EXPLORING REASONS FOR THE HIGH STAFF TURNOVER AMONGST PROFESSIONAL NURSES AT THE MANDENI SUB-DISTRICT PRIMARY HEALTHCARE FACILITIES

By

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DECLARATION

I, Mrs Babhekile Rejoice Msomi, declare that the work in this thesis has not been submitted to UKZN or any other tertiary institution for the purpose of obtaining an academic qualification, whether by myself or by another party.

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DEDICATION

This study is dedicated to my mother, Francisca Matu Ndaba, who raised me until I became a professional nurse. I thank God Almighty for the wisdom He imparted on my mother such that out of all the challenges she faced, she kept on sending me and my siblings to school.

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ABSTRACT

Introduction

Primary healthcare (PHC) facilities are the first level of health care, therefore it is essential that these services are always accessible to the local community. The South African healthcare system has adopted a primary healthcare approach aiming to achieve health for all South African citizens. This is the reason why PHC services are rendered free of charge in all public clinics in South Africa. However, professional nurse turnover is impacting negatively on accessibility as well as quality of services rendered in the rural PHC clinics. Therefore, this research seeks to explore the reasons for high staff turnover amongst the professional nurses and to increase access of PHC services to the community and improve quality of services delivered by these clinics.

Aim

To explore the reasons for high staff turnover amongst professional nurses at the Mandeni sub-district PHC facilities.

Method

A qualitative exploratory study was conducted in seven PHC clinics and one Community Health (CHC) clinic was selected. Five professional nurses, including one operational manager were selected purposely. Data was collected using unstructured interviews. The main research question for this study was: “Why have you decided to leave employment at the PHC clinic?”

Results

The study’s findings revealed that professional nurses were overworked due to high patient load, lack of support from the management, favouritism, poor working conditions, professional nurse shortage, unmanageable subordinates, intimidation at the workplace, ever complaining community, financial problems, family responsibilities, poor work schedules and doing on-call duties, and lack of resources like poor water supply.

Recommendations

It is recommended that professional nurse staffing norms be reviewed for rural PHC clinics using workload indicator staffing needs (WISN). Management support should be strengthened so that problems like lack of resources are acted upon timeously. A standardised policy and guideline should be developed to give directions about how on-call systems for professional nurses should be done.

Key words: Primary health care, professional nurse, nursing, turnover.

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ACRONYMS

Acronyms	Terms
ANC	Antenatal Care
ARC	African Health Profession Regulatory Collaborative
ARV	Antiretroviral drugs
CHC	Community Health Centre
DENOSA	Democratic Nursing Organisation of South Africa
DHIS	District Health Information System
DPSA	Department of Public Service and Administration
HRH	Human Resources for Health
ICN	International Nurses Congress
IRIN	Integrated Regional Information Network
KZN	Kwazulu-Natal
MDGs	Millennium Developmental Goals
NDoH	National Department of Health

OSD	Occupational Specific Dispensation
PHC	Primary Health Care
PN	Professional Nurse
PSC	Public Service Commission
QWL	Quality of Work Life
RM	Registered Midwife
RN	Registered Nurse
SANC	South African Nursing Council
SDGs	Sustainable Developmental Goals
USCDC	United States Centre for Disease Control and Prevention
WHO	World Health Organisation
WISeR	Workplace Innovation and Social Research Centre
WISN	Workload Indicators of Staffing Needs

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

This chapter will elaborate more on the background of the study, and the extent of professional nurses' turnover globally. It will present a summary of the research methodology, as well as the significance of the study to nursing practice, education, management, and the research body of knowledge and operational definitions.

1.2 Background

There is an international shortage of registered nurses/professional nurses which is related to many factors including turnover (Steyn, Klopper, Coetzee and van Dyk, 2015, pp.605-2). South Africa, like many sub-Saharan countries, has been hard hit by the HIV/AIDS pandemic and challenges such as shortage of professional nurses, high attrition rates and the migration of skilled nurses like primary health care (PHC) trained nurses from rural to urban areas, is a cause for concern (Steyn *et al.*, 2015, pp.605-2). Flinkman, Isopahkala-Bouret and Salanterä (2013, p.1) report that the European Commission has estimated that there will be a shortage of 590 000 nurses by the year 2020.

PHC services have suffered registered nurse shortages through migration of nurses from rural to urban, public to private and from primary to higher levels of care (Abuosi and Abor, 2015, p.596). Similarly, James (2016, p.1) comments that South Africa has a nurse-based healthcare system. James (2016) further highlights that South Africa has 270 437 nurses but are short of 44 780 professional nurses. He maintains that a shortage of professional nurses will compromise care (James, 2016, p.1). He is also concerned that the PHC setting is worse, as registered nurses are expected to perform standby duties at facilities without the support of an experienced medical officer at night (2016, p.1). Khumalo (2014, p.17) supports James' (2016, p.1) claims by stating that nurse-patient ratios have increased from 1:15 to 1:50 in South Africa, and this situation could be worse in 2017 since there are delays of about 12 months before filling nurse posts.

In an attempt to reduce the high turnover of registered nurses (RNs) in South Africa, an Occupation Specific Dispensation (OSD) was developed and implemented in 2007. It was

agreed that nursing would be the first profession to benefit from OSD (George and Rhodes, 2012, p.3). PHC nurses met the criteria for inclusion in the OSD announced in 2007, which stipulated that human resources for health in the public service should be re-graded according to their qualifications and years of experience with their remuneration increasing (George and Rhodes, 2012, p.3).

George and Rhodes (2012, p.8) recommends that working conditions in the public sector be improved in order to reduce RN shortages. Studies have been conducted about RNs' turnover, but little information is known about the reasons for turnover at PHC facilities in South Africa (Almalki, Fitzgerald, and Clark, 2012, p.9). Maldistribution of nurses is a concern for poor South Africans who use public health facilities, because half of the 270 437 nurses are in the public sector caring for 84 per cent of the population, while the other half are in the private sector providing for the remaining 16 per cent of the population (James, 2016, p.1).

1.2.1 International

The World Health Organisation (WHO) (2016) estimates a shortage of almost 14.5 million physicians and other health human resources including nurses worldwide. Flinkman, *et al*. (2013, p.1) report that "the current and the growing shortage of professional nurses which is estimated to be at 590 000 nurses by the year 2020 is a global concern". WHO report that "nurses and midwives trained in sub-Saharan Africa who emigrated from their countries represent 5 per cent of the current workforce and it was increasing" (WHO, 2006, p.99). Colosi (2016, p.6) reports that "the vacancy rate for RNs continues to rise and currently stands at 8.5 per cent and this is aggravated by the RN Recruitment Difficulty Index which is a clear indication that PN or RN labour shortage is intensifying in America" (Colosi, 2016, p.6).

1.2.2 National

Table 1.1 shows the provincial distribution of RNs versus the population of South Africa in 2015.

Table 1-1: Provincial Distribution of Registered Nurses versus the Population of South Africa

Province	Population (estimated) 2015	Registered nurses 2015	Population per qualified registered nurse	Students
Western Cape	6 200 097	16 701	371:1	2 118
Eastern Cape	6 916 185	15 392	449:1	3 611
Northern Cape	1 185 629	2 250	527:1	243
Free State	2 817 942	8 075	349:1	1 294
KwaZulu-Natal	10 919 077	30 475	358:1	3 387
North West	3706 962	9 621	385:1	2 003
Gauteng	13 200 349	35 770	369:1	4 498
Mpumalanga	4 283 887	7 106	603:1	958
Limpopo	5 726 792	11 464	500:1	1 922
Total	54 956 920	136 854	402:1	20 549

Source: South African Nursing Council, 2016

The Republic of South Africa, Department of Health (2013) reports that there is a gap between the number of nurses who successfully completed their educational programmes each year and those who register with the South African Nursing Council (SANC) (Republic of South Africa Department of Health, 2013, p.30). The department also reports that the attrition rate of nurses who complete their training but do not register the following year is estimated at 40 per cent. The number of nurses who enter training and actually qualify is estimated at about 50 per cent and this requires investigation. An estimated 18 per cent of nurses on the SANC register are not actively working (Republic of South Africa Department of Health, 2013, p.30). RNs comprise only 16 per cent of new nurses registering, and are estimated to decline from 50 per cent in 2009 to 37 per cent in 2020. RNs are older than other

categories of nurses with 43.7 per cent being over 50 years old and retiring at a rate of 3000 per annum for the next 10-15 years. The total number of nurses on the SANC register has grown from 177 721 to 248 736 i.e. a net increase of 71 015 (40 per cent growth), however the RN category has grown from 47 955 in 2014 to 51 040 in 2016, which is 5.4 per cent increase (SANC, 2016, p.1). In 1998, the official ratio of people per RN in South Africa was 1:447 and this has only improved by 2.5 per cent in ten years. In 2015, the RN per patient ratio was 1:358 (SANC, 2016, p.1). Therefore, there is a need to train RNs at a degree level as per international trends. This will in turn close the gap which is estimated to be 20 per cent of professional RNs trained at universities and 80 per cent trained at nursing colleges (Republic of South Africa Department of Health, 2013, p.31).

The nursing human resource for health's strategic plan (2012/2013-2016/2017) has formulated seven strategic priorities which are as follows: devise a formula emanating from the information for future supply of nurses for public and private hospitals, PHCs and non-governmental organisations including the new staff nurse category; develop a detailed data base for nurses; establish safe nurse staffing guidelines; identify the financial implications for training nurses with necessary skills to work at PHC settings; develop turn-around strategies to attract nurses who have left the nursing profession and the re-employment of retired nurses (Republic of South Africa Department of Health, 2013, p.53).

The strategic plan for nurses (2012/2013-2016/2017) has highlighted that the re-engineering of PHC will have an impact on the future supply of nurses for South Africa (Republic of South Africa Department of Health, 2013, p.55). The PHC re-engineering model came out with a new structure that requires the creation of new posts, addition of vehicles and new technology for monitoring and evaluation of health services rendered. Table 1.2 below shows details of the existing professional nurses and the vacancies that need to be filled, which will inform the budgetary planning processes (Republic of South Africa Department of Health, 2013, p.55).

Table 1-2: Professional Nurses, HRH Goals 2011-2026

	2011	**2015**	**2020**	**2026**
Existing gap in the public sector	45 682	46 603	47 780	49 231

PHC team vacancies	9293	9480	9720	10 015
Additional workers to fill vacancies	-4092	-9027	-16652	-28 506
Total vacancies (goal to be reached)	50 884	47 056	40 847	30 741

Source: Econex calculations for NDOH HRH Draft Strategy, June 2011.

The above table indicates the total number of vacancies to be filled by professional nurses (PNs or RNs). The strategy gives a picture of the financial and employment implications and safe nurse staffing norms and new policies which need to be modelled and integrated into realistic provincial plans (Republic of South Africa Department of Health, 2013, p.55).

1.2.3 Provincial

Kwazulu-Natal (KZN) is the second largest province in South Africa with a total population of 10 919 077 accounting for 21.4 per cent of the total South African population, and is served by 30 475 RNs (SANC, 2015, p.1). According to the SANC (2015, p.1), the RN patient ratio for the KZN province is 1:358. This number does not make provision for illegal immigrants and refugees who are living in the KZN province. According to Statistics South Africa (2015, p 1), the province has a net migration of 12 100 people (out-migration of approximately 195 200, and 207 300 in-migration) which means there are many people who come into the province compared to people who are leaving the province, which increases the workload in primary healthcare facilities.

Some PHC facilities are located in the areas where there are Reconstruction and Development Project (RDP) houses and informal settlements. HIV/AIDS prevalence and non-communicable diseases like hypertension, diabetes mellitus and epilepsy are fuelling the healthcare system challenges in the province. When looking at the geographical distribution of RNs in KZN, rural PHC clinics are negatively affected by shortages of PNs as most nurses do not like working in the rural areas (James 2016, p.1). Uys and Klopper (2013, p.2) confirm a lack of PNs or RNs in PHC settings. Therefore, plans should be in place to increase the production of RN/M's through a four-year comprehensive qualification to ensure positive outcomes (Uys and Klopper, 2013, p.2)

1.3 Problem Statement

Mandeni sub-district has a population of 150 848 which is served by seven PHC clinics, two mobile clinics, and one community health centre (District Health Information System, 2016/2017). There is no district hospital. This situation puts a strain on the regional hospital. Adding to the challenge is the growing burden of care for healthcare professionals. RNs in three PHC clinics have the highest clinical patient load in the country at 70 per day, substantially higher than the provincial average of 40 per day. There is also a continuing shortage of RNs as many leave the sub-district for better working environments. There is a need to explore why the professional or RNs leave Mandeni sub-district PHC services. Currently, one professional nurse is leaving the sub-district per quarter. Noticeably, there is an increased rate of PN absenteeism in the two facilities that have a high headcount. This is confirmed by the following tables:

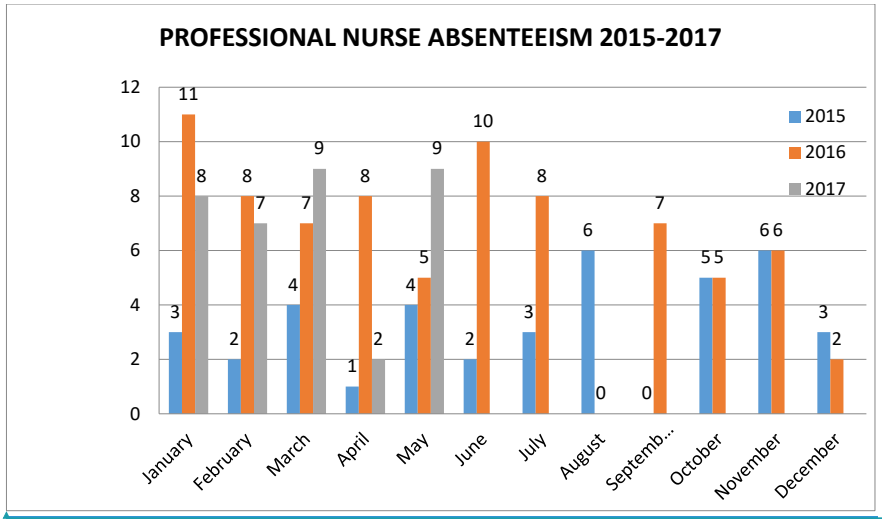

Table 1-3: Absenteeism of professional nurses from 2015-2017

Noticeably, professional nurses were frequently absent from duty in 2016 because employment of new staff was put on hold and this may be associated to fatigue due to increased workload (KZN circular, 62, 2016).

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Table 1-4: Professional Nurses who resigned in 2017

Months	January	February	March	April	May
Number exited	0	0	1	1	0

Table 1-5: Absenteeism Rate for Nurses in Clinic A

Month	**Absence rate for all categories**	**Sick leave**	**Unplanned leave**	**Planned leave**
January	53%	35%	8.7%	20%
February	44%	34.5%	4.5%	13%
March	37%	28%	3%	5%
April	70%	48%	18%	10%
Total	204% (average 37.8%)	145% (average-36.2%)	34.2% (average-8.5%)	48% (average-12%)

The table above shows the trend and variations of absenteeism among all categories of nurses. Generally, nurses are frequently absent in January and this could be associated with an extension of planned leave for the festive season, and the schools' registration period. However, the picture shows that the majority of nurses report in sick resulting in a monthly increase in sickness absenteeism. This could be associated with job stress and burnout, fatigue and exhaustion due to high patient numbers.

Table 1-6: Absenteeism of Professional Nurses

Month	Overall absence	Sick leave	Unplanned leave	Planned leave
January	53%	8.7%	2.3%	12%
February	34%	20%	5.1%	9%
March	11.5%	4.8%	1.7%	3%
April	50%	10.3%	3%	6%
Total	57%	43.8%	12.1%	30%

PNs are the heart of PHC facilities; the above picture tells us that PNs frequently report sick.

1.4 Purpose of the Study

The purpose of this study is to explore the reasons for professional or registered nurses leaving the Mandeni sub-district PHC facilities.

1.5 Research Objectives

The objective of this study is to:

- Explore reasons for professional nurses leaving the Mandeni sub-district PHC facilities.

1.6 Research Questions

The research question is:

- Why do professional nurses leave the PHC clinics in the Mandeni sub-district?

