Investigation into factors influencing nursing values in South Africa

by

Talita van Schalkwyk

Thesis presented in partial fulfilment
of the requirements for the degree of
Master of Nursing Science
in the Faculty of Health Sciences at Stellenbosch University

Supervisor: Ms. L.A. Paterson

March 2012

DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the authorship owner of the copyright thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Signature

Date: March 2012

ABSTRACT

Nursing is influenced by the values of each nurse (Mellish & Paton, 1999: 6). Values form an integral part of human reality; they predict thoughts, feelings, actions and perceptions. Nursing in South Africa, is defined as a "caring profession" (Act No. 33 of 2005) and forms a subculture of the South African population, with nurses coming from different cultural and ethnic groups, being of various ages and both genders. It was identified that a need exists to understand nursing values and the factors influencing these values. Consequently, together with the lack of research data regarding values in South Africa and the factors influencing them, the importance to do an investigation into the factors influencing nursing values was identified.

The aim was to do an in-depth study into the factors influencing nursing values of nurses working in nursing facilities in the Paarl district employed by the Provincial Administration of the Western Cape, in the West Coast Winelands Region of the Western Cape. The objectives were to determine the main reason for entering the nursing profession for nurses working in these facilities; to identify the most important part of nursing practice; to identify the core nursing values; to determine the factors influencing nursing values and the factors influencing nursing care.

A quantitative research design using a descriptive, explorative survey was conducted. The population included the three categories of nurses, with a total population of 470 nurses (N = 470). Research questionnaires were distributed to 388 participants working on the days of data collection in all nursing departments, excluded nurses not permanently employed by the Provincial Administration Western Cape, including nursing agency staff, students doing practica and personnel on leave. The return rate was 60.56% (n = 235). The questionnaire was based on a literature review and the objectives, and a pilot test ensured reliability and validity. The results of the pilot study (n =10) were included in the findings, leading to 245 respondents (n = 245) being included in the main study. The questionnaire consisted of four sections and was validated by an expert in nursing science and research methodology, a biostatistician, a quality assurance manager and ethical committees. Four open-ended questions were included to provide richer and more diverse data.

Only the researcher was involved in data collection that took place during day and night duty. Descriptive statistics and appropriate inferential statistical tests were used in analysing the data.

Ethical approval was obtained. Anonymity and confidentiality of respondents were observed and written consent was obtained from respondents.

It was identified that nurses enter the nursing profession due to altruism and the most important part of nursing encompasses caring. Differences in values important for behaviour of a nurse, patient care and ethical decision making were identified. Findings depicted that age, years of experience, qualification obtained, job description and department influence different values. Results identified that political and social factors, as well as motivation influence nursing practice. Recommendations include setting a clear value structure for nursing in South Africa; attention to the evaluation of staff performance and management; enhancing motivation of staff and the development of a management-for-nurse strategy.

OPSOMMING

Verpleging word beïnvloed deur die waardes van elke verpleegster (Mellish & Paton, 1999:6). Waardes vorm ’n integrerende deel van die menslike realiteit, dit voorspel gedagtes, gevoelens, handelinge en gewaarwordinge. Verpleging in Suid-Afrika word gedefinieer as ’n versorgingsberoep (Wet No. 33 van 2005) en vorm ’n subkultuur van die Suid-Afrikaanse bevolking, met verpleegsters van verskillende kulturele en etniese groepe wat verskeie ouderdomme en albei geslagte insluit. Dit is geïdentifiseer dat ’n behoefte bestaan om verplegingswaardes en die faktore wat hierdie waardes beïnvloed, te verstaan. Gevolglik, gesamentlik met die gebrek aan navorsingsdata aangaande verpleegwaardes en die faktore wat dit beïnvloed, in Suid-Afrika, is die belangrikheid geïdentifiseer om ’n ondersoek te doen aangaande die faktore wat verpleegwaardes beïnvloed.

Die doel was om ’n dieptestudie te doen van die faktore wat die verpleegwaardes van verpleegsters beïnvloed wat in verpleeg instansies in die Paarl-distrik werk in diens van die Provinsiale Administrasie van die Wes-Kaap, in die Weskus Wynlandstreek van die Wes-Kaap. Die doelwitte was om die hoofrede te bepaal waarom verpleegsters wat in hierdie fasiliteite werk die verpleegberoep betree het; om die belangrikste aspek van die verpleegpraktyk te identifiseer; die kern verplegingswaardes te identifiseer; en die faktore te bepaal wat verplegingswaardes en verpleegsorg beïnvloed.

’n Kwantitatiewe navorsingsontwerp is toegepas deur van ’n beskrywende, ondersoekende opname gebruik te maak. Die bevolking het die drie kategorieë van verpleegsters ingesluit, met ’n totale bevolking van 470 verpleegsters (N=470). Navorsingsvraelyste is versprei aan 388 deelnemers wat op die dae van data-insameling gewerk het in die verpleegdepartemente en het verpleegsters uitgesluit wat nie permanent indiens was van die Provinsiale Administrasie van die Wes-Kaap, asook verpleegagentskap personeel, studente wat praktika verrig en personeel op verlof. Die terugkeerkoers was 60.56% (n=235). Die vraelys was gebaseer op ’n literatuurstudie en die doelwitte van die studie, ’n loodsstudie het betroubaarheid en geldigheid verseker. Die resultate van die loodsstudie (n=10) is ingesluit in die bevindinge, wat gelei tot 245 respondente (n=245) in die hoof studie. Die vraelys het bestaan uit vier afdelings en is geldig verklaar deur ’n spesialis op die gebied van verpleegkunde en navorsingsmetodologie, ’n

biostatistikus, ’n kwaliteitversekeringsbestuurder en etiese komitees. Vier oop-vrae is ingesluit om omvattende en meer uiteenlopende data te voorsien.

Slegs die navorser was betrokke by data-insameling wat gedurende dag en nag skofte plaasgevind het. Beskrywende statistiek en geskikte afleibare statistiese toetse is gebruik in die analisering van die data. Etiese goedkeuring is verkry. Anonimiteit en vertroulikheid van respondente is behou en geskrewe toestemming is verkry van respondente.

Bevindinge het getoon dat verpleegsters die verpleegberoep betree weens hul onbaatsugtigheid en dat die belangrikste aspek van verpleging versorging is. Verskille in waardes wat belangrik is vir die gedrag van ’n verpleegster/verpleër, pasiënt versorging en etiese besluitneming is geïdentifiseer. Daar is bevind dat ouderdom, ondervinding in jare, kwalifikasies behaal, posbeskrywing en die departement verskillende waardes beïnvloed. Resultate het bewys dat politieke en sosiale faktore, asook motivering verpleegpraktyk beïnvloed. Aanbevelings sluit die daarstelling van ’n duidelike struktuur van verpleegwaardes in Suid-Afrika; die nodigheid vir aandag aan die evaluering van personeelprestasie en -bestuur; die verheffing van personeelmotivering en die ontwikkeling van ’n bestuur-vir-verpleegster strategie.

ACKNOWLEDGEMENTS

I would like to acknowledge and express my sincere appreciation to:

- My Heavenly Father, that granted me a passion for nursing and granted me the strength to undertake and complete this research project, all praise and thanks go to Him;
- My husband, David, for your love, patience, understanding, constant support and encouragement to live my dreams;
- My parents, for teaching me the value of perseverance, for supporting and encouraging me throughout my career, for loving and believing in me;
- Pa Charl and Ma Annake, for your continuous support, love and encouragement throughout my career and for your believe in me;
- Melaní, Janike, Helena, Jannie and Liezel and my friends and family that supported and encouraged me throughout the study, thank you;
- My supervisor, Ms. L.A. Paterson, for your guidance, support and encouragement and for insuring that I develop myself and reach my goal;
- Prof. M. Kidd for your guidance and support with statistical analysis;
- Nazma Vajat, for your assistance and support with literature search and for always lending an ear;
- Joan Petersen, for your support and patience;
- Ms. Illona Meyer for the language editing;
- Ms. Lize Vorster for technical editing;
- My colleagues and friends from both Western Cape College of Nursing and Paarl Hospital for your support, encouragement and understanding;

- The Department of Health Western Cape, the Management of the institutions where the research was conducted, but mostly the respondents that took part in the research whom without this study would not have be possible.

With sincere appreciation
Talita van Schalkwyk December 2011

TABLE OF CONTENTS

Declaration ..... **ii**

Abstract ..... **iii**

Opsomming ..... **v**

Acknowledgements ..... **vii**

List of tables ..... **xv**

List of figures ..... **xvi**

List of addenda ..... **xvii**

List of acronyms and abbreviations ..... **xviii**

CHAPTER 1: SCIENTIFIC FOUNDATION OF THE STUDY **1**

1.1 Introduction 1

1.2 Rationale 1

1.3 Problem statement 4

1.4 Research question 4

1.5 Aim 4

1.6 Objectives 4

1.7 Research methodology 4

1.7.1 Research design *4*

1.7.2 Population and sampling *5*

1.7.2.1 Inclusion criteria 5

1.7.2.2 Exclusion criteria 5

1.7.3 Instrumentation and data collection *5*

1.7.4 Pilot study *6*

1.7.5 Validity and reliability *6*

1.7.6 Data collection *7*

1.7.7 Data analysis and interpretation *7*

1.7.8 Ethical consideration *7*

1.7.9 Limitations *8*

1.8 Conceptual framework 8
1.9 Operational definitions 9
1.10 Timeline 9
1.11 Study layout 10
1.12 Conclusion 11
CHAPTER 2: LITERATURE STUDY 12
2.1 Introduction 12
2.2 Nursing era 13
2.3 Nursing in the South African context 13
2.4 Nursing values 16
2.4.1 Values and education 20
2.4.2 Values and culture 21
2.4.3 Values and work experience 22
2.5 Caring and nursing values 22
2.6 Motivation 23
2.7 Conceptual framework 26
2.8 Conclusion 28
CHAPTER 3: RESEARCH METHODOLOGY 29
3.1 Introduction 29
3.2 Aim 29
3.3 Research question 29
3.4 Objectives 29
3.5 Research design 29
3.6 Population and sampling 30
3.6.1 Inclusion criteria 32
3.6.2 Exclusion criteria 32
3.7 Instrumentation 32
3.7.1 Content of the questionnaire 33
3.8 Pilot study 35
3.9 Reliability and validity 36

3.10 Data collection 36
3.11 Data analysis and interpretation 37
3.12 Ethical consideration 37
3.13 Conclusion 38
CHAPTER 4: PRESENTATION, ANALYSIS AND INTERPRETATION OF RESEARCH FINDINGS 39
4.1 Introduction 39
4.2 Data analysis 39
4.3 Description of statistical analysis 41
4.4 Results 42
4.4.1 Section A: Biographical data 42
4.4.1.1 Gender (n = 237) 42
4.4.1.2 Ethnic group (n = 231) 43
4.4.1.3 Religion (n = 237) 43
4.4.1.4 Age group (n = 237) 44
4.4.1.5 Experience (n = 237) 44
4.4.1.6 Highest qualification obtained (n = 233) 45
4.4.1.7 Current job description (n = 238) 46
4.4.1.8 Current department (n = 238) 47
4.4.2 Section B: Nursing values 47
4.4.2.1 Question B1: Identify the main reason why you decided on nursing as a career (n = 245) 48
4.4.2.2 Question B2: Do you feel that you are still in nursing practice due to the reason for entering the nursing career? (n = 238) 49
4.4.2.3 Question B3: Identify the part of nursing most important to you (n = 223) 50
4.4.2.4 Question B4: Prioritize each of the following professional values which influence your behaviour as a nurse 51
4.4.2.5 Question B5: What values are important to provide proper patient care in your daily work as a nurse? 57

4.4.2.6 Question B6: Which values do you often use in order to make ethical decisions? 63

4.4.3 Section C: Political factors 69

4.4.3.1 Question C1: Do you feel that appointment of nurses is done fairly? 69

4.4.3.2 Question C2: Do you feel that Staff Performance (SPMS) is rated fairly? 69

4.4.3.3 Question C3: Rate your knowledge of the acts, regulations and policies applicable to your work 70

4.4.3.4 Question C4: Describe the political factors that are influencing your nursing practice 71

4.4.4 Section D: Socio-economic factors 76

4.4.4.1 Question D1: Do you feel that you are receiving remuneration according to the level of work you deliver? 76

4.4.4.2 Question D2: Can you keep up with the financial demands of life? 76

4.4.4.3 Question D3: Do you feel that if your salary level were higher you would have been better motivated towards nursing care? 77

4.4.4.4 Question D4: Did you receive a significant salary increase during Occupation Specific Dispensation (OSD)? 78

4.4.4.5 Question D5: Do you think that the institution employs enough personnel to deliver proper nursing care? 79

4.4.4.6 Question D6: Can you keep up with the demands of work and still ensure proper care? 79

4.4.4.7 Question D7: How motivated are you to deliver proper care? 80

4.4.4.8 Question D8: What is the level of conflict in the department you are working at? 81

4.4.4.9 Question D9: What is causing the conflict in the department? 82

4.4.4.10 Question D10: Describe the social factors that are influencing your nursing practice 86

4.4.4.11 Question D11: Comments 92

4.5 Analysis of quantitative data 97

4.5.1 Values influencing behaviour as a nurse and biographic data 98

4.5.1.1 Values influencing behaviour as a nurse and highest qualification 98

4.5.1.2 Values influencing behaviour as a nurse and current job description..... 98

4.5.2 Values important to provide proper patient care and biographical data..... 99

4.5.2.1 Values important to provide proper patient care and age group..... 99

4.5.2.2 Values important to provide proper patient care and number of years of experience..... 99

4.5.2.3 Values important to provide proper patient care and current department working in……. 100

4.5.2.4 Values important to provide proper patient care and current job description .. 100

4.5.3 Values often used in order to make ethical decisions and biographic data 101

4.5.3.1 Values often used in order to make ethical decisions and number of years of experience..... 101

4.5.3.2 Values often used in order to make ethical decisions and highest qualification obtained 102

4.5.3.3 Values often used in order to make ethical decisions and current department ……..102

4.5.3.4 Values often used in order to make ethical decisions and current job description ……102

4.6 Conclusion..... 103

CHAPTER 5: DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS 104

5.1 Introduction..... 104

5.2 Discussion and conclusions..... 104

5.2.1 The main reason for entering the nursing profession 105

Objective 1: Determine the main reason for entering the nursing profession for nurses working in these facilities..... 105

5.2.2 The most important part of nursing practice 105

Objective 2: Identify the most important part of nursing practice for nurses working in these facilities.... 105

5.2.3 The core nursing values of nurses..... 106

Objective 3: Identify the core nursing values of the nurses working in these facilities.... 106
5.2.4 Factors influencing nursing values 108
Objective 4: Determine the factors influencing nursing values 108
5.2.5 The factors influencing the nursing care of the patient 113
Objective 5: Determine the factors influencing the nursing care of the patient 113
5.3 Recommendations 121
5.3.1 Clear value structure for nursing in South Africa 122
5.3.2 Staff performance and management 122
5.3.3 Enhancing motivation of nursing staff 123
5.3.4 Management-for-Nurse strategy 123
5.4 Recommendations for further studies 124
5.4.1 Expansion of research 124
5.4.2 Influence and effectiveness of unions 124
5.4.3 Implementation of Occupation Specific Dispensation in nursing 124
5.4.4 Staff performance management as motivator and promoting performance 124
5.4.5 Political factors affecting nursing practice and nursing values 125
5.4.6 Social factors affecting nursing practice and nursing values 125
5.5 Limitations of the study 125
5.6 Summary 126
List of references 129
Addenda 134

LIST OF TABLES

Table 3.1: Summary of questionnaires distributed and questionnaires returned 31
Table 4.1: Gender distribution 43
Table 4.2: Ethnic distribution 43
Table 4.3: Distribution of Religion 44
Table 4.4: Age distribution 44
Table 4.5: Number of years of experience 45
Table 4.6: Highest qualification obtained 46
Table 4.7: Current job description 46
Table 4.8: Current department 47
Table 4.9: Participants' reasons for entering the nursing profession 48
Table 4.10: Most important part of nursing 50
Table 4.11: Values influencing nursing behaviour 52
Table 4.12: Values important to provide proper patient care 58
Table 4.13: Values utilized to make ethical decisions 64
Table 4.14: Political factors influencing nursing practice (n = 122) 72
Table 4.15: Causes of conflict in the departments (n = 174) 82
Table 4.16: Social factors influencing nursing practice (n = 181) 87
Table 4.17: Comments 92

LIST OF FIGURES

Figure 4.1: Are participants still practising nursing due to the reason entering the profession... 49
Figure 4.2: Fair appointment of nurses 69
Figure 4.3: Staff performance management system rating..... 70
Figure 4.4: Knowledge of acts, regulations and policies..... 71
Figure 4.5: Remuneration according to the level of work delivered..... 76
Figure 4.6: Keeping up with financial demands 77
Figure 4.7: Would a higher salary lead to better motivation towards nursing care? 78
Figure 4.8: Did participants receive OSD? 79
Figure 4.9: Do you think the institution employs enough personnel to deliver proper nursing care? 79
Figure 4.10: Can you keep up with demand of work and still ensure proper care? 80
Figure 4.11: Level of motivation 81
Figure 4.12: Level of conflict in the department 82

LIST OF ADDENDA

Addendum A: Consent form 134
Addendum B: Participation information leaflet 137
Addendum C: English questionnaire 140
Addendum D: Afrikaanse vraelys……...150
Addendum E: Ethical approval 162
Addendum F: Research permission from Department of Health Western Cape 165
Addendum G: Proof of language and technical editing 168

LIST OF ACRONYMS AND ABBREVIATIONS

ANOVA	Analysis of Variance
EPMDS	Employee performance management and development system
OSD	Occupation Specific Dispensation
SANC	South African Nursing Council
SPMS	Staff Performance Management System

CHAPTER 1: SCIENTIFIC FOUNDATION OF THE STUDY

1.1 INTRODUCTION

Nursing is a human science concerned with interpersonal activity which is directly influenced by the values of each individual nurse (Mellish & Paton, 1999:6). As early as the nineteenth century Florence Nightingale found that nursing could not only be concerned with scientific knowledge and technical skills, but is directed by specific human values (Rassin, 2008:614). According to Pera and Van Tonder (2005:7), the primary goal of nursing is to provide optimal care for every client, but the nursing practitioner has to know what he or she believes in and be conscious about his or her values to perform professional nursing care. According to Shaw and Degazon (2008:45), nursing has become more focused on the financial incentives, career opportunities and career stability, in today's modern fast-paced world.

