

NURSE MANAGERS' EXPERIENCES WITH NURSES CARRYING OUT COMPULSORY COMMUNITY SERVICE

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ABSTRACT

The South African Nursing Council promulgated the compulsory community service (CCS) policy, in regulation *R765 of 2007*, for nurses of the four-year diploma or degree in nursing. The implementation of the CCS policy takes place at public health institutions. There have been no studies to date on how nurse managers experience this process of the CCS policy implementation. The findings of the study will inform future changes to the policy, such as guidelines for nurse managers on how to handle community nurse practitioners (CNPs) that are placed in their



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institutions. This study explores the experiences of nurse managers with nurses who are placed at their institutions to carry out compulsory community service. Descriptive qualitative design was used to gather data from nurse managers using individual interviews and data were analysed using Tesch's content analysis. The main categories that were identified were: valuing the CNPs, role modelling behaviours, benefiting from mentoring, dealing with challenges and following the process. The community nurse practitioners were valued by two groups of nurse managers. Support and professional development were provided on an ad hoc basis, leading to inconsistencies in their management. The following are recommended: the guidelines of the CCS policy to provide structured guidelines for the development of the CNPs during the CCS year; mentorship for the CNPs that is evaluated at regular intervals through formalised reports; and a scope of practice for the CNPs.

Keywords: compulsory community service policy, community nurse practitioners, nurse managers, experiences

INTRODUCTION AND BACKGROUND INFORMATION

Newly qualified nurses who need to register as nurses (general, community and psychiatry) and midwives with the South African Nursing Council (SANC) have been carrying out compulsory community service (CCS) since 2009. The CCS policy for nurses was legislated in 2005 in the *Nursing Act No 33 of 2005* (Republic of South Africa, 2006) and is guided by regulation *R765 of 2007* (SANC, 2007).

Prior to the implementation of the CCS policy for nurses in South Africa (SA), newly qualified nurses were registered by the SANC for their relevant qualifications acquired from nursing education institutions (NEIs). They were employed in health institutions and were not obligated to serve any period of internship or pre-registration service. Upon employment, newly qualified nurses followed the scope of practice of registered nurses (SANC, 1984) and had some orientation depending on the institutional policy (personal experience).

It has been confirmed in literature that the graduates from most western countries enter a workforce that is challenged by nursing shortages, limited resources and high patient acuity. Nurse leaders have had to consider introducing programmes to improve new graduates' transition from being students to professionals (Scott *et al.*, 2008:81; Dyess and Sherman, 2009:621).

The shortage of nurses in SA became alarming after 1994, when a high proportion of nurses left the public health sector, citing, among other reasons, better salaries and improved working conditions elsewhere (Oosthuizen and Ehlers, 2007:16). Rispel (2015:1), Wildschut and Mqolozana (2009: 8), Mokoka, Oosthuisen and Elhers (2010: 484) have also highlighted the nurse shortage problem in SA, which is intensified by the quadruple burden of diseases, which are HIV/Aids, injuries from violence, diabetes,

and other non-communicable diseases, as more patients are admitted for hospital care (Mayosi, Solomon and Benatar, 2014:1347).

In western countries the increased shortage of nurses has led to more new graduates being employed in public health care, resulting in a higher ratio of inexperienced nurses providing direct care (Cheng *et al.*, 2014:7). Studies on the new graduates' experiences in the first six months of professional practice have reported that these nurses experienced stress during their transition from the sheltered world of academia to the realities of the working world (Duchscher, 2008:9; Clark and Holmes, 2007:1218; O'Shea and Kelly, 2007:1541). These nurses found it difficult to gain an understanding of the organisations and to cope with the clinical competencies that were necessary for practice (Duchscher, 2008: 6). Halfer and Graf, (2006:150) predicted turnover rates could affect organisations negatively if the challenges of graduates were not addressed. Following these reports a number of initiatives have been implemented in graduate nurse programmes to ease their transition into professional practice (Scott *et al.*, 2008:82).

