

This chapter presented the results obtained from the data collected in the focus-group interviews. The biographical data of the participants were summarised. The themes and subthemes that emerged from the transcribed data were presented. The next Chapter will outline and discuss the results of the study.

CHAPTER 5

DISCUSSION OF RESULTS

5.1 INTRODUCTION

In this chapter the results of the focus-group interviews are discussed. The purpose of the study was to explore the experiences of nurses regarding in-service training (IST) at a public hospital in the Western Cape.

5.2 PARTICIPANTS' BIOGRAPHICAL DATA

Biographical background data were collected at the beginning of the focus-group interview (FGIs). Seventy-one nurses, comprising three different categories, participated in the focus-group interviews. There were 23 registered professional nurses (P), 24 staff nurses (S), and 24 auxiliary nurses (A). Included in this data were age, gender (F–Female and M–Male), years of employment (Employ), area of work/department and whether they had attended IST (Y–Yes and N–No), as well as how many topics they had attended in the last six months. Gender comprised 67 females and 4 males. Their ages ranged from 26–59 years and length of employment from 2–39 years. Areas of work were maternity, with 25 participants. Maternity included the antenatal, postnatal, neonatal, and labour wards. Other participants included 12 from the surgical wards, 11 from the medical section, 8 from paediatrics, 3 from the emergency centre, 4 from the outpatient department, 4 from the operating theatre, 3 from the mental health section and 1 from the infection prevention and control section of the hospital. Attendance of participants at any IST programmes over the last six months also varied from 0–6 sessions, with two participants not attending any IST.

5.3 THEME 1: EXPERIENCE OF THE PLANNING OF IST PROGRAMMES

During this overarching theme, the participants relayed their experiences regarding IST programmes. Participants identified the importance of professional development and in-service training at the workplace in order to upskill themselves on a regular basis. However, participants reported a decline in the emphasis on professional development and in-service training of nurses at the hospital where they were working. This corresponds with a study done by Harrington (1989:28-31), at a private hospital in South Africa where there was a similar decline in IST programmes. Delport et al., (1989:26-27)

also investigated in-service training and conclusions from this study highlighted that in-service training improved the quality of nursing care, hence IST is deemed important.

Poggenpoel et al., (1985) developed nine recommendations for effective IST, used as a frame of reference for IST in the current study. IST in nursing is seen as essential in assisting all categories of nurses to stay updated with current developments and to enable them to accomplish the demands of nursing practice. The first objective of the study is discussed below, as it relates to the experience of nurses regarding IST. The following subthemes emerged from this overarching theme and are deliberated in the following sub-sections.

5.3.1 FEAR OF POSSIBLE MEDICO-LEGAL RISKS OR LITIGATION

Participants P3, P20, A11 and A21 stressed the point of IST's importance for the protection and safety of their patients. However, leaving the ward to attend IST could result in medico-legal incidents should too few staff be available to cover the ward to render patient care.

Research indicate a noteworthy relationship between outputs in quality patient care, education and training of nursing staff. The requirement to improve educational results and outputs, along with major changes in medical care, validates the expansion and administration of new medical models for nursing that need to be adopted and included in the curricula for the training of all categories of nursing staff (Chaghari et al., 2016:498). Participants P3, S8, S17, A21, A22, and A23 suggested that IST is essential, important, and good, and needs to be ongoing, in order to learn and overcome their fears of possible risks and medico-legal hazards. In-service training (IST) also addresses inadequacies in capabilities of nurses to equip and empower them for changes applied by the nursing services and to cope and prevent risks before complications arise. Booyens & Bezuidenhout (2014:258), concur with Muller (2009:351), that IST is invaluable and will contribute to mitigating the fear of possible medical legal risks or litigation. IST training should include changes in legislation and the use of information technology in nursing in order for nurses to be aware of medical legal hazards and to practise safely within their scope of practice and ethical legal parameters (Letlape et al., 2014). Hence, continuous in-service training is required on these aspects to assist nurses to cope, supervise and modify their clinical practice, as changes are inevitable. Hindrances and challenges should be discussed and addressed through the processes of planning to implementation (Letlape et al., 2014).

According to Jooste (2018:249), the perseverance of education and training of nurses is to ensure an organisation proves and pledge to continue to improve the capabilities and

capacity of its healthcare professionals. Performance monitoring of individuals and groups is essential for all stakeholders involve in organisations. Nursing care also happens within a team function. Muller, (2009:351) agrees that the more nurses attend IST, the more effectively nurses will function within a team context in a unit, and members will be able to empower and learn from one another.

According to Booyens and Bezuidenhout (2014:262-265), the connection between the quality of patient care and how much nurses know and how well they execute their duties, cannot be ignored. Organisations who coach and do a great investment with ongoing education and training, receive rewards and results. This is shown and becomes known and visible through excellent patient care. Education and training serve as a motivator to do their best (Erasmus et al., 2009:3; Booyens & Bezuidenhout, 2014:262-265). Participants (P3, P15, P20, P22, A11, A19 and A23) declared that IST programmes empowered them to manage risks before complications occurred or prevented them from happening in the first place.

5.3.2 ASSESSMENT OF TRAINING NEEDS

During the interview, while asking participants what their training needs were, they responded as follows:

Participant A23 declared that nurses should be motivated to help themselves to develop. They cannot be too busy to attend IST programmes, as IST is for their own self-development. Participants P9, P17 and P21 identified themselves as appropriate resources to assist with the IST programmes to cover their needs. They noted that the current IST programmes were too general with regard to the presentation of topics. Their training needs were more advanced than those of general nurses. Muller (2009:351), agrees that a learning needs assessment should be done prior to the development of IST programmes.

Past experiences and existing knowledge are integrated into new content and contribute to learning to equip themselves better to manage life situations (Knowles, 1980, cited in Muller & Becker, 2016:506). The nurse educator should apply the principles of adult learning when presenting programmes. This includes using their experience and building on what they know, whether it is a task, problem or life orientation. Individual nurses have an obligation to determine their own learning needs by applying self-directed learning. After assessment of these needs, they can establish the resources needed and available to meet these needs (Letlape et al., 2014). Polit and Beck (2010:36), affirm that because nursing is outcomes or evidence base practice driven, nurses should be engaging in self-directed learning and continuous development activities, to ensure that their training

needs are met to stay updated with the transformation in nursing. Jooste concurs (2018:275), that adult teaching principles should be considered: adult learners need to know why they should learn something, and be self-directed and involved in their own learning.

Jooste (2018: 256), claims the importance of nurses' development in healthcare units cannot be underestimated. Participant A22 requested managers to take IST seriously and care about the development of their staff. She claimed that this would also encourage lower category nurses to value IST. This statement by Participant A22 concurs with Jooste (2018:256), that healthcare managers are responsible for giving their members opportunities for continuous learning. Jooste (2018), further contends that in nursing development, the emphasis is on translating knowledge, principles, skills and theory into clinical practice, aimed at producing quality client care.

Nurses should be considered adult learners and active participation in the learning process should be encouraged. In this study, participants identified themselves as resources to assist with planning, implementation and evaluating of IST programmes. Participants verbalised this need and were keen to be actively involved in planning and implementing these programmes, despite their experiencing challenges overall. This concurs with the framework of Poggenpoel et al., (1985:49), recommending that trainers can plan more effective IST programmes with the assistance of IST committees. Professional nurses with specialised skills should be included on these committees as they could actively contribute to IST programmes. Muller et al., (2019:370) said personnel should be involve to do self- evaluation of their knowledge, skills and use every chance they get to share it with other staff. This will assist them to become lifelong learners.

Chaghari et al., (2017) conclude that all possible methods be taken to endorse and encourage empowerment and competency among employees, thus contributing the organisation to achieve its goals. One such measure is that in-service training is applicable to update staff's occupational knowledge and professional skills. Active involvement of nurses in in-service training can lead to effective learning. Involvement of staff in such programmes is the utilisation of adult learning principles, learning objectives and guiding their own learning. Nurse education and training programmes should be practical and comparable to their job description. The need to enhance the effectiveness of in-service training of nurses therefore is an inevitable requirement for the design for a new optimal model for in-service training of nurses.

5.3.3 INVOLVEMENT OF STAFF IN IST PROGRAMMES

Participants revealed a need to be part of IST in the workplace. Participants P17, P19, P21, S4 and S24 made it known that involvement in presenting IST would make them

feel more inclusive and interested in updating their knowledge and skills. This coincided with a study done by Nel (1986), that the involvement of staff members regarding relevant needs for in-service training, management's involvement, improvement of presentation and the availability of adequate resources, are important. Jooste (2018:150), agrees that leaders play an essential role in achievement of learning goals and needs. Poggenpoel et al., (1985), in their eighth recommendation, agree with Nel (1986), and suggest that methods such as self-experience exercises, simulation and even role play could be used more often to enhance IST presentations. Letlape et al., (2014), revealed in a study that that all nursing staff, irrespective of their category, should take responsibility and be accountable for the presentation of IST. They concluded that the aim of IST should commence with IST needs assessment firstly and secondly the method of presentation of all the programmes. All nurses should acknowledge the importance of IST and all the benefits it holds for all stakeholders, either presenting, or attending (Letlape et al., 2014). This will allow for more involvement by all nursing staff at the workplace.

Furthermore, P1and A1 agreed that more experienced people could be included to give IST. Planning for in-service training and inviting external and experienced presenters will contribute to the success of any such programme. Bloor et al., (2004:39), recognised nurses as the most important asset for organisational transformation, as they are the staff able to query outdated practices and welcoming current and updated ways of treatment and training. This was also illustrated in this study by P11 and S13, as they expressed a need to teach other colleagues how to do new things that they had learned in IST. This concurs with Poggenpoel et al., (1985:49), who agree that feedback is needed from nurses attending the in-service training programmes to eliminate negative factors involving training. By giving feedback to colleagues who were unable to attend, others are empowered and stimulated to want to attend IST.

Norushe et al., (2004:70) also alluded to some advantages that psychiatric nurses experienced regarding in-service training. These findings included empowerment, quality care rendered to patients, and a general improvement of work. They also suggested that in-service training should be presented by all categories of nurses. Their study also found that IST holds many personal and professional benefits for nursing staff, although challenges are present and should be dealt with accordingly. The participants raised many reasons why they considered in-service training to be advantageous to their careers. In this current study, participants concurred with Norushe et al., (2004:70), as P11 and S16 said that they felt empowered after attending IST, while P11, P13 and S17 noted how they had learned so much about rendering quality care to their patients. Participants also mentioned how they improved their work relationships with colleagues in a therapeutic environment. They also felt encouraged and motivated to further their studies and they were eager to keep their knowledge and skills up to date, while they also

learned to work more independently (P11, P13, P16, P17, P18, P19, P22, S10, S15, A13, A14, A21, and A23).

Respect and relational understanding are some benefits mentioned in this study. The relationship between superiors and subordinates is improved because of continuous in-service training (Erasmus et al., 2009). Participants in this study concurred that respect or relationships are important ingredients, and A22 felt the manager should be supportive of IST to encourage attendance, whereas P11 disclosed that the manager should communicate immediately to the staff when information is shared. This will allow shift leaders enough time to ensure IST attendance by the staff on their wards/units.

The physical benefits of in-service training believed by participants in the study by Norushe et al., (2004), were a reduction in staff injuries and patient injuries. Therefore, in-service training assisted psychiatric nurses to share information and skills in order to deliver quality services to patients and their families, thus leading to a decrease in patient injuries as also found in a study by Kneisl and Trigoboff (2009:22). In the current study, most participants (P1, P5, P13, P17, P20, S14, S16, S17, A1, A9, A11, A18 and A23) mentioned gaining and sharing knowledge and skills do assist in the reduction of patient injuries and litigation against nursing staff.

The psychological advantages of in-service training raised by participants were a feeling of more confidence and an increased ability to manage stress and anxiety (P18, P19, S4, S12 and A11). Participants stated that some challenges they faced preventing them from attending in service training were ignorance of their individual training needs, no motivation and replication of topics (A5, A9 and A12), added were limited opportunities for staff to express their needs with regard to in-service training, limited resources, and a lack of planning (A9, A10, and A22).

Participants in this study recommended exactly what the participants in the study by Norushe et al., (2004) recommended for the improvement of in-service training. This includes the involvement of staff members regarding in-service training. Training should be based on needs. Points noted were: recent and interesting topics, exemplary and proactive management, in-ward in-service training, and centralised in-service training, presentation improvement for the trainers, learning resources should be made available, planning for in-service training, and external presenters or experienced facilitators to present some of the specialised topics.

Farzi et al., (2018) explored the challenges of clinical education in nursing and strategies to improve it. Their findings concur with those of Nel (1986) and Bloor et al., (2004) that employing experienced clinical educators is vital to enhancing IST. Suggestions included enhancing the learning environment, developing the relationship between faculty and

practice, participation of clinical nurses in clinical education, and paying attention to how participants behave when they enter these programmes. Participants in this study agreed that the clinical educator is one of the main components of education. He or she needs to pay attention to effective clinical education principles to ensure the transfer of learning does take place. During this current study, participants (P19, P20 and P23) described the clinical educator at this health facility as very passionate and that she always focuses on quality patient care.

Farzi et al., (2018) had similar findings in their study, which also recommended that the orientation at the beginning of training can improve the clinical education of nurses. The above findings were also true for this current study, as the participants indicated that all nurses should be included in IST in order for them to stay abreast of changes and new knowledge in the clinical environment. Participants P1, P11, P17, P21 S24, A5, A10, and A22 also pleaded that they should be consulted regarding appropriate topics for presentation. They do not wish just to be told what topics will be presented, but would like to be part of the decision making. The framework of Poggenpoel et al., (1985) also suggests that nurses should be consulted regarding topics and participation in order to make IST a success. Hence, Poggenpoel et al., (1985) suggest consultation with in-service training committees consisting of nursing managers, professional nurses and teachers in nursing, in order to plan more effective in-service training programmes. Attention should be given to the fact that nurses' high workloads could possibly interfere with their attendance at in-service training programmes. It is important that these factors be considered when planning in-service training programmes for nurses, in order to allow them to attend (Poggenpoel et al., 1985).