According to Shaw and Degazon (2008:45) altruism is apparently one of the primary motivators for persons entering nursing as a career. This altruistic view is characterized by values such as "commitment, compassion, generosity, perseverance, benevolence and sympathy" (Altun, 2002:271). However, nursing gets targeted by bad press suggesting how patients are neglected by nurses, how they are being turned away from health institutions by nurses and most importantly, the poor nursing care given by nurses (Schroeder, 24 April 2009:6; Sidumo, 24 April 2009:3). This gave rise to the importance of setting a good value basis in every nursing facility.

Values can be defined as "a set of beliefs and attitudes about the truth, beauty and worth of any thought, object or behaviour" (Tjale & De Villiers, 2004:50). Values are expressed in all decisions made, in all actions and lie at the core of diverse human behaviour (Pera & Van Tonder, 2005:8; Rassin 2008:614).

1.2 RATIONALE

Values form an integral part of every individual's life, it is "linked to a person's identity and way of life" (Pera & Van Tonder, 2005:8). Thoughts, feelings, actions and perceptions are determined by the well-known values a person hold and determine what a person attach value to (Mohr, Deatrick, Richmond & Mahon, 2001:31).

Different authors highlight and assist in explaining the importance of values in nursing. The most highlighted nursing values are confidentiality, responsibility, accountability, maintaining of standards of personal conduct, safety, dignity, rights of people and a co-operative relationship with co-workers (International Council of Nurses 2000), altruism, human dignity, social justice, autonomy, integrity (Shaw and Degazon, 2008:45), equality, freedom and truth (Altun, 2002:271). The Provincial Government of the Western Cape identified the overarching values as caring, competence, accountability, integrity and responsiveness (Western Cape Government, 2011).

Nursing in South Africa is viewed as a "caring profession which supports, cares for and treats a health care user to achieve or maintain health and where this is not possible, cares for a health care user so that he or she lives comfortably and with dignity until death" (Act No. 33 of 2005). The White Paper for the transformation of the Health Service in South Africa highlights that the focus of the health system is to deliver quality health care in a caring environment (Department of Health, 1997b). Caring is directed by values, such as compassion, interest and a concern for people (Tjale & De Villiers, 2004:141). The values of courtesy, respect and dignity are emphasized in the White paper on transformation of public service and assists in setting values for the public service, to ensure optimal care for the citizens of South Africa (Department of Public Service and Administration, 1997b).

Values are learned and developed in early life, through influences by caregivers and the family, growing up and further development, formal learning, peer experiences and societal institutions (Pera & Van Tonder, 2005:8). With research into factors influencing nursing values it was identified that there are significant differences in values displayed by persons from different levels of education, with differing lengths of experience (Mc Neese-Smith & Crook, 2003:266; Rassin, 2008:627) and in differing work positions (Mc Neese-Smith & Crook, 2003:266; Rassin, 2008:626).

Culture can be defined as the values, beliefs, norms and customs that are acquired and shared by a group of people, which guide the members in their thinking, decision making and actions (Pera & Van Tonder, 2005:167). South Africa is a country with nine provinces, with an estimated population of 48 687 000 residents (Statistics South Africa, 2008:3). Within these provinces different culture groups reside. Nursing can be seen as a subculture of the South African population with an estimated population of 212 806 nurses that stem from different culture groups, ethnic groups, ages and both genders (SANC, 2009b:2; Shaw and Degazon,

2008:44). These differences in nursing are evident in statistics from the South African Nursing Council (SANC) stating that 92.5% of the South African nursing workforce is female (SANC, 2009b). SANC also reveals that the significant age difference that occur in the nursing profession are presenting an older workforce with only 24% of professional nurses being younger than 40 years of age (SANC, 2009a).

In the Culture-care Diversity and Universality model (Tjale & De Villiers, 2004:22) political and social factors are highlighted as having an effect on caring, viewing nursing in South Africa against the immense political and social changes in South Africa since 1994 and the possibility of the influence by these factors on nursing are questioned. In the new regime strategies were introduced to ensure the effectiveness of service. Some of these were the introduction of Affirmative Action in the Public Service (Department of Public Service and Administration, 1998) and placing the importance of employment on race, gender and disability. The Employee performance management and development system (EPMDS) was introduced with the aim to plan, manage and improve the employees' performance to ensure the overall performance and service delivery of Government Departments, and also aimed at improving the motivation of employees (Department of Public Service and Administration, 1997b) and introduction of Occupation Specific Dispensation (OSD) for Nursing in 2007, with career pathing, pay progression, grade progression, recognition of seniority, increased compensation, performances, and recognition of prior experience and recognition of prior learning at heart (Public Service, Co-ordinating bargaining council 2007:3). Shortage of personnel, insufficient salaries (Newhouse, 2004:354), work load and conflict between personnel have been shown to have a negative influence on nursing care (Le Sergent & Haney, 2005:9). In previous arguments the influence of values on caring was debated, raising the question of the influence of all of these factors stated on the values of nurses.

Franco, Bennett and Kanfer (2002:1256) is of the opinion that resource availability and the competency of workers are not the only factors ensuring good performance and thus nursing care, but are also greatly influenced by the motivational level of workers. Motivation is one of the main components to ensure effective work being delivered (Jooste, 2010:200). Frederick Herzberg has greatly influenced the way motivation at the workplace is viewed. The theory by Herzberg explains individual motivation by identifying employees' needs, determining what satisfies their needs and by establishing what measures they pursue to fulfil their needs. Herzberg's theory of motivation divides factors of motivation into two categories, namely the hygiene factors and motivation factors. (Training and development solution, 2001 – 2011). This

motivational theory was viewed from a management perspective, as well as issues affecting the working environment, in order to evaluate the effective motivation of personnel and to establish the level of nursing care.

1.3 PROBLEM STATEMENT

Viewing nursing values in South Africa against this background it was identified that there is a great need to understand nursing values. In relation to the diversity of this country and the population it serves, as well as the multiculturality and the political and social background of South Africa, it is of importance to do an investigation into the factors influencing nursing values.

1.4 RESEARCH QUESTION

Which factors influence the nursing values of nurses working in nursing facilities in the Paarl district, in the West Coast Winelands Region of the Western Cape?

1.5 AIM

The aim of the study was to do an in-depth study into the factors influencing nursing values of nurses working in Nursing Facilities in the Paarl district employed by the Provincial Administration of the Western Cape, in the West Coast Winelands Region of the Western Cape.

1.6 OBJECTIVES

The objectives for the study were to

- determine the main reason for entering the nursing profession for nurses working in these facilities
- identify the most important part of nursing practice for nurses working in these facilities
- identify the core nursing values of the nurses working in these facilities
- determine the factors influencing nursing values
- determine the factors influencing the nursing care of the patient.

1.7 RESEARCH METHODOLOGY

1.7.1 Research design

A quantitative approach with a descriptive research design was applied in the research. A quantitative approach aided in the provision of precise numerical data for scientific evidence to reach the objectives of the study. In this study the relationship between different factors

affecting nursing values, as well as those upheld by nurses were explored, which coincide with the criteria by Burns and Grove (2007:24) postulating that a descriptive research design is applied to describe concepts and identify relationships.

1.7.2 Population and sampling

The population of the study included the three categories of nurses working at Paarl Hospital, Sonstraal Hospital and also the District Nursing facilities situated in the Paarl district, with a total population of 470 nurses.

Convenience sampling was applied to the study. Sampling was aimed at including all 470 nurses working in Paarl Hospital, Sonstraal Hospital and the district nursing facilities in the Paarl region, of which 10 respondents were included in the pilot study. Questionnaires were distributed to 388 respondents (N = 388) after an information session and were returned by 235 respondents (n = 235), this resulted in a 60.56% return rate.

1.7.2.1 Inclusion criteria

- All nurses permanently employed by the Provincial Administration of the Western Cape, from nursing facilities in the Paarl region were included in the study.

- These nurses represented all nursing departments, namely casualty, theatre, surgery, medical, midwifery, orthopaedic, high care, paediatric department and primary health care departments.

1.7.2.2 Exclusion criteria

- Nurses currently doing practica at the different nursing facilities as part of an educational course were excluded from the study.

- Nurses not permanently appointed by the Provincial Administration of the Western Cape working in any of the institutions, including agency personnel.

- Nursing personnel on leave during data collection.

1.7.3 Instrumentation and data collection

A self compiled survey questionnaire was used to collect data at the health care facilities and was constructed based on the scientific evidence from a literature study and consultation with the biostatistician. The questionnaire consisted of four sections.

Section A included the biographical data namely the gender, age group, ethnic group, nursing position, religion, qualifications, work area and years of experience of each respondent.

Section B was devoted to nursing values. Likert scales, rating scales and closed-ended questions were used to collect data. A Likert scale was used where respondents had to prioritise the professional values they uphold and which influence their behaviour, the values needed for proper care and the values they apply for ethical decision making. It is a four point Likert scale with the options to choose from, namely high priority, priority, little priority and no priority; numerical values of 1, 2, 3 and 4 were awarded to each response, with 1 being awarded to the most negative answer and 4 to the most positive answer (Burns & Grove, 2007:388). The Likert scale is applicable to this study as it measures the opinion or attitude of participants, but also provides in assigning a numerical value to each scale that ensures the quantification of data (Burns & Grove, 2007:388).

In Section C the political factors affecting values and in Section D the social factors affecting values were questioned by using a variation of questions ranging from open-ended questions, rating scales and closed-ended questions.

1.7.4 Pilot study

To provide an accurate representation of the proposed study, the pilot study was undertaken under similar conditions in which the data collection was conducted (Burns & Grove, 2007:38). The pilot study was not done for statistical or reliability reasons, only ten respondents (n = 10) were included in the pilot study and the pilot study was conducted in Paarl Hospital by using convenience sampling in the different wards, including all levels of nurses.

The results of the pilot study were applied to adjust the questionnaire according to time allocation for completion of the questionnaire and also with regard to clarification of questions in the questionnaire during the information session, but no changes were made to questions in the questionnaire. The respondents, as well as the results from the pilot study were included in the main study on recommendation of the biostatistician, resulting in a total sample of 245 respondents (n = 245) being included in the main study.

1.7.5 Validity and reliability

Validity is defined as the level of accurate reflection of the examined conceptual construct (Burns & Grove, 2007:559). The measuring instrument was presented to an expert in research methodology and nursing to ensure content validity. It was also presented for consideration to

the Quality Assurance Manager of Paarl Hospital and it was further validated through peer review. Content and construct validity were assured by the use of scientific evidence found through the literature study as the basis for the formulation of the survey questionnaire. The construct validity was established through the considered opinion of an expert in research methodology and nursing (De Vos et al., 2008:162).

Reliability is the consistent measurement of a concept on a measuring instrument (Burns & Grove, 2007:552). The close involvement of the expert in research methodology and nursing and a biostatistician in the compilation of the measuring instrument ensured that the measuring instrument accurately reflected the concepts it intended to measure (De Vos *et al*., 2008: 162).

1.7.6 Data collection

The questionnaires were distributed by the researcher to the respondents after attendance of an information session, after which time was provided to complete the questionnaire and an information leaflet was also provided especially for those respondents that could not attend an information session. The completion of the questionnaires and submission thereof were conducted in a two week time period.

1.7.7 Data analysis and interpretation

Data was analysed with the assistance of the biostatistician and expressed in frequency tables and histograms. A Microsoft EXCEL spreadsheet was developed by the biostatistician that was used to capture the quantitative data. Qualitative data was captured, examined for completeness and accuracy, after which it was grouped into common themes and quantified. Descriptive statistics were used to describe and summarise the quantitative data (Brink, 2006:171). After statistical analysis inferential statistics were used to make presumptions about the population and significance of the study (Brink, 2006:171).

1.7.8 Ethical consideration

Ethical approval was obtained from the Health Research Ethics Committee at Stellenbosch University and from the Department of Health of the Western Cape.

Participation in the study was voluntary and anonymity and confidentiality were preserved, by only using data for research purposes and not stating the identity of any participant at any stage during the study.

Informed written consent was obtained from all participants by the researcher, after an information session with participants and an information leaflet was distributed to all participants stating the purpose of the study. No risks were foreseen for this study and the researcher was available to answer any queries.

1.7.9 Limitations

Due to time and financial constraints the study was limited to the Paarl district and facilities of the Provincial Administration of the Western Cape. The convenience sample used in the study may not have been representative of all nurses, and may therefore reduce the applicability of the findings.

The self report method of data collection may have the possibility of resulting in a false positive result. A further limitation during data collection was participants' previous experience with research that was conducted in the nursing facilities, which reconstructed their opinions about research. The workload in the different departments attributed to nursing personnel feeling that they do not have the time to complete the questionnaire. With regard to the limitations in the completion of the survey questionnaire there were a lot of questions that were unanswered which is indicated in the discussion of each question. A limitation in the questionnaire was a lack of full definition of each value, as values unknown to respondents could have let to respondents not rating those values, possibly leading to the large amount of missing data.

1.8 CONCEPTUAL FRAMEWORK

The theoretical concept of Leininger on the subject of Culture-Care Diversity and Universality predict that different cultures identify, know and practice care in different ways, but that some similarities about care do occur among cultures (Leininger, 1985b as cited by George 2002:491). The model affirms that values, beliefs and norms are shaped by the world view and cultural and social structures of the group (Tjale & De Villiers, 2004:22).

Leininger conceptualized that seven cultural and social structure dimensions, namely technological factors, religious and philosophical factors, kinship and social factors, political and legal factors, economic factors, educational factors and cultural values and way of life have a great influence on the care delivered (Tjale & De Villiers, 2004:22). According to this model, humans are caring beings that are guided by cultural care values, beliefs and practices of the specific culture which function as basis for nursing care (George, 2002:494).

The theorists Paterson and Zderad (George, 2002:387), conceptualized in their humanistic nursing theory that nursing is focused on a nurturing response of the nurse to a client in time of need and is directed towards the development of well-being of the client. In delivering this nurturing care the nurses need to know their values, biases, myths and expectations that contribute to the level of nursing care they deliver (George, 2002:386).

1.9 OPERATIONAL DEFINITIONS

- **Auxiliary nurse** –"is a person registered as such in terms of section 31 of the Nursing Act and educated to provide elementary nursing care in the manner and to the level prescribed" (Act No. 33 of 2005);

- **Nursing** - "caring profession which supports, cares for and treats a health care user to achieve or maintain health and where this is not possible, cares for a health care user so that he or she lives comfortably and with dignity until death" (Act No. 33 of 2005);

- **Professional nurse** - "is a person registered as such in terms of section 31 of the Nursing Act and is qualified and competent to practice comprehensive nursing independently in the manner and to the level as prescribed and who is capable of assuming responsibility and accountability for that practice" (Act No. 33 of 2005);

- **Staff nurse** - "is a person registered as such in terms of section 31 of the Nursing Act and educated to practice basic nursing in the manner and to the level prescribed" (Act No. 33 of 2005).

- **Value** - "a position taken and expressed through conduct, feelings, imagination and knowledge and is linked to a person's identity and way of life" (Pera & Van Tonder, 2005:8).

1.10 TIMELINE

April 2009	Completion of a Literature Study
July 2009	Submission of the Research Proposal (first draft)
October 2009	Submission of the Research Proposal (second draft)
April 2010	Submission of the Proposal for ethical approval
May 2010	Receiving consent from Health Research Ethics Committee of Stellenbosch University
July 2010	Submission of Proposal to the Western Cape Department of Health Ethics Committee

December 2010	Receiving consent to undertake the study from the Western Cape Department of Health Ethics Committee
December 2010	Completion of the pilot study
December 2010	Information session at the facility and collection of the data
October 2011	Data analysis and completion of chapter 1, 2, 3, 4 and 5
November 2011	Editing of language and technical layout
December 2011	Completion of thesis and submission at the University of Stellenbosch
February 2012	Revision and corrections
February 2012	Presentation of thesis for examination
March 2012	Graduation ceremony

(Mouton 2001:199).

1.11 STUDY LAYOUT

Chapter 1:

This chapter provided a scientific foundation of the study, by briefly focussing on the rationale for the research, the aim and objectives of the research. The research design and methodology were introduced. Concepts were clarified and the ethical considerations were discussed.

Chapter 2:

Chapter 2 provides an outline of the relevant research and literature on values and applicable topics. The theoretical framework for the study and the relevance to the research problem, are discussed.

Chapter 3:

In this chapter the research methodology applied in the study is described and discussed, including the research design, population, sampling and data analysis.

Chapter 4:

The results are presented, analysed and interpreted in Chapter 4. The results are presented in the format of frequency tables and histograms.

Chapter 5:

In this chapter conclusions and recommendations are discussed based on the scientific evidence gained by the study.

1.12 CONCLUSION

Nurses enter the nursing profession primarily due to the value of altruism, yet the nursing profession is portrayed in the press as lacking in this value and is shown to be more focused on the financial incentives, career opportunities and career stability. Values are linked to culture. South Africa is a country with nine provinces, with nursing forming a subculture of South Africa. These nurses come from different culture groups, ethnic groups, ages and genders. This study's aim was to do an in-depth study into the factors influencing nursing values of nurses working at nursing facilities in the Paarl district. A quantitative approach and descriptive design were applied and from the three categories of nurses working at these facilities a convenience sample was selected to complete the survey questionnaire. The purpose of the study was to identify the core nursing values of the nurses working in these nursing facilities, to determine the factors influencing these nursing values and to determine how these factors which influence the nursing values ultimately affect the nursing care of the patient. Following on this is the literature study guiding the research by focussing on the global factors influencing nursing values. The nursing values, with reference to the possible effect of education, work experience and culture, and the Culture Care and Diversity Model of Leininger including the Humanistic Nursing Model of Paterson and Zderad will be discussed as the conceptual framework.

CHAPTER 2: LITERATURE STUDY

2.1 INTRODUCTION

A value-framework is an essential human reality, it directs the priorities individuals live by and outlines an individual's world view (McNeese-Smith & Crook, 2003:260). A detailed definition of values state that a value is "a position taken and expressed through conduct, feelings, imagination and knowledge and is linked to a person's identity and way of life" (Pera & Van Tonder, 2005:8). Values do not only influence all decisions made and all actions expressed, but lie at the core of the diversity of human behaviour (Rassin, 2008:614). Each individual's thoughts, feelings, actions and perceptions are determined by the well-known values a person holds and determine what a person attaches value to (Mohr, Deatrick, Richmond & Mahon, 2001:31). In the nursing profession nurses are confronted with ethical, moral and legal matters daily where the values they cherish provide for the necessary guidance in decision making (Neumann & Forsyth, 2008:248).