As one of the strategies to provide human resources for health in SA, the Department of Health (DOH) legislated CCS for health professionals in the *Medical, Dental and Supplementary Health Amendment Act of 1997* (Republic of South Africa, 1997) for health professionals who wish to register their qualifications with the Health Professions Council of South Africa (HPCSA). The objectives of the CCS policy is to ensure improved provision of health services to all citizens of South Africa and to develop the health professionals by enhancing knowledge and skills in their chosen profession (KZN DOH, 2010).

In SA, qualifying nurses from the four-year degree or diploma in nursing, like other qualifying nurses, were licensed to practise in their registered qualification soon after successful completion of their educational programme. However, since 2009, Section 40 of the *Nursing Act (Act No. 33 of 2005)* has been implemented and all nurses qualifying from the four-year degree or diploma in nursing have to carry out a year of CCS in a designated health establishment as per regulation *R765 of 2007* (SANC, 2007) before their qualifications are registered by the SANC. Guidelines have been developed by the SANC for the processing of these nurses from completion of their education programme, to the commencement and completion of their CCS. The supervision and the development of the CNPs in KZN are guided by the KZN DOH policy for community service officers (KZN DOH, 2010).

Information about CCS for nurses was conducted at a road show, held by the National Department of Health (NDOH) representatives to inform managers about the CCS policy for nurses' implementation (Personal interview with professional coordinator of CCS policy for nurses 19 April 2012). The NDOH gazettes the health facilities where nurses may carry out CCS, and oversees the implementation of the policy at national level, while the SANC provides guidelines for the CNPs. Upon commencement and on completion of CCS, nursing managers of institutions ensure that these forms are completed and submitted to the SANC.

According to Gilson and Erasmus (2008), there is limited information on how policies are effectively implemented. Individuals tasked with policy implementation need clarity on their roles, interests and resources available for policy implementation (Lester and Goggin, 1999). The process of implementing the CCS policy for nurses is coordinated at different levels. At national level the National Department of health (NDOH) oversees the CCS policy implementation with appointed provincial coordinators from the various provincial DOHs. At provincial level the provincial coordinators are tasked with managing the implementation at the various health institutions' with nursing managers. Active communications are maintained between NDOH, provincial DOH and the health institutions.

There are no studies to date on the experiences of nurse managers who have to implement the CCS policy for nurses at their institutions.

STATEMENT OF THE RESEARCH PROBLEM

When South Africa introduced CCS for nurses in 2009, a new category of nurses was employed in public health institutions. Prior to the CCS policy for nurses, newly qualified nurses were registered with the SANC and were not obligated to serve any internship period. There are no formal transition programmes for newly qualified nurses on being employed in SA. When nurses joined CCS there were limited guidelines on how this category of nurse should be managed. During the CCS year, nurses are registered as CNPs and follow the rules of professional conduct that apply to registered nurses (South African Nursing Council, 2007). It has been found that newly registered nurses lack competence and ability to apply theoretical knowledge in the practical situation (Moeti, Van Niekerk and Van Velden, 2004:82). Therefore CNPs may also lack these competencies when they are employed at health institutions.

Prior to the study the researcher received comments from registered nurses in practice about the CNPs' unclear role expectations, that is, whether they (CNPs) should be regarded as 'interns' requiring mentoring or whether they could be used as 'professional nurses'. The CCS year is a compulsory preregistration period and could be an ideal opportunity for newly qualified nurses to transition and develop into their professional role. The problem leads to the following formulation of the research question:

RESEARCH QUESTION

What are the experiences of nurse managers while managing CNPs who are carrying out CCS?

PURPOSE OF THE STUDY

The purpose of the study was to explore the experiences of nurse managers in managing CNPs while implementing the CCS policy.