Significance of the Study

If healthcare facilities are short of professional nurses, it will be difficult to run the PHC facilities because professional nurses are the backbone of PHC services. Since PHC facilities have no resident doctors, PHC PNs or RNs are expected to screen all patients visiting the facilities, diagnose, treat and refer complicated cases to the next level care for further management. Therefore, if our PHC facilities lack such nurses, it means that all patients will

automatically go to the next level of care causing overcrowding, and quality nursing care will not be rendered to patients (Alotaibi, 2008, p.237). This will increase patient waiting time, complaints and litigations, thus causing a loss of money which could be used to improve service delivery. If managers know the reasons why professional nurses leave Mandeni health facilities, they can develop retention strategies which will address the challenges. Consequently, the professional nurses will continue working in the Mandeni sub-district and goals for achieving optimal health for people in KZN province will be achieved (Khunou and Davhana-Maselesele, 2016, p.2)

Demographic variables like gender, age, marital status, dependent children and adults, nationality, ethnicity, level of education, nursing tenure, organisational tenure, positional tenure, location of the PHC clinic, and payment per month, as alluded by Alotaibi (2008, p.237) are used in nursing research as predictors of turnover and turnover intention. Alotaibi (2008, p.237) highlights that demographic variables require more attention from administrators and policy makers because of their potential consequences in terms of the quality of nursing care delivered.

1.7.1 Practice

Policy makers and educators have introduced various strategies aimed at reducing the maldistribution of PNs (Grobler, *et al*., 2009, p.6). This means that turnover can be corrected if maldistribution of PNs is corrected and if the study findings are acted upon, the turnover of PNs can be reduced and that will also improve the quality of nursing care rendered at PHC facilities (Flinkman, *et al*., 2013, p.8).

Chrysler (2017, p.1) states that the most effective way nurses can influence health policy is by becoming a legislator who crafts policy. Most of the state budget goes to fund health care and most legislators are not from the healthcare field. The moment we experience a positive change in the healthcare system, then professional nurse turnover will be reduced as alluded to by James (2016, p.1).

1.7.2 Nursing Management

Nurse managers need to be actively involved or consulted when policies about cutting costs are formulated so that they can advise policy makers constructively (International Council of Nurses, 2015, p.43). Also, the International Council of Nurses (ICN) advocates for participation of nurses in health services decision making and policy development (International Council of Nurses, 2015, p.43). If budget constraints warrant that PNs not be employed, the quality of care delivered to patients will be compromised, leading to high litigation costs (Almalki, FitzGerald and Clark, 2012, p.2). The nurse managers need to be involved when decisions for not employing professional nurses are made because PHC facilities are the first level of care and high volumes of patients visit PHC clinics which are short of professional nurses; this in turn increases patient waiting time and complaints. Almalki, *et al.* (2012, p.2) agree with the importance of human resources in providing quality PHC services, by stating that it is integral for PHC leaders to assess the quality of their work and to understand their organisational and career intentions (Almalki, *et al.*, 2012, p.2).

The majority of PHC facilities experience shortages of PN's due a moratorium on filling vacant posts, in an attempt to curb spending by the KZN Department of Health (HRM circular no 62 of 2016). Consequently, filling vacant posts has become a challenge because institutions have to wait for provincial approval of posts for approximately 12 months before approval is granted. Furthermore, PNs who have left employment have found it difficult to be re-employed, which has a negative impact on patient care. PHC facilities are left with less experienced professional nurses (Alotaibi, 2008, p.243).

1.7.3 Research

This study is important because the findings could assist the sub-district and district to identify the possible reasons for PN turnover for the district, and implement strategies to reduce PN turnover.

1.7.4 Nursing Education

The issue of professional nurse turnover is very wide because it depends on how an individual can cope in stressful situations (Flinkman, *et al*., 2013, p.2). This study will inform

curriculum development to include a chapter that will look at how professional nurses should deal with work related stress.

1.8 Operational Definitions

Turnover

Reineholm, Gustavsson, Liljegren and Ekberg (2012, p.1) define "turnover as voluntary job mobility". In this study, we are looking at the turnover of PNs, meaning those who are leaving the sub-district to work in another sub-district or district.

Primary Health Care

PHC is referred to as the first level of care, a low-cost service, and the service that takes the 'load' from hospitals so that hospitals can do more important, essential or specialised work (WHO 1978, p3). In this study, PHC means services rendered in a fixed clinic, outreach programmes (mobile clinics, school health and ward-based outreach teams) and in the high transmission areas (Republic of South Africa Department of Health, 2011).

1.9 Conclusion

This chapter dealt with the background to the study, the extent of professional nurse turnover worldwide and explained definitions. The next chapter will concentrate on the literature review of the study.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The literature review will give a detailed picture of turnover by definition, legislative framework, and types of turnover. It will highlight stress and burnout as contributory factors, the possible reasons for turnover, overcrowding, sickness absenteeism due to ongoing stress, the cost of labour turnover as well as proposed retention strategies.

2.2 Primary Health Care

PHC is the first level of care. It is an inexpensive, affordable service and relieves the 'load' from hospitals enabling the hospitals to do more important, essential or specialised work. According to WHO, services rendered at PHC level should be available at all times, accessible to all types of clients, acceptable to the community and affordable (WHO, 1978, p.8).

High turnover of RNs defeats the idea and the purpose of primary care services, because accessibility of PHC services is compromised, leaving the community with no other option but to overcrowd hospitals for minor ailments that could have been attended to at PHC level. Akinyomi (2016, p.109) asserts that if the interrelationship between employees and the management is poor, employees will not hesitate to resign for other employment at any available opportunity. Conflict with managers and supervisors, especially in PHC settings, could be a frequent cause of employees' turnover. Working in a PHC setting could be stressful because more clients are seen at this level of care, therefore PNs who prefer to work under less pressure may resign for alternative employment opportunities that promise less stress such as working in a private or urban hospital (Akinyomi, 2016, p.109). The ICN (2015) affirm that South Africa has 39.3 nurses per 10 000 population, but the situation is more severe in rural PHC areas. The above nurse ratio does not correspond to the WHO recommendation of 50 per 10 000 population (WHO, 2006). PHC nurses are seen by the ICN Code of Ethics to have four significant responsibilities, namely: to provide promotive, preventive and restorative health, and to alleviate suffering. They are entrusted with a pivotal role of providing equitable health services, which are people and family-centred, evidence-based and continually improving in quality (ICN, 2015, p.16).

2.2.1 PHC Nurse Shortages

PHC services have suffered RN shortages through migration of nurses from rural to urban, public to private and from primary to higher levels of care (Nilson and Costanza, 2015, p.7). PN turnover in rural PHC facilities is a cause for concern because it is the first level of care where screening of all medical and surgical conditions happens, and a large number of patients are consulted. Therefore, the country needs to put more PNs at the PHC level so that health for all citizens is achieved. Flinkman, *et al.* (2013, p.1) report that "the current and the growing shortage of professional nurses which is estimated to be at 590 000 nurses by the year 2020 is a global concern".

The South African Health Review report estimated a PN shortage of 44 780 in the public health sector in 2011, showing a gross shortage of this category across the PHC system. In addition, the current SANC statistics show a decline in the production of nurses with specialist qualifications, especially clinical specialisations. The National Health Insurance (NHI) project, coupled with the new health sector reform policies, are increasing the demand for specialised PNs. With the implementation of PHC re-engineering, all health districts are expected to employ PNs who will perform outreach services e.g. outreach teams, school health teams, high transmission area and district clinical specialist teams. The NHI project aims to achieve universal access to high quality healthcare services, but this project will not succeed if the scarcity of PNs and its challenges are not addressed (Rispel and Bruce, 2015, p.118).

2.2.2 The Impact of the Nursing Shortage

Recently, as a turnaround strategy to correct the over-expenditure, the DOH in KZN made an announcement that there would be no employment of nurses. At PHC level where deliveries are conducted, lower PN staffing, increases the workload, and poor working environments are associated with nosocomial infections, high child mortality and medical errors (Aiken, *et al.,* 2014, p.1826). PHC nurses carry heavy workloads and are exhausted, and this is aggravated by PN turnover, job dissatisfaction arising from working longer hours and not having the resources to provide quality care.

2.3 Turnover

Reineholm, *et al.* (2012, p.1) define turnover as voluntary job mobility. The term also refers to the intention of the employees to leave their jobs. Intention to leave is an attitude that reflects the individual's tendency to change jobs (Reineholm, *et al.*, 2012, p.1). Employee turnover is viewed as movement of employees from one organisation to another (Pietersen and Oni, 2014, p.142). It is a measure of the number of employees leaving and being replaced within a particular period annually, calculated as a percentage of the total labour force at the beginning of that specific point in time (Akinyomi, 2016, p.105).

For the purpose of this study, we are going to discuss turnover of PNs who have left the Mandeni sub-district and now work anywhere outside the sub-district and the district. The nursing strategy (2013, p.55) reported that nurses who were leaving South Africa wrote several complaints describing their working conditions as 'unbearable' and stating that nurses can no longer 'cope' with the workload". Several reasons were highlighted such as changing bulbs, opening blocked drains, cleaning, dispensing and operating as ambulance drivers and undertakers using their own cars. They also raised concerns such as not being valued by their managers, the community they serve and the health care system as a whole (Republic of South Africa DoH, 2013, p.28).

2.3.1 Types of Turnover

Turnover is divided into voluntary and involuntary turnover. Involuntary turnover is referred to as uncontrollable or unavoidable, because the organisation cannot prevent this form of turnover e.g. death, retirement and ill health of nurses. Unavoidable turnover results from life decisions beyond an employer's control, such as a decision to move to a new area or the job transfer of a spouse. Voluntary or avoidable turnover can be controlled or prevented and is a major concern for organisations because it is linked to the management style and the retention strategies of that particular department, in this case the Department of Health at all levels (Pietersen and Oni, 2014, p.142). Avoidable turnover can be prevented by hiring, evaluating and motivating employees more effectively (Curran, 2012, p.12).

Turnover can arise from different aspects or factors that can be corrected or reduced. Some studies reveal that men are more likely to leave the public sector than women (Masum, *et al.*,

(2016, p.16). In the case of PNs, younger nurses quit more easily than older nurses who are about to retire (Flinkman, *et al.*, 2013, p.2).

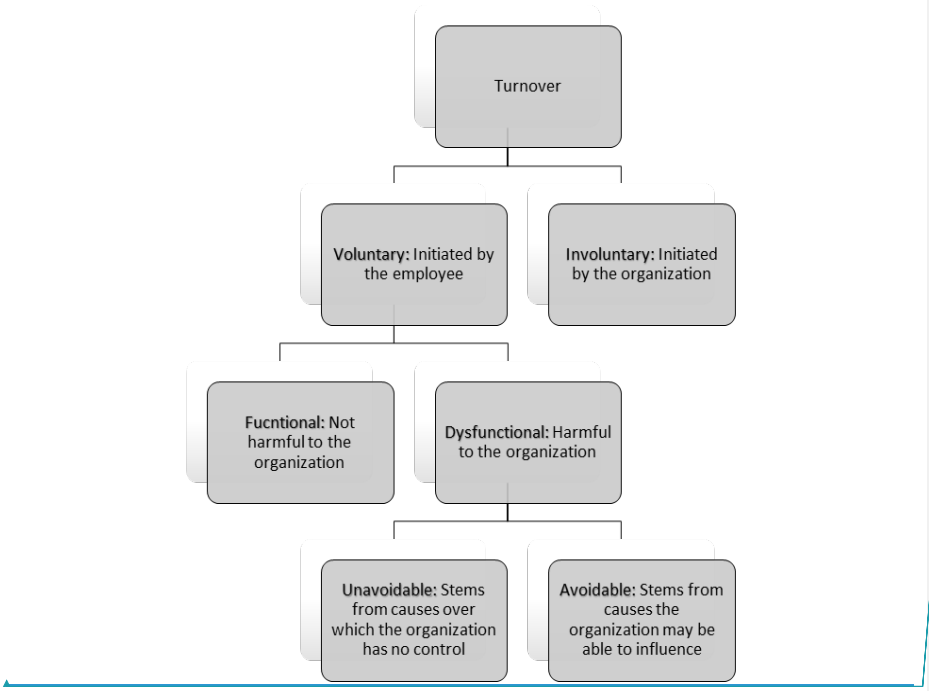

Figure 2-1: Types of employee turnover. Adapted from Allen (2015, p.1)

The figure illustrates that turnover can be initiated by the employee, for an example in PHC setting, if the professional nurse feels that the situation can no longer be tolerated, she or he can resign or transfer to a new place of employment. Sometimes, the employee is dismissed from work due to misconduct. Turnover can be functional if employees who are disrupting the smooth service of the organisation are leaving, like a nurse who is leading a mass action if she or he leave the organisation it may bring about peace.

2.3.2 Factors Contributing to Employee Turnover

Four categories of factors contributing to turnover are highlighted. Firstly, personal factors such as, stating that older employees are less likely to resign than younger employees are, females usually leave employment due to family responsibilities, but employees seek organisations offering better salaries. Secondly, organisation-wide factors which include career pathing, compensation, working conditions and job security. Thirdly, the work environment where staff relations and management style determine employee satisfaction; and fourthly, job related factors such as job requirements, autonomy, challenging work, stress and a sense of achievement (ICN, 2012, p.15-16; Pietersen and Oni, 2014, p.143).

Currently, in the public healthcare system, employees work under stressful and challenging conditions with higher unachievable target demands (Matlala and van der Westhuizen, 2012, p.12). Nurse turnover is associated with lower quality of care and increased mortality rates resulting in litigation (Yaa and Bowblis, 2016, p.1). PN turnover could result in the provincial health departments using agency staff to cover for the shortage of nurses. Current circumstances do not allow hiring, meaning that patients will suffer the consequences of PN turnover (Rispel and Bruce, 2015, p.120).

It is recommended that healthcare organisations should strive to maintain voluntary staff turnover below five (5) per cent, therefore strategies should be employed if staff turnover remains above five (5) per cent (Howard, *et al.*, 2013, p.2).

2.3.2.1 Victimisation/Horizontal Violence as a Contributing Factor

Turnover could result from an unpleasant work environment where there is horizontal violence or victimisation. This is characterised by gossiping, criticism, innuendo, scapegoating, undermining, intimidation, passive aggression, withholding information, insubordination, and bullying, verbal and physical aggression as reported by Bloom (2014, p.4). Nurses who experience victimisation in the workplace are likely to quit their employment (Becher and Visovsky, 2012, p.213).

According to Purpora and Blegen (2012, p.3), victimisation or horizontal violence is a behaviour which is directed by one peer towards another aiming to inflict pain or humiliate,

and devalues the worth of the recipient while denying them their basic human rights (Becher and Visovsky, 2012, p.211). Victimisation is a human rights issue. Individuals violating such rights, warrant discipline (Public Service Commission, 2002, p.22; Republic of South Africa Department of Labour, 1993, Act No. 5, section 12(1)). Nurses decide to leave employment due to workplace intimidation (Bloom, 2014, p.2). Hostile interactions directed at nurses in the workplace come from institutional management, clinic staff, doctors, patients, patients' relatives and the community. Such hostile interactions are demonstrated through acts of unkindness, discourtesy, sabotage, divisiveness, infighting, lack of cohesiveness, and unconstructive criticism (Bloom, 2014, p.3). Similarly, Saunders (2013, p.36) highlights the fact that the consequences of bullying can be so overwhelming that employee victims may leave their employment.

2.3.2.2 Burnout as a Contributory Factor

Burnout is characterised by feelings of tiredness or a negative attitude towards a previously enjoyed job, and this impacts negatively on colleagues and clients through a reduced personal fulfilment or work efficiency (Korunka, *et al.*, 2010, p.7). Burnout is further divided into stages, firstly high workload associated with increased stress levels and job expectations; secondly physical or emotional exhaustion; thirdly lack of interest in the job; and finally, feelings of insufficiency (Korunka, *et al.*, 2010, p.9). This is congruent with the study by Bakker and Costa (2014, p.112) which points out that neuroticism and perfectionism predispose individual employees to cope in the wrong way with their high job demands. Burnt-out employees are likely to be late or absent from work but sometimes presenteeism and sub-standard performance occurs (Bakker and Costa, 2014, p.113).