As early as the nineteenth century Florence Nightingale established that this value-laden profession could not only be concerned with scientific knowledge and technical skills, but are directed by specific human values (Rassin, 2008:614). Pera and Van Tonder (2005:7), in agreement with Florence Nightingale, believe that the primary goal of the nursing profession is the provision of optimal care for every client, but for the provision of professional nursing care nursing practitioners need to know what they believe in and be conscious of their values (Pera & Van Tonder, 2005:7).

Ideals and beliefs of an individual and group are upheld by values and values provide an outline of reference to a basic understanding of reality through which people integrate, clarify and evaluate new ideas, events and personal relationships (Altun, 2002:270; Tjale & De Villiers, 2004:50). Acquiring values is a process of "moralizing, modelling, reward and punishment, explanation, manipulation, enculturation and life experiences" (Tjale & De Villiers 2004:50). The values a person attain are learned and developed in early life, through influences by caregivers and the family, as well as through growing up and further development, formal learning, peer experiences and societal institutions (Pera & Van Tonder, 2005:8).

Furthermore, in this chapter the researcher will discuss nursing in the South African context, the value of motivation and the current nursing era. Nursing values, with reference to the possible

effect of education, work experience and culture will be described; and the Culture Care and Diversity Model of Leininger including the Humanistic Nursing Model of Paterson and Zderad will be discussed as the conceptual framework.

2.2 NURSING ERA

Through the evolution of the nursing profession a unique contribution was made to the health care system (Mellish & Paton, 1999:3). This historic development of nursing was moulded by environmental-, demographic-, socio-cultural and socio-political factors and progressed with the development in science and technology (Mellish & Paton, 1999:15). Nursing has developed from a profession dominated by religion to nursing characterized by well-educated, free-thinking nurses from both genders, from any cultural background and with the ability to adapt to provide in the care needed (Mellish & Paton, 1999:46). In the early days nursing in South Africa corresponded with being powerless due to the influence of race, social class and gender and fulfilling the role of a servant (Jooste, 2010:6). Yet through the years nurses provided leadership not only in nursing, but also in the bigger health sector (Jooste, 2010:6). Nursing is in an era where nurses are educated, well represented and empowered to make well thought through choices, which make contributions to the health sector, the nation and even globally; consequently there is a need to establish the values that guide the modern era nurse.

The primary motivator for persons entering the nursing career is assumed to be the value of altruism (Shaw and Degazon, 2008:45). This altruistic view is characterized by values such as "commitment, compassion, generosity, perseverance, benevolence and sympathy" (Altun, 2002:271). However, evidence by Shaw and Degazon (2008:45) revealed a picture of nurses in the modern era who is attracted to nursing due to “the financial incentives and the career mobility and stability”. In recent years this noble profession has been targeted by bad press suggestive of how patients are neglected by nurses, how they are being turned away from health institutions by nurses and most importantly, the poor nursing care given by nurses, which all show a lack in altruism (Schroeder, 24 April 2009:6; Sidumo, 24 April 2009:3). This occurrence is also evident in the growth in the number of professional misconduct cases investigated by SANC in the recent years (SANC 2008). These trends show a lack in the core of caring, which is the driving force of nursing.

2.3 NURSING IN THE SOUTH AFRICAN CONTEXT

South Africa is a multicultural country with an estimated population of 48 687 000 residents (Statistics South Africa, 2008:3). Within the nine provinces of South Africa resides various

culture groups, each with a different set of values deeply embedded in culture (Tjale and De Villiers, 2004: 48). Culture is defined as the values, beliefs, norms and customs that are acquired and shared by a group of people, which guide the members in their thinking, decision making and actions, consequently values form the essence of any culture (Pera & Van Tonder, 2005:167).

Nursing forms a subculture of the South African population with an estimated population of 212 806 nurses who come from different culture groups, ethnic groups, age and gender (SANC, 2008b: 2; Shaw and Degazon, 2008:44). These differences in nursing are evident in statistics from the South African Nursing Council (SANC) stating that 92.5% of the South African nursing workforce are female (SANC, 2009b). SANC also reveals that the significant age differences that occur in the nursing profession are presenting an older workforce with a mere 24% of professional nurses being younger than 40 years of age (SANC, 2009a).

Nursing in South Africa is defined as a "caring profession which supports, cares for and treats a health care user to achieve or maintain health and where this is not possible, cares for a health care user so that he or she lives comfortably and with dignity until death" (Act No. 33 of 2005). The focus of the South African health system is to deliver quality health care in a caring environment, by applying the values of courtesy, respect and dignity (Department of Health, 1997b; Department of Public Service and Administration, 1997b).

The history of nursing in South African greatly focuses on division according to race, class and gender (Marks, 1994: 1). This history display a female dominance in nursing, however history also prevails inequality towards nurses with regard to legal system, wages, access to positions of power and authority (Marks, 1994: 3). This phenomena reflected dominance and subordination between nurses and doctors, as a result of inequality between men and woman, it lead to male dominance in medicine. This resulted in doctors receiving higher social status and economic power (Marks, 1994: 4). The struggle for autonomy and social and economical recognition by nursing against the predominant male medical profession resulted in professionalisation of nursing (Marks, 1994: 4; Rispel & Schneider, 1991: 2). Professionalisation is the process by which an occupation comes to achieve particular traits such as education that is intellectually specialised and the training is institutionalised and licensing for practice is needed, the establishment of a professional association and the demand for full autonomy of work (Rispel & Schneider, 1991: 1). The process of professionalisation of nursing in South Africa was marked by the first nursing training courses being established by Sister Henrietta

Stockdale at the Kimberly Hospital in 1877 (Rispel & Schneider, 1991: 6). This was followed by Henrietta Stockdale greatly contributing to South Africa becoming the first country in the world to grant state registration to trained nurses in 1891, with the establishment of the South African Medical Council (SAMC) (Mellish & Paton, 1999: 31; Rispel & Schneider, 1991: 6). In 1944 statutory control of nursing were gained with the control being placed in the South African Nursing Council (SANC), which function as controlling and disciplinary body in nursing (Rispel & Schneider, 1991: 13). "SANC regulates nursing training, scope of practice of all nurses and standards of nursing care" (Rispel & Schneider, 1991: 13).

Apart from gender inequality class division in nursing was evident since the earliest days of nursing, with the origin in a distinction that was made between the first trained nurses in South Africa, being English "lady nurses" drawn from the Anglican Sisterhood, and paid nurses, from the working class (Marks, 1994: 6). This led to "lady nurses" fulfilling a supervisory role and paid nurses fulfilling the cleaning and servant role (Marks, 1994: 6). This class division however soon led to racial and ethnic distinction, resulting in racial division (Marks, 1994: 7). The nursing profession was influenced greatly by the political and social pressure in the country; this was especially prominent during the apartheid era (Marks, 1994: 16). After 1948 the amount of African nurses increased drastically, this was the time under apartheid that the nursing profession was most effectively legally segregated (Marks, 1994: 9). The segregation led to policy indicating that no other race group can provide nursing care to white patients, however by the 1950's urbanisation and industrialisation of the black population has intensified dramatically, resulting in urgency in the provision of health care in major urban centres, consequently placing a demand on the number of black nurses (Marks, 1994: 10). Even though the nursing profession was dominated by the black, coloured and Indian nurses, the nursing fraternity was marked by decision making, policy making and appointment of persons of power and authority being placed on the white nursing population (Marks, 1994: 14). This picture however started to change by the late 1970's with black nurses playing a crucial element in the strategy of the black trade union movement, due to the collapse of apartheid in nursing (Marks, 1994: 164). The history of modern nursing is highlighted by the drive by nurses to achieve social and economic recognition as educated, professional women of all races (Marks, 1994: 167).

Marks (1994) seminal work on race, class and gender in the South African Nursing profession undoubtedly provides food for thought regarding the development and growth of the Nursing profession in South Africa. This also highlights the possible influence of these variables on nursing care and consequently nursing values, identifying exciting prospective for research

studies. However, in this study the researcher's primary focus was current and contemporary factors affecting the values of the nursing fraternity. In hindsight it is also evident that the target population did not comprise of enough men and proper representation of the different racial groups to structure the research around gender and racial group.

2.4 NURSING VALUES

The diverse representation of the nursing workforce represents differences in culture, race, age, ethnicity, gender, national origin and lifestyle (Shaw and Degazon, 2008:44). Within this representation a variety of personal and professional values exist, which form the basis for the study. Values form a very important part of nursing as most nursing values are obtained from the desire of the nurse to care for others and determine the actions and performance of the nurse (Jooste, 2010:22).

Utilizing the conceptual frameworks, the application of the different literary theories and empirical research, the focus of the study will be towards reaching the objectives to

- determine the main reason for entering the nursing profession for nurses working in these facilities
- identify the most important part of nursing practice for nurses working in these facilities
- identify the core nursing values of the nurses working in these facilities
- determine the factors influencing nursing values
- determine the factors influencing the nursing care of the patient.

The International Council of Nurses considers the provision of safe and competent nursing care to be the core professional value (International Council of Nurses, 2000). The main values identified in these areas and discussed in the code of ethics are: confidentiality, responsibility, accountability, maintaining of standards of personal conduct, safety, dignity, the rights of people and a co-operative relationship with co-workers (International Council of Nurses, 2000). The overarching values identified by the Provincial Government of the Western Cape are caring, competence, accountability, integrity and responsiveness (Western Cape Government, 2011).

Contrary to this, some researchers found other values to be fundamental in nursing. Shaw and Degazon (2008:45), conceptualize that the values of altruism, human dignity, social justice, truth, autonomy and integrity are elemental. Altun (2002:271) agrees with Shaw and Degazon

(2008:45) on the importance of altruism, human dignity and social justice, but include aesthetics, equality, freedom and truth as essential values for nurses. Fagermoen (1997:438) revealed that the values were all linked to the most important value, namely human dignity. Other values were identified, namely autonomy, value of personhood, reciprocal trust, integrity, security, privacy, general humanity and hope (Fagermoen, 1997:438). These values can be defined as follows:

- **Confidentiality** can be described as "the nondisclosure of information except to another authorized person" (Mosby's medical, nursing, & allied health dictionary, 2002:413);

- **Accountability** is described as "being accountable or responsible for the moral and legal requirements of proper patient care" (Mosby's Medical, nursing, & allied health dictionary, 2002:14);

- **Advocacy** is "a process whereby a nurse provides a patient with the information to make certain decisions. A method by which patients, their families, attorneys, health professionals, and citizen groups can work together to develop programs that ensure the availability of high quality health care for a community. Pleading a cause on behalf of another, such as a nurse pleading for better care of a patient" (Mosby's Medical, nursing, & allied health dictionary, 2002:50);

- According to Mosby's medical, nursing, & allied health dictionary (2002:71) **altruism** is "a sense of unconditional concern for the welfare of others. It may be expressed at the level of the individual, group, or the larger social system", "the concern for welfare and well being of others. Shaw & Degazon (2008:45) describe this value as "the expression of selfless concern for others when there is no obvious reward to be gained for oneself, except the belief someone else will benefit or avoid harm". According to Altun (2002:271) altruism is reflected with the qualities of "commitment, compassion, generosity, perseverance, benevolence and sympathy";

- **Compassion** is defined as "pity inclining one to spare or succor" (The English illustrated dictionary, 2005:173);

- Pera & Van Tonder (2005:33) describe **beneficence** as "the prevention of evil or harm and the promotion of good";

- **Non-maleficence** is defined as "intentionally refraining from actions which can cause harm (Beachamp & Childress, 2001:114, as cited by Pera & Van Tonder, 2005:33);

- According to The English illustrated dictionary (2005:410) **humanity** is a "benevolent act";

- **Confidence** is described as a "firm trust; assured expectation" (The English illustrated dictionary, 2005:177);

- The English illustrated dictionary (2005:194) define **courtesy** as a "Courteous behavior or disposition, by favor not by right";

- **Competence** is described as being "adequate, sufficient, properly qualified, ability to do a task" (The English illustrated dictionary, 2005:173);

- The English illustrated dictionary (2005:283) describes **equality** as a "condition of being equal". Altun (2002:271) define this value as "having the same rights and privileges" and that it reflects "fairness and having the same rights, privileges or status";

- **Freedom** is the "liberty of action; power of self-determination; independence of fate or necessity" (The English illustrated dictionary, 2005:332). Altun (2002:271) describes freedom as "the ability to exercise choice or action" and that it involves the qualities of "self-direction, self-discipline, independence and the capacity to exercise choice";

- "Being independent; not depending on the authority of another; autonomous, free" is a description of **independence** according to The English illustrated dictionary (2005:427);

- **Integrity** "refers to nurses acting in accordance with an appropriate code of ethics and accepted standards of practice" (Shaw & Degazon, 2008:45);

- The English illustrated dictionary (2005:403) describe **honesty** as "being fair and upright in speech and act, not lying, cheating, or stealing";

- **Privacy** is described as "being withdrawn from society or public interest; avoidance of publicity" (The English illustrated dictionary, 2005:671). Rassin (2008:620) describe that "a patient's privacy must be maintained and he or she should not be exposed beyond what is necessary for treatment";

- Pera & Van Tonder (2005:54) define **responsibility** as "the allocation and acceptance of an instruction where everyone involved knows who does what";

- **Safety** is defined as "freedom from danger or risks, being sure to bring no danger" by The English illustrated dictionary (2005:745);

- **Security** is described as "reliability, certainty not to fail or give way" (The English illustrated dictionary, 2005:770);

- **Human dignity** can be described as "the inherent worth of an individual" (Altun, 2002:271), it entails "awareness of a patient's values and beliefs and to honor them (Rassin, 2008:620);

- Shaw & Degazon (2008:45) describe **social justice** as the "upholding moral, legal and humanistic principles. It serves as the underpinning for how decisions are made in terms of the equitable distribution and allocation of health care services and resources such as education and having a safe workplace";

- **Trustworthiness** is described as being "worthy of trust" (The English illustrated dictionary, 2005:914), the English illustrated dictionary (2005:914) describe trust as "confidence in, reliance on, some quality of person, or truth of statement";

- The English illustrated dictionary (2005:914) describes **truth** as "the state of being true, loyalty, honesty, accuracy". Altun (2002:271) describe this value as "faithfulness to fact or reality" and involves attitudes like "knowledge, realism, curiosity, rationality, inquisitiveness, responsibility and self-confidence";

- **Excellence** is described as "surpassing merit, thing in which person excels" (The English illustrated dictionary, 2005:290). Rassin (2008:620) describes excellence as "nurses initiating activities that establish and promote the profession and will contribute beyond the call of duty; they must take responsibility within their professional accountability and behave as role models to all colleagues";

- **Autonomy** is described as the "right of self-government, freedom of the will" (The English illustrated dictionary, 2005:50). Rassin (2008:620) identifies by giving a patient autonomy "a patient has the right to receive information related to his or her diagnosis,

treatment and prognosis, taking into account his or her desire and ability to understand this information";

- **Fairness** is defined as "in a fair manner" and "show promise of doing" (The English illustrated dictionary, 2005:298);

According to Mellish and Paton (2003:122), values can be divided into professional values and social values. Professional values are greatly influenced by the local and international professional bodies (Mellish & Paton, 2003:122). Social values are influenced by the Human Rights Charter, universal ethical principles and the legal framework of the country, but are also elemental to ethical conduct (Mellish & Paton 2003:122). Ethical decision making is a vital part of ethical conduct of a nurse and is influenced by the legal framework common law principles, human rights charter and the country and professional Acts and Regulations (Mellish & Paton 2003:123). Individual values are concerned with personal beliefs about what is the right thing to do in a situation (Mellish & Paton 2003:123). Rassin (2008:614) identified that the most prominent professional values are human dignity, equality among patients and prevention of suffering. It was identified that honesty, responsibility and intelligence were rated as the most significant personal values (Rassin, 2008:626).

Values are organized into a system that ads meaning to an individual's life, this system of values can arise from needs or wants and originates from a person's culture, family, peer group or work education (Fry & Johnstone, 2008:6). Understanding values aids in understanding the purpose of life and form the basis of ethical judgment (Brown, 2003:58). Brown (2003:58) conceptualizes that values function as guiding principles for individuals and the organization; therefore it is necessary to understand the values that govern the practice of each nurse, facility and organization.

2.4.1 Values and education

Professional values are learned from formal education and informal observation of nursing practice during clinical placement (Fry & Johnstone, 2008:10). Values are learned in the affective domain, together with attitudes, beliefs, feelings and emotions, and rely on the educator's creativity to stimulate those elements if it is taught in the formal sense. The process of teaching in the affective domain is more complex than teaching in the cognitive or psychomotor domains and consequently gets neglected frequently (Neumann and Forsyth,

2008:248). This form of education is especially important in pre-graduate courses with students who have not been working and socializing in nursing.

Neumann and Forsyth (2008:248) cite Van Valkenburg and Holden (2004), by stating that "values in health care are often caught, not taught". Shaw and Degazon (2008:44) contemplate that to unite students and nursing in a collective culture it is of utmost importance to bridge the difference among nurses by a professionalization process in learning to integrate core nursing values in the nursing curriculum. Neumann and Forsyth (2008:248), describe strategies for teaching in the affective domain and the positive effect it has on teaching core nursing values, which is by focusing on the needs of the group and flexibility while teaching or facilitating.

Mc Neese-Smith and Crook (2003:265) identified that nurses with a bachelor's degree had significant higher ratings than associated-degree nurses with regard to the value of aesthetics. Rassin (2008:624) disagrees with Mc Neese-Smith and Crook when acknowledging that aesthetics received the lowest rating from academic nurses. It was identified that non-graduate degree nurses rated the values altruism, association, economic returns, security, supervisory relations and surrounding higher than nurses with a masters qualification (Mc Neese-Smith & Crook 2003:265).

2.4.2 Values and culture

Cultural values are beliefs learned in the culture about what is believed to be good or bad (Frisch and Frisch, 2002:115). Within any specific society there are fixed rules for making choices in order to reduce uncertainty and conflict, these indicate which behaviours are important and what to avoid, and therefore are the values of that specific culture (Tjale and De Villiers, 2004:120). Mc Neese-Smith and Crook (2003:266) and Rassin (2008:615), found that differences occur in values between persons from different cultures.

The cultural values function in combination with the belief systems and are important and significant to the existence and experience of the group (Fry & Johnstone, 2008:7). Every culture has its own ethical system with a set of values which was produced by the specific culture and the history of the culture (Fry & Johnstone, 2008:7). Differing cultures influence "attitudes, beliefs, caring practices, decision making and the behaviour of the individual in the healthcare context" (Fry & Johnstone, 2008:7). Rassin (2008:618) recognized that nurses who originate from Israel rated family security, happiness, excellence and salvation, higher than nurses born in the Soviet Union. The nurses from the Soviet Union rated accomplishment,

social recognition and politeness high (Rassin, 2008:618). Mc Neese-Smith and Crook (2003:265) identified significant higher scores in the values of associates, creativity, aesthetics, management, prestige, security and surroundings in Filipino nurses than Caucasians.