DEFINITIONS OF KEY TERMS

The operational terms in this study are:

Compulsory community service (CCS) is the compulsory service for a period of one year after completion of the four-year diploma or degree in nursing, before registration as a nurse (general, community and psychiatry) and a midwife.

Community nurse practitioner (CNP) is the name for a nurse who carries out compulsory community service according to regulation *R765 of 2007* (SANC, 2006).

Community service officer is any health professional who carries out CCS.

Nurse managers are registered nurses who are employed in administrative positions at a health institution. They may be:

Nursing managers who are responsible for the management of nursing staff.

Deputy nursing managers are second in charge of nursing staff.

Unit managers are the operational managers of nursing units.

RESEARCH METHODOLOGY

A descriptive exploratory qualitative design with a constructivist perspective was used (Creswell, 2009:206) to explore the experiences of a purposive sample of nursing managers from health institutions of KZN by means of individual interviews, using a semi-structured interview guide, during the period September to December 2012. This study is part of a larger study that was guided by an adaptation of the consolidated framework for implementation research (CFIR) by Damschroder *et al.* (2009:3). There are five major domains within this framework, which are: the interventions (the CCS policy implementation); the inner setting (KwaZulu-Natal Department of Health (KZN DOH)); the outer settings (SANC and NDOH); and, the individuals involved in the implementation and the process of implementation. Within this framework the nursing managers make up a sub-set of individuals from the inner setting of KZN DOH involved with the implementation of the CCS policy for nurses. The conceptual framework for the larger study, which used a case study approach, was adapted from the consolidated framework for implementation research (CFIR) by Damschroder *et al.* (2009:3).

Study setting

The study took place in health districts of KZN. KZN is one of the nine provinces in South Africa and has 11 health districts, eight of which are classified as rural districts (KZN DOH, 2001).

Selection of districts and health institutions for the study

Three health districts were selected to represent individuals from the inner setting, ensuring there was representation of the northern, southern and midlands districts of KZN. The districts that were purposively selected were UMgungundlovu, EThekweni and UThungulu districts because the greater numbers of CNPs were allocated to these districts and included the district that the researcher received comments about the uncertainty of managing the CNPs. Thereafter two health institutions per district, which also had greater numbers of CNPs allocated to them in January 2012, were purposively selected.

Study population

All senior nursing managers, deputy nursing managers and unit managers who had experience with CNPs were included for participation in the study. A purposive sample of senior nurse managers or the deputy nursing managers, and unit managers were invited to participate in the study. A total of six senior nursing managers or deputy nursing managers, and 21 unit managers were interviewed.

Data collection process

Data was collected from September 2012 to March 2013, and the interviews lasted from 30–60 minutes. Nursing managers' and deputy nursing managers' interviews were conducted in their offices away from the nursing units, while the unit managers were interviewed in a room that afforded privacy in their nursing units.

The open-ended questions for the interview were guided by the conceptual framework of the study and were structured to facilitate free expression (Creswell, 2009:206). The main questions asked were: 'can you tell me about your experiences of having CNPs in your institution/unit', and 'how did you manage the CNPs allocated to your institution/unit'? Probes were used when there was a need to obtain more clarification of the responses obtained. An audio digital recorder was used to record the interviews with the permission of the participants and all the interviews were conducted by the first author. The audio recordings were transcribed verbatim.

Ethical considerations

Ethical approval for the main study was obtained from the research ethics committee of the University of KwaZulu-Natal (UKZN), reference HSS/1245/011D. Permission to conduct the study was also obtained from the KZN Department of Health, the selected districts' offices and the selected health institutions. Nursing managers at selected health institutions were contacted to schedule interviews as long as it did not inconvenience their administration duties. A brief overview of the study and its purpose were presented

to participants through a letter of information. Participation was voluntary and written consent was obtained from all participants. Anonymity was assured by the use of codes when reporting, and confidentiality was maintained by keeping recordings in a secure system accessible only to the researcher. The participants were informed that they could withdraw from the study at any time.