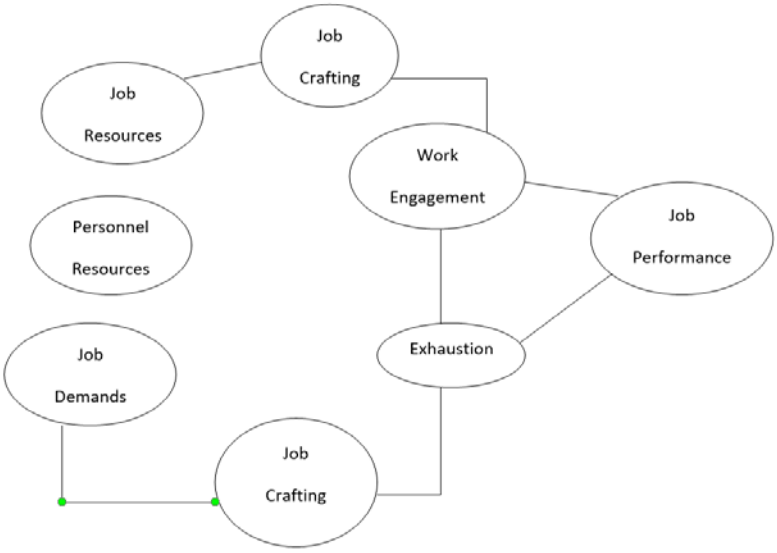

Figure 2-2: The Job Demands - Resources model. Adapted from Bakker and Costa (2014, p.113).

Illustrates factors which could contribute to professional nurse turnover, like if employees lack equipment, shortage of staff where the available workers are not coping with the job, gets tired, sometimes poor planning about work may aggravate the situation.

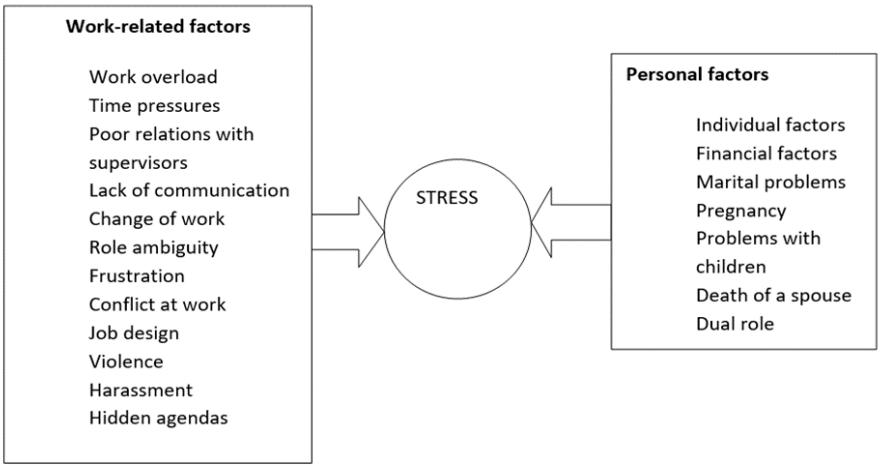

Figure 2-3: Possible causes of stress for the individual employee. Adapted from Bratton and Gold (2003, p.170)

Figure 2.3 illustrates that stress could be caused by factors related to the nature of work or it could arise from personal factors. Therefore factors like patient workload, unavailability of flexible time to attend to personal matters without absenting from duties, poor relations with the supervisor as well as with colleagues, no clear roles spelt out for that specific job, poor job design or working system, violence and harassment could lead to employee turnover. Some individuals cannot cope with any form of stress like financial problems, divorce, difficult pregnancies can make someone to quit nursing as a profession. Delivering a child with gross abnormalities could make a female professional nurse to resign from employment so as to take care of a child, like in a case of Cerebral Palsy. Death of a spouse who was running a family business could warrant a working alive partner leave employment to run a family business.

2.3.2.3 Sickness Absenteeism Resulting from Stress

Sickness absenteeism is viewed by Baydoun, Dumit, and Daouk-Öyry (2016, p.2) as an inability to show up at work when the employee is expected to be at work, due to sickness. Nurses' illness is linked to job stress, workload and working conditions. The work setting, nursing schedules and the duration of shifts has been highlighted as being associated with

higher rates of absenteeism. PNs working in rural PHC settings are more likely to fall sick due to high patient workloads (Baydoun, *et al.*, 2015, p.2). Moreover, the emotional demands resulting from caring for the sick and dying people is seen to contribute to sickness absenteeism of nurses (Daouk-Öyry, *et al.*, 2013, p.2).

Physical demands such as lifting heavy loads and standing for long periods of time, are associated with working overtime and long hours (Rispel, 2015, p.2; Daouk-Öyry *et al.*, 2013, p.2). Musculo-skeletal conditions are prevalent among nurses and could lead to frequent absence from work due to long sickness (Kumalo, 2015, p.1). Lees (2015, p.4) attests that absence affects economic and strategic issues, more so when the colleagues of the absent nurse have to perform the duties of the nurse who did not come to work. The consequence is interruption in the processes and delays in the services rendered to the patients.

Manzi, *et al.*, (2012, p.1) document inadequate staffing of health facilities, a high degree of absenteeism, low productivity of staff and inadequate staffing of RNs. These authors found that clinical staff gave various reasons for absence from duty e.g. attendance at seminars, long training, official travel and entitled annual leave. In contrast, primary healthcare nurses were present for seven hours a day, but only worked productively for 57 per cent of the time (Manzi, *et al.*, 2012, p.1).

2.3.2.4 Reasons for Job Mobility

Some reasons for RNs turnover are decreased motivation due to repetitive tasks, low variety, low autonomy, job dissatisfaction and career development (Reineholm, *et al.*, 2012, p.5). This is congruent with Flinkman. *et al.'s* study which points out that younger nurses are less likely to stay long-term because they are expected to devote themselves to their duty and on no account to put pleasure first (Flinkman, *et al.*, 2013, p,2) before patient care (Aiken, *et al.*, 2014, p.1829). The ICN (2015, p.6) have highlighted several reasons for PN turnover like working long hours under stressful conditions leading to fatigue, injury and job dissatisfaction. Adding to the problem is poor nurse staffing, heavy loads and an unstable working environment, coupled with a lack of equipment.

2.3.2.5 Overcrowding

Primary healthcare facilities are overcrowded due to an increasing number of clients who visit PHC clinics. The Mandeni sub-district has a 40 per cent HIV positivity rate and more than 15000 patients remaining in care. Bekker, *et al.* (2014, p.108) assert that PHC facilities have increasingly become congested, burdened by an ever-increasing pool of stable patients returning for ART, thereby stretching scarce human resources and leading to stress and burnout resulting in PN turnover.

2.3.3 Turnover Costs

Boushey and Glynn (2012, p.2) attest that one-fifth of workers voluntarily leave their jobs each year and an additional one-sixth are fired or otherwise let go involuntarily. However, in the nursing profession the PN is the heart of the PHC services so there are costs involved in replacing the PN. The savings accumulated from firing, in the case of involuntary turnover due to sub-standard performance, will be recovered by the cost of replacing that PN by one who will perform the job better than the one fired. In the case of nursing, costs will be incurred if medical errors or clinical mistakes result into litigations because the Department of Health will have to compensate the victims and incur the cost of defending court cases (Boushey and Glynn, 2012, p.5). McNamara (2012, p.538) attests to the fact that turnover costs cannot be attributed to monetary value but to patients' lives, because patients suffer prolonged pain, delays in treatment, misdiagnosis, mistreatment, and death, because of disruptive behaviour.

Boushey and Glynn (2012, p.5) divide the costs into direct separation costs e.g. exit interviews, severance pay, and higher unemployment taxes; the cost of hiring overtime staff for temporary cover; replacement costs such as advertising, search and agency fees, screening applicants, including physical or drug testing, interviewing and selecting candidates, background verification, employment testing, hiring bonuses, and applicants' travel and relocation costs; the training costs such as orientation, classroom training, certifications, on-the-job training, uniforms, and informational literature.

Allen (2015, p.2) estimates the cost of replacement to range from 50-60 per cent of an employee's annual salary, and above 12 per cent of pre-tax income for the organisation. The

indirect costs are highlighted to be: loss of productivity from the departing employee who may spend their last days at work writing exit memos or with reduced morale; the need for appointing new staff; strain from extra work that has to be shared amongst other employees; costs incurred as the new employee learns his or her job, including reduced quality, errors and waste, and lost clients; and lost institutional knowledge.

Akinyomi (2016, p.109) estimates the cost to range from 30 per cent to as high as 400 per cent of a single employee's annual salary. In contrast, some organisations focus more on increasing productivity and improving customer satisfaction rather than trying to solve problems of turnover by getting replacement staff (Akinyomi, 2016, p.110). Curran (2012, p.19) states that employees who are allowed to participate in decision making are less likely to resign and confirms that there is a link between service delivery and decreased turnover rates.

2.4 Legislative Framework

The Public Service Act 103 of 1994

The Public Service Act No. 103 of 1994 and the Public Service Regulations No. 40167 of 2016, play an important role in setting out the circumstances under which employee exits are affected. They outline the responsibilities of the employee and the employer regarding termination of service. These documents spell out that if an employee wishes to resign or retire, they may do so at any time if he or she has given the department appropriate notice. An employer seeking to terminate an employee's contractual obligations is responsible for notifying the employee in advance and compensating the employee for the income that he or she would forfeit.

However, in a PHC setting, it is difficult to find experienced PHC nurses, which affects the smooth running of the service. In such cases, high turnover rates pose a risk to the institution, due to the lost human capital, such as skills, training and knowledge. Turnover of PNs incurs both replacement costs and a competitive disadvantage to the institution. The audit report on vacancy rates in the Public Service Commission (2008, p.2) reveals that the biggest challenge is service delivery, which is also associated with the slow rate of filling the posts for RNs, especially PHC trained nurses.

The Public Service Amendment Act 30 of 2007

The Public Service Amendment Act 30 of 2007 states that managing human resources effectively and strategically must be the cornerstone of transformation of the Public Service (Republic of South Africa Department of Public Service and Administration, 2007). The changes caused by high turnover rates in primary health facilities has a negative impact on service delivery (Public Service Commission, 2008, p.2).

PHC services in South Africa have suffered RN shortages through migration of nurses from rural to urban, public to private and from primary to higher levels of care (Abuosi and Abor, 2015, p.596). The WHO (2006, p.100) reports that 184 459 RNs and midwives work in South Africa whereas 13 496 (seven per cent) in the European countries. This means that, surprisingly, more nurses are practising in the country, however few PNs are practising in rural PHC clinics because more professional nurses prefer to work in the urban areas rather than rural PHC clinics.

The ICN has drawn up the foundation for the ethical recruitment of nurses worldwide which are as follows: effective human resources planning and development; credible nursing regulation; access to full employment; freedom of movement; good faith contracting; equal pay for work of equal value; access to grievance procedures; safe work environment; effective orientation/mentoring/supervision; employment trial periods; freedom of association and regulation of recruitment (International Council of Nurses, 2001). MacPhee and Borra (2012, p.8) assert that lack of control over working conditions and work positions is a 'push' factor associated with the migration of nurses.

2.5 Strategies to Reduce Turnover

The strategy spells out that an employee who has been offered a post on a higher salary level or notch in another department or any other organisation outside the public service, may be retained in line with the objectives and priorities of the Department of Public Service and Administration (DPSA), if such an employee has: firstly a critical skill (he/she needs to achieve the core operational objective of a component/branch); secondly, a scarce skill (he/she has highly valuable skills which are difficult and expensive to recruit and are available on short notice); and thirdly, a high level of performance (his/her performance is

rated in terms of Performance Management and Development at 130 per cent and above for the past six months).

The option to retain an employee shall occur to the extent that the retention offer made to the employee by the prospective new employer shall be similar to the total remunerative package, to the notch closest to the salary scale used in the public service that DPSA may consider offering. An employee can be horizontally transferred within the DPSA if this would address career development aspirations. Due consideration must be given to such an employee whose performance is rated as more than fully effective (100+); and where service delivery ethic is displayed through high performance; and where the DPSA wants to prevent the loss of the knowledge, competence and exemplary public servant service attitude of the employee (Public Service Regulation, 1/vll/c.2.5).

It is important for the public service to develop and implement an effective career management system (PSC, 2008, p.2). Public institutions are compelled to remain competitive in terms of ensuring that they are well equipped to retain their most valued human resources, which is the challenge when looking at the high turnover in the public service (PSC, 2010, p.18). However, the challenges associated with poor service delivery relates to the fact that there is a general skills shortage in the public service.

The employee may be retained because of the service delivery ethic displayed by the employee through high performance and where the department wants to prevent the loss of knowledge, competence and exemplary public servant service attitude of the employee. Special measures to ensure the retention of women and people with disabilities should be targeted, for example prevention of sexual harassment and accessibility for people with various disabilities as stipulated in the Protection from Harassment Act (17 of 2011). This is congruent with the code of good practice on the employment of people with disabilities and a code of good practice on the integration of employment equity into human resources policies and practices.

The DPSA should provide growth, development and empowerment opportunities to ensure employees acquire competencies that improve their ability to work in other areas within the DPSA to enable progress to higher salary levels. The DPSA should ensure that employees

have access to development and training that supports work performance and career development like bursaries, short courses, job rotation, in-house training to further their education and expertise. The DPSA should design and evaluate jobs in scarce and high-risk categories and evaluate them to maximise the compensation that can be offered to employees (DPSA 2008, p.3).

Dawson, *et al.* (2014) suggest strategies to reduce staff turnover as; provision of employment options; rewarding good performance; enhancing professional development and training opportunities; and improving management practices. Chiller and Crisp (2012, p,234) state that professional supervision plays an imperative role in contributing to workforce retention. Professional supervision has three diverse functions that entail management, support and professional development, and include sharing of ideas between the less experienced supervisee and more experienced supervisor, in a discussion meeting.

Werner, *et al*. (2012, p.167) highlight that some organisations use contingent workers, and rehires and recalls in order to overcome staff turnover, but KZN province does not support this strategy. 'Contingent workers' is defined as people hired with no implicit or explicit contract for long-term employment, 'free agents', independent contractors, and temporary workers. Improving supervisor-employee relationships should be viewed as an on-going process rather than a one-off event. It is essential to have reinforcement and allow time to apply the skills. Akinyomi (2016, p.110) affirms that the quality of the relationship an employee has with immediate managers lengthens the employee's stay in an organisation. In addition to that, working environments that are comfortable, relatively low in physical and psychological stress, facilities and attainment of work goals, is viewed as factors that will produce high levels of contentment among the PNs (Akinyomi, 2016, p.110).

Conclusion

A comprehensive exposition of the concepts related to turnover has been described. The following chapter will describe the methodology of the study.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter outlines the research design, recruitment plan, population and selection criteria, sampling method used, data collection and data analysis and ethical consideration for the study.

3.2 Research Design

A qualitative exploratory and contextual using narrative approach was suitable for this research topic. The design allows the study participants to express their views freely, and the interviews also give the researcher an opportunity to talk with individuals who have left the sub-district (Grove, Burns & Gray, 2013, p.23) .The opportunity was indeed a valuable one because the participants were free to express their emotions, whereas the researcher was afforded a privilege to see non- verbal gestures (Creswell, 2013, p.20)

This type of a research may lack a clear course at the outset, and may change direction more than once because the researcher will be directed by the participants' responses (Mahmud, 2012, p.36). This approach is directed at understanding a phenomenon from an individual's perspective (Creswell, 2009, p.8).