There are two global cultures world-wide, namely collectivistic cultures (with loyalties of the individual to a group such as the family, which can outweigh individual rights) and an individualist cultures (the rights of the individual are central and must be balanced with notions of the common good) (Davis, 1999:123). Flynn and Aiken (2002:68) cite Hofsede (1997) and say that a classification system with nurse immigration data indicates that over 74% of international nursing graduates, which form the majority of international nurse graduates, originate from collectivistic cultures. With South Africa having a multicultural society the cultural value structure differs greatly, therefore there is a need to determine the influence of the cultural value structure on the nursing value structure of the different population groups of South Africa.

2.4.3 Values and work experience

Nursing values can be taught, but are only really internalized during the practice of nursing (Jooste 2010:22). There is an essential difference between the theoretical acquirement of a value and its implementation, which is influenced by the level of experience of the nurse and the full execution of a value actually only starts after the individual has had some experience in nursing (Rassin, 2008:627).

Rassin (2008:627) found that the length of work experience has an effect on human dignity as a value and the value of privacy. Nurses with a maximum of two years working experience rated dignity lower than nurses with additional experience, while the group with additional experience rated privacy lower than the nurse with a maximum of two years experience (Rassin 2008:627). Rassin (2008:627) attributes this phenomenon to the inability to internalize the value of human dignity, because human dignity is a complex value, which includes privacy; therefore only part of the internalization process takes place and leads to a high rating of privacy in a person with less experience. Mc Neese-Smith and Crook (2003:266), revealed that entry level nurses place higher value on economic returns than persons with greater experience and that experienced nurses showed lower value for altruism than entry level nurses.

2.5 CARING AND NURSING VALUES

Health care has an immense influence on the lives of persons and nations (Searle, Human & Mogotlane, 2009:266). Nurses make up a great amount of health care workers of a country and

the nature of nursing is nursing deeds delivered in a caring manner. Caring entails commitment to beneficence and compassion and is a collective nursing trend (Jooste, 2010:6). In recent years health care has become more complex, with the changing disease profile of patients, complexity of modern medicine, advancement in technology, high priority of nursing administration and social changes occurring (Corbin, 2008:164; Searle, Human & Mogotlane, 2009:319). In this elevation of complexity the responsibility of each nursing practitioner is to ensure patients still receive a good level of care.

The caring ethic encompasses a nurturing and empathetic view, with emphasis on helping, commitment and involvement (Jooste, 2010:6). The caring act is directed towards the safeguarding of the health and wellbeing of patients (Fry & Johnstone, 2008:45). This caring relationship is extended beyond the patient and should also include the family and the community of the individual (Mulaudzi, Mokoena & Troskie, 2000:1).

The characteristic of care is the beneficent attention to a person other than the self (Cortis & Kendrick, 2003:78). Although caring is a human trait, it lies at the heart of nursing and provides in essence this beneficent attention to the individual person, by having a distinct attitude, technique and competency that conveys the act of caring (Cortis & Kendrick, 2003:78). This caring ethic in nursing goes beyond the human triad of caring manifesting in a feeling of sympathy; it entails the feeling of responsibility for the patient's needs, concerns and existence (Kong, 2008:208).

The values of a person determine every action executed and has an influence on decisions, and consequently also determine the care a person delivers (Mulaudzi, Mokoena & Troskie, 2000:1). Nursing care is patient-directed and is driven by the values of the carer and form the basis of nursing in South Africa. It is evident that there is a lack of literature devoted to the identification of the values applied to care for a patient and that the lack thereof influences the essence of the nursing core in providing nursing care. Nursing in the South African context, can be viewed as a caring profession (Act No. 33 of 2005) and with values expressed in all decisions made and in all actions (Pera & Van Tonder, 2005:8; Rassin, 2008:614) the effect of these cultural and social structure dimensions on values are however questioned.

2.6 MOTIVATION

Franco, Bennett and Kanfer (2002:1256) are of the opinion that resource availability and the competency of workers are not the only factor ensuring good performance and thus nursing

care, but are also greatly influenced by the motivational level of workers. Motivation is one of the main components to ensure effective work being delivered (Jooste, 2010:200). Franco et al., (2002:1255) agree and state that the performance of the health sector critically depends on the motivational level of the healthcare workers. This motivation is determined by different conditions, namely extrinsic conditions, for example financial incentives and intrinsic responses, for example personal growth (Jooste, 2003:56). To enhance the motivational level of health care workers various strategies should be included, such as economical-, psychological-, organisational developmental-, human resource management- and sociological strategies (Franco et al., 2002:1256).

Abraham Maslow developed a hierarchy of needs model, applicable to all human beings, in which the low-level needs, such as physiological and safety needs first needs to be satisfied before higher-level needs, such as self-fulfilment can be achieved. The first level on this hierarchy recount for physiological needs focuses on the sustainment of life. The following level is that of safety and security needs, with a focus on the need to be free from physical threats and emotional harm. Level three needs are focused on the social needs and relates to meaningful interaction with other people. The need for "belonging" is the fourth level of needs and only once that need is fulfilled the fifth level is reached. The person reaches full potential once the need for self-actualization is reached. (Booysen et al., 2004:107).

Frederick Herzberg has greatly influenced the way motivation at the workplace is viewed (Training and development solution, 2001 – 2011). The theory of motivation by Herzberg explains individual motivation by identifying employees' needs, determining what satisfies their needs and by establishing what measures they pursue to fulfil their needs. Herzberg's theory of motivation divides factors of motivation into two categories, namely the hygiene factors and motivation factors. The theory is based on the idea that "hygiene factors can de-motivate or cause dissatisfaction if they are not present, but do not very often create satisfaction when they are present; however, motivation factors do motivate or create satisfaction and are rarely the cause of dissatisfaction". (Training and development solution, 2001 – 2011).

This two factor content theory by Herzberg may be listed in order of importance as follows:

Hygiene factors leading to dissatisfaction are the following:

- Company Policy
- Supervision

- Relationship with employer
- Work conditions
- Salary
- Relationship with peers (Training and development solution, 2001 – 2011).

Motivation factors leading to satisfaction are the following:

- Achievement
- Recognition
- The work itself
- Responsibility
- Advancement
- Growth (Training and development solution, 2001 – 2011).

To create true satisfaction in employees with regard to their work both types of needs require to be fulfilled. When the hygiene factors have been satisfied providing more of them will not create further motivation but not satisfying them may cause de-motivation; however, when management does not fulfil all the motivation factors of the employees they may still feel motivated. (Training and development solution, 2001 – 2011).

The Department of Public Service implemented a strategy aimed at achieving "individual excellence and achievement" by introducing the Employee performance management and development system (EPMDS) (Department of Public Service, 2007). EPMDS was introduced with the aim to plan, manage and improve the employees' performance to ensure the overall performance and service delivery of Government Departments, which is also aimed at improving the motivation of employees. The implemented EPMDS program was called the Staff Performance Management System (SPMS) (Department of Public Service and Administration, 2007).

Motivated people tend to be more productive than those people that are not motivated (Tappen 2001:32 as cited by Jooste, 2003: 57). The productivity and affectivity of nursing will undeniably influence the level of care being delivered. In the quest to render service of a high standard and quality it requires to establish whether the level of motivation of nurses is significantly influenced by EPMDS and the effect this level of motivation has on the values of the individual nurse.

Shortage of personnel and insufficient salaries have been shown to have a negative influence on nursing and nursing care, as this has a great influence on the motivation and morale of workers (Newhouse, 2005: 354). In recent years the Health Sector and Nursing profession were confronted by a vast brain drain, losing valued nursing and skilled nurses to other countries, due to insufficient salary levels and basic conditions of service. In response to this phenomenon the Public Service introduced Occupation Specific Dispensation (OSD) for nursing in 2007 with the main aim to improve the salaries and conditions of service to ensure the attraction and retainment of skilled employees (Public Service Co-ordinating Bargaining Council, 2007:3). OSD brought about salary adjustment in accordance to speciality and re-calculation of experience, based on the years of experience and aspired to ensure "fair, equitable and competitive remuneration structures for all categories of employees" (Department of Health, 2007). However, what is seen in the Nursing facilities conveys a message of nursing personnel still feeling neglected and underappreciated, resulting in low morale and demotivation. There is a need to establish if OSD significantly contributed to motivating nursing personnel to ensure proper nursing care in comparison to the value system.

2.7 CONCEPTUAL FRAMEWORK

Burns and Grove (2007:171) identified that every quantitative research needs a framework to guide the study. The conceptual framework is a brief description of a theory, including those portions of the theory that will be applied or tested in the study (Burns & Grove, 2007:171). A combination of the theory of culture care diversity and universality by Leininger and the humanistic nursing practice model by Paterson and Zderad were applied in this study as conceptual framework due to their focus on care and the influence of values on the nursing care delivered.

Leininger constructed the Theory of Culture Care Diversity and Universality, which identifies the importance of caring in nursing. His theory conceptualizes that care is the essence of nursing and is determined by culture (George, 2002:490; Tjale & De Villiers, 2004:22). This theory predicts that different culture groups identify, know and practice care in different ways, but that some similarities about care do occur amongst cultures (Leiniger, 1985b as cited by George, 2002:491). Leininger indicates the similarities between cultures as universalities and the differences between cultures as diversities (George, 2002:491).

This theory by Leininger conceptualizes that seven cultural and social structure dimensions have a great influence on the care delivered (Tjale & De Villiers, 2004:22). These cultural and

social structure dimensions includes technological factors, religious and philosophical factors, kinship and social factors, political and legal factors, economic factors, educational factors and cultural values and way of life (Tjale & De Villiers, 2004:22). Culture is perceived by Leininger as "learned, shared, and transmitted knowledge of values, beliefs, norms and life ways of a particular group that guides an individual or group in their thinking, decisions, and actions in patterned ways" (Leininger, 1995, as cited by George, 2002: 491).

According to this theory humans are caring beings that are guided by cultural core values, beliefs and practices of the specific culture which function as basis for nursing care (George, 2002:494). Leininger places importance on the values of the nurse as an important part of determining the care delivered in the practice of nursing. This theory establishes that values, beliefs and norms are shaped by the "world view, language, religion, social, political, educational, economical, technological, ethnohistorical and environmental context" of the group. (George, 2002: 491, Tjale & De Villiers, 2004: 22).

Similar to Leininger, the theorists Paterson and Zderad theorized that values play a fundamental role in the level of care delivered in nursing. Paterson and Zderad conceptualize the humanistic nursing practice model which was developed from the experiences of both nurses and patients focusing on the influence of the concept of relationships in nursing (George, 2002:386). The humanistic nursing theory emphasizes that nursing is focused on a nurturing response of the nurse to a client in time of need and is directed towards the development of well-being of the client (George, 2002:387). This theory focuses on the aspect that in delivering this nurturing care the nurses need to know their values, biases, myths and expectations that contribute to the level of nursing they deliver (George, 2002: 386).

Humanistic nursing focuses on the dialogue, community and phenomenological science of nursing (George, 2002: 558). Dialogue is characterized by the interaction between humans, the meeting of people, relations between humans and sharing between individuals (George, 2002: 558). In a community there is a collaborative feeling of belonging (George, 2002:558). Phenomenologic nursology is the preparation of nurses to know each other, having an intuitive response to each other, learning about individuals through science, synthesizing information through using information already known about the individual, and development of a personal and general truth (George, 2002:558). This highlights the focus of humanistic nursing that identifies that nursing occurs in the context of relationship (George, 2002:387). All of these happen in a nurturing environment, by being open and caring (George, 2002:391).

There is a focus by both the theory of culture care diversity and universality, and the humanistic nursing practice model on the care delivered by nurses, thus coinciding with the definition of nursing in South Africa viewing nursing as a caring profession (Act No. 33 of 2005). With Leininger identifying the important role of caring in nursing and conceptualizing that care is the essence of nursing and the humanistic nursing theory emphasizing that nursing is focused on a nurturing response of the nurse to a client in time of need; as combination this formulates the essence of what nursing care in South Africa encompasses. The definition of nursing in South Africa emphasizes the necessity of nurses that “care for and treat a health care user to achieve or maintain health and where this is not possible, care for a health care user so that he or she lives comfortably and with dignity until death" (Act No. 33 of 2005).This sentiment is supported by the humanistic nursing practice model.

The focus of this study is directed by Leininger arguing that values, beliefs and norms are shaped by the “world view, language, religion, social, political, educational, economical, technological, ethnohistorical and environmental context” of the group (George, 2002:491, Tjale & De Villiers, 2004:22). With the humanistic nursing practice model indicating the importance of the nurses’ knowledge of their values, biases, myths and expectations and the strong direction thereof towards the human interaction which is an important part of nursing practice, it guides this study’s focus on the human interaction by nurses (George, 2002:386).

2.8 CONCLUSION

Nursing is practiced in South Africa in the context of caring by nurses from different culture groups, ethnic groups, age and gender. Values form an integral part of every individual's life, which is "linked to a person's identity and way of life" (Pera and Van Tonder, 2005:8). Thoughts, feelings, actions and perceptions are determined by the well-known values a person holds and determine what a person attaches value to (Mohr, Deatrick, Richmond and Mahon, 2001:31). The importance of grasping the factors influencing the value structure of nurses was discussed, viewing the narratives of different authors. Researchers identified different values as fundamental and important to nursing, some similarities consist, but significant differences do occur. Through the literature a number of factors influencing nursing values were identified, those identified by significant research were education, culture and work experience. The link between values and caring and motivation were investigated.

In the following chapter the research methodology and –design applied in the study are addressed.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research methodology is defined as the methods, techniques and procedures that are utilized in the quest to implement the research design or research plan (Babbie, Mouton, Vorster & Prozesky, 2006:647). In this chapter the purpose, objectives, research question, the research design, population and sampling, criteria for the study, the questionnaire utilized to collect the data, validity, reliability, pilot study and ethical considerations of the study are described.

3.2 AIM

The aim of the study was to do an in-depth study into the factors influencing the nursing values of nurses working in Nursing Facilities in the Paarl district who are employed by the Provincial Administration of the Western Cape, in the West Coast Winelands Region of the Western Cape.

3.3 RESEARCH QUESTION

The research question that guided this study was: "What factors influence the nursing values of nurses working in nursing facilities in the Paarl district, in the West Coast Winelands Region of the Western Cape?"

3.4 OBJECTIVES

The objectives for the study were to

- determine the main reason for entering the nursing profession for nurses working in these facilities
- identify the most important part of nursing practice for nurses working in these facilities
- identify the core nursing values of the nurses working in these facilities
- determine the factors influencing nursing values
- determine the factors influencing the nursing care of the patient.

3.5 RESEARCH DESIGN

Burns & Grove (2007:237), define research design as the blueprint for the conducting of research. Burns & Grove (2007:237), also state that designs are developed to reduce bias in a study and are the overall plan for conducting the study in order to answer the research question.

A quantitative research design using a descriptive, explorative survey was conducted at Provincial Administration of the Western Cape nursing facilities in the Paarl district to explore and identify the factors influencing nursing values. Quantitative research is "a formal, objective, systematic process in which numerical data is used to obtain information about a variable" (Burns & Grove, 2007:551). De Vos, Strydom, Fouché and Delport (2008:74) identify quantitative research as making inquiries into social or human problems, testing theories composed of variables, and using numbers and statistical analysis to determine the level of truth in the theory. De Vos et al., (2008:75) indicate that this form of research ensures that data collection is standardized and collected in a systematic format.

According to Burns and Grove (2001:39) quantitative research has the following characteristics:

- it makes use of deductive reasoning
- the meaning is given by the researcher who interprets the quantitative research results and thus uses ethical perspectives
- answers the research question that has been stated for the research
- to ensure an accurate reflection of reality, the topic under study is controlled, this reduces error and enhances the reliability and validity of the research results
- data is presented in figures that make quantifying easy
- a standardized procedure is followed during data analysis
- the sample is usually representative of the population.

3.6 POPULATION AND SAMPLING

A population can be defined as “the entire collection of people” (Maltby, Day & Williams, 2007:285). According to Burns and Grove (2007:324), the population could also be called the target population and includes all people that meet the sampling criteria of the study.

The population of this study included the three categories of nurses working at Paarl Hospital, Sonstraal Hospital and also the District Nursing facilities all situated in the Paarl district, with a total population of 470 nurses (N=470). The nursing population of Paarl Hospital consisted of 298 participants (n=298), namely registered nurses (n=129), staff nurses (n=79) and auxiliary nurses (n=90). The nurses from Sonstraal Hospital consisted of 28 nursing personnel (n=28), namely registered nurses (n=6), staff nurses (n=5) and auxiliary nurses (n=17). The district nursing facilities in the Paarl region include two Community District Centres and seventeen

Clinics, with a total of 144 nursing personnel (n=144) (registered nurses (n=84), staff nurses (n=26) and auxiliary nurses (n=34).

Sampling is the process of selecting participants to a study which is representative of the target population (De Vos, Strydom, Fouché & Delport, 2008: 194). A sample was selected by means of convenience, due to time and financial constraints, as questionnaires were distributed to all nurses working on the days of data collection in the different nursing facilities.

Convenience sampling as defined by Burns and Grove (2007:535), "includes all subjects in the study who happened to be in the right place at the right time". This insured representativeness of all different categories of personnel, all culture groups, both genders and the different age groups represented in the nursing workforce. According to the duty rosters of October and November 2010 the population consisted of 470 nursing personnel (N = 470). All persons on duty on the days of data collection were invited to participate in completing a questionnaire. All persons on annual or sick leave were excluded from the study; this consisted of 43 prospective participants not included due to being on either annual or sick leave. All nursing personnel on duty were invited to participate in the study. However, they had a choice whether to decline or to participate. Questionnaires were distributed to 388 respondents and returned by 235 respondents (n = 235), which meant a 60.56% return rate.

Table 0.1: Summary of questionnaires distributed and questionnaires returned

Nursing facility	Questionnaires Given out:	Questionnaires Returned:
Paarl Hospital	247	170
TC Newman	26	7
Patriot Plein Clinic	5	5
Klein Nederburg Clinic	2	2
JJ du Preez Le Roux	8	8
Dalvale	6	3
Windmeul	5	5
Soetendal	6	4
Klein Drakenstein	7	7
Mbekweni	10	9
Phola Park	7	4
Nieuwedrift	5	5
Simondium	5	3
Sonstraal Hospital	30	3

Wellington Community District Centre	10	0
House Macrone	7	0
Hexberg	2	0
TOTAL	**388**	**235 (60.56%)**

3.6.1 Inclusion criteria

- All nurses permanently employed by the Provincial Administration of the Western Cape, from nursing facilities in the Paarl district were included in the study.

