

UNIVERSITY OF KWAZULU - NATAL

AN ANALYSIS OF NURSE MANAGERS HUMAN RESOURCES MANAGEMENT  
RELATED TO HIV/AIDS AND TUBERCULOSIS AFFECTED/INFECTED NURSES IN  
SELECTED HOSPITALS IN KWAZULU-NATAL, SOUTH AFRICA – AN ETHNOGRAPHIC  
STUDY.

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AN ANALYSIS OF NURSE MANAGERS' HUMAN RESOURCES MANAGEMENT  
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STUDY.

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By

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AND CO-SUPERVISED BY PROFESSOR BUSI BHENGU

MARCH 2014

## DECLARATION

I declare that this thesis titled “An analysis of nurse managers’ human resources management related to HIV/AIDS and Tuberculosis affected/infected nurses in selected hospitals in KwaZulu-Natal, South Africa – an ethnographic study” is my own unaided work. It has not been previously submitted for any other degree to any other University. All sources used have been acknowledged through the use of referencing.

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## DEDICATION

This thesis is dedicated to

- The nurse managers who plan the staff provision in KwaZulu-Natal hospitals in South Africa.
- My late mother, Joan Burn Parkes, a nurse of the '50s, who replaced nursing with mothering
- My late husband, Sandy McIntosh

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## **ABSTRACT**

**INTRODUCTION:** Providing sufficient quality nurses in resource strapped countries is a human resource management challenge which nurse managers' experience on a daily basis.

**THE PURPOSE** of this study was to analyse and to determine the issues which affect the the human resources management of nurse managers in selected hospitals in the eThekweni District of the Province of KwaZulu-Natal, South Africa, and to formulate draft guidelines to assist nurse managers with human resource management.

**METHODOLOGY:** A constructionist, reflexive ethnographic approach was used. The ethnographer spent two years in the field collecting data from informants, who were nurse managers, in four (4) selected district hospitals. Data was collected using unstructured informant interviews, non-participant observation and confirmatory document analysis. Data analysis led to eliciting codes from the data, searching for semantic relationships, performing componential analyses and discovering the themes for discussion within the final ethnographic report. A nominal group process was used to develop the draft guidelines.

**FINDINGS:** The findings showed that the human resources management around sick nurses is a complex task. The themes of nurse managers' experiences were a "burden" of maintaining confidentiality, as well as an emotional burden. Administratively, they experience the burden of absenteeism and the burden of policy compliance. The final theme is the burden of the deaths of HIV and Tuberculosis affected/infected nurses.

**CONCLUSION AND RECOMMENDATIONS:** Organizations should create a non-judgmental work environment where non-disclosure by employees is respected in order to promote disclosure. They should have an awareness of the emotional effect on nurse managers and provide them with support. Emphasis needs to be placed on an HIV and AIDS policy and programme, incapacity leave workplace strategies and return to work policies. It is also recommended that contingency plans be provided when the death or prolonged absence of an employee impacts the staffing of the organization; consideration to be given to piloting and refining the draft guidelines; the management of employees on prolonged sick leave be included in the Nursing Administration Curricula taught to future nurse managers; and further research be conducted to assess employee reluctance to report needle stick injuries (sharps injuries) as well as the related phenomenon of stigmatization.

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## LIST OF ABBREVIATIONS

ANSM	Assistant Nursing Service Manager
ART	Antiretroviral Therapy
DENOSA	Democratic Nursing Organization of South Africa
DOH	Department of Health
DOL	Department of Labour
DPSA	Department of Public Service and Administration
DR TB	Drug Resistant Tuberculosis
EH & WSF	Employee Health and Wellness Strategic Framework for the Public
GEMS	Government employees medical aid scheme
GEPP	Government employee pension fund
HCW's	Health Care Workers
HIV	Human Immunodeficiency Virus
HPCSA	Health Professionals Council of South Africa
HR Manager	Human Resources Manager
HRO	Human Resources Officer
HWSETA	Health and Welfare Sector Education and training Authority
IOD	Injury on duty
IPCO	Infection Prevention and Control
KZN HR	KwaZulu-Natal Provincial Human Resources representative
MDR TB	Multi drug resistant Tuberculosis
MISS	Minimum information security standards of South Africa
NPO	Non - Profit Organization
NS	Night Superintendent
NSM	Nursing Service Manager
OHM	Occupational Health Manager
OHN	Occupational Health Nurse
PILIR	Policy for Incapacity Leave and Ill Health Retirement

SANC	South African Nursing Council Sector
SHERQ	Safety, Health, Environment, Risk and Quality Management
SNSM	Senior Nursing Service Manager
SO	Safety Officer
TB	Tuberculosis
UM	Unit Manager
USA	United States of America
XDR TB	Extreme drug resistant tuberculosis

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# CHAPTER 1

## INTRODUCTION

This chapter of the research report includes a study overview, which comprises the background of the study, the problem identification, the purpose of the study the objectives of the study, the research questions, the significance of the study, the operational definitions and the structure of the report.

### 1.1. BACKGROUND OF THE STUDY

Nurse Managers worldwide are mandated to ensure that the right number of people with the right skills are available at the right time to deliver health services at an affordable cost to meet the needs of the population (Beduz, Vincent & Pauze', 2009:5). In under-resourced countries this is difficult and nurse managers have to review their human resources planning in situations where increases in sick time or a need for over-time have been observed or staff are complaining (Beduz, Vincent & Pauze', 2009:51).

In 2007, the adult Human Immunodeficiency Virus (HIV) prevalence was 0.6% in the United States of America (USA), 0.3% in central and western Europe and 5% in sub-Saharan Africa (UNAIDS, 2008:6). HIV was the specific cause of morbidity and mortality of 10 per 100000 people in the European region and 11 per 100000 people in the American region, while for sub-Saharan Africa it was 198 per 100000 people (WHO (c), 2009:56). Although the prevalence of HIV and Tuberculosis (TB) is relatively low in the European Region, the United Kingdom Department of Health has published a document titled, *HIV Infected Health Workers: Guidance on Management and Patient Notification* (United Kingdom, DOH, 2005:1-74), which serves as a guide to the employers, the infected health care workers and the medical practitioners treating them.

In developing countries, the two most prevalent diseases are infections of HIV and TB and the number of people living with HIV is growing, despite reports claiming that there has been a decline in newly diagnosed cases of HIV as early diagnosis and antiretroviral treatment (ART) have resulted in fewer deaths (UNAIDS, 2008:3). Sub-Saharan Africa is at the epicentre of the HIV epidemic and, in 2011, the estimated

number of people living with the disease reached 34 million; 69% of whom were living in Sub-Saharan Africa (UNAIDS, 2011:24 & 210; SAHR, 2013:231). Furthermore, for every two people who have commenced antiretroviral therapy (ART), five others, not on ART become newly infected (UNAIDS, 2008:3). Africa has the world's highest mortality figures for both HIV and non-communicable diseases. In the African region, the mortality statistics for HIV was 198 per 100000 people, with South Africa reporting 771 per 100000 people (WHO (c), 2009: 54 & 56). South Africa has the greatest HIV epidemic in the world and in 2009, 5.6 million people were living with HIV (UNAIDS, 2011: 24). The estimated national prevalence of HIV in the general adult population in South Africa is currently and has remained constant at 17.3% (South Africa, DOH, 2012: iii). KwaZulu-Natal is the province which is most affected by the epidemic, with an incidence of 2.3% (UNAIDS, 2011: 24). The HIV prevalence in the general adult population in KwaZulu-Natal is currently 24.7% (South Africa, DOH, 2012: iv; SAHR, 2013:232).

In Africa, many health workers leave employment as a consequence of contracting HIV or die from the disease, thus reducing employee numbers (Munjanja, Kibuka, & Dovlo, 2005:26; Tawfik & Kinoti, 2006:11; Dieleman, Biemba, Mphuka, Sichinga-Sichali, Sissolak, van der Kwaak, van der Wilt, 2007:144; Gerein, Green & Pearson, 2012:41). Even though sub-Saharan Africa has only 1.3% of the world's health care workforce, they have to cope with 25% of the world's burden of disease. Added to this, the density of health workers is 0.8 per 1000 people, while the world average is 4.2 per 1000 people (WHO (a) 2007:4). Africa has 2 physicians and 11 nurses and midwives per 10000 of the population, while Europe has 32 physicians and 79 nurses and midwives and the Americas have 19 physicians and 49 nurses and midwives per 10000 (WHO (c), 2009: 104). It is thus evident that Africa has an inadequate supply of nurses and physicians compared to the developed regions. Furthermore, Tawfik & Kinoti (2006:4) and Chaudhury, Hammer, Kremer, Muralidharan & Rogers (2006:95) claim that absenteeism by affected/infected health care workers as a result of their own illnesses can be as high as 34%. Although needle stick injuries (sharps Injuries) and occupational exposure to HIV accounts for 4% of health care worker infections in sub-Saharan Africa, it has 70% of HIV cases, while in developed countries HIV accounts for only 4% of the disease prevalence,



but they have 90% of the world's occupational infections (Sagoe-Moses, Pearson, Perry & Jagger, 2001:4).

According to Abdool Karim, Churchyard, Abdool Karim & Lawn, South Africa, as a developing country, has a developing population affected by HIV and TB and has one of the most serious TB epidemics in the world (2009:1; South Africa, National Strategic Plan on HIV, STIS and TB: 2012 – 2016: 13 & 24; SAHR, 2013:227) where TB has continued to escalate on the back of the HIV epidemic. The co-morbidity rate of HIV and TB in South Africa is 63% (South Africa, DOH, 2012: vii). In South Africa TB is the leading cause of death among those who are HIV infected (UNAIDS, 2013: 67). Added to this, South Africa is one of the top ten countries in the world with a high incidence of drug resistant TB (Abdool Karim et al., 2009:3-5; UNAIDS, 2013:67; SAHR, 2013:227). This is supported by the 2009 WHO TB report, which indicates that South Africa is amongst the top five countries in the world to have 16000 multidrug resistant TB (MDR TB) cases (WHO (d), 2009:2) and that between 2005 and 2007, the prevalence of MDR TB rose from 19% to 69% (WHO (d), 2009:146).

The 2013 health indicators reported in the South African Health Review, (2013) report HIV mortality as 31.9% and 49 deaths per 100000 people for TB in HIV negative people and 192 per 100000 people for TB in HIV positive people (SAHR, 2013:228). However, in 2010, KwaZulu-Natal has shown a decrease in the mortality rate from 26.5 to 18.7 per 1000 persons for men aged 25–49 years and from 22.5% to 17.6% per 1000 persons for women in the same age category since the commencement of providing anti-retroviral therapy (UNAIDS, 2011:25).

South Africa has a health workforce density of 8 physicians and 41 nurses and midwives per 10000 people (WHO (c), 2009:102) and the mean life expectancy is currently 48.4 years for men and 51.6 years for women (Abdool Karim et al., 2009:3). Fifty – nine percent of HIV positive people in the 15 – 49 year old group are women (UNAIDS, 2011:24). The yearly production of professional registered nurses is 1 896, but in one year alone an estimated 2 745 succumbed to AIDS (South Africa, DOH, 2006:60). It is therefore clear that the supply does not meet the demand (South Africa, DOH, 2006:60). Thurlow, Gow & George (2009:12) estimate that 26.4% of KwaZulu-Natal's working age population is HIV positive, whereas the figure

is 15.9% in the rest of South Africa, and that the predicted deaths by 2025 will reach 2/5ths of the adult population in this province. TB rates are at the highest in women in their twenties and men in their thirties which are the same age groups with the highest HIV prevalence. Extreme drug resistant TB (XDR TB) has been identified in 60 different health facilities in KwaZulu-Natal (Abdool Karim, Churchyard, Abdool Karim & Lawn, 2009:4 - 5).

The Health Professionals Council of South Africa has an “Impaired Practitioner Policy” which gives guidelines on how to deal with impaired medical and allied health professionals. On investigation of the South African Nursing Council policies, no such policy could be found to guide nurse managers in dealing with health impaired nurses in the clinical situation. The only data that is available is the Nursing Act (50 of 1978), as amended, which states in section 36 that *“a nurse’s practice may be restricted or suspended if he/she becomes mentally or physically “disabled” to such an extent that it would be detrimental to the public interest to allow that individual to practise”*. Sections 36 b) to d) include aspects of drug misuse or addiction. However, the Nursing Act no 33 of 2005 states in section 51 that *“For the purposes of this section “impairment” refers to a condition which renders a practitioner incapable of practising nursing with reasonable skill and safety”*. As of March 2013, the SANC Draft “Impairment” Regulation has been through public comment, have been signed by the State President and have been implemented.

The dilemma that faces nurse managers is that they cannot be perceived to discriminate against ill, non-performing nurses because of their HIV or TB status (Section 54 (1) (a) of the Employment Equity Act, No (55 of 1998) and The Code of Good Practice, published by the Department of Labour, on key aspects of HIV/AIDS and employment, 2006:2). On the contrary, it is required that employees who are HIV positive should be supported and allowed to continue to work in their current position as productively as possible, for as long as they can, in as normal conditions as possible, until they are medically unable to do so. Section 187 (1) (f) of the Labour Relations Act, (66 of 1995) contends that no employee may be dismissed because of their HIV positive status, but if they are found to be incapable of working, fair procedures are to be used and their services may be terminated according to section 188 (1) (a) (i) of the same act. South African common law and section 14 of the Constitution of South Africa, (108 of 1996) contend that HIV positive people have the

right to privacy, which includes their status, and as such are not legally bound to disclose their status to their employer or co-workers. HIV positive employees may not be discriminated against in respect of job placement. The Department of Labour requires that when employees are so ill that they are unable to work, the employer must use the accepted guidelines in respect of dismissal for incapacity before the employee leaves employment, as is stipulated in section 8 of the Labour Relations Act (66 of 1995).

This study analysed the practices and beliefs characterising nurse managers who manage and plan the day to day staff provision in hospitals in the eThekweni District of KwaZulu-Natal. Nurse Managers are accountable to provide safe quality care to the patients and the community, while at the same time looking after the interests of both the employee and the employer. However, they are unable to do so in situations where the nurses have been newly diagnosed with immune-compromising conditions as a result of contracting HIV and have low CD4 counts. In addition, these nurses may also have been newly diagnosed with TB, MDR-TB or XDR - TB, and should be protected from infectious diseases until such time as their CD 4 counts have elevated and they are no longer sputum positive.

Currently the only guidelines nurse managers have when facing such situations as described above are to resort to the Labour Relations Act (66 of 1995) and any ill health retirement policy of the organization in which they work. While the Democratic Nursing Organization of South Africa (DENOSA, 2009) has been involved in research involving the organization's leadership contribution to HIV policy formulation, this research was based on gender issues in HIV, however, and not on the employment of nurses who are ill. Marchal, De Brouwere and Kegels (2005:303) state that realistic, open-minded analyses and assessments need to be undertaken and that unless the current thinking is revisited, the basic changes needed to effectively strengthen the health workforce are unlikely to be started. Dambisya, Modipa & Nyazema & Health Systems Research Group (2009:3) claims that offering treatment to infected health care workers indicates to them that they are valued.

This study needed to be conducted, so as to produce draft guidelines around the issue of HIV and TB in the nursing workplace, particularly as the majority of people

infected with HIV in South Africa are women and the workforce of nurses is comprised mostly of women (Shishana, 2009:30).

My own experience in a district hospital in KwaZulu-Natal indicated that HIV, TB, MDR TB, XDR TB, affect the health of nursing staff and result in compounding the nursing staffing shortages. Such guidelines would assist the difficult task of managing the human resources needs when the staff complement includes nurses who are sick themselves, as this ultimately has an effect on patient care.

## **1.2. PROBLEM IDENTIFICATION**

The Strategy for Nursing in South Africa contends that the impact of HIV on staffing must be taken into account (South Africa, DOH, 2008:16). A literature study to date has not indicated that there has been much research in the field of human resources management in respect of nurses who are indisposed. Although two South African studies have been done by Smit (2005:22-29) and Minnaar (2005:31-38), they do not relate to the specific phenomena of investigating the experiences of nurse managers in the human resources management in respect of HIV and TB affected/infected nurses. Smit (2005:22-29) and Minnaar (2005:31-38) state that their studies will assist in formulating policy, but after exhaustive exploration of the literature and South African Nursing Council (SANC) policy documents as well as those of the employer, the ethnographer found guidelines for the human resources management of HIV and TB affected/infected nurses in health care settings, scattered in many different legal documents. Subsequent to commencing this study, various other studies were identified which have been conducted in South Africa. Botes & Otto (2002:281-294) conducted research on the HIV infected worker in the occupational health setting; Demmer (2007:866-870) studied how people in KwaZulu-Natal cope with AIDS related bereavement; Rohleder (2008:1-261) investigated how organizations respond to disabilities associated with HIV; Somhlaba (2008:1-56) researched HIV stigma; Vollenhoven (2008:1-76) researched the quality of life of HIV infected employees in an occupational health setting; and Zulu (2009:1-39) assessed factors associated with default of drug pickups and clinic visits by patients on antiretroviral therapy. The studies of Smit (2005:22-29) and Minnaar (2005:31-38) were effectively the most relevant studies found.

The assumptions which formed the basis of this study were that nurse managers are faced with ethical dilemmas in respect of their human resources management decisions surrounding HIV and TB affected/infected nurses in the work place. They are torn between caring for the patients by ensuring competent nursing staff and accommodating nurses who are ill and not always able to fulfil their duties competently. Nurses who are affected/infected by HIV cannot be placed in the medical wards where the majority of patients have various forms of TB, as it would place both the nurse and the patient at risk. The risk to the patients is suboptimal care and the risk to the nurses is the potential to exacerbate their health status. However, not all nurses disclose their immune status to the nurse manager who plans the human resources needs of the organization, neither are these nurses compelled to do so

Nurse Managers have to rotate staff to accommodate absences from work, such as maternity leave, annual leave, sick leave and study leave. Accommodating the immune-compromised nurses in select clinical placement leaves the more healthy nurses continually being placed in the medical wards having to nurse the sickest patients, without any respite. This can lead to stress, burnout, feelings of favouritism and nepotism and further illness, which all eventually result in absenteeism and compounded staff shortages. The nurse managers are therefore placed in an invidious situation where they are not only perceived to be uncaring for the staff, but also inept, in cases where staffing changes have to be made after the human resources plan has been finalised, which may further lead to staffing shortages which are beyond their control.

As The Strategy for Nursing for South Africa (South Africa, DOH, 2008:16) and Employee Health and Wellness Strategic Framework for the Public Service (South Africa, DPSA, 2008:24) contend that the impact of HIV on staffing must be taken into account, this study envisages enriching the human resource capabilities of nurse managers. The information which is available as a guide to nurse managers is fragmented and set out in many documents. My experience and the literature reviewed have shown that specific information to aid the human resources management in respect of these nurses does not exist, the available information is of a generic nature and applicable to all employees. It is hoped that the outcome of this

study will inform the development of draft guidelines to be compiled as one comprehensive document for human resources management in respect of HIV and TB affected/infected nurses in the work place, thus informing the utilization of nurses who are ill and influencing the decisions made by nurse managers related to human resources management.

The preliminary literature review which was conducted revealed that the impact of HIV on staffing in sub-Saharan Africa compounds an already stretched and overworked healthcare workforce (Munjanja, Kibuka & Dovlo, 2005: 4). It is hoped that this study will initiate debate around HIV and TB staffing impacts. While it is envisaged that the study outcome will inform the development of draft guidelines for the human resources management in respect of HIV and TB affected/infected nurses in the work place, including nurses' occupational health, the draft guidelines may also be included in nurse managers' curriculum, through inclusion by the South African Nursing Council in the Directive for Nursing Administration, although this does not fall within the aims of the study.

Although both Smit (2005:22-29) and Minnaar (2005:31-38) stated that their studies would assist in formulating policy, exhaustive exploration of the literature, the South African Nursing Council (SANC) policy documents and employer documents, I found no guidelines for the placement of HIV and TB affected/infected nurses in the work place. It is hoped, therefore, that this study will contribute to the body of knowledge around HIV in the public sector and the world of work in South Africa in the formulation of guidelines for human resources management in respect of HIV and TB affected/infected nurses in accordance with the Employee Health and Wellness Strategic Framework for the Public Service (South Africa, DPSA, 2008:24), in which section 1.3.1. states "*Develop a national framework on HIV in the work place*" (this national framework was published in 2012). It is likely that further areas of study in respect of the impact of HIV on nurse staffing will be identified through this study and it is hoped that studies of the same or similar nature in other sub-Saharan countries will be encouraged.

### **1.3. PURPOSE OF THE STUDY**

The purpose of this study was to analyse the culture of nurse managers' human resources management in respect of HIV and TB affected/infected nurses in order to develop draft guidelines to guide nurse managers in their human resources management.

### **1.4. OBJECTIVES OF THE RESEARCH**

The objectives of the research were to:

- Analyse nurse managers' daily activities when managing human resources needs in respect of HIV and TB affected/infected nurses
- Identify the nurse managers perceived priorities and concerns when managing human resource needs in respect of HIV and TB affected/infected nurses in work areas
- Analyse how nurse managers balance staff and quality nursing care while catering for HIV and TB affected/infected nurses' needs in under-resourced settings
- Develop draft guidelines to guide nurse managers in their human resources management in respect of HIV and TB affected/infected nurses

### **1.5. RESEARCH QUESTIONS**

The research questions were:

- What are the daily activities of nurse managers when managing human resources needs in respect of HIV and TB affected/infected nurses?
- What are the perceived priorities and concerns of nurse managers when managing human resource needs in respect of HIV and TB affected/infected nurses in work areas?
- How do nurse managers manage the human resources needs in respect of HIV and TB affected/infected nurses in under-resourced settings?

- How do nurse managers balance staff and quality nursing care while catering for HIV and TB affected/infected nurses' needs in under-resourced settings?
- What support do nurse managers require to guide their human resources management in respect of HIV and TB affected/infected nurses?

## **1.6. SIGNIFICANCE OF THE STUDY**

### **1.6.1. Nursing Practice**

This study is a micro-ethnography specifically exploring the management of human resources in respect of HIV and TB affected/infected nurses in selected hospitals in KwaZulu-Natal. This is the province with the highest burden of disease in South Africa for HIV and TB (UNAIDS, 2011:24) and the nursing workforce is as affected as the general population. The practice of nursing therefore experiences an ever diminishing number of nurses to staff hospital wards, thus compromising patient care.

The literature reviewed shows that specific information to aid the human resources planning and scheduling in respect of these nurses does not exist. The outcome of the research study, therefore, is expected to influence nurse manager management related to the provision of human resources where HIV and/or TB affected/infected nurses are at work. It is expected to inform the utilization of nurses who are ill as well as to inform the development of draft guidelines for the human resources management in respect of HIV and TB affected/infected nurses in the work place.

### **1.6.2. Nursing Management**

This research study is expected to enrich the human resource capabilities of nurse managers in accordance with The Strategy for Nursing for South Africa (South Africa, DOH, 2008:16) and The Employee Health and Wellness Strategic Framework for the Public Service (South Africa, DPSA, 2008:24), both of which contend that the impact of HIV on staffing must be taken into account.

The literature review reveals that the impact of HIV on staffing in sub-Saharan Africa is compounding already stretched and overworked health care workers (Munjanja,



Kibuka & Dovlo, 2005:4). This study will initiate debate around HIV staffing impacts. I envisage that the study will contribute to the formulation of draft guidelines, as a 'one stop' resource which nurse managers can use to assist their human resources management related to HIV and TB affected/infected nurses.

### **1.6.3. Nursing Education**

The study outcome will inform the development of draft guidelines for the human resources management in respect of HIV and TB affected/infected nurses in the work place, including nurses' occupational health. The draft guidelines will be able to inform Nurse Educators and student nurses of the responsibilities which are expected from the students once they are qualified; and inform trainee nurse managers' competence development in managing nurses infected by HIV and TB at work.

### **1.6.4. Research**

It is hoped that this study will contribute towards the formulation of a framework in accordance with the Employee Health and Wellness Strategic Framework for the Public Service (South Africa, DPSA, 2008:24), section 1.3.1. which states: "*Develop a national framework on HIV in the work place*", thus increasing the body of knowledge around HIV in the public sector and the world of work in South Africa. It is likely that the study will reveal areas requiring further study in respect of the impact of HIV on nurse staffing and will encourage research of the same or similar nature in other sub-Saharan countries.

## **1.7. OPERATIONAL DEFINITIONS**

**Nurse manager:** A nurse who is trained as an administration specialist and who plans, directs, controls and organizes work in a nursing service. (SANC, R.1501 of 8 July 1983)

**HIV and/or TB affected nurses:** In this study affected nurses includes nurses who may be infected with HIV and/or TB. However the Nurse Managers are not always certain that the nurse is actually infected unless the nurse has actually disclosed to the Nurse Manager.

**Human resources management** constitutes professional management that helps employers ensure that sufficient, competent staff is available to care for patients and that helps employees expand their work experience and skills by shifting personnel to different departments or units of the same department (Ho, Chang, Shih & Liang, 2009: 2 of 10). In this study, human resources management refers to the daily placement or provision of trained nurses in clinical situations to work in and care for patients in wards/units in district hospitals, which include teaching hospitals, private hospitals, clinics, community health centres and specialist areas. Human Resource planning is where providing sufficient numbers of competent nurses to provide nursing care to the health care users of each hospital is a priority. The productivity of the Nursing Service at each hospital is dependent on Human Resource management and planning (USAID, 2005:16).

**HIV:** A disease process caused by the Human Immunodeficiency Virus, a retro-virus, that breaks down the human body's immune system and is the cause of AIDS (South Africa, DOL, 2012:5).

**AIDS:** A disease of the immune system, caused by the Human Immuno Virus (HIV), usually leading to death from infections that the body is no longer able to resist (South Africa, DOL, 2012:4).

**TB:** A serious infectious disease caused by the tubercle bacillus which commonly affects the lungs through the growth of tubercules and is prevalent in individuals who have compromised immune systems. (South Africa, DOL, 2012:5).

## **1.8. RESEARCH REPORT STRUCTURE**

The chapter separations in this research report are as follows:

Chapter 1 constitutes an overview of the study, and includes the background of the study, the problem statement, the purpose and objectives of the study, the research questions, the significance of the study and the operational definitions

Chapter 2 provides a literature review

Chapter 3 contains the research methodology, the philosophical underpinnings, the paradigm and the research approach. It also describes the research setting, the ethnographic data collection, data analysis, guideline development, trustworthiness and ethical considerations used in the study.

Chapter 4 provides the presentation of the findings of the study, which were triangulated by using grounded theorising, a document review and Spradley's domain analysis. It also includes a discussion and interpretation of the findings

Chapter 5 discusses the process and formulation of the draft guidelines produced and provides the conclusions, limitations of the study, recommendations and the ethnographer reflexivity.

## **1.9. CONCLUSION**

In this chapter I have provided a foundation to the study through providing the background of the study, the problem identification, the purpose and objectives of the study, the research questions, the significance of the study and the operational definitions.

The following chapter will provide a review of the literature relevant to the study.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1. INTRODUCTION**

In this chapter I cover the literature review conducted for this study. The review includes human resources planning, employee fitness for work, the emotional effects of leadership on nurse managers, a brief overview of HIV and TB and their associated challenges to nursing management, the legislative framework guiding nursing management in South Africa and an overview of the process of guideline formulation.

#### **2.2. LITERATURE SEARCH STRATEGY**

In accordance with the requirements of qualitative research, a literature review was conducted both prior to and during the process of conducting the study. Academic peer reviewed literature and grey literature (technical literature) were searched using Ebscohost and Google Scholar, PubMed, Medline and CINAHL. Websites of the South African Government, the Department of Public Service and Administration, the Department of Labour, the World Health Organization, the International Labour Organization and the KwaZulu-Natal Department of Health were consulted using the following search terms: human resources planning and scheduling; fitness for work; employee health and wellness; employee assistance programs; HIV workplace policies; HIV prevalence among health care workers; TB in health care settings; TB prevalence among health care workers; stigma in HIV & TB; HIV and TB disclosure; emotional effects of leadership, organizational culture; occupational health in health care settings; health care worker protection; maintain confidentiality at work; sick leave; abuse of sick leave; and health care worker deaths. Searches spanned the period 2005 to 2012, but seminal literature has been used which predates 2005.

My own theoretical sensitivity, knowledge and experience as a manager and occupational health nurse also contributed to the sourcing and selection of documents for the literature review. Technical literature sourced for this review has been used to enhance my theoretical sensitivity and to add to the validation of the

study findings (Corbin & Strauss, 1990:50-52). As I have used grounded theorising as one of the strategies for data analysis, it is fitting that the technical literature was searched for and used through the course of the data analysis in order to enhance and verify my theoretical sensitivity and to validate the findings emerging from the data. This process enhanced the iterative process which I used throughout this study (Foley, 2002:476).

### **2.3. HUMAN RESOURCES PLANNING AND SCHEDULING OF NURSES IN HEALTH CARE ORGANIZATIONS**

The human resources planning of nurses in health care organizations is a contentious issue and has been a topic for discussion and study for years. A study conducted in 1982 by the Israeli Ministry of Health, the Civil Services Commission, the Nurses and Orderlies Foundation and the National Board of Governmental Hospital Workers identified the following variables to be considered when calculating the nursing staff required to staff a unit: group categorization of the unit; number of patients; shift time; and patient classification in respect of status and level of dependence on the nurses. However, this study and the recommendations it made did not include annual leave, sick leave, maternity leave or study leave, all of which are deemed legal absences from work and which reduce the available work hours available to employers from nurses (Rassin & Silner, 2007:65; South Africa, 1997:1-78).

The various approaches of clinical placement and scheduling of nurses in the South African context include the professional judgment approach; the nurses per occupied bed method; the acuity-quality method; the timed-task/activity approach; regression-based systems (Hurst, 2002:7-20), and also the placement of nurses in training. If issues of illness, maternity leave, study leave and annual leave are not be taken into account in the planning and the clinical placement of nurses, it will result in gaps in service provision and the relocation or rotation of nurses throughout the nursing service on a daily and monthly basis. While legal absences from work are controllable and can be managed through good planning and scheduling of the staffing of the service, the situation becomes uncontrollable, however, when legal absences and the training needs of both undergraduate students and professional registered nurses who are involved in part-time study compound nurse managers

having to cope with on-going staff illnesses which debilitate the workforce. These members of staff cannot carry out their normal duties and must either be given lighter duties or have their employment terminated. Furthermore, although Gosh & Cruz (2005:368) recommend that one needs to provide for the legal absences, as stated above, so as not to affect the actual nurse availability for clinical placement, in my experience this provision is often not considered in the overall hospital staffing establishment in which South African nurse managers have to work. Gosh & Cruz, (2005:368) also allude to the time and effort that nurse managers put into staff planning and scheduling as well as the complexity of the task. Hence, such changes made, based on requests after the fact, compound the complexity and the time and effort used by these nurse managers.

When calculating nursing staff required to nurse patients in units, nurse managers also depend on skills mix, which involves including staff of different categories to provide quality nursing care to the patients admitted to the units (Rassin & Silner, 2007:65; Beduz, Vincent & Pauze, 2009:31). In South Africa, there are three categories of nurses used to nurse patients in the health care provider units which are Professional Registered Nurses, Enrolled Nurses and Auxiliary Nurses (South Africa, 2005:1-45). A suitable mix of these categories should satisfy different patient needs and disease profiles. The mix can be adjusted according to the workload created by the patient needs with the aim of providing the best staff combination that will efficiently provide the treatment, quality and service required by both the patients and the service provider (Rassin & Silner, 2007:67; Gosh & Cruz, 2005:365). However, nursing staffing norms cannot be regulated because of factors such as patient needs, demographics, economics, staff availability, personnel quality, organizational settings, managerial competence, technology and culture, among others (Gosh & Cruz, 2005:364; National Human Resources Planning Framework, 2006:19). Each work environment is different from the next, which makes the setting of specific staffing norms problematic. To illustrate, the differences in work environments which make specific staffing norms a problem, South African Health Care provision facilities, especially hospitals, are divided into outpatient and inpatient facilities. Outpatient facilities are either general or specialised and may or may not include emergency services, whilst the inpatient facilities are subdivided into wards or units such as medical, surgical, obstetric, gynaecological, paediatric, intensive

care units and operating theatres. Each one of the settings alluded to here would require different staffing needs.

Hurst (2002:1&6) reviewed five methods commonly used for nurse human resources planning. These five methods included the professional judgment approach; the nurses per occupied bed method; the acuity-quality method; the timed-task/activity approach and regression-based systems (Hurst, 2002:7-20). The systematic review analysed the strengths and weakness of each method and came to the conclusion that the accuracy of the staffing recommendations may be enhanced by combining two or more methods (Hurst, 2002:20). According to Hurst (2002:10-12), the average nurses per occupied bed is a popular and simple method often used for determining the number and mix of staff and for comparing standards (Hurst, 2002:11). From my own experience, the average nurse per occupied bed method is the method most commonly used in the South African context along with the acuity-quality method and the professional judgement approach.

The contextual aspects of skill mix are also difficult to capture, using workforce management systems (Gerdtz & Nelson, 2007:67). Findings from a systematic review of international literature conducted by Flynn & McKeown (2009) to identify critical factors and issues that need to be taken into account when making staffing level and skills mix decisions revealed that there are no single nurse staffing or skill mix models which have been shown to take into account all the variables which affect nursing workload, nor have the models been found to be related causally to patient, nurse or organizational outcomes. Their findings revealed the following:

- Patient outcomes such as mortality rates, hospital acquired infections, patient falls, pressure ulcers, suicide, length of hospital stay, medication errors, post-operative complications or infection rates and serious adverse incidents, such as cardiac or respiratory arrest, impact on patient care and that higher levels of nurse staffing and a skill mix with qualified nurses as the majority, are associated with improved patient outcomes, as do contextual factors, such as the hospital management and their commitment to quality of medical care (Flynn & McKeown, 2009:762).
- Nurse outcomes were described as the incidences of physical injury, exposure to aggression and violence, levels of sickness and absenteeism,

nurse reports of job satisfaction or dissatisfaction and burnout and the review of the literature by Flynn & McKeown (2009:762) found little evidence on which to base such a link.

- There are inconclusive results in relation to the question of optimum nurse staffing levels and skill mix. Despite the evidence suggesting an association between nursing skill mix and some important patient outcomes, the evidence did not support specific minimum nurse-patient ratios for acute hospitals. Organizational issues and the working environment were found to have strong correlations between the characteristics of patients and work environments and also between nursing workload, staffing levels and the quality of outcomes for nurses, patients and the organization. High nurse staffing ratios were associated with lower inpatient mortality rates and reduced length of stay in hospital. The education, training and knowledge of qualified nurses results in the prevention of adverse patient events and a reduction in the use of hospital resources by patients. An association was shown between total nursing hours, skill mix and some patient outcome measures, but were inconclusive in respect of minimum nurse-patient ratios in hospitals (Flynn & McKeown, 2009:763).
- Confounding variables are described as care and interventions, material resources and facilities, physical geography as well as factors that may also impact on any relationship between nurse workload, staffing levels, skill mix and outcomes with examples being patient dependency levels and the use of nursing agency employees (Flynn & McKeown, 2009:763).

Human resources management, planning and scheduling of nursing staff is thus a complicated and time consuming exercise which is inevitably affected not only by the absence of ill nurses, but also by the nurses who are still able to work, but may not be able to work in situations which may affect their health in the long term. This study focused on the experiences of the nurse managers who are tasked with the human resources management in respect of immune-compromised nurses.

Minnaar (2005:37) concluded in her research that nurse managers in the health services are managing HIV affected/infected nurses, but are doing so without any formal policy on HIV in the workplace. Although staff care is important, it would



appear that to date, no policy or guideline has yet been formulated by the nurse managers who participated in Minnaar's study (Minnaar, 2005:31-38). In South Africa, especially in KwaZulu-Natal, nurses are lost through death as a result of full-blown AIDS, pulmonary TB (TB), multidrug resistant TB (MDR TB), extreme drug resistant TB (XDR TB) and complications of antiretroviral treatment, exacerbating the problem further (Cullinan, 2003:31). Tawfik and Kinoti (2006:8) believe that there is a need for policy development in respect of human resources planning concerning the placement of immune-compromised nurses, especially in TB (TB) wards, and the replacement of health workers who may die as a result of HIV. These researchers maintain that this is an urgent national need as more and more nurses are becoming ill as a result of infection with HIV and/or TB in the form of multi drug resistant TB and extreme drug resistant TB. This claim is supported by both the Strategy for Nursing for South Africa (South Africa, DOH, 2008:1-32) and The Employee Health and Wellness Strategic Framework for the Public Service (South Africa, DPSA, 2008:1-59).

In the editor's choice of the South African Medical Journal, deV van Niekerk, states that it is critical to make sure that workers with CD4 counts below 200 cells/ $\mu$ l are not placed in the TB wards in order to protect them from contracting TB, particularly extreme drug-resistant TB (deV van Niekerk, 2007:108). Moreover, it is not only the worker's health that could seriously be affected, but the workers could also endanger patients' lives. As death and leaving employment are the major causes of the health worker shortage in Africa (Munjanja, Kibuka, & Dovlo, 2005:26; Tawfik and Kinoti, 2006:11), Tawfik and Kinoti (2006:9) contend that solutions need to be found by developing policies that promote worker safety and ensuring that care and treatment are provided for health care workers with HIV. It is interesting to note that the Health and Welfare Sector Education and Training Authority (HWSETA) makes no reference to the loss of health care employees due to illness or death in the discussion on factors affecting the sector profile, and especially in the section on staff attrition (South Africa, HWSETA, 2007:11). How to go about developing policies which prioritise healthcare workers and the implementation of the policies are the short term priorities for National Governments (Tawfik & Kinoti, 2006:14).

## **2.4. EMOTIONAL EFFECTS OF LEADERSHIP ON NURSE MANAGERS**

Stewart, Holmes & Usher (2012:225), in a global study conducted to determine the present leadership milieu that nurse leaders' experience, agree that there is a dichotomy between caring and the bureaucratic administrative requirements of their positions. These same authors found that nurse managers experience difficulty in "juggling" their roles of 'nurse' and 'leader' or manager (Stewart, Holmes & Usher, 2012:224). They constantly have to sort the urgency of the care that they give to patients admitted, the staff and the organizational needs.

Fox & Spector (1999:917) regard the emotional reaction to frustration as a sub topic of job stress. These authors describe employee reactions to "frustrated events" or "organizational situational constraints" as frustrations perceived when the individual's experiences do not allow them to achieve their work objectives or the required performance and the negative emotional state which the individual experiences as a consequence. These authors found that there is a positive correlation between organizational situational constraints and frustration. Kath & Stichler, Ehrhart & Schultze, (2012:9) found that the most significant job stressors for nurse managers are role overload, organizational situational constraints and role ambiguity. Stewart, Holmes & Usher (2012: 227) state that in ensuring that organizational demands are fulfilled, there is a personal detrimental effect on the manager, both physically and mentally. O'Donnell, Livingston and Bartram's (2012:203) study findings indicate that where nurse managers are involved in employee behaviour, they deem the processes involved as complicated, time consuming, laborious and stressful. Cummings, MacGregor, Davey, Lee, Wong, Lo, Muise & Stafford, (2010:381) state that healthcare organizations should have leaders who use relational skills in their interaction with employees and should show concern for the employees.

Employees lack of trust in their ability and possible depression because of the perpetual conflicting interactions and demands made on them (Stewart, Holmes & Usher, 2012:227; Fox & Spector, 1999:917; Kath & Stichler, Ehrhart & Schultze, 2012:2 & 9) are consequences of the stress nurse managers experience in the daily execution of their work. Cummings et al., (2010:378) claim that trust can be developed by using a relational approach in dealing with employees through

listening, showing empathy and engaging with employee concerns. Cummings et al., (2010:378) refer to this as “*tuning in to the emotional needs of the staff*”.

Stewart, Holmes & Usher, (2012:227) indicate that the nurse managers’ loss of traditional nursing roles for the administrative power and financial role of Human Resources Management are a cause of burnout. Kath & Stichler, Ehrhart & Schultze (2012:7-9) found that although interpersonal conflicts were not a significant contributor to nurse manager stress, they do in fact experience high levels of stress at work. Stewart, Homes & Usher (2012:227) refer to such situations as “*anxiety at failing to meet demands*.” This form of conflict is supported by Fox & Spector (1999:917).

## **2.5. HIV AND TB**

In the context of health care workers in South Africa, the most prevalent form of immune-compromise is HIV and the previously stated forms of TB (Abdool Karim et al., 2009:1; Thurlow, Gow & George, 2009:12). Thurlow, Gow & George estimate that 26.4% of KwaZulu-Natal’s working-age population is HIV positive, where the figure is 15.9% in the rest of South Africa and that the predicted deaths by 2025, in the absence of antiretroviral therapy, will reach 2/5ths of this province’s adult population. The study conducted by Thurlow et al., (2009:12) estimated the economic impact of HIV on the KwaZulu-Natal province and the rest of South Africa, but while agriculture, manufacturing, tourism and transport employment sectors were included in their study, no mention was made of the health care sector at all, which is a major flaw of the study (Thurlow et al, 2009:16). However since ART was implemented by the National Department of Health in 2004, an increase in life expectancy has occurred which has led to people living with HIV and fewer people dying from the disease (Bor, Herbst, Newell & Bärnighausen, 2013: 6).

### **2.5.1. History of HIV in South Africa**

Abdool Karim et al., (2009: 2-3) describe the history of HIV in South Africa, which goes back to the years 1982-1987, when homosexual men were the first affected people. During the period 1983-1985, one hundred (100) cases of haemophiliacs with HIV were reported, who were also men, who had contracted the disease through contaminated blood and blood products. From 1988-1994, the HIV profile

became that of a generalised epidemic among the heterosexual population and, from 1995 to the year 2000, there was a further rapid spread of the virus. Since 2000, however, the country entered the AIDS mortality phase, where the life expectancy of the population dropped by 20 years and there has been an increase in the maternal and infant mortality rates. According to Abdool Karim et al., (2009: 3), the mean life expectancy is 48.4 years for men and 51.6 years for women. Since the introduction of antiretroviral treatment in 2004, there has been an increase in the life expectancy of men and women in South Africa. The life expectancy in 2011 has increased from the figures shown above to 60.5 years and that of women is 57 years and men is 64 years (Bor, Herbst, Newell & Bärnighausen, 2013: 6)

### **2.5.2. Prevalence of HIV among Health Care Workers**

As in the case of the general population, health care workers, including nurses, can become infected with HIV due to their personal sexual behaviour (ICN, 2006:6). The Health and Welfare Sectoral Education Training and Authority (South Africa, HWSETA, 2007:10) makes the point that the degree to which health care employees are either infected or affected is only known related to the national averages determined by the Actuarial Society of Southern Africa and other analysed statistics. Shisana, Hall, Maluleke, Chauveau & Schwabe (2004:849) conducted a study investigating the prevalence of HIV among South African health care workers and found that 15.7% of health care workers working in the public sector and private sector in four provinces in South Africa in 2002 were living with HIV. The same study found that the younger the health worker, the higher the risk. The estimated prevalence in the 18 to 35 year group in the general population was 20%, whilst in 2011, the estimated prevalence in the 15 to 49 year group in the general population was 17.3% (South Africa, DOH, 2012:56). However, the prevalence for the same age group attending antenatal clinics in KwaZulu-Natal was 24.7% (South Africa, DOH, 2012:57). The prevalence among professional health workers was 13.7% in 2004 (Shisana, et al. 2004:846) and 15.2% in 2007 (HWSETA. 2007:2). The findings of the study by Shisana et al (2004:849) were that the prevalence of HIV among South African health care workers, at the time, was highest among single, black health care workers (Shisana et al., 2004:849). Shisana et al., (2004: 850) maintained that occupational exposure was probably high among South African

health care workers and that concomitant TB or drug resistant TB infection was a worry. They further predicted that, as a consequence of the 15.7% prevalence among health care workers, health care workers sick with HIV would be absent more frequently, thus reducing the effectiveness of the care they could deliver; and that health care workers not infected with HIV would be overburdened with work. These researchers recommended that the South African Ministry of Health form a committee of experts to advise on the formulation of policy guidelines for health care facilities to manage HIV positive health workers as well as in-service training related to universal infection and prevention control precautions (Shisana et al., 2004:850).

Shisana, Simbayi, Zuma, Jooste, Pillay-Van-Wyk, & Mbelle, Parker, Zungu, Pezi & the SABSSM III Implementation Team (2009:1-98) conducted a further survey in 2008 of the HIV prevalence, incidence, behaviour and communication and found that the prevalence is high in women in the 25 to 29 year age group at 32.7% (Shisana et al., 2009:30). Considering the point made by HWSETA (2007:10) above, one must assume that nurses in this age group (25 to 29), who are the future leaders of the profession, also have a prevalence of about 32.7%. The prevalence of HIV infection among public hospital employees was estimated by Connelly, Veriava, Roberts, Tsoetsi, Jordan, De Silva, Rosen, Bachman & De Silva (2007:119) to be nearly similar to that in the adult population as a whole (at that time), which was about 16%. A particularly disconcerting finding by Connelly et al., (2007:117) was the high prevalence of HIV infection among nursing students. A further major observation of their study was the significant percentage of health workers with CD4 counts less than 200 cells/ $\mu$ l (18.9%) (Connelly et al., 2007:118). Uebel, Nash & Avalos (2007:501) support the researcher's claim by stating in their study that nurse managers in South Africa acknowledge that caring for HIV-infected nurses is a critical component of their work, particularly in KwaZulu-Natal.

### **2.5.3. Tuberculosis**

In an article in *The Lancet* of August 2009, Abdool Karim et al., stated that South Africa has one of the most serious TB (TB) epidemics in the world, and that in the last ten years, South Africa's dealing with the co-relationship of HIV and TB has been marked by denialism, ineptitude, obtuseness and deliberate efforts to undermine scientific evidence as a basis for action. In 1995, South Africa

commenced the directly observed treatment short course strategy (DOTS) for dealing with TB. However, in spite of DOTS, standardised recording and an improved central control of TB at all levels in the health system, TB has continued to escalate on the back of the HIV epidemic. In 2004, the South African Government declared that TB was a national crisis and formulated and implemented a crisis plan with the aim of increasing political commitment and obtaining financial support for TB control (Abdool Karim, Churchyard, Abdool Karim & Lawn, 2009: 3). In 2007, a TB plan was adopted which aimed at providing those ill with TB easy access to effective, efficient and high-quality diagnostic, treatment and care services.

However, more than 50% of new TB cases have HIV. The number of TB cases and notification rates are highest in the province of KwaZulu-Natal at 1066 per 100 000 population in 2006. This province has both the highest prevalence of HIV among pregnant women and the worst TB program indicators in South Africa (Abdool Karim, Churchyard, Abdool Karim & Lawn, 2009:4). TB rates are at the highest in women in their twenties and men in their thirties, which are the same age groups with the highest HIV prevalence. Added to this, South Africa is among the top ten countries in the world with a high prevalence of drug resistant TB (Abdool Karim et al, 2009:3-5; South Africa, National Strategic Plan on HIV, STIS and TB: 2012 – 2016: 13 & 24) and extreme drug resistant TB (XDR TB) has been identified in 60 health care facilities in KwaZulu-Natal. Added to all the above, the most prevalent notifiable, cause of death in South Africa is TB.

South Africa has formulated two strategic plans for the period 2007- 2011, the HIV & AIDS and Sexually Transmitted Infections (STI) Strategic plan as well as the TB Strategic Plan for South Africa, which should improve the provision of health care to the HIV and TB affected people of the population (Abdool Karim et al, 2009:1-5; South Africa, National Strategic Plan on HIV, STIS and TB: 2012 – 2016: 13 & 24). The aims of the HIV & STI Strategy are: (1) prevention; (2) treatment, care and support; (3) legal and human rights; and (4) research, monitoring and evaluation, while the aims of the TB Strategic Plan for South Africa are: (1) to strengthen the implementation of the DOTS strategy; (2) address HIV and TB, MDR TB, and XDR TB; (3) contribute to health systems strengthening; (4) work collaboratively with all

care providers; (5) empower people with TB and their communities; (6) coordinate and implement TB research; and (7) strengthen infection control.

#### **2.5.4. Prevalence of TB among Health Care Workers**

O'Donnell, Jarand, Loveday, Padayatchi, Zelnick, Werner, Naidoo, Master, Osburn, Kvasnovsky, Shean, Pai, van der Walt, Horsburgh, & Dheda, (2010:516-522) found that 78% of health care workers admitted to a public sector TB referral hospital in the eThekweni District of KwaZulu-Natal were young women with a high prevalence of HIV. The percentage of health care workers admitted for multidrug resistant TB (MDR-TB) or extreme drug resistant TB (XDR-TB) and HIV at the time of their study was 67% (O'Donnell, Jarand, Loveday, Padayatchi, Zelnick, Werrner et al., 2010:518). These researchers also found that the hospitalization of health care workers due to MDR-TB was 64.8 per 100 000 health care workers; while the hospitalization of health care workers due to XDR-TB was 7.2 per 100 000 health care workers. These hospitalization figures are significantly higher than those for the general public where MDR-TB hospitalization was 11.9 per 100 000 persons in the general adult population and for XDR-TB 1.1 per 100 000 persons in the general adult population (O'Donnell, Jarand, Loveday, Padayatchi, Zelnick, Werrner et al. 2010:518). These figures give some insight into the extent of the TB problem among health care workers serving the KwaZulu-Natal population.

#### **2.5.5. Absenteeism**

The rate of absenteeism in South Africa is 9% in the private sector and 30% in the public sector (Adcorp in Sunday Times, 20 May 2012). As the accepted rate of absenteeism is between 3% and 4 %, it indicates that the rates in both the public and private sectors in South Africa are way above the accepted norm. Absenteeism is a problem which results in not only costs to the country, but also to companies and the sick individuals themselves. The Public Service Amendment Act (30 of 2007) makes provision for the termination of services of employees who are persistently ill (see section 2.6.1.8.). An updated determination and directive on leave of absence in the public service was published in August 2012 by the Department of Public Service and Administration (DPSA) and specifies that supervisors of employees take note of time frames for the processing of sick leave, incapacity leave applications and management of incapacity leave applications of deceased employees (South Africa,

DPSA, 2012:11). Employees have the responsibility to manage their sick leave responsibly and applications for sick leave must reach the employer within five days of becoming ill (South Africa, DPSA, 2012:23). The supervisor must ensure that the applications reach the Human Resources division within two days of receipt of such applications (South Africa, DPSA, 2012:23). This policy covers both temporary and permanent incapacity leave and the rules for managing such incapacity. Mfusi and Steyn (2012:157) conducted a study to assess the problems school principals experienced managing school teachers with HIV, and their findings revealed a high level of absenteeism as a result of sick educators applying for long periods of absence due to their disease status as well as employees applying for leave of absence to attend to sick family members or to attend funerals (Mfusi & Steyn (2012:158). The findings also revealed that when educators were absent for long periods or persistent absences occurred, the Department of Education was unable to provide schools with replacement staff, thus increasing the stress levels of the others who took over the load of their sick colleagues (Mfusi & Steyn, 2012:158-160). Similarly, Smit (2005:26) found that nurses who care for HIV affected patients experienced an increased workload, because fewer nurses were caring for more and more patients.

#### **2.5.6. Stigmatization of people who are HIV and TB affected/infected**

In South Africa, the prevention of stigma and discrimination is grounded in the Constitution (108 of 1996); the Employment Equity Act (55 of 1998); the Employee Health and Wellness Strategic Framework (South Africa, DPSA, 2008:1-59) and the South African Code of Good Practice on HIV and AIDS and the World of Work (South Africa, DOL, 2012:1-18).

Stigma and discrimination continue to be an on-going aspect of both HIV and TB (Mcfarlane & Newell, 2012:143). People who are HIV affected and infected feel guilty and ashamed of their HIV status and often blame their own behaviour for their disease and, as a consequence, do not disclose their status (National Stigma Strategy, 2007:2; Holzemer, Uys, Makoae, Stewart, Phetlhu, Dlamini, Greeff, Kohi, Chirwa, Cuca & Naidoo, 2007: 547 & 548). Affected or infected people do not want others to know their disease status, either at work or at home, as they fear stigmatisation (Opollo, 2013: 17-26; Bairan, Jones Taylor, Blake, Akers, Sowell &



Mendiola, 2007: 242-250; South Africa, DOL, 2012: 8-9; Norman, Chopra & Kadiyala, 2005:4; Mcfarlane & Newell, 2012:144; Holzemer, Uys, Makoae, Stewart, Phetlhu, Dlamini et al, 2007:547-548). Turner (2009:229-300) refers to keeping secrets from others and keeping secrets from ourselves. In both cases, secrets are kept for fear of what the informed does or does not do with the information; fear of how the informed perceives us and fear that the informed will tell the secret to others.

Singh, Chaudoir, Escobar & Kalichman (2011:842) found that health care workers who take care of people living with HIV receive adequate support from nurses and community care workers, but not from family or the church. This lack of support from family and the church may be why affected/infected nurses do not want to disclose their status at home or at work. Furthermore, employees tend not to inform their employers of their HIV status for fear of dismissal (Dieleman, Biemba, Mphuka, Sichinga-Sichali, Sissolak, van der Kwaak and van der Wilt, 2007:144). Stigmatisation within work places remains a problem and leads to denial and a sense of hopelessness and shame for the affected employee (Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola, 2007: 248; Holzemer, Uys, Makoae, Stewart, Phetlhu, Dlamini et al, 2007:548). Employees may believe that being HIV infected indicates promiscuity or prostitution on their part and therefore do not want the employer to think of them in this manner (Masupe, 2011: 70, Turner, 2009:229).

In a study conducted by Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola, (2007:246), it was found that participants did not want to disclose their status to employers or strangers although some informants stated that they found it easier to disclose to strangers. People who are HIV affected or infected have the right not to disclose and should such an individual choose not to disclose, employers need to remain non-judgemental of employee decisions not to disclose (Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola, 2007:249; South Africa, DOL, 2012: 8 -9).

### **2.5.7. Nurse Deaths**

Despite health care workers, and especially nurses, being exposed to occupational health risks, the occupational death rate for healthcare workers is largely unknown (Sepkowitz & Eisenberg, 2005:1003). In the United States of America, between 1992

and 2002, 28 healthcare workers passed away as a consequence of complications related to needle stick exposures (Sepkowitz & Eisenberg, 2005:1004). By 2005, Sepkowitz & Eisenberg (2005:1006) established that 46% of 57 known and recorded occupationally acquired HIV infected health care workers had sero converted to full blown AIDS. Forty seven percent (47%) of the 57 known occupationally acquired HIV transmissions were nurses. The subsequent retroviral treatment provided to these infected health care workers resulted in severe liver damage (Sepkowitz & Eisenberg, 2005:1006). The same researchers reported on the prevalence of TB among health care workers in the United States of America. TB infections resulted in the deaths of at least nine immune compromised health care workers (Sepkowitz & Eisenberg, 2005:1006).

The authors of 'Help wanted' (2007:17) stated that the loss of health care workers in Lesotho, Mozambique and Malawi is primarily due to HIV related deaths. Dieleman, Biemba, Mphuka, Sichinga-Sichali, Sissolak, van der Kwaak and van der Wilt (2007:144) concur that many health care workers in Zambia pass away as a result of HIV complications. O'Donnell, Jarand, Loveday, Padayatchi, Zelnick, Werner, Naidoo, Master, Osburn, Kvasnovsky, Shean, Pai, van der Walt, Horsburgh, & Dheda, (2010:518) reported hospital mortality rates of 32% of health care workers with multi drug resistant TB, while the mortality rate of health care workers with extreme drug resistant TB was 30%.

Gandhi, Shah, Andrews, Vella, Moll, Scott, Weissman, Marra, Laloo, and Friedland (2010: 80–86) claim that XDR-TB has a high mortality rate in people infected with HIV and claim that there was a 98% mortality rate among XDR-TB infected individuals from an HIV endemic area in KwaZulu-Natal. These researchers found in their study that 71% of patients with MDR-TB and 83% of patients with XDR-TB died (Gandhi, Shah, Andrews, Vella, Moll, Scott, Weissman, Marra, Laloo, and Friedland (2010:82).

The information provided by these studies is an indicator that nurses who are HIV affected/infected and may have the double infection of TB have a higher risk of death and there can be no doubt that a population of sick nurses must have an effect on the delivery of care to the people they serve.

## **2.6. LEGISLATIVE FRAMEWORK WITHIN WHICH NURSE MANAGERS WORK IN SOUTH AFRICA**

The following is the legal framework within which nurse managers work in South Africa. The foundation document on which all other pieces of legislation and policy frameworks are founded in South Africa is the Constitution (108 of 1996).

### **2.6.1.13. The South African Nursing Council (SANC, 2011) Draft Regulations relating to the conducting of inquiries into alleged unfitness to practise due to disability or impairment of persons registered in terms of the Nursing Act, (33 of 2005)**

The Nursing Act (33 of 2005) makes provision for the formulation of these regulations in Section 51 of the Act titled “Unfitness to practise due to impairment” (Nursing Act, 2005:36 & 37).

These draft regulations, which were published for comment during August 2011, were signed as a statutory regulation, on 19 December 2012. They clearly stipulate the responsibilities of the SANC, the impairment committee and the affected/infected nurse in respect of a complaint of disability or impairment received by the SANC in respect of a sick nurse registered or enrolled with the SANC. The regulation states that the affected/infected nurse is to be informed of such complaint in respect of his/her alleged disability or incapacity.

It is important that nurse managers who manage sick nurses at work are aware of both the existence of the regulation and are familiar with its contents so that they can refer to it to manage a nurse who is ill and at work when all other options have been exhausted.

### **2.6.1. The Constitution 108 of 1996**

This piece of legislation is the supreme law of South Africa and as such supersedes any other legislation in the country. Section 24 of the Bill of Rights within this Act provides that all South Africans have the right to an environment that is not harmful to their health or wellbeing; whilst Section 27 allows for everyone to have the right to access to health care services, including reproductive healthcare (Constitution 108 of 1996 as amended: 1253 & 1255). The intent of this Act is to ensure that people are treated fairly, equitably, with respect and dignity and that their privacy is protected,

including the privacy of their medical information (Constitution, 108 of 1996 as amended: 1243).

Various other legislative documents ensure that these sections of the Bill of Rights are upheld in respect of employees at work.

#### **2.6.1.1. Labour Relations Act 66 of 1995 as amended 2002**

The purpose of this Act is to enhance economic development, social justice, labour, peace and democracy within the workplace. This Act makes provision for negotiation and bargaining between employers and employees, encourages employee inclusion in decision making at work and makes provision for the effective resolution of labour disputes.

This Act states that an employer is not compelled to disclose the HIV status of an employee unless the employee grants permission and that an employee may not be dismissed based on his/her HIV status (Section 187(1) (f)).

#### **2.6.1.2. Basic Conditions of Employment Act (75 of 1997, as amended 2002 & 2007)**

The Basic Conditions of Employment Act stipulates conditions of service, which are the minimum conditions all employees are entitled to, such as hours of work, annual leave, maternity leave and family responsibility leave, among others. It also stipulates that employers provide their employees with the minimum number of sick leave days (Section 22(2)). According to this Act, permanent employees in the public sector in South Africa are allowed thirty six (36) days sick leave, on full pay, in a three (3) year cycle of employment (Basic Conditions of Employment Amendment Act 75 of 1997 as amended 2002 & 2007).

#### **2.6.1.3. Employment Equity Act, (55 of 1998)**

This Act ensures that no individual is unfairly discriminated against on the grounds of either real or perceived HIV status (Section 54(1)a); that applicants for employment may not be discriminated against in respect of his/her HIV status (Section 6(1)); that harassment of employees based on his/her HIV status is prohibited, as is violence in the workplace (Section 6(3)); that testing employees for HIV is prohibited (Section 7(2)); that employers are to provide reasonable accommodation of employees,

including employees with HIV, with access to equal employment opportunities (Section 15(2)(c)); that reasonable accommodation may be required in the event of an employee voluntarily disclosing his/her HIV status and that accommodation is required when the work changes or the work environment changes or when the impairment affects the employee's ability to perform the functions of his/her job.