ANALYSIS

Data was inductively analysed using Tesch's steps of content analysis (Tesch, 1990:142–145). The transcripts were read over and over again while simultaneously listening to the audio recordings of the interviews. Manifest content analysis was used to describe all participating nurse managers' experiences and perspectives that emerged from the text (Elo and Kyngäs, 2007:109). Descriptive codes that captured the meaning of the participants' expressions were assigned to categories and subcategories.

The first author did the initial analysis of the interviews and the findings were then discussed with second and third authors until consensus was reached.

A coding system was used (Polit and Beck, 2012:510) whereby each health institution, roleplayer rank and individual participant was identified by a code, for example, institutions were coded A, B, C, D, E and F and each level of participant was also coded to represent nursing manager (NM), deputy nursing manager (DNM) unit manager (UM), for example, the nursing manager from health institution A would be NM-A, or DNM A, while the unit manager from that institution would be UM1-A.

Trustworthiness

The criteria for trustworthiness in qualitative data inquiry, namely, credibility, dependability, confirmability and transferability were followed for academic rigour (Lincoln and Guba, 1985:301). Credibility of the information was assured by the researcher conducting the interviews herself, using multiple sources of data (nursing managers, deputy nursing managers and unit managers). Follow-up validation interviews were conducted with two deputy nursing managers and three unit managers at two different health institutions. Dependability was obtained by prolonged data collection (7 months) and having discussions of the transcriptions, to reach consensus of the codes and categories identified, with the supervisors of the study. Confirmability was achieved by being very aware of personal biases during interpretation and trying to 'put them aside' as well as by using verbatim quotes reflecting the participants' rather than the researcher's perceptions. Transferability of the findings cannot be certain as similar findings may not be obtained if the study is repeated in another context, however, thick descriptions of the research process were provided to give the reader a sense of 'being there'. At the same time, the readers can make their own conclusions regarding the study's transferability (Shenton, 2004:70).

RESULTS

A total of six senior nursing managers or deputy nursing managers, and 21 unit managers were interviewed until data saturation was reached. All participants were females with the exception of one male unit manager. Four categories were identified, namely: valuing the CNPs, role modelling behaviours, benefitting from mentoring, dealing with challenges and following the processes. The sub-categories have been merged within the descriptions of each category.

Valuing the CNPs

CNPs were valued for their flexibility in being placed in any unit of the health institution because of having a comprehensive qualification:

My experience is that I like them because you are in a position to allocate her in the medical ward You are also in a position to allocate her in maternity ... unlike somebody that was doing the bridging [a registered nurse who does not have a comprehensive qualification] (NM-A).

Another nurse manager appreciated that they were able to have a guaranteed staff member for one year:

We would train 25 or 30 people and all 30 people would stay here ... and within 6 months at least fifty percent had disappeared ... with community service that has stopped So definitely we have benefitted (DNM-B).

Unit managers also valued the CNPs' eagerness to carry out professional roles in the units:

He used ... to jump to do this ... because he wants to learn more. Really I don't know why they are not permanently here in our unit, (UM2-E).

The mutual benefits of having CNPs allocated to the unit were also appreciated:

We are being upgraded by their knowledge. So everybody's benefitting, because nursing is dynamic ... because we cannot know everything We are helping each other systematically (UM3-F).

Benefitting from mentoring

Unit managers expressed the benefits of mentoring the CNPs on different levels such as being a role model, obtaining a sense of fulfilment, enjoyment from teaching and receiving positive feedback.

With me I enjoy teaching. ... I just loved teaching. I am happy to see somebody grow ... so I enjoy teaching (UM1-B).

Role modelling behaviours occurred by precept and example such as:

I have got to groom them to be good registered nurses ... so that I must lead with example (UM2-A).

One of the unit managers felt having CNPs forced them to behave in a specific way:

You know having them in the department ... it's where, as clinicians we get ourselves always being able to portray the right thing ... where a student can see I'm going to copy you know the style of this one (UM2-E).