- These nurses represented all nursing departments, namely casualty, theatre, surgery, medical, midwifery, orthopaedic, high care, paediatric department, administration, education and primary health care departments.

3.6.2 Exclusion criteria

The following were criteria for exclusion from the study:

- Nurses currently doing practica at the different nursing facilities as part of an educational course.

- Nurses not permanently appointed by the Provincial Administration of the Western Cape working in any of the Institutions, including agency personnel.

- Nursing personnel on leave during data collection.

3.7 INSTRUMENTATION

Quantitative research utilizes measuring instruments consisting of either questionnaires and checklists or indexes and scales as a data collection method (De Vos et al., 2005:159). A survey questionnaire was compiled by the researcher based on the scientific evidence from a literature study and consultation with the biostatistician to determine the factors which influence nursing values.

Brink (2008:146) regards the questionnaire process as the writing down of a response to a question in a printed document by participants of a study. A well-designed questionnaire is compiled to meet the objectives of a study, correlate the content of the questionnaire, stating the problem guiding the research and the objectives for the study. It should also aim at gaining the most comprehensive response, in a realistic time span and using reasonable resources (Brink,

2008:147). For this study the researcher used a questionnaire to collect data about factors influencing nursing values.

According to Gillham (2000:8) the following are characteristics of a questionnaire:

- they are less expensive and many respondents can be reached within a short period of time
- a lot of information can be gathered within a short time period
- the questionnaire can be completed in the respondents' own time without the pressure of immediate response
- anonymity can be maintained
- questions are standardised, every respondent gets the same questions.

Survey questionnaires can be used with many different research designs, including one with a descriptive design (Burns & Grove, 2009:245). A self-reporting questionnaire was the best method to use in this study as it included the criteria set by Babbie (2007:244), because this research was conducted within a large target population that could not be directly observed when measuring the attitudes of respondents. The researcher distributed the self reporting questionnaire to the target population.

The questionnaire consisted of four sections and was validated by an expert in nursing science, a research methodologist, the biostatistician and the ethical committee. The structure of the questionnaire was based on the conceptual framework and literature study. Due to the nature of language of preference in the different facilities the questionnaire was available in English (Annexure C) and in Afrikaans (Annexure D).

3.7.1 Content of the questionnaire

Burns and Grove (2009:382), depict that the questionnaire is often used in descriptive studies and compile data such as demographic information about the respondents and their attitudes, opinions, knowledge or their intentions. The questionnaire included closed-ended questions, where a response had to be selected from a list of possible responses, and open-ended questions, where respondents could provide personal opinions for questions. Closed-ended questions provide the researcher with the ability to code and analyse responses, and it ensures that respondents can complete more questions in a limited amount of time (Brink, 2008:149).

Brink (2008:149) indicates that open-ended questions provide "richer, more diverse data than can be obtained with the use of closed-ended questions".

The self reporting questionnaire was compiled and distributed by the researcher and consisted of four sections.

Section A includes the biographical data namely:

> Gender, Ethnic group, Religion, Age group, Years of experience of each participant, Highest qualification, Nursing position and their Work area. Participants indicated suitable answers with an *X*. This section collected data for measurement on the nominal scale category. This measurement scale is used for data that can be organized into categories, but the different categories are not comparable and categories must be compiled to ensure that responses only fit one category (Burns & Grove, 2007:363).

Section B was devoted to nursing values. The participants had to identify, on a nominal scale, their main reason for entering the nursing career from a list of possibilities (B1) and if they are still in the nursing profession, for the same reason that they entered the career (B2). In the next question the participants identified the aspect of nursing practice most meaningful to them from a nominal scale of possibilities (B3).

The following variables in this Section were measured on the ordinal scale, where the variables were ranked quantifiably higher or lower in priority (Burns & Grove, 2009:375). A Likert scale was applied where participants had to prioritise the professional values they uphold and which influence their behaviour as a nurse (B4), the values needed for proper nursing care (B5) and the values they apply for ethical decision making (B6). The Likert scale had four options to choose from, namely high priority, priority, little priority and no priority, with numerical values of 1, 2, 3 and 4 awarded to each response, with 1 being awarded to the most negative answer and 4 to the most positive answer. This information was captured on an Excel worksheet. The Likert scale is applicable to this study as it measures the opinion or attitude of participants, but also provide in assigning a numerical value to each scale that ensures quantifying of data (Burns & Grove 2007:388).

In **Section C** the political and legal factors affecting values was evaluated. Questions in this section included the participant's opinion on the justness of employment of nurses (C1) and the equity of the Staff Performance Evaluation System (C2). A nominal scale was applied to this

question in order to test the feelings of respondents about the given question. Brink (2008:141) indicated that it is possible to rate personal feelings on a nominal scale.

Respondents' opinion regarding their knowledge of the acts, regulations and policies affecting their work were assessed by using the interval-scale measurement and using a rating scale (C3). A rating scale can be defined as "scales that list an ordered series of categories of a variable and is assumed to be based on an underlying continuum" (Burns & Grove, 2007: 552).

The section ended with an area for a description of individual political factors affecting respondents' nursing practice. This question was the first of four open-ended questions (C4).

Section D was devoted to socio-economic factors affecting values. Questions included the participants' opinion on the remuneration they receive. Firstly, whether the remuneration is according to the level of work they deliver (D1), secondly whether they can keep up with the financial demands of life (D2) and thirdly whether they would have been better motivated towards nursing care if the salary they received were higher (D3). Participants had to identify whether they received a significant salary increase during Occupation Specific Dispensation (D4). Participants were then questioned on their opinion whether enough people were employed at the institution to deliver proper care (D5), as well as whether participants can keep up with the demand of work and still ensure proper care (D6). Up to this point in the Section all questions were measured on a nominal scale.

Participants had to rate their level of motivation on an interval-scale from nil to ten with nil being totally demotivated and ten being highly motivated (D7). The same rating scale was used for the participant to identify the level of conflict in the department (D8). The following two questions were open-ended questions and devoted to a description of the causes of conflict in the department (D9) and the social factors that have an influence on the participants' nursing practice (D10). The questionnaire also provided respondents with an opportunity to provide individual comments (D11).

3.8 PILOT STUDY

The pilot study is seen as a trial run for the main research, where a small scale of the research is conducted to test the research methodology and questionnaire for any unforeseen problems, ambiguity and inaccuracies (Brink, 2008:54). The pilot study established the feasibility of the proposed study (De Vos et al., 2008:206).

To provide an accurate representation of the proposed study, the pilot study was conducted under similar conditions in which the data collection was undertaken and all categories of nurses were included (Burns & Grove, 2007:38). The pilot study was not done for statistical or reliability reasons, therefore only ten participants (n = 10) were included in the pilot study and the pilot study was conducted in Paarl Hospital by using convenience sampling from different departments.

The pilot study formed part of the actual study as this was recommended and approved by the biostatistician. The purpose of the pilot study was to test the research design and, questions for ambiguity and inaccuracies. The results of the pilot study were applied to adjust the questionnaire according to time allocation for completion of the questionnaire, but no changes were made to the questions.

3.9 RELIABILITY AND VALIDITY

Validity is defined as the level of accurate reflection of the examined conceptual construct (Burns & Grove, 2007:559). Content and construct validity is assured by using scientific evidence found through the literature study as the basis for the formulation of the survey questionnaire (Brink, 2006:160). To further ensure content and construct validity the measuring instrument was presented to an expert in research methodology and nursing for judgment, to a Quality Assurance Manager and was validated by peer review. The questionnaire was further validated by the Health Research Ethics Committee at Stellenbosch University and the Provincial Research Coordinating Committee of the Department of Health of the Western Cape during ethical evaluation.

Reliability is the consistent measurement of a concept on a measuring instrument (Burns & Grove, 2007:552). The close involvement of the experts in research methodology and nursing, and the biostatistician in the compilation of the measuring instrument ensures that the measuring instrument accurately reflects the concepts it intended to measure (De Vos et al., 2008:162).

3.10 DATA COLLECTION

According to Burns and Grove (2007:41), data collection should be a precise and systematic process that collaborate the study outcomes and research question. The most common procedure of data collection is through questionnaires, experiments or an interview (Maltby et al., 2007:23).

Data collection was done by the researcher through distribution of the questionnaires to the participants after participants attended an information session. The information session was aimed at providing details of the study, discussing the questionnaire and explaining the completion of the questionnaire. Time was also allocated to questions arising. Hereafter, all personnel were invited to partake in the study. The information session was held with nursing staff in the different wards or departments at the specific facilities on both day and night duty.

Time was provided after the information session for the completion of the questionnaire. A tamper free deposit box was supplied at every session for the submission of the completed questionnaires.

3.11 DATA ANALYSIS AND INTERPRETATION

Data was analysed with the assistance of the biostatistician and expressed in frequencies, tables and histograms. An Excel spreadsheet was developed by the statistician that was used to capture the quantitative data. Qualitative data was captured, examined for completeness and accuracy, where after it was grouped in common themes and quantified. Descriptive statistics were used to describe and summarise the quantitative data (Brink, 2006:171). After statistical analysis inferential statistics (Spearman correlation coefficient, Kruskal-Wallis and ANOVA) was used to make presumptions about the population and significance of the study (Brink, 2006:171).

3.12 ETHICAL CONSIDERATION

During the study the ethical principles of respect for persons, beneficence and justice were upheld by ensuring that the participants' rights are adhered to (Brink 2008:31). The researcher adhered to the guidelines by Brink (2008:35) by providing clear and comprehensive information about the research, getting informed written consent from participants and receiving approval to conduct research from the appropriate review boards and committees.

Ethical approval was obtained from the Health Research Ethics Committee at Stellenbosch University (Addendum E) and from the Provincial Research Coordinating Committee of the Department of Health of the Western Cape (Addendum F), by submission of the proposal of the research project, as well as a proposed informed consent document (Addendum A), information leaflet (Addendum B) and questionnaire.

Participation in the study was voluntary and anonymity and confidentiality were preserved during the study, as well as during feedback by only using the data for research purposes and

not stating the identity of any participant at any stage during the study. An untraceable number was allocated to each questionnaire to ensure that anonymity is preserved through using the number of the questionnaire during data analysis. Only the researcher, the statistician and supervisor had access to the collected data.

Informed written consent was obtained by the researcher from participants after an information session with participants and an information leaflet was distributed to participants stating the purpose of the study and giving the basic information on the study. A member of the population that could not attend the information session, but wanted to participate in the research, was provided with the information leaflet. No risks were foreseen for this study, but for any queries the researcher provided her contact information on the information leaflet.

3.13 CONCLUSION

This chapter discussed the research methodology of the study that was followed and described the research design, population and sampling, validity and reliability, pilot study, data-collection, instrumentation, limitations experienced in the study and ethical considerations that were adhered to. Chapter four will present the analysis and discussion of the research results.

CHAPTER 4: PRESENTATION, ANALYSIS AND INTERPRETATION OF RESEARCH FINDINGS

4.1 INTRODUCTION

Values form part of the core of human behaviour; therefore it has a direct influence on nursing and is expressed in decisions that are made, in actions, thoughts, feelings and perceptions (Mohr et al, 2001: 31; Pera & Van Tonder, 2005:8; Rassin, 2008:614). Research revealed that there are significant differences in values displayed by persons from different levels of education, differing lengths of experience (Mc Neese-Smith & Crook, 2003:266; Rassin, 2008:627) and differing work positions (Mc Neese-Smith & Crook, 2003:266; Rassin, 2008:626).The purpose of this study was to determine the factors influencing nursing values of nurses working in nursing facilities in the Paarl district, in the West Coast Winelands Region of the Western Cape.

Research questionnaires were distributed to 388 participants, to all categories of nursing personnel, working on the days of data collection. A total of 235 of the 388 (60.56%) questionnaires were completed and returned by respondents. The results of the pilot study (n =10) were included in the findings, leading to a total of 245 respondents (n = 245) included in the main study.

Data collection took place by utilising a self-report questionnaire, consisting of four sections. Section A collected the biographical data of respondents, Section B evaluated the nursing values of respondents, while Section C estimated the political and legal factors affecting values and Section D was devoted to socio-economic factors affecting values.

In this chapter, the raw data is presented, analysed and interpreted. Thereafter, the results are discussed and correlated with the findings as discussed in the literature review. The data in this research is largely quantitative and is presented in histograms and frequency tables.

4.2 DATA ANALYSIS

Data analysis requires categorizing, ordering, manipulation and summarizing of collected research data to ensure that a meaningful description can be made (Brink, 2008:170). Quantitative, in majority, and qualitative data, through open-ended questions, were included in the study. Analysis of quantitative data was done by using statistical strategies, descriptive

statistics summarised the data, whereas inferential statistics allowed presumptions to be made about the population of the study (Brink, 2006:171). The responses to all the questions were addressed according to the layout of the questionnaire.

The responses to quantitative data were analysed and presented in frequency distribution tables and histograms. Statistical analyses included the calculation of the mean, median and standard deviation. The mean value is described as the average value for the variable and is calculated by dividing the sum of measurements by the number of measurements, which shows the balance point of the responses (Burns & Grove, 2009:232). The median refers to the middlemost point in the distribution of the variable; therefore it determines the central point, by dividing the distribution into two equal parts (Burns & Grove, 2008:231). The standard deviation is generally used with interval and ratio data description and is an indication of how closely values are grouped around the mean (Burns & Grove, 2009: 235; Brink, 2008:178).

Statistical significance was measured by determining the probability value. According to Maltby et al. (2007:258) the probability value (*p*-value) can be described as the "probability of getting a value of the test statistic higher than that observed by chance alone". Significance testing is the determining factor, based on probability testing, whether two variables are related or not (Maltby et al., 2007:115). This probability is expressed in terms of percentages, since there can never be assumed that findings are 100 percent correct; a criterion of confidence needs to be set at either 99% or 95%. In reference to significance testing these two percentages are termed as a 0.05 significance level (95% confidence level) or a 0.01 significance level (99% confidence level). This indicates that there is a probability of 5% (95% confidence) or 1% (99% confidence) that an error has occurred. (Maltby et al., 2007:115). During this study a 95% confidence interval was applied to establish the relationship between variables. Implying that a *p*-value of less than 0.05 ($p < 0.05$) indicates a statistically significant relationship and a *p*-value of larger than 0.05 ($p > 0.05$) that a statistically insignificant relationship occur (Maltby et al., 2007:116).

Qualitative data was collected in open-ended questions and provided richer, more diverse data to enhance the findings obtained in the close-ended, quantitative questions (Brink, 2008: 149). The qualitative data was analysed by describing, where responses were coded, analysing, where common themes were sought after, and interpreting the responses provided by respondents (Burns & Grove, 2007:79). This analysis was concerned with the analysis of written words and involved reading through the data repeatedly (Brink, 2008:119). During coding, the data was broken down into meaningful portions, with the aim to cluster the coded

material (Terre Blanche, Durrheim & Painter, 2006:324-326). Terre Blanche et al., (2006: 324-326) prescribe that themes should preferably evolve naturally from the data. The common themes or recurring consistencies from responses were searched for and the responses were grouped into specific themes and sub-themes.

4.3 DESCRIPTION OF STATISTICAL ANALYSIS

Raw data was captured by using the Microsoft Excel computer program, where after STATISTICA Version 9 StatSoft Inc. (2009) data analysis software system, (www.statsoft.com.) was used to analyse the data. Percentages were rounded off to the nearest whole number; therefore some of the frequency distributions reflect percentages of 99 or 101. Spearman's correlation, ANOVA and Kruskal-Wallis were applied as inferential statistical tests to make inferences about the population of the study.

The Spearman correlation coefficient can be described as "a correlation coefficient (*rho*) between -1 and +1 which indicates the degree to which two variables are related" (Maltby et al., 2007:259). It is a non-parametric test, applied to test whether a statistical significant relationship exists between two continuous variables (Maltby et al., 2007:155). During this test "both variables are measured on or transformed to ordinal scales" (Brink, 2006:180). It indicates either a positive relationship (+) or a negative relationship (-) between the two variables (Maltby et al., 2007:158). Burns and Grove (2007:424), indicate that a value between 0.1 and 0.29 is a weak relationship, a value between 0.3 and 0.5 is a moderate relationship and a strong relationship is a value of higher than 0.5.

Analyses of variance (ANOVA) allow a comparison between more than two mains simultaneously, in this way values are used to determine the difference between different means (Brink, 2006:183). This test determines the relationship between continuous response variables and nominal input variables and is associated with the symbol *F* (Brink, 2006:183).

Brink (2006:183) identify that the Kruskal-Wallis test is a non-parametric test, used to compare the significant difference between several groups. The Kruskal-Wallis test is mostly used when the relationship is tested between two variables, with one variable on the nominal scale and a measurement variable, with the measurement variable not meeting the normality assumption of an ANOVA. It can also be defined as the non-parametric analogue of a one-way ANOVA. This can be attributed to the possibility of an inaccurate estimation of the *p*-value in a one-way ANOVA when the data are very far from a normal distribution (McDonald, 2009:165).

During analysis of the qualitative data (responses to the open-ended questions) the raw data were processed manually in Microsoft Excel, by reporting responses verbatim. This entails reporting word for word what respondents reported to ensure authenticity and ensuring the trustworthiness of the data collected. The responses were coded after viewing the underlying meaning of the responses by respondents, as a search for themes or recurring regularities was undertaken (Brink, 2008:184). Responses were read and reread to understand the underlying meaning and to ensure accuracy. A list was compiled of themes and subthemes, abbreviated as codes that were written next to the appropriate responses. Categories of responses were identified to function as theme or subtheme and the frequency of such responses were recorded. Burns and Grove (2007:88) identified that the quantification of qualitative data ensures that data stay academically truthful and it is easier for the researcher to see confirming evidence, therefore the responses to the open-ended questions were quantified. The themes and subthemes were reported with the narrative providing examples of responses and function as support for the appropriate theme or subtheme.

4.4 RESULTS

4.4.1 Section A: Biographical data

This section included al the personal information of each participant. This data was utilized to address the objective to determine the factors influencing nursing values by making correlations and will be discussed as differential statistics.

4.4.1.1 Gender (n = 237)

Table 4.1 specifies that the majority of respondents were females (n = 226) (95%), with only 11 males (n =11) (5%) who participated in the study. A total of eight respondents (n = 8) did not complete this question. These findings could be attributed to the historic female dominance in the nursing profession, seen in the statistics of the SANC with 92.5% of nurses being female (SANC 2009b). Due to a small sample size of the male group no correlations could be drawn with regard to gender group.

