

Newly qualified professional nurses' experiences of mentorship in community health care services

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Abstract

The purpose of this study was to explore and describe the newly qualified professional nurses (NQPNs) experiences of mentorship in community health care services. A qualitative-phenomenological design was used. Focus group interview was done to collect data from NQPNs employed in the primary health care services and community hospitals in Limpopo Province. The study was guided by Orem's theory of self-care deficit. The study findings revealed that NQPNs experienced self-care deficiencies regarding the performance of specific competencies related to dealing with psychiatry, midwifery practices and community health. The NQPNs also expressed poor adaptation in the organizational and health practice cultures and low interaction with the community they serve. The study came up with recommendations related to adaptation/adjustment, health and nursing practice culture, development of skills competencies, improvement of good relationships between NQPNs and community and the development of mentorship model.

Keywords: Mentorship, reality shock, newly qualified professional nurses, adaptation, self-care deficiencies, competencies.

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Introduction

The national Department of Health (NDoH) is entrusted with the responsibility to ensure access to health services for the people of South Africa. The demands with regard to health care services in the Republic of South Africa (RSA) pose a challenge to the NDoH regarding the placement of health professionals in underserved settings and this includes the Newly Qualified Professional Nurses (NQPNs). The NDoH implemented compulsory community service in 1998 for doctors, dentists and pharmacists. The compulsory community service for doctors, dentists and pharmacists was implemented with the objective of attracting health professionals to underserved areas such as community health care services. A rural and scarce skills allowance was also introduced to attract and retain health professionals in the public health sector, as this group seems to

move to private sectors and developed countries. According to Thom (2004) 600 South African doctors are registered to practice in New Zealand, 10 per cent in Canada while 6 per cent are in the United Kingdom (UK).

The emphasis on health care in the RSA is on the provision of Primary Health Care (PHC) services with the aim of reducing inequalities of access to health services, particularly in rural areas and deprived communities. The promotion of equity, accessibility and utilization of health care services could be realized by distribution of health care personnel throughout the RSA in an equitable manner (DoH, 2003). The Republic of South Africa (RSA) (1997) White paper for transformation of the health system in South Africa, indicate that the maldistribution of human resources should be addressed primarily through an incentive-driven process, with service requirements of a maximum of two (2) years in an under-served area after completion of graduate or post-graduate studies. There should be obligatory service requirements for all health professionals to spend at least two (2) years in a public sector prior to entering health practice.

The NQPNs are expected to render community service and this group might be having self-care deficiencies with regard to execution of their roles and responsibilities in the community health care services. These NQPNs might not have been adequately trained during their undergraduate programme requiring them to register as a nurse (general, psychiatric and community) and midwife according to SANC regulation (R425). During the first year of employment in community health care services, the NQPNs may need mentorship from their seniors. The support and guidance that mentors are expected to provide to NQPNs could contribute to optimal competence and retention of this group in the community health care services. Furthermore, collaborative partnership and mentor-mentee contract could enhance the mentorship of NQPNs employed in community health care services.

Janas (1996) cited direct and indirect benefits of mentorship, namely, development of personal work ethic and standards, increased career aspirations, greater personal interest and expression of talents, enhanced ability to work towards a vision, increased creativity and tolerance. Owens and Patton (2003) concur with Janas (1996) that during mentorship professional nurses who are mentors have a chance for growth and development within the practice of nursing and professional replenishment to become expert practitioners. Similarly, the mentors benefit by keeping current with new knowledge and outlooks brought in by the NQPNs. Mentorship also fulfils a psychological function when there is trust, emotional support, shared problem-solving, role-modelling, counselling, acceptance and affirmation. Mentors have the opportunity to fulfil generative needs by passing on wisdom to NQPNs and developing their sense of competency and self-worth.

According to Lloyd-Jones, Walters and Akehurst (2001) the benefits of mentorship in mentees are related to the number of occasions on which the student and mentor work together. NQPNs who received the support and guidance of mentors reported greater self-actualization, more job satisfaction, better peer relationship and less stress than those without mentors. Owens and Patton (2003) support the notion that mentorship mind-set focuses on having a positive impact on recruitment and retention of NQPNs.