5.4 THEME 2: EXPERIENCE OF THE IMPLEMENTATION OF IST PROGRAMMES

5.4.1 TIME

Time was one of the barriers that hinder effective IST and should be addressed by the clinical educator and the broader organisation**.** Participants revealed that the time of IST commencement, the length or duration of the topic, and short notifications for attendance, were all challenges they faced regarding IST. Information is not disseminated timeously on topics, who can attend, and how long the training will be. Commencement of IST does not match available times in the wards according to participants P1, S7, S8, S9, A9, and A19. Participants also commented on the duration of the IST programmes. Participants P3, S2 and A5 noted they were too long, while S13, A10 and A12 found them too short.

Amerioun et al., (2012) proposed that the success of in service training is proven with an appropriate training need assessment to form the basis for programmes. Once the needs were determined, an assessment should be done to decide on an acceptable time and

space for training to take place. Furthermore, managers' supervision of employees and their encouragement will prompt nurses to participate in in-service training courses. Amerioun et al., (2012), suggest that the best time for nurses to participate in IST needs to be established. A suitable and appropriate system for scrutinising the quality of in-service training courses is vital. Their findings concur with those of this study. Participants P1, S8 and A19 stated IST takes place during the busiest times in the wards and departments, which practically made it impossible for staff to attend. Similar to the study of Amerioun et al., S7, S9 and A5 also verbalised the challenge of not being able to leave their work areas, but indicated timeframes when their ward activities would allow them to attend IST should be considered. Participants A5, P3 and P12 referred to poor time management, as training is planned to start at a specific time, but participants arrive late and delay the presenter from starting on time. Participants P3 and P12 also divulged that the training does not start according to the scheduled time. These statements by the interviewees coincide with the suggestion of Amerioun et al., (2012) of monitoring and evaluating the quality of IST, which will include timeframes.

5.4.2 IST TOPICS

Nearly all the participants stated that the topics were refreshing, empowering and very good. Several participants added that IST was useful, they gained knowledge and it could be applied practically. The relevance of topics presented during IST was also mentioned during the interviews. This varied somewhat among the different categories and also among the different wards and departments. The professional nurses found topics during IST too general, as many of them are specialist nurses, in, for example, paediatrics, neonatal care, and advanced midwifery. These professionals (P8 and P17) wanted to have more updates on their various specialties in order to stay abreast of developments. They felt this was lacking in the IST programmes at this workplace. The lower categories, for example, the auxiliary nurses (A1, A5 and A9), felt that IST is repetitive and not varied enough for them to learn new skills and obtain new knowledge. They were ready for the next challenge of gaining more knowledge on advanced procedures like intravenous therapy and blood transfusions, despite these being beyond their scope of practice. They were tired of doing record keeping over and over again revealed that they could do it …*in their sleep already* (A1). Khomeiran et al., (2006:69) identified the following factors that influence healthcare workers' further development: curiosity, readiness to know more about work-related issues, and willingness to ask questions. This was clearly illustrated and verbalised by the auxiliary nurse categories as mentioned above. They were motivated and eager to learn more. They seem to be ready to accept further responsibility and accountability for patient care. Participants found topics to be informative and often learned new skills and information, so they valued this as part of their continuous development and updating of their skills and knowledge. Nursing managers who invest in

ongoing IST are rewarded with better patient care, because nurses will become more motivated to perform to the best of their ability.

According to Chong et al., (2013:1) CPE attendance was highest when the topics reflected the needs of the nurses. A low attendance rate could be due to programmes not based on nurses' learning needs and time constrains. Specialist nursing topics were rated important, and this was reflected in this current study when participants P17 and P21 indicated the need for specialisation topics. CPE providers should examine critically the existing education approach and explore more innovative teaching methods such as e-learning and self-directed learning, taking a problem-solving approach. Collaboration among nursing leaders in every area is vital to improve our practice.

5.4.3 KNOWLEDGE AND SKILLS

Participants were happy with the trainer who provided the training. They agreed that she was doing everything necessary to update and keep them abreast of new knowledge and skills. She is knowledgeable and confident to answer all their questions. After IST, participants were clear on procedures, what is expected of them, and how to apply their newly learnt knowledge. A study by Willets and Leff (2003:237-243), concluded that their training programme was effective in increasing the knowledge and skills of these nurses. Munro et al., (2006), Lam et al., (1993:233-237) and Gournay (2000:243-249) all found that in-service training increases the knowledge and skills of staff members. This was also the case in this study where participants P1, P17, S11, S16, A1, A14, and A21 agreed that IST increased their knowledge and skills. In this study, participants also agreed that IST was refreshing and stimulated their brains to think deeper as stated by participant S15.

In-service training must be task and results oriented. Van Dyk et al., (2001) concluded that the focus of IST should be to enhance those specific skills and abilities needed to perform the job and should make a real contribution to the improvement of the quality of psychiatric nursing care (Van Dyk et al., 2001:3). Personal characteristics like self-motivation of practitioners influence their readiness to participate in learning activities.

Ridge (2008:28) cited in Booyens and Bezuidenhout (2014), describes rapid changes in medicine, treatment modalities and medical technology that happen on a daily basis. Hence, it is required that nurses and healthcare personnel will have to undergo professional development and education on a continuous basis in order to stay abreast of new developments. Participant S16 stated that *I can agree with my fellow colleagues in-service training empowers you with a lot of new knowledge and it actually keeps you updated with new developments; sometimes there is new developments in our nursing career and that's very good and you learn a lot and it benefits you in the wards (S16:FG2)*. Satisfaction of patients

with the care rendered would appear to play an important role in motivating healthcare workers to develop themselves in order to render better patient care (Khomeiran et al., 2006:69). Participants A10, A12 and S13 indicated IST programmes would help them to manage better if programmes were either longer, repeated and practical. Learning computer skills was important for these nurses, especially in the light of changing technologies and record keeping. They were eager to learn computer skills and to update their knowledge and skills in this regard.

5.4.4 STAFF SHORTAGES

According to Muller et al., (2019:239) shortages due to emigration of doctors and nurses to countries abroad places severe constraints on the provision of healthcare services. Hennie Bierman, head of the Solidarity Occupational Guilds, quoted in Slabbert (2019), declared a critical shortage of nurses in South Africa. Statistically, for every one nurse there are 401 patients, and this has an impact on the quality of care. In this report a heavy workload, shortage of staff, lack of support and challenging work circumstances are some factors mentioned which closely coincide with the participants of this current study.

According to Jooste (2018:249), the purpose of nurses' training programmes is to enable the organisation to show a commitment to developing its healthcare professionals. It also encourages them to realise the need to improve their own and other individuals' performance. These training programmes support the development of employees in order to improve the performance skills of individuals, teams and healthcare organisations as a whole. According to Jooste (2018:217), human assets, as opposed to some other resources, can increase in value owing to training, development and experience that enables the acquisition of skills and abilities. Hence, enough staff should be distributed in order to render quality patient care. However**,** a number of participants in this study (P12, P13, S14, S16, S17, and A1) revealed that more staff were needed to allow attendance at and participation in IST. Owing to staff shortages, some participants indicated that they were working alone in a ward or unit, hence making attending these IST programmes impossible (P12, P16 and S5) and also making themselves prone to mistakes which could lead to putting patients at risk. This could also lead to litigation issues for these nurses. Nursing shortages continues to be a threat in the healthcare system. Creating a culture of staff development is one way to combat skill shortages (Booyens et al., 2019:219).

5.4.5 WORKLOADS

High workloads (38.9%) and unsuitable times (19.2%) were indicated as main factors for poor attendance of IST according to Poggenpoel et al., (1985). These were the same

findings in this current study, where participants (P9, P16, S7, S8, A2, A3 and A9) indicated being very busy when IST programmes were presented.

The major indirect result of shortages of staff revolves around the increased workloads experienced by remaining staff and the consequential remedies management has to seek, often without consideration the quality of work life (Booyens et al., 2019:239). A study by Karaman (2011:1), on nurses' perceptions of online continuing education, provided learners with a variety of benefits such as convenience, flexibility and opportunities to work collaboratively. Online education has considerable potential for nursing staff to participate in continuing education. This study also concluded that owing to intensive workloads and shifts, it was very difficult for nurses to attend face-to-face classes. Advanced online learning technologies are indispensable, particularly for nurses, because of the need for life-long learning and professional development as mentioned by participants in this current study. Participants were faced with challenges like time constraints and staff shortages leading to excessive workloads, as mentioned in this study.

Coventry et al., (2015) in their study on the organisational impact of nurse supply and workload on nurses' continuing professional development opportunities, concluded that culture, leadership and workload issues impact nurses' ability to attend continuing professional development. The consequences affect competence to practise, the provision of safe, quality patient care, maintenance of professional registration, and job satisfaction, recruitment and retention. Organisational leadership plays an important role in supporting attendance at continuing professional development as an investment for the future. According to Muller et al., (2019: 355), individuals can only perform well if managers foster an environment that is challenging and conducive to producing a high standard of work. This environment includes opportunity and capacity from managers and a willingness from individuals. This coincides with the findings of this study, where participants reported that they need buy-in and support from management from top to operational level in order to make it possible for all staff to attend IST.

Workloads in the various departments posed a major issue as revealed by participants P1, P9, P16, S7, S8, and A2, who stated that they were very busy in the morning and that they had no time to attend IST. The wards also have busy routines in the morning, hence they cannot afford to leave and attend IST. Nurses are also expected to escort patients to other hospitals and departments, for example, radiology or operating rooms, as there is a lack of porter staff as stressed by participants A5 and A9.

Poggenpoel et al., (1985:49) also mentioned nurses' high workloads to be taken into consideration, they have the possibility of interfering with attendance at IST. IST should therefore be planned in such a way that nurses are able to attend.

5.4.6 DECENTRALISED TRAINING

Poggenpoel et al., (1985:49) advised appropriate strategies should be employed to encourage active participation in training programmes. The blackboard should be integrated with other teaching aids to ensure more effective teaching, such as simulation, where nurses are totally involved in the learning. In-service trainers mostly use formal lectures as a method of teaching. Lectures are not viewed as the most effective way of adult teaching because they do not bring about optimal participation in the learning process. It is critically important to consider the preferences of nurses in the methods of training to ensure their involvement in their own development (Poggenpoel et al., 1985:49). Some participants (P6, P16 and P18) requested that IST should take place at ward level. Participants felt that if IST were brought back into the wards, they could even get trained first thing in the morning. The lack of IST for those that have to do night duty was mentioned by participants P6, P17, A13 and A18. One of the participants (P12) indicated while she was on night duty for seven months, she did not learn any new skills or knowledge, as no IST is offered to night duty staff. It is important to reinforce nurses' attitudes that in-service training is of value for professional growth and enrichment of knowledge (Poggenpoel et al., 1985), so all shifts and categories of staff have to be included in IST. They miss out on learning new knowledge and skills, as alluded to by Muchinsky et al., (2003) and concurred with by Poggenpoel et al., (1985), who say in-service training is one of the activities in the workplace that keep nurses informed and equip them to perform to the best of their abilities. The professional nurses alluded to the fact that they do not have time to teach lower categories on the wards, owing to hectic time schedules and rosters. One of the professional nurses (P18) admitted that if staff were allowed to attend IST, it would assist her with her teaching function. Similarly, P13 agreed that it would also help with re-allocation in the case of staff shortages. 5.5 THEME 3: COMMUNICATION

5.5.1 LACK OF COMMUNICATION AND INFORMATION

Some participants (P11, P15 and S24) declared that they are not informed of in-service training sessions/schedules, neither do they receive a training programme, or have any input into IST as mentioned by S24. This corresponds with Nel et al., (2005), who state that advertising well in advance is vital to get maximum attendance at these programmes. Emails, posters on notice boards and reminders regarding IST programmes should be communicated at all meetings, prior to hosting training. Circulating eye-catching flyers at least two weeks in advance could also assist in advertising these programmes. Put up notices in high-traffic areas, such as in rest rooms, on bulletin boards and in staff lounges, and ensure that adequate seating and sufficient copies of handouts are available on nurses' arrival (Abruzzese, 1996:284). However, participants P11 and P15 confirm the findings of Lagrimas-Botha (2015:22), where only a small percentage of community

service professional (CSP) nurses were cognisant of an IST programme. Lack of communication, immense workloads, less time allocated, patient care priorities, and their exclusion as CSP nurses were the same reasons mentioned by the professional nurses in this study. A total of 40 participants (83.3%) knew that the health facility had an in-service training programme, while the remaining 8 (16.7%) participants indicated that they were not aware of an in-service training programme at their facility. This may be due to the lack of communication of the training programme to the staff by the senior registered nurse of the department. Because of the immense workloads of health workers in the departments, there is less time allocated to in-service training, as patient care is prioritised. Even where there is a designated training department in the hospital setting, CSPs in the hospital setting may also experience a lack of communication regarding available training. Of the 40 participants that indicated that there is an in-service training programme at the health facility, a total of 56.3% (*n* = 40) reported that in-service training was made available to the CSPs. In this study, nurses also tend to ignore notice boards as stated by participants P13 and A21. Keltner et al., (2011:117) state both verbal and non-verbal communication skills are important. Thus, creating awareness is vital at meetings, but nurses should be reminded of the programme on notice boards. This will ensure equal access when known to all, and not only will certain staff be aware of IST. This will allow more nurses to attend. Participants P11, S24 and A21 clearly alluded to this and concur with Keltner et al., (2011:117) regarding equal access and clear communication. These findings were also prevalent in Abruzzese (1996:284), who suggested the use of billboards and notice boards to advertise IST timeously in order to encourage more nurses to attend.