Table 4.1: Gender distribution

Category	Frequency (*f*)	Percentage (%)
Male	11	5
Female	226	95
Total	**n = 237**	**100**

4.4.1.2 Ethnic group (n = 231)

Figure 4.1 indicates that the majority of the population was Coloured (n = 169) (73%). The second largest group was 45 White respondents (n = 45) (19%) and the smallest group the 17 African respondents (n = 17) (7%). 14 of the respondents (n = 14) did not provide their ethnic group. Rassin (2008:618) and Mc Neese and Crook (2003:265) both identified a statistical significant relationship between culture and nursing values. No correlation was drawn with regard to ethnic group due to a small sample sizes. With the small sample size for both the African and White groups no inferential statistical tests were applied.

Table 4.2: Ethnic distribution

Category	Frequency (*f*)	Percentage (%)
African	17	7
Coloured	169	73
White	45	20
Total	**n = 231**	**100**

4.4.1.3 Religion (n = 237)

Indicated in table 4.3 Christianity was indicated as the leading religion with 216 respondents (n = 216) (91%), 11 respondents (n = 11) (5%) indicated that they follow no religion, seven respondents (n = 7) (3%) form part of the Islamic religion, two respondents (n = 2) (1%) indicated their religious participation as Jehovah Witness and only one respondent (n = 1) (0%) identified him/herself was a member of Judaism. Eight respondents (n = 8) did not provide a response to this question. This indicates that the majority of respondents have a strong religious stance and as indicated by Mellish and Paton (1999:46), the historical background of the nursing profession indicates an origin in religion.

Table 4.3: Distribution of Religion

Category	Frequency (*f*)	Percentage (%)
Islam	7	3
Christian	216	91
Jewish	1	0
Jehovah Witness	2	1
None	11	5
Total	**n = 237**	**100**

4.4.1.4 Age group (n = 237)

The age distribution (table 4.4) indicates that the age group 40 to 49 years were the largest with 113 respondents (n = 113) (48%), the age group of 30 to 39 years account for 45 respondents (n = 45) (23%), with 37 of respondents (n = 37) (16%) between 50 and 59 years, 27 of respondents (n = 27) (11%) were younger than 30 years and six respondents (n = 6) (3%) between 60 and 65 years. Eight respondents (n = 8) did not complete this question.

The statistics of the SANC reflects a national aging nursing corps (SANC 2009a). The age distribution of respondents also reflects a similar profile with the majority of respondents falling in the categories between the age of 40 and 65.

Table 4.4: Age distribution

Category	Frequency (*f*)	Percentage (%)
<30 years	27	11
30 – 39 years	54	23
40 – 49 years	113	48
50 – 59 years	37	16
60 – 65 years	6	3
Total	**n = 237**	**101**

4.4.1.5 Experience (n = 237)

Eight respondents (n = 8) did not complete this question. Table 4.5 shows that the highest number of respondents have between 21 and 30 years of experience (n = 83) (37%). The age group with the least amount of respondents (n = 16) (7%) were nurses with more than 30 years of experience. The remainder of the respondents' years of experience constituted to 25

respondents (11%) with less than four years of experience, 27 respondents (12%) with four to ten years of experience and 73 respondents (n = 73) (33%) with 11 to 20 years of experience.

According to Rassin (2008:627), nurses with a maximum of two years of experience rate dignity lower than nurses with more experience, whereas nurses with more than two years experience regard privacy as less important. Mc Neese-Smith and Crook (2003:266) also stated that experience has an influence on nursing values, with entry level nurses placing greater importance on economic returns and persons with greater experience showing lower importance for the value of altruism.

Table 4.5: Number of years of experience

Category	Frequency (*f*)	Percentage (%)
<4 years	25	11
4 – 10 years	27	12
11 – 20 years	73	33
21 – 30 years	83	37
> 30 years	16	7
Total	**n = 237**	**100**

4.4.1.6 Highest qualification obtained (n = 233)

The majority of the respondents have obtained a certificate (n = 106 or 45%) as highest qualification as indicated in table 4.6. The second largest group is that of the respondents that obtained a basic diploma (n = 56) (24%). Only 18 respondents (n = 18) (8%) have obtained a degree, 46 respondents (n = 46) (20%) have succesfully completed a post basic diploma and seven respondents (n = 7) (3%) have obtained a post graduate degree. Twelve respondents (n = 12) did not complete this question.

According to McNeese and Crook (2003:265) and Rassin (2008:624), educational level does influence values. McNeese and Crook (2003:265), report that aesthetics has greater importance for nurses with a bachelors degree, than for nurses with an associateddegree. Rassin (2008: 624) reported that esthetics are the least important to academic nurses. McNeese and Crook (2003: 615), identified that non-degree nurses regard the value of altruism, associated economic returns, security, supervisory relations and surroundings higher than nurses with a Master's qualification.

Table 4.6: Highest qualification obtained

Category	Frequency (*f*)	Percentage (%)
Certificate	106	45
Basic diploma	56	24
Degree	18	8
Post basic diploma	46	20
Post graduate degree	7	3
Total	**n = 233**	**100**

4.4.1.7 Current job description (n = 238)

According to table 4.7 respondents were predominantly Professional nurses (n = 109) (46%), whilst 55 respondents (n = 55) (23%) were assistant nurses and 52 respondents (n = 52) (22%) were staff nurses. In the minority were Operational managers (n = 18) (8%), Deputy Managers (n = 1) (0%) and nurses with any other job description (n = 1) (0%). Seven respondents (n = 7) did not complete this question.

Table 4.7: Current job description

Category	Frequency (*f*)	Percentage (%)
Assistant nurse	55	23
Staff nurse	52	22
Professional nurse	109	46
Operational manager	18	8
Assistant manager	2	1
Deputy manager	1	0
Other	1	0
Total	**n = 238**	**100**

4.4.1.8 Current department (n = 238)

Table 4.8: Current department

Category	Frequency (*f*)	Percentage (%)
Medical	21	9
Surgical	27	11
Theatre	18	8
Midwifery	37	16
Casualty	28	12
High Care	7	3
Paediatric	25	11
Orthopaedic	2	1
Primary Health Care	60	25
Other	13	5
Total	**n = 238**	**101**

The greatest amount of respondents that completed this question worked in a Primary Health Care facility (n = 60) (25%) as indicated in table 4.8. 16% of respondents (n = 37) were working in a Midwifery department and 12% of respondents (n = 28) worked in a casualty department. 27 respondents (n = 27) (11%) worked in a surgical department, 25 respondents (n = 25) (11%) in a paediatric department, 21 respondents (n = 21) (9%) in medical departments and 18 respondents (n = 18) (8%) in theatre. Thirteen of the respondents (n = 13) (5%) worked in any other department that was not listed, this included Administration and Education Departments. The minority groups were respondents from High Care (n = 7) (3%) and Orthopaedics (n = 2) (1%). Seven respondents (n = 7) did not complete this question.

4.4.2 Section B: Nursing values

Section B of the survey questionnaire was dedicated to the investigation into each respondent's main reason for entering nursing, if they are still practising nursing due to the reason for entering nursing and the most important aspect of nursing for each participant. It incorporated a Likert scale where participants had to rank the values that influence their behaviour as a nurse, patient care and ethical decision making. The Likert scale used the following response scale:

- High priority (4)
- Moderate priority (3)

- Little priority (2)
- No priority (1)

4.4.2.1 Question B1: Identify the main reason why you decided on nursing as a career (n = 245)

Categories in this question were reduced for statistical reasons to only five categories by combining career opportunity and career stability, and a way of receiving an income and good incentives and income. Figure 4.1 reveals that 54 respondents (n = 54) (24%) entered nursing due to career opportunity and stability and 20 respondents (n = 20) (9%) decided on nursing as it was a way of receiving an income and offered good incentives. 5% of respondents (n = 12) decided on the nursing profession since one of their family members was a nurse and consequently they decided on nursing as a profession. 5% of respondents (n = 11) entered nursing due to other reasons. The majority group was respondents that entered nursing because they wanted to help people (n = 131) (57%). Seventeen respondents (n = 17) did not complete this question.

As indicated in paragraph 2.2 the primary motivator for persons entering the nursing career is assumed to be the value of altruism (Shaw and Degazon, 2008:45). Altruism is defined as the "regard for the welfare of others" (Altun, 2002:271). As can be seen in table 4.9 the majority of respondents indicated that they entered the nursing career due to the desire to help people (n = 131) (57%).This desire can be translated into having regard for the welfare of others and therefore indicates a strong altruistic origin. These findings disagree with Shaw and Degazon (2008:45) who identified that nurses in the modern era are attracted to nursing due to "the financial incentives and the career mobility and stability".

Table 4.9: Participants' reasons for entering the nursing profession

Category	Frequency (*f*)	Percentage (%)
Career opportunity and stability	54	24
A way of receiving an income and good incentives and income	20	9
One of my family members was a nurse so I decided to do it	12	5
I wanted to help people	131	57
Other	11	5
Total	**n = 228**	**100**

4.4.2.2 Question B2: Do you feel that you are still in nursing practice due to the reason for entering the nursing career? (n = 238)

The predominant group of respondents (n = 187) (79%) indicated, as displayed in Figure 4.2, that they are still practicing nursing due to the reason they initially entered nursing, whilst 36 respondents (n = 36) (15%) reported that they no longer practise nursing for the same reason they entered the profession and 15 respondents (n = 15) (6%) was unsure whether they still practise nursing due to the reason they have entered the nursing profession as seen in Figure 4.2. Seven respondents (n = 7) did not complete this question.

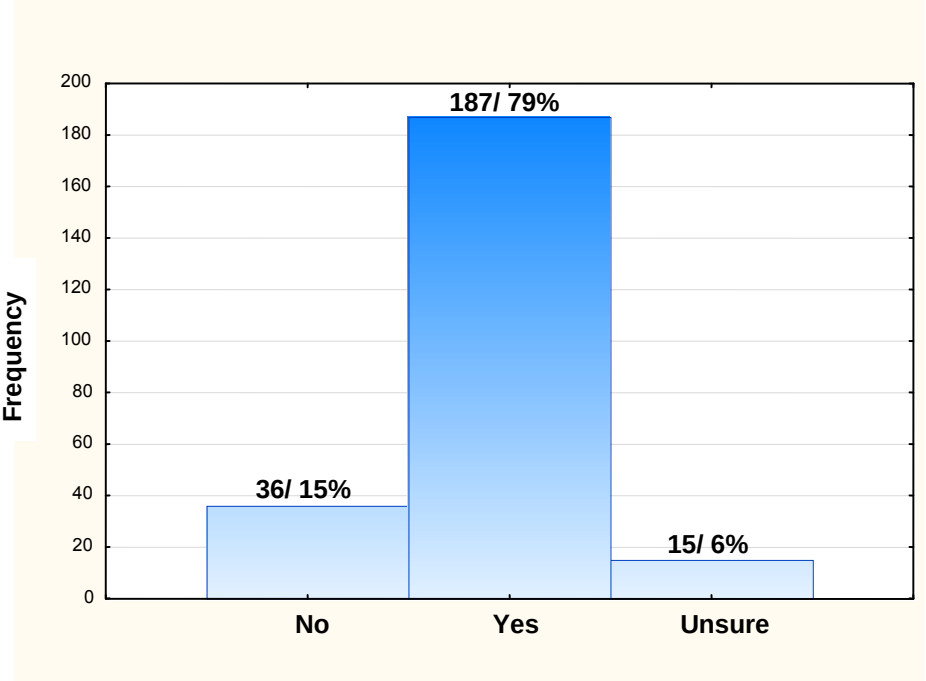


Figure 4.1: Are participants still practising nursing due to the reason entering the profession

4.4.2.3 Question B3: Identify the part of nursing most important to you (n = 223)

Table 4.10: Most important part of nursing (n = 223)

Category	Frequency (*f*)	Percentage (%)
Seeing a patient progress towards healing	110	49
Interaction with other professionals	3	1
Caring for the patient	29	13
Job stability and receiving the monthly remuneration	17	8
Gaining of new knowledge, getting clinical experience and being a competent nurse	60	27
Other	4	2
Total	**n = 223**	**100**

After reducing the number of categories in this question to only six categories table 4.10 reveals that for the majority of respondents (n = 110) (49%) the most important part of nursing is seeing a patient progress towards healing. The rest of the responses were divided as follows: interaction with other professionals (n = 3) (1%), caring for the patient (n = 29) (13%), job stability and receiving the monthly remuneration (n = 17) (8%), gaining of new knowledge, getting clinical experience and being a competent nurse (n = 60) (27%) and other parts of nursing (n = 4) (2%). This question was left uncompleted by 22 respondents (n = 22). The categories that were combined are job stability and receiving the monthly remuneration, gaining of new knowledge and getting clinical experience and being a competent nurse.

This finding supports the definition of nursing by the SANC (see paragraph 2.3) as indicated in table 4.10, where the majority of the respondents specified that the most important part of nursing entails a caring and patient directed service. Pera and Van Tonder (2005:7) identified that the primary goal of nursing is to provide optimal care for every client. As indicated, the sentiment of respondents is in agreement with this opinion. This viewpoint by respondents also corresponds with the focus of the South African health system, of delivering quality health care in a caring environment (Department of Health, 1997b).

4.4.2.4 Question B4: Prioritize each of the following professional values which influence your behaviour as a nurse

For this question a Likert scale was used to evaluate the professional values of the respondents that influence their behaviour as a nurse. Seen in table 4.11 the values that influence behaviour as a nurse that were predominantly ranked as high priority were:

1. Confidence (n = 171) (72%),
2. Quality care and excellence (n = 144) (68%)
3. Accountability (n = 151) (67%)
4. Integrity and honesty (n = 131) (63%)
5. Competence (n = 121) (59%)
6. Co-operative relationship with co-workers (n = 114) (55%)
7. Compassion and humanity (n = 109) (54%)
8. Privacy (n = 103) (52%)
9. Responsibility (n = 100) (52%)
10. Respect for the rights of people (n = 112) (51%)
11. Confidence (n = 104) (51%)
12. Trust and honesty (n = 94) (49%)
13. Respect for dignity and autonomy (n = 100) (48%)
14. Trustworthiness (n = 90) (47%)

This question was poorly answered; respondents tended to only rank the values important to the individual and then only rating it as either high priority or priority, leading to a lot of missing data, which will be reflected in the totals (n) of each of the 25 values.

Table 4.11: Values influencing nursing behaviour

		Frequency *(f)*				
	Value	**No priority**	**Little priority**	**Priority**	**High priority**	**Total (n)**
1	Confidentiality	7 / 3%	9 / 4%	49 / 21%	171 / 72%	n = 236 / 100%
2	Accountability	6 / 3%	5 / 2%	62 / 28%	151 / 67%	n = 224 / 100%
3	Advocacy	10 / 5%	25 / 12%	89 / 44%	79 / 39%	n = 203 / 100%
4	Altruism	3 / 2%	16 / 8%	94 / 48%	84 / 42%	n = 197 / 100%
5	Beneficence and Non-maleficence	6 / 3%	20/ 10%	100 / 52%	66 / 34%	n = 192 / 99%
6	Compassion / Humanity	4 / 2%	9 / 4%	80 / 40%	109 / 54%	n = 202 / 100%
7	Co-operative relationship with co-workers	2 / 1%	16 / 8%	76 / 37%	114 / 55%	n = 208 / 101%
8	Confidence	3 / 1%	10 / 5%	87 / 43%	104 / 51%	n = 204 / 100%
9	Courtesy	3 / 2%	8 / 4%	102 / 53%	80 / 41%	n = 193 / 100%
10	Competence	3 / 1%	9 / 4%	72 / 35%	121 / 59%	n = 205 / 99%
11	Equality	7 / 4%	21 / 11%	102 / 52%	67 / 34%	n = 197 / 101%
12	Freedom	17 / 9%	35 / 18%	96 / 50%	45 / 23%	n = 193 / 100%
13	Independence	6 / 3%	28 / 14%	104 / 54%	56 / 29%	n = 194 / 100%
14	Integrity / Honesty	1 / 0%	10 / 5%	66 / 32%	131 / 63%	n = 208 / 100%
15	Maintaining of standards of personal conduct	3 / 2%	13 / 7%	90 / 46%	89 / 46%	n = 195 / 101%
16	Privacy	3 / 2%	10 / 5%	84 / 42%	103 / 52%	n = 139 / 101%
17	Quality care / Excellence	2 / 1%	8 / 4%	57 / 27%	144 / 68%	n = 211 / 100%
18	Respect for dignity and autonomy	3 / 1%	16 / 8%	89 / 43%	100 / 48%	n = 208 / 100%
19	Respect for the rights of people	4 / 2%	7 / 3%	96 / 44%	112 / 51%	n = 219 / 100%
20	Responsibility	0 / 0%	5 / 3%	86 / 45%	100 / 52%	n = 191 / 100%
21	Safety / Security	6 / 3%	12 / 6%	102 / 54%	70 / 37%	n = 190 / 100%
22	Social justice / Fairness	6 / 3%	21 / 11%	104 / 56%	55 / 30%	n = 186 / 100%
23	Trustworthiness	3 / 2%	9 / 5%	90 / 47%	90 / 47%	n = 192 / 101%
24	Truth / Honesty	3 / 2%	8 / 4%	85 / 45%	94 / 49%	n = 190 / 100%
25	Value of personhood	3 / 2%	13 / 7%	91 / 47%	87 / 45%	n = 194 / 101%

Question B4: 1. Confidentiality (n = 236)

Table 4.11 demonstrates that 72% of respondents (n = 171) perceived confidentiality as high priority in nursing behaviour, with 21% of respondents (n = 49) feeling it is a priority, 4% (n = 9) indicated it is of little priority and only 3% of respondents (n = 7) indicated it as having no priority. Nine respondents (n = 9) did not complete this question.

Question B4: 2. Accountability (n = 224)

Twenty-one respondents (n = 21) did not provide an answer on the value of accountability. As revealed in table 4.11, 151 respondents (n = 151) (67%) prioritized accountability as high priority, whilst 62 respondents (n = 62) (28%) reported that it has priority, five respondents (n= 5) (2%) indicated it as having little priority and six respondents (n = 6) (3%) responded that accountability has little priority.

Question B4: 3. Advocacy (n = 203)

From table 4.11 it can be seen that advocacy was rated as high priority by 39% of the respondents (n = 79), 44% of respondents (n = 89) responded that it has priority, whilst for the minority of respondents it has little priority (n = 25) (12%) or no priority (n = 10) (5%). This question was not completed by 42 respondents (n =42).

Question B4: 4. Altruism (n = 197)

Table 4.11 reveals that altruism was of high priority to 84 respondents (n = 84) (42%), priority to 94 respondents (n = 94) (48%), priority to 16 respondents (n = 16) (8%) and no priority to 3 respondents (n = 3) (2%). 48 respondents (n = 48) did not provide an answer to this question.