Furthermore, mentorship not only promotes progression in NQPNs' career and enhances improvement in performance, but also increases the NQPNs' understanding of organizational culture of the health services. Mentorship is used by mentors to upgrade skills, bolster recruitment and retention, and increase job satisfaction of NQPNs (Kerka, 1998; Rosser & King, 2003). MacNeil (2005) concurs with other studies and indicates that today, as in the past, people continue to seek wisdom and counsel from those more experienced. The purpose of the study was to explore the NQPNs experiences of mentorship in community health care services.

Methodology

Design

A qualitative approach and phenomenological design was used to explore the NQPNs' experiences of mentorship in community health care services. The focus of the qualitative approach is on human experience and this enables the development of a rich description and deep understanding of the phenomenon under investigation. Only those individuals who experience the phenomenon are capable of communicating their experience to the outside world. In phenomenology there is interactive involvement of both researcher and the research participants. In this study the researchers studied lived experiences of NQPNs regarding mentorship in community health care services of the Limpopo Province.

Phenomenology also includes bracketing and intuition. Bracketing occurs when the researcher suspends or lays aside what is known about the experience being studied, thereby excluding pre-conceived ideas (Creswell, 2003). The researchers have deliberately set aside these pre-conceived ideas and were able to consider every perspective of the NQPNs.

Intuition occurs after bracketing and involves the process of actually looking at the phenomenon and the researcher tries to develop an awareness of the lived experience. The researcher focuses all awareness and energy on the subject of interest. Intuition is thought to allow an increase in insight and requires absolute concentration and complete absorption with the experience being studied. In

order to accomplish intuition in this study, the researchers paid careful attention during the focus group interview and asked probing questions. The researchers summarised each question at the end of the focus group interview. Furthermore, the researchers went to the community health care setting and used focus group interview to understand and interpret the meaning that NQPNs gave to their everyday practice in these services.

Population and sampling

The population comprised 5 746 professional nurses of whom 468 were males and 5 278 were females (DoH, 2004) employed in Public health care services of Limpopo Province during 2006. The accessible population was 150 NQPNs employed in clinics and community hospitals of the Limpopo Province. Due to insufficient NQPNs employed in the community health care services, purposive sampling was used to select the health care services and NQPNs for inclusion in the focus group interview.

The researcher purposefully chose two (2) community hospitals and two (2) clinics to select NQPNs employed in community health care services as these facilities employed more NQPNs. For instance, in one particular clinic and community hospital there were two NQPNs and Five NQPNs respectively. The sample size of twelve (12) was selected based on data saturation. Eight NQPNs were employed in community hospitals and four were employed in clinics. NQPNs were chosen based on the fact that they have worked in community health care services for less than a year. De Vos (2005) maintains that purposive sampling is best used when the participants included in the study have knowledge on the phenomenon being studied.

Data collection procedure

One structured focus group interview was conducted with 12 NQPNs for data collection. The group was small enough to enable all participants the opportunity to share insight related to the phenomenon and large enough to enable all participants the opportunity to share insight related to the phenomenon and large enough to provide diversity of perceptions. The focus group interview promoted self-disclosure among participants and to discern what they really thought and felt. During focus group interview there was continuous communication between the researchers and the participants, and among participants themselves. Throughout the focus group interview, the researchers' essential motivation was to listen and learn from participants.

The researchers arranged for interview date with the contact person and the participants employed at the community hospital. The arrangement was attained by formal telephone conversation and followed up in writing through a faxed

letter. The researchers confirmed again by telephone two days before the interview date as a reminder to the contact person and the participants. A boardroom was arranged as the venue for the focus group interview and this was a quiet environment with no interruptions. The venue was comfortable, non-threatening to participants as it was their place of employment, and it provided privacy for the focus group interview. The seating arrangement was around the table and this facilitated involvement, interaction and eye contact among participants and the researcher. A tape recorder was placed in the middle of the table to allow visibility and audibility of the participants during recording.