Reasonable accommodation may require adapting existing facilities to make them accessible to the employee; adapting existing equipment or obtaining new equipment; reorganizing work stations; changing training, assessment material or systems; job restructuring so that non-essential functions are reassigned; adjusting work time and leave and finally providing specialised supervision, training and support in the workplace.

#### **2.6.1.4. Occupational Health and Safety Act (85 of 1993)**

This Act requires that employers provide a safe working environment (Section 8(1)). It also stipulates the regulations for hazardous biological agents (2001). The regulations spell out the responsibilities of employees and employers. Employers are to conduct risk assessments, monitor employee exposure to such agents, conduct medical surveillance on all exposed employees, and provide the affected/infected employees with personal protective equipment.

In the context of KwaZulu-Natal, HIV and TB are diseases which often occur together in one individual and therefore health care workers have the potential to become infected with TB through their work environment. They have the right to a safe, infection protected working environment. It is incumbent on the employer to provide a safe working environment or an adjusted work environment for employees who are HIV affected/infected which may compromise their health at work.

The employee has responsibilities in terms of Section 14 of the Occupational Health and Safety Act (85 of 1993) in that they must be cautious during the performance of their duties and co-operate with the employer in together creating a safe and healthy working environment. To reduce risk to themselves, employees must comply with the organizational procedures in order to maintain safety and health; report unsafe conditions and incidents or injuries to themselves or other employees to the

employer; and not interfere with or misuse any equipment with which they are provided by the employer,

Section 8 of the Occupational Health and Safety Act (85 of 1993) requires that the employer provides and maintains a safe and healthy working environment with equipment that is not harmful to either the employee or other people; remove hazards where possible; reduce risks or control the risks at a tolerable level when the risk is inherent to the business, and monitor the controls to ensure efficacy. Medical surveillance is recommended where certain hazardous exposures occur, notably noise above 85 decibels (dB) and chemical and biological agent exposure. In such cases, employees must be informed of the nature and severity of the risks to which they are exposed and the necessary safe working procedures, which include the use of appropriate personal protective equipment (PPE); the training of employees in safe working procedures and the correct use of PPE and the enforcement of compliance with the Occupational Health and Safety Act (85 of 1993).

The Hazardous Biological Agents Regulations (South Africa, DOL, 2001:1-67) also fall into the realm of the Occupational Health and Safety Act 85 of 1993. The regulations are applicable to every place of employment where biological agents are either produced or present and which may have an effect on employee health. It is incumbent on the employer to ensure that employees are knowledgeable in respect of the regulations, the biological agent hazards at work, how to protect themselves from such agents and the potential health hazards which may be a consequence of exposure to such agents. Of specific relevance to this study are the stipulated risk assessment, exposure monitoring, medical surveillance and provision of personal protective equipment with respect to the hazard of TB in health care facilities. These regulations specifically protect employees working in environments where biological agent hazards are present such as health care facilities, laboratories, mortuaries and places such as abattoirs. These regulations, which legally entrench infection control, were promulgated in December 2001 (South Africa, DOL, 2001:1-67).

#### **2.6.1.5. The Employee Health and Wellness Strategic Framework for the Public Service (South Africa, DPSA, 2008:1-59)**

The Department of Public Service and Administration (DPSA) published a strategic framework in 2008, prioritising HIV and TB management; health and productivity management; safety, health, environment, risk and quality management (SHERQ); as well as wellness management, all of which address individual and organizational wellness in a proactive manner (South Africa, DPSA, 2008:2). This development is a radical departure from the original Employee Assistance Programme, which was limited in scope and practice and not strong on prevention. The four processes which ensure and promote implementation are capacity development initiatives; organizational support initiatives; governance initiatives; and economic growth and development initiatives (South Africa, DPSA, 2008:10). Formal disease management structures are to be put in place for non-communicable and communicable diseases in the public sector workplace, which includes HIV and TB (South Africa, DPSA, 2008:26). The core principles for the implementation of the strategic framework include ethics and confidentiality; accessibility and focus on all levels of employment eligibility; cohesion and integration; flexibility and adaptability; contextual differences; learning communities and organizations; an agenda of development; continuity through levels of governance; and needs of designated groups, such as women, older persons, people with disabilities and people living with HIV and AIDS (South Africa, DPSA, 2008:16).

Although the intention of this document is to give guidance to all work environments in the public sector, it still does not address the placement of employees whose health may be affected by placement in certain clinical areas. It does suggest, however, a framework for the planning of employee health and wellness strategies at organizational and departmental level, which can be used for guiding the data collection and analysis of this study. This study will contribute to ensuring human resources planning and management, as required in the organizational support initiatives.

#### **2.6.1.6. Implementation of the Employee Health and Wellness Strategic Framework: April 2009. (South Africa, DPSA, 2009:1-4)**

The Employee Health and Wellness Strategic Framework (2008:1-59) is a universal strategy developed for use by the public service. It became effective on 1 April 2009 and is applicable to all public servants employed in terms of the Public Services Act of 1994; The Correctional Services Act of 1998 and the employment of Educators Act 76 of 1998 (South Africa, DPSA, 2009:1).

The objectives of the strategy are to control health hazards at work, thus improving occupational health and safety; to provide a safe environment for both the public and employees within the public service; and to ensure that the public service manages risks and provides quality services to the South African public.

The policies derived from the pillars of the Employee Health and Wellness Strategic Framework (2008:1-59) include the following:

- Safety, Health, Environment, Risk and Quality Management Policy (SHERQ)
- HIV and AIDS and TB Management Policy
- Health and Productivity Management
- Wellness Management

The most pertinent aspects of the Employee Health and Wellness Strategic Framework (2008:1-59) in respect of nurse managers who are tasked with the managing and planning of human resources in district hospitals in the eThekweni district are HIV and TB management, and include prevention, treatment, care and support, human rights and access to justice and research, as well as monitoring and evaluation; health and productivity management, which includes the provision of a process that manages health care at work and injury on duty and/or incapacity due to ill health (South Africa, PILIR, 2009:1-29). It also encompasses disease management and chronic diseases, which address the reduction of vulnerability to HIV and TB; the reduction of viral transmission; human and legal support advocacy; the promotion of HIV behaviour change communication; promotion of health and health education; and bringing HIV and AIDS into the mainstream of care.



Treatment, care and support requires that employees are encouraged to become members of the Government Employees Medical Aid Scheme (GEMS); that employers provide and promote voluntary counselling and treatment at work; provide and promote anti-retroviral care and direct observed TB (DOT) treatment at work; provide employee and family assistance and support at work; promote patient accountability; and encourage early TB detection within the workplace. Human rights and access to justice requires that both employees and the employer stick to and comply with legislation and policies; prevent stigmatization and discrimination; monitor and redress HIV human rights violations; encourage human rights; and promote gender and sexual equality. Research, monitoring and evaluation includes conducting regular surveillance and the development of a monitoring and evaluation agenda

Health and productivity management, through the Policy for Incapacity Leave and Ill Health Retirement [PILIR] (South Africa, DPSA, 2009:1-29), offers a process to managed health care at work.

#### **2.6.1.7. Compensation for Occupational Injuries and Diseases Amendment Act (61 of 1997)**

This Act requires that employees must apply for benefits if he/she contracts an occupationally acquired disease as a result of exposure to infected blood or body fluids (Section 22(1) in Chapter IV). Section 22(1) of the Act makes provision for healthcare worker compensation in cases when it has been established that they have contracted drug resistant TB (DR-TB), and that their disease status has occurred:

*“as a result of and in the course of his/her employment involving the handling of or exposure to patients with drug resistant TB (DR-TB). Employees are entitled to compensation if they are injured while working or contract any work-related disease.”* (South Africa, 1997:16)

The types of compensation paid to workers for injuries or diseases are:

- Medical aid/assistance in the form of payment for medical care
- Temporary disability compensation
- Permanent disability compensation

- Compensation to families of diseased employees (Circular instruction 178, 2003:4)

The Compensation for Occupational Injuries and Diseases amendment Act (61 of 1997), Schedule 3, stipulates that TB is a compensable disease ONLY in the following work situations:

- When employees are exposed to Crystalline silica (alpha quartz), as found in the mines.
- When Mycobacterium TB or NTMs (non-Tuberculous mycobacteria) are transmitted to an employee during the performance of health care work from a patient suffering from active open TB (South Africa, 1997:48).

#### **2.6.1.8. Public Service Amendment Act (30 of 2007)**

The Public Service Amendment Act lays down the rules for the Public Service in South Africa, with the exception of members of the uniformed services, educators or members of the Agency or the Service. This statute lays down the rules for the termination of employment of a public servant. In the event that an employer decides to terminate an employee's services, the following legal reasons for termination of employment are provided for by this Act. The power to terminate the services of an employee, who is not a head of department (HOD) lies with the HOD, in terms of subsection (2(e)). (South Africa, 2007: 27).

An employee may be discharged from the public service (Section 17(2)) (South Africa, 2007: 27-28) in circumstances where the employee experiences continued ill-health; where an employee's post/position is done away with or there is a reduction in or reorganisation or readjustment of departments or offices; where an employee's termination of service will promote efficiency or economy in the department or office in which he or she is employed, or will be in the interest of the public service; on account of unfitness for his/her duties or incapacity to carry them out efficiently; on account of misconduct; if a person is appointed on probation, his or her appointment is not confirmed; where a person misrepresents his or her position in relation to a condition for permanent appointment; where a person's continued employment constitutes a security risk for the State; and if the President or a Premier appoints

him or her in the public interest under any law to an office to which the provisions of this Act do not apply (South Africa, 2007: 27-28).

This Act makes provision for the management of an employee where the employee is absent from work without permission (Section 17(3)) (South Africa, 2007:27). If an employee is absent without permission for more than a month, his/her employment is to be terminated due to misconduct, with the termination being effective from the employee's last day at work. However should such an employee return to work after a month and is able to furnish a good reason for the absence, then the employer may reinstate the employee to his/her job. In such cases the absence from work without permission is to be converted to vacation leave or leave without pay (South Africa, 2007:27).

#### **2.6.1.9. Policy for Incapacity leave and Ill Health Retirement [PILIR] (South Africa, DPSA, April 2009)**

Incapacity leave is leave granted to a sick employee at the discretion of the employer over and above the normal 36 days of sick leave that is allowed in a three year cycle (South Africa, DPSA, 2009:6).

This policy spells out a fair procedure to follow, which includes an investigation into the nature and extent of the incapacity; the effects of treatment provided to the sick employee; and alternatives to dismissal (South Africa, DOH, 2011:124)

Under normal circumstances additional sick leave may be granted if advised and required in order to undergo treatment for drug resistant TB (DR-TB), HIV or any other dread disease as either unpaid sick leave or sick leave at less than full pay. Such additional sick leave options would be regarded as fair (South Africa, DOH, 2011:124). Fairness can only be regarded on a case by case basis, and alternative factors, such as disability insurance and ill-health retirement benefits may be relevant to individual cases (South Africa, DOH, 2011:124).

This policy states the employer responsibilities, employee responsibilities and the responsibilities of the health risk manager for short periods, long periods and permanent disability applications.

In cases of short period incapacity leave, the employer responsibilities are to process the documents within the stipulated timeframes; make a final decision in respect of an employee's application for incapacity leave and/or ill health retirement, taking consideration of the advice of the health risk manager; register receipt of the application by the employee on a central data base; ensure all documents submitted by the employee remain attached to the application; grant, conditional on the findings of an investigation conducted, a maximum of twenty nine (29) consecutive working days temporary incapacity leave on full pay; notify the employee in writing; immediately complete part D of the application form and submit to the health risk manager; attach copies of employee sick leave records, including those for the current sick leave cycle; attach copies of employee's annual leave records for the same period; confirm that the health risk manager received applications sent along with the attached additional documents; and approve or reject conditional short period incapacity leave granted within thirty (30) working days of receipt of applications for short period temporary incapacity leave. If approval of conditional short period incapacity leave is granted, the employer converts granted leave to short period incapacity leave, but if conditional short period incapacity leave previously granted is rejected; the employee must be informed in writing within five (5) working days of the options available to the employee to convert the conditional short period incapacity leave previously granted to either annual leave or, where the employee does not have sufficient annual leave, unpaid leave. It is also incumbent on the employer to inform the employee in writing that the conditional short period incapacity leave has been refused and the reasons for the refusal so that the employee may appeal the decision in the form of lodging a grievance (South Africa, DPSA, 2009:8-9).

The employers' responsibilities in cases of long period incapacity leave are the same as those for short period incapacity leave, but an additional maximum of thirty (30) consecutive working days of temporary incapacity leave on full pay may be granted (South Africa, DPSA, 2009:12-13).

The employers' responsibilities in respect of an employee who has been found to be permanently incapacitated, but can continue to provide a service are to determine the feasibility of alternative employment; adapting either work duties or work circumstances so as to accommodate the employee or redeploying the employee

horizontally without loss of employment benefits, taking into consideration the required time and finances for required training and/or retooling of the position prior to making such decision in respect of the employee's continued employment; considering usage of the employee to his/her fullest ability; and considering the effect of the former on service delivery.

The employer may extend the thirty (30) working days already granted to a further thirty (30) working days, making a total of sixty (60) working days, in order to complete the commenced processes for termination of service due to ill health. If more than sixty (60) working days is required to complete the commenced processes, the employer needs to refer the case to the Director General of the Public Service and Administration, along with a report explaining the delay (South Africa, DPSA, 2009:20).

In cases of ill health retirement applications, the employers' responsibilities are to decide whether the ill health is permanent or temporary in nature and to decide whether to grant incapacity leave or not. On receipt of the outcome of the investigation, the employer must decide on alternative employment for the employee, adapting the employee's work duties/circumstances in order to accommodate the employee, or grant the employee ill health retirement. It is incumbent on the employer to inform the employee whether ill health retirement has been granted or not, with reasons for the decision. It is also the employer's responsibility to submit all relevant documents to the Government Employee Pension Fund (GEPPF) for processing of ill health retirement benefits.

This policy makes provision for maintaining confidentiality by stipulating that an employee is not compelled to disclose his/her HIV status or related medical condition to an employer or colleagues. The employer, therefore, shall treat available medical information of an employee with respect and confidentiality and under no circumstances disclose employee information to any person who is not authorised to be in possession of it, whether the employee voluntarily discloses his/her HIV status or not, without the employee's written consent. All documents in respect of an employee's medical condition must be treated as "confidential" and employers must comply with requirements of the minimum information security standards (MISS) of South Africa and require employees handling PILIR applications to sign a pledge of

confidentiality (South Africa, DPSA, 2009:20-21). Any employee in possession of medical information pertaining to another employee, who reveals such information to an unauthorised employee, shall be disciplined.

In terms of this policy, the employee responsibilities with respect to short period incapacity leave are to submit applications for incapacity leave or ill health retirement along with medical certificates and reports and notify the employer personally of sudden occurrence of incapacity (South Africa, DPSA, 2009:7).

In terms of long period incapacity leave, the employee must submit complete applications within five (5) working days of receiving back an incomplete application for correction; attach relevant medical certificates, medical reports, blood results, x ray reports, scan reports and any additional motivation (South Africa, DPSA, 2009:12)

In cases of applications for permanent incapacity leave the employee must grant permission for redeployment, having been fully advised of the proposed reallocation to a lesser graded position. If the employee is convinced that he/she will not be able to continue employment at a standard required by the employer, then the employee may precede with the process of termination of his/her services on grounds of ill health (South Africa, DPSA, 2009:20). In cases of ill health retirement, employees may apply for ill health retirement prior to their sick leave becoming exhausted. The cost of completion of ill health retirement application documents by medical practitioners is to be paid by the employee (South Africa, DPSA, 2009:21).

The health risk manager's responsibilities for short period incapacity leave stipulated in the policy are to acknowledge receipt of applications within two (2) working days of receiving applications; provide feedback stating that a response will be provided within twelve (12) working days of receipt of the application; conduct an assessment of the applications received; request further information before concluding its assessment, where necessary; maintain and protect employee confidentiality; submit its advice to the employer once the assessment is complete; and convert applications for valid reasons which require secondary assessment to a long period temporary incapacity application (South Africa, DPSA, 2009:10-11).

Although most of health risk manager's responsibilities in respect of long period incapacity leave are the same as those for short period incapacity leave applications, there are additional responsibilities involved in the process. A primary assessment of the applications received must be conducted advising the employer of the validity of the application, the appropriate duration of the leave and the need for a secondary assessment. This advice must be submitted to the employer once the primary assessment is complete. Furthermore, the secondary assessment requirement for ill health retirement should immediately be initiated (South Africa, DPSA, 2009:24-25).

The responsibilities of the health risk manager in receipt of an application for ill health retirement are the same as for both short and long period incapacity leave applications, but with the following additions. The employer must be advised whether alternative/adapted work duties/circumstances should be considered. The assessment criteria which the health risk manager is to use are stipulated in respect of the nature and extent of physical impairment, the nature and extent of psychological/mental impairment; job factors; the appropriate duration of absenteeism and the appropriate duration of the disease; employee capabilities despite his/her disease process; the employee's potential to perform alternative work; the employee's rehabilitation and reskilling potential; and the future earning potential of employee (South Africa, DPSA, 2009:24-25).

#### **2.6.1.10. Unemployment Insurance Act (63 of 2001)**

This Act makes provision for people who have previously worked and paid into the unemployment insurance to be paid a percentage of their previous salary when unemployed. This Act also contends that employers must ensure that employees have the right to access illness benefits (Section 20). All South African workers contribute to this fund, but there is, however, a salary ceiling of R120000.00 per annum and those who earn more than R120000.00 per annum will receive unemployment payments at the maximum rate of R120000.00 per annum.

#### **2.6.1.11. National Health Act (61 of 2003)**

This Act is the legislation which lays down the structure of the National Health Service in South Africa. It makes provision for the rights of the public who use the service and the rights and duties of the healthcare personnel working in the National

Health Service. In the context of HIV, this Act stipulates that health care workers must not be unfairly discriminated against as a result of his/her health status (Section 20(1):28).

#### **2.6.1.12. Nursing Act (33 of 2005)**

The Nursing Act, along with the Constitution (108 of 1996), forms the foundations for nursing practice in South Africa. However, nursing in South Africa is currently in a state of change in respect of the statutory regulations and there are currently two nursing Acts in effect, the Nursing Act (50 of 1978) and limited sections of the Nursing Act (33 of 2005). A circular from the South African Nursing Council (SANC) in 2007 is the last correspondence from SANC to educational and health care institutions in respect of the implementation of the Nursing Act (33 of 2005) and only certain sections of the Act became effective on 15 December 2006.

It is incumbent on nurse managers to ensure that they know the content of the Nursing Act (50 of 1978) and the Nursing Act (33 of 2005) as these Acts make provision for statutory control of nursing practice in South Africa and the formation of the South African Nursing Council, and affords the South African Nursing Council statutory rights over the practice of nursing. Central to the Nursing Act (33 of 2005) is the protection of the South African public from any acts and omissions by South African nurses. Specifically relevant to this study, this Act provides for the formulation of an Impairment Committee to deal with complaints received from any person with respect to nurses who may not be safe practitioners due to health problems.

There are SANC policies on HIV (2008), but these are patient centred and no mention is made of nurses who may be ill themselves. The only other SANC policy available is the policy on Nurses Rights (2008), but it makes no mention of the rights of nurses who are immune-compromised and who may have their health affected by their clinical placement. The Health Professionals Council of South Africa has such a policy pertaining to the impaired health worker, but it is based mostly on psychological impairments such as psychoses and addictions. The Nursing Act No. 50 of 1978 does not refer to impaired nurses, but in section 36 refers to a person or people who are so mentally or physically disabled that it would not be in the best



interests of the public to allow them to practice; or are schedule drug addicts or abusers.

As at March 2010, the above was all the guidance available for dealing with issues of ill health or impairment in the employment of nurses from our professional regulatory body. Fortunately The Nursing Act (33 of 2005), Chapter 5, section 51 states that

*“whenever SANC finds that a person registered in terms of the Act is or may be incapacitated as a result of disability or is or may be impaired, whether mentally or otherwise, to such an extent that it would be detrimental to the public interest to allow him or her to continue to practice; is unable to practice the profession with reasonable skill and safety; or in the case of a learner, has become unfit to continue with the education programme, the Council must appoint a committee to conduct an inquiry in the prescribed manner.”* (South Africa, Nursing Act 33 of 2005:36)

The Act defines "impairment" as a condition which

*“renders a practitioner incapable of practising nursing with reasonable skill and safety.”* (SANC, 2011:15)

However, section 51 of the Nursing Act (33 of 2005) has as yet to be implemented.

#### **2.6.1.14. The South African Code of Good Practice on HIV and AIDS and the World of Work (South Africa, DOL, 2012:1-18)**

This newly published document formed the basis from which the draft guidelines of this current study were formulated. As such, it is recommended that users of the draft guidelines ensure that they have this document in their possession and have read it in order to understand the context from which the draft guidelines were formulated.

The South African Code of Good Practice on HIV and AIDS and the world of work emanates from the Employment Equity Act 1998 55 of 1998 and was formulated in compliance with the Employee Health and Wellness Strategy (South Africa, DPSA, 2009:1-59).

The principles of this code are founded on respect for human rights, freedom and equity; the fact that HIV is a problem in workplaces in South Africa; a zero tolerance for discrimination and stigmatisation of employees affected or infected with HIV; gender equality; the right to continued employment; prevention of the transmission of HIV at work; access to treatment and support; trust; confidentiality and disclosure in a safe environment; and occupational health and safety at work (South Africa, DOL, 2012:33-34)

The code spells out the prevention of discrimination and the promotion of equal opportunity and treatment through the use of counselling and informed consent in respect of HIV testing at work. Confidentiality and disclosure are clearly discussed, stating that the disclosure of any information without the express consent of the employee concerned is a disciplinary offence (South Africa, DOL, 2012:12). Employees have the right to continued employment while they are able to work as the code explicitly states that HIV is not grounds for the dismissal of employees from employment (South Africa, DOL, 2012:39). This code requires that employers must make provision for the occupational health and safety of employees as well as provide treatment and care, the formulation of HIV workplace programmes and education and training to employees. Finally the code calls for the formulation of HIV monitoring and evaluation plans, which is in line with the department of performance monitoring and evaluation situated within The Presidency, the office of the President of South Africa.

#### **2.6.1.15. South African Nursing Council Impairment Committee**

The SANC has established an Impairment Committee, which is currently researching the terms of reference for the functioning of the committee. Unfortunately, as at March 2010, Chapter 5, Section 51 of the Nursing Act (33 of 2005) was still not operational. I have been in communication with the Chairperson of the Impairment Committee of the SANC who has expressed an interest and a need for collaboration between the committee and researchers. In August 2012, the South African Nursing Council Draft Regulations relating to the conducting of inquiries into alleged unfitness to practise due to disability or impairment of persons registered in terms of the Nursing Act, 2005 (33 of 2005) were placed on the South African Government website for public comment. These guidelines were signed by the President of South

Africa, and promulgated as a statutory regulation of The South African Nursing Council on 19 December 2012. The policy allows for any person to lodge a complaint to the SANC if they believe a nurse is not capable of safe practice. This committee is able to hold an inquiry into the circumstances which may cause the impairment of the nurse and make recommendations in respect of the nurses' fitness to practice as a nurse in South Africa.

## **2.7. THE VIEW OF HEALTH CARE WORKERS ON INFECTED HEALTH CARE WORKERS**

In a study conducted in 2008 by Kagan, Ovadia & Kaneti to determine the views of physicians and nurses on infected health care workers, they found that their study emphasized the need to formulate a policy to cope with professional and moral dilemmas related to infected health care workers involved in invasive procedures in the hospitals in which they are employed (Kagan, Ovadia & Kaneti, 2008:573). These authors further state that such a policy will protect the public, infected health care workers and the overall health system (Kagan, Ovadia & Kaneti, 2008:581). This view is supported by Jones, (2002:22-36) who suggests that further study is needed to support and assist HIV positive nurses around the world, enabling them to stay healthy and well in order to continue working as health care providers (Jones, 2002:35).

## **2.8. EMPLOYEE FITNESS FOR WORK AND MANAGEMENT OF EMPLOYEES' RETURN TO WORK**

While return to work policies are not the norm within the South African human resources field, such a policy would increase employee awareness of absenteeism management and have as its consequence a reduction in employee absenteeism rates.

A search was conducted in Ebsco Host using the search phrases return to work; and HIV, which resulted in only six articles. The search had to be narrowed down to only include HIV as adding AIDS and TB to the search resulted in articles irrelevant to the return of affected/infected people to their employment following a period of illness.

Information sources described and discussed the limited situations where a health care worker (HCW) can potentially infect a patient during an invasive procedure and

the findings are that HCW to patient infection is rare. As such, among employees working in a ward situation, there should be little need to restrict the return to work of an employee for fear of the nurse infecting the patient (Israeli HIV+ surgeon cleared to continue work, *AIDS Alert*, 2009:18-19; Israeli HIV+ surgeon cleared to continue work, *Hospital Employee Health*, 2009:35 - 36).

The ideal situation will be for the employee to return to work as soon as possible following an illness or injury (Young, Wasiak, Roessler, McPherson, Anema, & van Poppel, 2005:775) However, consideration must be taken of the fact that an ill employee returning to work creates a dynamic and complex social situation which requires more than simply putting the employee back to work. Special consideration must be taken of the co-workers who will have to work alongside the returning employee, and task distribution and workplace communication must be included in any contemplated policy (Tjulin, Maceachen, Stiwne, & Ekberg, 2011: 23).

Bor, Tansfer, Newell and Bärnighausen, (2012) found in a study they conducted in a South African rural area that patients had a 90% recovery of employment following early initiation of anti-retroviral treatment. The probability, therefore, is that health care worker employees in urban areas should also have no problem returning to work following illness due to HIV, TB or any other chronic disease.

The WHO has categorised HIV into the following four stages, which is a useful guide to determine employee fitness to work and the management of the employees' return to work:

Stage 1: *Asymptomatic* – At this stage an infected individual is able to function normally, has no visible sign of the disease and should be normally productive at work.

Stage 2: *Mild symptoms* - At this stage the individual may become periodically ill, but is still able to function normally. However, employers may observe short, more frequent absences from work. The WHO continues to describe a scenario associated with this stage where, as more individuals reach stage 2 and progress to stage 3 of the disease, the frequency and duration of the sick leave people take will increase as they become physically weaker resulting in them being unable to work for the duration of a full shift. As the virus affects the nervous systems, it may result in

impaired mental function and loss of limb control. In such circumstances, the WHO suggests moving the individuals to a “less taxing job”, replacing them with somebody who is not ill, or terminating the employment of the infected person, using a clearly stated procedure to manage poor performance due to ill health. It is clearly stated that the type of work the individual does must be considered when deciding on fitness for work.

Stage 3: *Advanced symptoms* - At this stage the individual is obviously ill and is no longer able to manage normal work activities. They are likely to be off work and confined to bed, all day, for more than 15 days a month. The WHO states that it is at this stage that the employer needs to make a decision on the employment relationship with the employee.

Stage 4: *Severe symptoms* - At this stage, the individual has full blown AIDS and will be unfit for work. It is also at this stage that employers provide anti-retroviral therapy (ART) to their affected/infected employees. Treatment with the ART commences when the CD4 count of the individual is 400. Previously, the CD4 count had to be 200, before stage ART was commenced. Employees needed to be off work for months until their immune systems had regenerated and their viral loads had decreased. It would take months before the individual was well enough to return to work. The implementation of CD4 counts of 400 as the benchmark for commencing ART was as recent as late 2009 and insufficient time has lapsed for any definitive data to indicate that the prolonged absences from work are no longer a problem (WHO (e), 2010:160). It is recommended that an employee should report to the relevant supervisor on the day of returning to work (South Africa, DPSA, 2012:23).

## **2.9. GUIDELINE FORMULATION**

Guidelines are documents which are formulated to direct and aid people in the workplace around specific topics. They also assist in guiding the formulation of context specific workplace policies and procedures. Oxman, Schünemann & Fretheim (2006) made recommendations to the WHO around guideline formulation and the researcher has referred to this seminal literature in providing a sound conceptual framework for the proposed guidelines which will be an outcome of this study.

Oxman, Schünemann & Fretheim (2006) made recommendations to the WHO as to what should be included when formulating guidelines, which included setting priorities; the composition of groups and the consultation and group processes; managing conflicts of interest; determining which outcomes are important; determining which evidence to include; synthesizing and presentation of the evidence; grading the evidence and recommendations; integrating values and consumer involvement, including equity, applicability, transferability and adaptation; reporting on guidelines; disseminating and implementing guidelines; and evaluation of guidelines (see Table 3.6).

### **2.9.1. Setting Priorities**

Oxman, Schünemann & Fretheim (2006(a)) found a limited number of studies which would assist a guideline formulator with respect to the criteria or processes for determining priorities, but did however find broad similarities in criteria used by various organizations. The authors recommend that if it is feasible to develop guidelines where quality guidelines are unavailable, low and middle income countries who experience problems related to high disease burdens and emerging diseases should be prioritized. They further recommend that various factors should be considered when determining feasibility, such as improving health status, minimising inequity and reducing expenditure, and that where implementation is considered feasible, it should not exhaust resources (Oxman, Schünemann & Fretheim, 2006(a):5 of 7). In order to reach consensus around priorities, these authors suggested including the resources needed to formulate guidelines within the normal organizational budget. The criteria used for setting priorities should be applied systematically and transparently; include consideration of issues which cannot be measured clearly and transparently; encourage full decision making by groups, including stakeholders and experts; and document how topics were selected so that the methods are transparent (Oxman, Schünemann & Fretheim, 2006(a):5 & 6 of 7).

### **2.9.2 Group composition and the consultation process**

Fretheim, Schünemann & Oxman (2006(a)) found that group composition has an effect on the recommendations made in guidelines. These authors recommend that a wide section of stakeholders as possible, in groups, should formulate guidelines. They also suggest including technical experts to obtain and search for relevant

information, such as people who are skilled in conducting systematic reviews, health economists, project managers, group facilitators, writers and editors as well as experts in the field around which the guidelines will be formulated. The group should be led by a leader able to lead and educate the group through the processes and tasks and who can facilitate collaboration to obtain an equal contribution of the members of the group (Fretheim, Schünemann & Oxman, 2006(a):5 of 6)

### **2.9.3. Managing conflicts of interest**

Boyd & Bero (2006) discuss how conflicts of interest, such as financial conflict, should be handled during guideline formulation by groups. Although these authors conclude that there is little available literature to guide the formulation of participant disclosure forms, they recommend that specific forms be developed to obtain sufficient detail from group members to determine the nature of the competing interests (Boyd & Bero, 2006:3 & 4 of 6). The management of conflicts of interest should be on an individual case basis. Open and transparent disclosure should be a minimum criterion and individuals with conflicting interests should withdraw from the process (Boyd & Bero, 2006:5 of 6).

### **2.9.4. Group processes of guideline development**

Fretheim, Schünemann & Oxman (2006(b)) suggest that methods such as the Nominal group method, the Delphi Technique or consensus conferences are useful as agreement achievement methods. A group leader able to facilitate such consensus strategies is important for the success of the group (Fretheim, Schünemann & Oxman, 2006(b):3 of 4).

### **2.9.5. Determining important outcomes**

Schünemann, Oxman & Fretheim (2006:3 of 6) suggest using as criteria, transparent and clear methods for establishing the outcomes and to include relevant stakeholders. The process of consultation should commence with establishing all the information relevant to the topic as well as a group decision on what is important as outcomes. These authors further suggest that the outcomes should be those which the group considers to be the benefits and effects of the guidelines they are formulating and that outcomes which do not have a direct effect on or are seen as important to patients should be specifically considered, while financial implications to

the end user as well as outcomes such as mortality, morbidity and quality of life, should take precedence. Finally, ethical considerations should form the foundation of the evaluating outcomes for the guidelines e.g. beneficence and autonomy. Where cultural differences may impact on outcomes, representatives from different cultures should be involved in choosing the relevant outcomes (Schünemann, Oxman & Fretheim, 2006:4 of 6).

Outcomes should be reflected in rank order of importance and divided into those beneficial and those which may not be of benefit to the users of the guidelines. Research should be used, if possible, to rank outcomes. Where there may be a variance between cultures, then the ranking of the outcomes should be per specific culture and where evidence is not available for any specific outcome, it should be stated that the evidence is not available rather than omitting the outcome (Schünemann, Oxman & Fretheim, 2006:5 of 6).

#### **2.9.6. Evidence to include in guidelines**

Oxman, Schünemann & Fretheim (2006 (b)) suggest including evidence of the effects of alternative interventions or actions found in the recommendations of research studies. They further suggest using context specific evidence and using studies whose design is dictated by the intervention and its considered outcome. They recommend including the type of evidence which is available for use, as well as the time and resources available to the group formulating the guidelines. These authors suggest being clear about the range of study designs which are included in the formulation of guidelines, but most importantly they suggest acknowledging uncertainty and avoiding confusing a paucity of evidence with evidence of no effect. These authors warn against using experts as a source of evidence, but where such people are used, their input should be informed and appraised systematically and transparently (Oxman, Schünemann & Fretheim (2006 (b)):5 of 7).

#### **2.9.7. Synthesis and evidence presentation**

Oxman, Schünemann & Fretheim (2006 (c)) suggest that the use of existing systematic reviews as evidence is beneficial because such reviews take an inordinate amount of time and resources to conduct. These authors further suggest the use of a standard assessment tool such as “A Measurement Tool to Assess



Reviews” (AMSTAR) to critically appraise the systematic reviews and to determine whether the review selected answers the questions asked (Oxman, Schünemann & Fretheim, 2006 (c):4 of 10). Evidence obtained from existing systematic reviews should be presented to the guideline formulation group as summaries of the best available evidence for each important outcome. Benefits, harmful effects and financial implications should be included in the summaries. One should include a review of the quality of the evidence along with summaries of the findings for each outcome. All stakeholders should be provided with the full systematic reviews presented as evidence. Further information should be provided on factors which may change the foreseen effects, needs, values and resources (Oxman, Schünemann & Fretheim, 2006 (c) : 8 of 10). Significantly, these authors found that obtaining information around systematic reviews for public health and non-clinical interventions may be difficult, because of the interdisciplinary basis for such research. They suggest different search strategies to those used in clinical interventions and employing a person who has specialist skills to search for relevant data. The reasons provided for such needs are lack of a standard language around such topics and the fact that empirically sound studies are in short supply. The use of grey literature and technical knowledge are recommended for formulating guidelines for public health and non- clinical interventions (Oxman, Schünemann & Fretheim, 2006 ( c ):7 of 10).

#### **2.9.8. Grading of evidence for use in guideline formulation**

Schünemann, Oxman & Fretheim (2006) state that the end users of guidelines need to have confidence in the evidence used and the recommendations made. Clear and systematic judgement approaches around the quality of the evidence used and the veracity of the recommendations made assist in preventing errors and assist critical appraisal of judgements, as well as aid the communication of the information provided. These authors suggest the use of an internationally accepted standard grading system such as “The Grading of Recommendations Assessment, Development and Evaluation” (GRADE) approach and that such a grading system should be consistently used to prevent both the guideline formulator and user confusion (Schünemann, Oxman & Fretheim, 2006 (b):4 &5 of 7). However, in 2010, The WHO recommended the use of the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (WHO, 2010:6). The essence is that the quality of

the evidence used needs to be made clear and transparent to those who will use the produced guidelines and that a consistent grading tool should be used.

#### **2.9.9. Integrating values and end user participation.**

Schünemann, Fretheim and Oxman (2006 (c)) recommend that the importance of the outcomes of a decision have a role in all guidelines or recommendations as does ethics and what is deemed to be right (Schünemann, Fretheim & Oxman, 2006 (c):5 of 8). They claim that the values should mirror those of the people who will be affected by the guidelines. Decisions made should be clear and guided by the people who will be affected by the decisions made (Schünemann, Fretheim & Oxman, 2006 ( c ):4 of 8). In formulating guidelines, the developers should allow for the guidelines to be adjusted to local needs. These authors clearly recommend that the draft version of produced guidelines should be reviewed by the end users of the proposed guidelines and that those requested to review the draft guidelines should be requested to specifically review the values which were used in the draft guidelines (Schünemann, Fretheim & Oxman, 2006 ( c ):2 of 8) .

#### **2.9.10. Including equity in Guideline Development**

Oxman, Schünemann and Fretheim (2006 (d)) suggest that the principles of equity are not discussed very adequately in either systematic reviews or clinical practice guidelines (Oxman, Schünemann & Fretheimm, 2006 (d):4 of 6). In order to ensure equity in the use of guidelines, developers should always question whether there may be reasons for expecting different effects of the guidelines, such as in advantaged or disadvantaged communities (Oxman, Schünemann & Fretheimm, 2006 (d):3 of 6). Where such different effects are expected, the developers should search for additional evidence to include in the evidence review in order to make more informed decisions around the effects of the guideline recommendations in differing communities. For the purposes of guideline developers formulating guidelines for disadvantaged communities, the authors suggest questioning the probability of the research results applying specifically to disadvantaged communities, whether there could be differences between advantaged and disadvantaged communities, whether there are important differences between the benefits and harms of interventions in advantaged and disadvantaged communities, whether the implications are different for either advantaged or disadvantaged

communities, and what information is important for the different contexts in order to make any required adaptations and decisions in respect of equity (Oxman, Schünemann & Fretheim, 2006 (d):3 of 6).

#### **2.9.11. Applicability, transferability and adaptation of guidelines**

Schünemann, Fretheim and Oxman (2006 (d)) suggest that, internationally, the resources for developing guidelines of exceptional quality are limited and that developing international guidelines can enhance access to such resources and encourage combining available resources, thus limiting duplication. This would also promote international collaboration between researchers from around the world. These authors believe that priority should be placed on international health concerns as well as on concerns prevalent to low and middle income countries, where the resources to such information may be problematic. These authors believe that local conditions and resources should be taken into consideration and highlighted for specific contexts. Schünemann, Fretheim and Oxman (2006 (d):6 of 10) recommend that the WHO should collaborate with organizations which produce systematic reviews and that generic evidence should be able to be adapted to local contexts. Local stakeholders may, however, need support from global organizations such as the WHO in order to make the developed generic guidelines adaptable to their local context. These authors continue to recommend that the processes, factors and reasons used to adapt generic guidelines for a local context should be reported on within the adapted guidelines (Schünemann, Fretheim and Oxman (2006 (d):8 of 10)

#### **2.9.12. Reporting guidelines**

Oxman, Schünemann and Fretheim (2006 (e)) recommend that a standard format should be used for the reporting of guidelines, using standard headings. The headings should form the structure of any guideline developed. An overview of the information in the format of an abstract should be provided in the guideline, which includes the date, where the developed guideline is in the process of its development and the focus of the guidelines should be evident where the disease or intervention under discussion is described. A description of any other interventions which may have been taken into consideration during the development of the guidelines should also be included in this section.

The goal that the guideline is anticipated to reach and the logic for the development of the guideline around the chosen subject should be evident, as well as who the end users of the guideline are anticipated to be and the context in which the guideline is intended to be used. Where the guideline is intended to be developed for a specific clinical practice intervention, the intended patient profile should be described and any exclusions from the intended profile. It is important to name the organization or person responsible for developing the guideline and to declare any conflict of interest that may arise. The financial source and the role of the financial source in the guideline development process should be documented.

The process used for searching for the evidence should be described, as well as the names of data bases used, the search terms used and the dates that the searches were made. There should also be descriptions of how the quality of the evidence used was determined, how the evidence was used to create the recommendations in the guidelines and how the various drafts were reviewed before release.

An update plan formulated for updating the guideline after release should be documented. An expiry date should be included as well as a list of operational definitions of terms used. The actions recommended by the guidelines and the logic and evidence behind the recommendations made should be clearly documented. Any anticipated benefits or harms around the use of the guidelines should be described as well as any value driven patient choices.

A graphic representation of the process to be followed in implementing the guideline such as an algorithm should also be included and any anticipated barriers to the implementation of the guidelines should be documented (Oxman, Schönemann and Fretheim, 2006 ( e ): 4 of 6). Oxman, Schönemann and Fretheim, (2006 ( e ): 1 of 6) further suggest that evidence quality should be clear and that a standard approach, adapted to the specific guideline in question, should be used.

### **2.9.13. Disseminating and implementing guidelines**

Fretheim, Schönemann and Oxman (2006 (c)) found that very few evaluations exist around changing clinical practice in developing countries (Fretheim, Schönemann & Oxman (2006 ( c ):3 of 4). The authors found systematic reviews relating to health care manager and policy maker decision making, where the evidence shows that the

timing of and the relationships between researchers and policy makers increase the use of research by policy makers. These authors suggest that implementation strategies are best formulated in the local context by local health leaders (Fretheim, Schünemann and Oxman, 2006 ( c ):3 of 4).

#### **2.9.14. Guideline Evaluation**

Oxman, Schünemann and Fretheim (2006 (f)) suggest conducting regular reviews of existing guidelines using an evaluation tool such as the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (WHO, 2010:6). These authors suggest including elements such as public health, health policy and equity in an adaptation of the aforementioned tool. Critical to such evaluations is determining the need for updating of existing guidelines. Oxman, Schünemann & Fretheim (2006 (f): 6 of 7) further suggest that experts who were originally not part of the development team should be requested to review the guideline periodically. Committees who develop guidelines should identify research priorities during their guideline development processes to inform subsequent research (Oxman, Schünemann & Fretheim, 2006 (f): 6 of 7)

It is evident from this very extensive series of articles produced by the authors Oxman, Schünemann and Fretheim (2006), that guideline formulation is a complicated, time consuming and resource driven process. It is also evident that using systematic reviews as a source of evidence or such issues as health service management may not be an easy project to undertake, but that existing guidelines should be updated, or adapted to suite individual contexts.

#### **2.10. CONCLUSION**

This chapter has presented the literature review and includes discussion of the relevant studies that are available with respect to human resources management of nurses in health care organizations, the emotional effects of leadership on nurse managers, the prevalence of HIV and TB among healthcare workers and the impact this has in the workplace in the form of absenteeism, stigmatization and nurse deaths. The legislative framework within which nurse managers work in South Africa was presented, and relevant policies and acts were highlighted. Finally an overview of guideline formulation was presented.

The next chapter will present the study methods used, the research paradigm of the study, the philosophical underpinning to the study, the research design, data collection, data analysis, trustworthiness and the ethical considerations of the study.

## **CHAPTER 3**

### **METHODOLOGY**

#### **3.1. PHILOSOPHICAL UNDERPINNING OF THE STUDY**

The philosophical point of departure determines what will be studied, the framework for data collection and analysis (Streubert Speziale & Carpenter, 2007:197). There are various schools of thought in ethnography, which include classical; systematic; interpretive (hermeneutic) and critical (Streubert Speziale & Carpenter, 2007:196). Classical ethnographies include and describe everything about the culture; Systematic ethnographies define what organizes the lives of the study group; Interpretive ethnography aims to discover the meanings of observed social behaviour, i.e. the culture is studied through analysis of inferences and implications found in the behaviour; and critical ethnographies rely on critical theory, i.e. the ethnographer along with members of the culture together create a cultural scheme and relate historical, social and economic situations with the focus on injustice and social oppression (Streubert Speziale & Carpenter, 2007: 196-197). Auto ethnography is theoretical with the ethnographer's subjective experience being central to the study while ethno nursing has nursing as the phenomenon of interest (Streubert Speziale & Carpenter, 2007: 196-197).

Initially this study was planned to be a critical ethnography. However, over time and following exhaustive reading of the subject of ethnography, I realised that I had made no mention of critical theory and that the focus of the study is not on injustice and social oppression. I realised that this study is an interpretive ethnography, which discovers the meaning of social practices and therefore follows an interpretive philosophy.

Nurse Managers, as an occupational group, is a culture in its own right, which has common practices which characterises the group as a specific work group. The sample in this study is a culture as nurse managers as an occupational group have common behaviours, beliefs and practices, despite being in different geographic areas or working in different organizations. Fundamental to the culture of nurse managers is planning, organizing, co-ordinating and controlling within a nursing

service (Huber, 2006:35). Culture is defined as the behaviours, beliefs and practices which characterise a specific group of people within their social, ethnic, age or work group (Leininger, 1991:95). The definition of culture can be extended to be the system of shared beliefs, values, customs, behaviours and artefacts that the members of society use to cope with their world and with one another, and that are transmitted from generation to generation through learning (Spradley, 1980:5-6). The basic foundation of culture is cultural traits, which can be material, interpersonal interactions, and can ultimately be abstract concepts and beliefs. Within cultures, various symbols, such as language and documentary artefacts, are symbolic of the studied culture and give meaning to the culture (Spradley, 1980:7). Symbols take on meanings in relationship to other symbols within a broader context of a meaning system. In order to understand the meaning of symbols, ethnographers need to determine how the symbols are related to one another and determine what principles join the symbols into bigger patterns and culturally whole phenomena, which is known as holism (Spradley, 1980:10). Holism departs from the perspective that cultural traits cannot occur on their own. Muller in Crabtree & Miller (1999:224) claims that culture influences not only what information is shared, but also how the information is shared with the ethnographer. Cohen, (2009:195) states that the three common characteristics of culture are that culture develops through an individual's interaction within an environment; that there are shared elements in culture; and that culture is passed from one generation to the next. Wilson (2010:202) refers to culture as *"the sharing of outlooks and modes of behaviour among individuals who face similar place-based circumstances"*.

### **3.1.1. RESEARCH PARADIGM**

A qualitative, non-experimental, constructionist approach was used with a reflexive ethnographic approach. The primary concept of ethnography is the nature, construction and maintenance of culture. Ethnography can be any description of a group as a way of identifying culturally common phenomena such as religion, social interactions or management styles (Goulding, 2006:298). Ethnography falls within the "emic" view (Hammersley & Atkinson, 2007:194; Hodgson, 2000, para2) and rejects the positivist approach, which is based on traditional scientific methods of experimentation (Hammersley & Atkinson, 2007:5; Hodgson, 2000, para 2) where artificial settings as well as / or what people say rather than what they do are studied



(Hammersley & Atkinson, 2007:6). The “emic” view is the main focus of ethnography and is the ethnographic research approach to the way the members of a culture perceive their world (Hammersley & Atkinson, 2007:7; Hodgson, 2000, para 2). As such, ethnography follows a “naturalistic” approach, where data collection occurs within the “natural” environment in which people live, work and interact socially and are not disturbed by the ethnographer (Hammersley & Atkinson, 2007:7; Hodgson, 2000, para 2).

### **3.1.2.EPISTEMOLOGY**

The epistemology central to ethnography is constructionism, which is described by Hammersley & Atkinson (2007:10-11) as the depiction of people, constructing their social world by the interpretation of the world by them and by their actions, which they base on their interpretations of their world. In this study, constructionism is used as the epistemology as nurse managers are depicted constructing their social world of the human resources management in respect of HIV and/or TB affected/infected nurses by their interpretation of that world and their actions, which is founded on their interpretation of the world of human resources management in respect of HIV and/or TB affected/infected nurses in the workplace.

### **3.1.3. THEORETICAL PERSPECTIVE (symbolic interactionism)**

Symbolic interactionism is the theoretical perspective in this study as it holds that people interpret stimuli and the interpretations of the stimuli change as events change and thus formulate the actions of people. The end result of the interpretation of stimuli is that different people will interpret the same stimuli differently, or an individual can interpret the same stimuli differently in different circumstances (Hammersley & Atkinson, 2007:7-8). As nurse managers interact with different individual HIV and/or TB affected/infected nurses and work in different organizations with different human resources management needs, they will experience different events and different people. Each individual nurse manager will have different interpretations of different situations and they will also interpret the same situations differently in different contexts.

### **3.1.4. RESEARCH APPROACH**

An ethnographic approach was selected as the study was conducted to participate unobtrusively in the working lives of nurse managers, for two years, observing what happened, listening to conversations, posing questions and collecting available data on the human resources management in respect of HIV and TB affected/infected nurses in the work place (Hammersley & Atkinson, 2007:3). This approach allowed me to become a part of the experiences and thoughts of the nurse managers and thus come to a better understanding of the deeper meaning of their culture. It will also allow readers of the research report to become more experienced themselves, through the reflexive character of ethnography (Hammersley & Atkinson, 2007:15 & 202). In this approach I became the research instrument (Hammersley & Atkinson, 2007:18; Streubert Speziale & Carpenter, 2007:199). The focus of the ethnographic approach was finding out what the observed practices were; what a ritual meant in the context of the nurse managers and, as such, the describing of and interpretation of cultural patterns (Streubert Speziale & Carpenter, 2007:200; Goulding, 2006:298). The main data collection sources in naturalistic settings are informant observation and unstructured, informal interviews (Hammersley & Atkinson, 2007:7). Ethnographic data can be analysed and reported as either interpretivism or symbolic interactionism (Hammersley & Atkinson, 2007:7 & 8; Hodgson, 2000, para 2, interpretivism and symbolic interactionism) and organized into “emic” and “etic” categories (Hammersley & Atkinson, 2007:194). “Emic” categories are categories which emerge as significant to the observed culture, i.e. the culture of the nurse managers tasked with the human resources management in respect of the HIV and TB affected/infected nurse, while “etic” categories are those used by the ethnographer to organize the research findings and to link them to theoretical debate (Hammersley & Atkinson, 2007:194).

### **3.2. ETHNOGRAPHY**

Ethnography is a description of a group as a way of identifying culturally common phenomena such as religion, social interactions or management styles (Goulding, 2006:298). The “emic” view is the main focus of ethnography and is the ethnographic research approach to the way the members of a culture perceive their world (Hammersley & Atkinson, 2007:7; Hodgson, 2000, para 2). As such, ethnography

follows a “naturalistic” approach, where data collection occurs within the “natural” environment in which people live, work and interact socially and are not disturbed by the ethnographer (Hammersley & Atkinson, 2007:7; Hodgson, 2000, para 2).

In this study, constructionism was used as the epistemology. Symbolic interactionism is the theoretical perspective in this study, as it holds that people interpret stimuli and the interpretations of the stimuli change as events change and thus formulate the actions of people. The end result of the interpretation of stimuli is that different people interpret the same stimuli differently, or an individual can interpret the same stimuli differently in different circumstances (Hammersley & Atkinson, 2007:7-8). As nurse managers interact with different individual HIV and/or TB affected/infected nurses and different organizations have different human resources management needs, they experience different events and different people. Each individual nurse manager has different interpretations of different situations and they also interpret the same situations differently in different circumstances.

### **3.3. DATA COLLECTION TECHNIQUES**

The ethnographic approach has six characteristics or techniques used by ethnographers in order to collect research data, these being the ethnographer as the instrument; fieldwork; the cyclic nature of data collection and analysis; the focus on culture; cultural immersion; and reflexivity (Streubert Speziale & Carpenter, 2007:199).

#### **3.3.1. The ethnographer as the instrument**

The main methods used by ethnographers in being the instrument of the research is that the nurse managers in the culture were interviewed and observed; the data of the culture was recorded and examined; and data was extrapolated from cultural documents (Streubert Speziale & Carpenter, 2007:199). The “emic” view involved recording the perspective of the nurse managers, as reflected by their use of language in describing their practices, beliefs and experiences (Streubert Speziale & Carpenter, 2007:199).

### **3.3.2. Fieldwork as a source of data collection**

Fieldwork is an essential characteristic of ethnography (Streubert Speziale & Carpenter, 2007:200). Issues involved in fieldwork include gaining entry to the field, impression management, field roles and managing marginality. In this research, entry to the setting involved obtaining consent to conduct the research and gaining access to the nurse managers employed in the selected hospitals. Consent to conduct the research was obtained from the relevant provincial health authorities, such as the Provincial Ethics Committee, the district authorities, the hospital authorities and the nurse managers themselves. Personalised, unstructured interviews were conducted with specifically targeted individuals, these being the nurse managers who plan the human resources in respect of HIV and TB affected/infected nurses who work in the wards of selected hospitals in KwaZulu-Natal, in South Africa.

The selected nurse managers were initially contacted by telephone to arrange interviews and this was followed up with an email to confirm the conversation before I made a personal visit to set an appointment or to conduct the interview. Direct and honest explanations were given regarding the nature of the study. At the first meeting, I determined how he/she would prefer us to set up times for meetings which were appropriate to his/her work. Meetings were confirmed at least one week prior to the date of the meeting (Noy, 2009:458 - 459).

Impression management required that I did not wear the uniform of a nurse manager, but rather wear clothes that are fitting for the role of a field worker. I therefore wore formal, professional, neat suits, without my epaulettes, thus keeping a position of acceptable "marginality". However, the reality was that at the first visit to a hospital, I realised that I would more likely be accepted in a position of acceptable "marginality" if I had in fact worn my uniform and epaulettes. Neither my gender nor age were perceived to be an issue as the nurse managers were also female, but I do acknowledge that it could have been an issue if one of the nurse managers had been male (Hammersley & Atkinson, 2007:68;73;76). Cultural stereotypes of ethnicity were not an issue, despite the ethnographer being white while the nurse managers were predominantly African and Asian (Hammersley & Atkinson, 2007:75).

Field roles can vary from complete observation to complete participation. One of the aims in this study was to maintain a “marginal” position, which is a position of being neither in nor out of the group and neither a complete observer nor a complete participant (Hammersley & Atkinson, 2007:89), which I believe was achieved.

Initially, I watched what people were doing, listened to what was being said, asked for explanations, formulated ideas and acted on the ideas so as to formulate an idea of the social structure of the setting and start to understand the informants’ culture. At this stage, I also conducted unstructured interviews with the informants and encountered experiences of self-revelation, self-doubt and inadequacy and found it difficult to bracket my own pre-conceptions and theoretical knowledge.

Changes in role can be made as the fieldwork progresses and aid the obtaining of relevant data and a sense of any bias in each role (Hammersley & Atkinson, 2007:79; 82; 86). However role changes were minimal through the duration of field work and I did not become a complete participant in the culture.

### **3.3.3. Participant observation**

Informant observation allows the ethnographer to remain detached whilst taking part in the topic under study (Eisenhart, 1988:105). As informant observation was used in this study, a formal observation guide with a set of questions was designed to direct the observations (Williamson, 2006:87 & 88) (Annexure 1). I was a non-participant observer in that I did not function as a nurse manager in the settings (Goulding, 2006:301).

Nursing management offices and nurse managers use documentation as an integral part of their daily lives (Hammersley & Atkinson, 2007:122). These documents were used to form part of the study as they provided data in respect of the setting in which the study took place, the context of the setting and who the key people in the hospital were, e.g. the organograms and organizational structures. As the data obtained from the documents was not always evident from informant observation or interviews, it was a source of verification of data provided by the nurse managers in informal and formal interviews and through observation. The documents were also a source of analytic ideas when developing generic concepts and/or formulating comparative analysis. Documents were not only obtained from the research setting,

but also from external sources such as electronic websites and databases (Hammersley & Atkinson, 2007:122 - 123).

Interviews are a form of informant observation which may be informal or formal (Hammersley & Atkinson, 2007:108). Informal interviews are difficult to separate from informant observation, but were used to reduce the potential of audience effect (Hammersley & Atkinson, 2007:108,177). Formal interviews, on the other hand, take place in a particular setting, which may result in data collected in these settings varying from data obtained from informal interviews (Hammersley & Atkinson, 2007:108). The presence of the interviewer, the role taken by the interviewer, the interview setting, the manner in which the interviewer presents him/herself in the interview, maintaining the interview situation, and interview context, may all impact on the interview and the data obtained from it (Hammersley & Atkinson, 2007:108-109).

The role taken by myself in this study was that of active interviewer in that the interview setting was used as a source of data. Due to the unnatural nature of an interview, I was able to compare what the nurse managers said and during my interviews with them with what they said and did in their daily work setting, which allowed me to understand how the individual behaved in different situations. To obtain a temporal context of the data, this study combined the data obtained from both interviews and informant observation. This allowed for determining the implications of time in both of the data collection sources and allowed for analysing what was said and when it was said over the course of both the interviews and informant observation (Hammersley & Atkinson, 2007:180).

#### **3.3.4. Informants**

Ethnographies develop through the collaborative relationship between the ethnographer and the informants, where the informants speak in their own "language". This provides a model which the ethnographer can mimic and information which the ethnographer can use (Spradley, 1979:25). Informants are ordinary people who do ordinary things, becoming informants of valuable information and any person can be used as an informant. A good informant is a person who is thoroughly absorbed in the culture and knows it well, is involved in the culture at the

time of the study, is found in an environment which the ethnographer knows little about, has enough time to spend with the ethnographer and does not analyse during the interactions with the ethnographer. According to Spradley, (1979:46), initial informants must meet all the above characteristics, whereas subsequent informants need not satisfy them all.

How long the informant has been part of the culture is important. Spradley, (1979:48) suggests that a minimum of one year full time is ideal. The length of time that the primary informants have been a part of the culture in this study is summarised in the table below.

**Table 3. 1: Summary of informants' length of time within the culture.**

Hospital A	Hospital B	Hospital C	Hospital D
8 plus years	10 plus years	10 plus years	20 plus years

Spradley (1979:29) warns against confusing subjects, respondents and actors with informants, as each role has a specific purpose in a study and one informant can take on each of these roles within a single study. This author makes the distinction that the language of the ethnographer is used to engage with respondents, while the language of the informant is used when engaging with informants (Spradley, 1979:31) and it is the phrasing of the questions which is of importance. Actors become the item observed in the natural environment, which is the means used to listen to and watch people in their natural environment (Spradley, 1979:32). The ethnographer must separate between treating people as actors and informants during the course of the research (Spradley, 1979:34).

Selection strategies can change during the course of the study according to the particular circumstances at the time (Hammersley & Atkinson, 2007:4). Initially, this study envisaged the use of four hospitals: one district public sector hospital, one Department of Health subsidised independently managed hospital, one private hospital and one regional hospital. It became necessary to change the selection of the study informants, however, as the nurse managers or unit managers who had

been approached at the private hospitals approached consistently refused to participate in the study. They were of the opinion that their staff did not fit the profile of nurses under discussion and that they could not contribute to the study in any shape or form. The nurse managers who participated in the study, therefore, were restricted to those who were employed by the public sector and semi-private hospitals. However, although the information obtained at the initial meeting with the nurse manager of the private hospital is limited, it has been included with the signed consent of the nurse manager.

Purposive selection is recommended for this type of study in that the informants must meet the criteria set by the phenomenon being studied (Creswell, 1998:118; Williamson, 2006:87). Nurse managers tasked with the monthly human resources planning of nursing staff were purposefully selected and those who did not have the experience of planning the monthly human resources of nursing staff were initially excluded from the study. However, during the course of the study, other categories of people emerged as being relevant to interview and observe and selected through either informant identification or observer identification or both and formed a basis for analytic ideas and strategies which added to the data collected (Hammersley & Atkinson, 2007:38).

During my time spent with the nurse managers, I determined at what time of every month each individual nurse manager planned the human resources for the staffing of the hospital for the following month. Temporal patterns and temporal variations were established so as to determine when it would be best to enter and remain in the field. This was done so as to ensure sufficient time spent in the situation to obtain the required data. Time in the field was interspersed with time for writing field notes, transcribing audio recordings and data analysis. In order to confirm the data collected during the interviews, I negotiated with the nurse managers to allow me to carry out observations at specifically important times of the day, weeks and months during which the human resources planning was done. The time selection in this study included the day to day, mundane and extraordinary periods of time and events (Hammersley & Atkinson, 2007:36 - 37).

I had to remain aware that I would need to identify contexts in which the informants act and therefore sample across all of the contexts that were relevant to the study



(Hammersley & Atkinson, 2007:39). In this study, the contexts which were relevant were the informants' own offices, the offices of the senior nursing services managers, Nursing service management meetings and one on one interviews with individuals. Individual meetings with unit managers and staff doctors were not necessary as data redundancy had occurred prior to my setting up meetings with them. Context changes did occur and required variable behaviours by me. For example, I was an informant observer in staff tea lounges, while, I became a non-informant observer or interviewer in people's offices (Hammersley & Atkinson, 2007:39). There was no need for me to employ an assistant to help me when the contexts changed as I adapted my own role to suit the context which I was collecting data.