This unit manager enjoyed mentoring the CNPs in the unit but felt a sense of loss when the CNP had to leave the unit to go to another unit.

You know what it's nice at times, but then it's sad at the end, especially when you look at when you've trained them, and then they're either rotated ... (UM3-D)

Dealing with challenges

Nursing managers had dealt with the challenges of restricted CNP status, too much supervision and delayed communications. One of the unit managers expressed her frustration with the limited registration:

Yes, the only problem was with the limited well registration in terms of our drug keys etcetera..... they can only step in in that limited capacity sometimes. The disadvantage is they can't replace a RN [registered nurse] (UM3-B).

Some unit managers experienced challenges with the CNPs such as frustrations by the CNPs status and the need to be followed closely.

The only problem we have is that they are not allowed to keep keys, [scheduled 6 and 7 drug cupboard keys] You have to put them with another professional nurse at all times ... (UM2-D).

The communication on CNP allocations was received late from KZN DOH and this created disorganisation for the nursing managers.

Yes, we get the circular that comes on the intranet which tells us how many [CNPs] are placed at our institutions. At times it has come very late up until the last day which is terribly, terribly unfair... from an allocation perspective because you don't just quickly do it, it takes time. (DNM-B).

Another concern about delayed communication was the rush to arrange accommodation for the CNPs:

At the present moment we are not aware who is coming in January [interviewed in December] ... and we have to prepare the accommodation for them. Ya, then the units where they would be allocated as well as the HR have to be notified to put them on the system (DNM-F).

The rotation of the CNP every 3 months was frustrating for this unit manager:

When they rotate on a 3 month basis, and you know you have taught the person everything ... they get moved, and you have to start all over again (UM3-D).

Following the process

All nurse managers followed the process required for coordinating the CCS year, from providing support to ensuring professional development of the CNPs. Nursing managers coordinated the CCS year from beginning until completion:

On completion of community service we complete the completion report and also on commencement as well. I then submit ... reports to the KZN College of Nursing (NM-D).

A deputy nursing manager who was responsible for allocations commented:

At the moment I am doing the allocation of human resources So my role is to allocate them [the CNPs] to the various disciplines and to ensure that their contracts regarding the vac [vacation] leave is fulfilled as well [DNM-B].

One of the nursing managers was relieved when the registration certificates of the CNPs arrived from the SANC and ensured that the necessary personnel were informed of this:

Once they are registered [as CNPs] the wards are notified and then we put it on our change list ... we send it [CNP registrations] to our HR [human resources] Department and we also then inform the allocation matron (NM-D).

Unit managers' coordinating roles were to monitor the CNPs so that their progress reports could be written at the end of their stay in the units:

[T]he quarterly report that is given to us so that ... we are going to write upon it Maybe you find whether he or she needs to be more educated on that, you write on the general notes about what you think (UM2-A).

All nurse managers recognised the need to provide support to the CNPs while they were in their institution. Support was generally in the form of institutional and unit orientation, ensuring supervision by registered nurses, delegation of registered nurse's roles and/or being available to the CNPs:

They [CNPs] follow ... the hospital orientation programme for the new employees ... they are being orientated on everything, and all the in-service trainings They do get time to read the policy files (DNM-E).

Ensuring supervision was considered necessary for the CNPs. This was mainly carried out by unit managers. Supervision was strong in the early months of their CCS year or whenever they were changed from one unit to another.

Okay, we have to make sure that they are being supervised... these are professional nurses, so we make sure that they ... able to work independently, though there is somebody overlooking ... (DNM-E).

A unit manager commented that she provided support to the CNPs as it would be unfair to the CNPs to leave them to function independently:

You cannot leave them all by themselves and say you are qualified ... it's not gonna be fair really [to the CNP] ... but when she's stuck, she needs to call you to say "can you please come and help me" ... we should be mentoring them, but because of the staff shortage it doesn't happen (UM1-C).