The researchers wrote notes to capture main responses to augment the tape recorder. Furthermore, the researcher asked the central question followed by probing questions as guided by the responses of the NQPNs to the central question. The probing was done after each response from participants until saturation. According to de Vos (2005), saturation is the point at which new data no longer emerge during the data collection process. The central question that was asked from the NQPNs was: *What are your experiences of being an NQPN in the community health care services?*

The focus group interview lasted for about one hour and the researchers confirmed with participants during the interviews and at the end of the sessions whether the information that these participants gave to the researchers was the same as that on the notes.

Data analysis

Open coding method was used as outlined in Creswell (2003). The steps considered during data analysis were as follows:

- Data collected via tape recording were transcribed verbatim wherein the information from the tape recorder was written as said by participants. Following data analysis, discussion and verification of findings were done with members of the focus group.
- A list of all topics identified was written down. Similar topics were clustered together and written in columns.
- Data that belonged to each category were assembled, collated and analysed.
- Similar topics in columns were arranged in themes and sub-themes as described in Table 1.

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. Confidentiality was ensured by not using participants' names during focus group interview.

Trustworthiness

Trustworthiness was maintained by using Guba's model as cited in de Vos (2005) on the criteria namely, credibility, dependability and confirmability. Credibility was ensured by prolonged engagement as researcher had contact with NQPNs during arrangements for interview, during focus group interview and follow up discussions. Dependability was ensured through written field notes during data collection and triangulation of data collection methods was used to ensure compensation of focus group interview. Confirmability was ensured by tape recordings and notes that were kept safely to enable conduction of adequate trail and to determine if the conclusions, interpretations and recommendations can be traced to their sources and are supported by the study.

Results and discussion

Twelve NQPNs of whom eight were employed in community hospitals and four employed in clinics, participated in the focus group interview. Table 1 provides the themes and sub-themes that emerged from data analysis and focus group interviews.

Table 1: Themes and sub-themes related to NQPNs' experiences

Themes	Sub-themes
1. Self-care deficiencies to perform competencies related to community health care services.	1.1 <i>Low confidence to perform specific cognitive, psychomotor and affective skills.</i> 1.2 <i>Low self-esteem during execution of patient care.</i>
2. Self-care deficiencies related to adaptation and adjustment to community health care services.	2.1 <i>Reality shock upon entering the community health care services.</i> 2.2 <i>Transition is stressful.</i> 2.3 <i>Inadequate orientation leads to poor adaptation/adjustment.</i>
3. Organizational culture conflicting with their values of studenthood	3.1 <i>Poor adjustment to organizational goals.</i> 3.2 <i>Perception of values that conflict with organizational management style.</i>
4. Self-care deficiencies related to interaction with the community they serve.	4.1 <i>Poor communication with patients and the community</i> 4.2 <i>Poor interpersonal relationships with health team members.</i>

Theme 1: Self-care deficiencies to perform competencies related to community health care services

NQPNs indicated that they had low confidence to perform specific cognitive, psychomotor and affective skills and low self-esteem during execution of patient care. The self-care deficiencies related to dealing with patients with psychiatric problems, midwifery skills and in particular delivery of babies and the research skills.

Sub-Theme 1.1: Low confidence level to perform specific cognitive, psychomotor and affective skills

The majority of NQPNs in this study expressed lack of confidence in performing clinical skills. Among those emphasized were issues related to dealing with psychotic patients, midwifery practice, HIV and AIDS, research, communication skills, management of community health care services and assessment of patients. One participant expressed self-care deficiencies in dealing with psychotic patients as follows: *“It is very scary even with the patients you think they know that you are new, mmm...let alone a psychotic patient when you are alone...Oh! My God, I can’t handle that”*. Thus, NQPNs require mentoring in handling psychotic patients as these are possible emergencies that they should handle at the community health care facilities.