5.5.2 FEEDBACK

Feedback is needed from nurses attending in-service training programmes to eliminate negative factors involving training (Poggenpoel et al., 1985:49). Participants P11, P20, S13 and A1 highlighted the importance of feedback to other colleagues who did not attend. This kind of feedback can also happen in formal and informal meetings, as alluded to by the professional nurses. This will assist all categories of staff to assist and educate patients and it will enhance the quality of nursing care. According to Muller and Bester (2016:520), patient education is a responsibility that is often neglected in healthcare, yet it forms part of a healthcare practitioner professional and legal responsibility and failure could be regarded as professional neglect. Those staff members who are fortunate to attend training should report and give feedback to colleagues who were unable to attend. This is a similar finding to that in a study done by Kneisl and Trigoboff (2009:22) with psychiatric nurses. After attending IST, these psychiatric nurses had to go back and share the information and skills they had learned in order for all staff members to be on par to deliver quality services to their patients. This also concurs with the fourth and ninth

recommendations of Poggenpoel et al., (1985) that alludes to quality patient care and negating negative factors if continuous feedback and updates happen.

Needham et al., (2005:649-655) investigated the effect of a training course on aggression management of patients, and findings indicated improvement in the nurses' perceptions of and tolerance towards patients after receiving a training course. This confirms the importance of in-service training for psychiatric nurses (Needham et al., 2005). Hence feedback is important, so that all staff can be up to date. Poggenpoel et al., (1985: 51) also suggest that nurses should be rewarded when participating actively in IST, instead of obtaining only enrichment from IST. IST should be correlated with quality patient care and cost effectiveness. These rewards could increase morale as mentioned by P1, and could be something tangible, for example, the issuing of certificates, as stated by P14 and A7.

5.5.3 REQUEST FOR IST ON NIGHT DUTY

Participants P12, S11, S18, A7, A13 and A18 noted that while on night duty, they cannot attend IST. They described this as a big disadvantage. Participants felt that the topics covered in IST led to an improvement in patient care, as nurses were less anxious. Improvement in the quality of care increased as they became more knowledgeable on the topics and could apply what they had learned. Their confidence increased, leading to less anxiety and stress, and improved skills, while rendering care to the patients. All participants concurred with Jooste (2018:273), that IST programmes maintained and increased employees' ability and competence in performing the tasks assigned to them, thereby assisting the organisation in achieving its goals and objectives. IST is a set of systematic and planned educational activities designed to improve employees' performance in the workplace, thereby increasing productivity and quality of services provided if the topics presented meet the needs of the staff who attend (Jooste 2018:273). Hence, night duty staff are severely disadvantaged when they do not have opportunities to attend IST.

5.6 SUMMARY

In this chapter, the results of the study were discussed. The findings were compared with the reviewed literature. The recommendations as a theoretical framework of Poggenpoel et al., (1985) were also applied to the study. In Chapter 6, conclusions, recommendations, and limitations of the study, as well as possible future research and benefits emanating from the study, are discus

CHAPTER 6

CONCLUSIONS, RECOMMENDATIONS, LIMITATIONS AND SUMMARY

6.1 INTRODUCTION

The purpose of this study was to explore the experiences of nurses regarding in-service training (IST) and to develop recommendations for the in-service training unit in a Western Cape public hospital to support the training needs of nurses.

The objectives of this study were to:

- Explore and describe the experiences of nurses regarding current in-service training programmes offered at a public hospital in the Western Cape and
- To develop recommendations for the in-service training unit at a public hospital in the Western Cape, to support training needs of nurses.

Chapter 1 gave an overview of the research study. This was followed by a relevant literature review in Chapter 2. Chapter 3 discussed the methodology and design adopted for the study. An analysis of the findings was presented in Chapter 4. In chapter 5 the results were discussed. This chapter notes the limitations of the study, benefits to both staff and the organisation are highlighted, as well as potential topics for further research. The study concludes with recommendations.

6.2 CONCLUSIONS

OBJECTIVE ONE

The first objective of this study was to explore and describe the experiences of nurses regarding current in-service training programmes at a public hospital in the Western Cape.

From the findings of the study:

- The participants described their experiences of current IST programmes positively.
- Participants mentioned gaining and being empowered with knowledge, skills, experience and information.

- Participants also shared that IST was like a refresher course, as it served as a reminder of what they had learned earlier and kept them updated.
- Participants declared that current IST was very applicable and practical.

However, staff were unhappy regarding the nature of topics and lack of time to attend IST, and fearful of medical legal hazards occurring if only a few staff were left to render patient care while others were attending IST. Staff also indicated that they would like to be part of arranging IST, as they are specialists in some fields and could contribute to these programmes. The first recommendation of Poggenpoel et al., (1985) suggests that in-service trainers can plan more effective in-service training programmes with the assistance of in-service training committees consisting of nursing managers, professional nurses and teachers in nursing. This is what came to light in this study as well. The Skills Development Act 97 of 1998 is the primary legislation restructuring the country's national education and training system (Booyens et al., 2019:224). Currently a skills development committee exists where all categories of staff are represented. This skills development committee, currently functional, could be formally constituted as the committee tasked to assist with IST at this institution, as well as helping to do in-service training needs identification. This is a platform where training needs could be submitted.

In-service training should be planned to be effective to skill the nurse to meet personal and professional goals. It should be focused on the identified training needs, therefore cannot be done randomly. According to the participants in this research, in-service training should not be the responsibility of only the professional nurses or unit managers, but of all the nursing staff in the unit, including students. The focus should not only be on the importance of in-service training, but also on needs identification and the presentation of in-service training. If all the categories of nurses know what in-service training is, its importance and how they will benefit from either presenting or attending, this will improve the planning and conducting of in-service training. A suggestion box is recommended where nurses can practically and personally submit their training needs or make suggestions to improve their experiences of IST. Attendance at in-service training programmes could be improved by optimal involvement through group discussions where these adult learners could share their experiences frequently to ensure their views are known. These discussions should correlate informally but effectively with the in-service training programmes, with quality patient care and cost-effectiveness. Alternative aids should be integrated to create learning opportunities. Formal lectures as a method of teaching are not viewed as the most effective way of adult teaching. Hence, Poggenpoel et al., (1985) suggest considering the preferences of nurses in the methods of training to ensure their involvement in their own development. Methods such as self-experience exercises, simulation, and even role play could be used more often as indicated by some participants to inject greater practicability into the training. This coincides with the teaching methods suggested by Poggenpoel et al., (1985). High workloads might require

training at different times. IST could also be instituted, if properly planned, to take place at ward level, as suggested by participants. Feedback with every training session could eliminate negative factors involving training. The committee involved in planning IST could also consider rewarding nurses who participate actively. This could also assist and enforce change in those nurses' attitudes who do not attend these training programmes. IST has been shown to be important with regard to nurses' professional growth and enrichment of knowledge, and enhances quality patient care. It should also benefit the institution financially, as there will be fewer cases of litigation and quality patient care will prevail. This correlates with the fourth recommendation of Poggenpoel et al. (1985) that if attention is given to correlating effective in-service training programmes with quality patient care, it should save the healthcare institution millions of rands. This implies working smartly in a cost-effective environment. Hence, cost effectiveness cannot be seen as an isolated factor but in real terms, can be correlated with quality patient care (Poggenpoel et al., 1985).

OBJECTIVE TWO

The second objective was to develop recommendations for the in-service training unit at a public hospital in the Western Cape, to support the personal and professional training needs of nurses. From the findings of the study, the recommendations below were developed.

Recommendation	**Actions**
Do an in-depth needs analysis of all training needs	Use different formats of gathering information on training needs On three levels namely the: - organisational, - job and - Individual's level.
Establish a committee	Current Skills development committee can identify training needs Shift leaders can assist with identifying learning needs during supervision rounds
Involvement of all nurses	Individual nurses can communicate and submit their own training needs Involve from planning, implementation, presentation and evaluating IST programmes for e.g. specialist

	professional nurses could present some relevant programmes
Formulate objectives	Identified training needs should have clear, measurable objectives with expected outcomes
Determine suitable timeframes	Do an analysis with the different wards and departments to determine applicable timeframes to continue with training without compromising patient care delivery
Night duty training	Determine how and when training can take place on night duty even if only once per month
Formulate a Standard operating procedure (SOP)	This SOP is to guide the planning, implementation and evaluation of the IST programme on a regular basis
Address all challenges and give feedback	All stakeholders to meet monthly to address and find practical solutions to overcome challenges
Training methods	Vary training methods to be practical and applicable to the topics
Communication and advertising	Timeous communication and reminders using different platforms Use different means of advertising for e.g. eye-catching flyers in high traffic areas
Centralized and decentralized training venues	Some training depending on the topic could take place on ward level and other topics require a bigger audience and venue
Awards or rewards	Stakeholders could brainstorm different type of rewards for e.g. for presenting a programme or active involvement and participation. Not just a certificate of attendance

6.3 BENEFITS OF THE FINDINGS FOR IN-SERVICE TRAINING

6.3.1 FOR THE STAFF

- All categories of nursing staff can benefit as their skills and knowledge will be updated regularly.
- It will empower staff and reduce anxiety, as they will be less fearful and anxious of making mistakes and incurring medical hazards with concomitant litigation.
- Nurses will be empowered with the necessary skills and knowledge, and if applied correctly, can contribute to better quality care, as they will be well informed through regular IST attendance and support programmes, particularly if they are allowed to participate and are part of IST programmes.
- Staff will stay motivated and their morale and attitude will enhance quality nursing care.

6.3.2 FOR THE HEALTH INSTITUTION (HOSPITAL)

- Nursing managers who invest in ongoing IST are rewarded with better patient care, as nurses are more motivated to perform to the best of their ability.
- Quality patient care will lead to cost effectiveness in the healthcare institution.
- The more staff members can attend IST on a regular basis, the fewer medical legal hazards will occur while these nurses attend to patients, as their knowledge and skills will be updated at regular intervals.
- Changes in technology, policies and guidelines will be implemented correctly as IST programmes will assist in updating nursing staff in their application.
- IST is a platform where staff can welcome new and updated practices, and this can lead to the success of hospital plans.
- Management that shows interest in the career development of staff will retain staff longer. This will grant job security for staff.
- The support of the employer will lead to job satisfaction of employees.
- If staff members have job satisfaction, absenteeism will decrease and staff may make less use of sick leave.

6.3.3 FOR THE PATIENTS

- Patient or client satisfaction will be displayed, as outcomes will be known through quality assurance.
- Staff will equip patients through health education and information. Patient questions and queries can be answered when staff are informed.

- Patients will experience confidence through knowledge and skills of staff caring for them. They can observe that the staff know what they are doing.
- Risks to patient care delivery are reduced and litigation prevented.

6.4 LIMITATIONS OF THE STUDY

One of the limitations of the study was that only one public hospital in the Western Cape was chosen for this study. Secondly, only nurses on day duty were included in the research study. Night duty staff were excluded from the study because of limited or fewer staff on duty at night; therefore, night duty staff cannot be removed from patient care activities for long periods for training. Thirdly, it could have been done on a larger scale if more healthcare facilities had been involved.

6.5 AREAS FOR FURTHER RESEARCH

The researcher hopes to engage in further research to assess whether the recommendations made in this study had an impact on future IST. The researcher would also like to use these study findings and recommendations to develop guidelines so that all healthcare facilities could benefit and improve their IST programmes.

6.6 CONCLUSION

The purpose and objectives of this study were achieved. The findings contributed to a better and fuller understanding of the views and experiences of nurses regarding IST. The researcher became aware of what was valued about IST and what needed to change, from planning IST to implementing it. Benefits personally and professionally, as stated above, can be increased, once the importance of attendance is fully understood by every individual nurse and fully supported by managers. Improved communication should mitigate obstacles. The recommendations developed from the findings are valuable, applicable and relevant, and can contribute to a positive change in IST. The study concluded and emphasised that IST does not receive the attention it deserves, although it is needed and invaluable for nurses in practice. The significance of this study contributed to the researcher's changing her approach to IST, as updating knowledge and skills in an evolving professional context cannot be neglected. Nurses should remain clinically competent and skilful. Wenger, cited in Steyn (2011:227), agrees with Poggenpoel et al., (1985:48) that competence may develop when people attend IST on a regular basis. Competence may also develop when people attend conferences, training

sessions or any other event which opens their “eyes to a new way of looking at the world” (Steyn, 2011:227). Professionals may identify their shortcomings through such training sessions and communicate their new-found insights with colleagues on their return to the wards. By doing this, staff members try to change how the institution defines competence and use their experiences to share with and empower their less competent and experienced colleagues to become more competent (Steyn, 2011:227). IST programmes could assist all nurses to become and remain competent, if the outcomes and recommendations are considered when planning in-service training programmes. Karaman (2011:5) and Chong et al., (2013:5) suggest that nurses should be provided with online learning alternatives as continuous training regardless of age, working experience or area of residence. Good examples are essential before online education can enhance nurses’ perceptions of the efficiency of online learning.

REFERENCES

Abruzzese, R.S. 1996. *Nursing staff development: strategies for success*. St Louis, MO: Mosby.

Alshuwairek, K.N. 2016. The effectiveness of the training programs on employee's performance: an empirical study at private sector companies in Saudi Arabia. *International Journal of Business and Management Review*, 4(9):1-23.

Amerioun, A., Ebadi. A. & Sanaienasab, H. 2012. Validity of "motivational factors of nurses' participation in continuing education programs" questionnaire. *Iranian Quarterly of Education Strategies*, 5(2):113-117.

Bloor, R., McHugh, A., Pearson, D. & Wain, I. 2004. A training course for psychiatric nurses in Russia. *Nursing Standard*, 18(39):39-41.
DOI: 10.7748/ns2004.06.18.39.39.c3626

Booyens, S.W. & Bezuidenhout, M. 2014. *Dimensions of healthcare management*. 3rd ed. Cape Town: Juta.