3.3 Study Setting

Mandeni is a semi-rural sub-district towards the Northern region of KZN. It is densely populated, serving a catchment population of 150 848 currently. There is one Community Health Centre which serves almost 50 per cent of the population. Clinic A is situated in an industrial area, which is surrounded by informal settlements, it has been severely affected by political instability, and migration of clients due to retrenchments when industries close down. Currently, the clinic is serving a catchment population of 28 676 and these numbers are increasing annually. From clinic B up to clinic G the population numbers range from 6000 - 10000. Although, clinic H serves a smaller population of 5000, the PN's turnover is increasing. HIV prevalence is 40 per cent, and a total of 18 322 patients are on antiretroviral drugs, as reported by DHIS for the year 2016/2017. These figures are increasing monthly. The number of deliveries conducted in the year 2016/2017 was 1157. Children under five

years if age, diagnosed with severe malnutrition, were 33 and these figures are increasing monthly. The disease burden warrants careful allocation of resources in order to improve the health status for all sub-district citizens. PHC clinics, the first level of health care, are PN driven. If PN turnover is not acted upon, the community will suffer the consequences. The sub-district is semi-rural, but the road going to clinic H is very bad. Clinic B is a 24-hour clinic with a population of 28 676, it is situated in the industrial area, surrounded by an informal settlement. Based on the evidence highlighted by the study, this clinic seems to be severely affected by PN turnover followed by clinic A, which is situated in a densely populated township amounting to 72 242 with a high HIV/AIDS and non-communicable disease burden. Currently, the total population for the sub-district is 150 848, which is increasing annually.

3.4 Population and Sampling

The research population for this study was professional nurses who were employed at the particular sub-district during 1 June 2010 until 31 December 2015. Therefore, all profession nurses who met the inclusion criteria had a chance to be selected (Brink et al., 2012, p.131). Non-random method was used for selecting professional nurses (Yon, 2015, p.23) and a purposive or judgemental sampling allows the researcher to select participants who will yield more information on the topic under study. Consequently, the researcher, decided to use non-random, purposive sampling for the study because she was exploring turnover. Not all professional nurses fall under this phenomenon. The researcher did not distinguish between genders or age groups as turnover affects all nursing professionals. Since it is very difficult to recruit professional nurses who have a speciality in Primary Care, the researcher decided to select only PHC trained nurses (see table 3-1). The researcher could not find all the professional nurses who were selected, but after interviewing five of the participants saturation was reached. The list of potential participants was obtained from the human resource department and 11 participants were selected but six participants could not be found because their telephone numbers have changed.

For Palinkas, *et al.* (2015, p.11), sampling should be done following seven principles of sampling: Sampling should follow a sequence from the conceptual framework as well as research questions to be addressed by the study. Sampling should generate a thorough

database on the phenomenon under study. There should result a possibility of drawing clear inferences and credible explanations from the data. Ethical considerations should be put in place, and feasibility conducted of the sample plan. It should allow the researcher to transfer/generalise the conclusion of the study to other settings. The sampling scheme should be as efficient as it is practical (Palinkas, *et al.*, 2015, p.11).

For the purpose of this study, the researcher purposely selected all PNs who have resigned or transferred from the sub-district during the study period (01 June 2010 - 31 December 2015) as the study population (Polit and Beck, 2008, p.17). The human resource department gave the researcher a list of PNs who left during that period with their contact details. A purposive sample strategy was implemented by inviting the PNs to participate in the study telephonically. A total of eleven PNs were selected to be interviewed according to the agreed appointment schedule (Brink, 2010, p.124). The PNs were selected from the list of eight clinics. The characteristics of the clinics are summarised in table 4.1.

Table 3-3: Sampling strategy

Clinic	Category	Catchment Population	Number of PNs resigned	Number of PNs transferred	Number of PNs selected
A	CHC	72 742	14	11	3
B	PHC	28 676	11	10	2
C	PHC	10 364	1	1	1
D	PHC	7 314	0	0	0
E	PHC	7 157	1	1	1
F	PHC	6 944	2	1	1
G	PHC	6 555	2	1	1
H	PHC	5 092	2	1	1
Total		150 848	33	26	10

The PHC clinics are categorised according to their headcount which is between 13192 - 26384 for fixed PHC clinic and 65 895-105 432 for CHC (DOH, 2015,p. 24)

3.4.1 Inclusion Criteria

The study included all PNs or RNs who have signed the informed consent to participate in the study; all age groups; all racial groups.

3.4.2 Exclusion Criteria

Excluded in this study:

- All RNs who declined to give consent;
- RNs working overseas;
- RNs who have been promoted; and
- RNs who have retired.

3.5 Ethical Considerations

Ethical considerations was discussed in detailed as follows: The research study topic Exploring reasons for high staff turnover amongst professional nurses at Mandeni sub-district primary health care facilities was granted approval by the University of KwaZulu-Natal ethics committee (see appendix 4), KZN provincial Department of Health (see attached appendix 6), ILembe District Manager (see appendix 7) and by the Chief Executive Officer of Mandeni sub-district (see appendix 5). Although the study participants were professional nurses who were no longer working in the sub-district, but permission was granted based on the fact that the researcher had to go through all the information which was available at the sub-district for all professional nurses who left the institution and one participant was re-employed after leaving the sub-district for 3 years.

3.6 Data Collection

The interviews were conducted using an unstructured interview schedule, which was adapted after testing one PN who was not included as a participant. The PN was interviewed based on the researcher's knowledge that she is a trade union representative; therefore she will give

information that all nurses verbalise to her as a nurse representative. Data collection commenced from April 2016 and completed in August 2016. The researcher used a tape-recorder and notepad to write notes. For each participant the interview last about 30-60 minutes. All participants were willing to express true feelings about issues at hand.

Denzin and Lincoln (2011, p.421) state that narrative inquiry revolves around an interest in life experiences as narrated by those who live them. Similarly, Muylaert, *et al.* (2014, p.186) explain that narrative interviews are techniques to generate stories that can be analysed in different ways after capture and transcription of the data. Therefore, the interviewer must be able to note tone of voice, pauses, changes in intonation, and silence that can be transformed into narratives not heard (Muylaert, *et al.*, 2014, p.186) Consequently, the objectives of narrative interviews is to understand the context in which the biographies are constructed and the factors that produce change and motivate the actions of the informants (Muylaert, *et al.*, 2014, p.187). Similarly, tape-recording is viewed as helpful during the interview and after the interview because it offers an opportunity for the interviewer to listen carefully, probing, and paraphrasing the sentences to check understanding while maintaining eye contact (Edwards and Holland, 2013, p.69).

This was done so that participants can express themselves freely. Since the researcher gave participants freedom to choose the venue which will be comfortable for them, some were interviewed in their workplace if the environment was conducive for conducting interviews and some were interviewed in the researchers' car. Data saturation was reached when interviewing the fifth participant (Burns & Grove, 2011, p.317). Interviews were arranged such that the participant can give information about personal detail in closed ended questions and open ended questions were ask to allow the participant narrate or to express feelings about the matter in question (see appendix 2). The aim of the study was to enquire why professional nurses leave Mandeni sub-district and it enabled the researcher to determine the extent of turnover and make recommendations which will help all sub-district managers to reduce professional nurse turnover and improve the quality of services rendered by the sub-district PHC facilities (Grove et al., 2013, p.26).

Narrative research is viewed as an attempt to organize and express meaning and knowledge in a naturalistic setting (Brinkman& Kvale, 2015, p.178). This is why the researcher had to

let the participants choose the place of an interview because she wanted to eliminate any discomfort and allow participants to tell the truth. Attention was taken to physical environment; some interviews were schedule for the evening at 19H00, because less interruption is experienced during that time in the rural township. Confidentiality and anonymity was ensured to the participants, all participants were afforded time for questions and clarity before signing consent forms (Grove et al., 2013, p.172). Participants were informed that they could say everything the which to without fear of not getting employment in future and that they could discontinue the interview process at any time without fear of victimization. The main question was: Why have you decided to leave employment at Mandeni PHC facility? The researcher gave time for the participant to narrate his or her story, listen actively and the probing questions were relevant to the answers given by the participants like:

You said you left because of work pressure, and you have been working for this sub-district for more than three years now…What made you to say enough is enough I am now leaving?

I understand your immediate supervisor was ill-treating you…. What have you done to report the situation?

You said sometimes there was no water in the facility and you were expected to deliver patients….What happened to JoJo tank? (see appendix 9).The researcher made and kept notes after the interviews which she double checked with the participants. Non-verbal cues and emotions were noted and written down and included this information with data analysis.

3.7 Data Analysis and Data Presentation

Brink (2010, p.184) states that qualitative data analysis is described as a 'hands-on process' during which the researcher becomes deeply immersed in data; it is also sometimes referred to as 'dwelling' with the data. Therefore, data analysis is not a distinct step in the qualitative research studies process, but is done concurrently with data collection. Content analysis was used for the study, all the information collected was transcribed verbatim, and themes were formulated and grouped together according to the similarities as it is presented in the next chapter. Bengtsson (2016, p.10) points out that content analysis can be utilised in all forms of written texts no matter where the information comes from, and there are no definite

guidelines to be followed. Furthermore, Bengtsson highlights that content analysis fits in both quantitative and qualitative methodology as it can be inductive or deductive. Therefore, in qualitative content analysis data are presented in words and themes making it possible to infer the outcomes (Bengtsson, 2016, p.10). The researcher collected, organized and interpreted data. To minimize confusion, the researcher developed the process in phases and created different folders for literature review, interviews, transcriptions and all information was also emailed to my supervisor foe external back-up and a new flash drive was procured to keep data for my thesis. This was a wise decision because my personal computer had some problems and all folders got lost but there was a back-up hard drive. Hardcopies of the completed consent forms, field notes, voice recordings, and all electronic data were stored in a password protected folder on the researchers' personal computer to ensure that ethical principles were followed.

Two days after each and every interview session, the researcher typed the transcribed interviews verbatim from the digital recordings. Transcriptions were labelled with codes that were only known to the researcher. The contact details and identity of participants were kept in a separate file for future references and when need arises. The researcher had to listen to the recordings several times, during transcription for analysis of information process. Coding of data was done by the researcher and themes were formulated with the assistance of the research supervisor using Tesch's method of analysis (Creswell, 2014,p.198). The researcher had to make frequent appointments with the research supervisor during this process until themes were well formulated and the supporting literature was complete.

3.8 Academic Rigor

Ensuring compliance to scientific evidence refers to credibility, dependability, confirmability, transferability and authenticity of the study. Leedy and Ormrod (2005, p.154) affirm that rigor serves to evaluate the quality of the research by stating that a researcher uses rigorous, precise, and thorough methods to collect, record, and analyse data. Furthermore, the concepts of validity and rigor can be applied to all types of research because it is one of the criteria for ethical consideration of the scientific study (Polit and Beck 2008, p.537). Guba and Lincoln (1994) agree with the terms of rigor and validity by developing four criteria for trustworthiness of a qualitative study, namely: credibility, dependability, confirmability,

transferability; and they later added authenticity, after much emerging criticism (Guba and Lincoln, 1994).

3.8.1 Credibility

Polit and Beck (2008, p.540; 2012, p.175) define credibility as "an overriding goal of a qualitative research, and also refers to confidence in the truth of the data and interpretations". In this study credibility was ensured by writing notes, tape-recording, transcription using verbatim words, and formulation of themes and sub-themes using content analysis. The research supervisor was made to listen to the tape recordings for interview sessions, corrections were made and the researcher had to omit some questions that were irrelevant. When checking data collection tool the question about impact of HIV/AIDS was not well answered and the researcher did not utilize that question.

3.8.2 Dependability

Dependability refers to the stability (reliability) of data over time and over conditions (Shenton, 2004:72). To implement dependability, the written notes and tape-recorder were sent to the supervisor as an independent reviewer to check accuracy of data collected and findings. Quotes from the participants' stories were documented in the report findings. Participants were selected from human resource data base representing all clinics who were affected by this phenomenon of professional nurse turnover. (Polit & Beck, 2012, p.497).

3.8.3 Confirmability

Confirmability refers to the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning (Shenton, 2004:72). In order to comply with confirmability, the researcher recorded data using a tape-recorder, and after writing the notes read through the notes asking the respondents to verify the data collected. However, if the participant feels that some statements were misquoted, or the meaning is not clear, the data was corrected immediately after the session. The researcher was double checking the information that was narrated by each participants, for confirmability, so as to correct errors while the participant is available to ensure credibility of the study (Brink et al, 2012, p.99).

3.8.4 Transferability

Transferability refers to generalizability of the data, that is, the extent to which the findings can be transferred to or have applicability in other settings or groups (Shenton, 2004:69). A full description of the participants and the sub-district setting is clearly explained in detail by the researcher.

3.8.5 Authenticity

Authenticity refers to the extent to which the researcher fairly and faithfully shows a range of different realities (Polit and Beck, 2012:175). It is believed that authenticity is achieved if a text invites a reader into a sensational experience of the lives being described, and enables readers to develop a sharpened receptivity to the issues being depicted (Polit and Beck, 2008, p.540). This was achieved by the supervisor's reaction when she was listening to some of the recordings, which were very sensitive. When the supervisor was listening to the recordings, she was shocked to hear that one of the participants left because the participants life was in danger.

3.9 Conclusion

This chapter presented the research design, population and sampling, ethical consideration, data collection and analysis and presentation, limitations, recommendations and academic rigor. The next chapter will present the study findings.

CHAPTER 4: FINDINGS AND DISCUSSION

4.1 Introduction

In an attempt to know more about why the PNs decided to leave the sub-district and work somewhere else, five PNs were interviewed between April 2016 and August 2016. All five participants agreed to participate and signed consent before the interviews started.

4.2 Description of the Participants

A total of five study participants comprised of PNs who previously worked at clinic A, clinic B, clinic G, and clinic H. All five participants were qualified in general nursing, midwifery and primary healthcare. Two were males and the remaining were females. Four of them were married and one was single. Their ages ranged from 28-46 years. One participant was single, and the rest married. All participants were parents, and none lived with their families while they were employed at Mandeni sub-district. During the time of the interview in 2016, two of the participants lived with their families. The minimum period working in the sub-district ranged from 14 months to five years. Four of the participants were willing to come back and work in the sub-district if issues raised were attended to. One would not come back because he/she had bought a house and was staying together as a family. All participants were known by their supervisors and colleagues to be knowledgeable and very passionate about their profession.

Interviews were conducted from April 2016 until August 2016. Each interview session took 30- 60 minutes depending on the pace of the participant and the probing questions. During the interview sessions one participant seemed to be very angry with the supervisor, such that after the session the researcher asked if she could organise a counselling session, which was denied. Then after one week the researcher made an appointment to monitor the coping skills of the participant and she verbalised that the interview session was a healing process because she got an opportunity to express her anger to someone who could listen to her frustration. Transcriptions were written verbatim and the information was categorised and coded, as a result themes and sub-themes were formulated as follows.

4.3 Summary of the Themes and Sub-themes

The findings revealed four themes describing the reasons for high staff turnover amongst professional nurses at Mandeni sub-district PHC facilities. It can be summarised in the following table.

Table 4-4: Formulation of themes

Themes	Sub-themes
Employee – employer relationships	Victimisation in the workplace Poor employee – supervisor relationship Favouritism
Staffing the clinics	PN shortage Absenteeism Staff scheduling On-call system
Lack of district and sub-district management support	Poor water supply Poor infection control practices Clinic advisory committees
Employee financial problems	

4.4 Employee – Employer Relationships

4.4.1 Victimisation in the Workplace

One participant was informed that there was a man who came to the facility who wanted to see her. It was alleged that the man was sent to kill her.

> *Yes, but the main reason is when I heard that there were people who were planning to kill me* (PN 1 from clinic B).

The matter was reported to the immediate supervisor, but seemingly, no action was taken. The participant felt unsafe.

> *I was informed and was surprised to hear that at a later stage the informant told (the immediate supervisor) that there was a plot, but my supervisor never said anything to me* (PN1 from clinic B).

She expected the supervisor to call her and tell her about the rumours and try to protect her from danger, but that was not done.

> … *and she didn't phone the police* (PN1 from clinic B).

The participant resigned, giving 24 hours' notice.

> *Immediately* (PN1 from clinic B).

She resigned because she felt that perhaps she was no longer needed in the facility. Victimisation and intimidation, was noted from the above statements.

A PN was no longer comfortable at work and this is evident from the following quotation:

> *Staff members, the subordinates were turning against me, even the subordinates were against me* (PN from clinic G).

The abovementioned nurse was passionate about her nursing duties, as witness by the researcher who was working as the clinic supervisor during the time when the participant was working at the sub-district. All patients under her care were satisfied with the level of care received from the participant, to such a degree that when she left, the PHC office received complaints from the patients. Patients asked that the same nurse return to the clinic because patients no longer received the same courtesy as when the PN was still at the clinic.