The NQPNs overwhelmingly expressed concern about dealing with a woman in labour alone without supervision. They felt is not time yet to conduct delivery independently and one participant said: *“We need follow up and evaluation during delivery of patients, they should guide and assess us, we need constant guidance throughout until we are confident”*. When probing on HIV and AIDS issues related to pregnancy and labour, another participant indicated that *“When you see a person of your age group who is HIV positive and you also provide care for AIDS patients, it feels like you are also infected”*. The DoH (2000) indicated competence of health staff in terms of knowledge, attitudes and skills that staff should know with respect to the contents of the guidelines on management of occupational exposure to HIV, relation to patients in a non-discriminatory and non-judgemental manner and maintaining strict confidentiality about patients’ HIV status. Health care providers should seek to reduce fear and stigma of HIV/AIDS patients and provide the youth with friendly services that help promoting health-seeking behaviour.

With regard to research issues the group expressed self-care deficiencies in research and one participant said: *“Oh! Research...we learned that and did projects in groups during training. Putting it in practice is not easy...how do we start with research in this situation”*? The DoH (2011) indicated that Priority area 3 addresses research, monitoring and surveillance. NQPNs require

mentoring in research to enable competence in this aspect. NQPNs expressed self-care deficiencies pertaining to communication and one participant *said that "Giving health education is problematic, the clinic has no scheduled time for health education, like starting with health education before consultation of patients"*. When probing further another participant said: *"The terms used by patients with regard to explanation of conditions especially those related to reproductive health is a challenge. This influences the health education sessions with patients"*. These expressions imply that NQPNs might perceive health education to be possible only if done for a group of patients and disregard individual health education during consultations.

With regard to assessment of patients, NQPNs expressed their self-care deficiencies by saying: *"No much responsibility as students, you hide behind other people, but now that we are qualified, patients and their relatives expect you to do assessment, you must do something"*. The DoH (2000) indicated in the core norms and standards for clinics that a clinic should have at least one member of staff who has completed a recognized course of Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care. The professional with this recognised diploma could mentor the NQPNs in aspects of patients' assessment in clinics and community hospitals.

Sub-Theme 1.2: Low self-esteem during execution of patient care

NQPNs expressed lack of confidence and low self-esteem and one participant said: *"I was scared, it was not easy you are afraid of patients and I do not know how to put it, but is scary to tell the honest. Scared to remain alone, say a complication arise what will I do? What if an emergency occurs? This description reflects a lack of confidence in attending to emergencies and complications arising while caring for patients. When NQPNs in this study moved from the academic domain to the work realities of community health care services, they experienced uncertainty and insecurity about their new role. The therapeutic self-care demand regarding basic needs and, in particular, the need for self-esteem was expressed by one participant who said: "I wished I was a junior, enrolled nurse because I would be told what to do. If you give medicine and when writing the report you feel you are not doing the correct thing. If complications arise what would my subordinates think of me?"*

These findings agreed with Rosser and King (2003) of the UK who showed that when nurse practitioners were moved from clinical areas in which they were confident to new clinical areas they experienced uncertainty and insecurity about their new role. McKenna and Green (2004) in Australia conducted a study on experiences and learning during a graduate programme and the study revealed that the experiences of new graduates can be fear-provoking or satisfying, depending on a range of factors including the degree to which the individual is

provided with on-going support and encouragement. Many nurses in Australia leave the profession within the first 12 months following graduation. Hence, graduate nurse programmes have been developed in Australian hospitals to assist with transition processes by providing supportive environments and educational opportunities, but differ in delivery modes. Tzeng (2006) indicated that nursing leaders should encourage nurses to promote professionalism as well as positive self-concept and self-esteem.

Interestingly, the study conducted by Chang, Mu and Tsay (2006) of South Korea found that even an experienced nursing expert may perform as a novice when entering a new working environment or position.

Theme 2: Self-care deficiencies related to adaptation and adjustment to community health care services

Three sub-themes emerged from this theme, namely, NQPNs experience reality shock, transition is stressful and lack of orientation leads to poor adaptation/adjustment. Poor adaptation to the organization culture of the community health care services was a challenge to the NQPNs.