Booyens, S.W., Jooste, K. & Sibiya, M.N. 2015. *Introduction to health services management for the unit manager.* 4th ed. Cape Town: Juta.

Booyens, S.W. & Bezuidenhout, M. 2018. *Dimensions of healthcare management*. 3rd ed. Cape Town: Juta.

Booyens, S.W., Jooste, K. & Sibiya, M.N. 2019. *Healthcare services management.* 2nd ed. Cape Town: Juta.

Booyens, S.W., Jooste, K. & Sibiya, M.N. 2019. *Introduction to health services management for the unit manager.* 4th ed. Cape Town: Juta.

Brink, H., Van der Walt, C. & Van Rensburg, G.H. 2012. *Fundamentals of research methodology for health care professionals*. 3rd ed. Cape Town: Juta.

Brink, H., Van der Walt, C. & Van Rensburg, G.H. 2018. *Fundamentals of research methodology for healthcare professionals*. 4th ed. Cape Town: Juta.

Brooker, C., Waugh, A., van Rooyen, D. & Jordaan, P.J. 2016. Foundations of nursing practice. Fundamentals of holistic care. 2nd ed. Elsevier Ltd.

Bryman, A. & Bell, E. 2014. *Research methodology: business and management contexts*. Cape Town: Oxford University Press Southern Africa.

Burton, R. & Ormrod, G. 2011. *Nursing: transition to professional practice.* Oxford: Oxford University Press.

Chaghari, M., Ebadi, A., Ameryoun, A. & Safari, M. 2016. An attempt for empowering education: a qualitative study of in-service training of nursing personnel. *Iranian Journal of Nursing and Midwifery Research*, 21(5):498-503. DOI: 10.4103/1735-9066.193404

Chaghari, M., Saffari, M., Ebadi, A. & Ameryoun, A. 2017. Empowering education: a new model for in-service training of nursing staff. *Journal of Advances in Medical Education & Professionalism*, 5(1):26-32.

Chan, Z.C.Y., Fung, Y. & Chien, W. 2013. Bracketing in phenomenology: only undertaken in the data collection and analysis process. *The Qualitative Report,* 18(30), Art. 59, 9 pp.

Chong, M.C., Francis, K., Cooper, S. & Abdullah, K.L. 2013. Current Continuing Professional Education Practice among Malaysian Nurses. *Nursing Research and Practice,* 2014, Art. 126748, 6 pp. http://dx.doi.org/10.1155/2014/126748

Corbin, J.M & Strauss, A.L. 2008. *Basics of qualitative research: techniques and procedures for developing grounded theory*. 3rd ed. Thousand Oaks, CA: Sage.

Coventry, T.H., Maslin-Prothero, S.E. & Smith, G. 2015. Organizational impact of nurse supply and workload on nurses continuing professional development opportunities: an integrative review. *Journal of Advanced Nursing*, 71(12):2715-2727. https://doi.org/10.1111/jan.12724

Creswell J.W. & Poth, C.N. 2018. *Qualitative inquiry & research design: choosing among five approaches.* 4th ed. Los Angeles, CA: Sage.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport C.S.L. 2011. *Research at grass roots: for the social sciences and human services professions*. 4th ed. Pretoria: Van Schaik.

Delport, S.V., Greenfield, D.H. & Carolus, S.E. 1989. Midwives' in-service training in new born-care in the Cape. *Nursing RSA*, 4(1):26-27.

Easterby-Smith, M., Thorpe, R., Jackson, P.R. & Jasperson, L.J. 2018. *Management and business research*. 6th ed. London: Sage.

Erasmus, B.J., Loedolff, P. van Z., Mda, T.V & Nel, P.S. 2009. *Managing training and development in South Africa*. 5th ed. Cape Town: Oxford University Press Southern Africa.

Farzi, S., Shahriari, M. & Farzi, S. 2018. Exploring the challenges of clinical education in nursing and strategies to improve it: a qualitative study. *Journal of Education and Health Promotion*, 7, Art. 115. DOI: 10.4103/jehp.jehp_169_17

Geyer, N. (ed.). Armstrong, S., Bhengu, B., Kotze, W., Nkonzo-Mtembu, L., Ricks, E., Stellenberg, E., van Rooyen, D. & Vasuthevan. S. 2015. A new approach to professional practice. Cape Town: Juta.

Gournay, K. 2000. Role of the community psychiatric nurse in the management of schizophrenia. *Advances in Psychiatric Treatment*, 6(4):243-249. DOI: https://doi.org/10.1192/apt.6.4.24

Grace, P.J. 2009. *Nursing ethics and professional responsibility in advanced practice*. Sudbury, MA: Jones & Bartlett.

Green, J. and Thorogood, N. 2018, *Qualitative Methods for Health Research*, 4th Edition, London: Sage.

Harrington, D.C. 1989. *In-service education and staff development at a private hospital*. *Nursing RSA*, 4(10):28-31.

Holloway, I & Galvin, K. 2017. *Qualitative research in nursing and healthcare*. 4th ed. Chichester: Wiley Blackwell.

International Council of Nurses (ICN). 2012. *The ICN code of ethics for nurses.* Geneva: ICN.

Human, S & Mogotlane, S. 2017. *Professional practice. A Southern African nursing perspective.* 5th ed. Cape Town: Pearson.

Jasemi, M., Whitehead, B., Habibzadeh, H., Zabihi, R.E. & Rezaie, S.A. 2018. Challenges in the clinical education of the nursing profession in Iran: a qualitative study. *Nurse Education Today*, 67:21-26. https://doi.org/10.1016/j.nedt.2018.04.010

Jooste, K. (ed.). 2018. *The principles and practice of nursing and health care*: *ethos and professional practice, management, staff development, and research*. 2nd ed. Pretoria: Van Schaik.

Jooste b, K. (ed.). 2018. *Leadership in health services management*. 3rd ed. Cape Town: Juta.

Karaman, S. 2011. Nurses' perceptions of online continuing education. *BMC Medical Education*, 11, Art. 86, 6 pp. doi: 10.1186/1472-6920-11-86

Keltner, N.L., Bostrom, C.E. & McGuinness, T. 2011. *Psychiatric nursing*. 6th ed. St Louis, MI: Elsevier/Mosby.

Khomeiran, R.T., Yekta, Z.P., Kiger, A.M. & Ahmad, F. 2006. Professional competence: factors described by nurses as influencing their development. *International Nursing Review*, 53(1):66-72. https://doi.org/10.1111/j.1466-7657.2006.00432.x

Kneisl, C.R. & Trigoboff, E. 2009. *Contemporary psychiatric-mental health nursing.* 2nd ed. Upper Saddle River, NJ: Pearson.

Kotze, W. (ed.). Armstrong, S., Crous, L., Geyer, T., Mngomezulu, T., Potgieter, E., Subedar, H., Thurling, H. & Vasuthevan, S. 2019. *Nurse educators guide to management.* 3rd ed. Pretoria: Van Schaik.

Lagrimas-Botha, M.S. 2015. The adequacy of support for community service practitioners at health care facilities in two sub-structures in the Western Cape. Unpublished Master of Nursing Education thesis, University of the Western Cape, Cape Town, South Africa.

Lam, D.H., Kuipers, L. & Leff, J.P. 1993. Family work with patients suffering from schizophrenia: the impact of training on psychiatric nurses' attitude and knowledge. *Journal of Advanced Nursing*, 18(2):233-237. https://doi.org/10.1046/j.1365-2648.1993.18020233.x

Lategan, L.O.K. & Van Zyl, G.J. (eds.). 2018. *Healthcare ethics for healthcare practitioners*. Stellenbosch: African Sun Media.

Leedy, P.D. & Ormrod J.E. 2019. *Practical research: planning and design.* 12th ed. Upper Saddle River, NJ: Pearson.

Letlape, H.R., Koen, M.P., Coetzee, S.K. & Koen, V. 2014. The exploration of in-service training needs of psychiatric nurses. *Health SA*, 19(1), Art. 763, 9 pp.
Lincoln, Y.S. & Guba, E.G. 1985. *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Makhakhe, A.M. 2010. Nurses' experience of the transition from student to professional practitioner in a public hospital in Lesotho. Unpublished M Cur dissertation, North-West University, Potchefstroom, South Africa.

Muchinsky, P.M., Schreuder, A.M.G. & Kriek, H.J. 2003. *Personnel psychology.* 2nd ed. Cape Town: Oxford University Press.

Muller, M.E. 2009. *Nursing dynamics.* 4th ed. Johannesburg: Heinemann.

Muller, M. & Bester, P. 2016. *Nursing dynamics.* 5th ed. Cape Town: Juta.

Muller, M., Bezuidenhout, M. & Jooste, K. 2019. *Healthcare service management*. 2nd ed. Cape Town. Juta.

Munro, A., Watson, H.E. & McFadyen, A. 2006. Assessing the impact of training on mental health nurses' therapeutic attitudes and knowledge about co-morbidity: a randomised controlled trial. *International Journal of Nursing Studies*, 44(8):1430-1438. https://doi.org/10.1016/j.ijnurstu.2006.07.024

Needham, I., Abderhalden, C., Halfens, R.J.G., Dassen, T., Haug, H.J. & Fischer, J.E. 2005. The effect of a training course in aggression management on mental health nurses' perception of aggression: a cluster randomised controlled trial. *International Journal of Nursing Studies*, 42(6):649-655. https://doi.org/10.1016/j.ijnurstu.2004.10.003

Nel, P.S., Van Dyk, P.S., Haasbroek, G.D., Schultz, H.B., Sono, T.J. & Werner, A. 2005. *Human resources management*. 6th ed. Cape Town: Oxford University Press Southern Africa.

Nel, Z.J.C. 1986. The effect of in-service training on the quality of psychiatric nursing to mentally retarded persons. Unpublished master's dissertation, Rand Afrikaans University, Johannesburg, South Africa.

Norushe, T.F., Van Rooyen, D. & Strumpher, J. 2004. In-service education and training as experienced by registered nurses. *Curationis*, 27(4), Art. 1022: 63-72. https://doi.org/10.4102/curationis.v27i4.1022

Poggenpoel, M., Labuschagne, L., Muller, M., Nolte, A., Potgieter, M., Potgieter, S. & Powell, C. 1985. In service training in nursing. *Curationis*, 8(4), Art. 670: 48-52. https://doi.org/10.4102/curationis.v8i4.670

Polit, D.F. & Beck, C.T. 2010. *Essentials of nursing research: methods, appraisal, and utilization*. 6th ed. Philadelphia, PA: Lippincott, Williams & Wilkins.

Polit, D.F. & Beck, C.T. 2017. *Nursing research: generating and assessing evidence for nursing practice*. 10th ed. Philadelphia, PA: Lippincott, Williams & Wilkins.

Polit, D.F. & Hungler, B.P. 2010. *Instructor's manual for essentials of nursing research: methods, appraisal, and utilization*. 3th ed. Philadelphia, PA: Lippincott, Williams & Wilkins.

Roji, G. & Jooste, K. 2020. Perceptions of nurses on access to structural empowerment in a hospital in the Western Cape. *Curationis*, 43(1), Art. 2018. https://doi.org/10.4102/curationis.v43i1.2018

Sajjadnia, Z., Sadeghi, A., Kavosi, Z., Zamani, M. & Ravangard, R. 2015. Factors affecting the nurses' motivation for participating in the in-service training courses: a case study. *Journal of Health Management & Informatics,* 2(1):21-26.

SANC *see* South African Nursing Council.

Saunders, M.N.K., Lewis, N.K. & Thornhill, P.A. 2019. *Research methods for business students*. 8th ed. New York, NY: Pearson.

Shenton, A.K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2):63-75.

Slabbert, M. 2019. Solidarity announces action plan for nursing crisis in South Africa. May 16. https://gildes.solidariteit.co.za/en/solidarity-announces-action-plan-for-nursing-crisis-in-sa/ [9 July 2020].

South African Nursing Council. 1984. Scope of practice. Regulation 2598 of 1984.

South African Nursing Council. 2005. Nursing Act No. 33 of 2005.

Steyn, T. 2011. Implementing continuing professional teacher development: policy and practice. *Acta Academica*, 43(1):211-233.

Van Dyk, P.S., Nel, P.S., Van Zyl Loedolff, P. & Haasbroek, G.D. 2001. *Training management: a multi-disciplinary approach to human resources development in Southern Africa.* 3rd ed. Cape Town: Oxford University Press Southern Africa.

Willets, L. & Leff, J. 2003. Improving the knowledge and skills of psychiatric nurses: efficacy of a staff training program. *Journal of Advanced Nursing*, 42(3):237-243. https://doi.org/10.1046/j.1365-2648.2003.02612.x

ANNEXURE 1

Burns, N. & Grove, S.K. 2013. *Understanding nursing research: building an evidence-based practice.* 5th ed. Maryland Heights, MO: Elsevier/Saunders.

Butts, J.B. & Rich, K.L. 2008. *Nursing ethics: across the curriculum and into practice.* 2nd ed. Sudbury, MA: Jones and Bartlett.

Creswell, J.W. 1994. *Research design: qualitative, quantitative, and mixed method approaches.* London: Sage.

Creswell, J.W. 2014. *Research design: qualitative, quantitative, and mixed method approaches*. 4th ed. Thousand Oaks, CA: Sage.

Flick, U. 2018. *Managing quality in qualitative research*. 2nd ed. Los Angeles, CA: Sage.

Frenk, J., Chen, L., Bhutta, Z.A., Cohen, J., Crisp, N. & Evans, T. et al. 2010. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *The Lancet*, 376(9756):1923-1958. https://doi.org/10.1016/S0140-6736(10)61854-5

Gill, P., Stewart, K., Treasure, E. & Chadwick, B. 2008. Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal*, 204:291-295. https://doi.org/10.1038/bdj.2008.192

Hughes, R.G. 2008. *Patient safety and quality. An evidence-based handbook for nurses.* Rockville, MD: Agency for Healthcare Research and Quality, US Department of Health and Human Services.

