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Identification of self-care deficiencies requiring mentorship of newly qualified professional nurses employed in community healthcare services in Limpopo Province, South Africa

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Abstract

Newly qualified professional nurses (NQPNs) allocated to community health care services do not always have access to other personnel for mentorship. Self-care could imply that when NQPNs achieve personal and professional maturity they should be competent and independent practitioners. Self-care deficiencies exist when NQPNs lack self-care and have an increase in self-care demands. The aim of the study was to determine the self-care deficiencies that require mentorship of NQPNs employed in community health care services of Limpopo Province. A quantitative research approach was used. The target population consisted of 150 newly qualified professional nurses and 40 professional nurses employed in similar settings as the NQPNs and served as mentors. Due to limited number of NQPNs and mentors all the 150 NQPNs and 40 mentors participated in the study. A questionnaire was used to collect data. The data were analysed using Statistical Package for Social Sciences (SPSS), version 18. The NQPNs appeared to be competent in most aspects of self-care in the cognitive, psychomotor and affective domains. However, they were perceived to be incompetent in performing critical skills such as managing emergencies, research aspects and organisational management. The study recommends the development of mentorship model for NQPNs.

Keywords: Newly qualified professional nurse, community health care services, mentor, mentorship, self-care deficiencies.

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Introduction

Orem (1991) describes self-care as the deliberate action of making judgements about how individuals can and should be assisted with respect to performance of self-care activities to know and meet their self-care demands. Self-care involves action that is positive, practical and a decision of choice. Self-care is a learned behaviour aided by intellectual curiosity, instruction and supervision from others and experience in the performance of self-care measures (Pearson, Vaughan &

Fitzgerald, 1998). Self-care deficiency/deficit is equated with incompetence and dependency of NQPNs, and self-care is equated with competence and independence of this group. Self-care deficiencies exist when NQPNs lack self-care and have an increase in self-care demands (George, 1995).

Self-care could imply that when NQPNs achieve personal and professional maturity they should be competent independent practitioners. The South African Nursing Council (2005) stipulates that professional nurses should demonstrate and maintain clinical competence in all required areas of nursing to practice as safe practitioners. Hird (2004) indicates that competence does not imply expertise, NQPNs are not experts, but they can be competent, they might be slow in the beginning, but develop further skills and speed in time.

The nature of decision making is related to the NQPNs knowledge, experience and degree of independence in relation to the complexity of the situations, and the learning environment. In acute situations, NQPNs have to make clinical judgements which involve triage within a short space of time, while decision-making related to chronic conditions often has to be built on multiple considerations and requires creativity and flexibility (Hlahane, Greef & du Plessis, 2006). In their professional life as nurses, NQPNs should be able to deal with situations in which they have to take ethically motivated and correct decisions and act in a professional way.

McCarthy and Murphy's (2007), study conducted in Ireland, indicated that the concept competence continues to be an issue that goes hand in hand with assessment of practice, giving rise to discussion and debate how competence should be measured or demonstrated in practice. NQPNs should be competent in cognitive, psychomotor and affective skills required for community health care services, namely, assessment and diagnosis of patients, prescription, execution of treatment, dispensing of essential medications, decision making and networking skills to enable referral of patients for further treatment. According to WHO (1995) nurses require competence to develop and perform functions that promote and maintain health and prevent ill-health. This requirement applies equally to NQPNs employed in community health care services. NQPNs should be competent in cognitive skills such as problem solving and critical thinking to ensure the provision of high quality services to individuals, families and communities (WHO, 1995). The affective competence includes interpersonal relationships, communication skills and therapeutic interventions within a supportive and caring relationship. Psychomotor skills include performance of clinicall skills pertaining to patient care (Grant-Mackie, 2000).

The competence of any nurse is based upon autonomy and accountability of that individual nurse. A study conducted by Cele, Gumede and Kubheka (2002) confirmed that the critical outcomes of clinical practice are to be competent, efficient, mature, independent, creative and critical thinking professional nurses

who should be able to render quality patient care. NQPNs employed in community health care services should possess these skills to enable this group to deal with diverse clinic and community hospital situations, such as initiating and facilitating community health care structures and committees.