Sub-Theme 2.1: Reality shock upon entering the community health care services

One participant explained the experience of reality shock as follows: *“I was scared, you are even afraid of patients, I don’t know how to put it, but is scary to tell the honest truth. We are still adapting, I have learned that it is important to go back to books, those books have what we do here.”*

Adaptation refers to a constant ongoing process that requires a change in structure, function or behaviour so that the person is better suited to the environment (Smeltzer & Bare, 2004) In an adaptive system, the person has capacity to adjust effectively to environmental changes and can also affect the environment (Fitzpatrick & Whall, 1996).

Poor adaptation to community health care services could lead to NQPNs experiencing reality shock and spending most of their time complaining about the new organizational culture. The voluntary and deliberate engagement of NQPNs in activities that lead to adaptation to community health care services, reflect self-care agency that actualize self-care activities. NQPNs in this study revealed the possession of attributes to assess the needs for self-care. McCloughen and O’Brien (2005) supported these findings by indicating that nurses with less than two years working experience poses a lack of emotional competence and a reduced ability to cope with work-related stress. Furthermore, these authors observed that a high percentage of new graduate nurses leave the profession within 12 months of graduation. Newton and McKenna (2007)

reported that the year following graduation is one of immense personal and professional development.

The move into the role of new graduate nurse was described by McKenna and Green (2004) of Australia as evoking stress and can be overwhelming. Stress is attributed to increased accountability for practice, ward and patient management responsibilities and necessary proficiency of clinical skills. This may be compounded by applying knowledge from undergraduate courses into patient care along with acquisition of new skills. As a consequence, reality shock is a common occurrence for new graduates.

Sub-Theme 2.2: Transition is stressful

One participant said: "*Heish, I thought they would assist me when I do not know, with the medications they have different names, generic and trade names. Sometimes you may give the patient wrong medication*". Other participants also expressed stressful experiences during transition from academic to working culture of community health care services. Transition involves movement from one state to another, the associated experiences and the consequential development. Transitions create change identity, role, relationships, ability and behaviour, and are associated with stress. Individuals experience change, contrast and surprise during role transition. Change, the objective difference between old and new roles, creates the need to learn new tasks. Transition is a time of uncertainty which can be alleviated by the presence of formal support structures, including effective mentorship and plans for professional development. McCloughen and O'Brien (2005) indicated that new graduate nurses experienced stress and fear and further expressed the need for support to make the transition from student nurse to registered nurse, as they reported feelings of being overwhelmed and extremely vulnerable, and acknowledged the importance of encouragement and guidance during this period.

Newton and McKenna (2007) cited that the first six months of undertaking a graduate programme was perceived by the participants as the most difficult and were described as surviving and beginning to understand. Surviving centers on the realities of practice where graduates are coming to terms with the realities of the real world of nursing. There is quiet focus on themselves as individuals, and trying to manage their time and get the task done. Beginning to understand relates to the graduates learning to know where they fit in, knowing who to ask, and when not to ask. It is about learning how to establish their place in the nursing culture and organization. It is widely recognised that the process of transition from student to practitioner and from novice to advanced beginner-level practitioner, is a stressful experience for newly qualified nurses. There is often the untenable professional-bureaucratic conflict arising from the differences in the culture between the school of nursing and the hospital setting.

There is also lack of appropriate individual support and a supportive clinical learning environment during the initial post-qualification period, coupled with sudden increases in levels of responsibility and accountability that come with being a registered nurse (Johnstone, Kanitsaki & Currie, 2008).

Sub-Theme 2.3: Inadequate orientation leads to poor adaptation/adjustment

An overwhelming majority of participants indicated that poor adaptation is attributed by lack of orientation programmes. One participant expressed insufficient orientation as follows: *“No proper orientation, they leave you alone”*. Another participant said: *“I was left alone for the first week, I did not know what to do”*. Yet another participant added and said: *“Being students we must be committed to practicals so as to know what to do. We have been left alone in wards, with orientation I started to feel comfortable”*. One participant said: *“Orientation, what we have done during practicals in hospitals help us here.*

The controversial findings on orientation where some NQPNs received orientation and others did not are surprising. There could be lack of orientation programmes in the community health care services or it might be attributed by the individual professional nurses' choice to orientate NQPNs or not. It could also relate to poor interpersonal relationships among NQPNs and professional nurses as one participant said *“Do not be superior to them, respect them, then they will help you as they are experienced. It depends how you ask for assistance and if you relate well. These people have been in the working situation for a long time”*. Such expressions suggest a lack of orientation programmes for NQPNs in community health care services.