Krueger, R.A. 1998. *Developing questions for focus groups.* Thousand Oaks, CA: Sage.

Macnee, C.L. 2004. *Understanding nursing research: reading and using research in practice.* Philadelphia, PA: Lippincott, Williams & Wilkins.

Morgan, D.L. 1998. *The focus group guidebook.* London: Sage.

Muller, M.E., Bezuidenhout, M.C. & Jooste, K. 2006. *Healthcare service management*. Cape Town: Juta.

Muller, M.E., Bezuidenhout, M.C. & Jooste, K. 2011. *Healthcare service management*. 2nd ed. Cape Town: Juta.

Pera, S. & Van Tonder, S. 2011. *Ethics in healthcare*. 3rd ed. Cape Town: Juta.

Streubert, H.J. & Carpenter, D.R. 2011. *Qualitative research in nursing: advancing the humanistic imperative*. 5th ed. Philadelphia, PA: Wolters Kluwer Health.

Swanepoel, B.J., Erasmus, B.J. & Schenk, H.W. 2008. *South African human resource management: theory & practice*. 4th ed. Cape Town: Juta.

APPENDICES

Appendix A: Research Information Sheet and Informed Consent

Title: The experiences of nurses regarding in-service training programmes at a public hospital in the Western Cape

Principal Investigator: Vyjayanthimala van Heerden

Email: Vyjayanthimala.VanHeerden@westerncape.gov.co.za

Address:

33 Kitchener Street

Parow

7500

Cell 073 4448 429

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to this study, please contact:

Supervisor: Dr Hilda Vember

Email Vemberh@cput.ac.za

Phone 021 9596183

Department of Nursing

Faculty of Health and Wellness Sciences

CPUT

Symphony Road

Bellville

7530

Dear Participants

I, V. van Heerden, am a postgraduate student registered at the Cape Peninsula University of Technology. This letter of invitation serves to request your participation in my study, where I shall explore the experiences of nurses on in-service training programmes at a public hospital in the Western Cape. Please take time and read more information about this research study. You are allowed to ask questions, participation is voluntary and your decision to withdraw at any stage of the study will be respected without consequences or harm. The principles of ethical guidelines will be upheld throughout this research process, as approved by the Research Ethics Committee of the Faculty of Health and Wellness Sciences at CPUT.

2.1 Purpose of the study

The experiences of nurses on in-service training programmes at a public hospital in the Western Cape.

2.2 Description of the study

IST is essential to keep you up to date with changes in healthcare delivery. This is one way of ensuring that all nurses are updated with policies and procedures to render quality patient care. Participation in this study will help to determine the experiences of nurses on in-service training programmes and develop recommendations to assist with the training of nurses.

2.3 Risk or discomfort

There is no anticipated risk or discomfort in this study. Participants can exit at any stage without any victimisation. Participants will not be subjected to any risks in this project, but might feel anxious in having to reveal their true experiences regarding in-service training programmes. Should this happen, the participants could be referred to the onsite employee assistance programme for help.

2.4 Benefit to the participant or others

The results could assist in ascertaining the experiences of nurses on in-service training programmes. The results will be used to develop recommendations to assist with the training of nurses. The study can assist in making the organisation function better by making employees enhance performance, fill gaps in learning, and remedy deficiencies in skills and knowledge. It will reduce anxiety and uncertainty, as IST empowers. Employees will become fully productive, as programmes will be based on and changed according to the results as shared by nurses' experiences.

2.5 Conditions of participation

No risks, harm or discomfort are anticipated by your participating in this study. The focus-group interviews will be done with participants allocated a coded name, either P1, S1 or A1, for the different categories of nurses. Consent forms and the attachment to demographic variables will be

kept confidentially. Consent is required for the recording of the interviews of participants and all involved in the study to maintain confidentiality of information shared in the focus groups. A trained independent person will conduct the interviews.

2.6 Rewards

There will be no financial reward or direct costs for participants in this study.

Declaration by Participants

I declare that:

I have read this information and consent form and it is written in a language that I understand and am comfortable with.

I had a chance to ask questions and all my questions have been sufficiently answered.

I understand that taking part in this research or study is voluntary and I have not been forced to take part.

I may choose to withdraw from the study at any time and will not be prejudiced in any way.

I may be asked to leave the study before it is completed, if the researcher feels it is in my best interests, or if I do not follow the study plan as agree to.

I give permission/consent that the focus-group interview may be recorded.

I understand that the discussion in the group will be kept confidential and will not be discussed or spoken about outside the study venue.

I also consent that my information may be:

- Used and kept for future research studies

Signed at place……. Date……...2019

Signature of participant ……

Signature of witness……..

Code number…….

Cape Peninsula University of Technology

Declaration by the Investigator

I, Vyjayanthimala van Heerden, declare that the information in this document has been explained to

(Name of participant)……

I encouraged her/him to ask questions and provided adequate time to answer them.

I am satisfied that he or she adequately understands all aspects of the research, as discussed above.

I declare that all information will be kept confidential from the start to the finish of the study.

Signed at place…….on date……2019

Signature of investigator……...

Signature of witness……..

Appendix B: Request permission letter Employer permission letter

Appendix B: Request permission letter Employer permission letter

Cape Peninsula
University of Technology

33 Kitchener Street
Parow
7500
31 May 2018

Dr.D.Stokes (CEO)
New Somerset Hospital
Green Point
Cape Town
8051

Request for permission to conduct research

I am Vyjayanthimala van Heerden. I am the clinical educator and currently enrolled for a Master of Nursing degree at Cape Peninsula University of Technology (CPUT). I request permission to conduct a research study in the Nursing Department of New Somerset Hospital.

The purpose of the study is explore and describe the experiences of nurses on in-service training programs at this public hospital in the Western Cape. The population will be the different categories, permanent employed nurses on day duty. Data will be collected via focus group interviews. No names will appear or be mentioned on data collection instrument to ensure anonymity.

I am hereby seeking your consent and support to approach the permanent nurses on day duty to participate in this study. My supervisor is Dr. Vember in the Department of Nursing Science at CPUT.

Upon completion of the study, I undertake to provide you with a bound copy of the full research report. If you require any information do not hesitate to contact me via email Vyjayanthimala.VanHeerden@westerncape.gov.za, cell 073 4448 429 or at work 021 402 6306.

Thanking you in anticipation

Yours faithfully

Heerden

Vyjayanthimala van Heerden

Appendix C: Interview Guide

The experiences of nurses on in-service training programmes at a public hospital in the Western Cape

It will take approximately 45–60 minutes to complete.

Thank you for your time.

Code number……

Please answer all questions. Please tick (✓) your answer in the appropriate box provided

1. How old are you?

2. Gender?

Male	
Female	

3. Which qualification have you obtained?

Registered Professional Nurse	
Registered Nurses Nurse	
Registered Auxiliary Nurse	

4. How long have you been employed in this public hospital?

5. In which ward/department are you working currently?

Surgical	
Medical	
Paediatrics	
Maternity	
Emergency	
Mental health	
Outpatient	

6. Have you attended in-service training?

Yes	
No	

7. On average how many in-service training programmes have you attended in the past 6 months?

8. What were the topics of the in-service training programmes you have attended?

……
……
……
……
……

How do you experience IST programmes at this public hospital?

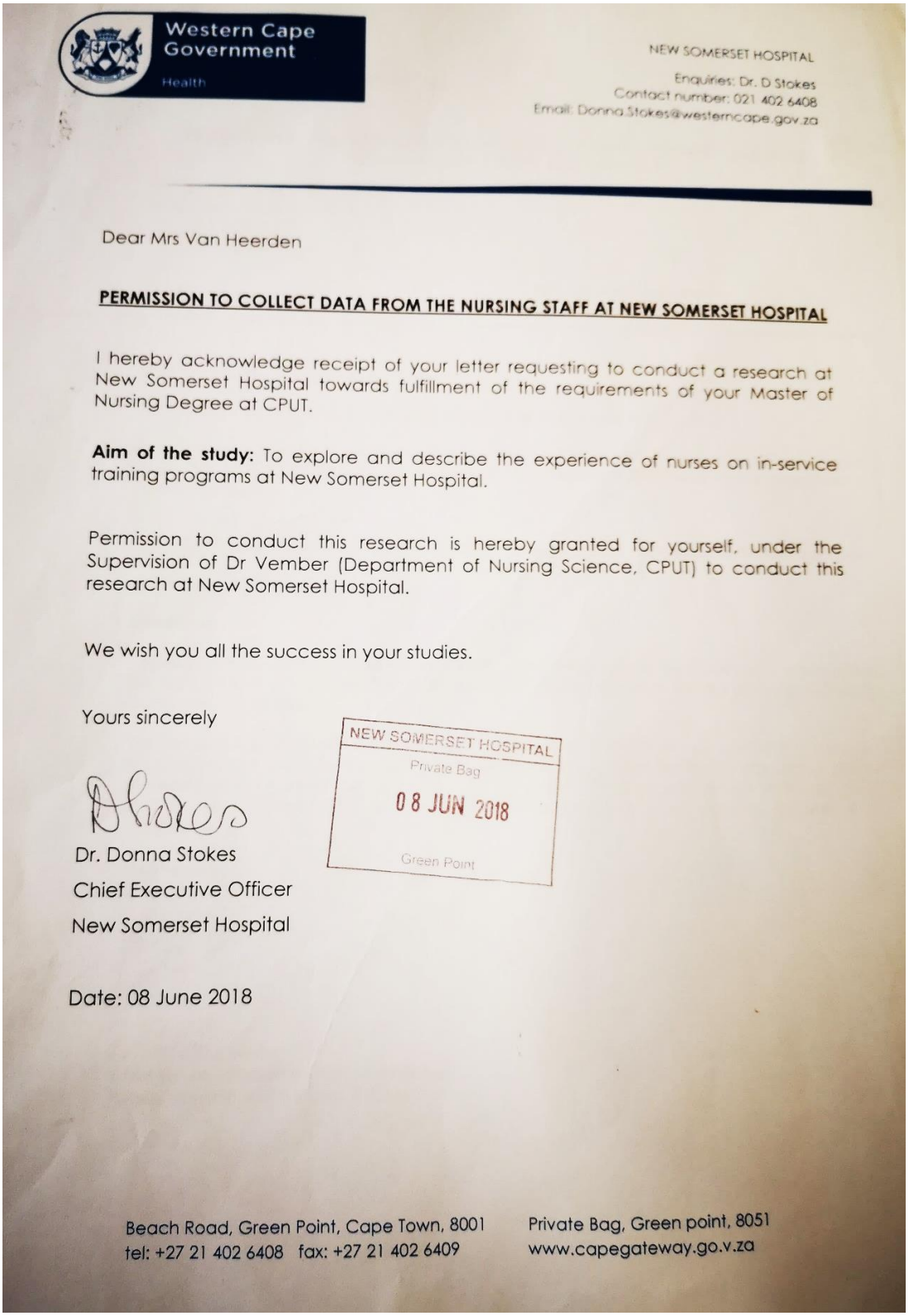
How could we improve these programmes?

Probing questions (starting with why do you think –/tell me more –) will be asked when necessary, if participants do not relay their experiences efficiently.

Do you have anything else you want to add?

Thank you for your co-operation

Appendix D: Permission Approval Letter



Western Cape Government
Health

NEW SOMERSET HOSPITAL
Enquiries: Dr. D Stokes
Contact number: 021 402 6408
Email: Donna.Stokes@westerncape.gov.za

Dear Mrs Van Heerden

PERMISSION TO COLLECT DATA FROM THE NURSING STAFF AT NEW SOMERSET HOSPITAL

I hereby acknowledge receipt of your letter requesting to conduct a research at New Somerset Hospital towards fulfillment of the requirements of your Master of Nursing Degree at CPUT.

Aim of the study: To explore and describe the experience of nurses on in-service training programs at New Somerset Hospital.

Permission to conduct this research is hereby granted for yourself, under the Supervision of Dr Vember (Department of Nursing Science, CPUT) to conduct this research at New Somerset Hospital.

We wish you all the success in your studies.

Yours sincerely

NEW SOMERSET HOSPITAL
Private Bag
08 JUN 2018
Green Point

Dr. Donna Stokes
Chief Executive Officer
New Somerset Hospital

Date: 08 June 2018

Beach Road, Green Point, Cape Town, 8001
tel: +27 21 402 6408 fax: +27 21 402 6409

Private Bag, Green point, 8051
www.capegateway.go.v.za

Appendix E: Ethical Clearance by CPUT

Cape Peninsula
University of Technology

HEALTH AND WELLNESS SCIENCES RESEARCH ETHICS COMMITTEE (HW-REC)
Registration Number NHREC: REC- 230408-014

P.O. Box 1906 • Bellville 7535 South Africa
Symphony Road Bellville 7535
Tel: +27 21 959 6917
Email: sethn@cput.ac.za

18 July 2018
REC Approval Reference No:
CPUT/HW-REC 2018/H15

Dear Vyjayanthimala van Heerden - 215141423

Re: APPLICATION TO THE HW-REC FOR ETHICS CLEARANCE

Approval was granted by the Health and Wellness Sciences-REC to Ms van Heerden for ethical clearance on 31 May 2018. This approval is for research activities related to student research in the Department of Nursing Sciences.

TITLE: **The experiences of nurses on in-service training programs at a hospital in the Western Cape**

Supervisor: Dr H Vember

Comment:

Approval will not extend beyond 19 July 2019. An extension should be applied for 6 weeks before this expiry date should data collection and use analysis of data, information and/or samples for this study continue beyond this date.