Sometimes high performers end up becoming victims of victimisation. Kim and Glomb (2014, p.620) reveal that high task performance can be one such triggering factor because when compared to other employees, high performers are likely to enjoy higher pay, more prospects for promotion, higher social status, and more courtesy and acknowledgement. Consequently, the study pointed out that these additional resources may incite other members to resort to destructive activities.

Saunders (2013, p.36) highlights that the consequences of bullying to the victim can be overwhelming. Some employee victims leave employment due to bullying (Cunnif & Mostert, 2012, p.3; Mvunelo, 2013, p.112). The clinic has a policy addressing violence and abuse in the workplace. The policy outlines the procedure for dealing with the incidents of violence towards staff and the disciplinary actions or sanctions applicable in terms of the disciplinary code (Public Service Commission, 2002, p.22). The institution has a policy in place to deal with intimidation in the workplace, but is unable to take action if the matter is not reported by the victim.

4.4.2 Poor Employee – Supervisor Relationship.

One PN was not on good terms with the supervisor. The supervisor arrived at the clinic without prior arrangement and made changes without consensus. The supervisor would implement changes like changing the routine in nursing duties which according to the participant was working well for the clinic without any agreement with the operational manager and the staff or explain why changing the routine and as a result there was resistance to change from the staff and conflict between the staff and the operational manager which could have been prevented. This is evident from the following quotations:

> *I can say it wasn't a good relationship because the supervisor would come to the clinic without giving notice that she is coming* (PN1 from clinic B).

Neither did she explain why she visited the clinic as stated below:

> *Sometimes she would come to the clinic and never come to say I'm here to do this.*
>
> *If the supervisor came to the clinic and did not find you, she would change things in the clinic and not tell you the reason for changing* (PN1 from clinic B).

In this regard, Herbers (2012, p 81-82) points out that it is virtually impossible for employees who dislike each other, or their boss, to be happy in their work. In addition, Khamisa, *et al.*, (2015, p.660) state that in the overburdened South African health system, nurses may fail to meet their job demands due to poor staff management, which may negatively affect morale. This is congruent with the study conducted by Munyewende, Levin and Rispel (2016, p.2) who attest that competent PHC managers should be able to facilitate the implementation of

health care reforms, through ensuring staff participation and managing complex change. The study affirms that on-going assessment of health managers' competencies is associated with health system strengthening, staff retention and job satisfaction (Munyewende, *et al.*, 2016, p.2). It is expected that the manager should develop leadership skills like: being able to take actions, adapting to changing environments, have self-confidence, be a great communicator, show humbleness, be a life-long learner, have interdisciplinary focus, be conflict embracing, be a visionary, have systems-oriented thinking and be familiar with the latest technology (Dolamo, 2014, p.4).

Heaton and Atherton (2012) cited in Dolamo (2014, p.4) concur with the following characteristics of leaders: receptive to new and creative ideas, managing and coaching staff through human relationships, long-term success by avoiding occasional episodes of power-related stress, be a good listener, sensitive to the emotional impact of the behaviour from others, display a positive attitude, promote reality through spoken words, act as a mediator and establish performance expectations. Maxwell (2013) cited in Dolamo (2014, p.5) affirms that a manager should employ managerial as well as leadership skills, which include; providing direction, setting a good example, values people, giving feedback to followers on issues and mentoring future leaders.

Nurse managers are expected to transform leadership skills into qualities like having a positive attitude, courage, introspection, cultural identity, communication skills and also embrace diversity of all kinds (Dolamo, 2014, p.5). It is not good for any manager to undermine the intelligence of staff members; each step taken to correct the working system should involve every individual in the decision-making process. This is done so that the manager gets the buy-in of all relevant stakeholders, in order to deal with resistance to change (Dolamo, 2014, p.9).

4.4.3 Favouritism.

A PN complained about a supervisor who expected that when the PN was off-duty, far from the workplace, that the PN return to work and orientate a newly employed nurse.

> *The thing that made me leave was that I was at home. There was a new staff member, then she called me and told me that these professional nurses cannot work alone. I*

> *work alone, maybe the whole week I would work alone, but that professional nurse wouldn't work alone. That's why I decided that maybe I no longer belong in this facility, maybe it's the way she is chasing me out* (PN from clinic G).

A PN complained that a supervisor made the PN work alone for abnormal, on-call extra duties, whereas the colleagues of the PN were offered assistance. This participant was made to work alone even if other staff members were present. Her perception was that this was because those nurses were friends of the supervisor. The logic being that the new nurse could not work alone. Chrysler (2017, p3) states that supervisors should strive towards winning the trust of their employees in order to reduce litigation. Furthermore, three key factors are emphasised; to avoid favouritism, provide flexibility and to take responsibility.

4.5 Staffing the Clinics

4.5.1 Professional Nurse Shortage.

Four of the five PN's complained about PN shortages and the on-call working system which exacerbated the shortage and the quality of care.

> *But at our clinics there is a shortage of nurses, you will be on call at night. Maybe you have two deliveries which will take you more than five hours at night, and in the morning, you are expected to be there at 7 o'clock. There is no one else to work so that you rest.* (PN from clinic G).

> *There was a shortage of professional nurses and the community was very rude* (PN2 from clinic B).

Hassan and Heywood (2007, p.331) attest to the fact that budget cuts, frozen posts and decreased funding in the healthcare sector poses a threat to the healthcare workers, and their rights are neglected. The PNs who were working at 24-hour clinics were concerned about the increasing number of patients who visit their clinics. The quality of care rendered to the clients is compromised and medical and clinical errors are possible, leading to litigation.

One PN highlighted that it could be the reason why the facility where she was working had an increasing number of fresh still births.

> *You leave the patient alone and go to [the] antenatal care (ANC) room and do your ANC, then maybe you will hear the patient screaming and you remember oh there was a patient in labour. You will leave these ones and go to [the] labour ward, maybe that's why sometimes we find FSBS (still born babies) most of the time* (PN 2 from clinic B).

They were unable to monitor women in labour closely. The maternity guidelines state that women who are about to deliver should be closely monitored by doing half-hourly observations (Republic of South Africa Department of Health, 2016, p.45).

> *If the patient is in labour you must stay with the patient until delivery, but there you had to leave and continue with your ANCs* (PN2 from clinic B).

Due to the shortage of PNs at the time, women were left alone so that the nurse could continue consultations with the queue of patients waiting for the same nurse. As a result, patients waited more than three hours before being consulted by the PN. The patients pass bad remarks, shouting at the PN, telling the PN to work faster, telling her she is lazy.

> *It was difficult because there was a shortage of professional nurses and the community was very rude* (PN2 from clinic B).

The increase in the number of stable patients who were collecting their medication for chronic illness was a challenge because the 24-hour clinics are situated in a densely populated community, in an industrial area surrounded by informal settlements.

> *I think the headcount was high too, compared to the professional nurses, since there are factories around the clinic and informal settlements there* (PN2 from clinic B).

At the time, issuing of medication in the community was not yet implemented; hence, patients were very rude to nurses because they had to wait in the long queues for collection of medication. The shortage of professional nurses is a cause of concern as this is confirmed by the study findings of Kovane, (2015: 3.4) where 69% of professional nurses strongly agree that the amount of work is overwhelming and patient staff ratio is too high.

> *There are patients from different areas. They [are] all there, and most of the community [are] there. Some of them are collecting ARVs there and if they are coming to collect ARVs they are coming in numbers* (PN2 from clinic B).

The increase in the number of patients that are visiting the PHC clinic was an issue of concern for nurses working in the clinic as the following statements highlighted:

> *The HIV/AIDS effect was too bad on Fridays because the patients come in numbers after 12h00. We used to have patients in numbers in such a way that you can just find 40 patients at the time, then when you finish [with] them they will continue coming, because the nearby factories were also closing at 13H00* (PN from clinic A).

> *We suggested that due to many patients at CHC we think it is important to come to work on holidays and weekends* (PN from clinic A).

This is congruent with the study that was conducted by Makhado and Davhana-Maselesele (2016, p.6) which affirms that nurses who are working with HIV/AIDS patients are prone to high emotional exhaustion and high depersonalisation leading to burnout. The recommendations of the study done by Makhado and Davhana-Maselesele (2016, p.7) was firstly to encourage internal personal coping strategies. Secondly, the provision of a positive practice environment should be encouraged. Thirdly, nurses should be allowed to express their concerns and have its legitimacy understood, receive stress management training, and have policies in place so as to reduce stress levels; and fourthly social support is viewed as the mechanism to reduce burnout and stress amongst nurses.

The situation was aggravated by the PNs who would not report on duty because they were sick or did not come on duty for other reasons. Oke & Dawnson, (2012, p.317) and Pereira, Fonseca & Carvalito, (2012, p.374) who stated that stress could lead to physical symptoms that could make employees feel sick and do not report on duty which also contribute to turnover.

> *People were booking off sick* (PN1 from clinic B).

They did not report their absence from work either. In addition to that, if the PN took her time off as a refund the other PN who was left behind to continue with duties, accumulated more

hours too, and it became a vicious cycle of accumulated hours that could not be refunded in full. Overcrowding and patient workload is viewed as one of triggering factors for workplace violence against nurses by (Boafo, 2017, p7).

> *I was on call for 13 days, but when I saw my claim form only two nights were claimed, and what about these other 11 days? So I got that bad attitude about on-call because somebody was taking out my money* (PN from clinic G).

This is congruent to the study conducted by (-Cunniff & Mostert, 2012, p.3) who reported that sometimes nurses feel that they are unfairly treated by their supervisor as a result such nurses would not come for their duties just for revenge. Mvunelo (2013, p.112) affirms that workplace bullying can cause another worker to suffer while other workers are comfortable in a workplace; such workers are the first ones to quit employment.

Generally, all the participants raised their concerns about patient overcrowding and high workloads which they were unable to handle. This is consistent with the study of Makhado and Davhana-Maselesele (2016, p.2) which states that currently, public healthcare facilities are overcrowded due to a unified and transformed health system, which gives the majority of the poor population an opportunity to free healthcare services. Additionally, better-equipped facilities are crowded due to people shopping around for effective health services as in the case of clinic A and B, where patients arrive for care because they are dissatisfied with service delivery in the clinics nearest to where they live.

4.5.2 Absenteeism

Sickness absenteeism was noted in clinic B during 2016 because in KwaZulu-Natal DoH due to delays in the replacement staff (HR circular, 62 of 2016). Therefore, employment processes were taking more than six months for a vacant post to be filled and that contributed to professional nurse turnover. All categories of staff members were not reporting on duty and there was no valid reasons mentioned by that specific staff member and the disciplinary processes were not helping to control frequent absence from duty because the root cause was not identified. The following statements confirm this.

> *General workers' absenteeism, ….* (PN1 from clinic B).

Yah people were booking off sick (PN2 from clinic B).

Kramer and Son (2016, p.940) points out that healthcare personnel are unprotected from work-related threats to their physical health. A Tanzanian research study documents inadequate staffing of health facilities, a high degree of absenteeism, low productivity of staff and inadequate staffing of RNs (Manzi, *et al.,* 2012, p,1). Salaree, *et al.* (2014 p.274) affirms that burnout is demonstrated in an individual by a sense of worthlessness, tiredness, demotivation, or overuse of medication, that could lead to suicidal attempts, frequent sickness absenteeism from work and eventually quitting the nursing profession.

This had a negative impact on staff relations because the PNs who did not fall sick felt that they were overworked by those who did not come on duty, and no disciplinary measures were in place to control the behaviour.

> *I decided to leave employment at clinic because of working pressure; there was a shortage and poor communication between myself and management* (PN1 from clinic B).

DENOSA is of the opinion that working conditions should be improved, as money cannot compensate for bad working conditions (Bodenheimer and Sinsky, 2014, p.2).

4.5.3 Staff Scheduling

Staff scheduling was a challenge as is evident in the following statements:

> *The off-duties while we were having no operational manager were not done in the way we are comfortable with. We were given one day off in the middle of the week. [This was] a challenge because we were not living in the Mandeni sub-district, sometimes we move to our home to visit our relatives as well* (PN from clinic A).

The off-duties were designed such that the participant worked day and night for a continuous period of more than seven days. Her perception was that nobody cared about the participants' welfare (PN) or the welfare of her patients. The participant experienced loneliness and isolation as there was no one to whom she could express her feelings or cry to.

Some employees have an added responsibility to look after the welfare of their family members; this means that their off duties should accommodate social responsibilities:

> *I left the clinic due to personal reasons, since I am the bread-winner for my family and I wanted to get a lump sum of money so that I can finish some projects that I have started at home* (PN2 from clinic B).

> *I got married and I was still staying at my homestead and I decided to get my own house* (PN from clinic H).

> *Sometimes we move to our home [and] visit our relatives as well* (PN from clinic A).

Bird (2016, p.3) argues for a number of legal reforms that would allow working families, especially single-parent and low-income families, basic access to the rights and protections of flexible work. Similarly, Steyn *et al.* (2015:652-2) affirm that nurse scheduling, which addresses nursing constraints and preferences while improving service delivery, will result in a higher performance and a better-quality work environment.

Nurse scheduling solutions are viewed as part of workforce management tools, like time and attendance, workforce payroll, workforce planning and profiling. The legal reforms in the area of flexible work can help sustain a productive workforce and a healthy society (Bird, 2016, pp.3-4). Management support is crucial to improve staff morale and to generate a sense of ownership in the organisation.

4.5.4 On-Call System

Two of the participants were working in a facility that used an on-call system. This system worked as follows; a PN would work a normal shift during the day then after 16H00, if there was a patient who needed care, the security officer would call the nurse, depending on the number of patients and the type of service required. The security officer fulfilled the role of a triage officer.

> *The on-call system was challenging because when you are a professional nurse working after hours you are alone* (PN from clinic H).

Participants agreed with the fact that PHC services have to be accessible to the local community at all times, however they were dissatisfied with the way the on-call system is done.

> *It was challenging because if you experience a woman who comes for delivery you will manage that woman alone. The on-call system was not fruitful for me. You go alone to the clinic at night. People disturb you while you are asleep* (PN from clinic H).

Participants raised the fact that since there are few PNs in the PHC facilities, it is not feasible for them to work alone day and night for about seven days, because the quality of care rendered is compromised.

> *In a case of [an] emergency there is no time to do everything and it was challenging their practice* (PN from clinic H).

> *So, our clients were suffering because I have to do everything [on] my own whereas there were people who were supposed to do that work* (PN from clinic G).

> *Sometimes you can't even monitor the patient who is in labour properly, because you must stay with the patient until delivery, but there you had to leave and continue with your ANCs. Sometimes you forget 'ukuthi hayibo', four hours have passed, and the patient needed to be reviewed. You leave the patient alone and go to ANC room and do your ANC then maybe you will hear the patient screaming and you remember, oh there was a patient in labour. You will leave these ones and go to labour ward, maybe that's why sometimes we find FSBS (fresh still born babies) most of the time* (PN2 from clinic B).

The participants expressed concerns that patients arrive in labour after-hours, the PN is alone with the security officer, who is not a professional, to assist. If there is a need for a second opinion, the nurse has to phone someone else. Participants suggested that they:

> *Allocate an enrolled nurse and a professional nurse so that they can assist each other when there is an emergency in the facility* (PN from clinic H).

In order to mitigate PNs needing to do everything at night and staff shortages at night.

Masum, *et al.* (2016, p.2) state that nurse shortages could be due to extended working hours and lack of insight of the managers to give nurses a chance to work autonomously. Additionally, excessive workloads and lack of co-worker and supervisor support has been highlighted as fuelling the existing problem of turnover (Masum, *et al.*, 2016, p.4). PNs' dissatisfaction is viewed as a stumbling block towards offering quality healthcare services and enhances the intention of this category of nurses to quit employment in rural PHC settings (Masum, *et al.*, 2016, p.18). Peregrino de Brito and Barbosa de Oliveira (2016, p.93) agree with the fact that human resources of an organisation can contribute to superior performance and become a source of sustainable competitive advantage as long as they are valuable, rare and difficult to imitate (Peregrino de Brito and Barbosa de Oliveira, 2016, p.93).

The on-call system also affects the individual nurses, as expressed below:

> *It was clashing with my personal responsibilities because you can't work day and night being a human being* (PN1 from clinic B).