Consequently, when NQPNs are observed in practice, their behaviour illustrates the ability of this group to perform in line with professional standards. Professional nurses should take responsibility and accountability for the management of nursing care of individuals, groups and communities. NQPNs are not merely expected to perform nursing activities, but their tasks involve the provision of on-going comprehensive services aimed at the promotion of health, prevention of illness, curative and rehabilitative services. NQPNs should have self-care in cognitive skills such as problem solving and critical thinking to ensure the provision of high quality services to individuals. To make well-grounded decisions and deliver evidence-based nursing, NQPNs should develop cognitive, emotional knowledge and technical skills; and be able to apply this knowledge in the delivery of skilled practices (Hlahane, Greef & Du Plessis, 2006).

The purpose of this study was to identify the self-care deficiencies that require mentorship of NQPNs employed in community health care services Limpopo Province, South Africa.

Methodology

Design

Quantitative research method and descriptive design was used in order to collect data from NQPNs and mentors about the self-care deficiencies of the NQPNs.

Population and sample

The target population comprised 150 NQPNs employed in community health care services in the five districts of Limpopo Province, namely, Capricorn, Mopani, Sekhukhune, Vhembe and Waterberg. All the 150 NQPNs and the 40 mentors linked to the NQPNs participated in the study.

Questionnaire

A questionnaire consisting of a 4-point Likert scale, with two sections and 61 items was used to collect data. Section A comprised four (4) questions related to biographic data, section B had fifty-seven (57) questions that related to the competencies of NQPNs. Out of the 150 questionnaires distributed to NQPNs, 88 (59%) were returned, while out of 40 questionnaires administered to the mentors, 30 (75%) were returned.

Data analysis

The Statistical Package for the Social Sciences (SPSS), version 18 was used for data analysis. Descriptive and inferential statistics, chi-square tests and means were calculated. Data obtained from NQPNs and mentors were analysed concurrently to enable comparison of the responses from the two groups. The statistical significance of the competency score was set ≤ 0.05.

Validation of questionnaire

Content validity was ensured by the use of a quantitative research expert to review the questionnaire before data collection (Babbie & Mouton, 2009). Reliability was ensured by conducting an extensive literature review as a base for construction of the questionnaire and the questionnaire was pre-tested.

Ethical considerations

Ethical clearance was obtained from the Health, Safety and Research Ethics Committee of the University of Venda. Permission to conduct the study was obtained from the Department of Health and Social Development, Limpopo Province and the managers of the health care services.

Results and Discussion

Mentors were older than the NQPNs with mean age of 46 years and that of NQPNs was 30 years with the minimum age of 23 years. The items in section B were designed to determine the self-care deficiencies that require mentorship of NQPNs employed in community health care services as shown in Table 1.

Table 1: The competencies of NQPNs

Items		NQPNs (n=88)				Mentors (n=30)			
		Competent		Not competent		Competent		Not competent	
		F	%	f	%	F	%	F	%
6.1	Do assessment of children	58	66	30	34	20	67	10	33
6.2	Do assessment of male adult patients	57	65	31	35	22	73	8	27
6.3	Do assessment of female adult patients	68	78	19	22	25	83	5	17
6.4	Do assessment of geriatric patients	53	60	35	40	25	83	5	17
7.1	Make diagnosis of children	52	59	36	41	19	65	10	35
7.2	Make diagnosis of male adult patients	60	68	28	32	24	80	6	20
7.3	Make diagnosis of female adult patients	66	75	22	25	24	80	6	20
7.4	Make diagnosis of geriatric patients	48	55	40	45	23	77	7	23
8.	Do physical examination of women during ante-natal care	59	67	29	33	24	80	6	20
9.	Make independent decisions during caring for women in labour	53	60	35	40	21	70	9	30
10.	Manage psychiatric emergencies	38	43	50	57	17	57	13	43
11.	Manage integrated childhood illnesses (IMCI)	51	58	37	42	20	67	10	33
12.1	Manage health care services in clinics	52	59	36	41	20	67	10	33
12.2	Manage health care services in hospital	54	61	34	39	14	47	16	53
13.	Communicate with patients regarding their conditions	75	85	13	15	24	80	6	20