In this study, theoretical selection was used in that I selected informants who represented the characteristics I believed were relevant to the study, these being the nurse managers who plan the human resources of nurses in hospitals in the eThekweni district of KwaZulu-Natal (Williamson, 2006:87)

Unstructured, open ended interviews were conducted with the selected nurse managers, who represented all the nurse managers who had agreed to participate in the study. An adequate number of informants were the number of informants that were required for no new information to be obtained from the repeated interviews. Nineteen (19) informants were utilized in this study before data redundancy was reached. This number included the three primary informants, the one nurse manager at the private hospital at my initial meeting with her and fifteen opportunistic informants. The observation in my research journal dated 5 October, 2012 reflects:

*"Once I had data, I instinctively, when reading the transcripts, formulated further questions and identified further informants as opportunistic samples and collected more data" [ethnographer research Journal; 5 October 2012].*

Following new leads during the field work and capitalizing on the unexpected flexibility which presented itself in the settings which included events or encounters as they occurred in the field (Richie & Lewis, 2003:81) lead to my conducting confirmatory interviews with human resources officers/managers; occupational health nurses; infection prevention and control officers; a safety officer;

representatives of the Health Risk Management Company who advise employers on employee incapacity leave and ill health retirement applications, and a representative of the KwaZulu-Natal Department of Health Human Resources Directorate and employee representatives. This brought the number of informants to a total of nineteen (18 + 1). A focus group meeting was also held with representatives of an employee organization.

Table 3.2. below is a summary of the sampling strategies used, hospital sites, demographic information of informants and the data collection methods used in this study.

**Table 3. 2:** Sampling strategies, hospital sites, informants and data collection methods.

Type of selection used	Site	Hospital type	Participant	Demographic information	Data collection method
Theoretical					
	Hospital A	district	Assistant Nursing Services Manager	African female; Age - 60s	Non-participant observation; Unstructured and structured interview
	Hospital B	Government subsidised	Night superintendent	Asian female; Age – 30s	Non-participant observation; unstructured and structured interview
	Hospital C	Private	Nursing Services Manager	European female; Age – 50s	Unstructured interview <b>Refused to participate</b>
	Hospital D	Regional/Tertiary	Assistant Nursing Services Manager	African female; Age - 50s	Unstructured interview
Opportunistic					
	Hospital A		Human resources officer	African male; age - 30s	Unstructured and structured interview
			2 - Occupational Health Nurses	African females	Unstructured and structured interview
			Infection Prevention and Control Nurse	African female	Unstructured interview
	Hospital B		Human Resources Manager	European female; Age - 40s	Unstructured interview
			Safety officer	European male; Age - 60s	Unstructured interview
			Infection Prevention and Control Nurse	African male; Age – 30s	Unstructured interview
			Occupational Health Nurse	African female;	Unstructured interview

				Age - 40s	
	Health Risk Management Company	Provides advice to employer re granting of incapacity leave and/or ill health retirement	Administrator  Medical practitioner	European female; Age - 40's  European male; Age - 40s	Unstructured interview  Unstructured interview
	KwaZulu-Natal Dept of Health Human Resources Directorate	PILIR champion		Asian female; Age - 50s	Unstructured interview
	Employee representative organization	Employee representatives		seven (7) representatives	Focus group discussion

The ethnographer informant relationship changes as the research progresses (Spradley, 1979:79). Spradley (1979:79) describes the relationship between informant and ethnographer progressing through the stages of apprehension, exploration, cooperation and participation. In the case of my study, I had feelings of apprehension which were expressed by me in my field notes

*"I am apprehensive about setting out on this research journey and doubt my own abilities."* [Ethnographer, 18 July 2010]

I did make a conscious effort to eliminate informant apprehension and started all my interchanges with informants with the question, "*What have been your experiences in respect of Human Resources management related to nurses who are either HIV affected/infected and/or TB infected in the hospital?*" This allowed the informants to talk freely about their experiences and seemed to work well as I did not perceive any apprehension on the part of any of the people interviewed (Spradley, 1979:80).

Cooperation requires mutual trust between the informant and the ethnographer so that they know what to expect from one another and from their participation. It is important that the informant understands that during this stage it is his/her role to educate the ethnographer about the culture being studied (Spradley, 1979:83). Spradley (1979:83) describes three principles to be used in building a relationship with the informant, which are: explaining often; repeating statements and asking how things are used and not what they mean. Exploration developed quickly during this

study, as indicated below, where an informant was eliciting information from me in order to find out more about me.

*".....the type of patients that we have now are so sick, maybe you've never nurse them?"* [NSM, site A: 1 December 2009]

### **3.3.5. The cyclic characteristics of data collection and analysis**

Data is collected in the field so as to describe human differences and similarities and leads to more questions about the studied culture (Streubert Speziale & Carpenter, 2007:200). Finding solutions to the new questions results in further questions and so the ethnographer is involved in a continuous process of interviewing, observing, reviewing documents, analysing the data and going back to the field to conduct further interviews and observations, and to obtain more documents (Streubert Speziale & Carpenter, 2007:200). (Refer to section 4.9.1.) This cyclic process results in the ethnographer repeatedly interviewing, observing, reviewing artefacts, analysing the new data collected and returning to the field to repeat the cycle. Time and available resources are the usual limiting factors in this process (Streubert Speziale & Carpenter, 2007:200).

During the course of data collection and analysis, I returned to the field three to four times for each site to conduct further interviews, observe the informants in different contexts within the course of their daily work and constantly reviewed artefacts collected all through the process. However maintaining the cyclic process of observation and interviewing was difficult as I was exposed to what I perceived to be negative reactions from informants as is indicated by the following excerpts:

*"Must you come back again? We are so busy. Mrs.... is not in"*[Secretary, site A, 7 January 2011]

*[[I called on 13 April 2011 and spoke to the secretary in the Nursing Service Management office, asking her to inform the Occupational Health Nurse Manager that I will be able to honour the appointment. The secretary did not give the message to the Occupational Health Nurse Manager so the OHN was afternoon off.]]* [Ethnographer field notes, site A, 14 April 2011]

*"I was hoping you weren't going to come. But we will be finished by 11 o'clock, won't we? I have so much to do!"* [NSM, site A, 19 August 2011]

Due to my familiarity with the culture and as a consequence of comments such as those above, I became very conscious of “being an intrusion” in the work lives of the informants.

### **3.3.6. The focus on culture**

The entire aim of ethnographic research is to understand the lives of individual people who are connected through membership of a group. Ethnographers work to find and interpret the cultural meanings found within a group of connected people. The primary concept of ethnography is the nature, construction and maintenance of culture.

Culture is defined as the manner in which a group behaves, what the group produces or how it works in a functional manner and what ideas, beliefs and knowledge are utilized by a group of people as they live their lives (Streubert Speziale & Carpenter, 2007:200 - 201; Spradley, 1979:5).

Symbolic interactionism is the theoretical perspective in this study as it holds that people interpret stimuli and the interpretations of the stimuli change as events change and thus formulate the actions of people. The end result is that different people will interpret the same stimuli differently, or an individual can interpret the same stimuli differently in different circumstances (Hammersley & Atkinson, 2007:7-8). Symbolic interactionism emanates from three premises: that people act toward things founded on the meanings that things have for them; that meanings are founded on interaction with other people in society; and that meanings are interpreted differently by different people (Spradley, 1979:6-7)

As nurse managers interact with different HIV and/or TB affected/infected nurses and the organisation they work for has different human resources needs, they experience different events and different people. Each individual nurse manager has different interpretations of different situations and they interpret the same situations differently in different contexts.

The discovery of the cultural themes required immersion and during the course of this study I “immersed” myself in the work lives of nurse managers by observing how each one dealt with the human resources management in respect of HIV and TB

affected/infected nurses in the workplace. This took two years of intermittent observation, interspersed with periods of data analysis (Streubert Speziale & Carpenter, 2007: 201) i.e. from December 2010 to November 2012. Implicit in immersion is that I spent long periods of time focusing on the themes which emerged (Streubert Speziale & Carpenter, 2007:219), which has taken at least a year. Thematic choice cannot be made at the beginning and reflection is required as possible themes emerge from the data (Hammersley & Atkinson, 2007:194).

Use was made of both “emic” and “etic” categories. “Emic” categories are those of the nurse managers, termed “folk models” or “folk terms”, which include language, images and ideas which come from the culture itself (Hammersley & Atkinson, 2007:194; Spradley, 1979:108), while “etic” categories are my ideas and are used to title chapters or section titles (Hammersley & Atkinson, 2007:194). The aim of immersion is to identify patterns that were not previously evident at a specific point in the study and to explore previously found patterns, so as to ensure that they are feasible and valid (Streubert Speziale & Carpenter, 2007:219).

### **3.3.7. Reflexivity**

Reflexivity is defined as the ambivalence created by not only being a researcher, but also a member of the culture (Streubert Speziale & Carpenter, 2007: 201). In other words the researcher discusses the experience and, at the same time, lives in the culture (Streubert Speziale & Carpenter, 2007: 202). The use of reflexivity in the field and in narratives is advocated by many ethnographers such as Hammersley & Atkinson (1995 & 2007), Rosaldo (1993), Coffey (1999), Davies (1999), Foley (2002). Ethnographers become a part of the social world which they study (Hammersley & Atkinson, 1995:14). The researcher therefore changes the culture by his/her presence and, as such, may lose his/her objectivity and distance from the participants and the phenomenon being studied (Streubert Speziale & Carpenter, 2007: 202). Reflexivity results in a better understanding of a phenomenon and the cultural relationships within the culture (Streubert Speziale & Carpenter, 2007: 203) and enables us to debunk any ideas we may have of ethnographic narrative being objective reflections of what is real and concrete truth (Foley, 2002:473).

Reflexivity is described as being confessional, theoretical, textual and deconstructive (Foley, 2002:469) and is used during all field roles, data collection and analysis, as well as the ethnographic report writing process (Foley, 2002:473). Confessional reflexivity is traditionally used in auto ethnographic studies (Foley, 2002:469) and studies using Standpoint Theory (Foley,2002:474). Methodologically, ethnographers are compelled to investigate the “self-other” interaction more critically in the field in order to produce a defensible narrative (Foley, 2002:473). Auto ethnographers are openly subjective and as such the ethnographer is a living, exposed, contradictory, “multiple self” who develops a subjective, culture bound narrative (Foley, 2002:474). Auto ethnographers are required to be exposed observers and interpreters by being emotionally open (Foley, 2002:474). The use of autobiographic memories is required as well as the author’s emotions, such as sadness, guilt, anger or fear (Foley, 2002:475). Standpoint theorists require a placed, embodied, analytic manner of knowing based on solidarity and sensitivity from class and culture struggles (Foley, 2002:475). Both auto ethnography and standpoint theorists recommend intuition and experience as a way of knowing (Foley, 2002:475). As such the narrative language used in confessional reflexivity is day to day language, literary language of metaphor, irony, parody and satire, rather than scientific social language (Foley, 2002:475). The use of personal memories, stories and comparison of the observed with their own experiences becomes a part of the ethnographic narrative in confessional reflexivity (Foley, 2002:475). By keeping oneself as the self/author during cultural interaction with the participants in the study in confessional reflexivity, the ethnographer places him/herself in important positions. By observing the cultural scene, the ethnographer becomes a less elevated and authoritative participant and it forces the ethnographer to personally recognize the contribution of other people to the study and his/her responsibility to those people (Foley, 2002:475).

### **3.3.7.1. Theoretical Reflexivity**

According to Foley, (2002:476), theoretical reflexivity is based on the study of everyday experiences as lived by the participants and the ethnographer moves backward and forward in a “circular” motion between what he/she is seeing and his/her own ideas and experiences. Theoretical reflexivity then results in an objective, true reflection of the “cultural other”. This author further argues that the ethnographer must take into consideration how the debates and practices of his/her

own profession impacts on how and what he/she thinks and writes. The ethnographer thus places his/her practices within previous knowledge, which results in the nature of the data created being socially and historically clear, therefore negating the bias of his/her assertions (Foley, 2002:476). In theoretical reflexivity, the ethnographer therefore critically analyses the disciplinary and professional debates and contexts which influence his/her own thinking and interpretation and must practice a systematic, disciplined abductive (deductive and inductive) process of developing a theory in and against the traditional debates of their discipline (Foley, 2002:477). In other words, the ethnographer has his/her own conceptual framework through which he/she creates themes used for depicting the accepted cultural and political practices observed (Foley, 2002:477). The themes which emerge are always able to be reformulated within the field in which they were produced, they are the “lens” through which the culture is seen (Foley, 2002:477).

Concept formulation, subjective narratives (Ajjawi & Higgs, 2007:614), field notes, participant observation, documents or written narratives are used retrospectively to identify themes or concepts and interpret the themes related to the culture (Hammersley & Atkinson, 1995:7). Themes are described as simple, common meanings “seen” by the participants and researcher or “structures of the experience” and are not relevant except that they give control and structure to the research and the writing of the research report (van Manen, 2003:79, 87). They are abstract ways of describing the phenomenon one is attempting to understand (van Manen, 2003:87). Themes are a means to an end, the end being finding the meaning, giving structure to and describing the parts of the whole meaning and always the breaking down of meaning into its parts (van Manen, 2003:88).

### **3.3.7.2. Textual Reflexivity**

In textual reflexivity, documents are reflected upon. The documents may be historical documents or the eloquent use of representational practices such as policies, procedures and legislation (Foley, 2002:477).

### **3.3.7.3. Deconstructive Reflexivity**

The narrative, as the end product of an ethnographic study, requires an ethnographer to write the text in fragmented, single sentences, which move the



responsibility of making meaning of the text to the reader. In other words, the narrative is written in an unexpected, unconventional manner (Foley, 2002:480). This can be done by making use of endnotes, visual/verbal images, the author placing him/herself as a character in the text, and by teasing out the data into single sentenced examples of what was said and/or seen at the time in the field and interspersed with theoretical explanations, as well as the ethnographers own reflections related to his/her own experiences (Foley, 2002:480). In this way the ethnographer makes the text personal and reflexive and therefore more available and open to the public (Foley, 2002:480). In this study I have written the report using single sentence examples of what was said or what I saw in the field and included my reflections of how I experienced the field experiences.

### 3.4. FIELD EXPERIENCE

The following section describes my experiences in the field during data collection and includes the initial plan I had for data collection and the process of data collection that I followed.

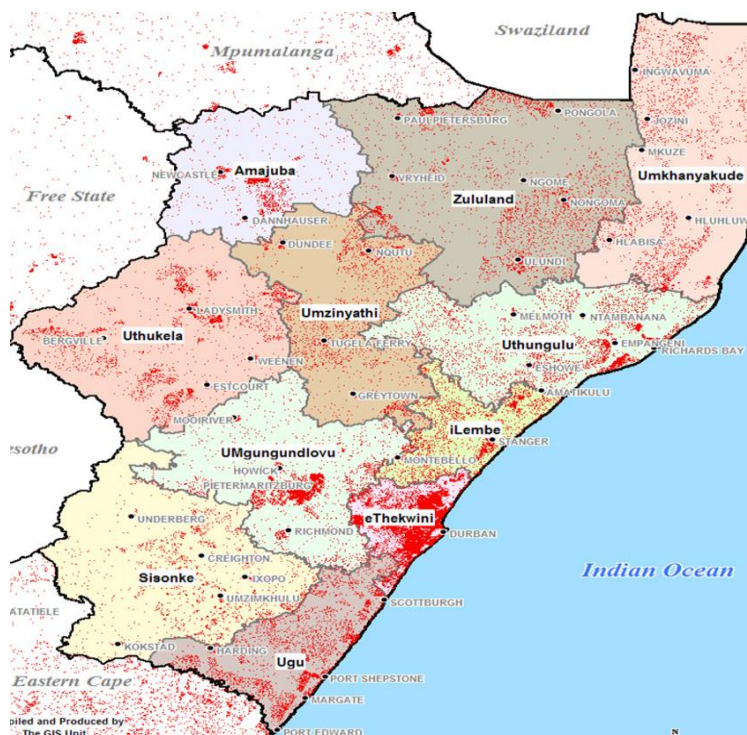
#### 3.4.1. RESEARCH SETTING

The study was conducted in urban hospitals in the province of KwaZulu-Natal, South Africa, as shown in the table 3.3. below (which was initially a template, flexible and subject to change as the study progressed).

**Table 3. 3:** Summary of Research Setting

URBAN AREAS	DISTRICTS	HOSPITALS	PUBLIC/PRIVATE
Durban	eThekwini	Hospital B Hospital C Hospital A Hospital D	Level 1; Semi-Private Private hospital Level 1; Public hospital Level 2; Public hospital Level 2 & 3; Public hospital

KwaZulu-Natal is situated on the east coast of South Africa. The district selected for this study is indicated on the map below as DC 22. This district was selected as it has a high prevalence of HIV and TB and is the district in which the ethnographer lives and works. The hospitals selected were level 1 and 2 hospitals in the eThekhwini district.



**Figure 3. 1: Map of KZN Health Districts**

District and regional hospitals were selected, but Tertiary level hospitals were excluded from the study. The hospitals were selected from the Hospital Year Book of South Africa (2007: 172- 180). The inclusion criteria for the selection of the hospitals to participate in the study were dependent on the availability and agreement of the nurse managers tasked with the human resources planning of the nurses to staff the hospital. The reason that urban hospitals were selected was based on the fact that the majority of women who are HIV affected/infected in KwaZulu-Natal are found in urban areas (Shisana et al., 2009:35).

#### **3.4.1.1. Description of the settings**

The following table summarises the settings and offers a comparison of the settings in terms of the informants, types of hospitals and the number of beds in each hospital.

**Table 3. 4: Descriptions of the settings and informants**

	<b>Hospital A</b>	<b>Hospital B</b>	<b>Hospital C</b>	<b>Hospital D</b>
<b>Informants</b>	African Zulu speaking	Asian English speaking	European English speaking	African Zulu speaking
	Age – 60s	Age – 30s	Age - 40s	Age – 50s
<b>Public/Private sector hospitals</b>	Public Sector	Government aided Independently managed	Private	Public Sector
	Medical care One surgical ward only	Medical care Only basic surgery performed	General	General
<b>Number of beds</b>	209	200	163	922

### **3.4.1.2. Hospital A**

Previous to 2003, this hospital was a tertiary hospital, but has since been re-established as a district hospital. As a consequence of the change in the level of care provided at this hospital, many employees have left its employ. The hospital comprises an acute medical (overnight stay) ward as well as one surgical ward. All the remaining wards are medical in nature. An accident and emergency unit was established, which includes an operating theatre. An obstetric service and an outpatient service are also available.

This particular hospital has always had high standards as a result of its history of being a tertiary hospital. This was verbalized by the NSM.

*"Our standards have always been high"* [NSM, site A, 1 December 2010].

The perception of constantly high standards in the hospital has resulted in the current employees' perceptions that the change to a district hospital has resulted in their hospital *"being degraded"*. However, this hospital was in fact downgraded from a tertiary to a district hospital.

*"being degraded"* [NSM, site A, 1 December 2010]

The staff establishment in the nursing service has also been changed. There are employees who have been medically boarded as a result of being absent for over one year from work. Nurses were rotated every three months when it was a tertiary hospital, which is no longer necessary. Employees who have received further training by the hospital or on their own motivation have had to resign as there were no posts for them in the higher category when they returned, even though the nurse manager motivated for them to be "*translated*" or upgraded when they had completed their training.

The informant told me that she has no norm documented that can be used as a guide as to how many staff can be granted annual leave in any one month, but that she learnt "theoretically", taking the number of staff available, that seven to eight nurses could be on leave in any given month. She has also stated that

*"if we look at the disease pattern, it's not the same as before"*[NSM, site A, 1 December, 2010]

The senior management team of this hospital consists of a hospital manager, a medical manager, a nursing manager, a human resources manager, a finance and systems manager and a pharmacy manager. At the time of the study, the pharmacy manager's post was vacant.

*"It is interesting to note that all these positions are filled by women in this particular hospital"* [Ethnographer, 25 February 2012].

The Vision of the hospital is

*"To achieve optimal health status for all persons within our catchment area"* [Hospital Vision, online, 25 February 2012].

It's Mission

*"to provide a sustainable, integrated, comprehensive and quality service delivery by:-*

*Upholding the rights and dignity of customers / clients; Upholding holistic quality care; Maintaining a healthy and safe environment; Continuing community involvement and Providing a comprehensive and integrated health service"* [Hospital Mission, online, 25 February 2012] .

The core values of the hospital are:

*"Team work; Openness and transparency through communication; Trust and integrity; Compassion; Innovation; Respect and courtesy"*  
[Hospital core values, online, 25 February 2012]

Within the public sector, contracting TB (TB) is regarded as an injury on duty (IOD). As at December 2010, there were four professional registered nurses away on long term sick leave, which had an impact on service delivery. Added to which there were staff members on maternity leave, annual leave and condoned study leave, which together resulted in a staffing shortage. The hospital is a receiving site for community service nurses, who are professional registered nurses awaiting registration with the South African Nursing Council (SANC). They are helpful, but require support from a qualified registered professional nurse.

The staff establishment in the nursing service is around 200 nurses for a hospital with 209 beds. Although the hospital still had services to commission, staff who had resigned, were sick or on maternity leave were not being replaced and the nurse manager responsible for staff planning was required to provide staffing for the newly commissioned departments from her existing staff.

To add to these challenges, according to the informant, the district manager of the eThekweni district believed that the hospital was over staffed and that there should be more enrolled nurses and enrolled nursing assistants than professional registered nurses.

The nursing management must maintain a high quality of patient care, and rely on an adequate good staffing norm to do so. They have not calculated their own staffing norm.

#### **3.4.1.3. Hospital B**

This hospital has been in existence since 1927 and is managed on a daily basis by a trust, as well as receiving additional funding from the Provincial Health Services of KwaZulu-Natal. It is registered in terms of the Non-Profit Organizations Act (Act 71 of 1997) as a Non-Profit Organisation (NPO) and is a Section 18A income tax exempt organisation. The hospital is situated on the outer boundary of the eThekweni district.

It is a 200-bed, level one district hospital, serving a population of approximately 750 000 people. According to the 2011 National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa, the eThekweni area has a prevalence rate of 38% (South Africa, DOH, 2012:32). It is the referral hospital for some 19 government community clinics and operates with a budget of approximately R107 million.

The patient profile is people from previously disadvantaged semi-rural areas who still have inadequate employment opportunities and health care providers. More often than not, the people are poor, malnourished, diseased and the victims of violence. Patients and their families have little or no means to pay for health care services. Often families are unable to take their loved ones home on discharge because they are unable to pay for transport to get them home. Children are often abandoned in the hospital and the parents cannot be traced because contact details given to the hospital staff are inadequate or they did not give these details to the hospital on admission.

The disease profiles of patients admitted to this hospital are related to HIV opportunistic infections, kwashiorkor and mersasmus or gastroenteritis as a consequence of inadequate water supplies within the communities. TB is rife among the patients seeking medical care in this hospital

The Hospital's Mission is:

*"We are missioned to imitate the healing ministry of Christ by rendering holistic, dedicated and compassionate health care to the communities we serve, in good stewardship of our resources"* (Hospital Mission, online, 25 February 2012) .

The hospital values are

*Compassion; Commitment; Integrity; Working Together; Mutual Respect and Continuous Development* (Hospital Values, online, 25 February 2012)

*"It is interesting to note that this hospital website only refers to nursing in the context of the Nursing college, no mention is made of nursing in the hospital services provided"* [Ethnographer, 1 December 2012]

Three hundred and seventy (370) nurses train at this hospital each year,

*"So there are about six hundred nurses easily"* [SO, site B, 7 February 2012]

*"Which explains people telling me there are about 600 nurses in this hospital"* [Ethnographer, 2 December 2012].

There are in fact, as at December 2012, two hundred and sixty four full time nursing employees at this site, added to which are three hundred and seventy nurses in training, which makes a total of six hundred and thirty four nurses.

#### **3.4.1.4. Hospital C**

This hospital is a private, 163 bedded, level one district hospital. It provides medical, surgery, midwifery and occupational health services within its catchment area.

This hospital has as its vision,

*"delivery of world class healthcare" which is achieved through quality care and personal patient and family care"* [Hospital Vision, online, 2 December 2012]

I met with five unit managers of this site on 8 February 2011 and explained the study methodology to them. I explained the difference between participant observation and non-participant observation and said I needed to liaise with a person who was happy to allow me to work with her and to shadow her. The unit managers informed me that they were unable to see the value in my being in the unit observing mundane day to day actions and thought that I would get more valuable information from interviews.

*"I wonder if they feel threatened by the process or me?"*  
[Ethnographer, 8 February 2011]

I explained that the purpose of my study entailed finding out hospitals' experiences with the phenomenon of nurses who are HIV and or TB affected/infected. One of the unit managers brushed me off, responding that as this only happens from time to time,

*"If there is not a person with such a problem, what will you observe?"* [UM, European, 1, site C, 8 February 2011]

I left them with consent forms to complete and said I would collect them at my next visit, which was scheduled for 22 February 2011. As I was leaving the NSM said.....

*"if you feel they are being obstructive tell me!"* [my exclamation]  
[NSM, site C, 8 February 2011]

I had to make it clear to the NSM that participation in the study was voluntary and that any potential informants should not be coerced into participation.

The plan of action on 22 February 2011 was to collect data from the unit managers in the form of a focus group discussion. The nurse manager or her deputy meets with the unit managers every afternoon at 15h00 and the plan was that I could have the 15h00 meeting with the unit managers.

*"Our meeting commenced at 15h20. I arrived at 14h55"*  
[Ethnographer, 22 February 2011].

The group comprised five people, one African, one Asian and three European unit managers,

*"who had all selected to sit in the same position around the table as they had done on my previous visit"* [Ethnographer, site C, 22 February 2011] .

We met in the board room which had a central oval table, with chairs and built in cupboards down the left wall. My description of how the five people were placed at the table uses the analogy of a clock with the 12h00 (the direction I was facing) as the point of departure. The hospital founder's photograph was on the wall at 12h00.

Starting at 12h00 *[[as I looked at the table from where I was sitting; Asian, three European, African]]* [Ethnographer, site C, 22 February 2011].

*"None of the five signed the informed consent forms"* [Ethnographer, site C, 22 February 2011].

One person was the spokesperson.

*"She is known to me, as she has worked at the hospital, from before my becoming the Deputy, then nurse manager there in about 1996"*  
[Ethnographer, site C, 22 February 2011].



The group could not see the value of their contributions to my study, especially, my non-participant observation of their mundane every day activities. They stated that they had not experienced any staffing problems/issues related to HIV or TB infected nurses. Employees are on medical aid and get ART. One sister had just had an employee put on ill health retirement and she said it had only taken two days from completing and submitting the documents to the approval of the individual's ill health retirement. They are empowered to use agency staff to replace people when they are sick. The Asian sister did however state that she had experienced problems related to a lack of direction in what to do to get people through the process of ill health retirement:

*"There is no documented guideline, we had to obtain information from a colleague, if we were aware that someone among them had previously done this"*[UM Asian, site C, 22 February 2011]

They observed that they did admit many nurses from public sector hospitals to their wards. The spokesperson stated that 20% of their staff were agency staff and that if it were to become 60%, it would become a problem for them.

She did state, however, that

*"morale problems have been experienced"* [UM, European 1, site C, 22 February 2011] .

She also stated that,

*"initially staff had been dismissed"* [UM European, 1, site C, 22 February 2011]

*"but since dismissal no longer happens, the staff are supportive of one another as the diseases are now de-stigmatized"* [UM European, 1, site C, 22 February 2011].

The unit managers declined to sign consent forms and said that they did not wish to participate in the study. I thanked them for their time and assured them that I did not wish them to perceive that they were being coerced into participating and that they had the right not to participate. I left the room and the hospital at 16h55. In keeping with the ethical requirements of the study I had not used the audio recorder without

their permission. Therefore all the information of this interview was recorded in the field notes only.

*"AT NO STAGE DURING ANY INTERACTION AT THIS SETTING WAS MY DIGITAL AUDIO RECORDING ON"* [Ethnographer, 22 February 2011].

#### **3.4.1.5. Hospital D**

This hospital is a 922 bedded regional and partly tertiary hospital which caters for patients from KwaZulu-Natal and the Eastern Cape provinces in South Africa. The hospital was first opened in 1936 to only African patients. I met with the SNSM of this hospital in his office. The meeting was brief as this informant was ill and going home as soon as we had concluded our meeting. During the meeting he telephoned both the ANSM and his secretary to inform them that I could conduct my research and that on the following day I could meet with all 8 ANSMs of the hospital after the early morning hand over, which I did.

I met with the 8 ANSM in the board room, where they held the early morning hand over between the day and night staff. There were in fact 10 people present. The room contained a large rectangular table with at least 20 chairs around it, in which the ANSM's sat. There were many empty chairs. On the walls of the board room were various cultural artefacts such as framed pictures and documents. Among the pictures were photographs of the President of South Africa, the Premier of KwaZulu-Natal and the South African Deputy President as well as an aerial photograph of the hospital. Among the documents on display were the following: Accreditation received from the Council for Health Service Accreditation South Africa (COHSASA); 2 certificates of commendation and a baby friendly hospital initiative document. I joined the meeting at 07h35, once the secretary arrived at work, and sat quietly observing and listening to the discussion.

The hospital vision is

*"To be a leading hospital in providing innovative quality health service in the spirit of ubuntu"* [Hospital Vision, online, 2 December 2012]

The hospital Mission is

*"To provide a coordinated, integrated and sustainable health service within the district health system through:*

*Incorporating the principles of Batho Pele in our daily practices.*

*Recruiting, developing and retaining a generation of appropriately skilled and motivated health workers*

*Optimal management and cost effective utilization of resources*

*Creating a culture that promotes team spirit" [Hospital Mission, online, 2 December 2012]*

### **3.4.2. PARTICIPANT SELECTION**

Hammersley & Atkinson (2007:4) state that participant selection strategies may change during the course of the study in respect of when and who the study informants will be and where the study will occur. During the course of this study, it did become necessary to change the selection of the study participants. The nurse managers or unit managers who were approached in the private sector hospitals refused to participate in the study, as they were of the opinion that their staff did not fit the profile of nurses under discussion and they did not believe that they could contribute to the study in any shape or form. The study, therefore, was restricted to informants who were employed in the public sector and semi-private hospitals.

The componential selection of informants within cases included selection of people, time and context (Hammersley & Atkinson, 2007:35).

#### **3.4.2.1. Selection of people or participants**

Purposive selection of nurse managers who were tasked with the monthly human resources' management and planning of nursing staff was done. This entailed meeting with the senior nursing services manager of each site to determine who would be the most appropriate individual to participate in the study.

It was necessary that informants meet the criteria set by the phenomenon being studied, i.e. that they were nurse managers tasked with the monthly human resources' management of nursing staff during the time of data collection (Creswell, 1998:118). Nurse managers who did not have experience in the management and planning the monthly human resources of nursing staff in the specific hospitals were excluded from the study.

It became evident during the course of the study that there were other categories of people who emerged as being relevant to interview. Identification of these informants was made through both participant identification and my opportunistic identification, which formed a basis for analytic ideas and strategies which added to the data collected (Hammersley & Atkinson, 2007:38).

### 3.4.2.2. Selection of time

During my consultations with the nurse managers, I ascertained what time of the month each of them planned the human resources for the staffing of the hospital for the following month. Temporal patterns and variations were established to determine when it would be most appropriate for me to enter and remain in the field. This was done to ensure sufficient time was spent in the situation to obtain the required data. Time in the field was interspersed with time for writing field notes, transcribing audio recordings and data analysis and resulted in protracted periods of time away from the field.

I attempted to negotiate specifically important times of the day, weeks and month with the nurse managers, but found this especially difficult. As the time selection in this study included both the mundane day-to-day and extraordinary periods of time and events (Hammersley & Atkinson, 2007:36- 37), some of the informants approached could not see how their mundane day-to-day periods of time and events could be of any value to my study.

**Table 3. 5:** Summary indicating best time for observation per hospital.

<b>Hospital</b>	<b>Time of month</b>	<b>Time of day</b>
<b>Hospital A</b>	First two (2) weeks of the month	07h00 to 16h00
<b>Hospital C</b>	Refused participation	
<b>Hospital B</b>	First two (2) weeks of the month	18h00 to 06h00
<b>Hospital D</b>	First two (2) weeks of the month	07h00 to 16h00

#### **3.4.2.3. Context selection.**

Context changes did occur and required variable behaviours by me. For example, in staff tea lounges, I was a participant observer, while in people's offices I became a non-participant observer or interviewer (Hammersley & Atkinson, 2007:39). The contexts which were relevant were the informants' own offices and the offices of the senior nursing services managers, where nursing services management meetings and one-on-one interviews with individuals were conducted. I selected to observe informants within these previously stated contexts.

#### **3.4.2.4. Theoretical selection**

I used theoretical selection in that I selected informants who represented the characteristics I believed were relevant to the study (Williamson, 2006:87), these being nurse managers who were tasked with producing and planning and managing the human resources of nurses in district hospitals in the eThekweni District of KwaZulu-Natal.

Unstructured, open ended interviews were conducted with the selected nurse managers, who represented all nurse managers who had agreed to participate in the study. The number of informants was deemed adequate when no new information was obtained from repeated interviews, i.e. redundancy had been reached. The decision on when redundancy had been reached was made between me and my research supervisor and co-supervisor. Together we agreed that redundancy had been reached in September 2012 following interviews with three primary informants and ten opportunistic participants, bringing the total to thirteen (13) informants. Although the private hospital I had contacted declined to participate in the study, I have included some of the data obtained from my original visits, with the permission of the informants.

#### **3.4.2.5. Opportunistic selection of informants**

Opportunistic selection of informants involved following new leads during the field work and capitalizing on the unexpected flexibility which presented itself in the settings. These included events or encounters as they occurred in the field (Richie & Lewis, 2003:81) and led to my conducting confirmatory interviews with a total of ten informants which included two human resources officers/managers in hospitals A

and B; two occupational health nurses in hospitals A and B; two infection prevention and control officers in hospitals A and B; a safety officer in hospital B; two representatives of a health risk management company who advise employers on employee incapacity leave and ill health retirement applications and a representative from the Human Resources Directorate of the KwaZulu-Natal Department of Health. A focus group discussion was also held with seven representatives from an employee organization (Refer Table 3.2. page 68).

#### **3.4.2.6. Gaining entry**

Entry to the setting was dependent on being given consent to conduct the research and interact with the nurse managers employed in the selected hospitals. Consent to conduct the research was obtained from the provincial health authorities, through the Provincial Health Research and Knowledge Management Secretariat, the district authorities, the hospital authorities, and the nurse managers themselves.

Direct and honest explanations were given at all times regarding the nature of the study. Initial contact was made by telephone in order to set up interviews with each selected nurse manager and this was followed by an email to confirm the conversation before making a personal visit. My intention to use email as a means of communication proved to be difficult with this group of informants as they either did not read their emails or had programs which were incompatible with the version of Microsoft word used by me, which resulted in difficulties when sending them copies of the research proposal, ethical clearance letters and requests for their input around transcripts and other information produced through this study. Therefore, at the first meetings, I determined how each of the informants would prefer us to set up times for meetings which were appropriate to his/her work. Meetings were confirmed at least a week prior to the date of the meeting (Noy, 2009:458 - 459). Table 3.6. below is a summary of what happened when informants were each contacted initially by me.

**Table 3. 6: What happened when informants were initially contacted.**

Hospital A	Hospital B	Hospital C	Hospital D	Risk Manager	Natalia HR	Unions
Initial telephone call made - sent proposal by email	Initial phone call made to deputy nursing services manager	<ol style="list-style-type: none"> <li>1. Initial phone call made to Chief Executive Officer</li> <li>2. Initial phone call made to nursing services manager</li> </ol>	I first made contact with the gate keeper at the hospital in second half of 2010, but felt that I was being ignored. I submitted all the required documents requesting for a meeting with the then NSM, but received no response. At the time I decided to move on to other sites and return to this site at a later date. July 2012, personally called on secretary of nurse manager and was referred to the person who manages all research in the site	Initial phone call made. Informed that I need to obtain permission from the Minister of Public Service to interview the Risk Manager. Phoned the Ministers office to find out what was required of me	Initial phone call to make an appointment with PILIR champion KZN Health website as a source of contact details has no contact details for Human Resources people	Emailed contact for each union found on web sites
Email was not responded to initially [unable to open Word document due to incompatible version]	Email sent to her	<ol style="list-style-type: none"> <li>1. Email sent to her</li> <li>2. Email sent to her</li> </ol>	Email sent to person who manages all research applications for the site	Couriered to Pretoria a copy of my proposal to Minister's office. Received written consent to interview risk manager	Emailed PILIR champion	Made appointment to conduct a focus group with one remaining - not cooperative
Follow up phone call made	Follow up phone call made	<ol style="list-style-type: none"> <li>1. Received reply email from nurse manager who did not believe that the nursing staff fitted the profile of my study. Had to seek another site</li> <li>2. Follow up phone call</li> </ol>	Made an appointment with the secretary. Arrived for the appointment to discover that the nursing manager was off sick for a few weeks.	Emailed risk manager permission letter from Minister	Follow up phone call made	Met union representative to make arrangements for focus group discussion and to "sell" the study to her

		made				
An appointment made for 15/10/ 2010	An appointment made for 14/10/2011	An appointment made for 10/08/2010	I met with him on 5 September 2012	Appointment made for me to interview risk manager in Pretoria on 28/10/2011	An appointment made for 23 May 2012	An appointment made for 27 September 2012

### 3.4.3. THE FIRST VISITS

The following section describes the context of the study by offering a description of my first visit to each of the sites in which this study was conducted. Included in this section the reader will find my own comments which were written in my field notes following my first visit to each of the sites. While it is not common practice to use the ethnographer's thoughts so early in a research report, I have included them to offer an insight into my own reactions to each of these visits.

#### 3.4.3.1. Hospital A

I arrived at the nurse manager's secretary's office and announced myself. I was asked by the secretary to sit down and wait for the nursing services manager. At the time, the cleaning supervisor was in the secretary's office.

*"secretary, open calm lady"* [Ethnographer first impression, site A, 15 October 2010]

The secretary informed me that as I had received permission to conduct the research from KwaZulu- Natal Health Department, the senior nurse manager felt that I could go ahead with the study and that I would need to see the nurse manager who planned the staffing for the hospital.

*"I feel I must make myself known to the senior nursing services manager"* [Ethnographer, site A, 15 October 2010]

I therefore first met with the senior nursing services manager and explained the study to her.

*"very positive response"* [Ethnographer, site A, 15 October 2010]

The senior nursing services manager then called the nurse manager who plans the staffing for the hospital into the meeting. She stated that she would be happy to work



with me, but that we would have to delay commencement of field work until the end of November 2010.

*"frustrated"* [Ethnographer, 15 October 2010]

The senior nursing services manager explained the current situation in the hospital. Two of their nurses had been booked off sick for twelve months and had applied to the risk manager in Pretoria for ill health retirement. The response from the risk manager was that the employees must be "placed back to work"

*"one is on crutches and can hardly stand"*[SNSM, site A, 15 October 2010]

*"occupying posts"* [SNSM, site A, 15 October 2010]

She continued to explain that although the hospital was short of nurses, she was unable to reallocate the posts occupied by the sick nurses. At one stage there were ten nurses away from duty on long term sick leave, and she was unable to fill their posts.

Once the statutory 36 days of sick leave are used up, the employees have to take unpaid leave, which places financial constraints on them.

*"nurses are in my office begging to work as they have huge debts to pay"*[ SNSM, site A, 15 October 2010]

The senior nursing services manager had attended a workshop on 14th October 2010 covering the Labour Relations Act (Act no. 66 of 1995 as amended 2002). When people asked how poor performance due to incapacity should be managed, they were told that poor performance due to incapacity must be used as a last resort. It was suggested that they place people in other departments if they cannot be placed in nursing posts.

*"we are expected to deliver service quality and care for staff"* [SNSM, site A, 15 October 2010]

*"How do they expect us to do this?"* [SNSM, site A, 15 October 2010]

The employee risk management policy states that a manager can appeal to the head office of the KwaZulu-Natal Health Department over employee risk management decisions.

*"I will do this and await a response"* [appeal] [SNSM, site A, 15 October 2010]

My last comment on these field notes:

*"a happy meeting"* [Ethnographer, site A, 15 October 2010]

### **3.4.3.2. Hospital B**

My first visit to hospital B was on 22 August 2011. I arrived at 11h50 for my 12h00 appointment. I had with me copies of ethical approval obtained from the university, the province and the hospital, as well as a copy of my research proposal to leave with the nursing services manager (NSM). On arrival at the main gate of the hospital, the security guard directed me to a parking within the hospital grounds. I entered the hospital reception area as instructed and was directed upstairs to NSM's office. There was no evident reception area, but I was directed to the office by one of the professional nurses who was in the passage at the time. There were two people in the office, both nursing service managers, and I explained my research and methodology to them.

The one NSM asked whether I had brought consent forms for the sick employees and I explained that they were not the target of my research. I was informed that the person who did the staff allocation was the night superintendent, who had worked in the nursing management office for a long time and had been doing the allocation for many years. The two NSMs had been in the Nursing Management office from January 2011 and April 2011 respectively. One of them informed me that I would be dealing with the other NSM as she had recently been diagnosed with a carcinoma and was to undergo chemotherapy. She had that day informed her staff and employer of the diagnosis. I thanked her for her time.

*"these things happen for a reason, I will retire shortly and will then be able to get involved in education around Carcinoma's in my retirement from the perspective of my own experience"* [NSM, site B, 22 August 2011].

*"I think about whether I have contributed sufficiently to nursing"*[NSM, site B, 22 August 2011].

*"feeling guilty about the state of the profession and wonder what else I could do to improve it"* [NSM, site B, 22 August 2011].

They agreed to inform the employees that I was conducting my research in the hospital and that they would arrange for me to meet the night superintendent. The NSM would inform me when I could commence my research.

*"I felt the meeting was positive and am excited about the prospect of moving to the next site"* [Ethnographer, Journal notes, site B, 22 August 2011].

I eventually secured an appointment to meet with the night superintendent [NS] of this site on 10 October 2011. In order to make the appointment, I communicated with the NS by email. The reason for the delay was that she works one week on and one week off and I had to wait for her to be on duty in order to meet with her. She had been ill herself and cancelled our first appointment, which meant waiting a further two week period before a date could be finalized. As this interview took place at night time, the NSM was kind enough to negotiate with the hospital authorities to permit me to sleep in the hospital guest flat after the interview. I live about 50 km from this site and felt that driving home after midnight was not safe. I also had to work the following day and would be tired if I had had to make the long trip home.

### **3.4.3.3. Hospital C**

I met with the nurse manager of this site at 14h00 on 10 August 2010 and explained my study to her. She agreed to discuss the possibility of participating in my research with the unit managers of the hospital.

*"The reason is that in private hospitals there is no regular staff rotation. Staff are placed in a unit, and remain there, unless they leave, or request a move"* [Ethnographer, site C, 10 August 2010].

*"The unit managers thus deal with the human resources issues among their staff and NOT the nurse manager or her deputy"* [Ethnographer, site C, 10 August 2010].

The NSM stated that she was happy to help, and suggested I also make an appointment to interview the Regional Human Resources Manager.

The NSM agreed that sick nurses are a problem,

*"particularly in getting nurses to admit that they are ill"* [NSM, site C, 10 August 2010].

*"Often they need to work to support and feed extended families"*[NSM, site C, 10 August 2010].

When employees have to take temporary disability/incapacity leave, they only receive a percentage of their salary, which makes it difficult for them to support their own and their extended families.

*"They try to stay at work for as long as possible"* [NSM, site C, 10 August 2010].

The NSM informed me that a senior member of her staff recently had a CD4 count of 10. The employee was admitted to a sister hospital for treatment and is now doing well. The process in their group of hospitals is that employees take sick leave or annual leave and then may apply for ex gratio leave and finally permanent disability. The informant indicated that the policy within this particular hospital is that sick employees can either work or are unable to work. This hospital does not encourage having sick employees at work.

*"organizational culture is that an employee can either work or not (there are no grey areas)"* [NSM, site C, 10 August 2010].

This informant continued to say that if the health of a nurse impacts on their efficiency or patient care then she MUST have sick leave or follow the process as described above. This hospital uses an agency to source staff in order to replace employees who are absent from work.

The informant made the following statement, which may be an indicator of the organisational culture around having sick nurses at work:

*"Private, paying patients cannot have sick looking staff caring for them, patients ask questions"* [NSM, site C, 10 August 2010].

She further informed me that there are CCTV cameras all over the hospital which are used in conjunction with nursing notes as evidence should disputes arise between patients and the organisation. The NSM stated that once employees have

commenced anti-retroviral treatment their condition improved, but sometimes employees refused treatment or denied that they were ill and that these staff members usually passed away very quickly. In this particular hospital, they knew that one of the registered nurses had been diagnosed with XDR/MDR.

*"Once staff are placed on ART, then they do well, but some refuse or deny that they are ill"* [NSM, site C, 10 August 2010].

*"These people die rapidly"* [NSM, site C, 10 August 2010].

The informant mentioned that medical practitioners often admit HIV infected patients to the hospital without informing the nursing staff of the patient's HIV status, which she perceived as a problem. This is illustrated in the following statement:

*"Medical practitioners, who admit patients to the hospital, do not inform staff of patients HIV status very often, which is a problem"* [NSM, site C, 10 August 2010].

I left the meeting with me agreeing to send the NSM an email copy of the research proposal along with the ethical approval, which I did. Once she had read the documents I had sent her, the informant gave me an appointment for the 8 February 2011 to meet with the hospital unit managers.

#### **3.4.3.4. Hospital D**

*"At long last today I met with the SNSM of .....Hospital"* [Ethnographer field notes, site D, 5 September 2012].

I first made contact with the gate keeper at the hospital in the second half of 2010, but felt that she was ignoring me. I submitted all the required documents requesting for a meeting with the then NSM, but received no response. I therefore decided to move on to other sites and return to this one at a later date.

In mid-2012, I again made contact with the same gatekeeper and sent her electronic copies of the required documents for the second time. She emailed me a letter requesting that I submit hard copies to her office, which I did. Within 48 hours I received a response that I had been granted permission to continue with my research at this site. Within two weeks of the date of receiving the permission, I had appointment to see the NSM. However, when I arrived on the given day and time, I

was informed by the secretary that NSM had been admitted to hospital and was thus unavailable.

I was out of the country for two weeks and finally got to meet with the NSM on 5 September 2012.

*"SNSM is not well and after seeing me today was on his way home sick again" [Ethnographer, site D, 5 September 2012]*

He agreed that I could conduct my research and stated that I must contact the assistant nursing services manager (ANSM) who would be deputising for him in his absence.

*"I will attempt to meet all the assistant nursing services managers (ANSM) of which there are 8 at the end of their meeting tomorrow morning" [Ethnographer, site D, 5 September 2012].*

The SNSM made the following statement to me:

*"if you have any problems with any of the ANSM's you must inform my secretary and even if I am still off sick I will make sure that they do not give you any problems" [SNSM, site D, 5 September 2012].*

*"It's interesting that this is the second nurse manager who has said this to me" [Ethnographer, 5 September 2012]*

I had to make it very clear that participation in my study was voluntary and that I would not request him to pressurise anybody to participate. This informant was the second nurse manager who, during the course of my data collection, had said to me that I should inform him/her if I experienced any problems with employees who may not want to participate in my study. As I had elected to ensure that any informant could withdraw from the study at any stage without penalty, I would be breaching the ethical considerations which I have stated I would use during the study if I were to inform the nurse manager of an informant's reluctance to participate,

I made the following notes in my field notes following my appointment with this informant:

*"I will rather bow out gracefully" [than coerce people to participate in the study] [Ethnographer, 5 September 2012].*

*"We will see what happens tomorrow"* [whether I have problems with the NSM's] [Ethnographer, 5 September 2012].

#### **3.4.4. DATA COLLECTION**

Data collection actually took place using non-continuous participant observation over a two year period. During this period of observation, interviews and document content analysis were done to obtain relevant data. I unobtrusively observed the informant nurse managers in their work environment, as a “marginal” non-participant observer. The nurse managers were fully aware of the purpose of the study and the study process (Refer Annexure 2).

During the course of the observation, interviews were conducted and with informant consent, recorded, using a digital audio recorder (See Annexure 3). Documentary content analysis was done at the same time, using relevant legislation, policies and procedures (Refer Annexure 5).

During any given day in the course of the fieldwork, field notes were made during the period of observation and after each observation ended. Once the observation period had been completed for the day, before leaving the hospital parking area, I sat in my car and added to the notes made during the observation in a note book which I carried with me wherever I went during the course of the field work. This enabled me to document my perceptions and what I had seen immediately after each field encounter (Spradley, 1980:70). The information I had recorded in my note book was then typed into a section titled, Field notes, in the Microsoft OneNote program, where I had set up a workbook. A separate sheet was used for each day of field work and the workbook contained all the information I had collected over the two years relevant to my study. It was in the field notes that I recorded information where I related what I had seen and heard, the answers given to questions asked, formulated or collected documents, as well as my own reflections on what was seen and heard and how my being a non-participant observer affected the data collection (Streubert Speziale & Carpenter, 2007:210). When documenting observations, use was made of language identification and both the verbatim principle and the concrete principle, which required the recording of what was seen and heard, in as much

detail as possible, without any interpretation (Streubert Speziale & Carpenter, 2007:211-213).

Language identification led to my distinguishing my thoughts from what the informants had said. I did however find this separation between ethnographer thoughts and informant speech very difficult to do in written field notes, but easier to achieve in the transcribing of the recorded interchanges. On occasion, I did manage to write down exactly what an informant had said during observation, thus using the verbatim principle and indicated separation of my thoughts from what I heard and saw as demonstrated below:

*“time is money”* [Ethnographer field notes, Unit Managers’ Meeting, site A, 14 September 2011]

*“Sister .....has to know who has transport and who doesn’t when deciding who to phone “I am desperate”* “[Ethnographer field notes, site B, 3 November 2011]

*“I showed her how to find information to use at work”* [[she is a University student]] [Ethnographer field notes, site B, 3 November 2011].

The use of the concrete principle was extremely challenging during my writing of field notes and I tended to use generalities so that I would not miss any information (Spradley 1980:68). Spradley (1980:68) states that the concrete principle is not easy as most of us are taught to “*condense, summarise, abbreviate and generalise*” and the writing of field notes requires “*expanding, filling out, enlarging and give specific detail*” within the notes. I found that I too have been taught to summarise and generalise information and found that I struggled with expanding and providing specific detail within the field notes which I wrote.

The field notes I took during the non-participant observation constituted condensed accounts of what had happened, what I heard and what I thought (Spradley, 1980:69). I did expand on the notes as soon as I could after the field encounters and found that during this process of typing the condensed version of the field notes, memories of what actually occurred in the field came flooding back to me, which I could add to the condensed notes (Spradley, 1980:70).



I kept a field work journal during the course of the study in which I recorded my thoughts, fears and experiences of not only the field work, but the whole ethnographic experience.

#### **3.4.4.1. Participant observation**

The purpose of participant observation is to participate in appropriate activities within the culture and also to watch the activities, the people and real life aspects of the culture. Ethnographers observe with the aim of both participating in the activities as they occur and watching what other people do and how they behave and interact with one another (Spradley, 1980:54). During participant observation, the ethnographer has to become very alert to the things people in the situation would normally not be aware of within the normal day to day participation in the culture. Achieving this heightened awareness was extremely difficult for me as I was so familiar with the culture that I was also unaware or "tuned out", rather than having a heightened awareness which ethnographers who are in an unfamiliar environment would become aware of (Spradley, 1980:56).

Initially, I conducted descriptive observations for each site, where I was attempting to determine "*What is going on here?*" (Spradley,1980:73). Spradley (1980:76-80) classifies the types of descriptive observations in the same manner that he classifies interview questions referring to grand tour observations and mini tour observations. Grand tour observations cover nine things to look for in any social encounter, which are spaces, actors, activities, objects, actions, events, time, goal and feeling. While all nine may not have the same importance in all social encounters, they can be used to assist the ethnographer in making grand tour observations (Spradley, 1980:78). Although I knew I should glean information during each observation around these characteristics, I did not really understand their significance and therefore found this difficult to do.

#### **3.4.4.2. The emic/etic challenge**

Ethnography falls within the "emic" view (Hammersley & Atkinson, 2007:194; Hodgson, 2000, para 2) and rejects the positivist approach, which is based on traditional scientific methods of experimentation (Hammersley & Atkinson, 2007:5; Hodgson, 2000, para 2) where artificial settings as well as/or what people say rather

than what they do are studied (Hammersley & Atkinson, 2007:6). The “emic” view is the main focus of ethnography and is the ethnographic research approach to the way the members of a culture perceive their world (Hammersley & Atkinson, 2007:7; Hodgson, 2000, para 2).

Emic language explanations are explanations given by the informant in the same language as would be used in normal conversation within the cultural setting. Examples of "emic" language in this study are as follows:

*"There was just one case that happened, not very long ago. It, it hit on me because this nurse was so good, she would teach other students, perfect."* [NSM, site A, 13 January 2011]

The emic language in the above quote is “*it hit on me*” which the informant explained as the case she described affected her badly in that the case affected her emotions.

*“One other thing that happens is the tendency is, say for the doctor to say even light duty area, you can work. Okay if you’ve got ten in the department that light duty area, so called because now you have to look at the area that at least there isn’t much traffic in this area let me put, but if you’ve got ten sick who is to go and who is not to go? So you now face a challenge of you’ve got to have sick and well people and the well ones not always understand the fact that this one is sick because at the end of the day we all get paid.”* [NSM, site D, 26 September 2012]

In the above example the emic language is “*light duty*”. The informant does not believe that there are light duty areas in a nursing service. Areas such as the CSSD and paediatric wards are examples of such light duty areas.

The ethnographer encourages the use of such language during interchanges between the informant and ethnographer as it is the language which the informant uses in mundane daily activities (Spradley, 1979:31).

Ethnographers use the language of the informants as a means to describe the culture of the informant. Whether the culture is evident or hidden, the nature of the culture is shown either through comments made by the informant or information gleaned through interviews with the informant. In this study, the ethnographer overheard examples of informant speech such as telephone conversations between

informants and sick nurses, informants telephoning nurses to come to work to replace staff who were not at work or personal discussions between informants and sick nurses. Society uses language to pass on its culture from generation to generation, and culture is found in speech (Spradley, 1979:9).

Cultural inferences are made by ethnographers through using what people tell them or say, from the way people act and from the tools they use (Spradley, 1979:8).

Human beings use language as means of constructing their reality. Different people speak different languages both within and outside the different cultures. Although research is often conducted in English, there are semantic differences between what people of the same language mean when they say something (Spradley, 1979:71). In other words an ethnographer's interpretation of what is meant by an informer always relies on some form of translation of what was said. The ethnographer must decide on whether he/she will use the informants' language or the ethnographer's language. This study uses both the informants' and ethnographer's language in describing the meaning and the language of that which was not obvious, i.e. theoretical sensitivity (Spradley, 1979:71; Corbin & Strauss, 1990:76).

Language forms the basis for the relational theory of meaning. Since informant meaning is what ethnographers use to describe a culture, cultural meanings are found in symbols. Language is the foundation of cultural symbolism in all cultures and is used to talk about the symbols found in the culture. Symbolic meaning is founded on the relationship of symbols with one another. Ethnographers break the code of the symbols and find the rules which support the symbols, which is done through finding the relationships between the cultural symbols (Spradley, 1979:99) i.e. symbolic interactionism.

The ethnographer informant relationship changes as the research progresses (Spradley, 1979:79). Spradley (1979:49-50) emphasises that when ethnographers research cultures that they are not familiar with, the very lack of familiarity results in them not taking things at face value. He claims it is best to have an informant who is very familiar with the culture studied working together with an ethnographer who is totally unfamiliar with the culture under study.

As a consequence of my own in-depth familiarity with the culture I studied, I experienced what I believe to be major problems. I found myself experiencing difficulty with conducting participant observation in that nursing services managers in this context often engage with employees in a confidential situation which requires privacy. However, I was witness to more than one encounter that nursing services managers had with employees, where they did not ask the employee if he/she would mind me being present. Although these dialogues provided me with valuable information, I felt very uncomfortable, as illustrated in my field notes and the following comments which I wrote.

*“I am finding being a fly on the wall very difficult. My instinct is to get involved.”* [Ethnographer field notes, site A, 28 March 2011]

*“I feel like taking her in my [Ethnographer] car and getting the problem solved!!!* [Ethnographer field notes, site A, 28 March 2011]

The fact that I wrote comments such as those was a clear indication of the difficulty I experienced in remaining a non-participant observer, as well as the familiarity which I had with situations as they unfolded before me. I also experienced difficulty with interpretation of information I obtained throughout the study, as well as during my data analysis, in that I kept instinctively wanting to base the information I received on my own theoretical sensitivity of the phenomenon. In spite of my own feelings, however, during the course of data collection it did not appear that anybody was uncomfortable with my presence when I was with them during non-participant observation.

I did discover very early on that image or impression management was a critical issue (Hammersley & Atkinson, 2007:68; 73; 76). I had initially intended to be as unobtrusive as possible by not wearing a uniform, but very quickly discovered that not wearing my uniform actually brought attention to me just because of my attire. I then decided to wear my uniform, which resulted in my being totally accepted into the culture at all the sites. My total acceptance was particularly evident during ward rounds with informants, unit manager meetings and morning hand over meetings between night and day staff, where there was little questioning of my presence during such every day cultural meetings between informants and employees.

I took on the role of a “marginal” informant observer, unobtrusively observed the

informant nurse managers in their work environment.

**Table 3. 7:** Summary of Data Collection Techniques and Interventions and Sampling Techniques used

<b>Ethnographic Characteristics</b>	<b>Data Collection Techniques</b>	<b>Practical Interventions</b>	<b>Sampling Technique</b>
<b>Ethnographer as Instrument</b>	Observer Informant for duration of study "Marginality"	Informal & Formal interviews Observation using Observation guide Document content analysis	Purposive Theoretical Criteria & Opportunistic
<b>Field work as a source of Data Collection</b>	Gaining entry/access  Impression management	Permission from gatekeepers: Email Telephone Personal Appointment  Appearance Attitude Gender issues Cultural Stereotypes Age Sex Race	Purposive Theoretical Criteria
Field roles	Marginality –Informant as observer & Observer as informant	Field notes Digital Audio taping	Purposive Theoretical Criteria & Opportunistic
Interviews	Unstructured	Digital Audio taping	Purposive Theoretical Criteria & Opportunistic
Documentary Content Analysis	Legislation Human Resource Policies Procedures	Photocopies Photographs Scanned digital copies	Purposive Theoretical Criteria & Opportunistic
<b>Cyclic Characteristic of Data collection &amp; Analysis</b>	Continuous interviewing, Observing, Reviewing documents, analysing data & returning to the field		Purposive Theoretical Criteria & Opportunistic
<b>The focus on Culture</b>	Observing group behaviour, productivity, ideas, beliefs and knowledge		Purposive Theoretical Criteria & Opportunistic
<b>Cultural Immersion</b>	Long-time non-continuous field work	One year to collect data "Emic" and "Etic" categories Make thematic choices Identify patterns not previously obvious	Purposive Opportunistic

<b>Reflexivity</b>	In the field In narratives In document review	Verify findings & challenge information from informants	Purposive Opportunistic
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### 3.4.4.3. Data collection instrument

I was the instrument of the research and interviewed and observed the nurse managers in the natural working environment (Streubert Speziale & Carpenter, 2007:199).

### 3.4.4.4. Ethnographic interviewing

Spradley (1979:58-68) describes ethnographic interviewing as a "speech event". The components of ethnographic interviews are the definite purpose of the interview, ethnographic explanations and ethnographic questions. The purpose of questions in this research was to elicit how nurse managers manage the staffing of hospital units, how they experience the management and planning and what the issues are that affect the clinical placement of the employee in environments in which employees are HIV and/or TB affected/infected.