Johnstone, Kanitsaki and Currie (2008) asserted that support is critical to graduate nurse transition from novice to advanced beginner-level and to the integration of neophyte practitioners into safe and effective organizational processes. If theoretical knowledge is to be transferred successfully into practice, transfer of knowledge must take place in a supportive and non-threatening environment that well integrates the neophyte practitioner of nursing into the organization's systems and processes.

Theme 3: Organisational culture conflicting with NQPNs' values of studenthood

Goals include standards for behaviour and performance and are intended to increase efficiency and effectiveness by specifying the desired outcomes towards which individuals, teams and the organization should work (Khoza, 2005). The sub-themes consisted of poor adjustment to organizational goals and perception of values that conflict with organizational goals.

Sub-Theme 3.1: Poor adjustment to organizational goals

The organizational goals that pose a challenge to NQPNs include working 24 hours at the clinics, working on night duty, protocols and standards, rigid routine of the PHC facilities and implementation of Batho-Pele principles. NQPNs expressed poor adjustment to working 24hours and one female participant said that: *"We work day and night. I mean you work during the day and sleep at the clinic to be on stand-by-e...on call"*. Working 24 hours at clinic where the health care providers at community health care facilities work normal hours during the day and are on stand-by during the night also poses as challenge to NQPNs. The 24-hour services at clinics should be done for accessibility of facilities and in accordance with the Batho-Pele principles. The Limpopo Province DoH (2005) drew a policy on provision of 24hours of service with the goal of ensuring access to integrated community health care services. The policy was also drawn based on the South African Constitution, Act 108 of 1996, Chapter 2, section 27 (1), which indicates that everyone has the right to have access to health care services, including reproductive health care (RSA, 1996).

Among the guidelines in this policy is that every clinic with reasonable accommodation, security and three or more professional nurses, is expected to render 24-hour services. Staff members at these clinics are expected to work 24 hours on a rotational basis and those who render full-time night duty should provide all clinic services, while those rendering an on-call system should attend to all emergencies. The policy further emphasizes that all suitable facilities should comply and that failure to comply will result in disciplinary action. The concerns of NQPNs during the focus group interview regarding 24-hour services and rigid clinic routines are understandable as this group was removed from student status and introduced to a uniform condition of professional nurses employed in clinics. NQPNs are expected by the employer to comply with rigid routines that are new to them.

Sub-Theme 3.2: Perception of values that conflict with organisational management style

NQPNs expressed values that conflict with management style and one participant said: *"You have no say in rules and procedure and this includes policy making and decision making. Authorities make decisions and you are new, nobody listens to you"*. Such expression shows that the NQPNs have not adjusted to the management style of community health care services.

Organizational missions and policies reflect, apart from basic values, new business values such as excellence, vision, competition, risk-taking, cooperation and achievements. The policies provide guidelines regarding interactions with patients and families, colleagues, other professionals and the public. Without

understanding the values, norms, beliefs and experiences from which the students' perceptions are formed, the clash between educators and those they educate is inevitable. Customer-first focus and clinical excellence in care-giving should be emphasized in health care giving functions (Hendel & Geven-Liban, 2003).

Chung, Wong and Cheung (2007) indicated that new graduates expected themselves to be familiarised with hospital policy, routine ward management, management of emergencies, and the role of being in-charge on the day and night shifts, case management and team work.

Theme 4: Self-care deficiencies to interaction with the community that NQPNs serve

In relation to the above category, sub-categories include poor communication with patients and community as well as poor interpersonal relationships with health team members. Language used by patients in that the NQPNs served was unfamiliar to the NQPNs and that lead to challenges in identification of patients health care needs.