Items		NQPNs (n=88)				Mentors (n=30)			
		Competent		Not competent		Competent		Not competent	
		F	%	f	%	F	%	F	%
14.1	Apply crisis intervention skills in clinics	46	52	42	48	20	67	10	33
14.2	Apply crisis intervention skills in hospital	54	61	34	39	17	57	13	43
15.	Educate youths with regard to HIV/AIDS prevention	66	75	22	25	28	93	2	7
16.	Prescribe medicines according to essential drug list	54	61	34	39	22	73	8	27
17.1	Write research proposal	34	39	54	61	14	47	16	53
17.2	Construct research questionnaire	34	39	54	61	17	57	13	43
18.	Apply Batho-Pele principles to patient care	68	77	20	23	28	93	2	7
19.	Advocate for the rights of patients	69	78	19	22	27	90	3	10
20.	Execute life-saving interventions	60	68	28	32	28	93	2	7
21.	Show respect for the dignity and uniqueness of patients	74	84	14	16	27	90	3	10
22.	Practice nursing within the prescription of relevant laws	68	77	20	23	25	83	5	17
23.	Do resuscitation of the new born baby	39	44	49	56	25	83	5	17
24.	Apply appropriate research findings	40	46	48	54	16	53	14	47
25.	Draw a health service budget	25	28	63	72	15	50	15	50
26.	Design HIV/AIDS awareness programme	45	51	43	49	17	57	13	43
27.	Deliver a new born baby	57	65	31	35	26	87	4	13
28.	Create a mission statement relevant to nursing practice	47	53	41	47	18	60	12	40
29.	Carry out immunization	61	69	27	31	27	90	3	10
30.	Organize community health forums	36	41	52	59	19	63	11	37
31.	Organize HIV/AIDS partnership Programmes	38	43	50	57	18	60	12	40
32.	Compile procedure manuals for nursing practice	37	42	51	58	18	60	12	40
33.	Create awareness of rights pertaining to HIV/AIDS patients	59	67	29	33	21	70	9	30
34.	Observe time management with regard to provision of patient care	63	72	24	28	24	83	5	17
35.	Conduct family planning	67	76	21	24	24	80	6	20
36.	Carry out pre and post HIV testing	41	47	47	53	19	63	11	37
37.	Keep records pertaining to care of patients	72	82	16	18	26	87	4	13
38.	Support of HIV positive clients on Anti-retroviral therapy	48	55	40	45	17	57	13	43
39.	Provide prevention of mother to child transmission (PMTC) services	48	55	40	45	19	63	11	37
40.	Make referral of patients	66	75	22	25	26	87	4	13
41.	Give report to other health team members	74	85	13	15	26	87	4	13
42.	Supervise home-based care givers	56	64	32	36	18	60	12	40
43.	Audit patients' records for quality assurance	65	74	23	26	18	60	12	40
44.	Differentiate between urgent and non-urgent conditions	67	76	21	24	25	83	5	17
45.	Compile staff records and reports	63	72	25	28	26	87	4	13
46.	Adapt to community services	53	60	35	40	25	83	5	17
47.	Do assessment of post-natal mothers	64	73	24	27	25	83	5	17
48.	Apply teaching principles during health education	73	83	15	17	25	83	5	17
49.	Allocate personnel in the health unit	63	72	24	28	22	73	8	27
50.	Manage conflict in the health unit	54	61	34	39	18	60	12	40
51.	Develop standards for quality patient care	65	74	23	26	23	77	7	23

The NQPNs appeared to be competent in most aspects of cognitive, psychomotor and affective domains. However, the findings in eleven items revealed that NQPNs perceived themselves as being not competent in performing ten skills,

whereas mentors perceived NQPNs to be competent in these skills. The skills are indicated in Table 2 as the management of psychiatric emergencies, manage health care services in hospital, write research proposal, construction of research questionnaire, writing of a research report, resuscitation of the new born baby, application of research findings to patient care, drawing of health service budget, organisation of community health forums, organization of HIV/AIDS partnership programmes, compilation of procedure manuals, and carrying out pre and post HIV testing.

Table 2: Self-care deficit competencies requiring mentorship

Specific items		NQPNs (n=88)				Mentors (n=30)			
		Competent		Not competent		Competent		Not competent	
		F	%	F	%	F	%	F	%
10.	Manage psychiatric emergencies	38	43	50	57	17	57	13	43
12.2	Manage health care services in hospital	54	61	34	39	14	47	16	53
17.1	Write research proposal	34	39	54	61	14	47	16	53
17.2	Construct research questionnaire	34	39	54	61	17	57	13	43
17.4	Write research report	34	39	54	61	19	63	11	37
23.	Do resuscitation of the newborn baby	39	44	49	56	25	83	5	17
24.	Apply appropriate research findings to patient care	40	46	48	54	16	53	14	47
25.	Draw a health service budget	25	28	63	72	15	50	15	50
30.	Organize community health forums	36	41	52	59	19	63	11	37
31.	Organize HIV/AIDS partnership Programmes	38	43	50	57	18	60	12	40
32.	Compile procedure manuals for nursing practice	37	42	51	58	18	60	12	40
36.	Carry out pre and post HIV testing	41	47	47	53	19	63	11	37