Ethnographic explanations enable the informant to educate the ethnographer about his/her culture. There are five kinds of explanation which are: 1) project explanations, where the ethnographer explains the purpose of the study to the informant in easy to understand language whilst simultaneously receiving the informant's cultural knowledge during the interchange; 2) document explanations, where the ethnographer writes down information received, records the interaction between the informant and ethnographer or does both at the same time; 3) emic language explanations, which are explanations given in the same language as would be used in normal conversation within the cultural setting of the informant, with the ethnographer encouraging the use of such language during interchanges; 4) interview explanations, which assist informants to understand what is expected during the interchange and gives interviews a more formal nature (Spradley, 1979:60); and finally, question explanations, which may or may not be required to explain the kind of question one wishes to pose to the informant.

The main data collection sources in naturalistic settings are informant observation and unstructured, informal interviews (Hammersley & Atkinson, 2007:7). Informal interviews are difficult to separate from informant observation, but were used to

reduce the potential of audience effect (Hammersley & Atkinson, 2007:108,177). The interview itself becomes a clear setting in formal interviews, which may result in data collected in these settings varying from data obtained out of the formal interview (Hammersley & Atkinson, 2007:108). The presence of the interviewer, the role taken by the interviewer, the interview setting, the manner in which the interviewer presents him/herself in the interview, maintaining the interview situation, and interview context, may all impact on the interview and the data obtained from it (Hammersley & Atkinson, 2007:108-109).

Many interpersonal skills come in to play while interviewing informants, such as the asking of questions; attentive listening; verbally showing an interest in the informant; adopting a passive role; being interested and showing it by maintaining eye contact, among other nonverbal engagements (Spradley, 1979:46).

#### **3.4.4.5. Ethnographic questions**

Spradley (1979:60) states that he has identified more than thirty types of ethnographic questions. However the three main types of questions are descriptive, structural and contrast questions. Descriptive questions describe what an informant does or experiences, while structural questions enable the ethnographer to gather information around "domains", which are the basic units of explanation within the informant's culture and give an insight into how the informant organises the cultural knowledge. Contrast questions give the ethnographer an explanation of the meanings pinned to emic language within the cultural setting. Each of the three types of questions was introduced into the exchanges as the relationship developed between the ethnographer and the informant (Spradley, 1979:66).

Spradley (1979:86) also referred to descriptive questions as grand tour questions. As this study was conducted in various hospital locations, I needed the informants to provide me with the important features of the cultural scene. Therefore, a typical grand tour question with which I commenced my interaction with informants was, "*What have been your experiences in respect of human resources management related to nurses who are either HIV affected/infected and/or Tb infected in the hospital?*" (Spradley, 1979: 87). Another example of a grand tour question was asking

nurse managers to describe their typical work day, from the time that they arrived at work until they left for home.

Spradley, (1979:88) explains that mini tour questions are the same as grand tour questions, but are relevant to a very small part of an experience of the informant and follow initial domain analysis, occurring during subsequent encounters/interviews. These types of question are asked to verify or refute the ethnographer's explanation of the emic phrases used (Spradley, 1979:126). Mini tour observations and the related mini tour questions are what Spradley (1980:79) refers to as the same as those one uses for grand tour observation, but are related to more finite aspects of the experience studied. In other words mini tour observations and questions are what the ethnographer uses to describe the social detail of the culture (Spradley, 1980:84). The following is an example of a mini tour question I asked during the course of my field work.

*“and do you inform them that you can't place a person, but as you said, you don't mention the diagnosis, so in other words are you asking them for permission and getting their consent to discuss it or not?”* [Ethnographer field notes; 13 January 2011]

My presence and my effect on the interview process were used as a source of data. The role taken by myself in this study was that of active interviewer in that the interview setting was used as a source of data. I attempted to compare what the nurse managers said and did during the interviews with what they said and did in their work setting in order to understand how the individuals behave in different situations. Through changing the features of the interviews, I attempted to identify what aspects of the interview setting produced different responses. The manner in which I presented myself in the interviews also aided the identification of what produced varying responses from the nurse managers. To obtain a temporal context of the data, this study combined interviews with informant observation, which allowed for determining the implications of time in both of the data collection sources allowing for analysing what was said, when it was said over the course of both the interviews and informant observation (Hammersley & Atkinson, 2007:180).



Ethnographers do not enter into an interview with predetermined questions to ask, nor are they limited to one questioning method, but will have a list of issues to be covered during the interview (Hammersley & Atkinson, 2007:117).

In this study, personalised, unstructured interviews were conducted with specifically targeted individuals [informants], who were the nurse managers who plan the human resources in respect of HIV and TB affected/infected nurses who work in the wards of selected hospitals in KwaZulu-Natal, in South Africa. Unstructured interview guides were used to guide the informal interviewing of the informants (See Annexure 4).

### **3.5. DATA ANALYSIS**

Data analysis in ethnography occurs at the same time as data collection, but the discovery of cultural themes and the taking of a cultural inventory are specific to the data analysis phase (Streubert Speziale & Carpenter, 2007:219). Hammersley & Atkinson (2007:158) categorically state that there is no prescribed method for data analysis in ethnography, nor are there procedures which will ensure success. It is therefore vital that although ethnographers have no prescribed methods of data analysis, they must be aware that data is information with which to think. The lack of prescribed methods of data analysis became a major stumbling block for me, as I felt that I was going around in circles and not achieving anything. Eventually I discovered that Spradley (1979 & 1980) provided a prescribed method of data analysis which gave me a structure with which to work with my collected data

#### **3.5.1. The grand tour of all four hospitals**

During the initial visits to the four hospitals the ethnographer carried out an observation of the environment in which each of the nurse managers worked. Table 3.8. Offers the reader an insight into locations and objects identified during these grand tour observations.

**Table 3. 8: List specific locations and objects following Grand tour observation**

	Objects	Objects	Objects	Objects
Locations	Hospital A	Hospital B	Hospital C	Hospital D
<b>SNSM</b>	desk	desk	desk	desk
	Closed book case with	cupboard	cupboard	
	Chairs x 3	Chairs x 3	Chairs x2	Chairs x 3
	Desk top computer	Desk top	Desk top	Desk top computer
	Telephone	Telephone	Telephone	Telephone
	Wash hand basin			
	Photograph of daughter			
	Filina cabinet			Filina cabinet
<b>NSM</b>	Desks x2	desk	N/A	Desk
	Chairs x 10	Chairs x 2	N/A	Chairs x 5
	Closed book case with	Steel	N/A	N/A
	Telephone	Telephone	N/A	Telephone
	Wash hand basin	N/A	N/A	N/A
	4 drawer filina cabinet	N/A	N/A	N/A
	Desk top computer on a	Desk top	N/A	Desk top computer on a stand
	Table	N/A	N/A	N/A
	Notice board containing	N/A	N/A	N/A
<b>Board</b>	Tables x 2	N/A	Oval table	Very large rectangular table
	Picture frame containing	N/A	N/A	N/A
	Chairs x 25		Chairs x 10	Chairs x 20

	Mobile whiteboard x2		Built in	
	Honours Board		Photograph of	Framed Baby Friendly Hospital
	Shield x2			Arial photograph of hospital
	Hospital badge			Photographs of the President of
	Notice board			Framed COHSASA certificate
	Overhead projector			Framed certificates of
	Television on a stand			

### 3.5.2. Identifying the cultural themes

Identifying the cultural themes requires careful examination of the collected data so that repeated, implied and explicit patterns can be classified (Streubert Speziale & Carpenter, 2007:219; Hammersley & Atkinson, 2007:194). In accordance with the recommendations of Aronson, (1994, performing a thematic analysis), the transcribed interviews were used to identify patterns or themes which emerged from the interviews. Data that related to themes that had already been identified was collated together and related themes were then deconstructed into sub-themes. The end result was that the emergent themes were collated to form a picture of the culture of nurse managers' collective experience of human resources management in respect of HIV and TB affected/infected nurses in selected hospitals in KwaZulu-Natal (Aronson, 1994, performing a thematic analysis). Comment was then obtained from the nurse managers, which was used to formulate further questions which were included in the theme analysis (Aronson, 1994, performing a thematic analysis). The in depth literature review assisted me in making inferences in respect of the interviews conducted and the selection of themes. Thematic statements were then formulated so that a story line could be created (Aronson, 1994, performing a thematic analysis)

### 3.5.3. Taking a cultural inventory

The cultural inventory is the beginning stage of writing the ethnography. Its purpose is to begin organizing the data collected and requires listing cultural domains; listing

analysed domains; collecting sketch maps; listing themes; completing an inventory of examples; identifying and organizing domains; completing a table of contents; completing an inventory of miscellaneous data; and suggesting areas for future study (Streubert Speziale & Carpenter, 2007:220). Various computer packages were utilised, NVIVO 8 for data management; The Brain to create sketch maps; Microsoft Word to search for common phrases and words; and Microsoft One Note for recording and storing field notes.

#### **3.5.4. Interpreting the findings**

This study was organized using chronological data and trajectories as the major means organizing the report with sub-sections and chapters organized using trajectories as well as “emic” and “etic” categories, as suggested by Hammersley & Atkinson (2007:195) as being useful for data analysis based on careers, key processes and developmental cycles. As this study focuses on the process and cyclical nature of the human resources management and planning in respect of HIV and TB affected/infected nurses, I believe this was appropriate. The combining of the ethnographic findings with my own analytic commentary was done by the use of exploration between types and cases and through comparing an ideal case with the actual cases of the study. The ideal case was constructed to document the key features of the phenomena of human resources management in respect of HIV and TB affected/infected nurses, while the actual process was observed and constructed through interviewing the nurse managers who plan and implement the human resources management in respect of HIV and TB affected/infected nurses. A reflection has, therefore, been written of how the actual compares with the ideal, the concrete with the abstract, the local with the generic and the substantive with the theoretical. Hammersley & Atkinson (2007:164) distinguish between sensitizing concepts and definitive concepts. According to these authors, sensitizing concepts are unclear, unspecific concepts, which are suggestive, such as where to look for data as a point of departure for data analysis. Definitive concepts, on the other hand, are those which are common to objects, have clear definitions of characteristics or benchmarks and prescribe what data to look for (Hammersley & Atkinson, 2007:164).

### **3.5.5. Making a domain analysis**

Making domain analyses results in further questions to ask and making more observations to explore the roles and relationships among the informants of the culture studied (Streubert Speziale & Carpenter, 2007:215).

### **3.5.6. Making a taxonomic analysis**

A taxonomic (typological) analysis is a detailed analysis of the chosen domains (Streubert Speziale & Carpenter, 2007:216; Hammersley & Atkinson, 2007:172) and will result in identifying relationships either among the parts of the culture or the culture to the whole organization (Streubert Speziale & Carpenter, 2007:216). Further observations and more questions will emanate from the taxonomic (typological) analysis, as will the revelation of groups or categories, not previously thought of (Streubert Speziale & Carpenter, 2007:217).

### **3.5.7. Grounded theorizing**

Central to grounded theorizing is the repetitive process of formulating and creating clear research problems, which is on-going throughout the process of report writing and can be both formal and informal in nature. In its formal form, it begins to occur in analytic notes and memoranda, and in its informal form it is a part of the researcher's ideas and hunches and, as such, feeds into the research design and data collection processes chosen. This is the process which is used in grounded theory as well as ethnographic research which does not generate theories, but generates descriptions and explanations. The core to grounded theorizing is the relationship between data and ideas (Hammersley & Atkinson, 2007:158-159). Grounded theorizing has traditionally been used in pragmatist symbolic interactionism (Hammersley & Atkinson, 2007:166). The total complexity of the social situation of nurse managers' human resources management in respect of HIV and TB affected/infected nurses was treated as the unit of analysis using the following three analytic strategies. Situational maps were used as a means for expressing the elements of the situation and examining the relationships between the expressed elements; mapping of the social world as a depiction of collective commitments, relations and sites of action; and positional maps as strategies for simplified plotting of positions stated and not stated in arguments, discussions, narratives as well as visual and past data which

resulted in complex relationships between the levels and layers of the situation (Clarke, 2005:86).

Table 3.9. below is a summary of the data analysis method, technique and interventions used and the anticipated outcomes of this study.

**Table 3. 9: Summary of the data analysis method, technique and interventions used, and the anticipated outcomes.**

DATA ANALYSIS METHOD	TECHNIQUE	INTERVENTIONS	OUTCOMES
Discovery of Cultural Themes	In depth examination of verbatim transcribed interviews	Find repeated implied patterns Themes were deconstructed into sub – themes Comment from informants re authenticity of transcriptions (NVIVO 8)	Further questioning of informants  Literature review for argument development  Formulate thematic statements
	Grounded theorizing	Reformulating research problems Formal informal	Occurs in analytic notes & memoranda “etic” ideas & hunches <b>Situational maps</b> to express situational elements & relationships between elements <b>Social world mapping</b> to depict collective relations, sites of action <b>Positional maps</b> plot positions stated or not stated in arguments, discussions, narratives, which will result in complex relationships between the levels and layers of the situation
Cultural Inventory	Initial report writing	List cultural domains – <ul style="list-style-type: none"> <li>• Public Sector</li> <li>• Private Sector</li> </ul> List analysed domains Collecting sketch maps Listing themes Completing inventory of examples	Completed Ethnographic report
Interpreting Findings	Data organization  Own analytic commentary	Chronological data Trajectories	Chapters & sub sections organized by trajectories & “emic” & “etic” categories Literature review
	Domain analysis	Each setting People Places Documents activities	Formulate a structure for later informant interaction & Identify patterns/themes from already collected data
	Taxonomic (typological) Analysis	Detailed analysis of each setting	More questions Groups /categories not

		Identifying interdepartmental relationships Further observation  Relate Themes to Theoretical framework	previously identified
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Hammersley & Atkinson (2007); Crabtree & Miller (1999) and Streubert Speziale & Carpenter (2007).

### 3.6. GUIDELINE DEVELOPMENT

The purpose of this study was to formulate draft guidelines to assist nurse managers in the human resources management in respect of HIV and/or TB affected/infected nurses. The ethnographer formulated draft guidelines using Oxman, Schünemann & Fretheim (2006 e: 4 of 6) as a framework for the headings within the guidelines. These authors produced a series of sixteen articles which discuss and describe the step by step process of developing guidelines for the WHO. After reading all these articles, article 14 of the series was selected as most appropriate as a framework to guide the formulation of the draft guidelines in this study.

Table 3.10. below is a summary of the steps for guideline formulation and includes the relevant article title, the authors and the year each article was published.

**Table 3. 10: Summary of steps for guideline formulation (Oxman, Schünemann & Fretheim, 2006)**

Nr.	STEP	TITLE	REFERENCE
1		Improving the use of research evidence in guideline development: <b>1. Guidelines for Guidelines</b>	Schünemann, Fretheim & Oxman (2006a)
2	<b>Priority setting</b>	Improving the use of research evidence in guideline development: <b>2. Priority setting</b>	Oxman, Schünemann & Fretheim (2006a)
3	<b>Group composition and consultation process</b>	Improving the use of research evidence in guideline development: <b>3. Group composition and consultation process</b>	Fretheim, Schünemann & Oxman (2006 a)
4	<b>Managing conflicts of interests</b>	Improving the use of research evidence in guideline development: <b>4. Managing conflicts of interests</b>	Boyd & Bero (2006)
5	<b>Group processes</b>	Improving the use of research evidence in guideline development: <b>5. Group processes</b>	Fretheim, Schünemann & Oxman (2006 b)
6	<b>Determining which outcomes are important</b>	Improving the use of research evidence in guideline development: <b>6. Determining which outcomes are important</b>	Schünemann, Oxman & Fretheim (2006)
7	<b>Deciding what evidence to include</b>	Improving the use of research evidence in guideline development: <b>7. Deciding what evidence to include</b>	Oxman, Schünemann & Fretheim (2006b)
8	<b>Synthesis and presentation of evidence</b>	Improving the use of research evidence in guideline development: <b>8. Synthesis and presentation of evidence</b>	Oxman, Schünemann & Fretheim (2006c)
9	<b>Grading evidence and recommendations</b>	Improving the use of research evidence in guideline development: <b>9. Grading evidence and recommendations</b>	Schünemann, Fretheim & Oxman (2006b)
10	<b>Integrating values and</b>	Improving the use of research evidence in guideline	Schünemann, Fretheim

	<b>consumer involvement</b>	development: <b>10. Integrating values and consumer involvement</b>	& Oxman (2006c)
12	<b>Incorporating considerations of equity</b>	Improving the use of research evidence in guideline development: <b>12. Incorporating considerations of equity</b>	Oxman, Schünemann & Fretheim (2006d)
13	<b>Applicability, transferability and adaptation</b>	Improving the use of research evidence in guideline development: <b>13. Applicability, transferability and adaptation</b>	Schünemann, Fretheim & Oxman (2006d)
14	<b>Reporting guidelines</b>	Improving the use of research evidence in guideline development: <b>14. Reporting guidelines</b>	Oxman, Schünemann & Fretheim (2006 e)
15	<b>Disseminating and implementing guidelines</b>	Improving the use of research evidence in guideline development: <b>15. Disseminating and implementing guidelines</b>	Fretheim, Schünemann & Oxman (2006 c)
16	<b>Evaluation</b>	Improving the use of research evidence in guideline development: <b>16. Evaluation</b>	Oxman, Schünemann & Fretheim (2006 f)

Online. <http://www.health-policy-systems.com> [Accessed: 28 April 2010]

A group of experts who made up an advisory group to assist in the process of guideline development was composed of nurse managers who plan and implement the human resources in respect of HIV and/or TB affected/infected nurses, as well as occupational health practitioners who care for such nurses in the workplace. Different processes are available to use for reaching consensus, with the most common methods being the Nominal Group Technique (NGT) and the Delphi Method and Consensus Conferences (Fretheim, Schünemann & Oxman, 2006 a: 4). Following the Nominal Group Technique, individual nurse managers were invited to be a part of a group which contributed amending the draft guidelines written by the ethnographer based on the findings of the study. The amendments to the draft guidelines were suggested by the members of the group, which was comprised of nurse managers and occupational health practitioners working in the eThekweni District of KwaZulu-Natal, who were not part of the informants selected to participate in the ethnography. Consensus was reached on the contents of the draft guidelines by all informants of the nominal group. The Nominal group method was selected in preference to the Delphi Technique, due to the fact that the Delphi Technique is time consuming (de Villiers, de Villiers & Kemp, 2005:642).

A literature search was conducted to determine whether there were any existing guidelines in the international domain which could be adapted. A search of South African grey literature revealed that certain guidelines have been formulated, but each of these related specifically to either HIV, TB, incapacity leave and ill health retirement, sick leave or “unfitness” to practice as a nurse. It became apparent that no single document was available which included all of the above mentioned. The



draft guidelines encapsulate all the former into one document. An implementation framework was formulated, following which, the draft guidelines will be disseminated and implemented. However, implementation of the draft guidelines does not fall within the scope of this study.

### **3.7. TRUSTWORTHINESS**

Trustworthiness is described as the quality of the final findings of qualitative research and the conclusions drawn from the final findings (Lincoln & Guber, 1985:291). Trustworthiness includes credibility, transferability, dependability and confirmability (Lincoln & Guber, 1985: 300).

#### **3.7.1. Credibility**

Credibility gives internal validity to the collected data and the interpretation of the data and was ensured by virtue of the duration of the study, which has been completed over a period of three years (Miles & Huberman, 1994:278-279; Lincoln & Guba, 1985: 314).

There are various techniques which qualitative researchers use to ensure the credibility of their work. A recognised and acceptable research methodology, triangulation and tactics to ensure honesty from the informants were techniques that were used in this study to ensure credibility as well as frequent debriefing sessions, peer review by my research supervisors, my own reflexivity documented in a field journal, member checks, information obtained opportunistically from people who were randomly encountered and rich description (Shenton, 2004:64–69).

##### **3.7.1.1. Triangulation**

Triangulation uses a combination of more than one research strategy in a single study. This improves the credibility of the data as the weaknesses of one method are compensated for by the strengths of another method. There are four types of triangulation from which an ethnographer can choose: data triangulation; investigator triangulation; theory triangulation and method triangulation. This study used data triangulation and methodological triangulation to confirm the findings and conclusions (Streubert Speziale & Carpenter, 2007:381). The data triangulation includes temporal, spacial and corporal elements. Data was collected at different

times in the multiple selected hospitals and from different people in a setting. Furthermore, other informants were identified to be interviewed as the study progressed (Streubert Speziale & Carpenter, 2007:383). The methodological triangulation included participant observation, unstructured interviews and field notes in order to determine what informants said to me was what they actually do in the course of their daily work. Sequential implementation was used, in that the qualitative study was completed and the findings were used to formulate the draft guidelines, which were read, discussed and amended by a nominal group of nurse managers and occupational health practitioners who had not participated in the study (Streubert Speziale & Carpenter, 2007:384).

In respect of the theoretical triangulation for this study, only symbolic interactionism was used as a framework. . Until such time as data is collected, it is difficult to say which theoretical frameworks are to be used. Hammersley & Atkinson (2007:159) state that it is a problem to make a total ethnography to fit only one theoretical framework. TB

### **3.7.2. Transferability**

Transferability envisages that the study findings can to be transferred to a similar, but different setting or context (Miles & Huberman, 1994:279; Lincoln & Guba, 1985:316). It is not the aim of qualitative research to be duplicated in exactly the same situations. The idea is that the study is context based, usually specific to a specific, geographic area, population and culture. To ensure transferability, details of the number of organizations, the context in which the study was conducted, how long the study took, who the study informants were, what data collection methods were used, how many and how long the data collection sessions were and how long it took to collect the data are recorded in the final research report (Shenton, 2004:70).

### **3.7.3. Dependability**

Dependability refers to the stability of the data and was ensured in this study by the long period of data collection (Miles & Huberman, 1994:278; Lincoln & Guba, 1985: 316). The data collection phase was non-continuous, taking place over a period two years until no new data was being obtained, i.e. data redundancy. The research report of this study has sections describing the research design, what was planned

and what was ultimately done, details of data collection in the field and a reflective evaluation of the study process, as it was done (Shenton, 2004:72).

#### **3.7.4. Confirmability**

Confirmability is the degree to which the data confirms the findings of the study through the keeping of a journal, field notes, an audit trail and record keeping of any changes to the method and, finally, my own reflections whilst conducting the study (Miles & Huberman, 1994:278; Lincoln & Guba, 1985:318). My own beliefs, values and norms, as well as decision making and methodological choices, which form the basis for decision making, have been recorded in the research report. In other words, trustworthiness was determined by means of using the ethnographic research design. My reflection was documented and concepts identified. The voluntary informants of the study responded to the unstructured open ended interviews and the nurse managers and I collaborated in respect of the interpretation, also allowing concepts to emerge. This discussion of how the interpretations arose from the data and the interpretative process are critical for the authenticity and trustworthiness of the study (Laverty, 2003:18; Ajjawi & Higgs. 2007:622, 623). Informants were given copies of the interview transcription for verification of the data found. My research supervisors also contributed to confirmability of the data findings in this study.

### **3.8. ETHICAL CONSIDERATIONS**

Ethical considerations in research are based on the ethical principles of respect for people, beneficence and justice, and as such have been put in place to ensure respect for informants, to protect them from harm and to ensure fairness in the process of the research study (Belmont Report. 1979:1-10).

This study subscribes to the ethical standards described by Emanuel, Wendler, Killen and Grady (2004:930-937). They state that exploitation of informants must not occur and that community participation, social value, scientific validity, fair selection of informants, positive risk-benefit ratio, independent review, informed consent and respect for informants should be taken into account.

### **3.8.1. Community Participation**

The study involved nurse managers and had the intention of informing guideline formulation in collaboration with nurse managers who plan and implement human resources in respect of HIV and TB affected/infected nurses. The chairperson of the SANC impairment committee was approached at the beginning of the planning of this study in respect of this research and he voiced a need for such research to inform the decisions of the impairment committee. The ethnographer networked with various nurse managers from different hospitals.

### **3.8.2. Social value**

The collected and analysed data was used to formulate practice norms and values for nurse managers to follow. It is hoped that the research will have an impact and input on the implementation of the impairment clause of the Nursing Act 33 of 2005. It will thus largely influence and benefit the life of every practicing HIV and TB affected/infected nurse in South Africa. The research will have a social value for HIV and TB affected/infected nurses, who will benefit from clearer human resources practices in their work place. It follows that nurse managers who make collaborative decisions with sick nurses about their wellbeing in the work place will benefit from clear guideline formulation.

### **3.8.3. Scientific validity and integrity**

The objectives of the study were to explore the experiences of nurse managers in the workplace when managing and planning human resources needs in respect of HIV and TB affected/infected nurses to work in environments which may further compromise their health. Nurse managers' were interviewed individually. Once the data was analysed, the collected data was initially transcribed by the ethnographer and later by a single data transcriber so as to ensure confidentiality. The electronic data base was saved on a computer and protected by a password, known only to the ethnographer. The recordings and data hard copies will be stored, locked in a safe, for five years at the School of Nursing and Public Health at the University of KwaZulu-Natal. All data will be destroyed five years after completion of the study using incineration or shredding of hard copy documents and electronic data will be permanently deleted.

#### **3.8.4. Selection of informants**

The informants (nurse managers) were purposively selected, but had the opportunity to refuse to participate in the research. Purposive sampling was needed as there is usually only one person in each hospital who is tasked with the human resources planning of nurses each month and the object and purpose of the study was to explore the culture of nurse managers who are faced with a sick workforce.

#### **3.8.5. Risk-benefit ratio**

No potential risks were foreseen in respect of the study subjects (Hammersley & Atkinson, 2007:218). The benefits to the profession of nursing outweighed the risk to the individual informants. Informants' names and identifying data have not been disclosed. The study was conducted in the workplace of each nurse manager (Hammersley & Atkinson, 2007:217). Although there were no costs to the informants who participated in the study, the ethnographer had to fund the meetings with the employee representative focus group and the nominal group. There was also a possibility that the ethnographer may experience changes to her own beliefs through conducting the research (Hammersley & Atkinson, 2007:21).

#### **3.8.6. Independent Ethics Review**

The Constitution of South Africa Act 108 of 1996 was central to any ethical considerations in this study in that the human rights of the informants are protected by this act. However, independent ethics reviews were obtained from the Research Ethics Committee of the University of KwaZulu-Natal, the provincial authorities, and from the ethics review committees of the individual hospitals.

#### **3.8.7. Informed consent**

The identity of all the nurse managers and the organizations in which they work has been protected. Informed consent was obtained in writing from each nurse manager and nominal/focus group member who volunteered to participate in the study.

#### **3.8.8. On-going respect for recruited informants and study communities**

Informants of the research were ensured that they could withdraw from the study at any stage without penalty (Hammersley & Atkinson, 2007:226). The informants were provided with information which was elicited in the course of the study (Hammersley

& Atkinson, 2007:215). Each participating hospital will receive its own copy of the end product of the research, as will the South African Nursing Council Impairment Committee, the office of the Premier of KwaZulu-Natal, the Health Risk Manager, the employee organization and the Director General of the Department of Public Service and Administration of the South African Government. The research will be published in a professional journal once completed, and the informants and the organizations where they are employed were informed that such publications will occur (Hammersley & Atkinson, 2007:214-216). Articles will be written, based on the findings of the research so as to further inform nursing management practice.

### **3.9. CONCLUSION**

In this chapter I have presented the methodology used, the research paradigm of the study, the philosophical underpinning to the study, the research design, data collection, data analysis, trustworthiness and the ethical considerations of the study.

In the following chapter the findings of the study will be presented.

## **CHAPTER 4**

### **FINDINGS OF THE STUDY**

#### **4.1. INTRODUCTION**

This chapter provides the analysis of the findings, which were triangulated by using grounded theorising, a document review and Spradley's domain analysis process (1979:107-112 & 1980:85-99).

The findings presented in this chapter are the result of observation, participant interviews and interviews I conducted with the informants to confirm the theoretical and opportunistic sampling and document analysis.

Data was analysed using in vivo coding [through the use of NVIVO version 8] and Spradley's domain analysis process (1979:107-112 & 1980: 85- 99), which enabled me to identify cultural themes, formulate a cultural inventory, and conduct domain and taxonomic analyses. Data was also analysed with reference to Hammersley and Atkinson (2007:158-159 & 166), which enabled me to use grounded theorising to produce an emergent theory of nurse managers' human resources management in respect of nurses who are affected/infected by HIV and/or TB.

#### **4.2. DATA ANALYSIS**

The audio recordings made during unstructured interviews with the informants were initially transcribed verbatim by me. Once I had experience of the transcribing process, I employed a transcriber to transcribe the data which then freed me to continue with the data analysis. Data was analysed initially manually. I read the transcriptions in total and then line by line, recording what I believed the informants were telling me, as notes in the right hand column of the transcript hard copy. I made an Excell spread sheet of what I believed was emanating from each transcript.

##### **4.2.1. Discovery of cultural themes**

All verbatim transcriptions of audio recordings were examined in depth by me. I searched for repeated implied patterns. Themes were deconstructed into subthemes. I provided the informants with a copy of their verbatim transcribed

interviews to read. We agreed on a date for my follow up appointments at which time I would receive comment from the informants regarding the authenticity of the verbatim transcripts. One informant did request that I exclude certain personal information which she had provided within the interview, which I did.

#### 4.2.2. Making a cultural inventory

Making a cultural inventory entails making a written collection of data collected. This enables the ethnographer to determine what information has actually been collected and highlights the gaps in the data, thus contributing to data immersion so as to determine the cultural themes for the study. The steps in making a cultural inventory include listing all the cultural domains, listing potential unidentified domains, making mind maps, finding examples from the collected data and listing data which does not fit the domains already found (Spradley, 1979:190-192). The following is a table which is an example of a list of cultural domains found in this study (which is not exhaustive).

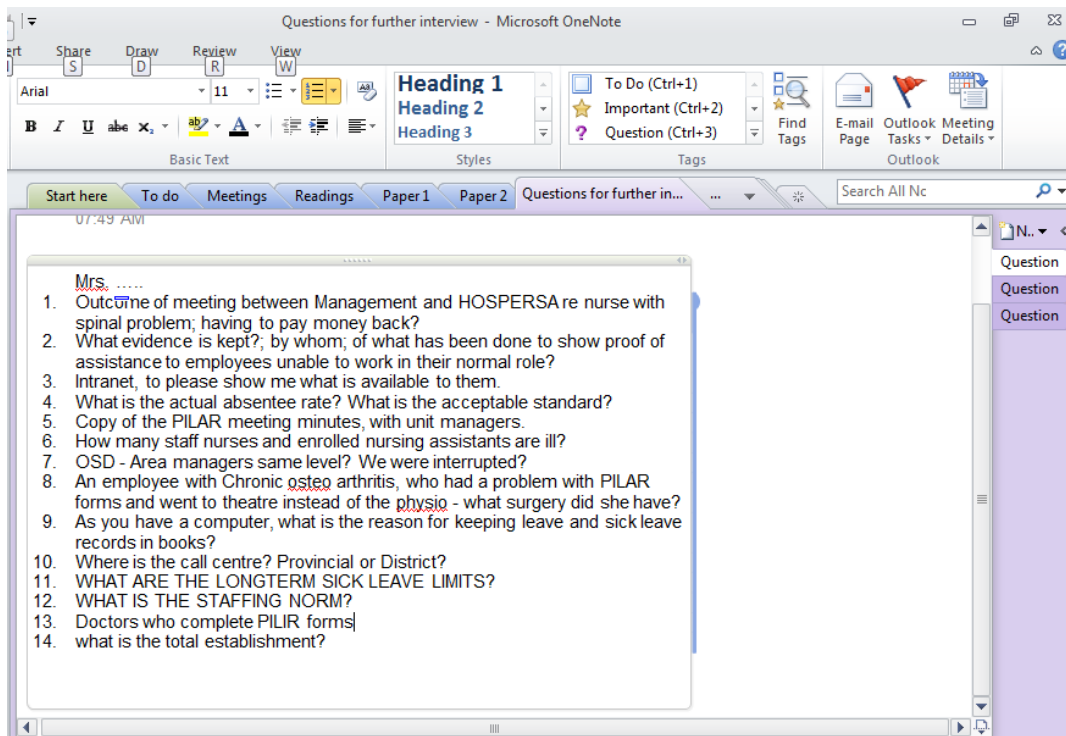
**Table 4. 1: An example of a list of cultural domains and missing/included information**

THEMES	Sub - Themes	What is identified /not identified	What happens? Effect	Consequence
POLICY (National; Regional; Departmental; Generic)	Department of Health			
	Policy & Procedure committee			
	Absenteeism			
	Injury on Duty (IOD)			
	Labour Relations			
	Planning	No Policy in place		
	Training			
	Needle stick Injury			
	Sick Leave	Sick leave exhausted	Follows them [[Action]]	
		Staff know rules		
		Form submission	delayed	
		Form completion	delayed	
		Compliance	Non - compliance	
CONFLICT	Employee	Organizations/Unions	Challenge	Fight for



			employer &/manager	them
		Employer conflict		Fight is started
	Between Team Members			
EFFECT	Organization/Institution	Hitting on	Impacts service delivery	
	Manager [[Overwhelmed]]	Feels helpless		
		Sad		
		Destroys me		
		Gets too much for me	too much to handle	
			Affects/impacts own health	
			Over working myself	
		Hit on me	Affects me	
		Frustrates		
		It was a bomb to me	Devastating effect	
		Stressful		
		Touched my heart		
		Impacts on own personality	Soft person	
	Unit Managers	Stressed		
		Available leave		

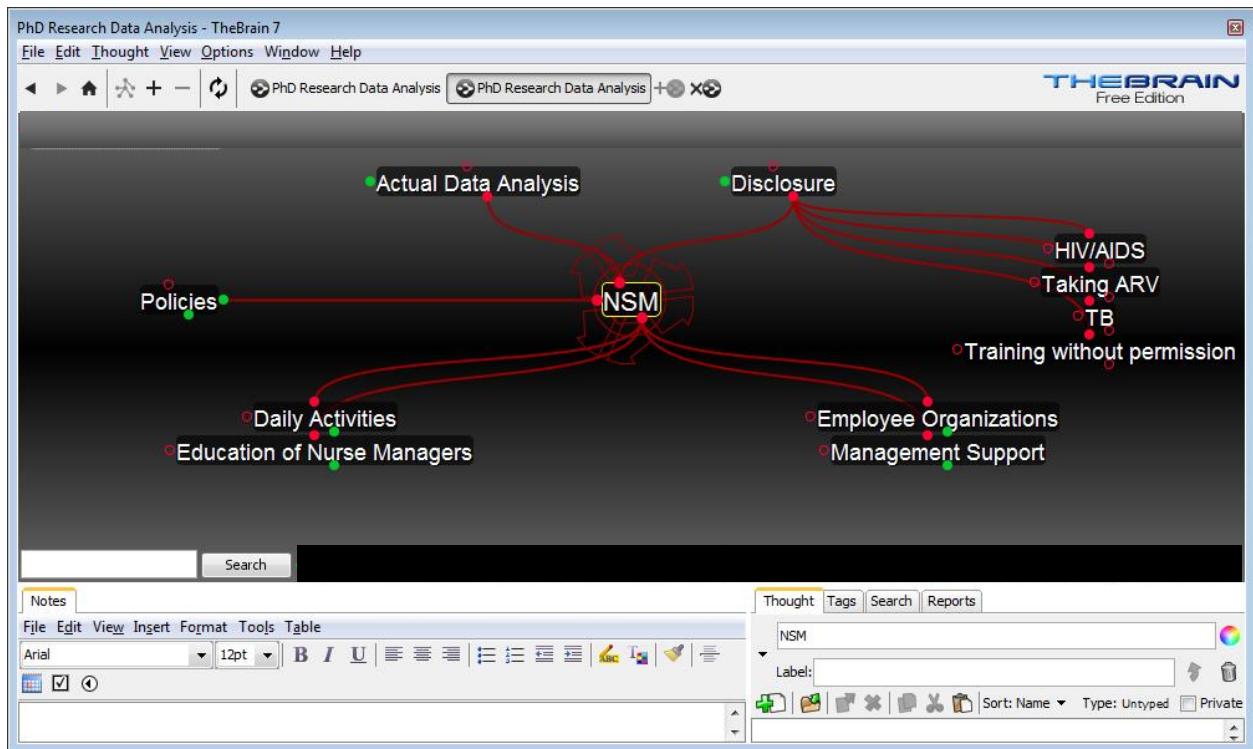
I asked informants further questions which had come to me during the in depth examination of the transcripts. See figure 4.1. below which is an example of questions which I listed which I needed to clarify following analysing a transcript of an interview with an informant around human resources management.



**Figure 4. 1: Sample of the ethnographer’s planned further questions to ask an informant.**

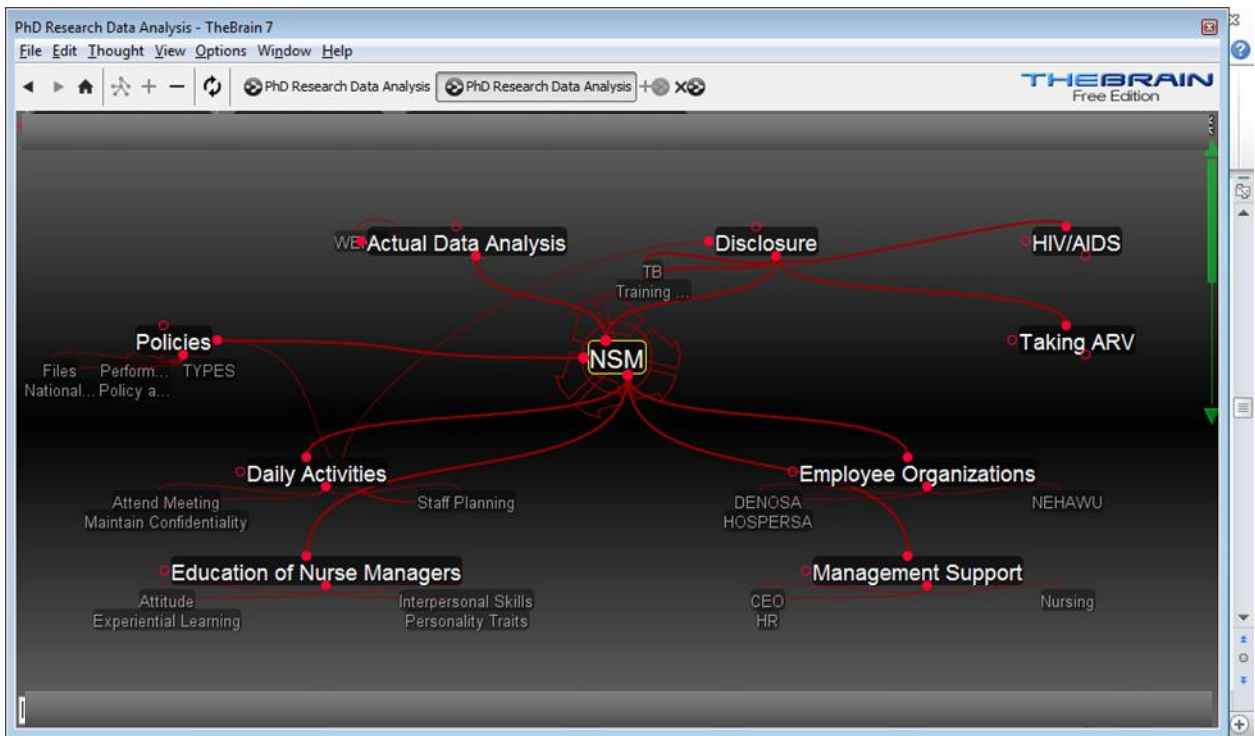
During the course of the very protracted data analysis for this study I discovered cultural themes by using mapping. I created a large map of the entire research using “The Brain”, a program downloadable off the internet in which such maps can be created and where one can link various domains with each other within the map (Refer Figure 4.2.).

The examples of mind maps below are shown as screen dumps from my laptop. Figure 4.2. shows the nurse manager and what she has to do in her job, based on the study objectives, while Figure 4.3. shows the same information, but is expanded to show what is encompassed in each aspect of his/her work and the links between these aspects of her work. Nurse Managers’ deal with employees who are infected with HIV; TB; who may be taking ART. She deals with such employees disclosure. Policies are an aspect of her worklife. Her daily activities include educating her junior colleagues i.e. nurse managers. Nurses who are training without permission is an aspect of her work as are employee organizations. Management support is an aspect in her work as well.



**Figure 4. 2: Sample of mapping indicating NSM site A and the subthemes in collapsed form.**

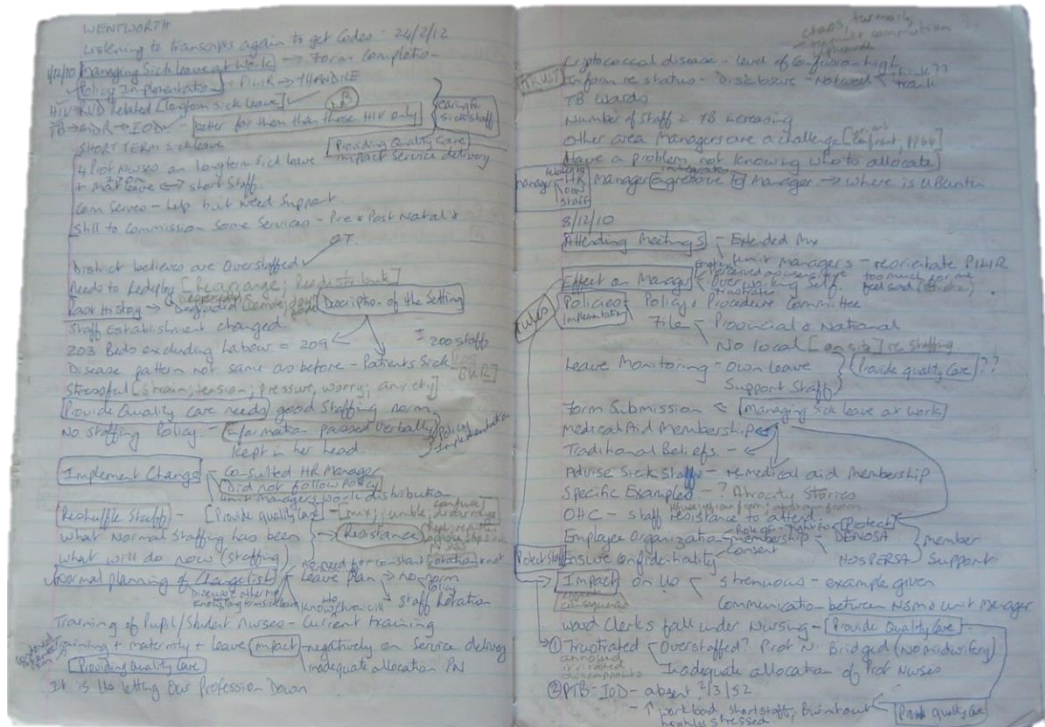
The following figure (4.3.) shows the same information which is in Figure 4.2. in its expanded form. One can see from this screen dump that disclosure is linked to HIV, TB and taking ART as well as daily activities. Daily activities include staff planning, attending meetings and maintaining confidentiality. Staff planning has a link to maintaining confidentiality. Policies are linked types of policies, policy files, policy application/implementation, and performance and to her daily activities. Education of nurse managers links to attitude, experiential learning, interpersonal skills and personality traits. Employee organizations links to three employee organizations which are represented in hospitals in this district and Mmanagement support links to CEO, HR and Nursing.



**Figure 4. 3: Sample of mapping indicating NSM site A in expanded form**

### 4.2.3. Grounded theorizing

I used grounded theorizing, both formally and informally. Formal grounded theorizing happened in both analytic notes made by me and in memoranda I wrote expressing my ideas and hunches. See excerpt in figure 4.4. below.



**Figure 4. 4: Sample of analytic notes made by the ethnographer during the study**

Informal grounded theorizing occurred in situational maps where I expressed situational elements and relationships between elements of a theme. I used social world mapping to depict collective relations (Refer above figures 4.2. & 4.3.)

Positional maps were used during brainstorming sessions with my research supervisors in which we depicted complex relationships between the levels and layers of situations. Refer Figure 4.5. below.

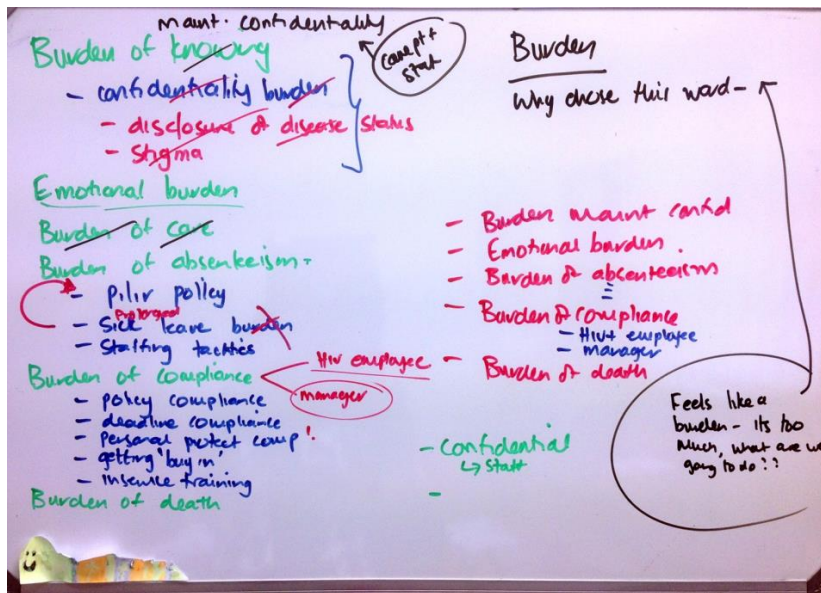


Figure 4. 5: Sample of brain storming using positional maps.

#### 4.2.4. Making a domain analysis

During a period away from the field and following Spradley's domain analysis, I analysed all the transcriptions from all the interviews conducted and all the field notes I had written in order to make a domain analysis. I identified the "cover term" which is the name I gave the cultural domain, for example, manager. I then identified terms which were all the sub-categories of the cover term, for example, area manager, middle manager, midwifery manager, health promotion manager, occupational health manager, infection control manager and medical & surgical in-patient manager, among others, until I had exhausted all the sub-categories of managers. Finally, I sought the semantic relationships between categories within a domain (Spradley, 1980:89).

Domains fall into three categories which are folk domains, mixed domains and analytic domains (Spradley, 1980:90 – 91).

The steps I used to make the domain analysis were to use the semantic relationships as a point of departure. I then reread the field notes and listened repeatedly to the original audio recordings of interviews (Spradley, 1980:92).

Spradley gives nine different types of semantic relationships that one can use for making a domain analysis. Table 4.2. below lists these various types of semantic relationships, the form of the relationship and examples from my data.

**Table 4. 2: Semantic relationships and examples from the study**

	SEMANTIC RELATIONSHIP	FORM	EXAMPLE
1.	Strict inclusion	X is a kind of Y	Human resources planning (is a kind of) PLANNING Getting nurses to admit that they are ill (is a kind of) PROBLEM
2.	Spatial	X is a place in Y OR X is a part of Y	Secretaries office (is a place in) Nursing Management complex Waiting area (is a part of) Human Resources complex
3.	Cause-effect	X is a result of Y	'Occupying posts' (is a result of) employees prolonged absence
4.	Rationale	X is a reason for doing Y	they get more time to actually sit down and do packs (is a Reason for) place them uhm in our central sterilizing department CSSD
5.	Location-for-action	X is a place for doing Y	Mrs..... office (is a place for doing) the change list
6.	Function	X is used for Y	Desk top computer (is used for) producing the change list
7.	Means-end	X is a way to do Y	Stay away on payday (is a way to) avoid 'loan sharks
8.	Sequence	X is a step (stage) in Y	Documents must be completed within 5 days of becoming ill (is a step in) applying for incapacity leave
9.	Attribution	X is a characteristic of Y	"I am desperate" (is a characteristic of) Nurse Managers unhappy in the way she was treated (is a characteristic of) a patient

Spradley, (1979:117 – 118)

The data I had collected mostly fitted into the strict inclusion, cause-effect, means-end and sequence semantic relationships. I prepared domain analysis worksheets in Microsoft Excel, selected field note entries and transcriptions per hospital, then searched both manually and electronically (using Microsoft Excel and Word as well as NVIVO 8) for cover terms which I believed fitted each semantic relationship. I repeated this process through all hospital data and all the semantic relationships, then listed all the domains I had found for the public sector. I also listed all the domains I had found during my brief encounter within the private sector domain and have included all the limited information gleaned from my initial meetings with the NSM and unit managers of hospital C. This process constituted my initial report writing.

The findings are presented in section 4.4. below consist of the completed inventory of themes and examples from the data which represent the themes discovered.

#### 4.2.5. Taxonomic analysis

Taxonomic analysis is described by Spradley (1979:94) as a search for the internal structure of domains which in turn results in contrast sets of data.

A detailed analysis of each setting was done. Interdepartmental relationships were identified. Following identifying the interdepartmental relationships, I returned to the field to conduct further observations, specifically to confirm or refute the interdepartmental relationships I had previously found and to determine if there were further categories which I had not previously identified. See Table 4.3. below as an example of a taxonomic analysis I conducted.

**Table 4. 3: Taxonomic analysis of kinds of Leave**

					RULE	DOCUMENT STORAGE	PLANNING
	LEAVE		[ANNUAL] LEAVE/VACATION LEAVE	Unpaid leave			
				Paid leave			
			MATERNITY LEAVE				
			FAMILY RESPONSIBILITY LEAVE				
		SICK LEAVE	SICK LEAVE	Short term	only give 36 weeks [days] in		



					a three year cycle		
				Long term			
			INCAPACITY LEAVE	Short term			
				Long term			
			IOD/OCCUPATIONALLY ACQUIRED DISEASE				
							BOOK LEAVE
			WORK WITHOUT LEAVE				pull for the whole year
						LEAVE FILE	

The draft guidelines which I formulated as an outcome of this study are the product of the taxonomic analysis conducted. Within the draft guidelines the themes have been related to the theoretical framework. (Refer draft guidelines, Annexure 13)

#### 4.2.6. Componential analysis

Componential analysis is described by Spradley (1979:174) as searching for meaning components that are linked to cultural symbols. In componential analysis one is searching for the characteristics of a symbol. Table 4.4. below is an example of componential analysis I conducted on the domain of emotions.

**Table 4. 4: Componential analysis of kinds of emotions**

EMOTIONS	MANAGER OWN EMOTIONS	EMPLOYEE EMOTIONS
strenuous,	√	
being cross,	√	
anger,	√	
frustrated,	√	
sad, ‘	√	
‘destroys me’,	√	
‘a bomb to me’,	√	
‘touched my heart’	√	
unfair,		√
frustrated,		√
Happy,		√
Shock,		√
Surprise		√

From this table it is evident that nurse managers describe their emotions as “strenuous”; “being cross”; “anger”; “frustrated”; “sad”; “destroys me”; “a bomb to me”

and “touched my heart”, while they described employees’ emotions “unfair”; “frustrated”; “happy”; “shock” and “surprise”. Most of the emotions described by the nurse managers were negative, with only “touched my heart” as a positive emotion. However, their perceptions of employees’ emotions were a mix of both positive and negative emotions. One emotion that was common to both groups was frustration.

Such analyses were conducted across all settings and all domains that arose from the study.

Table 4.5 below is a componential analysis I conducted comparing the Public and Private sector hospitals.

**Table 4. 5: Componential analysis between public and private sector hospitals**

		PUBLIC SECTOR	PRIVATE SECTOR	THEME
Daily nurse manager activities	Ward rounds	√	√	
	Assist in OPD	×	√	“shuffling around of staff”
	Phoning for replacement staff	√	√	“shuffling around of staff”
	Receive reports of staff not on duty	√	√	“shuffling around of staff”
	Identifying replacement staff who have own transport	×	√	“shuffling around of staff”
	Repeated interruptions with staffing issues.	√	√	“shuffling around of staff”
	Change list and allocation	√	√	“shuffling around of staff”
	Teaching Rounds	√	√	policy compliance
	[Stock taking] intervention to obtain stock	√	√	policy compliance
	Training around PILIR	√	×	policy compliance
	Phone Human Resources	√	×	Maintain confidentiality
	Consult with sick/pregnant employees	√	√	Maintain confidentiality; Employee

				disclosure;
	Phone calls - ill employee	√	√	Maintain confidentiality;
	Monitor, approve and capture employee sick leave; sick certificates; leave	√	×	Maintain confidentiality;

In order to illustrate the use of componential analysis to determine the cultural themes for the study, I have presented only a single aspect of nurse managers' daily activities. The table above gives an idea of the similarities and differences I found around their daily activities between public sector hospitals and private sector hospitals. Activities carried out by the nurse managers are illustrated by a "tick", while those they do not carry out are illustrated by a "cross".

The nurse managers do daily ward rounds in both the public and private sectors. In district hospitals in the public sector, the nurse manager tasked with staff management places nurses in general nursing units, such as medical and surgical wards, on a monthly basis. The unit managers of the specialist units such as the operating theatres, maternity units and intensive care units manage their own staff planning and advise the nurse manager of their needs. She then has to find replacement staff for these units from other specialist units or from the general hospital wards.

In the private sector, nurse managers provide each unit with a permanent workforce. The unit managers inform the nurse manager on a monthly basis of the staffing needs for the following month. However the specialised units operate in a similar way as the public sector, with the nurse manager having to find staff that has been permanently placed in another wards to satisfy the staffing needs.

The nurse managers in the public sector hospitals do not themselves assist in units that are short of staff, but "*shuffle the staff*" around to replace missing employees, while in the private sector hospital, the night superintendent, who plans the staffing, helps out in units where there is a need.

Both the public and private sector nurse managers spend time telephoning for replacement staff. The main difference, however, is that in the public sector, the replacement staff is taken from other units while in the private sector either "agency"

or “*locum*” staff is called in to work. The public sector makes no provision for “*agency*” or “*locum*” staff.

In both sectors, the nurse manager receives information about who is on duty and who is absent from work, and the reasons for absences. They also experience repeated interruptions during the day relating to staffing issues.

The expectation in the public sector is for the nurse manager to ensure that her unit managers are trained in the management of Incapacity Leave and Ill Health Retirement Policy (PILIR), while in the private sector this function lies with the human resources division. In the public sector, the training role is in fact placed with the Human Resources Directorate, but they train the nurse managers and delegate any further training of nurses to them.

The public sector nurse managers communicate with the Human Resources Directorate within the hospital, whereas in the semi-private hospital, the nurse manager who plans the hospital nurse staffing does not do this because she is on night duty.

In all sectors the nurse managers consult with ill nurses, either face to face or telephonically. However in the public sector, the nurse manager monitors, approves and captures employee sick leave; sick certificates and leave, whereas the unit managers in the semi-private and private sector are expected to do this.

In this section, I have given a brief idea of how I conducted componential analyses in this study. The large volume of data collected makes the recording of each componential analysis in this report difficult to include. However, the cultural themes which are discussed in section 4.4. below are the outcome of componential analysis conducted across all sites.

### **4.3. INTERPRETING THE FINDINGS**

The questions which emanated from the study objectives (Refer to section 1.5) are answered through the interpretation of the findings which follow.

These questions were the very essence of the study and guided the selective observations I made (Spradley, 1980: 128-129).

Data has been organized in chronological date order by theme, and within the theme and sub-theme by hospital. Sub-sections within chapters have been organized using “emic” and “etic” categories. Interpretation of the findings is founded on the analysis which I conducted of the data

#### **4.4. THE HUMAN RESOURCES MANAGEMENT ANALYSIS**

I found the following two quotes which seemed very appropriate to the findings of this study as they highlight the “burdens” experienced by the nurse managers in the sites of this study. These quotations by Ovid and Ella Wheeler Wilcox depict in a small way what the nurse managers in this study have shared with me.

*“The burden which is well borne becomes light.”* OVID (n.d.)

*“It is easy to tell the toiler how best he can carry his pack  
But no one can rate a burden's weight until it has been on his  
back”* — Ella Wheeler Wilcox (n.d.)

I selected the word, “*burden*”, as the common theme of this study because all of the informants observed or interviewed presented to me a sense that they felt strained, weighed down and even at times overwhelmed by the management of employees who are at work, but are sick. I sensed that the informants not only worried about the employees themselves, but also the effect that sick employees might have on the organizational ability to provide quality care. The nurse managers confirmed that they were affected by the feelings mentioned above.

‘Burden’ as a verb has the following synonyms: bother, encumber, handicap, load, oppress, overload, overwhelm, saddle with, strain, tax, weigh down and worry (Oxford Paperback Dictionary and Thesaurus, 1997:90).

The following excerpts from transcriptions of conducted interviews indicate the sense of “*burden*” which informants expressed during interviews.

*“Well from my side, it’s quite strenuous”* [NSM, site A, 8 December 2010]

*“At times really it, it gets too much”* [NSM, site A, 13 January 2011].

*“all of a sudden you'll find that this person is ill. They may be HIV positive, and it destroys me.”* [NSM, site A, 13 January 2011]

[employee away long term] *“What do I do?”* [NSM, site A, 1 December 2010]

*“What to do with her?”* [NS, site B, 3 November 2011]

*“what to do”* [to get people through the process of ill health retirement.] [UM, site C, 22 February 2011]

*“what do I do?”* [SO, site C, 21 December 2011]

*“So at the end of the day we don't know where we stand.”* [ANSM, site D, 26 September 2012]

It is interesting to note that I made the following comment in my initial bracketing of my own experience as a Nurse manager planning the human resources needs in a district hospital in the eThekweni District of KwaZulu-Natal.

*“So what to do?”* [Ethnographer bracketing notes, 22 June 2009]

This statement by me indicates that I experienced the same sense of exasperation as the informants in my study.

An exchange between a nurse manager and a sick nurse indicates the ‘burden’ which nurse managers experience. The discussion was about the sick nurse returning to work.

An informant asks the nurse how she feels about coming back to work and states, *“I do not know how to help you”*. [Ethnographer field notes, site A, 28 March 2011]

“Burden” is also an “emic” term used by informants, as illustrated by the following quote:

*“workload is increased, people are sick, they are short staffed, you know, it it it's an added burden too, to, to, the staff [[who remain at work]], they are burnt out, highly stressed, you name it, you know, so it is a problem”* [NSM, site A, 8 December 2010].

“Burden” is a term which is commonly used in various subjects. The medical field uses terms such as “burden of disease”; “stroke burden”; and “burden of cancer” The term has also been applied to history, for example, “burden of Southern History” and within financial or economic literature with terms such as “economic burden”; “financial burden”; and “tax burden” being used. In legal spheres, the term “burden of proof” is used.

In the context of this study, the term burden was conceptualised by nurse managers as the burden of maintaining confidentiality; an emotional burden; the burden of absenteeism; the burden of compliance; and the burden of death. These have therefore been identified as the themes of the study.

The themes and sub-themes of the study have been summarised in Table 4.6. below.

**Table 4. 6: Summary of study findings**

Human Resource Management - FINDINGS		
THEME	SUB THEME	
Burden of maintaining confidentiality	Employee disclosure of disease status	Stigma
Emotional Burden		
Burden of Absenteeism	Prolonged sick leave	
	Policy for Incapacity Leave and Ill Health Retirement	
	“shuffling around the staff”	
Burden of Policy Compliance	Nurse Manager Policy Compliance	
	Occupational Health and Safety Policy Compliance	
Burden of Death		

#### 4.4.1. Burden of maintaining confidentiality

Confidentiality is defined by the South African HIV and AIDS in the world of work (2012:30) as the *“right of any person, worker, job applicant, jobseekers, interns, apprentices, volunteers, and laid-off and suspended workers to have their information, including medical records and HIV status kept private”*.

In the context of this study, the burden of maintaining confidentiality refers to the knowledge that nurse managers have in respect of information provided to them by nurses who are ill in the workplace. The nurses' disclosure of such information to nurse managers places them in a position of trust, which requires them to maintain confidentiality in respect of what is known about the employee.