The investigator(s) should understand the ethical conditions under which they are authorized to carry out this study and they should be compliant to these conditions. It is required that the investigator(s) complete an **annual progress report** that should be submitted to the HWS-REC in December of that particular year, for the HWS-REC to be kept informed of the progress and of any problems you may have encountered.

Kind Regards

Dr. Navindhra Naidoo
Chairperson – Research Ethics Committee
Faculty of Health and Wellness Sciences

Appendix F: Interview Transcriptions

For the sake of authenticity, interviews have been transcribed verbatim and the grammatical structure of sentences has not been changed.

FOCUS GROUP ONE (FG1)

REGISTERED PROFESSIONAL NURSES (CODE P)

8 PARTICIPANTS (CODE NAMES P1-P8)

26 FEBRUARY 2019

Fear of possible medico-legal risks/litigation	
Assessment of training needs	
Involvement of staff in IST programmes	
Time	
IST. Topics	
Knowledge and skills	
Staff shortages	
Workload	
Decentralised	
Lack of communication/information	
Feedback	
Request for IST on night duty	

I experience it as very informative because even if I send my nurses to IST they come back and do the information they gained by the IST they received (P1:FG1)

IST is a must it is a must at any institution, because how are we going to learn and for us here, from my experience at…, this program is constant, it is ongoing teaching regarding whatever has taken place within public sector hospitals, and also keep nurses out of the court out of legal legalities, cases that can most probably make their courts sounds like proven guilty. The person

providing the training is doing all the necessary steps to keep you on par and is related into the nursing and it is nothing outside that is not related to nursing actions (P3:FG1)

IST is very good it is training the nurses to do the right procedures to the patients (P5:FG1)

ASK A QUESTION Are there services from the outside which is considered as IST also? (P6:FG1)

The training here focus on the adult absolutely nothing on neonates training or paediatrics (P8:FG1)

as for theatre most of the time we do make time for the people coming from outside before we start working we don't get time to come down if we could get the same, someone to come to us and we get the IST before we start working as we are doing for other people that is coming from the outside because we don't get to come down for the IST because we have already started on the cases (P6:FG1)

So then get the provider of the IST to move into theatre and then also, just a suggestion that for paediatrics and neonates, get somebody in the program to have things related to paediatrics and neonates that needs to be improved because they have a huddle in theatre once a month and take opportunity of that huddle to do IST relating into the theatre program (P3:FG1)

I would suggest that somebody, even early mornings, we not busy early mornings in the morning we start at 8 if we can have IST between 7-8 in OPD, which is just like theatre, it's a separate entity from the ward, we don't do recordkeeping the same as the wards, in record keeping I had to develop a new plan and teach the nurses to write in the doctors notes, wound clean and dressing done, as requested by doctor, and what you must put on the wound. And that is important because sometimes it's difficult because we have a lot of clinics and some of the nurses move out of OPD that are endoscopes by a separate place so it's difficult if they can just come and give us IST there(P1:FG1)

WHAT CAN BE IMPROVED AND WHAT IS LACKING IN IST

We need to let it run if you probably have it at 10 have it to move it to 11 because then at least the bulk of the morning work is done we need to look at the timeframe I think 11 let us start at 11 and lunchtime is 12 for me we don't need more than an hour for IST if the topic is interesting (P3:FG1)

*That is a good suggestion P3 but for us in OPD for us I would like every three months to have one IST in out patients like sister P....uh... 6 no, P3 requested training in theatre and sister… requested *laughter in background* P8 suggested it is s a good suggestion this is important for us because at the end of the day it will help with my staff morale, if they can attend it every time. Because at OPD its sometimes so busy that you run... 11hoo is out for us as P3 said, for us between 7 and 8 will help us, so there needs to be an adjustment for us between those times (P1:FG1)*

I would also suggest for sister…. to not to work alone on the IST. She must involve more people and experienced people from OPD so they can do the... and have a special person for theatre and a special person for maternity, if she can also involve those people it can go better There is experienced people here, she doesn't need to hire people to come give lectures, the experienced people we have here can give IST (P1:FG1)

I think if she also go the wards they cannot come down to IST

She had that have that only 2 or 3 people withdraw she tried it and it was not a good idea (P3:FG1)

FOCUS GROUP TWO (FG2)

REGISTERED PROFESSIONAL NURSES (CODE P)

8 PARTICIPANTS (CODE NAMES P9-P16)

27 FEBRUARY 2019

My experience with in-service training is we I didn't get information as supposed to. I only hear from the grapevine that there is in-service training in that only when I request my manager for the form because what normally happens they are given forms to distribute to the wards with the program. if I don't ask … or I don't ask my om will not know what is happening so I just most of the time since I saw it is not happening I been going to … and say what is happening this week it's like that or when I remember when I see her where is my list so I take it that some people struggle to get information on what is happening as far as that is concern (P11:FG2)

What can I say since we moved from King Edward to 7th floor we don't have that list of in-service training of in-service training but normally what we are doing in the ward we are always doing ward in-service training it is not easy for us to come out HUMM to go to in-service training where it is since we are based that side it is quiet very rare for us to go out its only when we get students I don't know if we are just protecting our patients more like that side (P15:FG2)

We also experience that same we have shortages of staff in the ICU there's only 2 so one can't go and leave the other one alone to do all the work so time constraints and staff that the problems we experience and also when we do night duty but I was on last year on seven months night duty there nothing on night (P12:FG2)

LAUGHING

Sometimes the clinics are very busy in the morning out patients there is no time to come to come to in-service (P16:FG2)

No the time is alright but I mean we become so busy in the clinics that you can't you can't I am the only one the only registered nurse and the OM (P16:FG2)

I think I agree with…say and my sister next to me is that things we become so busy in the ward and we prioritize things that we need to do in the ward maybe if they can COUGH/SNEEZE do approach where they can actually come to the wards and do something that like that maybe that pertains to the kind of work that we also do and things that we deal with in the ward (P9:FG2)

As a presenter and a trainer myself I have now listen to all my colleagues and yes my understand the workload and the shortage of staff. But the request now for coming to the ward. We have tried that before and what we found was while you are at ward level with the staff they get called away all the time you start with your training or you've just starting or you halfway through then they (P6:FG2)

need them for patient care so what we want is not that we want every staff member out of the ward to come to training therefore is like someone said they don't get the training program but … gives out that training program at the beginning of the month to your operational manager and they supposed to bring it to your ward supposed to go on your notice board and you suppose to prioritize around the timeframe around the topics so if the topic is not for you maybe it's for someone else it maybe for the lower categories all we need is one person out of every department, unit or section and I always feel it's just my opinion when that person come out of the ward to the seminar room the lecture room that person is away from patient care for just an hour that all we ask that person is not distracted so that person can come can he can come or he or she can come and can improve they can upgrade they can go and reflect back and can gain knowledge and skill that they need for patient care because sometimes even me when I go to certain workshops and certain seminars it's a matter of I forgot or yes it like what is the word I am looking for it's a refresher it's a refresher course a refreshment of your mind set because not all of us is in that particular area when we get reallocated then we have that knowledge and that skill cause we sometimes get reallocated form medical to surgical and we've been working in medical maybe for years and all of a sudden you now get reallocated to surgical so IST is a form of refreshment ne it is form of skilling our people to get that necessary knowledge for our patients to give our patients holistic save patient care so IST should not just be seen we away from the ward we away from the patient it should be seen as we doing something good so that we can give that holistic save patient care that's just my opinion(P13:FG2)

In the IST like sister to repeat something P6 it's good to get IST you do get like a refresher you refresh your thinking you can improve in the ward what we do (P16:FG2)

I believe if the Om can communicate with the staff the minute they get information here they take that and put it on the board ask the colleagues to write down which in-service training they will they allocate themselves and the manager or the shift leader the manager does not have to do it. She can give the shift leader and said listen allocate your people for these days and make sure that the person attends and us the rest of the group the rest of the team we can we know stay in the ward when that one goes to learn when she comes back she gives us feedback and so you know next time is somebody opportunity I don't think there will be shortage of staff is there all the time but if I say if the four of us is in the ward its P5 time today the three of us will clock cover up when he comes back he can give us feedback when we sit waiting for something of visiting time he can give us feedback and then tomorrow we know it is P6 or next week it is

P6 turn so we just go on like that and it will be easy to have that because everyone will get equal opportunity and will get empowered to give proper care to our patients nursing is evolving we not just stuck with doing the thermometer temp there is different ways of doing temperature and when somebody keeps on and telling us training us on that we training other we know on that sits gonna be easy I believe(P11:FG2)

I think also just add on to what she said if the person that must go for the training if he knows beforehand and he knows also in to be on time because that is the other thing the training does not start on time if she means the time that the person is away like that person will come 09h00 for the training and the others come ten pass quarter pass nine making that the training then longer which means the person that came on nine o clock is longer out of the ward (P12:FG2)

Away from the work situation so if I know I am tomorrow for IST I will go earlier to tea or I will ask my co to go earlier to tea so that we can be here early

I second them P2 because sometimes they don't tell you in time like by the time of the IST you will be called that you must to go down first of all you don't know what they are going to talk about you are not prepared but if they can just tell us in time because you don't even see that month allocation for is you don't know where it is they are supposed to put in the notice board so that all of us can see (P10:FG2)

Sometimes the list is on the wall. I saw in my ward there was there is a list the nurses have a tendency of not checking the notice board it's rare they don't (P13:FG2)

check the nurses you have to tell them today is the IST in my ward we normally send normally send one nurse or whoever to the training because we got a list and my manager always telling that today so or so or so or so is going to the IST ja I agree with that I have been experiencing that but the thing is about the time you send the nurse to the IST at 9 but the IST start at 0930 because of the other people from the other wards they come so late to attend the IST and about to the report back they don't report back they don't give feedback sometimes it is seminar outside they don't come for feedback

That is why in my ward is very important we have more nurses they must be alert more vigilant patient is not breathing if the patient went to the toilet that is why (P13:FG2)

informal type of training there you get the in-depth formal training but staff need that formal training we also call it on the spot teaching part of management everyone has got a right to we have changed out timeframes we still waiting punctuality and communication(P14:FG2)

FOCUS GROUP THREE (FG3)

REGISTERED PROFESSIONAL NURSES (CODE P)

7 PARTICIPANTS (CODE NAMES P17-P23)

12 MARCH 2019

I can say I gained the experience of something that I maybe I didn't look or something that I did wrong so now know how to do that (P23:FG3)

The IST I take it as a refresher course. Some of the things we have learned, maybe studied and by times you occupy some forget it so it is like a refresher course somma remind ourselves that proper way of doing things(P22:FG3)

It's very informative firstly and secondly there's topics we don't sometimes that we don't even know about so we get to increase our knowledge and skills by entering IST especially there topics we not aware or topics I know that when we go to IST most of the time it basic nursing care that's been presented to us can I bring the pros and the cons in pros is good basic nursing care we all need basic nursing care but we have different levels in the hospital. I'm in a specialty department, I am trauma trained, ICU trained in a specialty department, advanced midwifery we need to balance its not just basic nursing care. We need that when you can also reach out to those in specialty we need that information as well we do it in our trauma unit in our emergency unit when we work a pm on a Monday or Tuesday most of the time I am allocated to do IST with the staff because there is patients with certain diagnosis and the nursing management is different and sometimes we need read on that knowledge so we need to gain experience or knowledge and skills in that certain diagnosis of the patient they need also bring in some specialty (P17:FG3)

I would firstly just like to say… is very passionate about what she is doing the problem I think is more by the wards sometimes especially for us we don't have a routine in labour ward so sometimes got new difficult to send the older staff the ones we have for long we do miss out sometimes just because you feel it's your responsibility is to cover the ward goes well in the ward she is very passionate does teach you and the stuff that you learn here you take back to the ward, and tell the people that you work with there this is what you must do with this documentation, the blood-kit what must you use it for so you do learn the stuff to teach the people that you work with also (P20:FG3)

It is quiet challenging for me, because as sister mentioned now because sometimes you really need to focus on the level of our specialty, because I mean with the IST I have attended with... She's is passionate about it everything, but it is more a general thing general you know we need sometimes to be specific we do really need to attend IST also I also want to mention. Too she also plays a big role in our IST especially on the waste management. Those are the very things we need to know to passion it's a general thing with the IST it is really for me you do expand your knowledge and the passion and everything but we need to focus on our level of our specialty(P21:FG3)

I also feel that its beneficial especially for the lower categories, they also get to know the documentation, and all that things so when they come to the wards you don't expect them to

know what they are doing it makes the workload little bit lighter for me as a registered nurse especially cos we don't always have time to show them (P18:FG3)

I would like to say it gives as giving us strength at times because for me when I went to school last year you get to you've been doing this things they been shown to you but when doing it the right way so I found out that you know all these things but you also not applying it the way you should but when you get to sit in class and then things are clear and light for you then you I've been doing things the wrong way but you've been given IST as sister has said for us in Labour ward people they need at least to be specific in terms of education wise because we also get students like yesterday I had students they fresh from class, they haven't been taught anything and it was a very busy day I had to orientate them but I did not have a chance the whole day to say come here this is this do this like this and shame they were like sister I don't know I am expecting them 4th years I am expecting them to know everything I am like go put a catheter then they talk to long take too long I get irritated but then I also thought okay they told me it is there 1st day in labour ward they don't know anything so I had to be lenient and to be at least more understanding because at the same time I need to teach them so when they get out of there next year they going to by acting they gonna be sisters they will come to… will not be lenient they will have to be there alone and you know so it is a refresher for us but it has to be broaden in a way because it helps a lot(P19:FG3)