NQPNs (57%) perceived themselves as not competent and 43% as being competent in managing psychiatric emergencies, whereas 57% of mentors perceived NQPNs to be competent and 43% perceived them not competent in this regard. NQPNs followed a curriculum that stipulates that students should accumulate 600 hours in psychiatric practice under the supervision of a registered psychiatric nurse (SANC R425). Despite the SANC requirements NQPNs might not have been adequately exposed to learning psychiatric skills.

Merson and Baldwin (1995) indicated that psychiatric emergencies include active suicidal behaviour and actively threatening violent behaviour. The nurse should take control of the situation with clear instructions to colleagues regarding physical restraint and sedation if necessary. Gwele and Uys (1995) state that there were complaints that comprehensively trained nurses lack competence in psychiatric and community health nursing. Hlahane, Greef and du Plessis (2006) also indicated that professional nurses perceived their own skills as lacking with regard to mental health care. Sharrock and Happell (2006) further indicated that the mental health content that undergraduates received was

inadequate to equip them to care for patients with mental health problems in any setting.

With regards to the management of health care services in community hospital, the NQPNs (61%) perceived themselves to be competent whereas mentors (47%) responded that they were not competent. Apparently mentors as experienced professional nurses realised that NQPNs were not yet experienced to manage a health service unit as they were still new in the services.

Both NQPNs (61%) and mentors (53%) indicated that NQPNs were not competent in writing research proposal. Although NQPNs in this study were guided on research proposal writing during their training as included in the curriculum, their exposure appears to be inadequate to render them competent in this regard. Ravert and Merril (2008) indicated that the baccalaureate-prepared nurse has added responsibilities related to research, such as helping investigators gain access to clinical sites for research thus influencing the method of data collection and implementing research findings.

Regarding construction of research questionnaire, 61% NQPNs perceived themselves not to be competent, whereas 57% mentors responded otherwise. SANC (2005) listed research as one of the competencies for quality of practice which indicated that professional nurses should collaborate with other members of the health care team to identify actual and potential areas for nursing and health research in order to improve or maintain quality care. With regard to writing research report 61% of NQPNs responded that they were competent in writing research report, whereas 63% mentors indicated that NQPNs were competent in this aspect. Apparently the mentors were less involved in research activities, whereas NQPNs were involved in research during training and were able to identify their own lack of competence regarding the writing of research report.

In terms of applying appropriate research findings to patient care, 55% NQPNs perceived themselves as being not competent to apply research findings to patient care whereas 53% of mentors indicated that NQPNs were competent to apply research findings. The writing of research proposal precedes all research activities such that lack of competence in this aspect could lead to self-care deficiencies in applying research findings to patient care. NQPNs require mentoring in the research process whereas the mentors in this study might not be well-grounded in principles of research and require research programmes at clinical or practical level. SANC (2005) maintains that professional nurses should utilise health and population epidemiological data as indicators to inform nursing practice.

Blenkinsop (2003) conducted a study in the UK on research as an essential skill of a graduate nurse and stressed that nurse graduates should have research skills,

which are transferable skills that are essential for practice as qualified nurses. The analytical skills acquired during data analysis are transferable into the practice area and delivery of high quality care which involves patients, relatives and other members of the multi-disciplinary team. The utilization of research knowledge has been described as one of the most urgent challenges in the field of nursing. Chesney et al. (2001) indicated that the research knowledge and skills of practitioners and academics need to be enhanced throughout medical education. Although the study was conducted on medical practitioners, it could be relevant to the research skills of NQPNs. Ravert and Merrill (2008), in a study of partnership of service and academia, reported that through partnership with the Dean of the college and the Chief Nursing Officer, University faculty members were encouraged to collaborate with the hospital as they conducted research in clinical settings. Furthermore, it was evident that the nurses in the hospital were interested in research and evidence-based practice, but lacked the necessary skills and resources.