Sub-Theme 4.1: Poor communication with patients and the community

One participant expressed poor communication with patients as follows: *“The words used by patients to describe their conditions is a challenge. The terms used in OPD for STIs, HIV and AIDS descriptions are not the ones used where we trained”*. In community health care settings, NQPNs should communicate appropriately with the patients to enable them to be involved in their own care. Through communication NQPNs can identify patients' needs and provide relevant care. The DoH (1998) maintains that a lack of effective communication between health care providers and patients may lead to poor therapeutic outcome of conditions that patients come to health services seeking assistance. Patients' compliance to treatment may rely on health education as this empowers them to make informed decision whether to comply or not. Interpersonal relationships, communication and understanding the other through caring are the essence of what nursing does. Blenkinsop (2003) cited that communication skill is essential in nursing practice to gain the understanding and cooperation of the patient regarding the care offered.

Sub-Theme 4.2: Poor interpersonal relationships with health team members

One participant expressed poor communication with staff members as follows: *“Yaa! Especially when you are newly qualified you feel afraid when you work with old nurses. You have to know what is expected of you as a professional nurse like ee...how to communicate with other people”*. On probing further

another participant said: *"Yoo! You ask a question and you get told that you are from a university, what were you taught? If they don't answer me, I go to the next sister"*.

Such expressions could imply that NQPNs feel that they are not supported in terms of interaction in areas of employment. Communication channels between mentors and NQPNs should be established to facilitate dialogue for any issues that may arise. Pre and post-conferences should be carried out for briefing and de-briefing on the placement. Working with ward nurses in patient care not only requires interpersonal skills, but also imagination and communication skills (Chung et al., 2007).

Hendel and Gefen-Liban (2003) in their study recommended that the newly graduated nurses should continue the socialization regarding their profession practically, mostly in interaction with other staff and patients. For some newly graduate nurses role difficulties, stigma, negative attitudes and resistance to change were experienced, while for others the experience was more positive, giving satisfaction and fulfilment, and a sense of being valued by colleagues. Nurse-doctor collaboration is not widespread because the nurses and doctors have not been socialized to collaborate with each other. They have traditionally operated under the paradigm of doctor dominance and nurse deference in which the doctor's position prevails on patient care issues. Increasing nurse-physician collaboration will require efforts directed at assisting nurses and physicians to work with each other in ways very different from what both have become accustomed to.

Sportsman and Hamilton (2007) cited that increased positive interaction among health care disciplines may positively influence patient outcomes and that nurses must be proficient in communication skills. Inherent in effective communication skills in health care is the ability to positively manage conflict, not only within a single discipline, but also across disciplines. Whether new graduates actually got the support from staff they were seeking and how much, often depended on the graduates confidence levels and own support-seeking behaviours. Those graduate nurses who exhibited most confidence tended to attract more support than did those who lacked confidence. One participant indicated that: *"Do not be superior to them, respect them, then they will help you as they are experienced"*. The realities of the ward situation such as people everywhere, doctors doing rounds and telephones ringing also posed barriers to transition of the graduate nurse as do visits by senior managers and other health team members, and community health committee meetings. Support to graduate nurses is a process that aids, encourages and strengthens and thereby gives courage and confidence to new graduates to practice competently, safely and effectively in the levels and areas they have been educationally prepared to work.

Recommendations

The following recommendations are made based on the findings of the study:

- There should be skills development for the NQPNs related to required clinical competencies, adaptation/adjustment, health and nursing practice culture.
- During the final year of learning, students should be delegated the responsibility of being in-charge of units to enable them to transit into professional nurses.
- There should be improvement of good relationships between NQPNs and the community, and between NQPNs and health care providers.
- Professional nurses should welcome NQPNs and socialise them into clinical settings by including them fully in the daily health care activities.
- NQPNs should be supported in terms of development of communication skills and therapeutic patient relationships that could lead to experience in managing care for patients.

Conclusion

The study concluded that NQPNs experienced self-care deficiencies to perform specific cognitive, psychomotor and affective skills. Furthermore, these NQPNs experienced poor adaptation to the community health care services organizational culture and poor communication with patients and the community as well as poor interpersonal relationships with health team members.

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