In an attempt to promote PN retention, Obura, *et al.* (2016, p.9) attest that managers should demonstrate respect, give recognition when it is due, foster effective communication between management and staff, and ensure adequate, flexible staffing.

4.6 Lack of Management Support

Poor support of the employees at PHC facilities was mentioned as an area that needs more attention from the sub-district and the district management team.

4.6.1 Poor Water Supply

The participants narrated that the PHC facility once had no water supply, but clinic services continued to be rendered such as, deliveries for women in labour. This was not safe for nurses and the patients because infection control and prevention policies were not able to be adhered to. Employee health and welfare was not well attended to at the PHC facilities. This contributed to the participants' resignations.

> *There was a time when we had no water and we were delivering patients. As far as I know even while I was in training we had to deliver patients, and patients were coming with ten litres or five litres of water* (PN1 from clinic B).

PNs who were staying in the nurses' residence woke up in the morning and there was no water to bath before going on duty.

Water supply was a big challenge to nurses working in clinic B and this clinic is a 24-hour clinic with a nurses' residence. This means nurses would have to look for water so that they could bath. They could not use the toilets. Patients arrived at the clinic carrying a 10-litre bucket of water so they could bath after delivery. This is evident from the following statements:

> *Patients were coming with ten litres or five litres of water for them to bath after delivery because we had no water in the clinic so there was a time where we had problems like that, even the tanks were empty* (PN2 from clinic B).

One PN was worried about hand washing after conducting deliveries as illustrated below:

> *You can't deliver a woman then and there is no water. Where are you going to wash your hands? And even the patient, where is [she] going to wash herself? And to tell the patient there is no water while the patient is waiting to deliver*… (PN2 from clinic B).

The municipal water supply was also a challenge due to delays in the delivery of water. Water interruptions occur in the clinics as described in the following quote:

> *The other day staff decided not to work because the clinic was stinking. We had no water - you can't even go to toilet because it was stinking, so we reported [it] and the management came. And that day they came and arranged portable toilets and arranged for the truck to bring us water* (PN2 from clinic B).

There was no water back-up system. The water tank stand had not been constructed. The water tank was on its side without water.

There was poor support from the systems department and this is evident by the delay in the construction of the Jojo tank stand, and the municipal delays in the supply of water.

> *[The] Jojo tank it was not on [a] stand or it was lying down, but there was something wrong with Jojo tank* (PN2 from clinic B).

> *Sometimes even the water truck does not come in time. There was a time the clinic was stinking; the toilets were full and there was no water* (PN2 from clinic B).

Alexander and Blackburn (2013, p.12) affirm that water shortages occur more in remote or rural areas as a result of equipment breakdowns, fuel shortages and in municipal systems. Water shortages or cessation in delivery may also lead to declines in water quality. Paliadelis (2013, p.380) points out that "if first line managers have inadequate facilities then their ability to effectively manage tasks relating to staffing, budgets and patient care is potentially reduced." Similarly, Mitchel, Obeidat and Bray (2013, p.903) concur that employees perform better at work when they are offered a working environment that provides the necessary support and the opportunity to contribute positively. Similarly, Zelnick (2017, no page) attests to the issue of infection control when nursing infectious patients so that nurses are protected. This is confirmed by the study conducted by (Benatar, 2013, p.154) which highlighted that clean water supply remains a challenge for health in South Africa. Shortage of water is a cause of concern as one district hospital appeared in the news that there was no water supply for five days and patients relatives were complaining about services rendered to patients were interrupted as laundry, kitchen and theatre services were negatively affected as reported by (Krishna, 2017, p.1 in South Coast Fever).

4.6.2 Clinic Advisory Committee

The clinic advisory committee is a structure which serves as a link between the community and the health facility. The formulation of the committee should be such that all catchment population areas are represented, the key figures of the community like ward councillor, the chief, izinduna, Non-governmental organisations, local pastors, youth representative, people with disabilities are represented in the committee. The committee represent all community groups and also protects the health facility in cases where there is political unrest or dissatisfaction about the services rendered. The committee is expected to seat monthly to discuss issues related to health services and planning for the events with the management of the health facility. It is vital that the roles are clear for each and every member of the committee so that there will be no conflict between the committee and facility staff. In clinic B the situation was out of control because according to the participants the committee members seemed to be ruling the clinic such that nurses had to be told by the committee members how to conduct their duties whereas they (the committee members) were not trained as nurses.

There were elements where participants referred to negligence and poor support from the top management and immediate supervisor, like in the case of poor water supply where nobody reported delays in the delivery of water from the municipality until there was strike action at clinic B due to lack of support from the management. The supervisor did not take action to protect the employees from intimidation and the clinic could not protect employees from verbal attacks in the community. The clinic advisory committee is expected to protect the employees and to act as a liaising structure between the community and the PHC facility. This was not the case in one facility.

> *They were against us (the staff) maybe there were no rules and regulations before they were nominated* (PN 2 from clinic B).

The clinic advisory committee members acted as the disciplinary committee for nurses.

> *Some of the clinic advisory committee members were a problem because they come to the clinic or they write letters to some of our professional nurses telling or ordering them what they should do in whatever way that they feel is suitable for them. They are*

> *just politically minded and that is causing a problem because they want to take politics into the clinic* (PN1 from clinic B).

There were times when employees were persecuted by the very same clinic advisory committee, which failed to intervene when problems arose from the community.

> *They are politically minded. I think their problem is the politics that they have because they think the clinic should be run according to their politics, which is a problem* (PN1 from clinic B).

The clinic advisory committee did not help when the community rebelled against the nurses, instead they wanted to instruct nurses how they should do their work.

Chipp, *et al.* (2011, p.8) suggest that in order to create a good relationship with the community, it is better to engage the local elders and community leaders because such people often hold the historical wisdom of the community and they can provide direction for new practitioners. Additionally, the community key figures are able to command respect and persuade other community members to be more accepting of the newly employed healthcare workers. Furthermore, the new healthcare workers will have to be patient in order to overcome community distrust that has developed because of negative relationships with the previous practitioners (Chipp, *et al.*, 2011, p.8).

Kramer and Son (2016, p.940) point out that healthcare personnel are unprotected from work-related hazards with regards to their physical health. Furthermore, their work environment is often stressful and filled with impending risks of exposure to biohazards, diseases and other physically demanding tasks that can lead to health problems.

Section 24 of the Constitution Act (Act no. 108 of 1996) stipulates “everyone has the right to an environment that is not harmful to their health or well-being”. Therefore, nurses like any employee have a right to safe working premises, and the employer must ensure that accidents and occupational diseases are prevented (Hassan and, Heywood 2007, p.330). The Occupational Health and Safety Act no. 85 of 1993 stipulates that employers must; ensure safe working environments, provide safe equipment and machinery, afford workers access to information about existing health risks in the premises, ensure proper supervision, and

implement health and safety measures (Republic of South Africa Department of Labour, 1993).

4.7 Employee Financial Problems

Three of the five PNs admitted that they wanted to get a lump sum of money, which means that financial management is a challenge to employees as evident below:

> *I wanted to get a lump sum of money so that I can finish some projects that I have started at home* (PN 2 from clinic B).
>
> *I received an offer with a better salary in a NGO* (PN from clinic A).
>
> *I was not coping with my financial problems* (PN from clinic H).

Three of the participants mentioned that their main reason for resigning was financial problems. They wanted to get a lump sum of money so that they could build a house or finish renovation projects which they were failing to complete. The participants asked the researcher if the sub-district could re-employ them. Unfortunately, all vacancies have been put on hold. It is even difficult to re-employ PNs who have resigned (HR circular 62 of 2016).

> *I received an offer with a better salary in a NGO. The offer was R10000.00 more salary than I was earning. That is why I left* (PN from clinic A).
>
> *I wanted to get a lump sum of money so that I can finish some projects that I have started at home* (PN2 from clinic B).
>
> *I was not coping with my financial problems* (PN from clinic H).

Financial issues seem to be a major reason for male nurses who decided to leave employment, and this is congruent with a study conducted by Masum *et al.* (2016, p.16) revealed that nurses leave employment due to financial problems. Phiri et al (2014, p 8) attest to the fact that budgetary constraints may influence nurses to work long shifts to get more money. Similarly, Rispel, Blauuw, Chirwa and de Wet (2014, p 1) affirm that more nurses in South Africa are engaged in moonlighting and agency nursing aiming to get additional

sources of income. The Inkatha Freedom Party has challenged the KwaZulu-Natal Minister for Health about the exodus of nurses seeking for greener pastures (Nkwanyana, 2016, p.1). Ndanyi (2014, pp.1) confirms that Kenyian nurses have left the country because they were not satisfied with salaries and working conditions. This is congruent to the study findings of Todorovic (2016, p.1) confirms that inadequate remuneration was one of the reasons why nurses are leaving nursing profession.

All participants were willing to return to work in the Mandeni sub-district if the challenges were attended to. Generally, the participants were not satisfied with the shortage of PNs, increased patient workloads, poor relationships with the management and the community, extended working hours and the on-call working system, an uncomfortable working environment with a high risk of contracting infection in the workplace, and the management style. Inability to manage finances was the first reason for the majority of the participants opting to quit employment in order to receive a lump sum of money. However, all participants appreciated the opportunity offered to work at the sub-district, by pointing out that they gained professional knowledge and skills, and they were given an opportunity to further their studies successfully.

4.8 Conclusion

This chapter was about data collection, transcription, coding, and formulation of themes, sub-themes and data analysis. The next chapter will be a discussion of findings, the conclusion, recommendations, the researcher's reflections and the limitations of the study.

CHAPTER 5: SUMMARY OF THE FINDINGS, RECOMMENDATIONS AND LIMITATIONS

5.1 Introduction

In an attempt to know more about why the professional nurses decide to leave the sub-district and work somewhere else, the researcher interviewed five professional nurses. The first interview was conducted in April 2016 and the last interview was conducted in August 2016. All five participants agreed and signed both consent forms before the interview started. The participants' ages ranged from 28 years to 46 years, two were males and three were females. Only one participant was single, and the rest were married. All participants had more than one child with a maximum of six children. They were all not staying with their families while they were employed at Mandeni sub-district. Two of them were now staying with their families and all were willing to come back and work in the Mandeni sub-district if the preventable challenges were attended to. Several issues were raised by participants such as:

5.2 Employee-Employer Relationships

5.2.1 Victimisation in the Workplace

A participant received a message from a colleague that there was a man who came from the facility who wanted to see her. She was told that the man was sent to kill her. The colleague, who actually told her, reported the matter to the immediate supervisor but seemingly no action was taken by the supervisor. The participant no longer felt safe. She was expecting the supervisor to call her and tell her about the rumours and try to protect her from danger but that was not done. She resigned, giving 24 hours' notice.

5.2.2 Poor Employee-Supervisor Relationships

Another participant was not on good terms with the supervisor. She was called while she was off- duty, far from the workplace to return and orientate a newly employed PN. Furthermore, the same participant was made to work alone even if other staff members were present. Her perception was that this was because those nurses were friends of the supervisor. The supported staff did not want to work when delegated by PNs. The perception being that they wanted to be delegated by the supervisor only.

The off-duties were designed such that the participant worked day and night for a continuous period of more than seven days.

5.2.3 Favouritism

One participant was devastated by the fact that the supervisor was not treating her like other PNs because she was the only nurse who was made to work long days for more than ten days. Sometimes, the lower category of staff, like enrolled nurses, would sit down with the supervisor and the participant would perform all the nursing duties, even the enrolled nurses' duties because they were friends of the supervisor.

5.2.4 Professional Nurses Shortage

Generally, all the participants raised their concerns about overcrowding and the high workload, which they were no longer able to handle. The PNs who were working at 24-hour clinics were concerned about the increasing number of patients who visit their clinics. Therefore, the quality of care rendered to the clients is compromised and medical and clinical errors are possible leading to litigation. Due to the shortage of PNs at that time, women were left alone so that the nurse could continue with the consultation of patients who were waiting for the same nurse.

The patient waiting time before consultation by the PNs was more than three hours, which is why the community was rude to nurses because they could not understand the reasons. The situation was aggravated by the PNs who would not report on duty because they were sick or did not come on duty. They did not report their absence from work either. This had a negative impact on staff relations because the PNs who do not fall sick felt that they are overworked because of those who did not come on duty, and no disciplinary measures are in place to control the behaviour.

The increase in the number of stable patients who are collecting their medication for chronic illness was a challenge because the 24-hour clinics are situated in a densely populated community, in an industrial area surrounded by informal settlements. At that time, the issuing of medication in the community was not yet implemented; hence patients were very rude to nurses because they had to wait in the long queues for collection of medication. The clinic

advisory committee was expected to protect the employees and to act as a liaising structure between the community and the PHC facility,- but it was not the case in one facility because the clinic advisory committee members act as the disciplinary committee for nurses.

5.2.4 Absenteeism

Sickness absenteeism was noted in clinic B during 2016, because in KwaZulu-Natal the DoH delays the replacement of staff (HR circular, 62 of 2016). Therefore, employment processes took more than six months for a vacant post to be filled and that contributed to professional nurse turnover. All categories of nursing staff members were not reporting on duty and there was no valid reason mentioned by specific staff member. The disciplinary processes were not helping to control frequent absence from duty because the root cause was not identified. This had a negative impact on staff relations because the PNs who do not fall sick feel that they are overworked by those who do not come on duty, and no disciplinary measures are in place to control the behaviour.

5.2.5 Staff Scheduling.

One participant was concerned about the off-duties that were sometimes designed such that professional nurses could not get enough time to stay with their families and relatives. This was not good because employees have an added responsibility to look after the welfare of their family members. Therefore, the off duties were not accommodating the social responsibilities of the employees because they worked day and night continuously.

5.2.6 on-Call System

Two of participants were working in a facility that was using an on-call system. This system worked as follows; a PN would work a normal shift during the day, then after 16h00, if there is a patient who needs care, the security officer would call the nurse, depending on the number of patients and the type of service required. The security officer was fulfilling the role of a triage officer. Participants agreed with the fact that PHC services have to be accessible to the local community at all times, but they were dissatisfied with the way the on-call system is done. They raised the fact that since there are few professional nurses in the PHC facilities; it is not feasible for the PN to work day and night alone for about seven days

because the quality of care rendered is compromised. In addition to that, if the PN takes her time off as a refund the other PN who is left behind to continue with duties accumulates more hours too, and it becomes a vicious cycle of accumulated hours that cannot be refunded in full. They expressed concerns that patients arrive after-hours in labour, the PN is alone with the security officer, who is not a professional to assist. If there is a need for a second opinion the nurse has to phone someone else. In a case of emergency there is no time to do everything and it was challenging their practice.

5.3 Lack of Management Support

Poor support of the employees at PHC facilities was also mentioned as an area that needs more attention from the management.

5.3.1 Poor Infection Control Practices

The participants narrated that the PHC facility once had no water supply but clinic services were rendered like, deliveries for women in labour. This was not safe for nurses and the patients because infection control and prevention policies were not adhered to.

5.3.2 Poor Water Supply

Water supply was a big challenge to nurses working in clinic B and this clinic is a 24-hour clinic with a nurse's residence. This means nurses would have to look for water so that they could bath, they could not use the toilets, let alone attending to labour ward patients. PNs who stayed in the nurses' residence woke up in the morning and there was no water to bath before going on duty. Patients who were in labour had to come to the clinic carrying a 10-litre bucket of water so that they could bath after delivery. There was no water back-up system. The water tank stand was not constructed. The water tank was on the ground, on its side and without water. The municipality water supply was also a challenge due to delays in the delivery of water. The employees' health and welfare were not well attended to at the PHC facilities. This contributed to the participants' resignations. The systems manager was responsible to report water supply problems to the sub-district management team, if the water supply problem was not resolved, the matter should have been reported to the district

management team. Seemingly, there was a delay in sorting the water problem hence some professional nurses decided to leave that particular facility.

5.3.3 Poor Support from clinic Advisory Committee

The clinic advisory committee does not help when the community rebels against the nurses instead they want to instruct nurses how they should do their work.

5.4 Employee Financial problems

Three of the participants mentioned that their main reason for resigning was financial problems. They wanted to get a lump sum of money so they can build a house or finish renovation projects many of which they were failing to complete. The participants asked the researcher whether the sub-district could re-employ them, but unfortunately all vacancies were put on hold during the research period. It was even difficult to re-employ PNs who have resigned. PNs admitted that they wanted to get a lump sum of money which means that financial management is a challenge to some employees.