NQPNs (56%) indicated that they were not competent in performing resuscitation of a newborn baby whereas 83% mentors stated that NQPNs were competent in this regard. This overwhelming number of mentors is surprising and could be attributed to the few deliveries at the clinics and the mentors might not have witnessed resuscitation performed by the NQPNs. If any delivery occurred, the mentors might have acted as supervisors to the NQPNs. Sellers (2004) indicated that if the newborn was not resuscitated the complications on the central nervous system could be hypoxaemia, hypercapnia, ischaemia, respiratory acidosis and metabolic acidosis. Asphyxia results in brain damage manifested by behavioural problems ranging from lethargy to coma, muscle tone may be diminished or absent with some form of seizure such as slight twitching to fitting and apnoeic episodes to convulsions.

Regarding managing health care services in community hospital, NQPNs (61%) perceived themselves to be competent and 53% mentors perceived NQPNs not competent in this regard. Although the NQPNs were taught health service management during training, it cannot be expected that they should be competent in this aspect. Hlahane, Greef and du Plessis (2006) noted that professional nurses with various qualifications might not always recognise their own limitations and they may consequently believe themselves to be competent.

On budget, the NQPNs (72%) indicated that they were not competent to draw up a health services budget whereas 50% of mentors responded that NQPNs were competent in this regard. The remaining mentors responded that NQPNs were not competent in drawing up a health service budget. Although NQPNs were exposed to unit management during their training they could not have been exposed adequately to be competent in this regard. The drawing up of a budget is done annually at senior management level and is the responsibility of the accounting officer, namely, the Chief Executive officer with the assistance of the

financial manager of the health care service. King (1991) supported the findings that nurses must remember that their role is also concerned with budgeting.

Regarding the organization of community health forums, NQPNs (59%) indicated that they were not competent whereas 63% of mentors indicated that NQPNs were competent. NQPNs may not be expected to be competent in organization of community health forums as they were new in community health care services during the time of the study as they hardly spent six months in these services. Regarding compiling procedure manuals for nursing practice NQPNs (58%) responded that they were not competent to compile procedure manuals for nursing practice whereas mentors (60%) indicated that NQPNs were competent in this regard. Procedure manuals guide nursing practice in health care services and it is expected that NQPNs should be competent in this regard. This is expected by SANC (2005) as a framework of standards for nursing practice.

Regarding the organization of HIV/AIDS partnership programmes and carrying out pre and post HIV testing counselling, conflicting responses were recorded, 57% of NQPNs indicated that they were not competent to organise HIV/AIDS partnership programmes whereas 60% of mentors responded that NQPNs were competent in this aspect. The curriculum for the comprehensive course (R425) is responsive to the SADC regional health problems. SANC (2002) outlined the recommended content on the education and training of nurses in HIV/AIDS wherein, among others, the diagnosis including counselling and testing (HCT), prevention and control of HIV were indicated. The National Department of Health (2007), in the HIV and AIDS strategic plan for South Africa 2007-2011, indicated that among the activities within the key priority area 1 namely, prevention, there should be creation of an enabling environment for HIV testing. NQPNs (53%) responded that they were not competent to carry out pre- and post- HIV testing, whereas mentors (63%) indicated that NQPNs were competent. HIV and AIDS pose a serious global threat and it is expected that NQPNs should be competent in pre- and post-testing to reduce infection rate. The World Health Organization (2002) maintains that more than 80% of people living with HIV in low and middle income countries do not know that they are infected. Health care workers should offer counselling and testing to all those who might benefit from knowing their HIV status and receive relief from advances in the treatment and prevention of HIV infection and HIV- related infections.

Recommendations

The study recommends that:

- During the final year of the four-year comprehensive course (R425), students should be delegated the responsibility of being in-charge of units and attend to emergencies of different types, to enable them to transit into

professional nurses. Students should have a period of practice towards the end of their programme to help prepare them for the role as registered practitioners.

- Students should be given the opportunity to manage the complete pathway of care and apply theory to practice, to think in critical situations for themselves and to use their initiatives.
- NQPNs should be encouraged to work independently in the final stages of training in order to give them the real life experience of qualified nurse prior to their formal transition into the nursing profession.
- The support of an experienced staff member is important in developing confidence in the ability of NQPNs to practice nursing effectively. Mentorship should therefore be included as an integral part of the nurse education programme.

Conclusion

The first year of professional practice is an important transitional time during which new professionals develop competencies in providing health care to patients. Mentors' role is most important in the first 3-6 months of new nurses' clinical experience. Patient care is generally improved in the clinical setting where NQPNs are mentored. NQPNs who have the support and guidance of mentors reported self-actualisation, job satisfaction and less stress than those without mentors.

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