Suggestions

I think it can be improve although it is not bad it's not bad at all because she is so passionate about it. In terms of We have students as I have mentioned they are here to learn so that they can come back and apply what they have learned so if it can start at that level like the categories it as 1st years what we need to do for them 2nd years 3rd years as they go up and grow they need to be that their level educational wise so that when they come and they are sisters after the four year that they done at least they have insight because at this point they don't have because the school is just giving it to them raw and they have to apply it not knowing if they do the right thing because what I have learned is that they come and they have that mentality that I am a sister it doesn't make it, I don't know, I have been there done that it when I first came to …. I was just a student people did not know where you come from you coming from there is different institutions so most people thought I come from a second institution I was not coming from because I told myself I am here to learn so if they can do it like that so that they can be able to say at the end of the day we have given it to you so you give it back to us (P19:FG3)

I think to maybe involve more people on different level facilitator on different level there's 1st, 2nd.3rd and 4th years students each one on diff level I thing to involve one facilitator that's involved with education at…hospital it will be too much so we need to work to appoint certain people just to facilitate this. Where specialty is concerned I think we in our department to be

involve in IST not just in our level in the hospital throughout everybody knows ask someone in the unit can you present this topic next month or next two weeks ask the person(P17:FG3)

I agree with P1 we can categories the different sections so we can understand the things they are going through some of us some people might hide beds what is happening in casualty there is understanding what is happening sister working in (P22:FG3)

…have to be there alone and you know so it is a refresher for us but it has to be broaden in a way because it helps a lot (P18:FG3)

I agree with P2 and especially if we the sister in the ward and you have a CSPN I don't know if you feeling the same very inexperienced I feel the CSPN actually need a lot we need a facilitator (P17:FG3)

Sometimes we have the idea that IST is for the one more we have the experience not to leave the ward we don't want to leave the ward something might happen (P22:FG3)

From my side I think a lot of us a problem with IST attitudes towards IST that what we do if extra then we can send at ward level apart from… (P20:FG3)

I still need yes I know there is a shortage of staff sometimes we see two or three secondly we have students here why not involve us we want quality nurses here even if not going to employ focus on the general side but specialty side and involve us why not always implementation of the we want good(P21:FG3)

FOCUS GROUP ONE (FG1)

REGISTERED STAFF NURSES (CODE S)

9 PARTICIPANTS (CODE NAMES S1-S9)

26 FEBRUARY 2019

…the experience is good so far regarding the IST, the problem is the time, the times of the IST, cos normally it's from 10-11 neh. Normally that time we are very busy in the wards, so sometimes we don't have time to attend IST at that time, if they can change the times it can be better for us (S8:FG1)

The time and the period of the IST it's too long (S2:FG1)

I am also working in the Orthopaedic ward. And sometimes there is...patients we must escort to Groote Schuur Hospital. The in- service training is very good I got a positive in… in in service training , but then there's times we can't attend this in-service training cause we are short staff in the ward or the one person that went to go escort patient to Groote Schuur hospital they spend the whole day sometimes they are done….the second I understand but they waiting for

transport the ambulance to come back to the hospital that is also a problem the in-service training that…gave us is very good and it's a positive (S4:FG1)

I think they must change the time because that time we are busy in the ward and it's difficult to attend the IST (S8:FG1)

I also second… about the time cos on 5 floor it's a Gynae ward in a week We have three days for theatre Monday, Tuesday and Thursday it's a busy day for us is gonna be hard for us to go to in-service training it's Monday, Tuesday and Thursday is gonna be busy days for us in the ward (S9:FG1)

I also second... the problem is the time because it's a time when there is a shortage of staff because if we are busy there in the ward then we can't come here to the IST (S7:FG1)

I second…but the problem is also the staff nurses they work alone in kmc so normally we go that side and it's a problem (S1:FG1)

in my experience there is a good side about it and bad side the good side is that it teaches us a lot and we can provide that to our patient care, so the bad side also I second …because there is shortage of staff and we cannot leave … time (S3:FG1)

We our operating manager we got on a weekly basis we've got meetings so then just after the meeting before tea time she gives us in-service training and she ask senior registered nurses to do in-service training nurses also to give us in-service training teach us a lot, because on daily basis we got theatre patients on the 1st floor so then… gives us the IST and she ask the registered nurse to also got a book in the ward sign the book if we can't attend in-service training (S4:FG1)

We got students on a monthly basis so December they wasn't there so the students aren't back so our operations manager said to our registered nurse that they must give IST to the new students and to the new CSPN that starts now especially hip replacements and knee replacements and this is very good for the students because sometimes it's their first time in the hospital, they come from different hospitals, so they don't know the setup in…hospital so our operational manager usually tells the registered nurses to give IST to them because they not familiar with the procedure here but it's very good.

I went to in-service training by…when she was…CPR and cardio resuscitation and I feel very confident when there is a mass call on any floor, I will go because I feel confident when I came back from…and I'm working here for a long time, I never work on 7th floor cos that's a medical ward but when they say mass call on 7th floor or 2nd floor, then I can go because what… told us.. (S4:FG1)

I cannot attend in-service training I work alone to relieve me Er. Ward I don't have time no one (S5:FG1)

I second they must change the time we are (S6:FG1)

The experience is good so far for the in-service training, but the problem is the time the times of the in-service training cause normally it's from 10h00 to 11h00 ne normally the time we are very busy in the ward sometimes then we cannot attend the in-service training if they can change the time is going to better for us….. (S8:FG1)

Improve

I think the problem is just that we have a shortage of staff so there can be more staff so everyone can have time to attend the IST - employ more staff address staff shortages (S5:FG1)

…second change the time from 11 to maybe to 13 or later (S8:FG1)

you see she said 11h00-13 but our lunch time is at 12 -1 and 1-2 so we can't go because I think at our ward this is our busiest time because we have to lunch time also , I think maybe after 2 or during visiting time you understand, because that isn't busy times, because in our wards it's only the staff nurses and the sisters that take the patients to theatre so between 10 and 1 that is a busy time, because if theatre phones for the nurse to fetch a patient then we must go fetch the patient and then we must have, I don't know about the others but we must have a long assessments to do, the potential slip, potential swelling , potential pain, this is how we do on Thursdays so I don't think we can have IST that time because your lunch time is also important between 11-1 so maybe after 2 after lunch here is (S4:FG1)

I agree with my colleagues, after lunch, but with us at theatre it's a different setting, as we normally do our IST at 8 in the mornings... unclear

No one here is from second floor now, but I'm working on 1st floor, they have a different setup, maybe because the operational manager is not there in the mornings when they come they had to do most of the washes while we on our floor is doing the washes so in the morning by them after 7 is the doctors for trial washes and then the observations so there's no one from them there but at the moment there 2 staff nurses absent, the operational manager is not there, the professional nurse is not there so I don't know if they can attend the IST after 1 because they are very busy . They're very busy on second floor which is surgical ward, they also got theatre cases everyday so I don't know, maybe you can mention washes in the morning ask the night shift can do half of the washes because when the theatre people comes to switch the patients then they still busy with washes one of the busiest ward in the hospital, the surgical ward after two

I want to go back to the time, when we mention the time, because there by labor ward, it is very busy every time, even after 1 sometimes it is very busy so I'm not sure if after 1 is fine

Sometimes in-service training, the person that gives IST is very long but can stop that person, tell that person, because sometimes IST is very long and I just want to know can a person stop that person and said

We getting a list, like this is a monthly list of in-service training my name is on the in-service training list but when I get there, she's not there, can someone else take over the IST or not. We

FOCUS GROUP TWO (FG2)

REGISTERED STAFF NURSES (CODE S)

9 PARTICIPANTS (CODE NAMES S10-S18)

27 FEBRUARY 2019

INTERVIEWER EXPLANED TO FEEL FREE TO SAY WHATEVER YOU WANT TO SAY

ARE WE READY YES

HOW DO YOU EXPERIENCE IST GOOD, BAD, POSITIVE, NEGATIVE

As I am attending the in-service training I learned a lot and I come to the discussion to the conclusion that somethings that I didn't know I pick up in my in-service training and then I go to my department and I discuss it with my colleagues also, ok, this thing should be done like that and not like that that is what I pick up in my training (S14:FG2)

Like you just said now you learn a lot in this in-service training. Sometimes you think you know but know not like all the constitutions when you attend the in-service training now you know she gave you a chance to ask her and she gave you an answer in a way that when you come out of the in-service training you clear. So it does help (S12:FG2)

It's good for in-service training just because we learn a lot and it make us to do the total nursing care properly to our patients. We don't miss anything what we have been thought by the trainer you did the training'. In fact I think last year it helps me a lot when my colleagues talk about the whole family as well because my child had a preterm, premature baby was born at 1.2, because I work to start with breastfeeding and milk matters, the baby today has grown up so big she never even give her the formula she was just breastfeeding because I applied the information to her. It helps us a lot (S17:FG2)

As I can agree with my a fellow colleagues in-service training empower you with a lot of new knowledge and it actually keeps you updated with new developments sometimes there is new developments in the our nursing career and that's very good and you learn a lot and it benefits you in the wards (S16:FG2)

In-service training is very good and she is refreshing your brain and your mind when you go to IST (S15:FG2)

As my fellow colleagues says it does good to us, like really, cause sometimes you totally forget what you were teaching at the college, but when you do in-service training and did pick up something that you totally forget and then you are able even to help those who did not even attend the in-service training in the ward when you back in the ward you can teach the others how to do the new things that you get in the in-service training (S13:FG2)

In-service training is good, very good it's helping as they say it's refreshing our minds (S10:FG2)

In-service training is very good. The other thing we can do we don't know when you go to In-service training don't know to in-service training you understand HIV's when you go to in-service training. You learn a lot. (S11:FG2)

I think if the IST few IST like take 30 min that particular .If the IST can go for such a long time like we can attend for 2 days the same thing you come to the understanding you can manage better they must be longer it must be longer(S13:FG2)

The other problem actually sometimes the program that is like on the IST you really want to go, but sometimes the staff shortage in the wards don't allow you to come so I think that's another problem that is keeping us from IST (S16:FG2)

There's sometimes that our management in our ward can't send us, because there is nobody to go and that make us that to you can't come and pick up that knowledge and come with it to the ward. I feel you must come more (S14:FG2)

I think the training it should be given to all of us but our problem as my colleagues said is shortage of staff and it is as I am sitting here we are short with 3 nurses who are not on duty only 2 nurses and we are very busy in the ward, that will make us late now because we don't have time, the time you say let's go train , others said I didn't even go, why must you go , you see, now also me do this now but now we are missing for our patients, they must try to minimize the shortage of staff and absenteeism we of staff said (S17:FG2)

They just said now maybe if we can have more hours of in-service training but I don't know how that will happen, everything have got an answer mos. (S12:FG2)

I think if they can even give the in-service training while you are on night duty because sometimes we also have a shortage and we stay a long time on night we just loss a lot (S18:FG2)

If they can change the time because as I am working in out patients early in the morning we busy can't go to in-service training because we busy on that time if they can change it to 12 to one or one to two on the lunchtime (S10:FG2)

As my colleagues did say Shortage of staff there is not staff nurse because labour ward delay the discharges (S11:FG2)

FOCUS GROUP THREE (FG3)

REGISTERED STAFF NURSES (CODE S)

6 PARTICIPANTS (CODE NAMES S19-S24)

12 MARCH 2019

I think it is a learning full it is a learning full opportunities that we as nursing staff get to learn (S20:FG3)

For me personally I don't attend a lot of it because I'm busy also give the staff that is new opportunity to go to IST because we find in the past that for them to learn (S21:FG3)

I have learned if there is changes we learn them quickly' what has changed, so we don't stick with the information that is not existent anymore (S22:FG3)

Also the IST that we are attending I feel like we can most of us all included, we must all know it so we can educate it for our patient, I'm feeling that in this IST almost we must all be included not certain people must go because things are changing, maybe you are just doing it by your mind and you no longer know it, you forgot some of the things (S24:FG3)

FOCUS GROUP ONE (FG1)

REGISTERED AUXIALARY NURSES (CODE A)

10 PARTICIPANTS (CODE NAMES A1-A10)

26 FEBRUARY 2019

The experience here is very good because you learn a lot of things you don't know but when it is IST time we don't always have time to come here because we either short staff or there is no staff to come down to IST I have a problem with that So if we could maybe have more staff on duty or more staff to be appointed then we have more time to come to IST (A1:FG1)

I think maybe if our supervisors can change the time because it's very early and at 10 o'clock we are very busy in the wards, maybe the afternoon can be used (A2:FG1)

That thing also of the time… can better time manage, the time if we say 10 o clock it must be 10 o clock till half pass the others can also come, like not 10 until 11, then the others won't be able to come, that can be easy like one group comes at 10 and the other at 10:30, I have a lot of years working here as a nurse but didn't come to a lot of IST because we short, the nurse must go there and the others must go there and we don't have the chance to go all of us to the IST(A5:FG1)

They can also have IST at night, because sometimes we are on night just like us on 6th floor so we don't attend any IST (A7:FG1)

IST is good but I just want to say with regards to time, we don't have time…unclear (A8:FG1)

The IST is good because we learn a lot some of us we are here for a long time in this hospital and we forget, we forgot everything, so when you go to IST you learn a lot, you get the skills there, about the time, 10 o'clock is difficult for us, sometimes we escort and then you can't leave the agent behind, so for me it's the time management, I think she can change the time they must change the time (A9:FG1)

I think they must also not when they doing IST repeat the same thing every time the next month is record keeping and the following month its record keeping again, they can also teach like

computer so we can gain skills we not gaining anything skills. Just like the firefighting …then we can get an e-certificate, I wish we have things like that get something like that at least when you get something (A5:FG1)

On my side the people giving IST, Stick on a topic when they give IST, I am a very slow learner because we forget what they say when they speak on one thing and just move on to the next, time is very short 30 minutes is not enough, stick on a topic and make it practical for us (A10:FG1)

Even if they say they can take some of the nurses without driver's license to give them the skill, but they don't finish the thing, like if they started to take 10 in 2019, they must make sure that those 10 people in 2019 are done and get their learners and pass their license and then 2020 they do another set of staff again, They can't do 2019 without finishing 2018, they must finish the thing not just start doing and not finishing. (A5:FG1)