Question B4: 5. Beneficence and non-maleficence (n = 192)

Fifty-three respondents (n = 53) did not complete this question. Table 4.11 depicts that beneficence and non-maleficence have priority to the majority of respondents (n = 100) (52%), whilst it has high priority to 34% of respondents (n = 66), little priority to 10% of respondents (n = 20) and no priority to 3% of respondents (n = 6).

Question B4: 6. Compassion and humanity (n = 202)

Table 4.11 shows that compassion and humanity are perceived as having high priority to 109 respondents (n = 109) (54%), priority to 80 respondents (n = 80) (40%), little priority to 9 respondents and no priority to 4 respondents (n = 4) (2%). This question was not answered by 43 respondents (n = 43).

Question B4: 7. Co-operative relationship with co-workers (n = 208)

More than half of respondents that completed this question (n = 114) (55%) indicated that this value has high priority, as indicated in table 4.11. In the minority group was the respondents that prioritised co-operative relationship with co-workers as priority (n = 76) (37%), little priority (n = 16) (8%) and no priority (n = 2) (1%). 37 respondents (n = 37) did not complete this question.

Question B4: 8. Confidence (n = 204)

Forty-one respondents (n = 41) did not respond to this question. Confidence (table 4.11) was rated as high priority by 104 respondents (n = 104) (51%), priority by 87 respondents (n = 87) (43%), little priority by 10 respondents (n = 10) (5%) and no priority by 3 respondents (n = 3) (1%).

Question B4: 9. Courtesy (n = 193)

Table 4.11 shows that the majority of the respondents indicated that courtesy is of priority to them (n = 102) (53%), however, 41% of respondents (n = 80) is of the opinion that it has high priority. Courtesy was of little importance to eight participants (n = 8) (4%) and no priority to three participants (n = 3) (2%). 52 of respondents (n = 52) did not respond to this question.

Question B4: 10. Competence (n = 205)

Competence was of no priority to 1% of respondents (n = 3), little priority to 4% of respondents (n = 9), priority to 35% of respondents (n = 72) and high priority to 59% of respondents (n = 121), according to table 4.11. This question was not responded to by 40 respondents (n = 40).

Question B4: 11. Equality (n = 197)

Forty-eight respondents (n = 48) did not provide an answer to this question. As revealed in table 4.11 the majority of respondents are of the opinion that equality is priority (n = 102) (52%). For 34% of respondents (n = 67) it has high priority, 11% of respondents (n = 21) are of the opinion that it has little priority and for 4% of respondents (n = 7) it has no priority.

Question B4: 12. Freedom (n = 193)

Table 4.11 depicts that 45 respondents (n = 45) (23%) perceived freedom as high priority, whilst 96 respondents (n = 96) (50%) perceived it as priority. 18 respondents (n = 35) (18%) indicated that it has little priority and 17 respondents (n = 17) (9%) that it has no priority. 52 respondents (n = 52) did not answer this question.

Question B4: 13. Independence (n = 194)

Fifty-one respondents (n = 51) did not provide a response to this question. According to table 4.11 independence is of priority for the majority of respondents (n = 104) (54%), whilst it has no priority for six respondents (n = 6) (3%), little priority for 28 respondents (n = 28) (14%) and high priority for 56 respondents (n = 56) (29%).

Question B4: 14. Integrity and honesty (n = 208)

Only 1 respondent (n = 1) (0%) rated this value as having no priority as seen in table 4.11. The predominant group responded that this value is of high priority (n = 131) (63%), while 32% of respondents (n = 66) indicated that it has priority and 5% of respondents (n = 10) that it has little priority. This question was not answered by 37 respondents (n = 37).

Question B4: 15. Maintaining of standards of personal conduct (n = 195)

Table 4.11 indicates that this value was rated as high priority (n = 89) (46%) and priority (n = 90) (46%) equally. The minority groups was those that rated this value as having little priority (n = 13) (7%) and no priority (n = 3) (2%). 50 respondents (n = 50) did not provide a response to this question.

Question B4: 16. Privacy (n = 139)

This question was not completed by 106 respondents (n = 106). Table 4.11 shows that 103 respondents (n = 103) (52%) recognize privacy as high priority, for 84 respondents (n = 84) (42%) it has priority, it has little priority for 10 respondents (n = 10) (5%) and no priority for 3 respondents (n = 3) (2%).

Question B4: 17. Quality care and excellence (n = 211)

Most respondents rated this value as having high priority (n = 144) (68%), whereas the other 32% comprised of the groups that rated it as priority (n = 57) (27%), little priority (n = 8) (4%) and no priority (n = 2) (1%) as indicated in table 4.11. 34 respondents (n = 34) did not answer this question.

Question B4: 18. Respect for dignity and autonomy (n = 208)

As seen in table 4.11 the majority group was that of respondents with respect for dignity and autonomy as high priority (n = 100) (48%), with the group that perceived it as priority (n = 89) (43%) closely trailing. The minority group was that of respondents perceiving this value as having little priority (n = 16) (8%) and no priority (n = 3) (1%). This question was unanswered by 37 respondents (n = 37).

Question B4: 19. Respect for the rights of people (n = 219)

Twenty-six respondents (n = 26) did not answer this question. Little more than half of respondents rated this value as having high priority (n = 112) (51%), while 44% of respondents (n = 96) rated it as having priority, 3% of respondents (n = 7) indicated that it has little priority and 2% (n = 4) that it has no priority (table 4.11).

Question B4: 20. Responsibility (n = 191)

Responsibility was ranked as high priority by 100 respondents (n = 100) (52%), priority by 86 respondents (n = 86) (45%) and little priority by five respondents (n = 5) (3%) as seen in table 4.11. This question was not completed by 54 respondents (n = 54).

Question B4: 21. Safety and security (n = 190)

Table 4.11 reveals that safety and security has high priority for 37% of the respondents (n = 70), priority for 54% of respondents (n = 102), little priority for 6% of respondents (n = 12), whilst it has no priority for 3% of respondents (n = 6). Fifty-five respondents (n = 55) did not answer this question.

Question B4: 22. Social justice and fairness (n = 186)

This question was unanswered by 59 respondents (n = 59). According to table 4.11 these values are largely perceived as priority (n = 104) (56%), with 55 respondents (n = 55) (30%) ranking it as high priority, 21 respondents (n = 21) (11%) ranked it as having little priority and six respondents (n = 6) (3%) ranking it as having no priority.

Question B4: 23. Trustworthiness (n = 192)

Trustworthiness was depicted in table 4.11 as high priority and priority evenly (n = 90) (47%), whilst having little priority (n = 9) (5%) and no priority (n = 3) (2%) for the least amount of respondents. 53 respondents (n = 53) did not answer this question.

Question B4: 24. Truth and honesty (n = 190)

These values were perceived as having high priority for the behaviour as a nurse as indicated by 49% of respondents (n = 94), priority by 45% of respondents (n = 85), little priority by 4% of respondents (n = 8) and no priority by 2% of respondents (n = 3). The question was unanswered by 55 respondents (n = 55).

Question B4: 25. Value of personhood (n = 194)

Table 4.11 reflects that this value was mostly perceived as high priority (n = 87) (45%) and priority (n = 91) (47%) and in the least as having little priority (n = 13) (7%) and no priority (n = 3) (2%). Fifty-one respondents (n = 51) did not complete this question.

4.4.2.5 Question B5: What values are important to provide proper patient care in your daily work as a nurse?

Table 4.12 represents the respondents' response on a Likert scale with regard to their values they utilize to provide proper patient care in their daily work as a nurse. Eight values were predominantly rated as high priority by respondents in this question, as follows:

1. Confidentiality (n = 178) (78%)
2. Quality care and excellence (n = 134) (65%)
3. Accountability (n = 121) (61%)
4. Competence (n = 111) (59%)
5. Responsibility (n = 105) (53%)
6. Privacy (n = 100) (52%)
7. Integrity and honesty (n = 94) (50%)
8. Value of personhood (n = 93) (48%)

This question was once again poorly answered; respondents tended to only rank the values important to the individual and then only rating it as either high priority or priority, leading to a lot of missing data, which will be reflected in the totals (n) of each of the 25 values.

Table 4.12: Values important to provide proper patient care

		Frequency *(f)*				
	Value	**No priority**	**Little priority**	**Priority**	**High priority**	**Total (n)**
1	Confidentiality	4 / 2%	3 / 1%	42 / 19%	178 / 78%	n = 227 / 100%
2	Accountability	1 / 1%	7 / 4%	70 / 35%	121 / 61%	n = 199 / 101%
3	Advocacy	5 / 3%	13 / 7%	93 / 49%	80 / 42%	n = 191 / 101%
4	Altruism	0 / 0%	12 / 6%	114 / 61%	62 / 33%	n = 188 / 100%
5	Beneficence and Non-maleficence	3 / 2%	19 / 10%	104 / 56%	61 / 33%	n = 187 / 101%
6	Compassion / Humanity	0 / 0%	6 / 3%	96 / 50%	91 / 47%	n = 193 / 100%
7	Co-operative relationship with co-workers	2 / 1%	5 / 3%	98 / 50%	92 / 47%	n = 197 / 101%
8	Confidence	0 / 0%	8 / 4%	100 / 51%	87 / 45%	n = 195 / 100%
9	Courtesy	2 / 1%	8 / 4%	106 / 56%	74 / 39%	n = 190 / 100%
10	Competence	0 / 0%	5 / 3%	73 / 39%	111 / 59%	n = 189 / 101%
11	Equality	7 / 4%	17 / 9%	109 / 58%	56 / 30%	n = 189 / 101%
12	Freedom	6 / 3%	34 / 18%	104 / 56%	42 / 23%	n = 186 / 100%
13	Independence	6 / 3%	23 / 13%	96 / 53%	55 / 31%	n = 180 / 100%
14	Integrity / Honesty	1 / 1%	8 / 4%	85 / 45%	94 / 50%	n = 188 / 100%
15	Maintaining of standards of personal conduct	1 / 1%	9 / 5%	95 / 52%	76 / 42%	n = 181 / 100%
16	Privacy	3 / 2%	9 / 5%	81 / 42%	100 / 52%	n = 193 / 101%
17	Quality care / Excellence	1 / 0%	7 / 3%	65 / 31%	134 / 65%	n = 207 / 99%
18	Respect for dignity and autonomy	1 / 1%	6 / 3%	115 / 63%	62 / 34%	n = 184 / 101%
19	Respect for the rights of people	0 / 0%	9 / 5%	99 / 51%	88 / 45%	n = 196 / 101%
20	Responsibility	1 / 1%	3 / 2%	90 / 45%	105 / 53%	n = 199 / 101%
21	Safety / Security	0 / 0%	10 / 5%	98 / 53%	78 / 42%	n = 186 / 100%
22	Social justice / Fairness	3 / 2%	22 / 12%	100 / 55%	56 / 31%	n = 181 / 100%
23	Trustworthiness	0 / 0%	5 / 3%	95 / 51%	85 / 46%	n = 185 / 100%
24	Truth / Honesty	0 / 0%	6 / 3%	95 / 50%	88 / 47%	n = 189 / 100%
25	Value of personhood	1 / 1%	8 / 4%	91 / 47%	93 / 48%	n = 193 / 100%

Question B5: 1. Confidentiality (n = 227)

According to table 4.12 confidentiality was mostly rated as high priority (n = 178) (78%) by respondents, whilst the minority of respondents recognize it as priority (n = 42) (19%), little priority (n = 3) (1%) and no priority (n = 4) (2%). 18 respondents (n = 18) did not answer this question.

Question B5: 2. Accountability (n = 199)

This question was not completed by 46 respondents (n = 46). 61% of respondents (n = 121) ranked accountability as high priority in patient care, 35% as priority (n = 70), 4% as little priority (n = 7) and 1% as no priority (n = 1), as indicated by table 4.12.

Question B5: 3. Advocacy (n = 191)

Depicted in table 4.12 the dominant group is that of respondents that rated this value as priority (n = 93) (49%), 80 respondents (n = 80) (42%) rated this as high priority, 13 respondents (n = 13) (7%) as little priority and five respondents (n = 5) (3%) as no priority. 54 respondents (n = 54) did not answer this question.

Question B5: 4. Altruism (n = 188)

Table 4.12 reveals that 61% of respondents (n = 114) is of the opinion that this value has priority, whereas 33% respondents (n = 62) indicated that it has high priority, only 6 % respondents (n = 12) indicated that it has little priority. 57 respondents (n = 57) did not respond to this question.

Question B5: 5. Beneficence and non-maleficence (n = 187)

Indicated in table 4.12 beneficence and non-maleficence was rated as high priority by 33% of respondents (n = 61), little priority by 10% of respondents (n = 19) and no priority by 2% of respondents (n = 3). The majority of respondents ranked these values as having priority (n = 61) (33%). This question was not completed by 57 respondents (n = 57).

Question B5: 6. Compassion and humanity (n = 193)

Table 4.12 reflects that these values was predominantly seen as priority (n = 96) (50%) and high priority (n = 91) (47%), whilst it was seen by the minority as having little priority (n = 6) (3%) and no priority (n =0). 52 of respondents (n = 52) did not answer this question.

Question B5: 7. Co-operative relationship with co-workers (n = 197)

According to table 4.12 this value has high priority for 92 respondents (n = 92) (47%), priority for 98 respondents (n = 98) (50%), little priority for five respondents (n = 5) (3%), no priority for two respondents (n = 2) (1%). This question was unanswered by 48 respondents (n = 48).

Question B5: 8. Confidence (n = 195)

Confidence was mostly rated as priority (n = 100) (51%), whereas it is the second mostly rated as high priority (n = 87) (45%) and least rated as little priority (n = 8) (4%) and no priority (n = 0), as seen in table 4.12. This question was not completed by 50 respondents (n = 50).

Question B5: 9. Courtesy (n = 190)

Depicted in table 4.12 courtesy was rated as high priority by 39% of respondents (n = 74), priority by 56% of respondents (n = 106), little priority by 4% of respondents (n = 8) and no priority by 1% of respondents (n = 2). Fifty-five of respondents (n = 55) did not complete this question.

Question B5: 10. Competence (n = 189)

Competence (table 4.12) is shown to have high priority to 111 respondents (n = 111) (59%), priority to 73 respondents (n = 73) (39%), little priority to five respondents (n = 5) (3%) and no respondents (n = 0) rated competence as having no priority. This question was unanswered by 56 respondents (n = 56).

Question B5: 11. Equality (n = 189)

Table 4.12 reflects that the majority of respondents experienced equality as priority (n = 109) (58%), whilst high priority (n = 56) (30%), little priority (n = 17) (9%) and no priority (n = 7) (4%) fell in the minority group. Fifty-six respondents (n = 56) did not complete this question.

Question B5: 12. Freedom (n = 186)

As shown in table 4.12 freedom is perceived as having high priority by 23% of respondents (n = 42), priority by 56% of respondents (n = 104), little priority by 18% of respondents (n = 34) and no priority by 3% of respondents (n = 6). This question was not completed by 59 respondents (n = 59).

Question B5: 13. Independence (n = 180)

This question was unanswered by 65 respondents (n = 65). Independence was depicted in table 4.12 as high priority for 55 respondents (n = 55) (31%), priority for 96 respondents (n = 96)

(53%), little priority for 23 respondents (n = 23) (13%) and no priority for 6 respondents (n = 6) (3%).

Question B5: 14. Integrity and honesty (n = 188)

Table 4.12 demonstrates that this value has high priority for 50% of respondents (n = 94), priority for 45% of respondents (n = 85), little priority for 4% of respondents (n = 8) and no priority for 1% of respondents (n = 1). Fifty-seven respondents (n = 57) did not complete this question.

Question B5: 15. Maintaining of standards of personal conduct (n = 181)

Reflected in table 4.12 this value was rated as priority for the majority of respondents (n = 95) (52%) and in the minority was respondents that rated this value as high priority (n = 76) (42%), little priority (n = 9) (5%) and no priority (n = 1) (1%). Sixty-four respondents (n = 64) did not answer this question.

Question B5: 16. Privacy (n = 193)

Privacy is illustrated in table 4.12 as having high priority for 100 respondents (n = 100) (52%), little priority for 81 respondents (n = 81) (42%), priority for nine respondents (n = 9) (5%) and no priority for three respondents (n = 3) (2%). This question was unanswered by 52 respondents (n = 52).

Question B5: 17. Quality care and excellence (n = 207)

This question was not completed by 38 respondents (n = 38). Table 4.12 show that the majority of respondents perceived these values as high priority (n = 134) (65%) in the providing of proper patient care. The minority of respondents perceived this value as having priority (n = 65) (31%), little priority (n = 7) (3%) and no priority (n = 1) (0%).

Question B5: 18. Respect for dignity and autonomy (n = 184)

According to table 4.12, 34% of respondents (n = 62) rated these values as high priority, 63% of respondents (n = 115) as priority, 3% of respondents (n = 6) as little priority and 1% of respondents (n = 1) as no priority. 61 respondents (n = 61) did not answer this question.

Question B5: 19. Respect for the rights of people (n = 196)

Table 4.12 depicts that this value has high priority for 88 respondents (n = 88) (45%), priority for 99 respondents (n = 99) (51%), little priority for nine respondents (n = 9) (5%) and no priority for no respondents (n = 0). This question was unanswered by 49 respondents (n = 49).

Question B5: 20. Responsibility (n = 199)

Forty-six respondents (n = 46) did not answer this question. As shown in table 4.12 responsibility was predominantly seen as having high priority (n = 105) (53%), whereas the minority was respondents perceiving it as priority (n = 90) (45%), little priority (n = 3) (2%) and no priority (n = 1) (1%).

Question B5: 21. Safety and security (n = 186)

Safety and security is shown in table 4.12 to have high priority to 42% of respondents (n = 78), priority to 53% of respondents (n = 98), little priority to 5% of respondents (n = 10) and no priority to no respondents (n = 0). This question was unanswered by 59 respondents (n = 59).

Question B5: 22. Social justice and fairness (n = 181)

Table 4.12 reflects that this value has priority for the majority of the respondents (n = 100) (55%), whilst it has high priority for 56 respondents (n = 56) (31%), little priority for 22 respondents (n = 22) (12%) and no priority for three respondents (n = 3) (2%). Sixty-four respondents (n = 64) did not answer this question.

Question B5: 23. Trustworthiness (n = 185)

This question was uncompleted by 60 respondents (n = 60). Trustworthiness (table 4.12) was seen as having high priority for 46% of respondents (n = 85), priority for 51% of respondents (n = 95) and little priority for 3% of respondents (n = 5), whilst no respondents (n = 0) feel that it has no priority.