Nurse managers' experience a '*burden*' once they know the HIV, TB or other prolonged disease status of their employees. They have to keep silent in order to protect the affected nurses from the continued stigma which surrounds these diseases in KwaZulu-Natal. Nurse managers' may not discuss the information with anybody else without the explicit consent of the employee (South Africa, DOL, 2012:37; SANC, HIV Policy (n.d.)). However, nurses only disclose their disease status to nurse managers whom they trust in the knowledge that the nurse manager will respect the confidentiality of what they know about the employee (Spitzer, 2004:6; O'Donnell, 2008).

Turner (2008:229) states that at times we would prefer not to have certain knowledge as ignorance protects us from the way things really are, prevents us from having to make difficult choices and even protects us from others. This is however not the case in situations where sick nurses have confided in their nurse managers. These nurse managers, having information which informs them of the way things are in respect of the ill employees, have to make difficult choices in respect of staffing the hospital nursing service and protecting the ill nurse. Having the information in fact assists in protecting the ill nurse from others at work.

South African law requires that the principles of human rights, equity and privacy be upheld in the workplace (South Africa, DOL, 2012:37). The Code of Good Practice on HIV and AIDS in the world of work (South Africa, DOL, 2012:1-18) in section 7.3. provides the rules for maintaining confidentiality, as does the South African Nursing Council HIV Policy (SANC, n.d. HIV policy).

Nurse Managers experience a '*burden*' once an employee has disclosed their status to them because they may not discuss the information with anybody else without the explicit consent of the employee (South Africa, DOL, 2012:37).



In their position of employment, nurse managers have been socialised to maintain a distance from the employees in respect of their personal lives so as to maintain a professional relationship. When an employee has disclosed his/her status, that distancing is breached and they can no longer remain detached. The employer/employee relationship becomes more personal and empathetic. The nursing managers, occupational health nurses and the senior nursing services managers are all exposed to this *'burden of maintaining confidentiality'*. However, it impacts the hardest on the nursing managers, who are at the 'coal face' of human resources policy implementation, and who are accountable for the management and planning of the staffing provision for the hospital every month, as well as ensuring that there are sufficient nurses to provide patient care on a daily basis. The *'burden'* is a direct result of being required to maintain confidentiality (South Africa, DOL, 2012:37) and the need to inform the senior nursing services manager (SNSM), either directly or through information documented in the allocation/change list, as a list of people off sick. However, without the consent of the employee, their illness should not be discussed with the SNSM, neither should their name be on a list of sick employees in the allocation/change list without their consent (South Africa, DOL, 2012:37).

An added *'burden'* of these diseases is prolonged absences of sick employees from work. An employee's prolonged absence from work makes it either difficult or impossible for the nurse manager to cover up the fact that the employee is not at work, nor will be for a long time. This makes the maintenance of confidentiality an added strain or weight for the nurse manager in her communication with other employees and other managers.

The informants in this study were aware that information of this nature should not be discussed with others. This was stated as follows:

*"At times you know, I, I come across somebody whom we thought she was excellent, but all of a sudden you'll find that this person is ill. They may be HIV positive, and it destroys me. I mean I am a human being. You'd want this to share with somebody, so that at least you get that out, much as I know it is not right"* [NSM, site A, 13 January 2011]

One informant informed me off the record that confidentiality affects her communication with the nursing manager, in particular, because affected nurses expected strict confidentiality

*“She [OHN] spoke off the record about confidentiality affecting her communication with people like the NSM. It seems that she believes that confidentiality aspects of particularly nurses’ information creates problems with communication, and that nurses particularly who attend the clinic for treatment really expect strict adherence to confidentiality.”* [Ethnographer observation, site A, 19 April 2011]

The nurse manager described a specific case, which confirmed that she did discuss certain cases with the senior nursing services manager in order to inform her of the illness of this particular nurse so that she will understand the situation if it comes to her attention that the nurse is not performing as expected.

Employees who are ill at work often do not cope too well in carrying out their duties when at work. Furthermore, in some cases, when employees who have been diagnosed with HIV become critically ill as a result of their disease, they have been admitted to the same ward in the hospital in which they work and placed on treatment. Whether or not they have disclosed their illness, maintaining confidentiality becomes even more of a ‘burden’ for the nurse managers as the employer and co-workers who are caring for them soon learn of their status. In such circumstances it is nigh impossible to maintain confidentiality, as illustrated in the following statement

*“Although he hasn’t really come out with it but he did end up being critically ill, admitted in the ward on treatment, so we basically know what is wrong with him.”* [NS, site B, 3 November 2011]

Although employees expect the employer to maintain strict confidentiality in respect of their disease status, in reality this is very difficult to achieve. Therefore, maintaining confidentiality is problematic for the nurse managers in that they may not disclose the diagnosis of the affected employee to others, as is illustrated by the statement below.

*“AND the challenge also comes from the other area managers because you cannot be telling them this person says they’ve got this they’ve got that”* [NSM, site A, 1 December 2010]

If the nurse managers are asked by their colleagues why a particular nurse is not placed in a specific clinical area, they have to inform them that they cannot disclose such information in an attempt to protect the employee. However, as soon as people hear that nurse managers cannot discuss or disclose what the matter is or even when they do not say anything, they immediately assume they know what is wrong so, in effect, nurse managers are actually disclosing that the individual is HIV and/or TB affected/infected. The statement below is a typical comment which nurse managers make in such situations.

*“You have to say to them no I know why, [I] have to protect the staff”*  
[NSM, site A, 1 December 2010]

When the nurse manager can neither confirm nor refute what ails the employee, colleagues automatically assume that the employee is HIV and/or TB affected/infected. This is illustrated by the following statement.

*“you know but maybe they will also think oh so that’s why”* [NSM, site A, 1 December 2010]

The informants, in discussing the confidentiality of information received from employees state that once they have been informed by another manager that they cannot be told what was discussed, they immediately assume they understand, thus making the maintaining of confidentiality in such situations extremely difficult.

This is illustrated by one of the informants in the following excerpt:

*“Luckily Mrs..... went out to address the person and luckily, [emphasises luckily] she said I cannot tell you what was discussed, but I understood”* [quietly] [NSM, site A, 13 January 2011].

There is a tacit unspoken understanding among nurse managers, that as soon as somebody says, we cannot disclose what is discussed, in fact EVERYBODY [my emphasis] knows what was discussed.

The nurse managers state that employees’ medical conditions are not discussed in the nursing services management office because they are aware that maintaining strict confidentiality is critical to managing sick employees. They did admit, however, that they do discuss particular nurses with the other managers although the

diagnosis of the employee is not disclosed. The reason for this is that there may be a time when the nurse manager is unable to plan the staffing and, should such an eventuality occur, the area managers need to be informed because they may have to take over the role of the nurse manager in his/her absence or inability to do the planning, as illustrated in the following statement.

*“I then discuss with my other managers, because there may be a time where I am unable to do the change list, it’s better for them also to know, but I don’t have to explain to them why”* [NSM, site A, 13 January 2011].

Nurse managers try to protect immune compromised nurses by not placing them in hospital units where they can potentially become infected with TB by having to nurse TB positive patients. In such cases, the nurse managers inform their colleagues that a particular nurse cannot be placed in a specific ward, but do not disclose the reason why. This also results in assumptions around the illness of the employee, making it very difficult to maintain confidentiality.

*“I just tell them that so and so, and so and so, cannot be put in such a department, so whether a person can be diabetic or whatever, you don’t have to tell them a person’s diagnosis”* [NSM, site A, 13 January 2011].

Attempts to maintain confidentiality also result in perceptions of favouritism as alluded to by this informant:

*“.....there is a lot of confidentiality, which is viewed by other people as you know, that favouritism”* [ANSM, site D, 26 September 2012]

Confidential discussions are held with the occupational health nurses employed in the hospital occupational health clinics in respect of ill nurses in order to protect them. An informant explains how the confidential discussions between her and the occupational health nurse actually transpired in the following excerpt.

*“What happens is the OHC and myself, it’s between the two of us the OHC, she’ll phone me and tell me this is confidential, are you alone, can we talk? And then discuss a person, because, they know what my role is, so ALL that is done in order to protect them”* [all is emphasised]. [Silence follows.] [NSM, site A, 13 January 2011]

The normal approach that the nurse managers follow is to discuss difficulties experienced with the senior nursing services managers, who have delegated the task of managing and planning the nurse staffing for the hospital to them. However, the senior nursing services managers are ultimately accountable for providing the nurse staffing for the hospital and the nurse managers therefore requires their approval when it is necessary to change the working place of ill employees, which is illustrated by the statement below.

*“final decision to say ok, so and so isn't well any more now, not like before. We need to maybe alter, change the department she's working in and then she agree”* [NSM, site A, 13 January 2011].

By handling the employees' disclosures sensitively, as discussed above, staff members can be redeployed to other work places, thus enabling the employee to continue to earn a salary in order to support his/her family

*“a person can be allocated in other areas, rather than make her leave the work, because she's got family to take care of”* [NSM, site A, 13 January 2011]

The confidentiality of employees obtaining their medication from the occupational health clinic at the workplace is protected by the occupational health nurse, who collects the employees' medication from the pharmacy before issuing it to them. The process described ensures that employees who are HIV and/or TB affected/infected cannot be identified as such. All employees attending the OHC are treated the same, which is confirmed by this statement:

*“The system is all the same for everybody who's sick.”* [OHN, site B, 1 February 2012]

There is a system in place where the OHC obtains the prescribed treatment from the pharmacy and keeps the medication in a brown paper bag, which is how all other treatment is received from the pharmacy. The employee will then visit the OHC and collect their treatment in the same way as any other employee would collect their treatment for minor illnesses.

I did wonder about violations of confidentiality, however, as on various occasions I was present at confidential meetings without the permission of the nurses

concerned. On 28 March 2011, I was present in the office of the NSM of hospital A for the entire duration of a discussion between the NSM and a nurse who had had a cerebrovascular accident “stroke” and who was a diabetic. At no stage during the discussion did the NSM ask the nurse if she minded my presence during their discussion. On a field visit to hospital C on 17 February 2012, I was present during an informal disciplining session between the night superintendent and three student nurses and again later during the night when the night superintendent was discussing a patient complaint with a registered nurse and an enrolled nurse. Again, the nurses were not asked whether it would be in order for me to be present during such discussions. These experiences lead me to wonder whether there are in fact violations of confidentiality, despite the information provided to me by the informants. Mfusi & Steyn (2012:163) state that the violation of confidentiality was a problem within school settings.

#### **4.4.1.1. Employee disclosure of disease status**

The findings revealed that nursing employees do disclose their disease status to the employer, either through the nurse manager, who plans the clinical placement of nurses in the work place on a monthly basis, or the occupational health nurse, especially when they are unable to work in certain areas and are no longer able to cope with the workload, as explained by the following examples:

*“People who are HIV affected or who are chronically ill, most of them approach me to inform me they've got, you know what ever disease they've got”* [NSM, site A, 13 January 2011]

*“we do have staff that are known and they do come forward because of their condition they end up having, not being able to work in certain departments.”* [NS, site B, 3 November 2011]

This is contrary to the findings of Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola, (2007: 246), who found that the majority of people do not disclose their status to employers or strangers. Their findings were supported by the following statement from one of the informants in my study

*“Of the fifteen I think I dealt with three that physically came through to me and said you know, here we are, we couldn't run away”* [SO, site B, 21 December 2011]

The current study found that the tendency is that when sick nurses find the workload too onerous, they often book off sick. The employees then disclose their status to the nurse managers in order to be placed in a ward or unit where the workload is perceived to be less. The employees either disclose their disease status to the nurse manager overtly or covertly. The disclosure often happens when the nursing manager places the employees in the TB ward, where treatment has been commenced, or with the undiagnosed patients in the medical wards, whose diagnosis has not been confirmed. The employees are then pre-empted to disclose their HIV status, as indicated below:

*“so if you try to explain to them they don't buy that they don't understand all they always say Matron I'm not well and you have to THINK what she means if she says I'm not well others will be frank to say I've got this or this” [NSM, site A, 1 December 2010]*

*“There is this belief that if you have been diagnosed with TB and HIV, these things and so your immunity is a bit low, you cannot work in certain areas” [ANSM, site D, 26 September 2012]*

Once the nurse manager knows that the nurse is ill, she then has two choices. Either she ignores the information and continues to make placement decisions, as she has no concrete information on which to base her decisions, or she makes decisions based on the information disclosed to her by the employee. It is crucial for her to have information from the employee, so that she is able to make her decisions in respect of their safe clinical placement as expressed by the following statements:

*“So once I know a person is chronically ill, it helps me with the allocation” [NSM, site A, 13 January 2011]*

*“so knowing who is co-infected helps me so that I don't expose them, once again to these high risk wards,” [NSM, site A, 13 January 2011]*

Once employees have disclosed their disease status to the nurse manager, she cannot place them in wards where they may be at risk of becoming infected with TB. If she has a large number of ill employees, she is unable to make informed decisions in respect of which employee to place where, for each month that she does the change list. Nurse managers, therefore, experience difficulty in knowing who to place in the wards, which can place affected/infected nurses' health at risk, as illustrated below:

*“always have a problem you know of not knowing whom to allocate ja” (pensive) [NSM, site A, 1 December 2010]*

This not knowing who can be placed in wards which can place individual nurses' health at risk add to the nurse managers' stress and emotional burden because of their fear of causing employees harm through their actions and decisions.

#### **4.4.1.2. Stigma**

There is a perception that the nurses affected/infected with HIV are more afraid of stigmatisation than the disease itself. Employees do not want others to know they are affected/infected and they therefore do not disclose their status as illustrated below.

*“along with that some people they just don't want to be known. Let's say if they know that they are HIV positive, they diagnosed outside, they don't want to be known not even in their homes. It's, it's difficult to disclose to a mother, to a sister, to everyone, so those people even here they're scared to disclose to anyone, not because they're scared you're going to go and spread this gospel to other people; no they just don't want to disclose because HIV has got a stigma.”*  
[OHM, site A, 14 April, 2011]

The above statement is supported by Singh, Chaudoir, Escobar & Kalichman (2011:842) where their study found that care-givers to people living with HIV receive adequate support from nurses and community care workers, but not from family and the church. This lack of support from family and church may be why affected/infected nurses do not want to disclose at home or at work.

According to Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola, (2007:248) and Holzemer, Uys, Makoe, Stewart, Phetlhu, Dlamini et al, (2007:547-548) stigmatisation within work places remains a problem and leads to denial, a sense of hopelessness and shame for the affected employee. The following statement from an informant in my study confirms that stigma continues to exist in the work environment of nurses in the hospitals sampled for my study:

*“We are sitting with a situation where the people are developing AIDS' because when they develop AIDS it's a stigma, they don't talk about it and they don't want others to know especially in this nursing community.”* [SO, site B, 21 December 2011]



There are some employees who do not disclose at all. They keep quiet about their status, maintaining a 'self -silence', as illustrated below:

*“There are those you, I think in every institution you get those few that just keep quiet about it.”* [NS, site B, 3 November 2011]

The 'self-silence' could be because the employee may believe that being HIV infected indicates promiscuity or prostitution on their part and therefore does not want the employer to think of them in this manner (Masupe, 2011: 70, Turner, 2009:229; Holzemer, Uys, Makoae, Stewart, Phetlhu, Dlamini et al, 2007:547-548). Employees could be using this 'self-silence' to protect themselves from the unpleasantness that the reality of their disease has for them, as well as avoiding making choices related to their disease. 'Self-silence' protects people from the unpleasant reactions of other people (Turner, 2009:229; National Stigma Strategy, 2007:2). Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola, (2007:246) support this finding in a study conducted by them where they found that people do not disclose to employers or strangers. However in their study there were informants who stated that they found it easier to disclose to strangers. Employers are not informed of employee status because employees fear dismissal.

One of the informants stated that it is important to be tactful when a problem has been identified, especially when an employee has not disclosed their status.

*“No we don't have, basically as I said it would be if you identify something then you go to the staff member but then as well you have to use tact because if they haven't actually come out and said that there is something wrong with them, you can't go now and say you know that uhm this is what you look like then it becomes a whole different story.”* [NS, site B, 3 November 2011]

Employees do not want anybody to know their disease status, either at work or at home as they fear stigmatisation (Opollo, 2013:17-26; Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola, 2007:242-250, South Africa, DOL, 2012:8 -9). Turner (2009:229-300) refers to keeping secrets from others and keeping secrets from ourselves. In both cases, secrets are kept for fear of what the informed does or does not do with the information; fear of how the informed perceives us and fear that the informed will tell the secret to others.

There is stigma attached to needle stick injuries (sharps injuries) and HIV. Few people who are HIV positive report their needle stick injuries (sharps injuries) to the employer, as expressed by the following statements:

*“Ja but just to say that there is a lot of stigma around these needle stick injuries and HIV AIDS as well” [IPCO, site B, 21 December 2011]*

*“Later on you will find that such a person had a needle stick injury but you have got no records, it was not reported” [IPCO, site B, 21 December 2011]*

Once an employee has had a needle stick injury and refuses prophylactic treatment, does not return for follow up and is not heard from again, the employer assumes that the employee has HIV. Bodkin & Bruce (2003:26; 27) found that health care workers failed to report needle stick injuries (sharps injuries) because they believed that the chance of becoming HIV positive in such circumstances was minimal, they did not know that they should report an injury or how to report the injury and finally because of the stigma attached to such an injury. The following statement illustrates that when an employee fails to return for treatment or refuses antiretroviral treatment following a needle stick injury, the employee has in fact disclosed their HIV status to the employer.

*“Some of the needle sticks, when you get the needles sticks you know immediately what their status is because they won’t take the prophylaxis [their choice] and they won’t come back and we don’t hear from them again.” [SO, site B, 21 December 2011]*

Denial pervades the society in which the nurses practice. An informant informed me, off the record, that some parents in a specific community in the eThewini district tell other members of their community that their children have carcinomas rather than admitting that their child has HIV, which could be their way of keeping the secret from others (Turner, 2009:229-300) and is illustrated by the following verbatim quote:

*“Parents are telling the community that their children have cancer and not HIV is a denying “A lot of “coloureds” in ..... are now HIV positive” [OHM, site A, 14 April 2011]*

This participant believed that denial is a big problem as employees just do not want to disclose. This is supported by the studies conducted by Bairan, Jones Taylor,

Blake, Akers, Sowell & Mendiola (2007: 248) and Holzemer, Makoae, Greeff, Dlamini, Kohi, Chirwa, Naidoo, Durrheim, Cuca & Uys, (2009:81-82) in which they found that denial, especially at work, is fuelled by stigmatization. It is important for nurse managers to be aware that it is unlikely that employees will disclose their status to them unless they have a close relationship or unless the employee perceives that the disclosure will benefit themselves in terms of working in an area of the hospital that will not be detrimental to them, as was the case in this study. It is imperative that nurse managers respect the employees' right not to disclose and that they remain non-judgemental of employee decisions not to disclose (Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola, 2007:249; South Africa, DOL, 2012: 8 -9).

Reluctance to disclose may also be as a result of non-disclosure at home and fear that once they disclose at work, the family will find out their HIV status (Norman, Chopra & Kadiyala, 2005:4). According to Masupe (2011: 84), the circumstances in which people find themselves determine whether they will disclose or not.

In some cases the sick health care workers have to be treated the same as any other person because the employee is in denial about his/her condition. The infected employees have not accepted their condition and pretend to have no knowledge about HIV. It seems that if one handles these employees sensitively, they slowly come to accept their condition and take their treatment, as illustrated hereunder:

*"Oh, I think mostly it's the denial part of it, denial part of it."* [OHN, site B, 1 February 2012]

*"They just pretend to be blank not knowing anything, because they haven't accepted condition, but slowly if you just work with them, they slowly, they accept it and they just take the treatment."* [OHN, site B, 1 February 2012]

However, if employees deny their HIV status altogether and refuse ART treatment, they deteriorate rapidly and die. The statement below was made by two of the informants in my study:

*"People [staff] die rapidly is the result of denying that they are ill"* [HR manager, site B, 14 December 2011]

This finding is supported by Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola (2007:248) in that increased new HIV cases and deaths are believed to be a consequence of denial.

Health care workers, especially those who are HIV infected, avoid obtaining health care assistance from the employer, as they perceive accepting health care assistance is an acknowledgment that they are HIV infected. Avoiding such employer assistance is an indicator that the employee is in denial and afraid that once they access health care at work, information of their status could reach people the infected employee does not want to disclose to (Norman, Chopra & Kadiyala, 2005:4; Masupe, 2011: 84; Holzemer, Uys, Makoae, Stewart, Phetlhu, Dlamini et al, 2007:547-548). The following statements indicate that employers are aware that infected employees are reluctant to use the occupational health facilities at work.

*“Well with this one that I am talking about she, she was just against attending our OHC.....”* [NSM, site A, 8 December 2010]

*“So they avoid the staff clinic like the plague, you will see how they dodge, you can get an idea of the ducking and diving that goes on, the avoidance of acknowledging that they have got these diseases.”* [SO, site B, 21 December 2011]

Hence, the employees avoid the employers, despite the efforts made by the employers to accommodate them. This increases the load of the burden of maintaining confidentiality for the nurse manager who knows the disease status of the employee, thus leading to emotional burden and stress.

During the course of this study, no mention was made of workplace disclosure procedures by any of the informants, nor did I find any reference to such workplace disclosure procedures during document searches.

#### **4.4.2. Emotional burden**

Nurses care for people by providing holistic health care. The WHO defines health as the physical, spiritual and psychological care of clients (WHO, 2007), which implies holistic care. In the work context, this results in the nurse managers managing and planning the staff allocation in the hospital to provide the patients with the best possible care. They are accountable to ensure that nurses are available to provide

quality care to the patients admitted to the hospital. When they have to deal with a situation where many of the nurses in the workforce are sick themselves, they are brought into conflict with both the organization and the nurses, particularly the sick nurses, or nurses who believe that they could become sick at work. Stewart, Holmes & Usher (2012:224) concur that nurse managers experience difficulty in “juggling” their roles of ‘nurse’ and ‘leader’ or manager. They constantly have to consider the best interests of the patients, the staff and the organization and prioritize which is the most urgent at any given time. This sorting of care according to the immediate need is termed in both “emic” and “etic” language as triage. It is not always possible to care for all three together all the time.

Stewart, Holmes & Usher (2012:225), in a global study conducted to determine the present leadership milieu that nurse leaders’ experience, agree that there is a dichotomy between caring and the bureaucratic administrative requirements of their positions.

The findings of this study revealed the emotional burdens experienced by nurse managers as informants expressed themselves using words such as frustration and exasperation, strenuous, stressful, frightening, heart break and compassion. The impact is that

*“it destroys me”*. [NSM, site A, 13 January, 2011]

Flemming (2008:32) states that frustration and mental pain is one and the same thing, which seems to be supported by the way the informants expressed their emotional burden. Managerial stress is a subject which has had much written about it over time; however I found little information related to frustration. Fox & Spector (1999:917) regard the emotional reaction to frustration as a sub topic of job stress. These authors describe employee reactions to “frustrated events” or “organizational situational constraints” as frustrations perceived when the individual’s experiences do not allow them to achieve their work objectives or the required performance and the negative emotional state which the individual experiences as a consequence. These authors found that there is a positive correlation between organizational situational constraints and frustration. Kath & Stichler, Ehrhart & Schultze, (2012:9) found that the most significant job stressors for nurse managers are role overload,

organizational situational constraints and role ambiguity. Their findings are supported by the informants in my study. O'Donnell, Livingston and Bartram's (2012:203) findings indicate that where nurse managers are involved in employee behaviour, the nurse managers deem the processes involved as complicated, time consuming, laborious and stressful.

Nurse Managers' become emotionally affected when they hear about the disease status of their colleagues. Informants have expressed that there are times when such information "*comes as a bomb to me*". Sadness is experienced when employees have to pay back salaries they have received, when the employer does not seem to assist them or does not take accountability for its decisions in respect of the employee welfare or when employees pass away. The feelings of sadness are exacerbated by feelings of frustration and exasperation when the employees perceive nurse managers to be insensitive, as illustrated below:

*"It frustrates me because people will look at us as if we are not sensitive, we are insensitive. Why wanting this, wanting that?"* [NSM, site A, 8 December 2010]

The above statement is an example of what Stewart, Holmes & Usher (2011: 227) allude to when they state that in ensuring organizational demands are fulfilled, there is a personal detrimental effect on the manager, both physically and mentally. Employees, asking why the nurse manager requires certain information from them, causing frustration to the nurse managers, may simply want to maintain their privacy (Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola, 2007: 243).

The statements below are an indication of the sense of exasperation and frustration which the nurse managers experience. These statements were made when nurse managers explained some of the situations that they had to deal with, such as an employee being absent for protracted periods of time; knowing that an employee is not a safe practitioner, but having no way of resolving the problem; not knowing how to get people through the ill health retirement process; and repeatedly having to reinforce organizational policy and practice.

[employee away long term] *"What do I do?"* [NSM, site A, 1 December 2010]

*“what to do”* [to get people through the process of ill health retirement.] [UM, site C, 22 February 2011]

*“what do I do?”* [SO, site B, 21 December 2011]

The following statements are an indication of the emotional turmoil the nurse managers face in their daily staff planning decisions:

*“a person can be allocated in other areas, rather than make her leave the work, because she's got family to take care of”* [NSM, site A, 13 January 2011]

*“And the manager of the area, supervisors of the area will always be grumpy, you know we are given a pool of sick people who do not perform.”* [ANSM, site D, 26 September 2012]

Despite being ill, nurses *“beg to work”*, as they often owe monies to loan sharks and often care for the children of siblings who are deceased, compelling them to work. Employees who have applied for incapacity leave receive their salary whilst awaiting the advice of the health risk manager. If the health risk manager advises the employer not to grant the employee the incapacity leave, the employee has to reimburse the employer with the salary received if he/she has no annual or sick leave days available.

*“Most of them are made to pay back, and it's very very sad, that they pay back lots, I mean eh, eh, large amounts of money that they need to pay”* [NSM, site A, 13 January 2011]

Although the health risk manager advises the employer on the merits of an incapacity leave application by an employee, the advice provided is not binding and the final decision rests with the employer (South Africa, DPSA, 2007:11; 15; 19; 25). However, in most cases, the employer does not decide on approval or disapproval of the employee's incapacity leave application nor does it take accountability for the final disapproval of an employee's incapacity leave application, but blames the Health Risk Manager, as illustrated by this excerpt.

*“Mm, look, I think I the saddest thing about this whole .....the health risk manager, ....., ....., what they saying is they advising the on the application, so you can't hold them [Health Risk Manager] to anything, but I think the jinx of the matter is with the management, in the fact that they need to sit down with the staff member, they are*

*the ones that make the actual decision, look at the staff member, especially, in an institution, where you have doctors, see if the staff member is actually sick, and if the staff member cannot perform their duties, and take the decision, are you going to approve or are you going to disapprove. You know, you keep on blaming the Health Risk Manager. In actual fact or in essence, the institution is supposed to decide on that so I think that's the problem as well."* [HRO, site A, 19 April 2011]

Cummings et al., (2010:381) state that healthcare organizations should have leaders who use relational skills in their interaction with employees and show concern for the employees. The above statement by an informant is an indicator that the management of this hospital are not perceived to interact in a relational manner with the employees and the fact that a health care organization takes no accountability for the decision to not recommend an employee application for incapacity leave shows a lack of concern for the employee (Cummings et. al. 2010:381)

This informant was upset because he was of the opinion that there are employees who do not receive adequate assistance from their employers in terms of salaries or health, who pass away as a result (Fox & Spector,1999: 917; Kath & Stichler, Ehrhart & Schultze (2012:9). The organizational situational constraint experienced by this informant left him with feeling of sadness, as indicated below:

*"Ah, I think it does affect me because, I've actually, I have my own opinion about it, in terms of I feel that some people are not being helped and what saddens me a lot is seeing somebody really being sick and in terms of their salary or in terms of their health they are not getting much out of it, and some cases the member starts, the member actually demised" .....* [HRO, site A, 19 April 2011]

The above statement is a further indicator of a perception of a lack of concern for the employee in this hospital (Cummings et. al. 2010:381).

One of the informants mentioned that it is young people in their late twenties or thirties who are dying, not old people. This phenomenon is in keeping with the prevalence rate estimates of people in the 15- 29 year old age group, which was estimated to be 17.8% of the total population in 2009 (National Strategic Plan on HIV, STIs and TB 2012-2016 , 2011:22), as illustrated by the following statements:



*“But the frightening thing that we find here is that when we have staff who die they are young.” [HR, site B, 14 December 2011]*

One of the consequences of the nurse managers’ *“burden of maintaining confidentiality”* is the stress they experience in trying to keep everybody happy at the same time, i.e. the patients and their families, the employees and the employer (Stewart, Holmes & Usher, 2012: 225). She is also stressed because she may have to breach the trust that employees have placed in her by disclosure of their disease status. She is often the first port of call which dissatisfied employees approach to lodge a grievance in respect of employee dissatisfaction.

Providing quality patient care requires adequate staffing numbers, which are not available when employees who are sick, on maternity leave or who resign are not replaced. The nurse managers find this very stressful, as expressed below:

*“Ja so it’s very stressful, you really have to maintain that high quality of patient care and you rely on on on um good staffing norm.” [NSM, site A, 1 December 2010]*

When nurse managers have learnt of an employee’s illness, they express emotional feelings for the plight of the employee, as expressed below:

*“you have this compassion for this people feeling sorry for them” [NSM, site A, 1 December 2010]*

Nurse managers believe that being in possession of this kind of knowledge changes their personality, which is indicative of the emotional burden they carry through the staff management process, as expressed by one informant as follows:

*“.....it just changes who you are.....” [NSM, site A, 1 December 2010]*

Medical certificates which have been incorrectly written result in organizational situational constraints in that they have an impact on both the return to work of an ill employee and, consequently, staff availability. This impacts organizational productivity and thus the nurse manager’s productivity (Fox & Spector, 1999:917).

Managing the Incapacity Leave and Ill Health Retirement Policy (PILIR), following up on employee PILIR applications and re-allocating other employees into areas where

employees are absent from work, all result in NSM stress. Employees may be absent from work for a variety of reasons or resign, but they are not replaced. In spite of these shortages, the authorities maintain that there are more than sufficient nurses to provide the required care, as stated by this informant:

*"We find that the staff are sick, some are on mat leave, others resign, they are never replaced, but the feeling is that we are still overstaffed, as it is next month, I am expected to re-allocate for those areas that I said we have to commission, so it's also very stressful"*  
[NSM, site A, 1 December 2010]

This is another indication that organizational situational constraints impact on both the NSMs' job satisfaction and their emotional wellbeing (Fox & Spector, 1999:917; Kath & Stichler, Ehrhart & Schultze, 2012:9). Nurse managers experience feelings of depression when employees they try so hard to accommodate display a lack of trust in their ability and because of the perpetual conflicting interactions and demands made on them (Stewart, Holmes & Usher, 2012:227; Fox & Spector, 1999:917; Kath & Stichler, Ehrhart & Schultze, 2012:2 & 9).

Stewart, Holmes & Usher, (2012:227) suggest that the nurse managers' change of role from traditional nursing to the administration and finance of human resources management are a cause of burnout. Kath & Stichler, Ehrhart & Schultze (2012:9) confirm that nurse managers do in fact experience high levels of stress at work.

Findings showed that nurse managers experience conflict within themselves in respect of the decisions they must make related to the clinical placement of ill employees and the expectations of the employer, and feel that at times they have a *"fear of destroying the employee's life"* as indicated below:

*"And it's extremely, extremely stressing, because you know that with the mistake that you make, you can destroy this person's life when she gets infected so."* [NSM, site A, 13 January 2011]

Stewart, Homes & Usher (2012:227) refer to such situations as *"anxiety at failing to meet demands."* This form of conflict is supported by Fox & Spector (1999:917). Kath & Stichler, Ehrhart & Schultze (2012:7), however, did not find that interpersonal conflicts were a significant contributor to nurse manager stress.

Employees who are not ill and continue working are also stressed and overloaded by the extra workload and, if and when they complain, the nurse manager is unable to explain the situation to them. These employees, therefore, have an incorrect perception of the situation as to them it appears that the nurse managers are not being fair to them (Spritzer, 2004:6). This is confirmed by the following statements:

*“workload is increased, people are sick, they are short staffed, you know, it it it’s an added burden too, to, to, the staff [[who remain at work]], they are burnt out, highly stressed, you name it, you know, so it is a problem” [NSM, site A, 8 December 2010].*

*“At times really it, it gets too much” [NSM, site A, 8 December 2010].*

*“So you now face a challenge of you’ve got to have sick and well people and the well ones not always understand the fact that this one is sick because at the end of the day we all get paid.” [ANSM, site D, 26 September 2012]*

The nurse managers get to know all of the nursing employees through the course of their work of managing, planning and scheduling the nurse staffing for the hospital, which indicates that nurse managers practice their management by using a relationship focus (Cummings, MacGregor, Davey, Lee, Wong, Lo, Muise & Stafford, 2010:378). By using such a relational approach, Cummings et al., (2010:378) have found that the nurse managers who listen, show empathy and engage with employee concerns develop a relationship of trust with their employees Cummings et al., (2010:378) refer to this as *“tuning in to the emotional needs of the staff”*

The findings of this study revealed such a relational approach, as illustrated by the statement below

*“you need to wear a person’s shoes, to get to understand a person”*  
[NSM, site A, 13 January 2011]

This statement also expresses the empathy the informant feels for the sick nurses once she is aware of their disease status. The consequence of the sick employee sharing such personal information and the feelings of empathy expressed by the informant is that nurse managers get to know the sick employee on a more intimate level, both professionally and personally.

It is little wonder, therefore, that nurse managers have expressed the emotional burden of frustration when they are perceived to be insensitive by the employees, because they are carrying out their duties as expected by the organization.

The impact of employees' disclosure and having to maintain confidentiality was also described as strenuous. On occasion, when information is provided to the nursing management about the health of an employee, there is a need to share the received information with another person, because of the emotional impact on the nurse manager, which was described by one informant as *"it destroys me"* and *"I am a human being"*. The nurse managers are aware that they should not be discussing the information they have received. This need to "share" such information is described as follows:

*"At times you know, I, I come across somebody whom we thought she was excellent, but all of a sudden you'll find that this person is ill. They may be HIV positive, and it destroys me. I mean I am a human being. You'd want this to share with somebody, so that at least you get that out, much as I know it is not right"* [NSM, site A, 13 January 2011]

Nurse Managers sometimes feel the need to "debrief" after being the recipient of distressing information.

A further expression of sadness expressed by informants was that there were cases of students in training [nurses] who did not want to disclose their disease status or receive treatment and became ill in the final months of their training or soon after they had completed writing their examination and consequently died. The following statements reflect the expressions of sadness and fear:

*"and you will find that sometimes it is sad because even the students, those that do not want to actually come forward and get help, they go ill in the exam month or just after they have written their exams, that you find that they end up dying." 'Which is pretty sad.'* [NS, site B, 3 November 2011]

*"But the frightening thing that we find here is that when we have staff who die when they are young."* [HR Manager, site B, 14 December 2011]

Employees sometimes recover, but with an immune system that is compromised they become re-infected or have a relapse of the disease. The informant was aware of at least one such case, as stated below

*“But then you see what happens is, sometimes our staff recover but with TB as soon as your immune system is compromised, we have had cases where staff members (I don’t know what the correct medical terminology is) but they struggle with TB once again.”* [HR Manager, site B, 14 December 2011]

*“Some of our staff members seem to have an on- going battle.”* [HR Manager, site B, 14 December 2011]

A further stress expressed by the informants in this study were related to employees receiving medical certificates from their attending medical practitioners with incorrect dates of absence, as illustrated below:

*“So in her case Doctor booked her from November till 1st of Feb, which is quite a long time, BUT other days have not been covered, so it its sooo stressful.”* [NSM, site A, 1 December 2010]

I observed the nurse manager in hospital A, while dealing with a nurse whose dates on a medical certificate were not correct, trying to make sense of when the nurse was due to return to work. The medical certificate stated that the nurse’s sick leave should end on 12 March 2011. The date of my observation was 28 March 2011. So for sixteen days (16) the nurse was either not at work when she should have been or the medical certificate had not been completed correctly. The following comment was made to me by the NSM at the time:

*[in exasperation] “Doctors! My anger is rising! It’s either their [doctors] refusal, or incompetence!” “In the words of a sister: They are letting them down! or the staff does not understand!”* [NSM, site A, 28 March 2011]

The level of frustration and anger is clear by the above statement and is an indicator of the emotions nurse managers experience through their day to administrative function.

#### 4.4.3. Burden of absenteeism

A recent report indicates that the state of absenteeism in South Africa is problematic and that both public and private sector employees mismanage their sick leave. However, the information on the public sector is more damning than that for the private sector. The absentee rate in the private sector is 9%, while it is 30% in the public sector (Sunday Times, 20 May 2012). This is very high. The accepted absentee rate is between 3% and 4%, which indicates that the rate in both the public and private sectors in South Africa is way above the accepted norm. This calculation has been made based on all employees using all their 36 days leave of absence in a 3 year cycle. Absenteeism is a common problem in the management of employees in the province of KwaZulu-Natal, South Africa, as is indicated by the following entry in my field notes:

*“The Provincial Premier believes that discipline is a way to reduce absenteeism”* [Ethnographer observation, site A, 14 September 2011]

It seems apparent that employees mismanage sick leave. Mfusi and Steyn (2012:157) conducted a study to assess school principals' problems in managing school teachers with HIV. As in my study, sick educators apply for long periods of absence due to their disease status (Mfusi & Steyn (2012:158). However these authors also found that employees apply for leave of absence to attend to sick family members or to attend funerals. Within the absentee burden, prolonged sick leave and absence as a result of PILIR are a concern.

During the course of my field work, I observed nurse managers dealing with the consequences of nurse absenteeism on a daily basis. On one such occasion, in hospital C on 3 November 2011, I observed the night superintendent phoning for replacement staff. I made the following entry in my field notes:

*“The staff nurse scheduled to work had phoned at about 18h15 to report that she will not be on duty. The staff nurse had been sick last night, but had been on duty. Sister J had checked with her in the morning, but she said she would be on duty. She phoned at the last minute to report sick”* [Ethnographer notes, site B, 3 November 2011].

The nurses in this hospital commence duty at 18h00, on the night shift. This nurse phoned after the commencement of work. The night superintendent was then placed in a situation in which there was a nurse absent from work and which they were not able to plan for.

#### **4.4.3.1. Prolonged sick leave**

When nurses are absent from work for longer than 36 days, their absence impacts service delivery, as explained by an informant below:

*“I wish, you will see my change list, because I've got about 4 professional nurses who are on long term sick leave. It's really hitting on the institution because we've got few, I mean even if you have, most of our posts with the PN's are filled, but the 4 that are away they have an impact on service delivery.”* [NSM, site A, 1 December 2010]

Service delivery quality is affected by people being absent from work, and this is exacerbated by the effect HIV and/or TB have had on the workforce.

The employer is not able to employ a replacement employee into a post held by somebody else, even although he/she is absent and non-productive. This creates staff shortages, as explained below:

*“had a case where an employee, was, applied for temporary incapacity, er, permanent incapacity, it was disapproved, so you going to have to have that staff member in, in your institution, she is going to be occupying a post while she's sick at home, and eventually the staff member will die,”* [HRO, site A, 19 April 2011]

*“but there is something that is not right, because at the end of the day the people would be going absent, they are booked off. Some of them are booked. They need to be boarded off but they are not boarded off. They still keep walking and they are counted as numbers and they're occupying posts.”* [ANSM, site D, 26 September 2012]

Mfusi & Steyn (2012:158-160) made similar findings in their study in which they interviewed school principals, stating that the Department of Education was unable to provide schools with replacement staff when educators were absent for long periods.

Prolonged absenteeism due to HIV and/or TB compound the normal shortages which occur when employees are away from work due to annual leave, ordinary sick leave, maternity leave, family responsibility leave, study leave or retirement. Managing such absenteeism on a daily shift by shift basis increases the workload and stress of the nurse managers and the employees who have to take on the extra workload.

Employees stay away from work on temporary disability leave for lengthy periods of time, pass away or return to work when their situation improves, as claimed by an informant in the following statement:

*“We have had some staff members who come back to work and then we have had others who unfortunately have passed on and we have had some that have been on that temporary benefit for at least a year.”* [HR Manager, site B, 14 December 2011]

#### **4.4.3.2. Policy for Incapacity Leave and Ill Health Retirement (PILIR)**

Incapacity leave is not a right. It is additional sick leave granted to an employee at the employer’s discretion to deserving cases and is managed in the public sector by reference to the Policy for Incapacity Leave and Ill Health Retirement (PILIR) (South Africa, DPSA, 2009:1-29). This means that the employer can refuse to grant an employee incapacity leave. The employer has the right to the final decision of accepting or turning down the employee application based on the facts that the employee presents [KZN HR, 23 May 2012]. However, employees have the perception that incapacity leave is additional sick leave to which they are entitled if they can present the employer with a medical certificate proving that they have been or are sick. This is supported by the fact that the temporary incapacity leave utilization rate in the KwaZulu-Natal Department of Health is 11.5% (KZN Provincial Government, 2012:8). In other words 11.5% of employees in this department have exhausted their 36 days sick leave for the sick leave cycle 2010- 2012.

The South African government realised in 2006 that employees were abusing leave and sick leave. The Policy for Incapacity Leave and Ill Health Retirement (PILIR) was then formulated and implemented in 2007 as a pilot project. General implementation occurred in 2009. There are five companies that provide health risk services to the South African Government by managing and advising the government on the merits



of each application for incapacity leave. The KwaZulu-Natal Provincial government employs one of these companies. The contracts for all five companies exist for the period of each sick leave cycle. The current sick leave cycle commenced on January 2010 and will be effective until December 2012, after which the companies must retender to provide the health risk management service.

Applications for incapacity leave can be made for short periods of time which relates up to and including twenty nine days in excess of the normal thirty six days of sick leave in a three year cycle or long periods of time, which is in excess of the extra thirty days initially applied for (South Africa, DPSA, 2009:7). An informant from the health risk management company stated that people should be encouraged to apply for PILIR as soon as it is evident they are ill.

There is a perception among nurse managers that PILIR has a value in that employees who apply for incapacity leave are compelled to disclose their disease status, as indicated below:

*“I do think that PILIR is a good thing to a certain extent because now a person is forced to disclose”* [OHM, site A, 14 April 2011]

When employees are seriously ill, they run out of available sick leave very quickly. The first thing that they are offered by the employer is temporary incapacity leave/short term incapacity leave which is available up to 30 days at any one time, provided the employee is seriously ill. All the informants made similar statements around PILIR as those below:

*“Now when you have a staff member who is seriously ill the sick leave runs out very quickly.”* [NSM, site A; HRO, site A; HR Manager, site B and KZN HR,]

*“So we then as a hospital offer temporary incapacity leave, which is a maximum of thirty days at any one time for a staff member who is seriously ill.”* [NSM, site A; HRO, site A; HR Manager, site B and KZN HR]

This policy gives clear guidelines for turnaround times between the sick employee and the employer, the employer and the health risk manager and the health risk manager and the employer (South Africa, DPSA, 2007:8). The informant from the health risk management company informed me that in 2011, KZN Health had been

submitting applications dating as far back as 2009. This informant explained that it is difficult for the health risk manager to approve applications when the delays have been so long and there is no evidence of treatment and rehabilitation.

In a non-public sector hospital, the Human Resources Directorate commences an application for temporary disability at the same time as applying for temporary incapacity leave. The application for temporary disability is commenced at this early stage because the process for temporary disability applications is long and very time consuming and involves a lot of documentation. However, the temporary disability claims are only submitted to the provident fund once the employee has been absent from work for three months. The process in hospital C is explained as follows:

*“So once we are making an application for temporary incapacity leave, then we also start the process for temporary disability because it’s a very long time consuming process that involves a lot of paper work.”* [HR Manager, site B, 14 December 2011]

*“If we have a staff member who has been unable to work for three months, we can then put the paperwork through to make a claim for temporary disability.”* [HR Manager, site B, 14 December 2011]

There are however contextual differences between the public sector and the private sector related to the duration of incapacity leave applications and at what stage applications are commenced for long term disability leave. Whilst the PILIR policy makes provision for concomitant applications for short and long term incapacity leave, none of the informants in the public sector (South Africa, DPSA, 2007:26) made mention of this. While both the public sector and semi-private hospitals expressed the time consuming process for incapacity leave applications, the private sector informant mentioned an application that had taken only two days from start to finish, as confirmed by the following field note entry:

*“One sister has just had an employee put on ill health retirement, it took two days completing and submitting the documents, to the approval of the individual’s ill health retirement.”* [Ethnographers field notes, site C, 22 February 2011]

A register is kept of incapacity leave applications and employers in the public sector can inspect this register to identify applicants who are problematic or if multiple

applications for incapacity leave have been submitted by the same employee, as stated below:

*“So I mean they can just interrogate the register and say ‘oh application number thirty five this is a problem employee to have repeated applications for each incapacity leave.’ [KZN HR, 23 May 2012]*

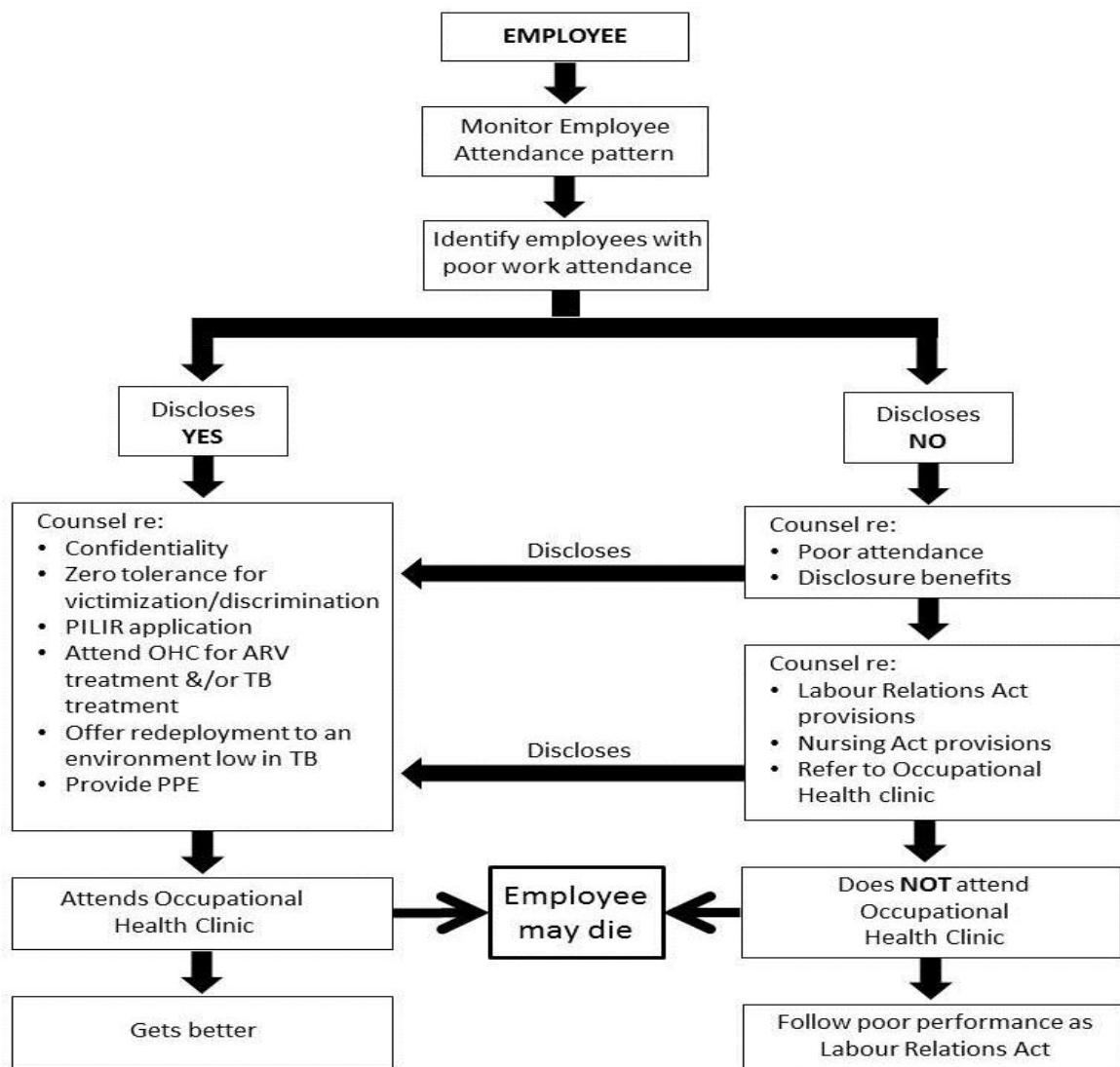
An emerging trend is that employees apply for incapacity leave and when the incapacity leave is declined, they then apply for Workmen’s Compensation for either an injury at work or an occupationally acquired disease.

*“Yes you see that is also becoming an emerging trend that employees will apply for incapacity leave and when that incapacity leave is declined then they say I actually got this injury, this TB or whatever from the workplace.” [KZN HR, 23 May 2012]*

The following is an illustration of the management processes around employees on prolonged sick leave. It is the responsibility of both the individual employee and the nurse manager to monitor the employee’s work attendance pattern. The responsibility for identifying employees with a poor work attendance pattern rests with the unit manager and the nurse manager. On identifying such an employee, the employee may or may not disclose the reasons for their poor work attendance. Where an employee does disclose the reason for his/her poor work attendance, the nurse manager should counsel the employee in respect of maintaining the confidentiality of the information received; the fact that a zero tolerance for discrimination and victimization will be upheld; how to go about making an application for incapacity leave; and the availability of the occupational health clinic at work where the employee can obtain anti-retroviral therapy or treatment for TB. The nurse manager should offer the employee redeployment to another environment where TB infection may not be a problem and discuss the availability of personal preventive equipment and the need to wear such equipment. If the employee attends the occupational health clinic and receives and takes the treatment offered, this employee should return to his/her previous state of productivity.

Where the employee does not disclose his/her disease status, the nurse manager should counsel the employee about his/her poor work attendance and discuss with the employee the benefits of disclosing his/her disease status. Should the employee

still not disclose, the nurse manager should counsel the employee about the provisions in the Labour Relations Act (66 of 1995), as amended, with regard to termination of the services of an employee no longer able to perform his/her work due to illness and provisions of the Nursing Act (33 of 2005) around impairment, and offer the employee referral to the occupational health clinic. Should this employee not attend the occupational health clinic as recommended, the nurse manager should follow the provisions for poor performance contained in the Labour Relations Act (66 of 1995), as amended.



**Figure 4. 6:** Algorithm depicting Management processes around employees on prolonged sick leave.

During the course of this study, hospital A had five employees in the nursing service absent from work, while in hospital C there were two, as illustrated by the following

table 4.7, however nurse managers did not have accurate annual statistics available for their own use. Hospitals B and D did not provide specific numbers for nurses sick with specific diseases.

**Table 4. 7:** Summary of diagnosis of employees absent long term during the course of data collection

<b>Diagnosis</b>	<b>Hospital A</b>	<b>Hospital C</b>
Co-infected	X	
Stroke	X	
Back problem	X	
TB		
Suspected TB		X
MDR - TB	X 2	X

Professional nurses fall into the most prominent job category for applications of long term sick leave applications [Health Risk Manager Interview, 28 October 2011]. However, according to KZN Provincial Government (2012:12), professional nurses in the KwaZulu-Natal Health Department fall into the most prominent job category for applications for both short and long term incapacity leave. The majority of long term disability leave applications are professional nurses with back problems, respiratory problems, HIV and carcinomas [Health Risk Manager Interview, 28 October 2011] (KZN Provincial Government 2012:12). This substantiates the perceptions of nurse managers and explains the “shortage” of professional nurses.

The most prevalent diseases in both short term (62.9%) and long term (43.1%) applications for incapacity leave are in descending order: respiratory diseases; psychiatric diseases, lower back conditions, cardiac conditions and chronic fatigue. In cases of TB, where the application does not stipulate whether the person has MDT-TB or XDR-TB, the health risk manager applies the National TB guidelines [Health Risk Manager Interview, 28 October 2011] which permit only two weeks of absence on initiating treatment. One cannot be booked off for six months once the contagious period has passed [KZN HR, 23 May 2012]. Employees need to return to work and continue to ensure that they take their medication. Therefore sufficient incapacity leave is given for recuperation, although it is not full recuperation. As long

as the employees can recuperate to some point and return to work to perform partial duties, the health risk manager expects them to do so.

The employer's role in applications for incapacity leave is that the employer has the option of converting incapacity leave applications turned down by the health risk manager to annual leave, if the employee has annual leave available. If the employee does not have annual leave available, then the application is converted to leave without pay, which then means that the employee has to pay back any salary paid to him/her whilst awaiting the decision of the health risk manager, as indicated below:

*"The employer then has the option of converting that incapacity leave to vacation leave if they have it and if they do not, then it is leave without pay and then that means they have to pay that back."* [KZN HR, 23 May 2012]

Such a situation increases the emotional burden of the nurse manager. He/she has to deal with the disgruntled employee.

Managing the policy on incapacity leave and ill health retirement (PILIR) results in stress, as it involves following up on employee PILIR applications, as indicated by the following statements:

*"Very stressed, very stressed, because I have been doing it from the past, ever since it started, I think, it was implemented, if I am not mistaken, in 2006 or 2007."* [NSM, site A, 1 December 2010]

*"If the person is sick, they know about the policy, that within 3 days if you don't report to HR, forms must be submitted by 5 days, and you find that most of them they submit them maybe even if it's after a month, you keep phoning them, you remind them and they still don't respond, and it's very, very stressful."* [NSM, site A, 1 December 2010]

The application process for incapacity leave is as follows: normal incapacity leave applications are sent directly to the health risk manager from the human resources component at the hospital. Generally, when employees return to work after being off sick, they apply for the incapacity leave already taken and for which they have been paid. There is a cut-off date for submissions each month, and hospitals and employees must work within the cut off dates. There is a set administrative process.

If everybody kept to the time frames then employees would receive feedback within a month of submitting their application. Each application made by each employee is given a number by the HR department in the hospital. In the case of nurses, applications are received by the human resources component from the nursing management office.

It is also the responsibility of the HR department in the hospital to receive the response from the health risk manager and advise the employee of the outcome of his/her application and apply the final decision made. Seventy percent (70%) of incapacity leave applications are turned down by the health risk manager, which is in other words the majority of the applications submitted, as stated by an informant below:

*“So the majority of the incapacity leave applications in this department are not advised by the health risk manager.”* [KZN HR, 23 May 2012]

It is the opinion of this informant that in most cases incapacity leave applications are not approved as a consequence of mismanagement. She went on to say that it is the belief of the South African Government that supervisors are reluctant to manage the process. This statement is supported by the fact that 54.4% of applications received by the health risk manager from the KwaZulu-Natal Department of Health are for short term temporary incapacity leave of three days or less (KZN Provincial Government 2012:3). Supervisors are reluctant to investigate why people are sick and to become involved in helping the employee. Following up and obtaining the completed incapacity leave application forms from the employees is the line managers' responsibility, and this is where the problem develops, especially in the nursing services, as nursing line managers do not follow up and receive the completed application forms, as is illustrated by the statement below:

*“They nurse, you know they need to do the administration, they need to do the home visits, they need to be more, not them as in the nurse manager personally but I mean via the other managers and supervisors.”*[KZN HR, 23 May 2012].

Treatment compliance and access to treatment are part of the decision making process of the employer during decision making in respect of whether to grant

incapacity leave to ill employees. If the HIV status of the employee is not disclosed to the health risk manager, the application may be deemed to be excessive for the diagnosis, especially where the applicant is applying for additional sick leave for “minor ailments” such as gastro [enteritis], upper respiratory tract infection etc. and are thus rejected. The prevalence of HIV among incapacity leave applications finalised by the health risk manager indicate that while 29.4% of short term incapacity leave applications are suspected to be HIV positive, only 2.2% are confirmed and while 23.3% of long term incapacity leave applications are suspected to be HIV positive, 12.4% are confirmed (KZN Provincial Government 2012:14). These statistics clearly indicate that the employees are not providing the required information on their applications for incapacity leave.

Applications for PILIR are also rejected on the basis that the treatment received for the condition was not optimal or the diagnosis submitted was vague. The health risk manager’s decisions are based on the diagnosis provided by the attending doctor. Vague diagnoses are submitted by doctors on sick leave certificates. A vague diagnosis is a diagnosis where the doctor documents the symptoms of the employee on the sick certificate and not a diagnosis. There is thus insufficient information on the sick certificate to inform the granting of incapacity leave. Examples of vague diagnosis are sore throat and sore foot, where they should have documented upper respiratory tract infection or tonsillitis and ankle sprain or fractured foot. The absence of an accepted medical diagnosis makes it difficult for the health risk manager to make more than a ‘desk top’ assessment. If the diagnosis does not convey how ill the employee actually is, the health risk manager may not advise that the employee be granted incapacity leave. Twenty-seven point three percent (27.3%) of short term incapacity leave applications are turned down due to vague diagnosis (KZN Provincial Government 2012:3). However through document analysis for my study, I found that medical practitioners are explicitly instructed to use “laypersons” terminology on medical certificates, which they comply with (PILIR, 2009:9; South Africa, DPSA, 2012:29; HPCSA, 2007:3). The diagnosis issue also contributes to the burden of absenteeism, as sick employees are requested to return to the doctor for correction of the diagnosis on the medical certificate.



The most prevalent reason why applicants' long term incapacity leave is turned down is due to the excessive duration of leave [i.e. excessive for the condition diagnosed and recovery period required] applied for (KZN Provincial Government 2012:3). The employee may pass away due to his/her illness and then the Department of Health may overturn the health risk manager's advice.

Injuries or diseases which should be claimed from the Workmen's Compensation Commission are initially applied for as incapacity leave, and when this is declined employees then request the employer to submit claims for occupational injuries or disease, as indicated by the statement below

*"Then you know something that they should have first put in as an IOD they wait for it to go as an incapacity leave and only when it is declined then they want to you know request it to be an IOD."* [KZN HR, 23 May 2012]

The health risk manager works from the premise that although the employee may be ill and therefore applies for incapacity leave, if the employee can perform either part or some of his/her duties then the employee is expected to perform the duties that she/he is able to, thus preventing the employee from being given incapacity leave unnecessarily.

#### **4.4.3.3. "Shuffling around the staff"**

Across the hospitals, nurse managers used various ways of "shuffling around the staff" in order to compensate for employees who were not at work, whether it was as a result of absenteeism, resignations, retirements or death. The "shuffling around of staff" is a way of maintaining the quality of care delivered to the health care users within the hospitals. In other words the nurse managers take a nurse from a ward that may have adequate or sufficient staff and less workload and redeploy the nurse to the ward where there is inadequate staff on the given day or they employ temporary staff. Strategies which the nurse managers use include telephoning wards with what they have been informed have a lesser workload for the day and request that nurses are redeployed from that ward to another for the day or they telephone staff employed at the hospital who are day off or on leave allowing these nurses to work extra hours in the form of overtime or they telephone and negotiate with nurses

who are on leave and bring them back to work or they telephone locum staff or an agency as are illustrated by the comments hereunder.

In the event of employees not having been replaced, locums were employed by the semi-private and private hospitals.

*“So in cases like at the moment where we haven’t replaced some of the staff uhm we end up using a locum staff for that period depending on the category again of the staff member.” [NS, site B, 3 November 2011]*

When they were unable to source locum staff, there were also times when the hospital employees were given permission to work more than the statutory 40 hours per week in an attempt to alleviate the staffing shortage and maintain quality care.

*“So as much as we know the stipulated hours that they are supposed to be working you find that some of the staff end up doing extra overtime because of the shortage we have and nobody else to call.” [NS, site B, 3 November 2011]*

Both the semi-private and private hospitals used an agency to assist with staffing when they experienced problems in sourcing nursing staff, but said that the agency was utilizing retired nursing staff whom they found to be more of a hindrance than a help. The nurse managers believed that retired nursing staff compromise quality care delivery.