As they are not sending us to school, they say that there is no bridging for us From EMA to EM, I suggest then to give us the skills in IST. like changing those topics, not repeating topics that are boring , because if you go for recordkeeping this Thursday and next Thursday again, you won't have excitement or interest, so they must change the topics regularly as A5 said so give us the IST and give us the skills (A9:FG1)

And you don't get given the right answer and they throwing you all around, one says this and you know other people at other hospitals, mostly private, they going to school and some of them are bridging, they never stop bridging, while we would stop bridging. They never stop, they continue (A1-FG1)

Even now, they don't ask the nurses in the ward, do you have grade 12 so that we can give you that chance to maybe do night duty to finish up your grade 12, or do you have something so that you can improve your grade 12, no they don't do, IST training recordkeeping only. They only appreciate you as a nurse they don't give you that energy, they don't motivate the nurses (A5:FG1)

3 years ago when they were telling us about this bridging course and not being able to go, if you wanted to do something else, you cannot do something else. Because you are in nursing, you must stick to nursing. So example if you did human resources and you wanted to continue? (A7:FG1)

I think because why the sisters when they want to learn more, they have chances to go learn at UNISA, UWC while they are still studying, if you also have a chance to do your stuff, you can also do because then the sisters they also does that, they go to UNISA, they go to UWC to do stuff more advanced, you can also do that, now others go and they pay themselves (A5:FG1)

I don't think we do have that opportunities like nurses to go and study by ourselves, if we want to go to study, what I heard is that you must resign and go and study by yourself, this opportunity is only on the sisters that they can go and study, not to us. What I heard is that the

nurses, there is no bridging course for us, if you want to go and study, then go by your own and you must resign here. (A9:FG1)

*What I want to suggest they must do is give us proper IST so that we can be better nurses for instance in the orthopedic section they must because we don't work only in our ward, sometimes you get taken out, then you go there and you don't even know how to handle somebody with broken hip , so they can give us proper IST, get people from outside like maybe people that are orthopedic trained to show us how to do all this stuff give us training about ivy fluids and all of that, we are the ones that are working with the ivy's , not the sisters and not the staff nurse, we the ones that's changing the drip, we the ones so that you can learn when is a drip out and when is the drip still into the tissue so I can that is how we can improve some of this IST and leave record keeping out, we can do it in our sleep, if …I forgot what I wanted to say now *laughter* just want to add to my colleague's we can improve our salaries working as a security (A10:FG1)*

If they can change really or they can call all the ENA's and tell us the proper answer so we can't hear from this one and this one ,because now we are talking different stories, if they can call us and tell us , listen here, the ENA's you are not going to do this a & b because of this and this and this, I think it will be fine to us and also I think it will be also a raise in The number of The people to go for the IST, if they can call us and tell us listen here like this and this (A9:FG1)

I just want to add on my colleagues as they were talking about improving our skills, I think as nurses we also need special courses to do to be a specialist since they not going to take us to the schools anymore so that we can just improve our salaries because we are the most group that are getting low wages, so if we gonna remain nurses , which means we are going to get this low income, also we are going to end up working as a security because this thing is not helping us, so if they can give us something that can improve our skills and improve our salaries as well (A10:FG1)

I think it's also ,it is western cape that doesn't give studies for the nurses because when I'm checking even to the companies , even if you are a lawyer or anyone we have the right to have a study period to go study something, or just to do something, even me here…I'm having 9 years I'm having at… now, they always having the story, even if they taking the nurses, the time they were taking nurses for the bridging courses they only take 2 nurses , how many nurses are here in…, more than 200 or 300 nurses and then they only take 2 nurses , I think they can improve like doing…hospital , taking 50 nurses for bridging not this thing of taking 2 nurses or 1 nurse(A5:FG1)

I don't think we have that opportunity you must resign if you want to go study you can go on your own (A9:FG1)

What I want to suggest they must give us proper IST. Get people from outside give us IST about the IV fluids and all of that when is the drip out left or when is a drip left recordkeeping out we can do it in our sleep (A1:FG1)

…must stick on the time (A5:FG1)

I think there must be separate times, so I'm here, next week again for IST, and others they are not coming, but why, so I think we must set things to attend IST (A2:FG1)

Try and listen to the nurses and ask us what is making us happy because they will never ever ask us, they just telling us what to do, they just giving orders (A10:FG1)

Also the thing of , they must also change the topics, like not they gonna do recordkeeping the whole month, they must do like 5 things , like different things in the month , not like you go to this IST record keeping but you were here before for recordkeeping , no new things coming, sr I think she must bring new things, new ideas… they can also come to the nurses and ask guys what are you interested in doing this week, what IST can we do this week (A5:FG1)

because last year we had a name list on which you decided which course you are going, there was a whole pile of courses, courses like social worker, HR, all of them and we never got feedback from that, that was last year I think in June July, this is a new year and we never got feedback from them and what I would suggest is also that they come up with new topics for IST, like I said we don't work in the same ward every year, every day, when you came here you got sent out to a different ward and like when I came there, I don't know what is happening in Gynae because I never worked in Gynae so can go in depth into certain stuff, to certain wards, like how to treat a patient with hip replacement or a patient with abdominal surgery, all of that, we don't know that things, because we have the same old topics every year(A1:FG1)

FOCUS GROUP TWO (FG2)

REGISTERED AUXIALARY NURSES (CODE A)

10 PARTICIPANTS (CODE NAMES A11- A20)

27 FEBRUARY 2019

To my side I want to improve because I didn't attend IST for a long time so I think I attended only once I should be improving was on because I been working night duty for a long time I did not have the time to attend the IST,,,,1

there is nothing wrong with IST it helps us to remember some stuff we have learned from the college maybe like to we are on the IST for the red things and the differentiate where you must throw the sharps and whatever's Sometimes you forgot to throw it in the wrong place that what we learn and about what and the skills…. (A17:FG2)

like I said I never been on IST for a long time it was once in 2017 so I don't remember much what they were talking about but I think IST is good because really it makes us to learn how to do things in the correct way like recordkeeping and all of those I think it is a good thing I don't have much to say cause (A18:FG2)

I think I attend IST 2 times and then I gained a lot because… informed us if there the hospital there is a fire what supposed to do how to take care of the patients in the ward she remind us how to take care of the importance of the patients in the ward (A20:FG2)

I tend to agree with them it is good it is refreshing the minds and go back in time what I nogal experience is there is so many changes like for instance I am in neonates and I worked like years ago in a medical or adult ward surgical like that say for instance there is something about TB anything about TB medication for me like if I have to go and work you know there's is shortage of staff and I don't know anything because years ago we used this kind of medication and now something develop so …and them do have IST on these kind of things but I would suggest I don't know what they talking about if they doing it like a meeting on diabetics ag I mean IST on diabetics or TB patients or something like that you know it is like follow-up IST because there is always something new coming out and then this IST was like two years ago about diabetics or TB patients just like this so that we can be on training up to date because you feel sometimes so lost out when they talk about things and even then if you are in this training and you don't work medical or for instance you outside IST freshen up, all in all Its quite good I attended IST less than 6 months and its quite good and You learn a lot and it is good thing as I said just that update (A14:FG2)

for us in theatre it is very rare to attend this IST the most of the IST we attend is instruments and the solution but the one I attended was about TB it refreshes my mind now I know the symptoms how to get TB ……maybe every 3 months every six months have theses chronic conditions to give us IST and if they can include the night staff because in my department there are people permanently night on night duty, they are missing out (A13:FG2)

The training that is done It is good to attend the IST especially like they explain all they do in the wards like in the wards they do most practical and there's more to learn knowledge in service like even if the other things are not our scope of practice how to handle a patient on a blood transfusion and the other staff and condition (A12:FG2)

I think IST is very good because it can make me to be more confident in the ward after the activity because you are sure what you are doing there was IST of a patient who want to abscond you can see the signs of the patient who want to abscond so we are taught how to deal with the patient so you must do this and this to prevent abscondment ….unclear…. and then to prevent have their money in their hand fears I left my child at home and go straight to the patient and ask some questions so we can patient want to go home to prevent the abscondment (A11:FG2)

I won't say anything wrong if there is incidents in the ward what to do it is good if like my colleagues say it is good (A19:FG2)

My experience I was attending the IST I think it was 2017 I was firefighting at least I gained something from…on how to get the patient out so it was nice (A15:FG2)

Improve

I would say there is so many gaps I don't know how the feel about 2 months ago we are going for the 3rd months what is the reasons might also be some problem UNCLEAR

For me if they can repeat this IST twice a month's (some response at the back saying JA) infection control we can attend for 3 times not just once (A12:FG2)

Like a brush off then it is like it is done like it is just flat

I think the other thing like…most of the time when you go there, the nurses don't attend the IST, she must make sure the nurses attend, if you go there is only 2 nurses the Om (A20:FG2)

I can … change the time most of the time is 10h00-11h00 can she go to 14h30 the ward is mostly it's very busy (A19:FG2)

I also want to add…can do IST for night duty people also, maybe like once a month maybe one shift and another shift so that we won't forget when we need to know the stuff and all that, like now, like now , I don't remember when last I was at IST, because I was on night duty the whole time , so maybe if she can make time for night duty also, at least we can also be on the same page like the others, because now we don't know nothing, so maybe if she can make time like once a month, both shifts, like maybe tomorrow it's another shift, then it can make a change, so if you switch to day shift , at least you know something because you went to IST (A18:FG2)

FOCUS GROUP THREE (FG3)

REGISTERED AUXIALARY NURSES (CODE A)

4 PARTICIPANTS (CODE NAMES A21-A24)

12 MARCH 2019

I only remember last one that I attended it was about recordkeeping about Recordkeeping at maternity we call the reason we did not do in the ward was the supposed to We take it carelessly. Sometimes we got issues with our management about recordkeeping there are caresses between the family and the nurses but everything we didn't write those and then when the management try to defend us, they can't because there is nothing they can use to defend us, , we find ourselves in difficult situation because of carelessness. So I felt that recordkeeping it was very good for me when I come back to the ward I just done what they told us what we must do and what is important must be done Everything done for the patient must be recorded, that can be your nurse record (A22:FG3)

IST is a very good idea, CORRECT JA because you think you know everything, but when you sit in this IST you tell yourself Jo I am for so long in nursing but I don't know that. Ok we do it whatever in the ward you think it's the right way when you sit in this IST then they teach you the right way and you think Jo all the years I do the wrong. But we think we do the right that what I say IST is very important. I sat one time in IST about and the topic was scope of practice for ENA's now in this ward it's the surgical ward is very busy ward then you think ok I will quickly do this maybe I hang quickly this drip because it is empty you forgot it is not in your scope of practice as ENA but I will do it for the ward for the patients you forgot there is nobody who assist you when you come in trouble you will stand alone. That day when we sit in this IST and the sister refresh our minds about scope of practice, because we don't go home every night and sit

with scope of practice after you done with the ward for the day you come at home and you think back what did you done today there you see jo today I have worked outside my scope of practice what about every something go wrong who will cover me but that time you don't think about it you think about the work must be done you don't think you will assist me now when I empty this drain but it is not in my scope of practice but I can do it for who I do it know I do it for my patient because maybe my baby my patient struggle but at the end of the day I will be in trouble when something go wrong That why I say IST is very important, refresh our mind every time don't do that do the right thing and I can say that….(A23:FG3)

IST is very good it makes our minds to be going far when you are when you attend and get something to learn .Lets take in our wards we are working with the sister when the doctors do rounds sometimes the ward was full and the sister sometimes she didn't even record the doctors' orders. When you are writing interim you suppose to check if the sister wrote the entry sometimes you find that this baby must be taking to the kmc and she did not even say so it is right to attend IST sometimes it makes you to gain more if you write that doctors order you suppose to take the sister sister show the sister that the doctor wrote this and this and this and you did not even record now so it is very important to do things in a good manner when you are working (A24:FG3)

I don't think we need more improvement. Reason you see it is IST today we are four of us where's the other nurses why sister…must improve more things if nurses is not evens interested in one IST you understand. She will put give more time her time and most of the time she will sit alone in the office like now the hospital is full of ENA's and they can't say they are so busy they can't attend and the in service training is for ourselves, she help us but they don't help themselves. So I think her input is more than enough, and her door is at all times open for anyone who want to know something, you understand you see it is only four of us, but then she give her the time a long time (A23:FG3)

…this is what I'm going to say hence they of the management our managers in the ward they must take it seriously. If they want us to take it seriously. They must force us to go downstairs for the IST. They must only ask one person if they always ask me to Bickersteth I am not going to ask where is the other nurses IST is not only for me this is still too big look we are only four I understand there at Bickersteth is a difficult ward you ask me this week is me I'm sure next week is gonna be another one we can't be only four because our management they are not they don't care about this. They just say you can just go there if I don't want to I can take this and go sit by the pharmacy it is not important even to my manager (A22:FG3)

In my opinion it is right if they can decide every week we must have once a week and during the week to attend one of these IST. They can organize maybe they can make Tuesday the staff must suppose go and attend it can help us to gain knowledge (A24:FG3)

Just to add on I can say I think out of every ward they must at least send one or two people to attend, it must be a must to attend the IST (A21:FG3)

Sometimes it is the same person going every week (all agreed in saying JA in the back round) same person goes to the same for to the IST so the others don't get a chance (A21:FG3

Appendix G: Editing Certificate

ELIZABETH S VAN ASWEGEN
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Language and technical editing | bibliographic citation

DECLARATION OF EDITING

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The Master of Nursing thesis titled 'The experiences of nurses regarding in-service training programmes at a public hospital in the Western Cape' by **Vyjayanthimala van Heerden** has been edited, the references have been checked for correctness and formatting according to the CPUT Harvard bibliographic citation style guide, and the candidate has been advised to make the suggested changes.

Dr ES van Aswegen
11 July 2020