5.5 Recommendations

It is recommended that:

- The sub-district management should look at the following issues: strengthening the support of the rural clinics such that avoidable problems like poor water supply, staff conflicts, absenteeism and community violence receive urgent attention.
- It is advisable that recruitment, selection and appointment of the clinic advisory committee should be implemented as stipulated in the policy.
- Extensive orientation, induction and regular in-service training about the terms of reference for the committee should be conducted to prevent role ambiguity.
- Strict rules should be implemented when the clinic advisory committee members are not adhering to the terms of reference.
- Victimisation in the workplace should be dealt with urgently and disciplinary measures should be implemented on the culprit, whether a member of management or a colleague is involved, and victims should receive counselling.

- Policy makers should relook at the staffing for rural PHC clinics as a matter of urgency.
- The NDOH and Provincial DOH should formulate a standardised policy and guidelines giving directions as to how the on-call system for professional nurses should be done, including remuneration thereof.
- The participants suggested that if PHC facilities can get enough PNs, the on-call system will be less strenuous on the nurses. Staff nurses should also be allowed to work on-call system like on night duty and the local community will receive quality care.
- It is advisable that a new bridging course, that includes midwifery, be developed and extended to at least ten years so that the existing pool of nurses who are not employed yet be given an opportunity to become professional nurses with midwifery.
- Tertiary institutions should develop a programme to upgrade the existing pool of enrolled nurses and enrolled nursing assistants to bridge the gap of professional nurse shortages.
- The tertiary institutions should revise the criteria for nurses with prior nursing background so that more professional nurses are produced to work in the public healthcare system and thus it will reduce the shortage of professional nurses in the rural PHC facilities.
- It is recommended that public servants are afforded an opportunity to withdraw a lump sum of money from their pension benefit if the need arises. This will prevent public servants or professional nurses from resigning with the aim of getting a big amount of money.

5.5 Limitations

The study was confined to the Mandeni sub-district, which makes it difficult to generalise the findings of the study. It was difficult to find all professional nurses who resigned from other clinics due to changes in their contact details.

5.6 Further Research

There is a need to do further research about the link between failure of professional nurses to manage finances and turnover. Another research study could be about how the professional nurses' workload at PHC level can be reduced?

5.7 Researcher Reflection

Since the researcher is also a nurse manager, sometimes feelings like 'we have failed our staff' kept on coming while conducting interviews. Some information was very sensitive such that the researcher did not know how to put it in writing so that the study participant is totally protected. Sometimes the researcher felt like crying after the interview session with some of the participants because they would relate sensitive stories.

5.8 Conclusion

The study revealed the reasons why professional nurses are leaving the Mandeni sub-district PHC facilities. It is evident that more support from the management is vital so that challenges like victimisation in the workplace, overcrowding in some clinics, poor relations among the staff and the community are dealt with urgently. The National and Provincial Department of Health should relook at the distribution of PNs between the rural and urban PHC facilities so that rural PHCs have enough professional nurses to render health services. NDoH should look at the policies to allow public servants to withdraw a certain amount of money from their pension fund to reduce resignation due to financial problems. The Provincial Department of Health should equip managers with the necessary skills, including leadership skills to deal with more difficult situations such as in the case where the clinic advisory committee is failing to perform its vital role.

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Appendix 1: Information Letter to Participants

Dear.....

You are requested to participate in a research study (Exploring the reasons for the high staff turnover amongst the PNs at the Mandeni sub-district PHC facilities). The researcher will give you information that will help you to understand the study, and what you will be asked to do during the study; the risks and benefits, and your rights as a study subject. If anything is not clear to you please ask the researcher to explain.

The study is conducted by Babhekile Rejoice Msomi, in partial fulfilment of the requirements for the Master's Degree in Health Service Management at the University of KwaZulu-Natal. The purpose of the study is to learn more about professional nurses' turnover at Mandeni health facilities.

You are requested to give your written informed consent to participate by signing and dating a form and putting your initials against each section to indicate that you understand and agree to the conditions. You have the right to ask questions concerning the study at any time. You should also immediately report to the researcher any new problems during the study. The telephone numbers of the researcher are provided. Call these numbers, or ask the researcher to call you back, if you have any questions or concerns about the study.

After receiving the signed consent form, the researcher will arrange for the interview session in an area that is appropriate for privacy, or by using a telephonic interview. Please write your full response by answering all questions and fax back to the researcher as soon as possible. The responses will be kept safe so that no one, except for the supervisor, will gain access to them. All responses to all questions will be completely confidential.

Participation in the research is completely voluntary. You are not obliged to take part in the research. If you choose not to participate your present or further nursing career will not be affected in anyway and you will not incur any penalty or loss of benefits to which you are entitled. If you agree to take part, you have the right to change your mind at any time during the study. You are free to withdraw the consent and discontinue participation without penalty.

Participation in the study will not result in any additional costs to you, nor will you be paid for participation.

Yours sincerely

Msomi B.R (Mrs)

Contact no: 072 7953 790

Fax no: 032 454 7529

Supervisor: Dr Jane Kerr

0836269423

Kerrj@ukzn.ac.za

Appendix 2: Interview Schedule

Please could you tell me why you decided to leave the employment of Mandeni PHC clinic?

Section A: Demographic information will request the following data:

Age

Marital Status

Number of dependants and their age groups

Number of years in the job you have just resigned/transferred from

Qualifications

Section B: Open-ended questions will be:

What were your experiences of your job as a professional nurse at Mandeni sub-district?

Describe how you experienced your relationship with your supervisor, colleagues and subordinates?

Describe how you experienced the work-place environment?

What are your comments about the link between your duties and your personal expectations?

How do you feel about doing an on-call after duty hours?

If you were an operational manager what strategies would you employ to retain professional nurses in your facility?

How did you come to the conclusion to leave?

Appendix 3: Consent to Audio Recording

Dear Participant,

My name is Babhekile Rejoice Msomi, I am a Health Service Management Masters candidate studying at the University of KwaZulu-Natal, Howard campus, South Africa. I am interested in learning about the reasons for the high staff turnover amongst the Professional Nurses at the Mandeni Sub-District. I am learning about professional nurses' turnover in the following health facilities: Sundumbili CHC, Isithebe clinic, Ndulinde clinic, Dokodweni clinic, Macambini clinic, Ohwebede clinic, Mandeni clinic Hlomendlini clinic, Sundumbili Mobile 1&2. Your clinic is one of my case studies. To gather the information, I am interested in asking you some questions.

Please note that:

- Your confidentiality is guaranteed as your inputs will not be attributed to you in person, but reported only as a population member opinion.
- The interview may last for about one hour and may be split depending on your preference.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after five years.
- You have a choice to participate, not participate or stop participating in the research. You will not be penalised for taking such an action.
- The research aims at exploring reasons for professional nurse turnover, and designs the retention strategies for staff working in rural health facilities.
- Your involvement is purely for academic purposes only, and there are no financial benefits involved.

If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	Willing	Not Willing
Audio equipment		
Photographic equipment		
Video equipment		

I can be contacted at:

Email: brmsomi1@gmail.com

Cell: 072 7953 790

My supervisor is Dr Jane Kerr who is located at the School of Nursing, Howard campus of the University of KwaZulu-Natal.

Contact details: email: kerrj@ukzn.ac.za Phone number: +283 626 9423.

You may also contact the Research Office through:

P. Mohun

HSSREC Research Office,

Tel: 031 260 4557 E-mail: mohunp@ukzn.ac.za

Thank you for your contribution to this research.

DECLARATION

I…… (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT **DATE**

…… ……

Appendix 4: Ethical Approval

20 April 2016

Mrs Babhekile Rejoice Msomi 200298678
School of Nursing and Public Health
Howard College Campus

Dear Mrs Msomi

Protocol reference number: HSS/0179/016M
Project Title: Exploring reasons for high staff turnover amongst professional nurses' at Madeni Health Facilities

Full Approval – Expedited Application

In response to your application received 05 February 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....

Dr Shenuka Singh (Chair)
Humanitities & Social Scinces Research Ethics Committee

/pm

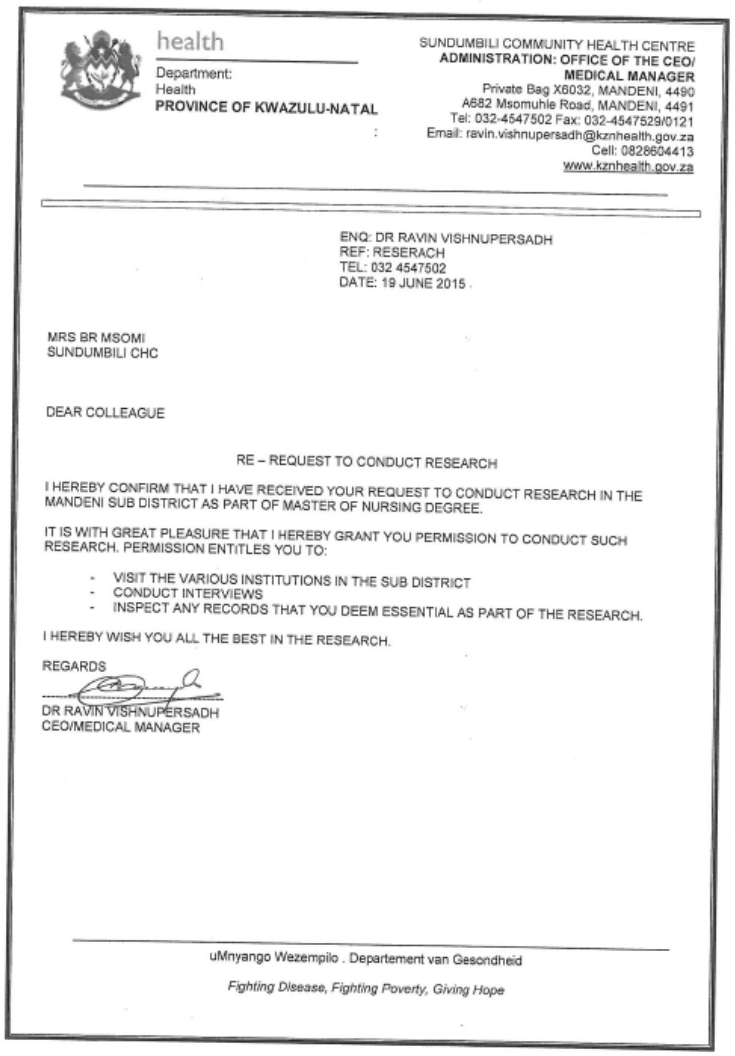
Cc Supervisor: Dr Jane Kerr
Cc Academic Leader Research: Professor M Mars
Cc School Administrator: Ms Caroline Dhanraj

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 8557/8350/4557 **Facsimile:** +27 (0) 31 260 4609 **Email:** ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

1910 - 2010
100 YEARS OF ACADEMIC EXCELLENCE

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

Appendix 5: Permission From Clinic



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

SUNDUMBILI COMMUNITY HEALTH CENTRE
ADMINISTRATION: OFFICE OF THE CEO/ MEDICAL MANAGER
Private Bag X6032, MANDENI, 4490
A682 Msomuhle Road, MANDENI, 4491
Tel: 032-4547502 Fax: 032-4547529/0121
Email: ravin.vishnupersadh@kznhealth.gov.za
Cell: 0828604413
www.kznhealth.gov.za

ENQ: DR RAVIN VISHNUPERSADH
REF: RESERACH
TEL: 032 4547502
DATE: 19 JUNE 2015 .

MRS BR MSOMI
SUNDUMBILI CHC

DEAR COLLEAGUE

RE – REQUEST TO CONDUCT RESEARCH

I HEREBY CONFIRM THAT I HAVE RECEIVED YOUR REQUEST TO CONDUCT RESEARCH IN THE MANDENI SUB DISTRICT AS PART OF MASTER OF NURSING DEGREE.

IT IS WITH GREAT PLEASURE THAT I HEREBY GRANT YOU PERMISSION TO CONDUCT SUCH RESEARCH. PERMISSION ENTITLES YOU TO:

- VISIT THE VARIOUS INSTITUTIONS IN THE SUB DISTRICT
- CONDUCT INTERVIEWS
- INSPECT ANY RECORDS THAT YOU DEEM ESSENTIAL AS PART OF THE RESEARCH.

I HEREBY WISH YOU ALL THE BEST IN THE RESEARCH.

REGARDS

DR RAVIN VISHNUPERSADH
CEO/MEDICAL MANAGER

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 6: Permission to Conduct Research from the Department of Health

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

ILEMBE HEALTH DISTRICT
1 King Shaka Building, King Shaka Street, Stanger, 4450
Private Bag X10620, Kwa Dukuza, 4450
Tel.: 032 – 437 3500 Fax. 032- 5511590/2
Email.merinda.banda@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Ms. Merinda Banda
Tel: 032 437 3500
Date: 21 July 2015

Mrs. B.R. Msomi
School of Nursing &Public Health
Howard College Campus: Health Sciences
University of KwaZulu-Natal
Durban
4000

REQUEST TO CONDUCT RESEARCH

Project Title: Exploring reasons for high staff turnover amongst Professional Nurses at Mandeni Sub-District Health Facilities

Support is hereby granted to conduct research on the above topic.

Please note the following:-

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health.
2. The research will only commence once this office has received authorization from the Provincial Department Research Committee in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research
5. You are expected to provide feedback on your findings to the District Office

P.P. TM Banda
Mr. SG Vikilahle
District Manager
ILembe Health District Office
Email: sthembele.vikilahle@kznhealth.gov.za

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email:
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management

HRKM Ref: 136/16
NHRD Ref: KZ_2016RP13_848

Date: 5 July 2016

Dear Mrs B.R. Msomi
UKZN

Approval of research

1. The research proposal titled **'Exploring reasons for high staff turnover amongst professional nurses' at Mandeni sub-district health facilities'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at all facilities in the Mandeni sub-district.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

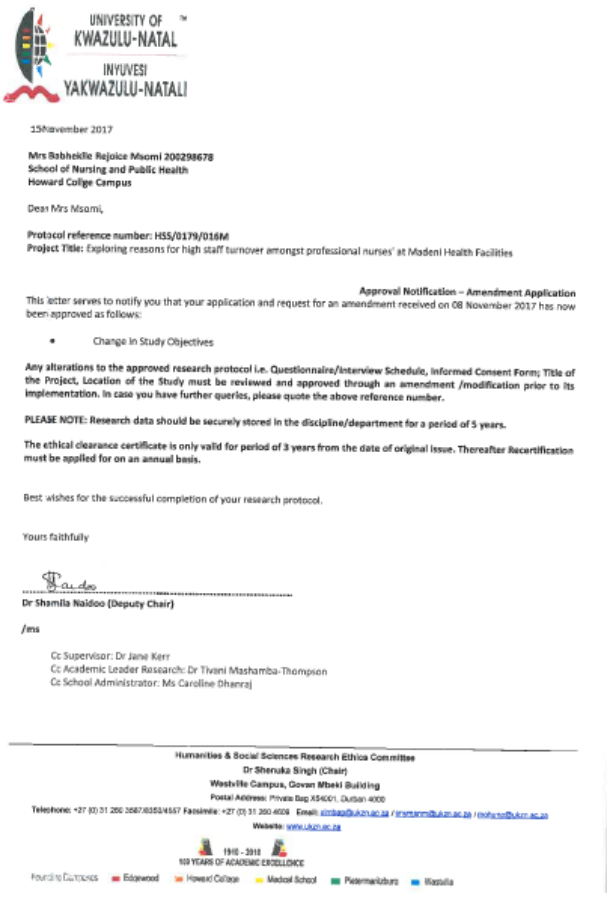
For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 06/07/16

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 8: Ethical Approval of study changes



UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

15November 2017

Mrs Babhekile Rejoice Msomi 206298678
School of Nursing and Public Health
Howard College Campus

Dear Mrs Msomi,

Protocol reference number: HSS/0179/016M
Project Title: Exploring reasons for high staff turnover amongst professional nurses' at Madeni Health Facilities

Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 08 November 2017 has now been approved as follows:

- Change in Study Objectives

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for period of 3 years from the date of original issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully

Dr Shamila Naidoo (Deputy Chair)

/ms

Cc Supervisor: Dr Jane Kerr
Cc Academic Leader Research: Dr Tivani Mashamba-Thompson
Cc School Administrator: Ms Caroline Dhanraj

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
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Website: www.ukzn.ac.za

1910 - 2010
100 YEARS OF ACADEMIC EXCELLENCE

Founding Campuses: Edgewood, Howard College, Medical School, Pietermaritzburg, Westville

Appendix-9: Participant- NM interviewed on the 01 May 2016

I- Thank you for availing yourself for this interview, as I have told you through telephonic conversation I am going to ask few questions about the study. The study is about high staff turnover amongst professional nurses at Mandeni Health facilities. Could you please tell me why you decided to leave the employment at Mandeni?