The CNPs were rotated in various units during the CCS year, accompanied by another registered nurse and delegated registered nurses' roles so that they developed as professional nurses:

We allocate them with the midwives in training ... so we mentor them here at the clinic ... (UM3-C).

In specialised units such as maternity and intensive care, the CNPs were rotated within the various units to obtain varied experiences:

Their allocation takes the form [changes] after every three months, they move to the next unit ... here in maternity ... but sometimes, you find that it's not easy to keep to the allocation (DNM-C).

Unit managers ensured professional development of the CNPs by delegating registered nurse's roles to them:

I make them to be in charge of the unit. If this one is in charge this day everything that is done and that is wrong in the unit she is going to answer for it. I allocate them ... under my supervision because they can still make [errors] (UM2-A).

DISCUSSION OF RESEARCH RESULTS

The findings of the main categories together with the subcategories are discussed below.

Valuing the CNPs

The nurse managers expressed valuing the CNPs who are comprehensively trained to nurse patients in any clinical setting, having a guaranteed professional nurse for one year and mutual benefits of having the CNPs in their units. The four-year qualification, as entry level for professional nurses, is in keeping with current trends internationally (Blaauw, Ditlopo & Rispel, 2014:26401). One of the objectives of the CCS policy for nurses was to ensure resources to underserved areas (KZN DOH, 2010). Although the institutions under study were not necessarily underserved health institutions, allocating CNPs to them was appreciated for relieving the nurse shortages. Newly qualified nurse graduates are also considered a priority in recruitment and retention for many healthcare facilities so that nurse shortages may be relieved (Cheng *et al.* 2014).

The eagerness of the CNPs to develop professionally was expressed by the participating nurse managers and this eagerness is considered by Newton and McKenna (2007:1236) as a sign of professional maturity.

Benefitting from mentoring (role modelling, enjoys teaching, sense of satisfaction, receiving positive feedback)

Mentoring the newly qualified nurse provided nurse managers with opportunities to role model behaviours, improved their sense of satisfaction and self-esteem when they received positive feedback. Cottingham *et al.* (2011:254) found mentoring to be beneficial to mentors in providing opportunities for teaching, mentoring and leadership. Participants in the study by Kramer *et al.* (2012:320) also commented on the satisfaction and confidence they experienced when graduate nurses developed as confident practitioners. The mutual benefits of having CNPs in their units were expressed by participants. Halcomb, Peters and McInnes (2012:10) acknowledged how practising nurses benefitted by maintaining currency of knowledge during their study on mentoring of undergraduate nursing students

In this study there was some mentorship provided but it was neither formalised nor structured. This could be due to the demands of high patient needs versus the limited staffing ratios available, as noted by Chernomas *et al.* (2010:78). In a study by Baumberger-Henry (2012:303), the mentoring provided after orientation was valued for graduate nurses as a future retention strategy. The managers expressed the role modelling of professional behaviours as necessary for developing the CNPs. Role modelling was helpful in easing the stresses by creating a supportive environment for development from the beginning (Chandler 2012:106).

Following the processes (coordinating, providing support, ensuring professional development)

The inner setting where the CCS policy for nurses was implemented is made up of concrete and abstract characteristics such as readiness for implementation and individuals' readiness for the implementation (Damschroder *et al.* 2009:12). Nurse managers followed the process of communicating with SANC and KZN DOH when CNPs commenced and completed their CCS. Communications were received through the KZN DOH coordinator of CCS for nurses. It was apparent that roles and responsibilities were not made clear to the health institutions receiving the CNPs. The implementation of policy can become challenging if there are inconsistencies between the values entrenched in a policy and the persons carrying out the policy (Brauns & Wallis, 2014:202).