*“Or the agency that we are using at the moment are sending us a lot of retired staff and you find it is not as productive because you end up orientating instead of having somebody to assist you.” [NS, site B, 3 November 2011]*

One of the roles of the night superintendent is to ensure that all employees scheduled to be at work are in fact on duty, where during the day, this role falls on the unit managers and not the nursing managers, as is explained below

*“Okay. As night super it is the usual thing you know uhm, checking the staffing and manoeuvring staffing, shuffling where there is a need.” [NS, site B, 3 November 2011]*

If there is a staffing shortage, nurse managers move an employee from one unit to another to compensate i.e. maintain quality care delivery

*“Sometimes it even involves shuffling staff from one unit to another due to needs for example the midwifery department, if we find that there is a lot of shortage and we end up using a lot of locum staff there and we have a midwife in another department who is not being utilized as she should we try to shuffle the staff around to accommodate that”* [NS, hospital B, 3 November 2011]

*“staff will be distributed according to their load, workload.”* [OHM, site A, 14 April 2011]

The nurse manager ‘shuffles’ the staff to accommodate the absence of the sick employees and employees are redeployed into wards where they would be most productive. When it is necessary to replace an employee altogether, the manager organises locum staff.

*“And then the manager just, she I mean, she shuffles around the staff and maybe if that staff needs to be replaced they organise locums and stuff but we have to report to them first when they’ve been granted longer sick leave, we know, we are the ones that report.”* [OHN, site B, 1 February 2011]

There are times when nurse managers have had to ask employees who are on annual leave to come in to work on a specific day during their leave in order to eliminate the staff shortage.

*“the researcher witnessed a telephone conversation the Nurse Manager had with a nurse where they negotiated the need for the nurse to work on a Sunday during her annual leave is a way to provide a sister to cover a Sunday.”* [Ethnographer observation, site A, 28 March 2011]

The “*shuffling around of the staff*” as described increases the workload and the burden of stress, which in turn adds to the emotional burden for the nurse managers and unit managers. This daily “shuffling” of employees increases the stress levels and workload of the employees who are “shuffled” as well as those who have to provide nursing care when colleagues are not at work. The increased stress levels and workload have an impact on quality care delivery. However the contrasts between the private and public sector settings in respect of management and planning for unexpected absences of nurses recognises the reality of the situation

and the nursing workforce appears to be coping with the personal disease burden whilst making an attempt at providing quality health care for sick patients.

#### **4.4.4. Burden of policy compliance**

Maintaining policy compliance within the nursing service is an important function of nurse managers. They are expected to comply with policies that have been introduced in order to ensure that there is standardisation within the organization. Policies are a means of ensuring that organizational goals and objectives are reached by all services and employees within an organization. In instances where policy compliance is problematic, conflicts and employee dissatisfaction can occur through inconsistent management.

##### **4.4.4.1. Nurse managers and policy compliance**

The nurse managers express a dichotomy between caring for the employees and human resources policy implementation once they know that an employee is sick. The very essence of being a nurse is caring for the ill. The essence of being a manager is policy implementation and power. Nurse managers not only have to fulfil the requirements of the Human Resources Directorate, through the human resources manager, in the implementation of human resources policies, whilst at the same time remaining empathetic and caring for sick employees, but they also have to provide quality patient care so that the patients and their families and their employer are kept satisfied. The dichotomy is explained as follows:

*“How do you then divide yourself because I know that policies are in place and they must be followed but at the same time where is that Ubuntu?” [NSM, site A, 1 December 2010]*

“*Ubuntu*” is a term which is included in various forms in the vocabulary of most African languages. The isiZulu term “*Ubuntu*” is the base on which the principles of ethnic morals and ethics are founded (Maluleke, 2012:5). The primary ethical values are respect for others, helpfulness, community, sharing, caring, trust, unselfishness and empathic relationships (Edwards, Cramer, Kelaiditis, Edwards, Naidoo, & Davidson, et al. 2011:98). *Ubuntu* emphasises collectively, togetherness, caring and sharing with others (Makoae & Jubber, 2008:38; Maluleke, 2012:15) and relates the physical and spiritual worlds, interpersonal relationships or humanism. The overall

concept of *Ubuntu* values people as a community, rather than as individuals (Maluleke, 2012:5). *Ubuntu*, in a nut shell, is expressed in the phrase ‘*A person is a person through other persons*’ and is a single word which emanates from the phrase “*umuntu ngumuntu ngabantu*” (Ross, 2010:44). Maluleke (2012:4) phrases *Ubuntu* as ‘*I am what I am because of who we all are*’ and states that *Ubuntu* emphasises group agreement or consensus.

The informant making the statement above is an African and an isiZulu speaker. The use of the word *Ubuntu* is an indication of the dichotomy between policy implementation and her cultural ethic of caring, trust and empathetic relationships with the nurses with whom she deals on a daily basis. The wellbeing of the total community is the overarching goal of *Ubuntu*. The morals taught which encourage community wellbeing are morals such as compassion, cooperation and communalism and are respected within African cultures (Maluleke, 2012:15). The informant is expressing that the policy compliance required of her, particularly in respect of human resources policies, contrast to her inherent belief of compassion and cooperation with sick employees. The dichotomy which she experiences adds to her stress and emotional burden in the course of daily work when dealing with sick nurses at work. The concept of *Ubuntu* encourages group cultural conversation, prevention of illness as well as healing. In many ways the demands of their duties add to nurse managers’ stress in that complying with policies and maintaining confidentiality becomes a burden as they contradict the cultural beliefs of the nurse managers in an African context.

My observation in hospital A was that policy compliance was in place and that there were policies. However, on one occasion, I asked the nurse manager if it would be possible to see the policy she used as a foundation for her staff management and planning. I received the following answer to my request:

“*We don't have a policy*” [NSM, site A, 1 December 2010]

I observed that the time frames for reporting sick as per the sick leave and PILIR policy are not adhered to by employees, and that nurse managers experience difficulty in getting employee compliance around such time frames.

#### 4.4.4.2. Occupational Health and Safety compliance

Section 8 of the OHS Act (85 of 1993) requires that the employer must identify the major hazards to which employees are exposed in the work place. Hazards identified at the sites are needle stick injuries (sharps injuries) and TB, as stated in the following quote.

*“You know I am a safety person so the act says in section eight that we must identify what is wrong, what are the major hazards and the major hazards are needle sticks and TB.”* [SO, site B, 21 December 2011]

All the hospitals reported an improved occupational health and safety compliance to a greater or lesser degree. The improved occupational health and safety compliance has been the result of policy implementation in instances where such policies were not in place, for example strict mask wearing policy for the wearing of N95 masks in respect of when and where N95 masks should be worn, in order to protect employee and patient health. Informants have reported that there have been improved provision of N95 masks to employees and designated areas for the wearing of N95 masks have been identified and implemented, as is explained below.

*“our staff are then provided with N95 masks, which are also expensive”.* [NSM, site A, 8 December 2010]

*“and we also developed a protocol and we identify risk areas where it is mandatory to protect yourself with an N95 mask.”* [IPCO, site B, 21 December 2011]

As a consequence, employees wear N95 masks in designated areas and are aware of the legal implications/ramifications. The Occupational Health and Safety Act nr: 85 of 1993, as amended, in section 16, named the chief executive officer (CEO) as the person who is legally responsible in any organization. The CEO may delegate this responsibility to another employee, but remains personally accountable. The legal responsibility of the CEO and the consequences to persons holding this post is explained by an informant below.

*“Ja he is.” “He understands the ramifications, he understands and he tells them [employees]; you are going to put me in jail.”* [SO, site B, 21 December 2011]

During my field study, the safety officer in hospital B informed the senior managers about the law and the implications/ramifications of the law for them. All the heads of department were gathered together and the informant explained to them that the employer cannot force employees to comply with the legal requirements. He asked the heads of department to do their best to encourage compliance, however, and warned them about its importance. He explained that the occupational health and safety policies have been implemented in order to protect employees from becoming infected by occupationally acquired infections, such as TB at work. Because KwaZulu-Natal has such a high TB prevalence and remains an area where HIV prevalence is high, implementation of and compliance with occupational health and safety policies is a critical management role.

In this hospitals 100% compliance with the wearing of N95 masks in the designated areas in accordance with the Occupational Health and Safety Act (85 of 1993 as amended) was achieved over an 18 month period through the use of a forceful tactic along with obtaining the '*buy in*' of employees and therefore their compliance.

The Occupational Health and Safety Act (83 of 1993) stipulates that employees use personal protective equipment in areas that are deemed unsafe and the employer has a responsibility to ensure that employees comply. An informant stated employees do not comply with wearing masks when he is not around and complain that they get hot when they wear the masks. The informant explained as follows:

*"because when I am not there they dodge and duck and dive and hide; "it's too hot."* [SO, site B, 21 December 2011]

The hospital policy of site B requires that N95 masks are worn in the medical and surgical wards because patients are mixed in those wards and there may be some patients who have undiagnosed TB in either of these wards. There are often patients in the medical wards awaiting confirmation of a TB diagnosis. These patients are infectious, which increases the risk for nurses becoming TB infected through their work. N95 masks must also be worn in the Out Patient Department (OPD) and paediatric wards

*"that doesn't mean we don't have patients who do not have TB in the Medical ward still and those in the TB ward are better than those in*

*the Medical ward while they are still waiting for results so if you try to explain to them they don't buy that they don't understand....."* [NSM, site A, 1 December 2010]

*"We encourage them to use protective clothing especially the N95 mask, so that they don't contract TB"* [OHM, site A, 14 April 2011]

The findings revealed that employees in hospital A have been reluctant to wear masks when caring for medical patients as they believe that they would not contract TB from patients in the medical wards, as illustrated by the statements below:

*"they've been not using masks, thinking that because they are medical patients they won't eh, contract TB from them."* [OHM, site A, 14 April 2011]

The reluctance of employees to comply with Occupational Health and Safety policies adds to the nurse managers' stress and their burden of ensuring policy compliance as they are accountable for ensuring policy compliance and it is their responsibility to ensure that nursing employees are protected from occupationally acquired diseases.

Informants from hospital C stated that their employees were quite good about the wearing of their N95 masks, thanks to the occupational health and safety officer and infection prevention and control officers who conduct in-service training, even on night duty, as expressed by the quote below:

*"And I must say our staff is quite good regarding that. We thank our occupational health and safety, he [[laughs]] makes sure of infection control as well."* [NS, site B, 3 November 2011]

While my observations during field work supported the above statement as the employees of that hospital were very good about complying with Occupational Health Policies, particularly around the wearing of personal protective equipment, this particular informant, however, failed to comply herself with the wearing of an N95 mask during our ward rounds through the hospital although she had asked me to do so.

In hospital A, it is the infection prevention and control section which ensures that N95 masks are provided to all the wards. Hospital C intended separating the trauma and casualty areas within the OPD in an attempt to prevent the spread of TB. The



informant used the following metaphor to explain why the separation within the OPD is necessary:

*“You know we are splitting it?’ ‘We are splitting Room .... which is our OPD, our casualty section and the trauma from out patients.” [SO, site B, 21 December 2011]*

*“You know the theory of coming there with a cut finger and ending up walking out with TB?” [SO, site B, 21 December 2011]*

*“So ja we are divorcing the two.” [SO, site B, 21 December 2011]*

In accordance with the Management of Drug-Resistant TB Policy Guidelines (South Africa, DOH, 2011:1-65), hospitals A, B and D employed cough officers to identify people who are coughing. People who are observed to be coughing are provided with a mask, and are triaged and fast tracked by placing them first in the queue for treatment.

An informant from hospital A explained that patients who cough whilst waiting to see the doctor are identified and removed from the queue to receive immediate treatment away from the remaining patients. The following comment confirms the early identification and removal of coughing people from the queues:

*“So they came up with er, er better way of trying to identify a way of Triaging them” [removing coughing patients from the queue] [NSM, site A, 8 December 2010]*

This process was confirmed by another informant at a different hospital

*“Firstly they are supposed to be fast tracked.” “If they even as much as cough just a little thing, then bang they have got to be first in the queue.” [SO, site B, 21 December 2011]*

*“Number two they have got to be given a mask” [SO, site B, 21 December 2011]*

However, this informant also stated that the process does not always work, and illustrated as follows:

*“walk in there and there are five people coughing and then I say to them; who is the cough officer? What is going on here? Why are these people here?” [SO, site B, 21 December 2011]*

The safety officer sounded exasperated when asked what he does when he finds that the cough officers are not doing what is required of them and replied as follows:.

*“and I say, what do I do?”* [SO, site B, 21 December 2011]

It became apparent, therefore, that cough officers are supposed to listen and watch for people who cough, but do not always perform their function. This can have serious consequences as it increases the risk of spreading the TB infection to other patients in the queue, as well as to the nurses. Both these scenarios add to the nurse managers' stress, emotional burden and burden of policy compliance because as nurse leaders, they are expected to ensure the safety of both patients and the staff at work.

The authorities sometimes use emotional pressure to get employees to become compliant. One of the informants explained his strategy:.

*“No. Disappointment, you know like a father figure, I am older than them. A lot of the nurses are young and then I go to them and I ask them in front of the others; what's the problem? Do you want to go and make the rest of your family sick?”* [SO, site B, 21 December 2011]

Employees are also provided with in-service training within the unit/ward, which is reinforced at central hospital level in order to ensure policy and personal protective equipment (PPE) compliance.

Infection prevention and control (IPC) provide in-service training in respect of the use of personal protective equipment to educate employees to protect themselves from needle sticks injuries (sharps injuries). The implications of needle stick injuries (sharps injuries) are emphasised during in-service training and employees are taught how to care for themselves if a needle stick injury should occur. These informants conducted training sessions on TB and needle stick injuries (sharps injuries) and have trained eight hundred and three individuals in the last year, as indicated below:

*“but we do engage in in-service training to make sure that is where we teach them to protect themselves from needle stick injuries and how to take care of themselves when they happen to have a needle stick injury.”* [IPCO, site B, 21 December 2011]

*“Eight hundred and three people have been through my training sessions on TB” [SO, site B, 21 December 2011]*

It is not possible to be compliant all the time so audits of quality, clinical care, infection prevention and control and occupational health and safety are conducted in an attempt to get compliance with the respective policies which are in place. Following the conducting of the policy compliance audits, reports are generated, in which non-compliant areas are named, as alluded to below.

*“So by doing audits you make them aware that they need to fulfil those grey areas or those gaps.” [IPCO, site B, 21 December 2011]*

*“It depends on what audits we are doing. Are we doing a quality audit, clinical audit, occupational audit, health and safety audits. And infection prevention and control audits” [IPC, site B, 21 December 2011]*

Nurse managers’ experience the burden of policy compliance in that they are expected to ensure that such compliance is achieved within the nursing service which they manage.

#### **4.4.5. Burden of death**

The burden of death is the burden experienced in nursing services and consequently the burden experienced by the nurse managers managing the nursing services as a result of young nurses passing away as a consequence of diseases such as HIV and/or TB. The nurses who have passed away are often not replaced immediately, leaving a gap in the workforce. Nurse managers then have to “*shuffle around staff*” in order to provide adequate nursing staff in wards/units affected by the death. Added to this is the emotional burden and added stress experienced by both nurse managers and other nurses at the death of a colleague.

Employees have been lost due to death in all the sites in which I conducted the research. These informants from two different hospitals reported that there had been two to three deaths of employees during the time of my data collection for this study.

*“Two sisters [Professional Nurses] demised is the result of illness” [NSM, site A, August 2011]*

*“Probably about two or three.”* [HR Manager, site B, 14 December 2011]

The data revealed that even young employees in their late twenties or thirties have died whilst in service.

*“But the frightening thing that we find here is that when we have staff who die they are young...It’s not old people, it’s young people in their late twenties and their thirties, which is very, very sad.”* [HR Manager, site B, 14 December 2011]

*“We had more, unfortunately one passed away recently due to complications”* [HR Manager, site B, 14 December 2011]

*“We have a lot of staff members that we have lost that have rested in peace in the past year”* [NS, site B, 14 December 2011]

One of the nurses passed away during my field work in site A, as illustrated by my field notes.

*“She stated that “It’s so busy, one of the staff died and we are having her memorial service today”* [Ethnographer field notes, site A, 22 December 2010]

Informants in Minnaar’s (2001:24) study informed her that nurse managers are expected to organize funerals/memorial services for employees who pass away as a result of HIV. Having to organize and attend funerals adds to the emotional burden, stress and workload of the nurse manager concerned.

Even students are affected, with many becoming ill in the final months of their training or soon after they have completed writing their examination, and if they do not receive treatment, sadly end up deceased

*“and you will find that sometimes it is sad because even the students, those that do not want to actually come forward and get help, they go ill in the exam month or just after they have written their exams, that you find that they end up dying”* [NS, site B, 3 November 2011]

In the week prior to one of my visits to hospital C, a student, who was known to be HIV positive and who had refused all treatment passed away, as confirmed by my field notes.

*“The student passed away the previous weekend is the result of being a known RVD, refusing all treatment, being in total denial.”*  
[Ethnographer field notes, site B, 10 October 2011]

There are also economic implications which emanate from students' deaths. These nurses have completed their training at a cost to themselves, their families, their employers and even the country, but this has all been in vain as the result of all this cost is never available for the supply of nursing care.

Informants told of employees and students who had been immune-compromised as a consequence of their HIV status passing away as a result of overwork as they had been studying, working and 'moonlighting' all at the same time. The informants told of employees denying that they were ill and therefore not commencing ART treatment and ultimately passing away, as illustrated here under.

*“People [staff] die rapidly is the result of denying that they are ill”* [NS, site B, 3 November 2011]

*“Staff are placed on ART, then they do well, but some refuse or deny that they are ill. These people die rapidly.”* [NSM, site C]

All of the above statements confirm that nurses are passing away due to their illnesses. These deaths exacerbate the nurse managers' already difficult job of providing adequate quality nursing care for the patients admitted to the hospitals. Nurse managers in all the sites organize memorial services for the deceased employee, which adds to their workload, stress and emotional burden.

Sub-Saharan Africa, like the rest of the world has an aging nursing workforce. The death of these young nurses means that there will be fewer nurses to replace those who are soon to retire, compounding the human resources deficits which already exist.

#### **4.5. DISCUSSION OF FINDINGS**

My findings highlight the “burdens” which nurse managers' experience during their daily human resources management, planning and scheduling around HIV and/or TB affected/infected nurses who are able to remain at work. The “burdens” which this group of nurse managers working in the eThekweni District of KwaZulu-Natal experienced are maintaining confidentiality in the context of employee disclosure of

their disease status, the stigma which remains entrenched around both HIV and TB, the emotional burden on the nurse managers, absenteeism and the nurse managers management of absenteeism in the workplace, specifically when nurses are off work and sick for long periods of time. Absenteeism results in the daily “burden” of “shuffling around of staff”. Nurse managers have to ensure policy compliance, particularly the policy of Incapacity Leave and Ill Health Retirement as well as Occupational Health and Safety Policies in place to protect both patients and employees. A further “burden” results from the death of young employees.

The findings of this study are important in that in sub-Saharan Africa, it is young women who are most affected by HIV and in South Africa, the prevalence of TB is the highest in the world (UNAIDS, 2011:24). It is most likely, therefore, that nurse managers in African countries to the north of KwaZulu-Natal and South Africa experience the same phenomena. During the course of this study I have not found other studies which have been conducted to determine how nurse managers experience the “burdens” alluded to above. However, Mfusi & Steyn (2012) conducted a study in which they discuss the problems experienced by school principals in managing HIV affected educators in South African schools.

My study makes it very clear that in the daily course of their duties, nurse managers have, in this context, the added responsibilities of ensuring that they maintain the confidentiality of information that has been provided to them by sick nurses. It is also clear that not being able to discuss the disease status of affected/infected nurses with colleagues, who may need to plan staffing when the nursing managers are unavailable, adds to the nurse managers’ stress and emotional burden. Doing no harm is the corner stone of our profession and keeping such information from colleagues can expose affected/infected employees to harm. It is clear that some nurses do disclose their disease status to the employer through the nurse managers, but, this is not always the case. Mfusi & Steyn (2012:163) had similar findings in that not all educators disclosed their disease status. Another similarity to my study was that Mfusi & Steyn (2012:163) were informed by school principals that employees declined to admit that they were ill and also refused ART treatment. However, Mfusi & Steyn (2012:163) found that some sick school employees believed that they had

been “bewitched” by colleagues and had visited traditional healers. This phenomenon was not exposed by my study.

According to Mfusi & Steyn (2012:163), informants agreed that the major reason employees did not disclose their HIV status was the violation of confidentiality. It is important, therefore, that nurse managers are aware of the circumstances in which nurses with HIV find themselves and the potential for conflict within the workplace as stated by the informants in the Mfusi & Steyn (2012:163) study, and be conscious of the fact that such nurses may be afraid of what the nurse managers or their colleagues will think of them and their life style should they disclose (Masupe, 2011: 70, Turner, 2009:229). When nurses have not disclosed their disease status to their partners, spouses or family, they are afraid to make their disease status known at work (Opollo, 2013:17-26; Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola, 2007:242-250, South Africa, DOL, 2012: 8-9). Nurse Managers’ need to be conscious of this phenomenon and have the skills, empathy and heightened awareness to identify such disclosure even in instances where disclosure is covert.

Stigma around both HIV and TB remain a concern. Once an employee discloses his/her disease status, they may be stigmatised by their colleagues at work or might even self-stigmatise. Mfusi & Steyn (2012:163) also found stigma and discrimination to be concerns within schools. A major concern is that when an individual is diagnosed with TB, it is commonly assumed in the context of this study that the individual has HIV as well (Mcfarlane & Newell, 2012:145), even if there is no evidence to prove this assumption. A further concern of both my study and that of Mfusi & Steyn’s (2012:163) is that employees fear that disclosure of their HIV status could put their jobs at risk. Perceived fear of job losses by affected nurses was not a finding in my study. Nurse Managers made no mention of nurses expressing fear of job losses. Mfusi & Steyn (2012:163) also state that the major contributor to stigma and discrimination is the violation of confidentiality.

The emotional effect on nurse managers is a concern as nursing has long been acknowledged to be a stressful occupation. Nurse managers’ feel the need to share the added emotional burden of disclosures around HIV, despite their confidential nature, so that their own emotions are not bottled up. Nurse managers’ believe that they need support to do what they do, in terms of their jobs. Stewart, Holmes &

Usher (2012:224) concur that nurse managers experience difficulty in “juggling” their roles of ‘nurse’ and ‘leader’ or manager. In a global study conducted to determine the present leadership milieu that nurse leaders experience, Stewart, Holmes & Usher (2012:225) agree that there is a conflict between caring and the bureaucratic administrative requirements of their positions.

Occupational health services and human resources practitioners should also be aware of the effect managing such ill nurses at work has on the nurse managers so that they can provide support to such executive employees. The only emotional effect which the informants in Mfusi & Steyn’s (2012:162-163) study allude to is frustration whereas the informants in my study express the emotional effect on them as frustration, exasperation, strain, stress, fear, heart break and compassion. Fox & Spector (1999:917) however regard the emotional reaction to frustration as a sub-topic of job stress. The impact is that “*it destroys me*”. Smit (2005:25) found that nurses who nurse HIV infected patients were perturbed by their own emotional exhaustion and stress. The nurses in her study also expressed that the manner in which HIV infected patients responded to their own illness and the dying process caused by HIV was emotionally draining. These findings are supported by the informants in my study where nurse managers expressed the emotional burden they experience in managing HIV affected/infected employees. Smit’s study (2005:26) noted fear as an emotion expressed by the nurses participating in her study, although the fear was not marked. This concurs with my findings where informants expressed that it was “frightening” that young nurses die as a result of HIV.

Absenteeism has long been a concern within nursing services. Mfusi & Steyn (2012:160) concur with the findings of my study as they found that prolonged or persistent absenteeism among educators who were HIV affected/infected is a major concern in schools, as such absenteeism leads to service delivery compromise. There is a difference in service delivery, however, between nurses and teachers. Patients who are in hospital cannot be not left unattended as is the case with pupils in schools rather the workload is increased for those nurses who are at work, who take up the load of those who are absent. This leads to increased levels of stress for the nurses taking on the added workload in their colleagues’ absences. Smit (2005:26), as far back as 2005, found that nurses who care for HIV infected patients



experienced an increased workload, because fewer nurses were caring for more and more patients. This supports my findings of workload increase of nurse managers attempting to manage the fewer available nurses to provide quality care to the patients. Mfusi & Steyn (2012:160) did find that educators who taught extra periods for sick colleagues also experienced increased stress levels.

There is no mechanism within the public sector that immediately replaces absent nurses. Nurse managers', therefore, have the unenviable task of "shuffling around of staff" or redeploying people who are at work day by day and even shift by shift. Mfusi & Steyn (2012:161) made a similar finding that there are often no replacement educators available. In my study, the management of sick employees' applications for incapacity leave was regarded as a time consuming activity. As far back as 2001, Minnaar (2001:23) found that HIV and the management issues around this disease take up a lot of nurse managers' time. Adding to the time taken by the nurse manager in following up of sick employees and the employees' application forms within the five day time frame, is the fact that employees are off work assuming that their application will be granted for additional sick leave. Vague diagnoses on medical certificates result in employee applications being turned down. Through document analysis for my study, I found that medical practitioners are explicitly instructed to use "laypersons" terminology on medical certificates, which they comply with (PILIR, 2009:9; South Africa, DPSA, 2012:29; HPCSA, 2007:3). However, the health risk manager requires a medical diagnosis and not "laypersons" terminology to be presented on medical certificates for short term incapacity leave applications. The diagnosis issue also contributes to absenteeism, as sick employees are requested to return to the doctor for correction of the diagnosis on the medical certificate. There is no mention of applications for PILIR in the study by Mfusi & Steyn (2012).

Mfusi & Steyn's (2012:162-163) informants expressed the frustration which they experience through the management of employees who are sick. In the case of the school principals, the frustration lay in the realm of the administration which accompanies sick leave such as the completion of sick leave forms for sick employees, whereas in my study, the nurse managers' frustration was around follow up of sick employees and their medical certificates.

The norm is that unit managers should spend 80% of their time on administrative functions and 20% on clinical functions. Management of the PILIR policy should be included in the 80% administration by the immediate line manager, for example the unit manager.

The informants in this study use innovative staffing strategies to provide adequate quality nursing care on a daily basis despite employee absences. The nurse managers make use of redeployment of staff in units where the workload is less than in another ward for the day or they allow nurses to work extra hours in the form of overtime or they bring people who are on leave back to work. These strategies are the only ones available to the nurse managers in the Public sector hospitals and are used in the Private and semi-Private hospitals sampled as well. However in the case of the Private and semi-Private hospitals sampled, if the strategies involving existing staff do not solve the problem immediately, they then employ temporary locum staff, use agency nurses as strategies to immediately replace absent nurses. Policy compliance forms an integral part of the daily work life of the informants of this study. However where staffing policies do not exist, planning is not done in a transparent manner. Should the nurse manager not be available for any reason, it would be difficult for colleagues to know what to do and which employees can work in which departments if no staffing policies exist. Consistent implementation of all human resources related policies is critical to ensuring a fair, equitable and harmonious workplace.

Death among nurses has become a norm within the context of this study. Not replacing deceased employees affects the quality of service delivered. Taken on its own, one or two deaths may have a minimal impact on service delivery, but when this is added to employee annual leave, sick leave, maternity leave, study leave and family responsibility leave, the effect of even a single death compound the staff shortages. Despite ART treatment being freely available in this district and more so to health care workers, deaths still occur because employees fear the stigma and disclosure related to taking ART treatment.

The findings of this study will be meaningful for the day to day practise within nursing management as the end result is the ever diminishing number of nurses to staff hospital wards, thus compromising patient care. This study informs the utilization of

nurses who are ill and has been the basis for the development of draft guidelines for the human resources management in respect of HIV and TB affected/infected nurses in the work place. The literature reviewed shows that specific information to aid the human resources management in respect of such nurses does not exist in the South African context. The study therefore enriches the human resource capabilities of nurse managers. The Strategy for Nursing for South Africa (DOH, 2008:16) and Employee Health and Wellness Strategic Framework for the Public Service [EH & WSF] (South Africa, DPSA, 2008:24) contend that the impact of HIV on staffing must be taken into account. The literature review reveals that the impact of HIV on staffing in sub-Saharan Africa compounds the already stretched and overworked health care workers (ICN, 2005:4). This study contributes to the body of knowledge around HIV and TB in the public sector and the world of work in South Africa, as stated in the Employee Health and Wellness Strategic Framework for the Public Service (South Africa, DPSA, 2008:24) and contributes to section 1.3.1. of EH & WSF which states: *“Develop a national framework on HIV in the work place”*. The study may encourage studies of the same or similar nature in other sub-Saharan African countries.

Despite this study being conducted in health care settings and being a qualitative study where one does not make generalizations, the findings could possibly be applied to other public sector work environments in South Africa and sub-Saharan Africa, where managers manage predominantly young women.

#### **4.6. CONCLUSION**

In this chapter I discussed the data collection and data analysis processes of human resources management. I offered an insight into my field experiences, what I had originally planned to do in the study, how the plan had changed, how I “did ethnography”, what happened at my initial visits to each hospital, and a summary of the context of each hospital. I explained in the data analysis section my experiences with the cyclic nature of ethnographic data collection and analysis, how I discovered the cultural themes I have used, how I made a cultural inventory and a domain analysis and how I interpreted the findings. The findings are presented with examples from my field notes, transcribed interviews and analytic notes. The following chapter presents the discussion of the findings.

## **CHAPTER 5**

# **SUMMARY OF FINDINGS, CONCLUSIONS, RECOMMENDATIONS AND GUIDELINE FORMULATION.**

### **5.1. INTRODUCTION**

In this chapter I summarise the research results; make my conclusions; reflect on my own experience of conducting this research and the impact which I have had on the research; make recommendations; discuss the limitations of the study and describe the guideline formulation process and the key aspects of the guidelines.

### **5.2. SUMMARY OF THE FINDINGS**

The summary of the findings will be presented in this section as they relate to the research objectives.

The findings of this study has generated new knowledge around the issues which nurse managers, involved in human resource management in respect of HIV and TB affected/infected nurses face on a daily basis. The issues which they are faced with are the maintenance of confidentiality, dealing with employee disclosure of their disease status and dealing with the effects of stigma on employee disclosure, reporting of needlestick injuries and employee reluctance to use the Occupational Health Services in the hospitals. Evaluating and monitoring of absenteeism, managing employees who are absent for prolonged periods of time, managing the PILIR applications, time lines for submission of such applications, managing disgruntled employees when they have their PILIR applications rejected by the employer and having to redeploy employees around the hospital every day. They are faced with ensuring policy compliance especially around PILIR and Occupational Health and Safety policies (including infection prevention and control policies and finally the issue of the loss of nurses from employment due to the death of nurses.

#### **5.2.1. Analysis of nurse managers' daily activities when managing human resources needs in respect of HIV and TB affected/infected nurses.**

During the course of their daily work nurse managers' deal with having to maintain confidentiality in everything they do. Not only is their maintenance of confidentiality a

foundation for “doing no harm”, but is a requirement of all professional nurses (SANC, R387, section 15(1)). Maintaining confidentiality is problematic in work situations where nurses may be HIV and/or TB affected/infected, because saying one cannot discuss a person’s diagnosis is tantamount to disclosing the diagnosis.

Nurse managers are faced with issues which emanate from the stigmatisation of both HIV and TB in that nurses do not all disclose their status, which make the clinical placements of nurses a challenge as the nurse managers do not know who to place where. Where nurses do disclose their status, nurse managers feel they need to “debrief” by discussing what they know with a trusted colleague, which results in them again not being able to maintain confidentiality. There is a stigma around nurses who contract needle stick injuries (sharps injuries), in that despite a legal requirement to report injuries to the employer, they do not do this for fear of finding out their HIV status, if it is not known, or fear that taking anti-retroviral drugs will expose their status at home, in the community and at work if they have not disclosed. It is incumbent on nurse managers to follow up on such workplace injuries, and to protect the employees, which is a challenge when nurses do not come forward. Conflict is a further daily challenge for nurse managers to deal with in that employees who are HIV affected/infected are often absent from work. Conflict develops when the nurse manager follows up on outstanding documents or when she is unaware of the employees disease status and the employee is placed to work in an environment which may affected his/her health. Nurse Managers also have to face conflict on a daily basis with employees who are bearing the increased workload.

Managing employees who are often absent from work is a daily activity of these nurse managers, especially when the unit managers have failed to manage absent employees correctly. The follow up of employee attendance patterns, medical certificates, return to work dates, applications for incapacity leave and ill health retirements, and the subsequent informing of employees that their applications have been turned down all rest with the nurse manager. As the employer representative, nurse managers have to manage the conflict of “fighting for their members”.

The provision of personal protective equipment and prevention of employee disease contracted at work is another daily activity and although this task is delegated to

either an infection prevention control officer/nurses and/or a safety officer, nurse managers have to work hand in hand with them to ensure compliance with Occupational Health and Infection control policies. The nurse manager has to ensure that not only does he/she comply, but that the nursing service as a whole complies with such policies. The nurse managers are accountable for the welfare of both patients and employees.

Policy compliance is required for the leave directive, which includes sick leave and prolonged sick leave, as well as workplace HIV and TB policies.

Providing adequate and competent nurses to nurse the patients requiring care is a further daily activity. Every day the nurse managers redeploy nurses to areas where staffing needs are the greatest. They have to find and provide substitute staff, where this is allowed, but most often have to “shuffle” staff around the hospital to ensure such staff is provided. This means being in daily contact with unit managers who report absent staff, and assisting them in providing staff from other areas in the hospital. Communication with the senior nursing service manager in order to report staffing issues is a daily activity, as is communication with the occupational health nurse, and attending doctors of sick employees.

Finally, nurse managers are also expected to organise the memorial services for employees who have passed away, or at least attend their funerals and visit the bereaved families at home. When an employee passes away, he/she again has to “shuffle around staff”.

### **5.2.2. Identify nurse managers’ perceived priorities and concerns when managing human resource needs in respect of HIV and TB affected/infected nurses in work areas.**

The priorities which nurse managers have when managing the human resource needs are providing staff on a daily and monthly basis and managing absenteeism.

Their major priority is the “shuffling around of staff” (Section 4.5.3.3) followed by protecting employees from harm at work (Section 4.5.4.2.)

Nurse Manager's major concerns are the prevalence of nurses contracting TB at work, making decisions which may harm the employee and the emotional impact that their daily activities have on themselves (Section 4.5.2.).

### **5.2.3. Analyse how nurse managers balance staff and quality nursing care while catering for HIV and TB affected/infected nurses' needs in under resourced settings.**

The major manner in which nurse managers balance staff and quality are through the "shuffling around of staff", where there are no available substitute staff. However in settings where substitute staff is available, a major daily activity is telephoning "locum" staff, "moonlighters" or nursing agencies in order to ensure sufficient nurses are available to nurse patients. The nurse managers in this study equate sufficient staff with providing quality care. They informed me that they are accountable for providing quality care. However, none of the nurse managers explained how they go about doing this except in terms of numbers of nurses. Ball, Murrells, Rafferty, Morrow and Griffiths (2013:1-10) support this perception with a study in which they found that nurses equate the amount of unperformed care with the quality and safety of care delivered to patients. Inadequate nurse staffing will always impact negatively on quality as was shown by McIntosh and Stellenberg (2009:19) in a study which they conducted of the quality of care delivered in a hospital in KwaZulu-Natal, where nurses were allowed to work extra hours in order to compensate for inadequate staff. In fact both the McIntosh & Stellenberg (2009:11-20) study and that of Hurst & Smith (2011:289) found that whether there were staff deployed from either within the hospital or brought in from external to the hospital there was a place and argument for either redeploying existing staff or employing temporary staff, in order to maintain an acceptable quality of the care provided.

### **5.3. CONCLUSION**

The findings of this study have shown that the human resources management of sick nurses in the workplace is complex and as such requires nurse managers to be knowledgeable in respect of human resources practices.

The nurse managers experience emotional and administrative challenges around the management of sick employees, which may bring him/her into conflict with either the

sick employee or the employer through the Human Resources Directorate. Maintaining confidentiality is problematic as there is a tacit understanding that when information cannot be shared, everybody knows what the employee's problem is. Stigmatization also remains a problem. Nurse policy compliance and unit manager time frame adherence are problems which delay the processing of employee applications for incapacity leave. There are emotional impacts on the nurse managers, as well as service delivery impacts on the organization as a result of HIV and/or TB affected/infected nurses remaining at work. Nurse managers employ various staffing tactics in an attempt to provide adequate staffing to nurse the hospital patients, which include redeployment, reshuffling, the use of agency nurses and the use of locum staff. In order to protect the employees, managers and employees need to be constantly monitored and evaluated to ensure that they comply with occupational health standards needs constant monitoring. Employees avoid using hospital occupational health facilities and fail to report injuries on duty and/or occupationally acquired diseases. Despite the free availability of ART, there are nurses not availing themselves of treatment and are dying as a result.

#### **5.4. REFLEXIVITY**

Reflexivity is described as confessional, theoretical, textual and deconstructive (Foley, 2002:469) and is used during all field roles, data collection and analysis, as well as the ethnographic report writing process (Foley, 2002:473) [Refer to Section 3.3.7].

In this section I reflect on my experience of this project from an "etic" perspective.

##### **5.4.1. Becoming an ethnographer**

I commenced this journey as an inexperienced academic and researcher, having resigned from my post as a nursing service manager.

My initial research proposal was written with hermeneutic phenomenology as the research approach. However, experts in our school suggested that this method should be reconsidered and that I should use an ethnographic approach. This meant studying ethnography as a method and amending the original proposal using ethnography. At the time, I doubted the advice I had been given and decided that I would email Max van Manen, the Hermeneutic Phenomenology expert, whose



textbook I had studied, to ask for his advice. I was surprised when he responded to me. His advice to me was that, based on the information I had provided to him, he suggested that I do indeed follow an ethnographic approach (Appendix 9). I was, like all students, disappointed and even disturbed that so much time had been invested in the proposal and that I had to go back and study a new method of conducting qualitative research from the beginning. I identified Hammersley and Atkinson (2007) as authors whose work I should follow, obtained the textbook and commenced formulating a revised proposal.

Making the initial contact with the gate keepers was not without its problems (Hammersley & Atkinson, 2007:58). Site A required that I resend the proposal as the nurse manager had been unable to open the document which I had originally sent. Site B (Private Hospital) did not believe that the staff in the hospital fitted the profile of my study. The following entries were made in my research journal around gaining entry to the Private Hospital sector.

*“Disappointed, but pragmatic.”* [Ethnographers feelings expressed in Research Journal, 18 July 2010]

*“I want to include a private hospital because I believe that South African research is too dependent on the public sector. It is time comparisons are made in the private sector.”* [Ethnographer thoughts, 18 July 2010]

Site C had no impediments to gaining entry, while at Site D, there was an initial lack of a response.

I have thought about whether I would do my field work differently if I had the chance to do it all again. Despite me explaining to the nurse managers that I needed to be present, but not interview anybody, they initially did not understand the process of making an ethnographic record. I reflected long and hard about how I could explain the concept so that people would understand the initial stages of an ethnographic study. I had a "light bulb" moment on Saturday 22 January 2011 that the following may be a way of explaining the observation in a way that would be easy for the nurse managers to understand.

*“pretend that I am a Nursing Administration student doing her 40 hours situational analysis”* [Ethnographer thoughts, 22 January 2011]

While this worked for me, the nurse managers also found it difficult to conceive that I was interested in and wanted to be present during their mundane day to day activities (Hammersley & Atkinson, 2007:36-37). It also may have been better if I had not collected the data myself, but had had a research assistant who had no knowledge of the culture to conduct the non-participant observation. However, despite the formality of the interactions and my intimate knowledge of the culture, I was provided with information which may not have been provided to a research assistant who knew nothing of the culture. My original intention had been to be a non-participant researcher and not a nurse in uniform. However, after approximately two visits to site A, I realised that it may be best to actually wear my uniform. I came to this conclusion because I felt my lack of my uniform was actually attracting attention to myself, as people were very interested in what I was wearing and commenting on how much they liked my clothes. My intention was to be a non-participant observer, but still to be unobtrusive. I attended unit manager meetings in my uniform, which did not seem to distress any of the unit managers present, as indicated in my research journal.

*I am sitting among staff along the wall. There does not appear to be any issue among them with me being there – given attendance register to sign. Given minutes [Ethnographer field notes made during a Unit Manager Meeting site A, 14 September 2011]*

My initial field notes were very much a summary of the events I witnessed and people I met and places I entered. I was in fact taking notes. After consulting with one of the research supervisors, I made the following entry in my research journal:

*“they are too much of a summary and I must ensure more of how I feel is included” [Ethnographer notes following meeting with supervisor, 6 May 2011]*

#### **5.4.1.1. Lost in the journey**

At the time to start analysing my data, I was aware that I did not fully understand the data analysis process. I had no true understanding of how to actually analyse the data. I expressed this in a confused manner, as follows.

*“I don’t understand how to analyse data. I think my data is saturated.” [Ethnographer thoughts, 31 August 2011]*

I became more conscious of my lack of understanding of the data analysis process as I progressed through the research. As a consequence I read copious books, but still had difficulty making sense of it all [Ethnographer thoughts, 5 October 2011].

I collected data at one site first, so that I could determine how to analyse it. Once I had this data and was reading the transcripts, I instinctively formulated further questions and identified further participants as opportunistic samples and collected more data.

First, I colour coded sections of the first transcript electronically. When I told my supervisor, she advised me not to do that, but rather to use a piece of paper. Her concern was that I was “playing” with both my computer and my data rather than becoming immersed in my data. To a certain extent she was correct, I was attempting to “kill two birds with one stone”, in that I was attempting to discover what I could do with my computer and attempting to use the computer to assist me to become immersed in the data. I was very let down and disappointed so I used Weft QDA and analysed the first transcript using it [I did not use this program again]. The following is an excerpt from my research Journal:

*“It was brilliant [Weft QDA], as, in one afternoon, I found narrative links across transcriptions, and commenced forming my lists from which codes and themes could be formulated from the emic text”*  
[Ethnographer notes, 5 October 2011].

I had been “playing” again. My supervisor then said I should rather do it on paper. This sowed doubt in my mind that I was not doing the correct thing, so I purchased copies of Miles & Huberman (2002) and (1994) Qualitative data analysis. I read Miles and Huberman, (2002) within days, but still did not feel confident. I then found Huddersfield University qualitative research on line and read articles in the web site, watched videos of lectures and still felt as though I was taking what I already knew from my knowledge of occupational health and ill health in the workplace and using my theoretical sensitivity to formulate codes and themes.

Still not happy, I read Spradley (1979) and (1980) and then the coding sections of Strauss and Corbin and Saldana (2009) in an attempt to understand how to code the data. This still did not shed any light on the matter. Eventually I found an article by Ryan & Bernard (2003) on how to create codes and themes. This made sense, so

using the first transcription I began the following process and noted how I would continue:

- *Identified repetitions*
- *Identified pauses, emphasis, hesitations and coded the text on each side of these for participant turn taking*
- *Identified causal, conditional, time codes*
- *Then will go back to Weft QDA and check sections with text about the same content and identify variations between sections*
- *Lastly will identify technical themes*

[Ethnographer notes, 5 October 2011]

Having read Spradley (1979, 1980) I felt more confident about analysis:

*“Could publish sections of my work now, until today did not think I had sufficient work to do this!! Which emphasises my lack of imagination and creativity!” [4 September 2011]*

Through this search for how to “do” data analysis, I made a few discoveries. Ethnographers do not generally provide explicit guides for doing data analysis. In fact Hammersley & Atkinson (2007:159) explicitly state that there is no “formula” or “recipe” for analysing ethnographic data. They continue to claim that one must ignore any claims to such a guide. This proved to be my greatest challenge. My conclusion was that there are so many ways of analysing the data and so much data, that I became totally overwhelmed. I found that instinctively I was searching for just such a “formula” or “recipe”.

In my original proposal, I had not made mention of Spradley as a source, as I believed he could not contribute to my reflective ethnography. How wrong I was. I only really came to grips with the data analysis once I had started to follow Spradley’s (1979) process of domain analysis and semantic relationships (Spradley, 1979:107-112 & 1980:85-99; Spradley, 1980:89). I have reflected on why this was such a challenge for me. I had been taken beyond my comfort zone through the process of this study. My personal paradigm, I now realise is a pragmatic positivist one, which had, as a consequence, me “fighting” with the data. I instinctively found myself compartmentalising the data so that I could “see” in a simple form what I needed to do. I made mind maps, a skill which I did not initially have, of my data

(Figures 4.2 & 4.3); I coded chunks of transcriptions once I realised that sentence by sentence coding was taking me away from a global picture of the data; I edited, by cutting and pasting sections from transcriptions to create new transcriptions, enabling me to get a holistic picture of what the informants were telling me; and I took the 'headings' from sections in the newly constructed documents and created a domain analysis and taxonomy of the data. However, I still had the sense that I was imposing my knowledge on the data. Iteration of the constructed documents was the next step in the process. Having documented what I did in the data analysis, I made the following comment in my research journal.

*“I do however have a problem with using such a method, as it is too pragmatic for constructivist paradigm research”* [Ethnographer notes, 14 July 2012].

I have learnt through this rather circular and iterative process that my brain understands things better if they are very ordered than if they are not ordered.

Writing the final ethnographic report was a challenge, as writing for me is a chore. Again I found myself instinctively listing information and leaving out explanations, which I assumed the reader would know. I have had to make a concerted effort to improve my writing skills. I have attempted to ensure the rigor of my writing and the ethical principles required to protect both the organizations concerned and the informants. I have used both “emic” and “etic” language in the production of this ethnography and have kept mindful of the fact that the readers will be peers in the field of nursing management and the faculty.

#### **5.4.1.2. My sensitivities**

At the initial stage of the research process, once I commenced making my initial appointments, I was very excited and naïve enough to think that I had overcome the most difficult part of the research process and that the rest would not be too time consuming or too difficult to do. How wrong I was. I enthusiastically started making contact with gate keepers of the selected sites for the study, which I did one by one. The following is an excerpt from my reflective journal at the time, which indicates my insecurities around setting out on this journey:

*“I am apprehensive about setting out on this research journey and doubt my own abilities.”* [Ethnographer thoughts, 18 July 2010]

I had mixed emotions, having ups and downs, and I felt insecure through some of the process of gaining entry to research sites.

My own experience of being a nursing manager was very fresh in my mind and I was very aware of not wanting to be a nuisance, and not be in the way. Despite trying to bracket my own experience and to see the situations I was witnessing the daily activities of the informants in my study as if for the first time, I found this to be very challenging and difficult to do. I realised I was so much a part of the culture of nursing management that I felt that I was intruding and sensed that the managers reporting to the nurse managers were very formal and respectful to me.

*“I still have a sense that my being immersed in her work environment is a problem for her”* [Ethnographer thoughts, 20 January 2011]

I thought about whether it had something to do with my personality, professional culture or the fact that I work as a lecturer at the University. On reflection I believe it was a bit of each. My own sensitivity to being in their workspace was definitely a factor in my possibly not being as adventurous as somebody who knows nothing of the culture. I was faced with a conflict between my familiar role as a nurse manager and the very unfamiliar role of researcher, which compounded my sensitivity to the situations in which I found myself. I felt as if I was stepping over a cliff into the unknown.

Our professional culture is very formal and based on the British military rank system, so people may have seen me, a university lecturer, as a “rank” above them resulting in the formality I experienced. There was possibly doubt as to my motives, in that they may have been trying to determine whether I was there as an “expert” or a “critic” (Hammersley & Atkinson, 2007:60). My research journal entries below express my sensitivities to gaining access and being in the work environment of the nurse managers.

*“Possibly I am over sensitive to the nature and personalities of nurse managers, very aware that they are busy and believe that having people in their space when they are working is regarded as a pain in*

*the neck*” [Ethnographer thoughts, meeting with supervisor, 20 January 2011]

*“I have been overly conscious of the fact that I need to make appointments with them, that I must not be anywhere near the hospital without them knowing that I am around”* [Ethnographer thoughts, meeting with supervisor, 20 January 2011]

*“I am aware of my own formality which I know I used as a nurse manager.”* [31 August 2011]

At Site A, I was aware of a sense of formality among the nurse managers and between the nurse managers and me. They may have seen me as “knowledgeable” or a “threat” (Hammersley & Atkinson, 2007:60) or my being “white” in the context of older South Africans may have been an obstacle to the process of gaining entry and acceptance. However the following entry was made by me when reflecting on these issues:

*“I do not get a sense of this being a problem at all [my being white]. In fact the entire nursing management community in this particular hospital is reasonably multi-cultural”* [Ethnographer thoughts, 20 January 2011]

I had difficulty becoming a participant observer. I think, because I was so aware of the formality of the situation and what my effect on the process might be. I was perplexed over how to “do participant observation” as each person has an office and retreats to it after handover. My field notes reflected this concern as stated below.

*“So where to situate myself?”*

*“Passage? don’t see what is going on in the office – very bare; little traffic.”* [Ethnographer notes, 31 August 2011]

I found it difficult to write about my feeling as by nature, my feelings are often suppressed. I felt I would be exposing myself to others, which I was not comfortable doing. However, it is now evident to me that having to some extent achieved this, it was a very necessary part of reflection in the research process.

During the process of data collection, I realised that sometimes informants would give me the most relevant information when the audio recorder was not switched on, and that I would have to make my field notes immediately so that I did not forget what had been said during such “confessions” (Hammersley & Atkinson, 2007:142).

Collecting data from the health risk manager was challenging, in that, due to a political rally in the vicinity of the informants office on the day of meeting, we met at a restaurant in a shopping centre. On this occasion I could not rely on my audio recorder and had to depend on my field notes made during the interview and my memory to record the data. This was a good learning experience as my “crutch” was gone. I had to trust my field notes and memory.

I am not very creative or imaginative and feel this would hinder my completion of the research project.

Once I completed reading Spradley (1979), Participant Observation, I wrote the following in my research journal.

*“I keep getting this feeling of “if only I had known this before my proposal”. Then I guess that’s what doing the PHD is all about.*

*As I progress this is becoming clearer and clearer, but taking a long time.” [Ethnographer notes, 4 September 2011]*

The research journey has made me very aware of my personality. I have discovered that I do not deal well with stress, nor do I like being in situations where I believe I do not know what I am doing. I realise that in order to gain confidence and knowledge, I must persist and not give up, until I am able to function with reasonable confidence in situations. Over the period of four years, I have gone from a novice qualitative researcher with minimal qualitative knowledge and experience to a researcher with a functional knowledge of qualitative research.

This reflection has forced me to think of where I have come from and where I have ended up in my research experience. Although I personally found the experience traumatic, I believe I have matured and improved as a researcher.

## **5.5. RECOMMENDATIONS**

The following are the recommendations which the study makes to:

### **5.5.1. Nursing management practice**

- When nurses have not disclosed their disease status to their partner, spouse or family they are afraid to make their disease status known at work (Opollo, 2013:17-26; Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola, 2007:



242-250, Department of Labour, 2012:8-9). Nurse managers should be conscious of this phenomenon and have the skills, empathy and heightened awareness to identify such disclosure, even in instances where disclosure is covert.

- Organizations should:
  - respect the employees' right not to disclose
  - provide an enabling environment for employees to disclose their disease status by:
    - Ensuring that they do not perpetrate the denialist strategy which was a factor at the time of the Mbeki government by accepting accountability for decisions made in respect of an employee's Incapacity leave, salary and health decisions and not use the advisor (Health Risk Manager) as a scapegoat for management decisions which may be made
    - Make support groups available to employees where they are able to join other affected/infected employees in order to share their experiences. However membership of such groups should remain voluntary.
  - Be aware that nurse managers will be affected emotionally through their daily work. Provision of care and support to nurse managers by assisting them in terms of managing the emotional burden and stress they experience. Occupational health practitioners employed in hospital occupational health facilities should possibly assist by developing such support programmes
  - Make allowance for contingency plans to be available in the event of the death of an employee or prolonged absence of an employee, so as to ensure continuity of the nursing services. Examples of such contingency plans could be use of a relief pool, locum staff or agency staff. In the case of a relief pool, existing employees could be allocated to such a pool on a monthly basis. The relief pool employees would then report at each shift change to a central point (e.g. the nurse manager's office) for deployment to units within the hospital where an

individual or individuals may be absent. Such contingency plans would relieve the burden experienced by both the nurse managers and the employees working in a situation where a colleague is missing.

- Build trust within the nursing service and the human resource division by implementing impeccable document protection strategies in order to protect employee information, particularly around employee medical information. It is advisable to include such topics as the Policy for Incapacity Leave and Ill Health Retirement [PILIR] (South Africa, DPSA, 2009:1-29) and disclosure of disease status into both orientation/induction programs and in-service training programs held by the organization.
- Consider implementing compulsory membership of the Government Employees Medical Scheme (GEMS) for all employees. There are instances where existing employees are not on this medical scheme. Such employees then use medical services within public sector hospitals, where the employee does not work, which results in further prolonged absences from work while sitting in long queues awaiting care.
- Should implement a zero tolerance policy for stigmatization and discrimination of employees affected/infected by HIV and/or TB, which will further contribute to building employee trust in the employer.
- Should formulate and implement disclosure policies; return to work policies; policies and procedures for managing absenteeism in the world of work and policies and procedures for migration of information around leave and absenteeism per employee as employees are redeployed within the organization. It would be prudent to have generic documents around such topics as those stated above in order to ensure consistency of management of the issues across the organization.
- Have in place an implementation strategy with implementation time lines so as to ensure universal and consistent implementation of such previously stated policy documents.

- Nurse managers should remain non-judgemental of employee decisions not to disclose (Bairan, Jones Taylor, Blake, Akers, Sowell & Mendiola, 2007:249; South Africa, DOL, 2012: 8 -9).
- Workplace strategies around a workplace HIV and AIDS policy and programme, and incapacity leave and return to work policies need to be emphasised and operationalized for each nursing workplace in the context of this study, which should significantly contribute to employee trust in the organization.
- It is important to ensure that staffing policies actually exist to guide nurse managers on the daily human resources management and scheduling of staff; examples of such policies are: a scheduling policy, an allocation policy, a change list policy and a policy related to the redeployment of existing staff, the use of extra hours by existing staff and the use of temporary locum or agency staff.
- Nurse managers should monitor absenteeism at unit level and not rely on the provision of information by the Human Resources Directorate. A strategy should be considered for dealing with monitoring employee absenteeism, especially for employees who are often redeployed, as unit managers suggest that they have difficulty monitoring such employee absences from work.
- Within the eThekweni District, the nurse manager discussion group should consider piloting and refining the draft guidelines produced as guidelines for possible implementation in organizations within the context of the study.

### **5.5.2. Nursing management education**

- Nursing managers should be explicitly taught how to manage absenteeism in the workplace, particularly absenteeism related to employees who are HIV and TB affected/infected. The following topics should possibly be included in both a formal Nursing Administration curriculum orientation/induction and in-service programs for both nurse managers and unit managers:
  - 1) The issue of nurses attending medical practitioners in order to have PILIR forms completed, which may result in the employee having to sign for one day sick leave, and the ill employee being required to sign for unpaid leave should

he/she have exhausted the available sick leave . In such cases the employee may not be able to afford bus fare for the journey to work.

2) The importance of employees obtaining a diagnosis on a medical certificate which will be acceptable to the health risk manager so as to give the nurse managers and unit managers insight and the ability to identify employees who may be at risk for delayed applications for PILIR at an early stage.

- Organizations should provide practical education and training to unit managers and professional nurses in charge of shifts in respect of absentee monitoring and calculating leave and sick leave balances as part of orientation/induction and in-service training programs
- The management of employees on prolonged sick leave should be emphasised within the Nursing Administration Curricula taught to future nurse managers, and topics such as PILIR (2009); the application process; the nurse managers' role in the process; the South African Nursing Council (SANC) draft impairment regulation (2011); and relevant Occupational Health Management policies, such as the application and process for compensation for occupationally acquired diseases should be included.
- Emphasis should be placed on existing policies which nurse managers are expected to implement such as the Policy on Incapacity Leave and Ill Health Retirement and Occupational Health and Safety policies related to both the use of personal protective equipment and the prevention and follow up treatment of employees affected/infected by needle stick.

### **5.5.3. Nursing research**

- Pilot and refine the draft guidelines produced by this study
- The Department of Public Service and Administration and other stakeholders should reconsider the wording of diagnosis criteria for advising on incapacity leave by the health risk manager to comply with requirements, as stated in documents such as the Leave Directive (South Africa, DPSA, 2012:).
- Organizations should consider exploring the reasons for employees' reluctance to use the occupational health facilities provided by the employer in order to take corrective management steps so as to achieve efficient usage of such facilities by employees.

- Organizations should consider exploring employee reluctance to report needle stick injuries (sharps injuries) as well as the phenomenon of stigmatization around needle stick injuries (sharps injuries) that was reported in this study
- Ensure managers in other health services of the KZN Health Department are apprised of the findings of the study in respect of managing HIV and/or TB affected/infected employees e.g. Department of Works, Police Services, etc.
- Replicate the study on a larger scale than was done in this qualitative study which cannot be generalized. The study could possibly be replicated in other contexts such as a rural context or other provinces within South Africa.

## **5.6. LIMITATIONS OF THE STUDY**

The limitations of a study are described by Burns & Grove (2005:41) as those aspects of the study which may reduce the applicability of the study in other settings. The limitations of this study are as follows:

My familiarity with the culture studied in that I may have missed language differences which a researcher unfamiliar with the cultural scene would not miss (Spradley, 1979:50).

Findings in qualitative research are not normally applicable to other settings. This study was limited to the urban eThekweni District of KwaZulu-Natal. A rural setting was not included. Nurse managers managing sick employees in a rural area or in the other provinces of South Africa may have different experiences to those expressed by the participants of this study.

Whilst the study findings may only apply to the context of this study, I have, however, provided sufficient thick data for other researchers to replicate the study in other settings or on a larger scale.

Finally, the draft guidelines produced by this study have not been implemented or evaluated in the workplace and require that such implementation and evaluation should follow completion of this study.

## 5.7. THE GUIDELINE DEVELOPMENT PROCESS

The final objective of this study was to develop draft guidelines to guide nurse managers in their human resources management in respect of HIV and TB affected/infected nurses. This chapter explains the process of guideline development/formulation which was used in this study.

The technical literature sourced for the literature review was used to enhance my theoretical sensitivity and to add to the validation of the study findings (Corbin & Strauss, 1990:50-52). As I have used grounded theorising as one of the strategies for data analysis, it is fitting that the technical literature was searched for and used through the course of the data analysis of the study in order to enhance and verify my theoretical sensitivity and to validate the findings which emerged from the data. This process enhanced the iterative process which I used throughout this study (Foley, 2002:476).

The literature that is relevant to the draft guidelines has been discussed in Chapter 2 of this report. In order to eliminate repetition, the reader is referred to Chapter 2. I formulated draft guidelines, in collaboration with a nominal group of nurse managers employed in the public sector in the eThewini District in KwaZulu-Natal, South Africa, who were not informants of the study. I used articles written by Oxman, Schünemann & Fretheim (2006), specifically Oxman, Schünemann & Fretheim (2006,(e): 4 of 6) as a framework for the headings within the guidelines. These authors produced a series of articles which discuss and describe the step by step process of developing guidelines for the WHO. After reading all these articles, article fourteen (14) of the series was selected as most appropriate as a framework to guide the formulation of the draft guidelines in this study (Refer Table 3.10). The steps which these authors discuss in the article series are setting priorities; the composition of groups and the consultation process; managing conflicts of interest; group processes; determining which outcomes are important; determining which evidence to include; synthesizing and presentation of the evidence; grading the evidence and recommendations; integrating values and consumer involvement; including equity, applicability, transferability and adaptation; reporting on guidelines; disseminating and implementing guidelines; and evaluation.