P- Eh the problem was with the operational managers' attitude I won't say it was the staff attitude it was operational managers attitude towards me, he wasn't managing the work he was managing me. She seem to have personal things against me even if I did my work and I could see that I have done well but she will want more and more and she even go to an extend that even staff members (the subordinates) were turning against me when I was telling them to do work. They didn't do the work whilst the operational manager was on leave, when she came back she would, they will have their meetings against some of us as professional nurses and me because they said I was strict about time and work whereas the operational manager was not so strict I was acting as if I was the operational manager .So I think the attitude for the operational manager she thought that I was on the position to take her position.

I-OK then you decided to leave

P-She even go to an extend when I worked even overtime hours instead of knocking off at 16h00 I will knock off may be after 17h30 when I asked those hours back she will just shout at me when I'm trying to explain to her that these hours were like this and this, one time the thing that make me to leave I was at home with those hours(the overtime hours I was working) there was a new staff member then she called me and told me that these professional nurses cannot work alone whereas I was working alone may be the whole week I could work alone but that professional nurse wouldn't work alone. I came back then after working that day it was a Thursday I decided to work even Friday because my home is too far that I can just take a day off for one day. Then the following day was the chronic day busy day everybody knows that it's a busy day but I was left alone to be on my own, she didn't realize that, she was aware that I was working alone but because it was me I was supposed to work alone whereas the other professional nurses cannot work alone. That's why I decided that may be I am no longer belonging in this facility, may be it the way she is chasing me out, she is just afraid she could tell me that you can go if you want because even the subordinates were against me, everybody, the lay counsellors, the staff nurses didn't want to do their work because they have got that relationship with the operational manager. So our clients were suffering because I have to do everything my own whereas there were people who were supposed to do those work

I-so by the way you were working at X clinic, ok so how old are you?

P- right now I am 47 yrs

I-are you married?

P-no never married

I-How many dependants?

P-Three, two sons 27 and 19yrs, my granddaughter who is 4yrs

I-how many years have you worked at X clinic?

P-it's plus or minus 7 years

I-was this conflict started from the first year or was late?

P-No it didn't start at first because we were two professional nurses of which we were being treated the same way, after which the other professional nurse left then I was left alone with the new professional nurses of which they were her favourites but when we do discussed with those professional nurses they saw where the problem lies and we will always discussed the problems of our clients and how could we work but when the professional manager came she will do whatever to make me not to see the same with other professional nurses. She will make any think that came a conflict between me and the other professional nurses the problem started when the professional nurse I was working with had left because when we were two even if the operational manager was against us we will just come together and talk and then after that we laugh and go back to work and work as usually ignoring what she has said but after the new staff came that's where the problem started. It was just favouritism if I can say

I-ok what qualifications do you have?

P-At that moment I was doing PHC, if it was not because I was chosen to do PHC by 2011 I would have left by September 2011, unfortunately the managers were not aware of what was going on than before that new staff member came my operational manager at that attitude towards me she didn't want to do anything with me. I don't know may be its because anything which was wanted may be by the District by other managers they will ask it from me and she will have to ask from me any information and she didn't want to accept that I have got the information more than she has.

I-so what were your experiences as a professional nurse at Mandeni? Besides that conflict between your OM I'm talking about Mandeni sub-district now

P-Mandeni was the first place I enjoyed my profession, it was the first place because at first I was working at Y-hospital from there at LUM- Hospital but at Mandeni at the PHC level I didn't know that I have got that passion with primary health care but being at Mandeni I experienced lot of things because most of conditions they came and you have to deal with your own and after that I will say yes I did my work. This was the most interesting place I ever work even if it can happen I can work at Mandeni sub-district until I retire that's the most place I enjoyed most even after I left in 2013 I didn't enjoy anything from where I worked I only reminded of Mandeni

everything when I come across with it I will say whoo my managers I would have called them and they would give me this and this but here Mandeni is the first priority when it comes to other sub-districts. I like Mandeni because managers most of the managers are supportive except my immediate supervisor

I-ok can you describe how you experience your relationship; you have mentioned your relationship with your supervisor, now let me check your colleagues like the other PNS and your subordinates?

P- The PNS because they were new at the primary health care they used to consult when they encounter problems and we had a good relationship with them I even woke at night even when I'm not on call to help them if they need help any time because they came to me and ask I could do that I didn't have anything I can explain that may cause any conflict with them because everything we were doing we were sharing and I even gain lot of things because of helping other people because even if the condition is not directed to me but I will help that fellow colleague. With the subordinates there were those subordinates who were against what I was managing because I'm a professional nurse and I'm a supervisor on the absentia of my operational manager I will manage the work and others won't want to do because I will tell the person not to leave her place without reporting and even the ward like we had only two lay counsellors are would not allow two counsellors to leave at the same time then the counselling room will be left alone but because of my operational manager she will do that if my operational manager is not there they will ask if they are asking to leave or they are just reporting to leave to me so they will just report that they are leaving they are not asking for a permission to leave its their right to leave if they have social problem or personal problems they don't have that thing to ask from me. So it was because of my operational manager how she was operating, she was operating me not work

I-Hmmm I understand can you describe how you experienced the work place environment?

P-The workplace environment it was good, the community was good, we had equipment although but if you need anything I will just make a phone call and call my managers at CHC they will just send anything I need even with the medication I will just call the CHC managers at and I know that was the right channel of communication but I knew that I will get anything that was good the environment was good because I was supported by my managers either than my immediate supervisor

I-Ok, Hmmm what are your comments about the link between your duties and your personal expectations?

P-I don't understand the question

I- I mean we've got HIV pandemic does it have an impact to your personal expectations

P-yes it did have an impact because even now it has an impact if we are educating, we are going out to test people we are not expecting people from the place we are visiting but it seems as if we are doing nothing. Those who even in ARVs for viral suppression so that they won't infect because the more the viral load the higher the infection will be it seems as if we need to do more

I-How, are they not virally suppressed

P-I think with these classes which are said literacy classes now for those who eligible for ARVs must be done by the people who are experienced who are knowledgeable like professional nurses. If the professional nurses who are experienced I'm talking about NIMAART nurses can be given may be 30 minutes before the patient can be initiated because that person will understand what you talking about when you talking about eligibility, resistance and first line regimen, second line regimen and the infections and how they can because they have got this tendency that if you are HIV positive you won't have children so they are doing as they like because they know that they won't have children. That's why I'm saying the NIMAART trained nurse need to be there when the literacy classes are conducted at least 30 minutes of those three hours which are done by the lay counsellors and another thing these literacy classes on my experience I can even counsel if it will be conducted by the lay counsellor. As a NIMAART nurse I initiated more than three clients without attending those literacy classes but because I was telling them about what it is that is called adherence, what is the effect of these ARVs to them, to their families, to their partners and even to themselves and to the community what are the effects of it they are doing very correctly without attending those classes I have got them they are virally suppressed because we talk one on one and people out there they know everything about ARVS the only thing they lack is about resistance

I-Ok ehh how you feel about doing on-call after duties?

P-I don't have any problem about on-call after duties the thing that made me to cancel, to do away with that on-call system it was because of the things that were done by my operational manager and even some of my colleagues because at first I was on-call and I remember well I was in April when I was on-call for 13 days but when I saw my claim form only two nights were claimed and what about these other 11 days so I got that bad attitude about on-call because somebody was taking out my money. I don't have any problem about being on-call and I like that because at night you have got all the time to deal with the patient, to test the patient to talk about even if the patient is not taking ARVs correctly, even if they are reacting you've got all your time with the patient, all your time with that patient, that patient you may have not seen during the day may be seen by other nurse. But now because you are on-call you will be able to see that patient holistically, if you need that patient to be tested you will do that, if you need to counsel you will do that, if you need to counsel on adherence you will do this at night because you have got all the time and you are speaking one on one with that patient and you will understand and the patient and even if the patient has got a problem will be able even to call you. I enjoyed myself doing on-call duties

I-so you are saying the on-call system was giving you enough time with the client and enough time to examine the client?

P-yes even to counsel the family you do have enough time there are no other people that will disturb you by that time you just take the client behind the curtain and then relatives this side and you talk to the client you talk to the relatives

I-so the on-call duties at X-clinic was not busy

P- Although it was busy but lately the clients who were coming at night were the clients who were supposed to be there at night who will need your attention at night because there were no longer that time where the person will seat at home during the day and come at night. We did counsel the clients that at night we need to see those special circumstances, there were special patients, special conditions we were attending at night. And those patients who were coming at night were the patients who were suppose to be at your attention at that time not that she was delaying that because of our counselling that we established with our clients

I-If you were an operational manager what strategies would you employ to retain professional nurses in your facility?

P-Firstly when I'm doing the off-duties I will give them the rough paper that do your off duties make sure that a week you have got these 40 hours which is expected of you and make sure that the ward is covered and even if the person is having personal problems wants to leave may be for two hours I will tell the person that you have to interact this with your colleagues so that the clinic won't be left without any professional nurse. And the thing with the off-duties that people will do their own off-duties the only thing that I will be managing will be that the ward is covered, the hours that are needed from them will be worked not that you will work this and you will work this, no there will be the one who will chose who will work this Sunday who will work this. But at our clinics there is a shortage of nurses may it's because of the turnover, you will be on-call at night may be you have two deliveries of which it will take you more than five hours at night and in the morning you are expected to be there at 07h00 o clock you are expected to be at work no one else to work so that you rest. That's the main problem with the on-call system but if there would be enough nurses there will be no problem with the on-call system that at night you start by deliveries from may you have got the women at 10h00, you got other women after, you have to wait for an ambulance you get to bed at 02h00 am, after three o'clock you are called whereas at 07h00 you are expected to go to work because there is no other professional nurse to see patients. Nobody notices that you were awake at night because of shortage of staff especially professional nurses.

I- Was there any time where you were just alone as a PN

P –yes

I-What was the cause of the shortage?

P- At X-clinic where I was working we were only two professional nurses after that thing of the agents who were said to be cancelled we were only two and we were expected to do on-call whereas the other one will be off , because she was working on-call for a week and she is off, whereas in the morning they are those school kids who are sick. You are expected to be at work at 07h00 even if you were up the whole night because we were only two that why I say there was a shortage.

I-so you were only two as professional nurses and the operational manager was she not helping?

P-The operational manager even if she was there during the day, she won't work she would just go to the tea room, seat down with other staff members, you will be on your own. You will be on your own, we even talked about that with my colleague I was the one who got angry every day when I was supposed to be alone and she just counselled me and said just take as if you are alone even if she is there because she won't do anything, you will be always angry with her and you won't do the work. Because you will do the work and she will be just going up and down seating in the tea room with this other subordinates talking their personal things.

I-Hmm I understand you very well

P- When the meeting is called that meeting is called because the subordinates have got the problems with you as professional nurses and they have talked about that problem with the operational manager and you will be called there just to answer their questions. That's the one thing that I didn't want the most and one day that meeting was called and I even said thank God that I'm leaving and there was no one was aware that I was about to leave

I-besides the off duties when we were talking about the strategies to retain professional nurses what else would you change or would you employ as a strategy

P- In-service training if you do, you have a plan for in-service training because other people not because they don't like to work it's because they don't have that confidence to do those things you will see if they are running away from those things no its because they don't know how to the work . So the in-service then organise for the in-service, if you can take the new professional nurse and say you have to work with the kids without having done the IMCI thing. The IMCI thing has empowered me, I'm the one who was empowered and when I was back from the IMCI training I came and I said I will deal with the kids only and I was very happy because I knew what to do when the kid is coming. So the in-service and if there are courses send the professional nurse there not you as an operational manager because you are not doing anything about that thing and they will come back and apply the knowledge they have gained there

I-is that all about strategies

P-I think everybody will be willing to come and see what is new and you have to give them time and make them feel free come to you and ask and go and explain. If the person has done a mistake don't just shout we must correct our attitude when we are talking to them. We need to improve our attitude, our attitude must be positive. And you can go into an extend to ask am I still doing correctly am I still good Mphathi. The people will happy to see they have got that Mphathi who is approachable, the Mphathi, who knows how they are doing, who knows how they feel where they are. And if you see that a person has got a new behaviour just ask her, go to a corner with that person and ask her I can see you have changed what is your problem. The people will trust you and they will be able to tell you everything

I-so how did you come to the conclusion to leave saying enough is enough I must go?

P- It was because I had no one to talk to, when I had problems with my operational manager I had no one since the PN I was working with was sent to other clinic and even when I tried to call. It seems as if she had some gossip that she was told about me then I didn't have anybody to talk to and it was not a pleasant thing to leave but I had to cry every morning before I start working until I said enough is enough. I had to cry the general orderly had seen me several times crying before I could start working. That's when I decided now I have to take my CV and send anywhere, where I could be employed, fortunately enough Y-hospital just called me before I could send my CV. The managers have called me

I-so were you aware of the way where you can address your dissatisfaction besides confronting your supervisor? Were you aware where you can channel your dissatisfaction or your grievance?

P-I wasn't aware but at times I would just take a phone and just call even the nursing manager and talk with her she was supportive I talked with the AMN there were supportive but the problem I was working with this person so if I leave this clinic and go to another clinic the operational managers are friends so I wont do that because I will be just. I don't know how to put it, and then I decided just to leave the district

I-Hmmm ok is there anything that you feel is important for me to note whilst we are doing this interview

P-One day when I am called to be a manager I wish to know how are these managers are being appointed, which qualities are being noted to say this person is right for this position. Because I have gone may be five clinics, I can say out of five only two I at the good relationship with the people who managing my work and not me as a person who were able even to appreciate if I worked extra hours they would even appreciate if I have done anything correct and they even wish to retain me with them but unfortunately I had to leave because of some personal reasons. They even go to an extend that whenever you want to come back feel free to come back any time you are welcomed

I-Eh

P- but I think the managers must at times call those other employees like PNs and just had some questionnaires if they are satisfied a survey like so that they can be open because we needed somebody to talk to but we don't know who to talk to who I can open up so that I can cry until I get that support I need that's why I decided to leave and start other new people because every door was closed for me to open up and cry. That's why I left

I- Thank you for your inputs that you are or the feelings that you expressing today are valuable and they will assist because the findings we will have to communicate with Mandeni sub-district as to how the people who left the area feel about Mandeni sub-district, thank you

P- Thank you

Appendix 10: Letter Confirming Language Editing

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To Whom It May Concern

EDITING OF THESIS

I hereby confirm that I, Barbara Dupont, edited the thesis written by **Babhekile Rejoice Msomi,** titled "**EXPLORING REASONS FOR THE HIGH STAFF TURNOVER AMONGST PROFESSIONAL NURSES AT MANDENI SUB-DISTRICT PRIMARY HEALTHCARE FACILITIES**" and commented on the grammatical anomalies in MS Word Track Changes and review mode by the insertion of comment balloons prior to returning the document to the authors. Corrections were made in respect of grammar, punctuation, spelling, syntax, tense and language usage as well as to sense and flow. Reference guidelines and additional comments were provided to assist with corrections.

I have a been teaching English for the past 10 years, and have a Cambridge CELTA diploma in teaching English as a foreign language. I am also employed by the British Council as an official IELTS examiner for South Africa. I have been editing academic and other documents for the past two years, regularly editing the research dissertations, articles and theses of the School of Nursing, Environmental Studies and various other schools and disciplines at the University of KwaZulu-Natal and other institutions, as well as editing for publishing firms and private individuals on a contract basis.

I trust that the document will prove acceptable in terms of editing criteria.

Yours faithfully

B Dupont

Barbara Dupont

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