The participants in this study said they were providing support to the CNPs, but it appeared as if this was provided on an ad hoc basis. Du Plessis and Seekoe (2013:137) also found that the orientation was not well coordinated when newly qualified nurses worked as midwives. The policy by KZN DOH (2010) clearly states that the supervision and support of community service officers include all health professionals. The supervision and development of the CNP during the CCS year were necessary to develop their competencies, especially in the early months of their CCS year, and was confirmed by Moeti, Van Niekerk and Van Velden (2004:83). However, it was also necessary to be supported by experienced nurses during the first year to make the transition from student to professional nurse easier (Chernomas *et al.*, 2010:9).

Professional experience was provided for the CNPs by rotation to various units every three months. A nurse residency programme in the USA has confirmed the benefits in developing the novice nurse into a competent professional by exposure to a range of clinical experiences in a variety of nursing units (Brandenburg, 2014:54).

Dealing with challenges (frustrations with status, too much supervision, delayed communications)

The challenges that nurse managers had with the CNPs were their restricted status before their registration as CNPs. There was a sense of relief when the CNP registrations were received from the SANC as there could be less supervision of the CNPs. The confusion that the nursing managers experienced confirmed the comments received by the researcher before the study commenced. When the CNP category was introduced the objective of the policy was to retain the newly qualified nurses for at least one year after qualification. There were no clear directives for nursing administrators on any restrictions that need to be imposed on nurses carrying out CCS. Therefore nurse managers dealt with the nurses in the same way they dealt with other newly qualified nurses who were awaiting registration with the SANC.

A few nurse managers commented on too much supervision being a disadvantage to the nurse carrying out CCS. However, close supervision may be gradually weaned off in a structured transition programme where there is monitoring of progress in the development of confidence and critical thinking skills as professional nurses (Duclos-Miller, 2011).

It is well documented that efficient transitioning of new graduates will benefit in retaining nurses within an organisation and save costs in the long run (Hatler *et al.* 2011:92; Jameson *et al.* 2012:35; Laschinger *et al.* 2014:1087). However, effective transitioning has not been made explicit in the literature in spite of numerous studies conducted (Johnstone, Kanitsaki & Currie, 2008:51).

Support from nursing management has also been recommended in graduate residency programmes as significant in providing positive experiences for the graduate nurse during the transition period from student to registered nurse (Duclos-Miller, 2011:33).

Delayed communications were raised by the nurse managers because they affected the smooth operation of allocations to nursing units and accommodations for the CNPs. As pointed out by Cline (2000:553), effective communication is necessary for successful implementation of any policy. Communication is also pivotal for success of any policy intervention (Brynard, 2006).

CONCLUSIONS

Nurse managers valued the CNPs for their comprehensive training, eagerness to learn, and having a guaranteed staff member for one year. They followed the process of implementation of the CCS policy for nurses by adhering to the guidelines provided by SANC. At the same time there were frustrations experienced with frequent rotations, restricted status before they were registered with the SANC, as well as delayed communications. There was no evidence of a formalised mentorship programme for CNPs as specified in the policy from the KZN department of health.

RECOMMENDATIONS

There are no formalised programmes for the orientation of CNPs serving CCS. The CCS year must be seen as the opportunity to develop the newly qualified nurse into the critical thinking nurse, which is imperative for the proper management of patients with a rapidly changing profile. The following is recommended for the management and professional development of the CNPs during the CCS year:

- A structured orientation programme for all CNPs when they start their CCS.
- A structured mentorship programme that includes training of mentors and supervisors to monitor and assess the progress of the CNPs

- A minimum period of six months mentorship with extension up to one year after evaluation as recommended in other transition programmes.
- A reporting system that is designed to follow the progress being made by the CNP during the CCS year would help both the CNPs and nurse managers in ensuring the professional is capable of independent decision making on completion of CCS.

LIMITATIONS OF STUDY

The study was qualitative and confined to health institutions of one province in South Africa and may or may not be applicable in other settings.

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