I considered the following interventions and practices during the formulation of the draft guidelines:

Ensuring and strengthening compliance with employee rights and patient rights as enshrined in the South African Constitution Act (108 of 1996)

Ensuring and strengthening the prevention of victimisation and discrimination in the world of work, as enshrined in the Employee Equity Act (55 of 1998)

Consistent policy implementation

Ensuring and strengthening a safe working environment as enshrined in the Occupational Health and Safety Act (of 1993)

Ensuring and strengthening employee access to benefits to which they may be entitled in cases where the world of work has failed to provide them with employment safety

Ensuring and strengthening nurse managers' advocacy for employees managed by them.

The major outcomes which I considered during the formulation of the draft guidelines were:

The effect of prolonged employee absenteeism on organizational productivity and service delivery;

The effect of prolonged employee absenteeism on colleagues

The effect of prolonged employee absenteeism on the nurse manager, who is required to provide safe, quality care in an environment lacking in human resources.

The purpose of the draft guidelines is to provide nurse managers with usable and appropriate information in a single document for their human resources management of nurses who are ill as a consequence of HIV and/or TB and who are either absent on long periods of sick leave; who have remained at work despite their illness; or have returned to work following a protracted period of illness.

In respect of the Policy for Incapacity Leave and Ill Health Retirement (South Africa, DPSA, 2009:1-29), it is incumbent on both the employee and the immediate

supervisor of the employee to manage and monitor the employees' periods of absence from work (South Africa, DPSA, 2012:13&23-24). This means that the immediate supervisor must scrupulously monitor employees' absences away from work, identify absentee patterns and strictly adhere to deadlines for submission of applications for sick leave or incapacity leave and/or ill health retirement to the appointed health risk manager via the local Human Resources Directive (South Africa, DPSA, 2012:24). In respect of these draft guidelines, the immediate supervisor and the supervisor's manager represent the employer and are accountable to the employer for the correct implementation of the guidelines.

### **5.7.1. Bibliographic resources**

The bibliographic resources below were used during the formulation of the draft guidelines:

South Africa. (2012) Department of Labour. Code of Good Practice for HIV in the world of work.

South Africa. (2012) Department of Public Service and Administration. Determination and directive on leave of absence in the public service.

South Africa. (2008; 2009) Department of Public Service and Administration. Employee Health and Wellness Strategy and Framework.

South Africa. (2009) Department of Public Service and Administration. Policy on Incapacity Leave and Ill Health Retirement.

South African Nursing Council. (2011) Draft Regulation relating to the conducting of inquiries into alleged unfitness to practise due to disability or impairment of persons registered in terms of the Nursing Act, 2005 (33 of 2005).

South Africa. (2011) Department of Health. Management of Drug-Resistant TB Policy Guidelines.

### **5.7.2. Methodology of guideline formulation**

Evidence for the formulation of the draft guidelines was collected by searching grey literature using Ebscohost and Google Scholar using the following search terms: PILIR, sick leave, abuse of sick leave, employee health and wellness, return to work



and human resources planning. Websites of the South African Government the Department of Public Service and Administration, the Department of Labour, the WHO and the International Labour Organization were consulted and the following legislation was downloaded from the South African Government website: the Constitution (108 of 1996); the Occupational Health and Safety Act (85 of 1993); the Employment Equity Act (55 of 1998); the Basic Conditions of Employment Act (75 of 1997 as amended 2002 & 2007); the Labour Relations Act (66 of 1995 as amended 2002); the Public Service Amendment Act (30 of 2007); the Code of Good Practice on HIV and Aids and the world of work (South Africa, DOL, 2012:1-18); the South African Nursing Council Draft Regulations for the Committee for Incapacity (SANC, 2011:14-29); Management of Drug-Resistant TB Policy Guidelines (South Africa, DOH, 2011:1-65).

My own theoretical knowledge, my experience as a manager and occupational health nurse and my research contributed to the document selection for source documents for the formulation of these guidelines.

The criteria used to select documents and rate the quality of evidence that supports the formulation of this document included existing South African documents that have been produced to serve as:

Legislation impacting on labour, employee illness, equity, nursing, and occupational health and safety

Information to ensure fair, equitable, non-discriminatory decision making, policy and guideline formulation around employees in the work environment

Employee Health and Wellness; Occupational Health and Safety

HIV in the workplace

TB in the workplace

The South African Nursing Council statutory regulations around nurses who are not well at work.

The quality of the evidence found during the literature search was ascertained through use of the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (WHO, 2010:6) (Annexure 12).

The following nine (9) websites were searched for applicable reports:

The South African Government online. [www.gov.za](http://www.gov.za)

Health-e. [www.health-e.org.za](http://www.health-e.org.za)

KwaZulu-Natal Department of Health. [www.kznhealth.gov.za](http://www.kznhealth.gov.za)

Department of Public Service online. [www.dpsa.gov.za](http://www.dpsa.gov.za)

Department of Health online. [www.health.gov.za](http://www.health.gov.za)

Department of Labour online. [www.labour.gov.za](http://www.labour.gov.za)

World Health Organization. [www.who.int](http://www.who.int)

International Labour Organization. [www.ilo.org](http://www.ilo.org); <http://www.ilo.org/global/topics/hiv-aids/lang--en/index.htm>

Human Resources for Health. [www.human-resources-health.com](http://www.human-resources-health.com)

#### **5.7.2.1. Method for synthesizing evidence**

Relevant evidence was selected from the documents sourced, commencing with the Constitution Act of South Africa (no. 108 of 1996) and the documents alluded to in section 5.3.2. above. Schöneman, Fretheim and Oxman (2006: 4 & 5 of 7) recommended the use of The Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach. However, in 2010, the WHO recommended the use of the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (WHO, 2010:6). Randomised control trials and observational studies have mostly been used to determine the quality for clinical interventions, however Schöneman, Fretheim and Oxman (2006: 4 & 5 of 7) found little evidence of the use of The Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach in grading public health issues. These authors suggest the use of grey literature and technical knowledge (Oxman, Schönemann &

Fretheim, 2006 (c): 7 of 10), as was done during the gathering of evidence for these draft guidelines.

Through the above process, I did not find any evidence of the decisions which nurse managers need to make around HIV and TB infected nurses at work. The social systems i.e. social insurance and social security systems in the western countries either do not face the pandemic proportions of HIV and TB which are prevalent in the developing world nor is poverty an element of western societies, to the extent that it is in the developing world. Western countries provide equitable health care to citizens and social support to the families of their citizens through social insurances or social security which is not the case in South Africa. This enables sick employees to remain at home during acute and chronic illness.

### **5.7.3. Pre-release review**

Various experts were selected and invited to be part of an advisory group. This nominal group was composed of both nurse managers who plan and implement the human resources in respect of HIV and TB affected/infected nurses and occupational health practitioners. Different processes are available to use for reaching consensus, with the most common methods being the Nominal Group Technique (NGT), the Delphi Method and Consensus Conferences (Fretheim, Schünemann & Oxman, 2006: 4). My original plan was to use the Nominal Group Technique in preference to the Delphi Technique, due to the fact that the latter is time consuming (de Villiers, de Villiers & Kemp, 2005:642). A literature search was conducted in the both the international and domestic domains to determine if there were any existing guidelines which could be adapted, The search indicated that although there were many existing documents available in both domains, there was, however, no single document that covered all aspects, which means that the nurse managers require a library of documents as resources. Crotty (2003:50) suggests that a researcher is a “bricoleur” and, as such, has the ability to create a new whole from existing material which previously made up a different whole. Following this line of thought, I see myself as a “bricoluer”, taking information from various existing documents and creating a single reference document for use within the specific culture of nursing managers to assist their human resources management around caring for ill nurses at work (Crotty, 2003:50).

The documents alluded to in section 5.2.1. were sourced through the literature search and adapted to create the draft guidelines (See Annexure 13).

The purpose of the nominal group discussion was:

To determine whether the draft guidelines would provide nurse managers with the necessary guidance for the management of nurses who are chronically ill and are either away on long periods of sick leave or have remained at work despite their illness or who have returned to work following a protracted period of illness;

To determine the utility of the draft guidelines in practice for the stakeholders

To determine whether nurses who do voluntarily disclose their disease status to their immediate manager will be protected by the implementation of these draft guidelines at their place of work

To determine whether these draft guidelines provide nurse managers, unit managers and other stakeholders with relevant information on how to manage chronically ill nurses, especially nurses who are HIV affected/infected and/or TB affected/infected in the world of work

To determine whether these draft guidelines will facilitate nurse managers human resources management around the clinical placement of chronically ill nurses

To determine whether these draft guidelines will assist nurse managers' human resources management in order to facilitate their provision of competent, skilled nurses to provide quality nursing care to the health care users of acute hospitals in the eThekweni District of KwaZulu-Natal

To determine whether chronically ill nurses will be encouraged to voluntarily disclose their disease status to their immediate manager as a consequence of implementation of such draft guidelines.

After I had identified the potential stakeholders in the eThekweni district, I invited ten nurse managers and occupational health nurses to participate in the nominal group (See Annexure 11). The invitations explained the purpose of the nominal group, which was to evaluate the usefulness, feasibility and validity of the proposed guidelines, and included the date, time and venue for the nominal group meeting, an

agenda for the meeting and examples of evaluation questions that would be asked during the meeting. Prior to the nominal group meeting, each participant was provided with an information and preparation sheet to read, a copy of the draft guidelines and a copy of the questions to be discussed at the meeting. This enabled the participants to read the draft guidelines in advance and formulate their contribution to the discussion during the meeting.

The panel of experts met on 21 November 2012 at the School of Nursing and Public Health of the University of KwaZulu-Natal. . Only four people attended the nominal group to make amendments to the guidelines and signed written consent was obtained from them. It was my intention to make an audio recording of the discussion, but one of the participants requested that we did not record the discussion. In order to ensure that I upheld the ethical principles for conducting research (Emanuel, Wendler, Killen and Grady (2004:930 – 937), I did not record the discussion, but made notes once the experts had departed to record as much as I could remember of the discussions.

I presented a power point presentation of the draft guidelines to the experts. Once I had made my presentation, we then had an open structured discussion and certain changes to the draft guidelines were suggested by the experts. When we had completed the business of the meeting, I provided a light lunch to the experts and thanked them for their participation. We agreed that I would make the changes which they suggested and that I would email a copy of the changed draft guidelines for them to read, following which they would reply to me by email their confirmation and acceptance of the changes I made. This was done and confirmation and acceptance of the changes was received from them. Contact was made with other experts per email, with a copy of the draft guidelines attached, requesting them to read and amend the draft guidelines where they felt necessary and return the amended document to me. All the experts who had participated were provided with feedback, in the form of a report and an amended version of the draft guidelines for them to verify that the recommendations which they had made to the draft guidelines had been effected. Participants were requested to provide the researcher with written affirmation of changes to the draft guidelines in the form of e-mails. These were received and an email was sent to each participant thanking them for their participation in the formulation of the draft guidelines

Outcomes considered by the draft guidelines are the effect of prolonged employee absenteeism on organizational productivity and service delivery, on colleagues and on the nurse manager, who is required to provide safe, quality care in an environment lacking in human resources.

An implementation framework has been formulated by me, as follows:

**Table 5. 1: Implementation Framework for Draft Guidelines**

ACTION	DATE	RESPONSIBLE PERSON/DIRECTORATE	DATE ACCOMPLISHED
Identify correct stakeholder at KZN Health Nursing Directorate & Human Resources Directorate	January 2014	J Kerr	
Plan a combined meeting with stakeholders from Nursing Directorate & Human Resources Directorate	January 2014	J Kerr	
Determine the KZN Health process for acceptance of Draft Guidelines into Implementable	January 2014	J Kerr	

guidelines from the stakeholders			
Submit Draft Guidelines to KZN Health Nursing Directorate & Human Resources Directorate	January 2014	J Kerr	
KZN Health to implement final accepted Guidelines	At a date determined by the stakeholders		

#### **5.7.4. Update plan**

Whilst the dissemination and implementation of the guidelines does not fall within the scope of this study, the intention is to engage with the stakeholders once this study has been completed, as indicated in the table above. These guidelines are at present a draft document produced for presentation to the KwaZulu-Natal Provincial Department of Health and its Nursing Directorate & Human Resources Directorate. As indicated above, meetings will be scheduled with the relevant stakeholders at the KwaZulu – Natal Health Nursing and Human Resources Directorates in order to discuss the local context and the needs and processes for the acceptance of and the implementation of the draft guidelines. See section 2.9.13. and table 5.1. above. These authorities will make a final decision in respect of an update plan and expiry date for the guidelines in their current form.

#### **5.7.5. Rationale for development of the guidelines**

The rationale for the development of the draft guidelines was to collate the available and relevant information on the human resources management in respect of HIV and/or TB affected/infected nurses into a single document for use by nurse managers. This single document contains the relevant information on incapacity

leave, ill health retirement, and the occupational health and safety management of HIV and TB so as to assist nurse managers in effectively managing prolonged employee absences from work.

#### **5.7.6. Scope of the guidelines**

The target group or stakeholders for use of the draft guidelines was considered to be nurse managers who are tasked with the planning of employee provision in order to provide safe, quality health care in the eThekweni District of KwaZulu-Natal.

The diseases/conditions included in draft guidelines are the Human immunodeficiency virus (HIV); TB (TB) which result in prolonged employee absence from work.

The guideline category falls within Human Resource Management of Nursing Services Management, Occupational Health Services, Health Risk Management Services and all workers employed in the public sector health services, and include the full range of employees, from permanent to hourly employment arrangements. It also includes employees or students in training, where service agreements are in place, which include the medical surveillance of all trainees and where the training institution is registered with The Workmen's Compensation Commissioner and people whose employment is terminated for any reason, including those laid off or suspended from work (South Africa, DOL, 2012:7). The following interventions and practices were considered when formulating the draft guidelines:

Compliance with employee rights and patient rights as enshrined in the South African Constitution Act 1996 (Act 108 of 1996)

The application of the Batho Pele principles in incapacity leave management (South Africa, DPSA, (n.d)).

The prevention of victimisation and discrimination in the world of work as enshrined in the Employee Equity Act 1998 (Act 55 of 1998);

Consistent policy implementation

A safe working environment as enshrined in the Occupational Health and Safety Act 1993 (Act 85 of 1993)



Employee access to benefits to which they may be entitled in cases where the world of work has failed to provide them with employment safety

Managers advocacy for employees managed by them (South Africa, DOL, 2012:7-9)

### **5.7.7. Guideline objectives**

The objectives of the draft guidelines are:

To ensure that employees confidentiality is promoted and that employees who do voluntarily disclose their disease status to their immediate manager are not discriminated against or victimised at work

- To ensure that the local HIV workplace policy is implemented
- To provide nurse managers, unit managers and other stakeholders with draft guidelines on human resources management around incapacity leave, ill health and prolonged absenteeism in chronically ill employees, especially those who are HIV affected and infected and/or TB infected and affected in the world of work.
- To facilitate nurse managers' human resource management around the clinical placement of chronically ill employees, especially those who are HIV infected and affected and/or TB infected in KwaZulu-Natal
- To assist nurse managers to provide competent, skilled employees who will provide quality health care in health care services in KwaZulu-Natal
- To encourage chronically ill employees, especially employees who are HIV infected/affected and/or TB infected, to voluntarily disclose their disease status to their immediate manager

Definitions are provided within the draft guidelines which operationalize the terminology used in the draft guidelines (See Appendix 12; Section 5.4.)

### **5.7.8. Guideline recommendations**

Recommendations are made in the draft guidelines (section 5.5) and are as follows: monitor and reduce absenteeism (KZN, DOH, (n.d):3); identify and manage workplace factors causing poor work attendance (KZN, DOH, (n.d):3); formulate a strategy to manage absenteeism (KZN, DOH, (n.d):3); implement zero tolerance for

victimisation and/or discrimination in the workplace (South Africa, DOL, 2012:8); uphold the principles of maintaining confidentiality in the workplace (South Africa, DOL, 2012:9); offer employees who have voluntarily disclosed their disease status temporary redeployment to areas which have minimal risk of TB transmission (South Africa, DOL, 2012:13; South Africa, DOH, 2011:120); ensure the provision of personal protective equipment to all employees and patients in areas of collective gatherings of people (South Africa, DOH, 2011:117-118); consistently implement policies correctly; encourage employees' use of the workplace occupational health facility (South Africa, DOL, 2012:34; South Africa, DOH, 2011:21); build the trust of employees in the organizational management of illness at work; and advocate for employees in situations where you disagree with senior management decisions around the eligibility of an employee for incapacity leave or ill health retirement.

A decision making flow diagram (Algorithm) was devised to assist nurse managers in effectively managing employees' prolonged absences from work, incapacity leave and ill health retirement as a consequence of HIV and TB (See Appendix 12; Section 5.6.)

#### **5.7.9.Potential benefits and barriers Implementation**

The potential benefits of the draft guidelines are that the guidelines are envisaged to promote fair, equitable and non-discriminatory employment practices in nursing services; reduce nurse manager stress; improve nurse manager interaction with ill employees; standardise practice around management of ill employees at work; afford the same privileges to students as employees; standardise management of PILIR in the workplace; and promote employee health and wellness and occupational factors, especially around HIV and/or TB affected/infected employees.

The draft guidelines are a collation of the many existing policies and legislative documents around the topic of HIV and TB human resource management into a single document which may improve nurse manager knowledge and implementation of correct human resource practices in the selected setting of the study.

The potential barriers around the implementation of the draft guidelines are envisaged to be the lack of information technology resources available to nurse managers; nurse managers' lack of knowledge in respect of how to search for

relevant documents; nurse managers' dependence on the Human Resources Directorate to supply them with hard copies of the documents which are in existence and available; and the attitude of certain members of the Human Resources Directorate in respect of ill employees.

## **5.8. Guideline Recommendations**

The key aspects of the draft guidelines are the recommendations made in the Guidelines. The recommendations are to:

### **Operational level**

- Monitor and reduce absenteeism (KZN, DOH, (n.d.):3)
- Identify and manage workplace factors causing poor attendance (KZN, DOH, (n.d.):3)
- Encourage employee use of the workplace occupational Health facility (South Africa, DOL, 2012:34; South Africa, DOH, 2011:21)
- Advocate for nurses in situations where you disagree with senior management decisions around the eligibility of an nurse for Incapacity leave or ill health retirement

### **Organizational level**

- Formulate a strategy to manage absenteeism (KZN, DOH, (n.d.):3)
- Implement a zero tolerance for victimisation and/or discrimination in the workplace (South Africa, DOL, 2012:8)
- Uphold the principles of maintaining confidentiality in the workplace (South Africa, DOL, 2012:9)
- Offer employees who have voluntarily disclosed their disease status temporary redeployment to areas which have minimal risk of TB transmission (South Africa, DOL, 2012:13; South Africa, DOH, 2011:120)
- Ensure the provision of personal protective equipment to all employees and patients in areas of collective gatherings of people (South Africa, DOH, 2011:117-118)
- Consistently implement policies correctly
- Build the trust of nurses in the organizational management of illness at work

## **5.9. CONCLUSION**

In this chapter of the study, I have discussed a summary of the study findings and have given a description of the process I followed to draw up the draft guidelines, which are an outcome of this study. It also presented a discussion on how the draft guidelines were developed. The bibliographic resources used were noted and the methodology used was recorded. This chapter also contained a section on my reflections of my experiences while conducting this study, the study recommendations and the study limitations. The implementation of the draft guidelines does not fall into the scope of this study. The final draft guidelines are to be found as Annexure 13.

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## ANNEXURE 1: OBSERVATION GUIDE

		Monday	Tuesday	Wednesday	Thursday
TIME	Activity/chore	Peoples names/code & designation	Peoples names/code & designation	Peoples names/code & designation	Peoples names/code & designation
07h00	Hand Over				
08h00					
09h00					
10h00	Tea				
11h00					
12h00					
13h00	LUNCH				
14h00					
15h00					
16h00	HOME				

## ANNEXURE 2: INFORMATION LETTER TO INFORMANTS

### INFORMATION SHEET FOR QUALITATIVE DATA COLLECTION

(This information sheet was provided to the participants prior to obtaining their consent to participate in the study)

**Title:** *An analysis of nurse managers' human resources management related to HIV and TB affected/infected nurses in selected hospitals in KwaZulu-Natal.*

Supervisor: Dr. P. Brysiewicz – School of Nursing, University of KwaZulu-Natal  
Tel: 031-2601281  
Email: [brysiewicz@ukzn.ac.za](mailto:brysiewicz@ukzn.ac.za)

Co-Supervisor: Prof. B. Bhengu - School of Nursing, University of KwaZulu-Natal  
Tel: 031- 2601134  
Email: [bhengub2@ukzn.ac.za](mailto:bhengub2@ukzn.ac.za)

University of KwaZulu-Natal Human and Social Sciences Ethics Committee:  
Phume Ximba  
Tel: 031 – 2603587  
Email: [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za)

Dear Sir / Madam

RE: Request for participation in the above research

I am a student at the University of KwaZulu-Natal, involved in a PhD study which I am required to conduct as a part of the PhD program. The research project which I am conducting is in respect of the title indicated above and has as its purpose analyzing the experiences of Nurse Managers in respect of the human resources management of HIV affected/infected nurses in their specific work place. It is believed that the information gained from this study will assist in the formulation of guidelines that will assist Nurse Managers in their daily practice related to the human resources management in respect of HIV affected/infected nurses as determined by the study. You have been approached to participate in the study as you meet the criteria in respect of the people identified to participate in the study. This will involve my observing your day to day activities, a tape recorded interview, which will take about one hour. The recording will be transcribed into text and given to you or sent to you by email, (which ever you prefer), to verify and correct.

Please note that your identity and any information given to me by you will be treated confidentially by ensuring anonymity in the reporting of any information you provide by ensuring your name is not used for any documents produced. There will be no risk attached to your participation in the study. Participation is voluntary, as you are free to participate or to refuse participation at any stage during the study without any penalty. Please feel free to ask any questions you may wish to ask. My contact telephone number is: 031- 2601432.

Your contribution to this study will be highly appreciated.

I thank you for your participation.

Jane Kerr

### **ANNEXURE 3: INFORMED CONSENT FORM**

I----- freely and voluntarily consent to participate in the research study titled:

*An analysis of nurse managers' human resources management related to HIV and TB affected/infected nurses in selected hospitals in KwaZulu-Natal.*

I understand that it is believed that the information gained from this study will assist in the formulation of guidelines that will assist nurse managers in their daily practice related to the human resources management in respect of HIV and TB affected/infected nurses as determined by the study.

I understand that I am free to participate or to refuse participation at any stage during the study without any penalty or prejudice to me. I have been informed that there will be no risk attached to my participation. I have been given the right to ask questions related to the study.

I have read the contents of this document with understanding and sign knowingly and consciously.

Participant Signature

Date

## **ANNEXURE 4: INTERVIEW GUIDE**

### INTERVIEW GUIDE

1. Describe your daily activities when managing the human resources in respect of HIV and TB affected/infected nurses in the work place.
1. What have been your experiences in respect to the human resources management of HIV and TB affected/infected nurses?
2. Explain how you dealt with a specific incident in respect to the human resources management of HIV and TB affected/infected nurses?
3. What concerns have you had to deal with in respect to the human resources management of HIV and TB affected/infected nurses?
4. What support have you had from the management team in respect of issues you have experienced related to the human resources management of HIV and TB affected/infected nurses?
5. What do you believe would assist you to facilitate your human resources management in respect of HIV and TB affected/infected nurses?
6. What role could the employee organizations have in aiding your human resources management in respect of HIV and TB affected/infected nurses?
7. What role could the South African Nursing Council have in aiding your human resources management in respect of HIV and TB affected/infected nurses?
8. How do the existing labour legislation, South African Nursing Council regulations, Code of good practice on key aspects of HIV and Employment (2006) etc. contribute to your human resources management in respect of HIV and TB affected/infected nurses?
9. What are your priorities and concerns when managing human resources in respect of HIV and TB affected/infected nurses in work areas?
10. How do you ensure that you balance staffing and quality nursing care while catering for HIV and TB affected/infected nurses' needs?
11. What controls your human resources management in respect of HIV and TB affected/infected nurses?
12. What do you think should change in respect of the academic education of Nurse Managers so as give them sufficient skills to deal with the decision making needs of the human resources management in respect of HIV and TB affected/infected nurses?
13. What resources are available to Nurse Managers to assist in the human resources management in respect of HIV and TB affected/infected nurses?
14. What would you recommend is done to assist you with the process of human resources management in respect of HIV and TB affected/infected nurses?
15. How should these recommendations be done? By whom? When?

## ANNEXURE 5: DOCUMENT CHECK LIST

TYPE OF RECORD	AVAILABILITY	COMPILED BY	MAINTAINED	DOCUMENT REFERENCE
Nursing Unit				
Nursing Acts				
Policies/Procedures/ Protocol related to clinical placements, staff allocation and staffing establishments				
Basic Conditions of Employment Act (75 of 1997)				
Labour Relations Act (66 of 1995)				
Employment Equity Act (55 of 1998)				
The Constitution of South Africa Act (108 of 1996).				
Strategy for Nursing for South Africa (2008)				
Code of good practice on key Aspects of HIV and Employment (2006).				
Human resources plans				
SANC directives for Training giving clinical placement requirements				
Organograms and organizational structures				



# ANNEXURE 6: UNIVERSITY OF KWAZULU-NATAL ETHICAL CLEARANCE LETTER



University of KwaZulu-Natal  
Research Office, Govan Mbeki Centre  
Westville Campus  
Private Bag x54001  
DURBAN  
4000  
Tel No: +27 31 260 3587  
Fax No: +27 31 260 4609  
sshrec@ukzn.ac.za

25 JUNE 2010

**MRS. J KERR (209539889)**  
**SCHOOL OF NURSING**

Dear Mrs. Kerr

**PROTOCOL REFERENCE NUMBER: HSS/0434/010D**  
**PROJECT TITLE: An analysis of Nurse Managers' human resources planning in respect of HIV/AIDS and Tuberculosis (TB) affected Nurses in selected hospitals in KwaZulu-Natal, South Africa – An Ethnographic Study**

In response to your application dated 21 June 2010, the Humanities & Social Sciences Ethics Committee has considered the abovementioned application and the protocol has been given **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 school/department for a period of 5 years.**

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

Yours faithfully

**Professor Steven Collings (Chair)**  
**HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE**

cc. Supervisor- Dr. P Brysiewicz  
cc. Prof. B Bhengu  
cc. Mr. S Reddy

# ANNEXURE 7: UNIVERSITY OF KWAZULU-NATAL ETHICAL CLEARANCE RENEWAL LETTER



3 August 2012

**Mrs Jane Kerr 209539889**  
School of Nursing and Public Health

Dear Mrs Kerr

**Protocol reference number: HSS/0434/010D**

**Project title: An analysis of Nurse Managers' human resources planning in respect of HIV/AIDS and Tuberculosis (TB) affected Nurses in selected hospitals in KwaZulu-Natal, South Africa – An Ethnographic Study**

#### RECERTIFICATION APPROVAL

This letter confirms that you have been granted Recertification Approval for a period of one year from the date of this letter: This approval is based strictly on the research protocol submitted in 2010.

**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 the amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years**

Yours faithfully

**Professor Steven Collings Chair**  
**Humanities & Social Sciences Research Ethics Committee**

cc Supervisor Professor Dr Petra Brysiewicz  
cc Professor B Bhengu  
cc Academic leader Professor M Mars  
cc School Admin. Mrs Caroline Dhanraj

**Professor S Collings (Chair)**  
**Humanities & Social Sc Research Ethics Committee**  
**Westville Campus, Govan Mbeki Building**  
Postal Address: Private Bag X54001, Durban, 4000, South Africa  
Telephone: +27 (0)31 260 3587/8350 Facsimile: +27 (0)31 260 4609 Email: ximbap@ukzn.ac.za / snymanm@ukzn.ac.za

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

Inspiring Greatness



## ANNEXURE 8: PERMISSION LETTER KWAZULU-NATAL HEALTH



Health Research & Knowledge Management sub-component  
10 – 103 Natalia Building, 330 Langalibalele Street  
Private Bag x9051  
Pietermaritzburg  
3200  
Tel.: 033 – 3953189  
Fax.: 033 – 394 3782  
Email.: [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)  
[www.kznhealth.gov.za](http://www.kznhealth.gov.za)

---

Reference : HRKM113/10  
Enquiries : Mrs G Khumalo  
Telephone : 033 – 3953189

16 July 2010

Dear Mrs Kerr

**Subject: Approval of a Research Proposal**

1. The research proposal titled '**An analysis of Nurse Managers' human resources planning in respect of HIV/AIDS and Tuberculosis affected nurses in selected hospitals in KwaZulu-Natal, South Africa – An Ethnographic study**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at **St Mary's, Wentworth and King Edward VIII Hospitals.**

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](mailto:hrkm@kznhealth.gov.za)

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely

Dr S.S.S. Buthelezi

Date: 22/07/2010

Chairperson, Health Research Committee  
KwaZulu-Natal Department of Health

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uMnyango Wezempilo . Departement van Gesondheid

*Fighting Disease, Fighting Poverty, Giving Hope*

## ANNEXURE 9: PERMISSION LETTER – DIRECTOR GENERAL OF PUBLIC SERVICE AND ADMINISTRATION



**the dpsa**

Department:  
Public Service and Administration  
**REPUBLIC OF SOUTH AFRICA**

Private Bag X916, PRETORIA, 0001 Tel: (012) 336 1000, Fax (012) 326 7802  
Private Bag X9148, Cape Town, 8000. Tel: (021) 467 5120, Fax (021) 465 5484

Enquiries : Mr MV Mamphiswana  
Tel No. : 012-336 1585  
Fax: : 0866188791  
File : 17/24/3/11

Mrs J Kerr  
P.O Box 25244  
Gateway  
**UMHLANGA RIDGE**  
4321

Dear Mrs Kerr

### **REQUEST TO CONDUCT INTERVIEWS WITH THANDILE HEALTH RISK MANAGEMENT IN FULFILLING THE REQUIREMENTS FOR THE PhD**

Your letter dated 25 July 2011 refers.

You are hereby granted permission to conduct interviews with Thandile Health Risk Management as part of your research in fulfilling the requirements for your PhD, on condition that-

- a) the information collected from the interview solely be utilised for purposes of your research in fulfilling the requirements for the PhD;
- b) no personal details of individuals shall be disclosed in any form; and
- c) on completion of your study, this Department, the Office of the Premier and the Department of Health in KwaZulu-Natal Provincial Administration be provided with copies of your final assessed PhD dissertation.

I wish you well with the completion of your studies.

Kind regards

**DIRECTOR-GENERAL (Acting)**  
DATE: 16/09/2011

Staatsdiens en Administrasie . Ditirelo tsa Puso le Tsamaiso . Ditshebeliso tsa Mmuso le Tsamaiso . uMnyango wemiSebenzi kaHulumeni nokuPhata

Muhasho wa Tshumelo ya Muvuso na Vhulanguli . Kgoro ya Ditirelo tsa Mmušo . Ndzawulo ya Vutirela-Mfumo na Valawuri

LiTiko le Tebasebenti baHulumende nekuPhatsa . ISebe leNkonzo kaRhulumente noLawulo . UmNyango wemiSebenzi kaRhulumente nokuPhata

## **ANNEXURE 10: EMAIL CORRESPONDENCE FROM PROF. MAX VAN MANEN**

**Sender:** Max van Manen <max.van.manen@ualberta.ca>

**Date:** 2/11/2010 10:12:06 PM

**Email address:** max.van.manen@ualberta.ca

**Recipients:** Kerrj@ukzn.ac.za,

**Attachments:** TEXT.htm Mime.822

**Subject:** Re: Literature sources for hermeneutic interpretation

Hello Jane

I do not believe that phenomenology is the optimal methodology for your study.

You are using the notion of lived experience in a much broader sense than would be appropriate for a phenomenological study (for example, your formulation of the experience of lived experience would raise difficult philosophical issues).

Lived experience is quite a technical term that requires some further phenomenological scholarship.

It seems to me that your study would indeed benefit from a more narrative and perhaps ethnographic approach.

I can imagine that certain ethical notions such as "moral distress" could become important for the nurse managers your study.

If you wish to find out more about the latter then you may contact Dr Wendy Austin who holds a research chair in nursing at my university. She is also well versed in phenomenological inquiry and could give you additional thoughts.

It is possible to suggest that there are some phenomenological notions embedded in your research question but they would have to be untangled.

Also, it is not quite appropriate to think of phenomenological inquiry as a series of steps. I explain this quite explicitly in my book *Researching Lived Experience*.

If you really want to take a phenomenological approach then I would suggest that you carefully read a few main texts (some of the secondary texts in the nursing field are quite superficial and poor).

You need good supervision of at least one professor well-steeped in phenomenology.

Best wishes

Max van Manen

## ANNEXURE 11: INVITATION LETTER TO EXPERTS

School of Nursing and Public Health,  
University of KwaZulu – Natal,  
Room 515, Desmond Clarence Building,  
Howard College,  
King George V Avenue.  
Durban.

3 November 2012

Tel: 031 2601432

Cell: 0836269423

Email: kerrj@ukzn.ac.za

Dear Mrs.

Nursing Manager

### **Inkosi Albert Luthuli Central Hospital**

I, Jane Kerr, a PhD Nursing student and employee of the School of Nursing and Public Health, invite you or an appropriate person delegated by you, to participate in a nominal group discussion in respect of draft guidelines formulated on the NURSE MANAGERS' HUMAN RESOURCES MANAGEMENT OF HIV AND/OR TB AFFECTED/INFECTED NURSES in the workplace.

The guidelines are an outcome of my PhD study: *An analysis of nurse managers' human resources management related to HIV and TB affected/infected nurses in selected hospitals in KwaZulu-Natal.*

The purpose of the nominal group is to evaluate how useful, feasible and valid the proposed guidelines will be.

Who should attend? Allocation Nursing Manager/Nursing Manager who deals with Human Resources matters in the Nursing Service

Venue: The Board Room  
School of Nursing and Public Health  
5<sup>th</sup> floor, Desmond Clarence Building  
Howard College  
Access through Gate three on old François Road

RSVP: No later than 16 November 2012 by 13h00 for catering purposes

DATE:

Agenda:	09h00	Welcome
		Presentation of the draft guidelines
	10h30	Tea
	11h00	Open structured discussion around the draft guidelines
	13h00	Lunch
	13h30	Thanks

Thank you in anticipation.

Mrs. Jane Kerr

School of Nursing and Public Health

University of KwaZulu – Natal

## ANNEXURE 12: AGREE INSTRUMENT

### AGREE II INSTRUMENT

HIV/AIDS Technical Assistance  
guidelines

Department of Labour



**DOMAIN 1. SCOPE AND PURPOSE**

1. The overall objective(s) of the guideline is (are) specifically described.

1 Strongly Disagree	2	3	4	5	6	X 7 Strongly Agree
------------------------	---	---	---	---	---	-----------------------

*Comments* How to deal with Discrimination (HIV related)  
- Respond to impact of HIV/AIDS in the workplace

2. The health question(s) covered by the guideline is (are) specifically described.

1 Strongly Disagree	2	3	4	5	6	X 7 Strongly Agree
------------------------	---	---	---	---	---	-----------------------

*Comments*

3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

1 Strongly Disagree	2	3	4	5	6	X 7 Strongly Agree
------------------------	---	---	---	---	---	-----------------------

*Comments* employees  
employees  
trade unions

**DOMAIN 2. STAKEHOLDER INVOLVEMENT**

4. The guideline development group includes individuals from all relevant professional groups.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
------------------------	---	---	---	---	---	---------------------

Comments *Commission for Employment Equity  
Employment Equity Directorate  
International Labour Organization  
United Nations Development Program*

5. The views and preferences of the target population (patients, public, etc.) have been sought.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
------------------------	---	---	---	---	---	---------------------

Comments *See above*

6. The target users of the guideline are clearly defined.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
------------------------	---	---	---	---	---	---------------------

Comments *Employees  
Employers  
Trade Unions.*

DOMAIN 3. RIGOUR OF DEVELOPMENT

7. Systematic methods were used to search for evidence.

1 Strongly Disagree	X	2	3	4	5	6	7 Strongly Agree
------------------------	---	---	---	---	---	---	---------------------

Comments not stated

8. The criteria for selecting the evidence are clearly described.

1 Strongly Disagree	X	2	3	4	5	6	7 Strongly Agree
------------------------	---	---	---	---	---	---	---------------------

Comments not described

9. The strengths and limitations of the body of evidence are clearly described.

1 Strongly Disagree	X	2	3	4	5	6	7 Strongly Agree
------------------------	---	---	---	---	---	---	---------------------

Comments not mentioned

DOMAIN 3. RIGOUR OF DEVELOPMENT continued

10. The methods for formulating the recommendations are clearly described.

1 Strongly Disagree	2	3	4	X 5	6	7 Strongly Agree
------------------------	---	---	---	-----	---	---------------------

Comments  
 Legal Framework  
 legal precedents used (SA context)

11. The health benefits, side effects, and risks have been considered in formulating the recommendations.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
------------------------	---	---	---	---	---	---------------------

Comments  
 N/A

12. There is an explicit link between the recommendations and the supporting evidence.

1 Strongly Disagree	2	3	4	5	6	X 7 Strongly Agree
------------------------	---	---	---	---	---	-----------------------

Comments  
 Legislative Framework  
 legal precedents (SA context)

DOMAIN 3. RIGOUR OF DEVELOPMENT continued

13. The guideline has been externally reviewed by experts prior to its publication.

<input checked="" type="checkbox"/> 1 Strongly Disagree	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7 Strongly Agree
--	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	--

Comments *no evidence of this found.*

14. A procedure for updating the guideline is provided.

<input type="checkbox"/> 1 Strongly Disagree	<input checked="" type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7 Strongly Agree
---	---------------------------------------	----------------------------	----------------------------	----------------------------	----------------------------	--

Comments *no evidence found*

DOMAIN 4. CLARITY OF PRESENTATION

15. The recommendations are specific and unambiguous.

1 Strongly Disagree	2	3	4	5	6	<input checked="" type="checkbox"/> 7 Strongly Agree
------------------------	---	---	---	---	---	---

Comments

16. The different options for management of the condition or health issue are clearly presented.

1 Strongly Disagree	2	3	4	5	6	<input checked="" type="checkbox"/> 7 Strongly Agree
------------------------	---	---	---	---	---	---

Comments

17. Key recommendations are easily identifiable.

<input checked="" type="checkbox"/> 1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
--	---	---	---	---	---	---------------------

Comments

DOMAIN 5. APPLICABILITY

18. The guideline describes facilitators and barriers to its application.

1 Strongly Disagree	X	2	3	4	5	6	7 Strongly Agree
------------------------	---	---	---	---	---	---	---------------------

Comments No evidence found.

19. The guideline provides advice and/or tools on how the recommendations can be put into practice.

1 Strongly Disagree	2	3	4	5	6	X 7 Strongly Agree
------------------------	---	---	---	---	---	-----------------------

Comments Check lists provided  
Examples of Policies Provided.

20. The potential resource implications of applying the recommendations have been considered.

1 Strongly Disagree	X	2	3	4	5	6	7 Strongly Agree
------------------------	---	---	---	---	---	---	---------------------

Comments no evidence found

DOMAIN 5. APPLICABILITY continued

21. The guideline presents monitoring and/or auditing criteria.

1 Strongly Disagree	2	3	4	5	6	<input checked="" type="checkbox"/> 7 Strongly Agree
------------------------	---	---	---	---	---	---

Comments

Check lists  
Policy examples

This document is a sound frame of reference for use, however is too generic for the purposes of providing nurse managers with guidelines for use in the world of nursing work.

J Kerr



DOMAIN 6. EDITORIAL INDEPENDENCE

22. The views of the funding body have not influenced the content of the guideline.

1 Strongly Disagree	2	3	4	5	6	<del>7</del> Strongly Agree
------------------------	---	---	---	---	---	--------------------------------

Comments

23. Competing interests of guideline development group members have been recorded and addressed.

1 Strongly Disagree	<del>2</del>	3	4	5	6	7 Strongly Agree
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Comments

NO mention made of group members

## OVERALL GUIDELINE ASSESSMENT

For each question, please choose the response which best characterizes the guideline assessed:

1. Rate the overall quality of this guideline.

1 Lowest possible quality	2	3	4	5	6 <input checked="" type="checkbox"/>	7 Highest possible quality
---------------------------------	---	---	---	---	---------------------------------------	----------------------------------

2. I would recommend this guideline for use.

Yes	<input type="checkbox"/>
Yes, with modifications	<input checked="" type="checkbox"/>
No	<input type="checkbox"/>

### NOTES

modifications need to be specific  
for - day to day planning & management  
use of nurse managers jkerr

## **ANNEXURE 13: DRAFT GUIDELINES**

### ***Draft guidelines for a Strategy to manage employee (nurse) incapacity as a consequence of HIV, TB in Health Care Services***

This document serves to provide a quick reference guide for Managers of Health Care Services to the requirements for the management of nurses who are chronically ill and who either are away on long periods of sick leave; or have remained at work despite their illness; or have returned to work following a protracted period of illness.

For the purposes of these draft guidelines the immediate supervisor and the supervisor's manager represent the employer and are accountable to the employer for the correct implementation of the draft guidelines.

The Draft guidelines include:

- General Requirements
- Key Legislative Requirements

These draft guidelines were developed as part of a PhD at the University of KwaZulu – Natal School of Nursing and Public Health, by Mrs. Jane Kerr (MCur) in collaboration with a nominal group of Nurse Managers employed in the Public Sector in the eThekweni District in KwaZulu – Natal, South Africa.

Names.

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Mr. Bongani Makhanya

Ms. Hlengiwe Gumede

Ms. Lindeni E. Nkosi - Gumbi

**Date: 21 November 2012**

# THE DRAFT GUIDELINES

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## **1. INTRODUCTION**

This document serves to provide a quick reference guide for Managers of Health Care Services to the requirements for the management of nurses who are chronically ill and who either are away on long periods of sick leave; or have remained at work despite their illness; or have returned to work following a protracted period of illness.

## **2. GENERAL REQUIREMENTS**

- It is incumbent on the immediate supervisor of the nurse to manage and monitor the nurse's periods of absence from work, as well as the responsibility of the employee to manage his/her own leave responsibly (South Africa, PILIR, 2007: 5; South Africa, DPSA, 2012:23).
- The immediate supervisor must:
  - Scrupulously monitor the nurse's absences away from work,
  - Identify absentee patterns and
  - Strictly adhere to deadlines for submission of applications for sick leave, incapacity leave and/or ill health retirement to the relevant Health Risk Manager via the local Human Resources Directive.

## **3. PRINCIPLES**

- Everyone has the right to an environment that is not harmful to their health or wellbeing (Section 24 of the Bill of Rights)
- Everyone has the right to have access to health care services including reproductive healthcare (Section 27 of the Bill of Rights)

## **4. LEGISLATIVE FRAMEWORK**

The following legislative framework includes documents which ensure that these sections of the Bill of Rights are upheld in respect of nurses at work.

- Constitution of South Africa (108 of 1996);
- Labour Relations Act (66 of 1995 as amended 2002);
- Basic Conditions of Employment Act (75 of 1997 as amended 2002 & 2007);  
Employment Equity Act, (55 of 1998);
- Occupational Health and Safety (85 of 1993);
- Public Service amendment Act (30 of 2007);
- Compensation for Occupational Injuries and Diseases Act (130 of 1993);
- Unemployment Insurance Act (63 of 2001);
- Nursing Act (33 of 2005);

- Code of Good Practice on HIV and AIDS and the world of work (South Africa, DOL, 2012:1-18);
- Employee Health and Wellness Strategic Framework (South Africa, DPSA, 2009:1-59)
- Policy for Incapacity leave and ill health retirement [PILIR] (South Africa, DPSA, 2009:1-29)
- South African Nursing Council. (2011). Draft Regulations relating to the conducting of inquiries into alleged unfitness to practise due to disability or impairment of persons registered in terms of the Nursing Act, 2005 (Act 33 of 2005).
- Management of Drug - Resistant TB. Policy Guidelines. (2011). (South Africa, DOH, 2011:1-65)
- Hazardous Biological Agents Regulations (South Africa, DOL, 2001:1-67).

Relevant information from each bill is supplied in section 7.

## **5. THE DRAFT GUIDELINES**

### **5.1. Rational for Draft guidelines**

The rationale for the development of these draft guidelines is to collate the available and relevant information on the human resources management around incapacity leave and ill health retirement, , and the occupational health and safety management of HIV and TB into a single document so as to assist nurse managers in effectively managing nurse prolonged absences from work.

### **5.2. Scope of Draft guidelines**

*Target Group for Draft guidelines*

- The users of these draft guidelines will be Managers who are tasked with the planning of nurse provision in order to provide safe, quality health care in KwaZulu –Natal

*Disease/Condition(s) included in Draft guidelines*

- Human immunodeficiency virus (HIV)
- TB (TB)

### *Guideline Category*

- Management of Human Resources
- Management of Nursing Services
- Occupational Health Services
- Health Risk Management Services
- All workers employed in the Public sector Health Services including permanent to hourly employment arrangements
- This includes:
  - Those in training; where service agreements are in place which
    - Include medical surveillance of all trainees and
    - Training institution is registered with The Workmen's Compensation Commissioner
  - People whose employment is terminated for any reason including those laid off or suspended from work

### *Interventions and Practices Considered in formulating the draft guidelines*

- Compliance with employee rights and patient rights as enshrined in the South African Constitution (108 of 1996)
- The Batho Pele principles (South Africa, DPSA, (n.d.)) in incapacity leave management
- The prevention of victimisation and discrimination in the world of work as enshrined in the Employee Equity Act (55 of 1998)
- Consistent Policy implementation
- A safe working environment as enshrined in the Occupational Health and Safety Act (85 of 1993)
- Employee access to benefits to which they may be entitled in cases where the world of work has failed to provide them with employment safety
- Managers advocacy for nurses managed by them

### *Major Outcomes Considered*

- Effect of prolonged nurse absenteeism on
  - organizational productivity and service delivery
  - colleague workload consequences
- The Manager required to provide safe, quality care in an environment lacking in human resources



### 5.3. Guideline Objectives

- To ensure that this document will ensure that nurse confidentiality is promoted and that nurses who do voluntarily disclose their disease status to their immediate manager are not discriminated against or victimised at work
- To ensure that the local HIV workplace policy is implemented
- To provide Managers, unit managers and other stakeholders with draft guidelines on how to manage incapacity leave in chronically ill nurses, especially nurses who are HIV affected and infected and/or TB infected and affected in the world of work.
- To facilitate Managers' decision making around the clinical placement of chronically ill nurses, especially nurses who are HIV infected and affected and/or TB infected, in KwaZulu – Natal
- To assist Managers' to provide competent, skilled nurses who will provide quality health care in health care services of KwaZulu – Natal
- To encourage chronically ill nurses, especially nurses who are HIV infected / affected and/or TB infected, to voluntarily disclose their disease status to their immediate manager

### 5.4. Definitions

Term	Definition
"nurse"	means "a person registered in a category under section 31(1) of the Nursing Act (Act 33 of 2005) in order to practise nursing or midwifery" (South Africa, 2005:6)
"practitioner"	means "any person registered in terms of section 31(1) of the Nursing Act" (Act 33 of 2005) (South Africa, 2005:6)
"unfit to practice due to disability or impairment"	means that; "a person registered in terms of the Nursing Act 2005 (Act 33 of 2005) is incapacitated as a result of disability or is or may be impaired, whether mentally or otherwise, to such an extent that; (a) it would be detrimental to the public interest to allow him or her to continue to practise; (b) he or she is unable to practise the profession with reasonable skill and safety; or (c) in the case of a learner, has become unfit to continue with the education programme" (South Africa, 2005:50; SANC, 2011:16).
"impairment"	refers to "a condition which renders a practitioner incapable of practising nursing with reasonable skill and safety" (SANC, 2011:15)

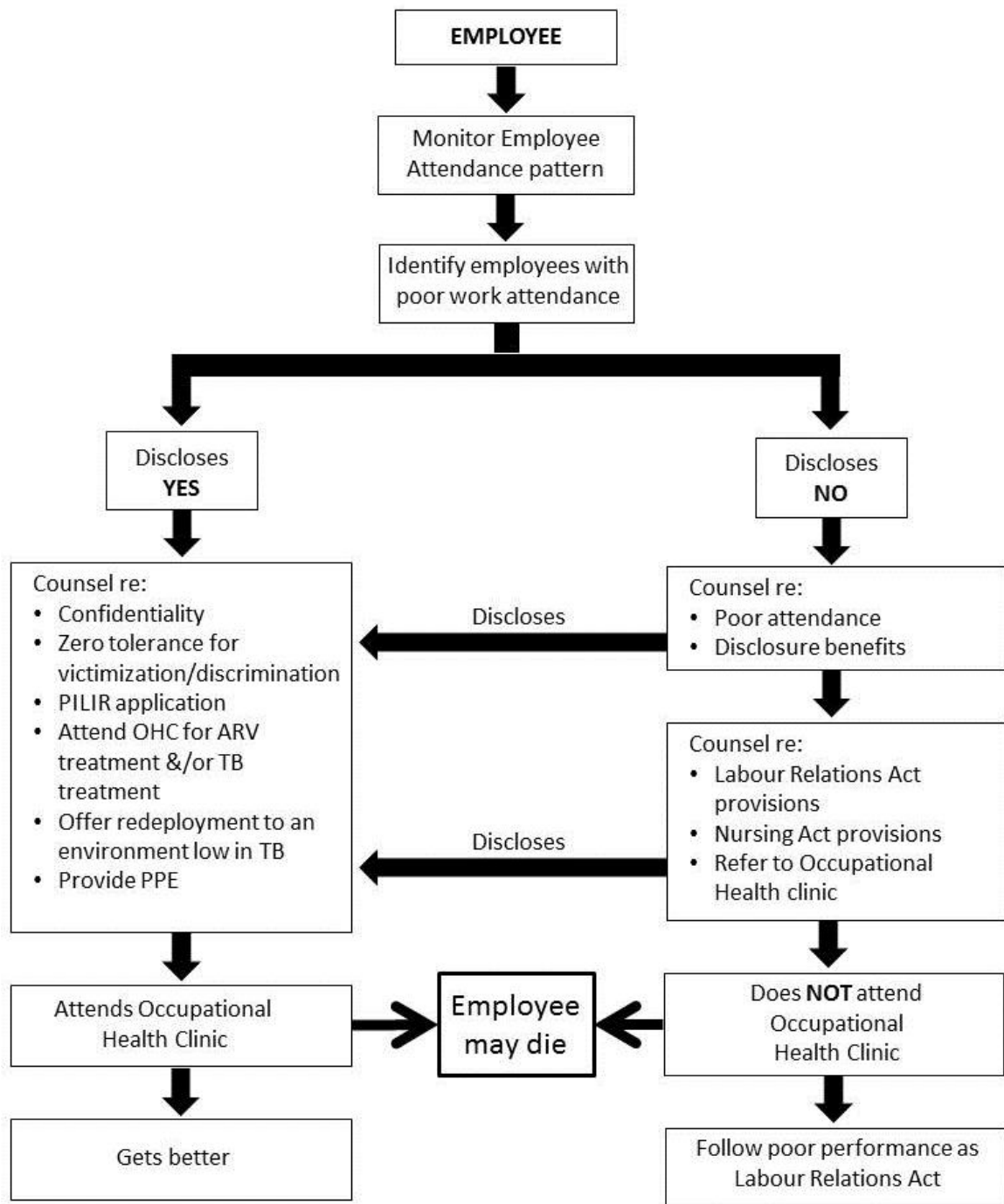
<p><b>“hazardous biological agent”</b></p>	<p>(HBA) is defined as “any micro-organism, cell culture, and human endo-parasite, genetically modified which may cause infection, allergy, toxicity, or create hazard to human health” (South Africa, DOL, 2001:4).</p>
--	--

### 5.5. Guideline Recommendations

- Monitor and reduce absenteeism (KZN, DOH, (n.d.):3)
- Identify and manage workplace factors causing poor attendance (KZN, DOH, (n.d.):3)
- Formulate a strategy to manage absenteeism (KZN, DOH, (n.d.):3)
- Implement a zero tolerance for victimisation and/or discrimination in the workplace (South Africa, DOL, 2012:8)
- Uphold the principles of maintaining confidentiality in the workplace (South Africa, DOL, 2012:9)
- Offer employees who have voluntarily disclosed their disease status temporary redeployment to areas which have minimal risk of TB transmission (South Africa, DOL, 2012:13; South Africa, DOH, 2011:120)
- Ensure the provision of personal protective equipment to all employees and patients in areas of collective gatherings of people (South Africa, DOH, 2011:117-118)
- Consistently implement policies correctly
- Encourage employee use of the workplace occupational Health facility (South Africa, DOL, 2012:34; South Africa, DOH, 2011:21)
- Build the trust of nurses in the organizational management of illness at work
- Advocate for nurses in situations where you disagree with senior management decisions around the eligibility of an nurse for Incapacity leave or ill health retirement

### 5.6. Decision making flow

The following figure is a graphical presentation of the stages in the decision making process in managing and decision making around an ill nurse at work as described by the draft guidelines.



**Figure 1. Presentation of the decision making flow**

### 5.7. Potential benefits and harms

#### *Benefits*

- Fair, equitable and non-discriminatory employment practices in Nursing Services

- Reduce stress on Manager and colleagues
- Improve Manager interaction with ill nurses
- Standardisation of practice around management of ill nurses at work
- Standardised management of PILIR in the workplace
- Standardised management of nurse Health and Wellness
- Standardised management of Occupational factors around especially HIV and TB affected/infected nurses
- Improve advocacy, staff retention and organizational productivity

*Harms*

None foreseen.

## **6. IMPLEMENTATION CONSIDERATIONS**

### **6.1. Principles underlying implementation of draft guidelines**

- Respect for Human rights and basic freedoms
- That confidentiality of nurse information will be upheld
- That ethical principles will be maintained
- That nurses living with HIV and AIDS and TB have rights equal to all other staff
- That nurses living with HIV, and who have voluntarily disclosed have the right to protection against any form of discrimination
- HIV and AIDS is to be regarded as all other serious and chronic disease in the workplace
- Employers and their representatives are to ensure that nurses are not unfairly discriminated against or stigmatised at work
- That nurses' HIV status does not preclude employment and other growth opportunities
- That the employer will prevent occupational exposure by prioritising a safe working environment
- That the employer will put mechanisms in place to identify and reduce any risk situations
- Employers are to ensure gender equality in its response to HIV and AIDS
- Employers to provide workplace access to health care and or access to medical insurance as well as compensation for occupational injuries and or diseases for all nurses

- Employers are to ensure workplace HIV and AIDS policies and procedures are devised and implemented following participation and inclusion of both nurses and employee representative organizations
- Occupational Health and safety is to be a priority in the form of providing personal protective equipment to prevent the spread of HIV and AIDS and TB especially in the health care sector (South Africa, DOL, 2012:8-9)

## **6.2. Recommendations for implementation**

- Urgently implement a workplace HIV and AIDS Policy and programme
- Build trust within the Nursing Service
- Encourage nurses to disclose their disease status
- Respect the decision of those nurse who do not wish to voluntarily disclose their disease status
- Implement compulsory membership of Government Employee Medical Scheme (GEMS)
- Implement a zero tolerance policy for stigmatization and discrimination
- Implement impeccable document protection strategies
- Monitor absenteeism at an operational level. Do not depend on the provision of information by the Human Resources Directorate
- Encourage employee absenteeism self-monitoring
- Provide practical education to operational Managers and the nurses in charge of a shift in respect of:
  - absentee monitoring
  - calculating leave and sick leave balances
  - policies and procedures for managing absenteeism in the world of work
  - policies and procedures for migration of information around leave and absenteeism per nurse as nurses are redeployed within the organization
- put in place an implementation strategy with implementation time lines

A major barrier to the application of the recommendations is:

- The lack of Information Technology resources available in Nurse Manager's offices and Occupational Health clinics to facilitate access to relevant documents
- Inaccurate job analysis and job descriptions
- Inadequate knowledge and experience of incapacity management among managers resulting in Managers dependence on the Human Resources Directorate to supply them with hard copies of the documents which are in existence and available.
- Inadequate communication between Managers and the Human Resources Directorate regarding sick leave information

- Inadequate PILIR education and awareness of Managers and nurses

## **7. LEGISLATIVE FRAMEWORK**

The following is the legal framework within which these draft guidelines are to be read, understood and implemented

### **7.1. The Constitution (108 of 1996)**

- Everyone has the right to an environment that is not harmful to their health or wellbeing (Section 24 of the Bill of Rights). (South Africa, 1996:1251)
- Everyone has the right to have access to health care services including reproductive healthcare (Section 27 of the Bill of Rights). (South Africa, 1996:1255)

The following legislative framework includes documents which ensure that these sections of the Bill of Rights are upheld in respect of employees at work.

### **7.2. Labour Relations Act (66 of 1995 as amended 2002)**

- An employer is not compelled to disclose the HIV status of an nurse unless the nurse grants permission for his/her HIV status
- A nurse may not be dismissed based on his/her HIV status (Section 187(1) (f)). (South Africa, 1995)

### **7.3. Basic Conditions of Employment Act (75 of 1997 as amended 2002 & 2007)**

- Employers must ensure that nurses receive the minimum number of sick leave days (Section 22(2)). (South Africa, 1997:24).

### **7.4. Employment Equity Act (55 of 1998)**

- No individual may be unfairly discriminated against on the grounds of either real or perceived HIV status (Section 54(1) a) (South Africa, 1998:45).
- Applicants for employment may not be discriminated against in respect of his/her HIV status (Section 6 (1)). (South Africa, 1998:14).
- Harassment of nurses based on his/her HIV status is prohibited as is violence in the workplace (Section 6(3)). (South Africa, 1998:14).
- Testing nurses for HIV is prohibited (Section 7(2)). (South Africa, 1998:14).

- Employers are to provide reasonable accommodation of nurses, including nurses with HIV, with access to equal employment opportunities (Section 15(2)(c)). (South Africa, 1998:18).
- Reasonable accommodation may be required in the event of an nurse voluntarily disclosing his/her HIV status
  - Adapting existing facilities to make them accessible to the nurse
  - Adapting existing equipment or obtaining new equipment
  - Reorganizing work stations
  - Changing training, assessment material or systems
  - Job restructuring so that non-essential functions are reassigned
  - Adjusting work time and leave
  - Providing specialised supervision, training and support in the workplace
- Accommodation, temporary/permanent, is required when the work changes or the work environment changes or when the impairment affects the nurse ability to perform the functions of his/her job

#### **7.5. Occupational Health and Safety Act (85 of 1993)**

- Employers must provide a safe working environment (Section 8(1)). (South Africa, 1993:8).

#### **7.6. The Public Service Amendment Act (30 of 2007)**

Termination of employment;

- The power to terminate the services of an employee, who is not a head of department (HOD) lies with the HOD, in terms of subsection (2) (e). (South Africa, 2007:27).
- Every employee may be discharged from the public service, excluding members of the services, educators or members of the Agency or the Service, (Section 17(2)); (South Africa, 2007:27-28) in the following circumstances;
  - “(a) **On account of continued ill-health;**
  - (b) Owing to the abolition of his or her post or any reduction in or reorganisation or readjustment of departments or offices;
  - (c) If, for reasons other than his or her own unfitness or incapacity, his or Her discharge will promote efficiency or economy in the department or office in which he or she is employed, or will otherwise be in the interest of the public service;

- d) On account of unfitness for his or her duties or incapacity to carry them out efficiently;
  - (e) On account of misconduct;
  - (f) If, in the case of an officer appointed on probation, his or her Appointment is not confirmed;
  - (g) On account of misrepresentation of his or her position in relation to a condition for permanent appointment;
  - (h) If his or her continued employment constitutes a security risk for the State;
- And
- (i) If the President or a Premier appoints him or her in the public interest Under any law to an office to which the provisions of this Act do not apply”.

Absence without permission is stated in the Act as follows;

- An employee who is absent from work without consent from his/her HOD, office/institution for longer than one (1) calendar month shall be regarded as no longer being employed by the Public Service as a consequence of misconduct. The termination of service will be effective from the date immediately following his/her last day at work. Employees who are members of the services or educators or a member of the Agency or the Service do not fall within this piece of legislation. (Section 17(3)). (South Africa, 2007:27).

The Act continues by stating that;

“If an employee who is deemed to have been so discharged, reports for duty at any time after the expiry of the period one (1) calendar month, the relevant executing authority may, on good cause shown and notwithstanding anything to the contrary contained in any law, approve the reinstatement of that officer in the public service in his or her former or any other post or position, and in such a case the period of his or her absence from official duty shall be deemed to be absence on vacation leave without pay or leave on such other conditions as the said authority may determine” (South Africa, 2007:27).

#### **7.7. Compensation for Occupational Injuries and Diseases Act (130 of 1993)**

- Employees must apply for benefits when he/she contracts an occupationally acquired disease as a result of exposure to affected blood or body fluids (Section 22(1)). (South Africa, 1993:19).

#### **7.8. Unemployment Insurance Act (63 of 2001)**

- Employers must ensure that employees have the right to access illness benefits (Section 20). (South Africa, 2001:22).



### **7.9. National Health Act (61 of 2003)**

- Health care workers must not be unfairly discriminated against as a result of his/her health status. (South Africa, 2003:28)

### **7.10. Nursing Act (33 of 2005)**

This Act, along with the Constitution Act (Act 106 Of 1996) forms the foundation for Nursing Practice in South Africa. It is incumbent on the users of these draft guidelines to ensure that they know the content of the Nursing Act 33 of 2005.

### **7.11. Code of Good Practice on HIV and AIDS and the world of work (South Africa, DOL, 2012:1-18)**

This newly published document has formed the basis from which these draft guidelines were formulated. As such it is recommended that users of these draft guidelines ensure that they have in their possession and have read this document in order to understand the context from which the draft guidelines were formulated

### **7.12. Employee Health and Wellness Strategic Framework (South Africa, DPSA, 2008:1-59)**

The strategy became effective on 1 April 2009 and is applicable to all public servants employed in terms of:

- The Public Services Act of 1994
- The Correctional Services Act of 1998
- The employment of Educators Act (76 of 1998)

The Employee Health and Wellness Strategic Framework [EHWS] (South Africa, DPSA, 2009:1-59) is a universal strategy developed for use by the Public Service (South Africa, DPSA, 2009:7).

The objectives of the EHW strategy are to:

- Control health hazards at work, thus improving Occupational Health and Safety
- Provide a safe environment for both the public and employees within the Public Service

- Ensure the Public Service manages risks and provides quality services

The policies derived from the pillars of the EHW Strategic Framework (South Africa, DPSA, 2009:23) include:

- Safety, Health, Environment, Risk and Quality Management Policy (SHERQ)
- HIV and AIDS and TB Management Policy
- Health and Productivity Management
- Wellness Management

In respect of the draft guidelines developed here under, the **HIV and TB Management** and **Health and productivity management, Disease management** pillars of the employee Health and Wellness Strategic Framework (South Africa, DPSA, 2009:23) are the most pertinent aspects of the strategy in respect of Nurse Managers who are tasked with the planning of the Human resources provision in district hospitals of the eThekweni district.

**HIV and TB Management** includes among others:

- Prevention including Health Education;
- Treatment care and support;
- Human Rights and access to justice and research as well as
- Monitoring and evaluation (South Africa, DPSA, 2009: 25).

**Health and productivity management** includes among others:

- the provision of a process to managed health care at work;
- Injury on duty/incapacity due to ill health (South Africa, DPSA, 2009: 27).

The above two preceding aspects are the crux of the draft guidelines here under.

**Disease management and chronic diseases**

- Reduce vulnerability to HIV and TB
- Reduce transmission of HIV and TB
- Human and legal support advocacy
- HIV behaviour change communication
- Promote health and health education
- Bring HIV and AIDS into the mainstream of care (South Africa, DPSA, 2009:27).

**Treatment, Care and support** (South Africa, DPSA, 2009:44).

- Encourage public servants to become members of Government employees medical aid scheme (GEMS)
- Provide and promote voluntary counselling and treatment at work
- Provide and promote anti-retroviral care (ART) and Direct Observed TB treatment (DOT) at work
- Provide employee and family assistance and support at work
- Promote patient accountability
- Encourage early TB detection

**Human Rights and access to justice** (South Africa, DPSA, 2009:45).

- Adhere and comply with legislation and policies
- Prevent stigmatization and discrimination
- Monitor and redress HIV human rights violations
- Encourage human rights
- Promote gender and sexual equality

**Research and monitoring and evaluation** (South Africa, DPSA, 2009:46).

- Conduct regular surveillance
- Conduct regular Health Risk Assessment
- Develop a monitoring and evaluation agenda

**Health and productivity management** (South Africa, DPSA, 2009:26).

- Offers a process to managed health care at work i.e. PILIR

**Injury on duty/incapacity due to ill health** (South Africa, DPSA, 2009:49).

- Injury on duty and occupational diseases
- Incapacity leave and ill health retirement
- Management support and counselling

**Occupational health education and promotion** (South Africa, DPSA, 2009:50)

Effects of chronic disease include:

- Increased absenteeism
- Increased sick leave usage
- Loss of experienced nurses due to early retirement or death of such nurses
- Reduced performance and productivity of nurses due to incapacity

- Reduced employee efficiency

### **Sick leave**

Permanent employees in the Public sector in South Africa are allowed thirty six (36) days sick leave, on full pay, in a three (3) year cycle of employment (South Africa, 1997:24; South Africa, DPSA, 2012:23).

### ***Ensure the following information is included in induction and orientation programs;***

Employee responsibilities (South Africa, DPSA, 2007:16; South Africa, DPSA, 2012:26):

- Must inform immediate supervisor immediately him/herself if unable to attend work. A message through a relative, co-worker or friend is only acceptable where the nature/degree of the illness/injury is severe and the employee is unable to do so him/herself.
- **Must manage own leave responsibly**
- Must submit applications to undergo clinical procedures in advance of the procedure being performed, unless the procedure is an emergency
- Sick leave applications must be submitted within five (5) working days of after developed world day of absence, by nurse, relative, co-worker or friend
- Should the nurse fail to submit a sick leave application within the stipulated time frame then the immediate supervisor/manager must:
  - Inform the nurse that if the application is not received within two (2) working days, the leave taken will be either unpaid leave or annual leave
- Where there are valid reasons for the nurse not meeting the deadline for submission of sick leave applications, the immediate supervisor/manager must immediately inform the Human Resources Division.
  - With the nurses consent the period of absence will be converted to either annual leave or unpaid leave
  - *Should the employee fail to submit his/her sick leave application within the stipulated time frame, or the supervisor/manager fail to properly manage the process, this must be seen in a serious light and disciplinary steps against the employee and/or supervisor/manager should follow (South Africa, DPSA, 2012:24).*
- Absences of three (3) days or more require a medical certificate indicating the reason for the absence from work and the duration of absence from work in lay persons language
- Where patterns of absence are identified, a medical certificate can be required for absences of less than three (3) days

- Where a nurse has been sick on more than two (2) occasions in an eight (8) week period, must submit a sick certificate no matter what the duration of the absence is
- The eight week period commences on the developed world day of absence and is calculated as a **CALENDAR** month.
- The nurse must submit the medical certificate within two (2) days, if he/she fails to do this, the period of absence will be taken as unpaid leave or annual leave with the employee's consent
- For every 15 consecutive **CALENDAR** days leave taken without pay, a nurse's sick leave entitlement shall be reduced by 1/72nd per sick leave cycle (South Africa, DPSA, 2012:25).

**7.13. Policy for Incapacity Leave and Ill Health Retirement [PILIR] (South Africa, DPSA, April 2009)**

“**Incapacity leave**” is leave, over and above the normal 36 days of allowed sick leave in a three year cycle, granted to a sick employee at the discretion of the employer (South Africa, DPSA, 2009:6).

**7.14. South African Nursing Council Draft Regulations (2011) relating to the conducting of inquiries into alleged unfitness to practise due to disability or impairment of persons registered in terms of the Nursing Act, 2005 (33 of 2005).**

See Annexure 1.

**7.15. Management of Drug - Resistant TB. Policy Draft guidelines. 2011 (South Africa, DOH, 2011).**

See Annexure 2.

**7.15.1. Hazardous Biological Agents Regulations (South Africa, DOL, 2001).**

These regulations are regulations which fall into the realm of the Occupational Health and Safety Act (85 of 1993). These regulations are applicable to every place of employment where biological agents are either produced or present and which may have an effect on employee health. It is incumbent on the employer to ensure that nurses are knowledgeable in respect of the regulations, biological agent hazards at work, how to protect themselves from such agents and the potential health hazards which may be a consequence of exposure to such agents. The regulations

spell out the responsibilities of employees and employers. Employers are to conduct risk assessments, monitor employee exposure to such agents, conduct medical surveillance on all exposed employees, and provide the affected employees with personal protective equipment. Of specific relevance to these draft guidelines are stipulated risk assessment, exposure monitoring, medical surveillance, provision of personal protective equipment around TB in health care facilities. See Annexure 2.

#### **7.16. WORKPLACE DIRECT OBSERVED TREATMENT [DOT] (South Africa, DOH, 2009:47).**

Workplace DOT has a positive effect for employees and employers. Normally, TB patients need approximately 2-weeks sick leave when their treatment is initiated. Following the initial two week period of treatment, TB patients are no longer infectious and are generally able to return to work, on treatment. Workplace DOT enables employees (nurses) to continue employment, if they are fit to do so, providing them with a continued income. Providing workplace DOT shows an employer's commitment to social and corporate responsibility. Retention and productivity of trained, skilled employees is promoted and kept at higher levels than can be maintained with increased employee turnover or prolonged absenteeism. Trained/ skilled staff is retained and productivity is maintained at higher levels than would be possible with high nurse turnover or long periods of absenteeism. The message created by workplace DOTS programs is that the employer cares for its employee's health and welfare, thus ensuring good employer, employee relationships.

A DOTS workplace programme gives the opportunity for fostering an environment in which to address stigma and victimization, as well as TB transmission anxieties. Early TB diagnosis is more probable as ill nurses access workplace DOT programs, reducing TB transmission in the world of work. The treatment supporter in the workplace could be an occupational health nurse, manager, supervisor, shop steward or other employee. Establishing workplace DOT requires:

- Training of workplace DOTs supporters.
- Establishing systems that allow treatment to be taken and monitored in privacy.
- Confidentiality to be ensured.

- Good communication with the community clinic where the client is registered.
- Allocating time for clinic visits so that medication can be collected, sputa provided for monitoring the response to treatment and clinical evaluation.

#### **7.17. Policy for Incapacity leave and ill health retirement [PILIR](South Africa, DPSA, 2009)**

Offers a process to managed health care at work

This policy spells out a fair procedure to follow which includes an investigation into:

- “The nature and extent of the incapacity,
- The effects of treatment,
- Alternatives to dismissal” (South Africa, DOH, 2011:124).

Under normal circumstances extended sick leave may be granted if advised and required.

“The provision of extended sick leave to an employee on:

- An unpaid basis or
- At less than full pay; in order to undergo treatment for drug resistant TB (DR-TB) or HIV or any other chronic disease, would be regarded as fair” (South Africa, DOH, 2011:124).

“Fairness can only be tested in the circumstances of each particular case, and such factors as disability insurance and ill-health retirement benefits as alternatives would be relevant” (South Africa, DOH, 2011:124).

**Incapacity leave** is leave, over and above the normal 36 days of allowed sick leave in a three year cycle, granted to a sick employee at the discretion of the employer (South Africa, DPSA, 2009:6).

#### **PROCEDURES FOR THE MANAGEMENT OF EACH TYPE OF INCAPACITY LEAVE**

**Employee’s (nurse’s) responsibilities** are to:

*“Personally submit an application for temporary incapacity leave or submit the application through a relative, fellow employee or friend within 5 working days after the developed world day of absence”* (South Africa, DPSA, 2012:26).

Regardless of the period of absence, provide a medical certificate issued by and signed by a medical practitioner that states the nurse’s illness as temporary

incapacity. If the employee has consented, the nature and extent of the illness or injury must be recorded on the medical certificate (South Africa, DPSA, 2012:25).

**Employers' responsibilities** are to:

Within two (2) working days of receiving an application for sick leave from the employee, recommend / not recommend the application, and submit the application to the Human Resources Division.

*Short period incapacity leave:*

- Process the required documents within the stipulated timeframes
- Make a final decision on whether to grant a nurse's application for incapacity leave and/or ill health retirement or not, taking into consideration the advice of the Health Risk Manager employed to advise the employer at the time of the application
- Register receipt of the application by the nurse on a central data base
- Ensure that all documents provided by the nurse remain attached to the application at all times during the application process
- Dependent of the findings of an investigation held, grant the nurse no more than twenty nine (29) consecutive working days temporary incapacity leave, **ON FULL PAY**
- If, as a consequence of investigation, it is apparent that the nurse should be re-deployed, retrained, retired due to ill-health, etc., the period from the date that such a decision was made by the Head of Department until the process of redeployment, re-training, retirement, etc. has been finalised should be covered by permanent incapacity leave (KZN, DOH, 2002:6)
- "Immediately complete part D of the application form and submit to the Health Risk Manager".
- "**Attach copies** of the nurse's sick leave records for the current sick leave cycle"
- **Attach copies** of the nurse's annual leave records for the same period
- **Confirm** that the Health Risk Manager received applications sent along with the attached additional documents
- **Approve or reject** conditional short period incapacity leave granted within thirty (30) working days of receipt of applications for short period temporary incapacity leave
- **If approval of** conditional short period incapacity leave granted is decided then convert granted leave to short period incapacity leave
- "**If** conditional short period incapacity leave previously granted **is rejected; notify the employee in writing** within five (5) working days of:
  - the options available to the nurse to convert the conditional short period incapacity leave previously granted to:  
**Annual leave** and where the nurse does not have sufficient annual leave



### **Unpaid leave.**

- That the conditional short period incapacity leave is refused
- The reasons for the refusal
- That the nurse may appeal the decision in the form of lodging a grievance”(South Africa, DPSA, 2009:8-12)

### *Long period incapacity leave:*

- Register receipt date of the application by the nurse on a central data base and the application form
- Return incomplete documentation to the nurse for correct completion
- “Grant, conditional on findings of an investigation conducted, a maximum of thirty (30) consecutive working days temporary incapacity leave **ON FULL PAY**”
- Notify the nurse in writing
- “Immediately complete part D of the application form and submit to the Health Risk Manager”.
- “Attach copies of the nurses sick leave records at least for the current sick leave cycle”
- Attach copies of the nurses annual leave records for the same period as above
- Confirm that the Health Risk Manager received applications sent along with the attached additional documents
- Approve or reject conditional long period incapacity leave granted within thirty (30) working days of receipt of applications for long period temporary incapacity leave
- If approval of conditional long period incapacity leave granted is decided then convert granted leave to long period temporary incapacity leave
- If conditional long period incapacity leave previously granted is rejected; “notify the employee [nurse] in writing within five (5) working days of:
  - the options available to the employee to convert the conditional long period incapacity leave previously granted to:
  - Annual leave and where the employee does not have sufficient annual leave
  - Unpaid leave”.
- That the conditional long period temporary incapacity leave is refused
- The reasons for the refusal
- That the nurse may appeal the decision in the form of lodging a grievance
- In the case of a secondary assessment being required:
  - Notify the nurse in writing to make him/herself available for further medical assessment
  - “Grant the employee [nurse] additional temporary incapacity leave days pending the outcome of the secondary assessment”
  - May require the nurse to return to work if:

- The nurse fails to comply with the requirement to undergo a secondary assessment
- “Employee [nurse] presents a further medical certificate for the same condition under review”(South Africa, DPSA, 2009:12-19)

*Permanent Incapacity leave:*

- “Determine the feasibility of:
  - alternative employment
  - adapting either work duties or work circumstances so as to accommodate the employee [nurse]”
- Redeploy a nurse who has been found to be permanently incapacitated, but who can continue to provide a service, horizontally without loss of employment benefits
- Consider the required time and finances for required training and /or retooling of the position prior to making such decision in respect of the nurse’s continued employment
- Consider usage of the nurse to his/her fullest ability
- Consider effect on service delivery
- May extend the thirty (30) working days already granted to a further thirty (30) working days to a total of sixty (60) working days in order to complete the commenced processes for termination of service due to ill health
- If further time is required to complete the commenced processes for termination of service due to ill health beyond sixty “(60) working days, refer the case to the Director General; Public service and Administration with a report explaining the reasons for the delay”(South Africa, DPSA, 2009:20-21)

*Ill health retirement:*

- Decide whether:
  - the ill health is permanent or temporary in nature
  - to grant the incapacity leave or not
  - on the outcome of the investigation in respect of:
    - alternative employment
    - “adapting the employee’s work duties/circumstances in order to accommodate the employee
  - on granting the nurse ill health retirement
- *inform the nurse of the decision to grant ill health retirement or not with reasons for the decision*
- *submit all relevant documents to Government employee pension fund (GEPF) for processing of ill health retirement benefits”(South Africa, DPSA, 2009:21)*

TYPE OF INCAPACITY LEAVE/ILL HEALTH RETIREMENT	TYPE OF LEAVE	DURATION	SUBMIT PROOF OF
TEMPORARY Application forms ANNEXURE A	SHORT PERIOD INCAPACITY LEAVE	UP TO TWENTY NINE DAYS (29) PER OCCASION AFTER EXHAUSTING 36 DAYS SICK LEAVE IN THE SICK LEAVE CYCLE	<ul style="list-style-type: none"> <li>• <b>Within five (5) working days of the developed world day of absence</b></li> <li>• <b>If application is not received within 5 days of the developed world day of absence then</b></li> <li>• <b>Employer must notify the employee that application is to be made within two (2) working days</b></li> <li>• If application is not received within the two (2) working days that leave will be deemed to be <b>either annual leave or unpaid leave</b></li> <li>• proof of being too ill/injured to perform work at the required standard</li> <li>• provide medical certificate indicating temporary incapacity</li> <li>• provide any relevant medical reports, blood test results, x rays or scan results; obtained at employee expense</li> <li>• provide consent for medical information to be made available to employer and/or health risk manager</li> <li>• undergo any further medical examination as per PILIR assessment process</li> <li>• <b>failure by the supervisor to take the steps above will result in disciplinary action against the supervisor</b></li> </ul>
Application forms ANNEXURE B	LONG PERIOD INCAPACITY LEAVE	ABSENCES OF THIRTY (30) DAYS OR MORE PER OCCASION AFTER EXHAUSTING 36 DAYS OF SICK LEAVE PER SICK LEAVE CYCLE	<ul style="list-style-type: none"> <li>• employee to undergo additional medical examination</li> <li>• functional assessment by an occupational therapist</li> <li>• offer employee alternative employment</li> <li>• accommodate employee by adaptation of work duties/circumstances</li> <li>• within five (5) working days of receiving the application:</li> <li>• verify that the employee has</li> <li>• completed and signed parts A &amp; B of the application form</li> <li>• obtained Part C of the application form completed by the attending medical practitioner</li> </ul>
PERMANENT INCAPACITY LEAVE Application forms ANNEXURE		Thirty (30) working days	<ul style="list-style-type: none"> <li>• Complete and submit to health risk manager along with ALL relevant documents</li> <li>• Where an employee has under gone a full assessment an abridged application must be used</li> <li>• Complete sections A;B;C &amp; D prior to submission to Health Risk Manager</li> <li>• May NOT apply directly for permanent incapacity leave</li> <li>• Once the employee has undergone the PILIR assessment process; and the process has found the employee to be permanently incapacitated; a maximum of thirty (30) working days permanent incapacity leave may be Granted by employer</li> </ul>
ILL HEALTH RETIREMENT		A maximum of sixty (60)	<ul style="list-style-type: none"> <li>• Employer must submit such application as soon as it is evident the employee may not</li> </ul>

TYPE OF INCAPACITY LEAVE/ILL HEALTH RETIREMENT	TYPE OF LEAVE	DURATION	SUBMIT PROOF OF
Application forms ANNEXURE E		working days	be able to return to work following incapacity
ADDITIONAL INFORMATION			<p><b>Psychiatric conditions:</b></p> <ul style="list-style-type: none"> <li>Recent clinical report from attending Psychiatrist</li> </ul> <p><b>Spinal conditions (including back/neck conditions)</b></p> <ul style="list-style-type: none"> <li>Recent clinical report from attending orthopaedic surgeon/neurologist</li> <li>Recent clinical report from attending physiotherapist/occupational therapist</li> </ul> <p><b>Cardiac disease</b></p> <ul style="list-style-type: none"> <li>Recent clinical report from attending cardiologist</li> </ul> <p><b>Pulmonary diseases</b></p> <ul style="list-style-type: none"> <li>Recent clinical report from attending specialist</li> </ul> <p><b>Chronic Fatigue</b></p> <ul style="list-style-type: none"> <li>Recent clinical report from attending specialist</li> </ul>
Application forms ANNEXURE F	SHORTENED APPLICATION FOR ILL HEALTH RETIREMENT		<ul style="list-style-type: none"> <li>Attach all relevant documents submitted to Health Risk Manager</li> <li>Attach Health Risk Manager's advice</li> </ul>
MAINTAIN CONFIDENTIALITY Application forms ANNEXURE F			<ul style="list-style-type: none"> <li>Employees handling PILIR information to sign Pledge of Confidentiality</li> </ul>

**7.18. South African Nursing Council Draft Regulations (2011) relating to the conducting of inquiries into alleged unfitness to practise due to disability or impairment of persons registered in terms of the Nursing Act, 2005 (33 of 2005).**

**DEFINITION**

"unfit to practise due to disability or impairment" means that;

"a person registered in terms of the Nursing Act 2005 (Act 33 of 2005) is incapacitated as a result of disability or is or may be impaired, whether mentally or otherwise, to such an extent that;

(a) it would be detrimental to the public interest to allow him or her to continue to practise;

(b) he or she is unable to practise the profession with reasonable skill and safety;

or

(c) in the case of a learner, has become unfit to continue with the education Programme” (SANC, 2011:16).

**"impairment"** refers to “a condition which renders a practitioner incapable of practising nursing with reasonable skill and safety”

**"nurse"** means “a person registered in a category under section 31(1) in order to practise nursing or midwifery”

**"practitioner"** means “any person registered in terms of section 31(1) of this Act”

Subject to the provisions of section 37 of The Nursing Act 33 of 2005;

“no person may practise as a practitioner unless he or she is registered to practise in at least one of the following categories(South Africa, 2005:25);

- “(a) Professional nurse;
- (b) midwife;
- (c) staff nurse;
- (d) auxiliary nurse; or
- (e) auxiliary midwife”.

### **Unfitness to practise due to impairment ((SANC, 2011:36 & 37)**

**Section 51.** (1) of The Nursing Act 33 of 2005; on unfitness for work states that;

“Whenever it appears to the Council that a person registered in terms of the Act is or may be incapacitated as a result of disability or is or may be impaired, whether mentally or otherwise, to such an extent that—

- (a) it would be detrimental to the public interest to allow him or her to continue to practise;
- (b) he or she is unable to practise the profession with reasonable skill and safety; or
- (c) in the case of a learner, has become unfit to continue with the education programme, the Council must appoint a committee to conduct an inquiry in the prescribed manner.

(2) If the Council after holding an inquiry finds the person registered in terms of the Act incapacitated or impaired as referred to in subsection (1), the Council may—

- (a) allow that person to continue practising the profession and in the case of a learner to continue with the education programme under such conditions as it may think fit; or
- (b) suspend that person for a specified period or stop that person from practising and, in the case of a learner, from continuing with his or her education and training programme.

(3) If a person referred to in subsection (2) applies for re-instatement, the Council must evaluate the person's ability to continue practising and may extend or withdraw the period of operation of the suspension.

(4) Section 49 must, with the necessary changes, apply in respect of a practitioner suspended in terms of subsection (2).

(5) A practitioner registered under this Act who contravenes or fails to comply with the provisions of subsection (2)(a) or (b) is guilty of an offence.

(6) The committee referred to in subsection (1) may appoint persons with relevant expertise and experience as assessors to advise such committee.

(7) For the purposes of this section "impairment" refers to a condition which renders a practitioner incapable of practising nursing with reasonable skill and safety'(South Africa, 2005: 40)

### **Lodging of Complaints** (SANC, 2011:16).

Section 3. (1) of the SANC draft regulation on unfitness for work states that;

“Any person who has reason to believe that a person registered in terms of the Act may be unfit to practice may submit a complaint in writing to the Registrar or to the Council.

(2) Where a complaint is addressed to Council and received by a Council member, the member must submit such a complaint to the Registrar within two (2) working days of receiving or being aware of such complaint”. (SANC, 2011:16).

**See Annexure A.**

**Return to work**

Return to work policies are not the norm within the South African human resources field.

Such a policy should aim to increase employee awareness of absenteeism management and have as its consequence a reduction in employee absenteeism rates.

It is recommended that the following be included in a return to work policy:

- Report to supervisor on the day of returning to work

Supervisor Responsibilities	Employee Responsibility
<ul style="list-style-type: none"> <li>• Review the sick certificate</li> <li>• Discuss concerns with the employee in respect of his/her absence from work</li> <li>• Discuss concerns around attendance patterns</li> <li>• Show concern for employees</li> <li>• Offer assistance and support</li> <li>• Ensure employee is fit for duty, by referring employee for a return to work assessment by the Occupational Health Nurse before allowing the employee back to work.</li> </ul>	<ul style="list-style-type: none"> <li>• Submit sick certificate to supervisor even if off sick for only a day (ensures effectiveness of return to work policy)</li> </ul>
Apply return to work counselling consistently <ul style="list-style-type: none"> <li>• Apply to ALL employees</li> <li>• Including those not suspected of abusing the system</li> </ul>	
Train supervisors to counsel employees returning to work <ul style="list-style-type: none"> <li>• Maintaining confidentiality is critical to success</li> </ul>	

In the light of this study this is especially a need within the realm of Nursing Management in respect of chronically ill nurses who are to return to work despite being ill with HIV and or TB or any other chronic disease.

A search was however conducted in Ebsco Host using the search phrase: Return to work; HIV resulting in six (6) articles only. The articles in a search using: return to work required narrowing down to include, HIV as adding AIDS and TB to the search resulted in articles irrelevant to the return of affected people to their employment following a period of illness.

Information sourced describes and discusses the limited situations where a health care worker (HCW) can potentially infect a patient during an invasive procedure and the findings are that HCW to patient infection is rare. As such, among nurses working in a ward situation, there should be little need to restrict the return to work of nurses for fear of the nurse infecting the patient (AIDS Alert, 2009:18-19; Hospital Employee Health, 2009:35 - 36).

The ideal situation will be for the nurse to return to work as soon as possible and permanently, following an illness or injury (Young, Wasiak, Roessler, McPherson, Anema, van Poppel, 2005:543-556)

Consideration must be made for the fact that an ill nurse returning to work is a dynamic and complex social situation in which more than just putting the nurse back to work on return to work is required. Special consideration must be taken of the co-workers who will have to work alongside the returning nurse. Task distribution and workplace communication must be included in any contemplated policy (Tjulin, Maceachen, Stiwne, & Ekberg, K. 2011:23).

However Bor, Tansfer, Newell and Bärnighausen, (2012:1459-1469) found in a study they conducted in a South African rural area that patients had a ninety (90%) recovery of employment following early initiation of anti-retroviral treatment. The probability is that should nurses, who are health care workers (HCW's), employed in an urban area, should therefore also have no problem returning to work following illness due to HIV, TB or any other chronic disease.



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## ANNEXURE A.

South African Nursing Council Draft Regulations relating to the conducting of inquiries into alleged unfitness to practise due to disability or impairment of persons registered in terms of the Nursing Act, 2005 (Act 33 of 2005).

Table 1. Summarises the responsibilities of Stakeholders involved (SANC, 2011:17 - 26)

SANC Responsibilities	SANC Responsibilities	SANC Responsibilities
<b>Complaint Receipt</b>	<b>Notice of Referral</b>	
<p>Following the receipt of the complaint, and before referring the allegations to an Impairment Committee:</p> <p>The Registrar may:</p> <ul style="list-style-type: none"> <li>• Obtain either further information/affidavit from complainant/respondent or any other person</li> </ul> <p>On receipt of further information: The Registrar must submit such complaint/information to:</p> <ul style="list-style-type: none"> <li>• The impairment committee at its next meeting</li> <li>• The chairperson of the Impairment committee, between meetings where urgent immediate action may be required</li> </ul>	<p>The Registrar must:</p> <ul style="list-style-type: none"> <li>• Inform respondent of receipt of the complaint in the form of a Notice of Referral delivered by Registered Mail/delivery service where delivery/receipt is recorded</li> <li>• Request the respondent to voluntarily submit to a medical examination</li> <li>• Provide the respondent with received information and enclose medical reports</li> </ul> <p>The Notice of Referral must:</p> <ul style="list-style-type: none"> <li>• Provide complaint/allegation details</li> <li>• Inform respondent of his/her right to: <ul style="list-style-type: none"> <li>○ Representation</li> <li>○ Being heard by the Impairment committee</li> <li>○ Submit records/reports from a medical practitioner of his/her own choice to rebut the allegation/complaint of his/her incapacity to practice</li> </ul> </li> <li>• Make written submission to the Impairment committee within 28 calendar days of being served the Notice of Referral</li> <li>• Inform respondent of referral to Impairment</li> </ul>	<p>The Registrar must: At the request of the impairment committee:</p> <ul style="list-style-type: none"> <li>• Request medical examiner/s to evaluate received medical reports /records and advise the committee on: <ul style="list-style-type: none"> <li>○ Respondents' mental and/or physical condition</li> <li>○ Respondents' fitness to: <ul style="list-style-type: none"> <li>▪ Practise Limited practise/supervised practise</li> <li>▪ Respondents' unfit to: <ul style="list-style-type: none"> <li>▪ Practise</li> <li>▪ Despite remission, could become unfit to practise</li> <li>▪ Require future limited practise/supervised practise</li> </ul> </li> </ul> </li> </ul> </li> </ul>

	committee if he/she fails to respond to said request for voluntary submission to a medical examination	
<p><b>Impairment Committee Responsibilities</b></p> <ul style="list-style-type: none"> <li>• May request relevant medical examiners to advise the committee on the future medical management of the respondent</li> <li>• Temporarily suspend <ul style="list-style-type: none"> <li>○ a practitioner for a period of no more than 90 days from practising as a nurse</li> <li>○ on terms/conditions as the committee may see fit</li> <li>○ pending an assessment/investigation</li> <li>○ if the committee deems the temporary suspension to be in the Public interest</li> </ul> </li> <li>• Schedule a <b>preliminary assessment meeting</b> to determine whether the matter should be referred for an inquiry.</li> <li>• Invite the respondent to: <ul style="list-style-type: none"> <li>○ Make personal representation</li> <li>○ Submit to a medical examination by a medical examiner appointed by the council at the cost of the council</li> </ul> </li> <li>• May adjourn its investigation until <ul style="list-style-type: none"> <li>○ Required information is received</li> <li>○ where the Respondent has undertaken an assessment /medical examination, <ul style="list-style-type: none"> <li>▪ a report on him/ her has been prepared, the Impairment Committee was notified that the Respondent is not</li> </ul> </li> </ul> </li> </ul>	<p><b>Preliminary assessment meeting</b> May:</p> <ul style="list-style-type: none"> <li>• Dismiss the complainant/allegation</li> <li>• Refer the allegation to SANC Professional Conduct Committee</li> <li>• Temporarily suspend the Respondent from practice pending an inquiry by SANC Professional Conduct Committee</li> </ul> <p>If there are no grounds for an inquiry, Shall direct the Registrar to:</p> <ul style="list-style-type: none"> <li>• communicate in writing its decision to the complainant and the Respondent</li> <li>• stating the reason(s) for such decision</li> </ul> <p>if an inquiry must be held</p> <ul style="list-style-type: none"> <li>• it must direct the Registrar who must communicate the decision to the Respondent</li> <li>• arrange for the holding of an inquiry</li> </ul>	<p><b>Respondent entitlement</b></p> <ul style="list-style-type: none"> <li>• to request the Impairment Committee/Council to suspend the suspension upon satisfactory proof that the suspension is unnecessary</li> </ul>

<p>mentally fit to stand for assessment</p>		
<p><b>Impairment Committee Enquiry</b> Registrar must:</p> <ul style="list-style-type: none"> <li>• provide the date, time and venue of the inquiry</li> <li>• Provide:</li> <li>• physical or mental condition on which allegation that he or she is unfit to practice</li> <li>• the decision of the preliminary assessment meeting, a copy of the finding/provisional suspension previously made, and the reasons for the decision;</li> <li>• Inform respondent of his/her right to: <ul style="list-style-type: none"> <li>○ Attend</li> <li>○ Representation</li> <li>○ provide evidence in support of his/her case</li> <li>○ call witnesses, cross examine any witnesses called by the impairment committee</li> <li>○ a copy of impairment regulations where they have not previously been sent to the Respondent</li> </ul> </li> <li>• Inform respondent if he/she fails to present himself/herself before the Impairment Committee at the place, on the date and time in the notice, the Impairment Committee may proceed with the inquiry in absentia</li> <li>• advise the Respondent of the findings that the Impairment Committee</li> </ul> <p>In cases where the Respondent admits the allegations</p> <ul style="list-style-type: none"> <li>• that his/her fitness to practise is impaired, the Impairment Committee requires further information for purposes of making a finding as to whether the complaint renders the Respondent unfit to practice, the Impairment Committee may:</li> <li>• call any witness summoned</li> </ul>	<p><b>Impairment Committee Findings</b> Impairment Committee may:</p> <ul style="list-style-type: none"> <li>• postpone the inquiry to a later date</li> <li>• adjourn the inquiry</li> <li>• to refer the Respondent for examination(s)/obtain further medical reports or other information as to his or her physical/mental condition</li> <li>• or with regard to her ability to practise</li> </ul> <p>make a finding on whether: the Respondent is:</p> <ul style="list-style-type: none"> <li>• fit to practise;</li> <li>• not fit to practice except on terms/conditions as may be determined by the Impairment Committee;</li> <li>• is unfit to practise;</li> <li>• suffers from a recurring/episodic physical/mental condition/illness which, despite remission, may be expected to render him/her unfit to practise/fit to practise</li> <li>• subject to such terms/conditions as may be determined by the Impairment Committee</li> <li>• provide reasons for such a finding;</li> <li>• recommend to Council that the Respondent be suspended from practicing for a determinate period with such conditions as the Impairment Committee may deem fit.</li> </ul> <p>after announcing its finding, the Impairment Committee considers it may be appropriate to provisionally suspend the Respondent pending the outcome of any appeal, the</p> <p>Impairment Committee shall</p> <ul style="list-style-type: none"> <li>• invite representations from the parties (where present) on whether/not the Respondent should be provisionally suspended;</li> <li>• take representations</li> </ul>	<p><b>Appeal process</b> The Respondent/complainant may appeal against the finding and/or penalty of the Impairment Committee to</p> <ul style="list-style-type: none"> <li>• the Appeal Committee appointed by the Minister in terms of section 57(1) of the Act.</li> </ul> <p>The appellant must</p> <ul style="list-style-type: none"> <li>• inform the Registrar by written notice within fourteen (14) calendar days from the date of the Impairment Committee's decision of his/her intention to appeal against the finding and/or penalty.</li> </ul> <p>Provisionally suspension of Respondent</p> <ul style="list-style-type: none"> <li>• suspension is effective until the appeal is finalised.</li> </ul>

<p>before the Impairment Committee by the complainant/Respondent to give oral evidence under oath</p> <ul style="list-style-type: none"> <li>• may accept such documentary evidence relevant to the complaint before making a finding that the Respondent is unfit to practise.</li> </ul> <p>Impairment Committee decision shall consider the:</p> <ul style="list-style-type: none"> <li>• reports,</li> <li>• written statements,</li> <li>• other documents circulated to members</li> <li>• oral representations made</li> <li>• may question any person present,</li> <li>• called to give evidence/who has submitted a report.</li> </ul>	<p>received into account prior to deciding whether/not to provisionally suspend;</p> <ul style="list-style-type: none"> <li>• deliberate in private;</li> <li>• announce its decision in the presence of the parties (where present),</li> <li>• shall give reasons for its decision.</li> <li>• may allow the parties to make additional submissions.</li> </ul> <p>finds the Respondent unfit for practice Impairment Committee may</p> <ul style="list-style-type: none"> <li>• allow the Respondent to continue practising the profession</li> <li>• a learner, to continue with the education programme under certain conditions</li> <li>• remove the Respondent's name from the register;</li> <li>• invoke Section 49 of the Act, with the necessary changes, in respect of a practitioner suspended in terms of these regulations.</li> </ul> <p>If conditions/limitations to practise are imposed on a Respondent</p> <ul style="list-style-type: none"> <li>• the supervisor/therapist must submit regular reports to determine whether there is compliance with the conditions/limitations</li> <li>• reviewed conditions/limitations once every six months until a decision on whether the Respondent is fit to practise</li> <li>• must report its findings and the penalty imposed to the Council.</li> <li>• Inform the Respondent of his/her right to appeal</li> </ul> <p>Mitigation of findings The Impairment Committee may invite any person who has an interest in the</p> <p>Proceedings</p> <ul style="list-style-type: none"> <li>• to submit written representations</li> <li>• shall invite representations from the Respondent as to any mitigating circumstances which may affect the Impairment Committee's finding and</li> </ul>	
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	<p>conditions, to be made.</p> <p>Complainant may,</p> <ul style="list-style-type: none"><li>• after the Respondent has addressed the Impairment Committee/provided evidence in mitigation of the findings to be made,</li></ul> <p>make representations to the Impairment Committee/lead evidence,</p> <ul style="list-style-type: none"><li>• orally/in writing,</li></ul> <p>regarding a suitable penalty to be imposed.</p>	
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## **ANNEXURE B.**

### **HEALTH CARE WORKERS AND Drug Resistant TB (DR-TB)**

In the context of KwaZulu – Natal, HIV and TB are often diseases which occur together in one individual.

Health care workers have the potential to become infected with TB (TB) through their work environment. They have the right to a safe, infection protected working environment. It is incumbent on the employer to provide a safe working environment or an adjusted work environment for employees who are HIV affected/infected or who have any other chronic disease which may compromise the employee's health at work.

The employee has responsibilities in terms of Section 14 of the Occupational Health and Safety Act (Act 85 of 1993) in that;

- The employees must be cautious during the performance of their duties and co-operate with the employer in together, creating a safe and healthy working environment.
- The employee must comply with the organizational procedures in order to maintain safety and health.
- The employee must report unsafe conditions and incidents or injuries to themselves or other employees, to the employer.
- Employee may not interfere with or misuse any equipment which they are provided with, by the employer, to reduce risk to the employee.

Section 8 of the Occupational Health and Safety Act (Act 85 of 1993) requires the following responsibilities of the employer:

- Providing and maintaining a safe and healthy working environment with equipment that is not harmful to either the employee or other people.
- Removing hazards where possible.
- Reduce risks or control the risks at a tolerable level when the risk is inherent to the business.
- Monitor the controls to ensure efficacy.
- Medical surveillance is recommended where certain hazardous exposures occur, notably noise above 85 decibels (dB), chemical and biological agent exposure.

- Inform employee of the nature and severity of the risks to which they are exposed and the necessary safe working procedures, which include the use of, appropriate personal protective equipment (PPE).
- Train employee in safe working procedures and the correct use of PPE.
- Enforce compliance with the Occupational Health and Safety Act (Act 85 of 1993).

**Hazardous Biological Agents Regulations** (South Africa, DOL, 2001:1-67).

These regulations which legally entrench infection control were promulgated in December 2001 (South Africa, DOL, 2001:1-67).

- Dissemination of information and training which encompasses: understanding the risk of infection to personal protection and engineering controls, the necessity for personal air sampling, medical surveillance, good housekeeping, personal hygiene and safe working procedures are found in Section 4 of the regulations.
- Duties of individuals exposed to a Hazardous Biological Agents focus on the prevention of uncontrolled release of an agent (in this case *M. TB*), adherence to instructions regarding environmental and health practices and the disposal of materials containing the agent(*M. TB*) including the decontamination and disinfection requirements are found in Section 5 of the regulation. It is incumbent on the employer to ensure that risk assessments are conducted, exposure monitored on a regular basis and medical surveillance of the employees are provided and can be found in Sections 6, 7, and 8 of the regulation.
- Section 9 of the regulation requires that medical records of employees as well as risk assessments performed must be safely kept for a period of 40 years.
- The control measures for prevention of exposure and the use of personal protective equipment are found in Sections 10 and 11.
- The measures required by health facilities to prevent the spread of infection in circumstances in which patients may present with unknown or undiagnosed infections by implementing regulated infection control measures are found in Section 15 of the regulations.

**Compensation for Occupational Injuries and Diseases Act, (Act 130 of 1993)**

The above act makes provision for Health Care Worker compensation when they are found to have contracted drug resistant TB (DR-TB), and their disease status has occurred as a result of and in the course of his/her employment involving the handling of or exposure to patients with DR-TB. Employees are entitled to compensation if they are injured while working or contract any work-related disease.

The types of compensation paid to workers for injuries or diseases are:

- Medical aid/assistance in the form of payment for medical care
- Temporary disability compensation
- Permanent disability compensation
- Compensation to families of diseased employees

EMPLOYEE RESPONSIBILITIES	EMPLOYER RESPONSIBILITIES	COMMISSIONERS RESPONSIBILITIES
<ul style="list-style-type: none"> <li>• Reporting the disease to the employer</li> <li>• In writing</li> <li>• As soon as possible following diagnosis by a medical practitioner,</li> <li>• Or within twelve (12) months of the initial diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>• Must complete and submit the Employer's Report of an Occupational Disease (W.Cl.1) to the Compensation Commissioner</li> <li>• Within seven (7) days following an injury</li> <li>• Within fourteen (14) days of receiving notification of the diagnosis of a compensable disease.</li> </ul>	<ul style="list-style-type: none"> <li>• To acknowledge the receipt of the documentation,</li> <li>• Register the claims</li> <li>• Make the decision to accept liability or not</li> <li>• Inform employer and employee of the decision made</li> </ul>
<ul style="list-style-type: none"> <li>• Should the employee fail to report the diagnosis to the employer within the twelve (12) months,</li> <li>• The employee forfeits any rights to entitled benefits (Section 43).</li> </ul>	<p>Subsequently, the following <b>reports must be submitted:</b></p> <ul style="list-style-type: none"> <li>• Developed world Medical Report for an Occupational Disease (W.Cl.22).</li> <li>• Claim for Compensation for an Occupational Disease (W.Cl.14).</li> <li>• Progress Medical Reports (W.Cl.22) until the worker's illness is <b>stable</b>.</li> <li>• Final Medical Report of an Occupational Disease (W.Cl.26) once the worker is <b>stable</b>.</li> </ul>	<ul style="list-style-type: none"> <li>• May refuse to award the whole/portion of compensation</li> <li>• May hold the employer responsible for medical costs in cases where wilful misconduct/neglect of the HCW/employer could be proven.</li> </ul>

The Compensation for Occupational Injuries and Diseases Act (Act 130 of 1993), Schedule 3, stipulates TB as a compensable disease ONLY in the following work situations:

- Crystalline silica (alpha quartz) as found in the mines.
- *M. TB* or NTMs (Non-Tuberculous mycobacteria) transmitted to an employee during the performance of health care work from a patient suffering from active open TB.

### **Infection Prevention and Control measures for DR-TB**

Hospital acquired infections are the result of delayed TB diagnosis and/or confirmation of Drug Resistant TB (DR-TB) as well as delays in commencing appropriate treatment, which exacerbate prolonged infectiousness. Inadequate/delayed isolation of TB suspects and patients, poor ventilation, lack of respiratory protective equipment and inadequate sputum collection procedures can result in exposure of Health Care Workers (HCWs), other patients and visitors to infection.

### ***Priorities of Infection Control (for in-patients and out-patients)***

Infection Control needs to occur at three (3) levels:

<b>INFECTION PREVENTION AND CONTROL LEVEL</b>	<b>AIM</b>
Administrative (Managerial/Organizational)	<ul style="list-style-type: none"> <li>• To reduce health care worker and patient exposure.</li> </ul>
Environmental	<ul style="list-style-type: none"> <li>• To reduce the concentration of infectious particles.</li> </ul>
Personal Protection - respiratory	<ul style="list-style-type: none"> <li>• Provides protection to HCW where the level of infection cannot be reduced by administrative/environmental controls</li> </ul>

The order of priority of the above levels of control is, in order of importance:

- Administrative controls
- Environmental controls some high risk areas
- Personal respiratory protective equipment may be used in certain high risk areas.

## 1. Administrative Controls

- To prevent infectious particles from being produced, thus limiting the exposure of Health Care Workers (HCWs) to *M.TB*.

Important administrative measures include:

- Develop and implement an infection prevention and control plan
  - To accelerate identification, isolation, testing and treatment of Drug Resistant TB (DR-TB) suspects and patients;
- Implement effective work practices;
- Educate, train and counsel Health Care Workers (HCWs) in respect of TB (TB);
- Health Care Workers (HCWs) medical surveillance for TB; active disease/infection.

## 2. Environmental Controls

- Are to be implemented jointly with the administrative controls and can be used to efficiently diminish the concentration of infectious particles to which health care workers (HCWs) or patients are exposed. Environmental controls are mostly significant in areas where there may be exposure to very concentrated infectious particles e.g.:
- Wards in which Extreme Drug Resistant TB (XDR-TB) patients are treated,
- Wards in which there may be a high concentration of infectious Multi Drug Resistant TB (MDR-TB) patients,
- Sputum collection (commencement) areas,
- Bronchoscopy theatres,
- Laboratories in which culture and susceptibility testing are carried out,
- Autopsy rooms.

The following principles reduce high concentrations of infectious particles in the work environment:

### ***Ventilation***

Adequate ventilation may be achieved by:

PROCEDURE	REASON	RATIONALE
Open Windows	<ul style="list-style-type: none"><li>• Use natural ventilation to its optimum</li></ul>	<ul style="list-style-type: none"><li>• Simplest</li><li>• Least costly</li></ul>

	<ul style="list-style-type: none"> <li>• Air dilution</li> </ul>	
Ceiling fans	<ul style="list-style-type: none"> <li>• Further contribute to natural ventilation maximisation</li> </ul>	<ul style="list-style-type: none"> <li>• Areas where windows can stay open</li> </ul>
Exhaust fans	<ul style="list-style-type: none"> <li>• Control air flow direction</li> </ul>	<ul style="list-style-type: none"> <li>• Prevents contamination of adjoining areas</li> </ul>
Exhaust ventilation systems/negative pressure ventilation	<ul style="list-style-type: none"> <li>• As a minimum provide six(6) air exchanges/hour</li> <li>• Prevent contaminated air from infecting adjacent areas</li> </ul>	
Air sanitisation <ul style="list-style-type: none"> <li>• Air filtration</li> <li>• Ultra Violet Germicidal irradiation (UVGI)</li> </ul>	<ul style="list-style-type: none"> <li>• Removes infectious particles</li> <li>• Kill Infective particles</li> </ul>	<ul style="list-style-type: none"> <li>• May be required in a facility where additional measures need to be in place to further reduce risk</li> </ul>

### 3. Personal Respiratory Protection Equipment

Prevent the person wearing the personal respiratory protective equipment from spreading/acquiring the infection.

The only types available for Drug Resistant TB (DR-TB) are masks and respirators.

EQUIPMENT	MODE OF FUNCTION	INDICATIONS FOR USE
Surgical Masks	<ul style="list-style-type: none"> <li>• Prevent micro-organism spread from person to person by entrapping large wet particles near the source i.e. mouth</li> <li>• Do not prevent inhalation of airborne droplets</li> <li>• Have limited filtration ability</li> <li>• Fit too Loosely around the mouth &amp; nose</li> <li>• Allow entry of airborne mycobacterium</li> </ul>	<ul style="list-style-type: none"> <li>• Provide to patient suspects/those with confirmed Drug resistant TB (DR-TB)</li> </ul>
Respirators	<ul style="list-style-type: none"> <li>• Filtered masks which cover mouth &amp; nose</li> </ul> <p>Recommendation;</p> <ul style="list-style-type: none"> <li>• disposable industrial mask with 1µm particle size and 95% efficient filter</li> <li>• "fit test" employees</li> </ul>	<ul style="list-style-type: none"> <li>• Prevent access to face via the edge of the mask</li> <li>• Provide customised mask for each employee</li> </ul>

## Specific Measures for Prevention of Nosocomial Infection

These include:

RECOMMENDATION	RESPONSIBILITIES
<ul style="list-style-type: none"> <li>Infection prevention &amp; control officers</li> </ul>	<ul style="list-style-type: none"> <li>Develop, implement, monitor &amp; evaluate infection control plans, policies &amp; procedures</li> </ul>
<ul style="list-style-type: none"> <li>Infection prevention &amp; control committee</li> </ul>	Membership to include: <ul style="list-style-type: none"> <li>Infection prevention &amp; control officer,</li> <li>Microbiologist,</li> <li>Medical practitioner/physician,</li> <li>Pharmacist,</li> <li>Housekeeping supervisor/ manager food service manager,</li> <li>Laundry service manager,</li> <li>Maintenance manager</li> <li>Hospital manager</li> <li>Nursing manager</li> </ul>
<ul style="list-style-type: none"> <li>Conduct risk assessments</li> </ul>	<ul style="list-style-type: none"> <li>Annual evaluate the risk potential in each area &amp; employee group of the hospital</li> <li>Risk classification to include:               <ul style="list-style-type: none"> <li>Community TB profile</li> <li>Number of infectious TB patients admitted/consulted</li> <li>Estimated number of infectious TB patients an occupational group is exposed to,</li> <li>Results of personal protective devices (PPD) test conversions among HCW</li> <li>Potential person-to-person transmission of M. TB.</li> </ul> </li> <li>Development&amp;/or implementation of policies and procedures for early               <ul style="list-style-type: none"> <li>Identification</li> <li>Detection/diagnosis</li> <li>Treatment</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Outpatient Triage</li> </ul>	<ul style="list-style-type: none"> <li>Identify active TB disease affected patients</li> <li>Symptomatic screening of symptomatic patients</li> <li>Separate waiting area for suspected TB patients</li> <li>Provide tissues for mouth covering</li> <li>Use surgical masks</li> </ul>
<ul style="list-style-type: none"> <li>TB isolation</li> </ul>	<ul style="list-style-type: none"> <li>Indications for/initiating isolation</li> <li>Designate a responsible person for starting/ending isolation</li> <li>Monitor isolation procedures</li> <li>Manage non-compliant patients</li> <li>Identify ceasing isolation criteria</li> </ul>
<ul style="list-style-type: none"> <li>Discharge plan</li> </ul>	<ul style="list-style-type: none"> <li>Outpatient appointment confirmed</li> <li>DOT placement</li> <li>Supply medications</li> </ul>
<ul style="list-style-type: none"> <li>Plan, install, evaluate, maintain and evaluate:               <ul style="list-style-type: none"> <li>Ventilation/engineering controls</li> <li>Respiratory protection programs</li> </ul> </li> </ul>	



<ul style="list-style-type: none"> <li>• In-service training</li> <li>• compliance with processes of Infection Prevention and Control to reduce risk of infection at work</li> </ul>	
<ul style="list-style-type: none"> <li>• Develop and implement periodic counselling and screening programs for Health Care Workers (HCW) for either latent/active disease</li> </ul>	
<ul style="list-style-type: none"> <li>• <b>Offer and make arrangements for redeployment to Health Care Workers (HCW) who are immune-compromised when deployed to areas of high risk</b></li> </ul>	
<ul style="list-style-type: none"> <li>• Treat any medical information provided by a Health Care Worker (HCW) to you as confidential</li> </ul>	
<ul style="list-style-type: none"> <li>• Immediate evaluation of nosocomial transmission</li> </ul>	

## Conducting Risk Assessment

TB (TB) risk is dependent on the source case disease severity, prolonged and intensive exposure to the case, therefore all Health Care Workers (HCW) are not at equal risk of infection. Many Health Care Workers will have the risk potential of the general public.

Categorization of risk is as below (South Africa, DOH, 2011:120):

Category of Risk	Definition	Wards
High Risk	Extensive, close contact with smear positive Multi Drug Resistant TB (MDR- TB) cases. <ul style="list-style-type: none"> <li>• Nursing staff</li> <li>• Medical Practitioners</li> </ul>	<ul style="list-style-type: none"> <li>• Medical</li> <li>• TB</li> <li>• Intensive Care Units</li> </ul>
	Immuno-compromised Health Care Workers (HCW)	Persistently care for MDR –TB cases
Medium risk	Sputum collection	<ul style="list-style-type: none"> <li>• Primary Health Care Centres</li> <li>• Out Patient Departments</li> </ul>
	Prolonged care contact by Health Care Workers (HCW) with TB affected patients, particularly those patients who have had: <ul style="list-style-type: none"> <li>• Repeated disease episodes</li> <li>• Poor compliance histories</li> </ul>	
Low risk	Health Care Workers (HCW) in Primary care facilities who treat TB patients (TB): <ul style="list-style-type: none"> <li>• Compliant with treatment</li> <li>• Support staff</li> </ul>	<ul style="list-style-type: none"> <li>• General Hospitals</li> <li>• Community Centres</li> </ul>

## Infection Control Plans

The foundation of infection control plans are the risk assessment outcomes. No matter what the risk level is, apply the following principles:

Activity	Topic
On-going education/training	<ul style="list-style-type: none"> <li>• TB transmission</li> <li>• Drug Resistant TB (DR-TB)</li> <li>• Infection Prevention &amp; Control procedures in place</li> <li>• Compliance with Infection Prevention &amp; Control policies/procedures</li> </ul>
Risk <ul style="list-style-type: none"> <li>• Awareness</li> <li>• Avoidance</li> </ul>	
Encourage HIV testing	
Redeploy immune-compromised employees	
Implement universal infection prevention & control policy & procedures	
Implement/adherence to cough hygiene practices	
Sputum collection <ul style="list-style-type: none"> <li>• In open areas</li> <li>• Cough booths if available</li> </ul>	
Nurse, admitted coughing patients	<ul style="list-style-type: none"> <li>• In single wards with good external ventilation</li> <li>• Keep room doors closed and windows open where engineering facilities are not available</li> </ul>

## Cough Hygiene

The Primary focus is on:

- Infected patient
- Health Care Worker (HCW) at risk of infection

Patients	Health Care Worker (HCW)
When coughing/sneezing: Cover mouths & noses with: <ul style="list-style-type: none"> <li>• Handkerchief</li> <li>• Mask</li> <li>• Tissue</li> </ul>	Wear respirators <ul style="list-style-type: none"> <li>• Nursing patients</li> <li>• During sputum collection</li> </ul>
Disposal of above items: <ul style="list-style-type: none"> <li>• Small plastic bags</li> <li>• Paper bags</li> </ul> Regularly dispose of bags used in larger refuse bags <ul style="list-style-type: none"> <li>• Incinerate</li> </ul>	
Disinfect with: <ul style="list-style-type: none"> <li>• 5% concentration of solution containing iodine</li> <li>• Hypochlorite solution with 10000 ppm active chlorine</li> </ul>	

## Sputum Collection

Correct sputum collection procedures should be followed.

Refer to: South Africa, DOH (2011:121).

## **Isolation Practices**

Provide isolation wards for the following TB (TB) patient categories:

- New, undiagnosed patients
- Multi Drug Resistant TB (MDR-TB) patients
- Extreme Drug Resistant TB (XDR-TB) patients
- Children, when in wards caring for adults as well
- Extremely ill patients

The above will ensure that cross infection with either different/new strains of the TB Mycobacterium are not spread.

Cease hospital isolation in the event of:

- obtaining three (3) negative sputum smear results obtained on three (3) separate occasions
- evidence of maintained clinical improvement
- cough has ceased/resolved

## **OCCUPATIONAL HEALTH PROGRAM IN DR-TB**

### **Employee Medical Surveillance Programme**

Employee medical surveillance programmes must be in place as a part of the Employee Health and Wellness Program.

The objectives of surveillance programmes are to:

- Ensure baseline information in respect of employee TB (TB) infection status, among others
- Determine individual employees with latent TB (TB) infection; then offer them preventative treatment to prevent the re-occurrence of active TB (TB)
- Determine which employees have active TB (TB) and commence them on immediate treatment
- Determine and record conversion rates of employees, negative at employment and later convert to positive
- Determine the possible sources of infection for all employees who are known to have converted from negative, on employment, to positive
- Disease notification
- Monitor and evaluate the infection prevention and control program

The elements of the medical surveillance programme include the following:

- Pre-placement medical examination (baseline health assessment).

- On-going surveillance.
- Exit medical examination.
- Post-employment medical examination.

Refer to: South Africa, DOH (2011:122) for further information in respect of Baseline health assessment requirements.

### ***Provider-Initiated Counselling and Testing (PICT)***

Health Care Worker	Employer
Risk counselled re: <ul style="list-style-type: none"> <li>• working with drug resistant (DR-TB) patients</li> <li>• risk increase if employee is/becomes HIV positive</li> <li>• required precautions</li> </ul>	Encourage HIV testing motivated by; <ul style="list-style-type: none"> <li>• Redeployment to less risky work areas for HIV positive employees</li> </ul>
Encourage voluntary employee disclosure of HIV status <ul style="list-style-type: none"> <li>• To a designated Health Care provider</li> </ul>	Maintain strict confidentiality
On-going surveillance <ul style="list-style-type: none"> <li>• Declare health status information</li> <li>• Answer specific questions re: early signs/symptoms of TB</li> <li>• If present; employee must be investigated for TB</li> </ul>	
Post exposure monitoring <ul style="list-style-type: none"> <li>• Report exposure to a Drug resistant TB (DR-TB) infectious patient for more than two (2) hours</li> </ul>	Clinically monitor such employees

### ***Record Keeping of employee medical information***

Each employee must have a confidential disease-monitoring file, in the occupational health facility, in which pre-placement TB screening procedures, the minimum physical examination and tests conducted, other health-related data, including records of results of tests conducted and updates of any changes in the health status of the employee are recorded.

Other essential recorded information should include:

- Name, job title, position, placement in facility, shift and hours worked.
- Date of employment in the specific health facility.
- Results of pre-placement health assessment.
- Results of on- going assessment.

Record of reported TB (TB) exposure:

- Post-exposure screening results.

- Treatment and follow-up management plans of employees who have confirmed TB (TB)
- Management and follow-up plans of employees on preventive treatment.
- Counselling provided to the employee.
- Strengthen internal TB procedures between employees supervisors Managers, & Occupational Health Service

Health Care Workers (HCWs) who contract drug resistant TB (DR-TB) at work should not be dismissed on the basis of incapacity once their paid sick leave has been exhausted. Implement the Policy for Incapacity leave and Ill health retirement (PILIR) at this stage.

Editing Declaration

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TO WHOM IT MAY CONCERN

Thesis Title: AN ANALYSIS OF NURSE MANAGERS' HUMAN RESOURCES  
PLANNING RELATED TO HIV/AIDS AND TUBERCULOSIS AFFECTED NURSES IN  
SELECTED HOSPITALS IN KWAZULU-NATAL, SOUTH AFRICA – AN  
ETHNOGRAPHIC STUDY

Author: Jane Kerr

This is to certify that I have edited the above thesis from an English language perspective only, and have made recommendations to the author regarding spelling, grammar, punctuation, structure and general presentation.

A marked-up version of the thesis has been sent to the author and is available as proof of editing.

I have had no input with regard to the technical content of the document and have no control over the final version of the thesis as it is the prerogative of the student to either accept or reject any recommendations I have made.

Therefore, I accept no responsibility for the final assessment of the document

Yours faithfully

A handwritten signature in black ink, appearing to read 'M Addis', with a horizontal line underneath.

Margaret Addis