Question B5: 24. Truth and honesty (n = 189)

Table 4.12 indicates that trust and honesty was rated by respondents as a predominant priority (n = 95) (50%) and high priority (n = 88) (47%). Six respondents (n = 6) (3%) rated these values as having little priority and no respondents (n = 0) rated it as having no priority. Fifty-six respondents (n = 56) did not complete this question.

Question B5: 25. Value of personhood (n = 193)

Value of personhood as reflected in table 4.12 had high priority for 48% of respondents (n = 93), priority for 47% of respondents (n = 91), little priority for 4% of respondents (n = 8) and no priority for 1% of respondents (n = 1). This question was not answered by 52 respondents (n = 52).

4.4.2.6 Question B6: Which values do you often use in order to make ethical decisions?

Reflected in table 4.13 is the respondents' indicated values used in order to make ethical decisions on a Likert scale. The values rated high priority predominantly in this question was:

1. Confidence (n = 146) (69%)
2. Accountability (n = 117) (59%)
3. Trust and honesty (n = 109) (57%)
4. Integrity and honesty (n = 108) (54%)
5. Compassion and Humanity (n = 97) (52%)
6. Respect for the rights of people (n = 94) (49%)
7. Responsibility (n = 94) (49%)
8. Competence (n = 89) (49%)
9. Quality care and excellence (n = 87) (47%)

This question was poorly answered; respondents tended to only rank the values important to the individual and then only rating it as either high priority or priority, leading to a lot of missing data, which will be reflected in the totals (n) of each of the 25 values.

Table 4.13: Values utilized to make ethical decisions

		Frequency *(f)*				
	Value	**No priority**	**Little priority**	**Priority**	**High priority**	**Total (n)**
1	Confidentiality	3 / 1%	7 / 3%	55 / 26%	146 / 69%	n = 211 / 99%
2	Accountability	1 / 1%	10 / 5%	69 / 35%	117 / 59%	n = 197 / 100%
3	Advocacy	5 / 3%	21 /12%	98 / 54%	58 / 32%	n = 182 / 101%
4	Altruism	4 / 2%	16 / 9%	107 / 62%	46 / 27%	n = 173 / 100%
5	Beneficence and Non-maleficence	3 / 2%	24 / 14%	93 / 53%	54 / 31%	n = 174 / 100%
6	Compassion / Humanity	3 / 2%	6 / 3%	82 / 44%	97 / 52%	n = 188 / 101%
7	Co-operative relationship with co-workers	3 / 2%	13 / 7%	98 / 53%	71 / 38%	n = 185 / 100%
8	Confidence	3 / 2%	10 / 5%	99 / 53%	76 / 40%	n = 188 / 100%
9	Courtesy	4 / 2%	18 / 10%	98 / 56%	56 / 32%	n = 176 / 100%
10	Competence	3 / 2%	8 / 4%	82 / 45%	89 / 49%	n = 182 / 100%
11	Equality	5 / 3%	12 / 7%	108 / 60%	54 / 30%	n = 179 / 100%
12	Freedom	6 / 4%	21 / 12%	168 / 63%	36 / 21%	n = 231 / 100%
13	Independence	2 / 1%	20 / 11%	112 / 64%	42 / 24%	n = 176 / 100%
14	Integrity / Honesty	1 / 1%	9 / 5%	82 / 41%	108 / 54%	n = 200 / 101%
15	Maintaining of standards of personal conduct	2 / 1%	10 / 6%	96 / 55%	67 / 38%	n = 175 / 100%
16	Privacy	3 / 2%	17 / 9%	88 / 47%	80 / 43%	n = 188 / 101%
17	Quality care / Excellence	2 / 1%	9 / 5%	87 / 47%	87 / 47%	n = 185 / 100%
18	Respect for dignity and autonomy	1 / 1%	10 / 6%	97 / 54%	70 / 39%	n = 178 / 100%
19	Respect for the rights of people	1 / 1%	6 / 3%	91 / 47%	94 / 49%	n = 192 / 100%
20	Responsibility	2 / 1%	3 / 2%	92 / 48%	94 / 49%	n = 191 / 100%
21	Safety / Security	9 / 5%	13 / 7%	108 / 59%	53 / 29%	n = 183 / 100%
22	Social justice / Fairness	4 / 2%	11 / 6%	107 / 59%	60 / 33%	n = 182 / 100%
23	Trustworthiness	3 / 2%	8 / 4%	91 / 49%	82 / 45%	n = 184 / 100%
24	Truth / Honesty	3 / 2%	4 / 2%	76 / 40%	109 / 57%	n = 192 / 101%
25	Value of personhood	3 / 2%	11 / 6%	91 / 48%	84 / 44%	n = 189 / 100%

Question B6: 1. Confidentiality (n = 211)

Confidentiality is shown in table 4.13 to be having high priority for 69% of respondents (n = 146), priority for 26% of respondents (n = 55), little priority for 3% of respondents (n = 7) and no priority for 1% of respondents (n = 3). This question was unanswered by 34 respondents (n = 34).

Question B6: 2. Accountability (n = 197)

As shown in table 4.3 accountability has high priority for the majority of respondents (n = 117) (59%) and the minority group of the respondents rating it as priority (n = 69) (35%), little priority (n = 10) (5%) and no priority (n = 1) (1%). 48 respondents (n = 48) did not complete this question.

Question B6: 3. Advocacy (n = 182):

Sixty-three respondents (n = 63) did not provide a response to this question. 32% of respondents (n = 58) ranked advocacy (table 4.13) as high priority, 54% (n = 98) as priority, 12% (n = 21) as little priority and 3% (n = 5) as no priority.

Question B6: 4. Altruism (n = 173)

As depicted in table 4.13 more than half of the respondents (n = 107) (62%) rated this value as priority, 46 respondents (n = 46) (27%) rated it as high priority, and it was rated as having little priority by 16 respondents (n = 26) (9%) and no priority by 4 respondents (n = 4) (2%). 72 respondents (n = 72) did not answer this question.

Question B6: 5. Beneficence and non-maleficence (n = 174):

Table 4.13 reveals that these values had high priority for 31% of respondents (n = 54), priority for 53% of respondents (n = 93), little priority for 14% of respondents (n = 24) and no priority for 2% of respondents (n = 3). This question was not completed by 71 respondents (n = 71).

Question B6: 6. Compassion and humanity (n = 188)

Fifty-seven respondents (n = 57) did not complete this question. The majority of the respondents ranked this value as high priority (n = 97) (52%), whilst the minority were respondents who rated this value as priority (n = 82) (44%), little priority (n = 6) (3%) and no priority (n = 3) (2%).

Question B6: 7. Co-operative relationship with co-workers (n = 185)

According to table 4.13 this value was predominantly ranked as priority (n = 98) (53%), while 38% of respondents (n = 73) ranked it as high priority, 7% (n = 13) as little priority and 2% (n = 3) as no priority. This question was unanswered by 60 respondents (n = 60).

Question B6: 8. Confidence (n = 188)

Confidence as value during ethical decision making was rated (table 4.13) as high priority by 76 respondents (n = 76) (40%), priority by 99 respondents (53%), little priority by ten respondents (5%) and no priority by three respondents (2%). 57 respondents (n = 57) did not answer this question.

Question B6: 9. Courtesy (n = 176)

More than half of the respondents rated courtesy as priority (n = 98) (56%), 32% rated it as high priority (n = 56), 10% rated it as little priority (n = 18) and 2% as having no priority (n = 4). This question was not answered by 69 respondents (n = 69)

Question B6: 10. Competence (n = 182)

Sixty-three respondents (n = 63) did not answer this question. As reflected in table 4.13, 89 respondents (n =89) (49%) ranked competence as high priority, 82 respondents (n = 82) (45%) as priority, eight respondents (n = 8) (4%) as little priority and three respondents (n = 3) (2%) as no priority.

Question B6: 11. Equality (n = 179)

As seen in table 4.13 equality was rated by majority of respondents as priority (n = 108) (60%). The minority group was respondents who rated this value as high priority (n = 54) (30%), little priority (n = 12) (7%) and as no priority (n = 5) (3%). 66 respondents (n = 66) did not complete this question.

Question B6: 12. Freedom (n = 231)

Depicted in table 4.13 more than half of the respondents indicated freedom as priority (n = 168) (63%). Whilst a mere 36 respondents (n = 36) (21%) rated it as high priority, 21 respondents (n = 21) (12%) rated it as having little priority and six respondents (n = 6) (4%) as having no priority. This question was unanswered by 14 respondents (n = 14).

Question B6: 13. Independence (n = 176)

As seen in table 4.13 64% of respondents (n = 112) ranked independence as priority, whereas 24% (n = 42) ranked it as high priority, 11% (n = 20) as little priority and 1% (n = 2) as no priority. 69 respondents (n = 69) did not answer this question.

Question B6: 14. Integrity and honesty (n = 200)

Integrity and honesty was predominantly rated as high priority (n = 108) (54%), according to table 4.13, whilst a minority of respondents rated it as priority (n = 82) (41%), little priority (n = 9) (5%) and no priority (n = 1) (1%). This question was unanswered by 45 respondents (n = 45).

Question B6: 15. Maintaining of standards of personal conduct (n = 175)

This question was unanswered by 70 respondents (n = 70). As shown in table 4.13 38% of respondents (n = 67) viewed this value as high priority during ethical decision making, 55% of respondents (n = 96) as priority, 6% (n = 10) as little priority and 1% (n = 2) as no priority.

Question B6: 16. Privacy (n = 188)

As reflected in table 4.13 privacy during ethical decision making was rated as high priority by 80 respondents (n = 80) (43%), priority by 88 respondents (n = 88) (47%), little priority by 17 respondents (n = 17) (9%) and no priority by three respondents (n = 3) (2%). 57 respondents (n =57) did not answer this question.

Question B6: 17. Quality care and excellence (n = 185)

Sixty respondents (n = 60) did not complete this question. Table 4.13 reveals that these values was seen as high priority (n = 87) (47%) and priority (n = 87) (47%) by equal amount of respondents, whilst nine respondents (n = 9) (5%) viewed it as having little priority and two respondents (n = 2) (1%) as no priority.

Question B6: 18. Respect for dignity and autonomy (n = 178)

According to table 4.13 the majority of respondents rated this value as priority (n = 97) (54%), with the minority group being respondents that rated it as high priority (n = 70) (39%), little priority (n = 10) (6%) and no priority (n = 1) (1%). Sixty-seven respondents (n = 67) did not complete this question.

Question B6: 19. Respect for the rights of people (n = 192)

Table 4.13 depicts that 49% of respondents (n = 94) viewed this value as having high priority, 47% (n = 91) as priority, 3% (n = 6) as little priority and 1% (n = 1) as no priority. Fifty-three respondents (n = 53) did not answer this question.

Question B6: 20. Responsibility (n = 191)

This question was unanswered by 54 respondents (n = 54). Seen in table 4.13 responsibility was rated as high priority by 94 respondents (n = 94) (49%), priority by 92 respondents (n = 92) (48%), little priority by three respondents (n = 3) (2%) and no priority by two respondents (n = 2) (1%).

Question B6: 21. Safety and security (n = 183)

As reflected in table 4.13 safety and security was perceived as priority by the majority of respondents (n = 108) (59%). However, it was perceived as high priority by 53 respondents (n = 53) (29%), little priority by 13 respondents (n = 13) (7%) and no priority by nine respondents (n = 9) (5%). Sixty-two respondents (n = 62) did not answer this question.

Question B6: 22. Social justice and fairness (n = 182)

Table 4.13 shows these values had high priority for 33% of respondents (n = 60), priority for 59% of respondents (n = 107), little priority for 6% of respondents (n = 11) and no priority for 2% of respondents (n = 4). Sixty-three respondents (n = 63) did not complete this question.

Question B6: 23. Trustworthiness (n = 184)

Seen in table 4.13 trustworthiness in ethical decision making had high priority for 82 respondents (n = 82) (45%), priority for 91 respondents (n = 91) (49%), little priority for eight respondents (n = 8) (4%) and no priority for three respondents (n = 3) (2%). This question was unanswered by 61 respondents (n = 61).

Question B6: 24. Truth and honesty (n = 190)

Table 4.13 indicates that this value was seen as high priority by the majority of respondents (n = 109) (57%), whilst 40% of respondents (n = 76) viewed it as priority, 2% (n = 4) as little priority and 2% (n = 3) as no priority. Fifty-five respondents (n = 55) did not complete this question.

Question B6: 25. Value of personhood (n = 189)

Value of personhood is reflected in table 4.13 as high priority for 44% of respondents (n = 84), priority by 48% of respondents (n = 91), little priority by 6% of respondents (n = 11) and no

priority by 2% of respondents (n = 3). This question was not answered by 56 respondents (n = 56).

4.4.3 Section C: Political factors

4.4.3.1 Question C1: Do you feel that appointment of nurses is done fairly?

A vast majority of respondents (n = 168) (71%) was of the opinion that appointment of nurses is not done fairly, with only 29% of respondents' (n = 69) response being positive. Eight respondents (n = 8) did not answer this question.

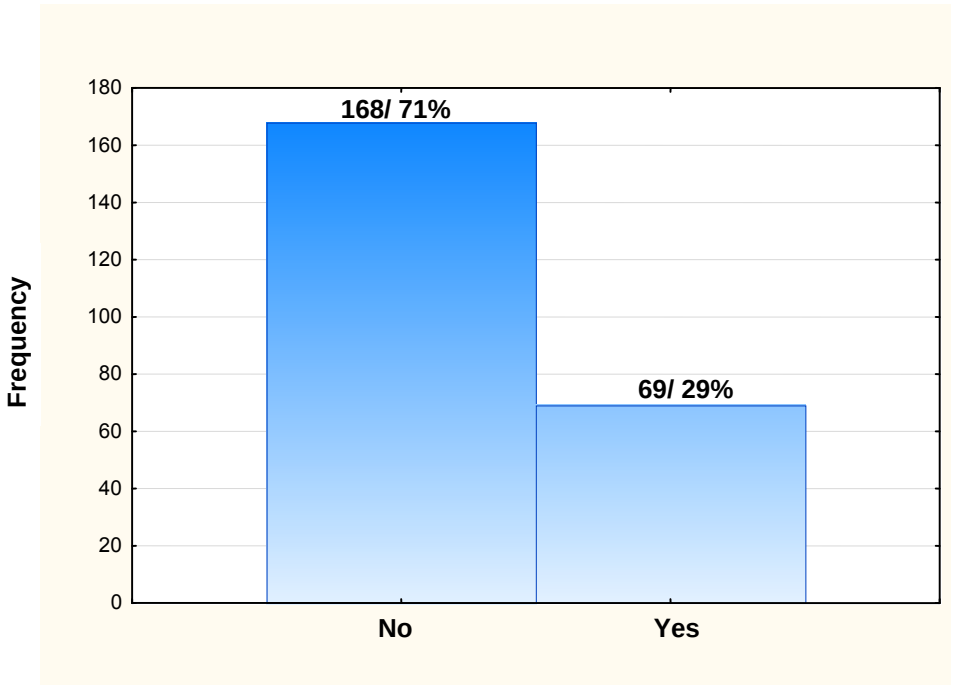


Figure 4.2: Fair appointment of nurses

4.4.3.2 Question C2: Do you feel that Staff Performance (SPMS) is rated fairly?

Figure 4.5 shows a substantial majority of respondents feels that Staff Performance is not evaluated fairly (n = 226) (95%), with respondents with a positive opinion about Staff Performance evaluation in the minority (n = 11) (5%). Eight respondents (n = 8) did not respond to this question. Staff Performance is evaluated according to the Employee performance management and development system in Provincial Administration of the Western Cape nursing facilities. This system was introduced with the aim to plan, manage and improve the performance of employees and to improve motivation (Department of Public Service and

Administration, 2007). With 71% of respondents indicating that this is not done fairly the risk might occur that employees' performance is not properly maintained and enhanced. However, in 4.4.4.7 the mean score for motivational level towards proper care is 6.7319, thus indicating that respondents are moderately motivated towards care.

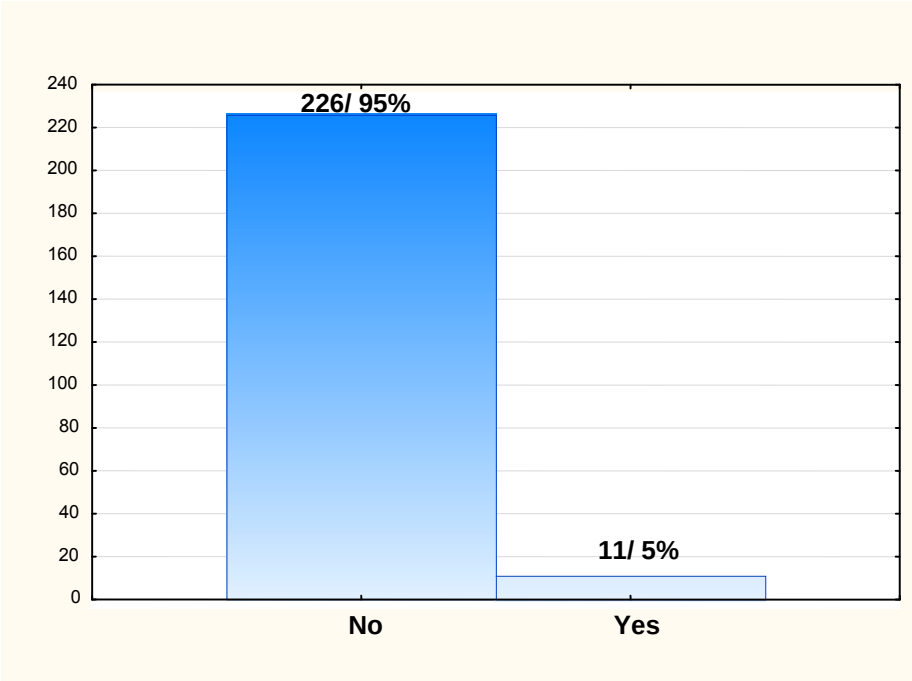


Figure 4.3: Staff performance management system rating

4.4.3.3 Question C3: Rate your knowledge of the acts, regulations and policies applicable to your work

As seen in figure 4.6 the majority of respondents rated their knowledge of acts, regulations and policies as a five or more on a scale of nil to ten. The mean for this rating scale was 6.2, with a standard deviation of 1.9. Only 13 respondents (n = 13) (6%) indicated that they have excellent knowledge of acts, regulations and policies, this could be closely related to the respondents indicating that nurses on ground level have no insight into acts, regulations and protocols in response to the political factors affect their nursing practice (table 4.14).

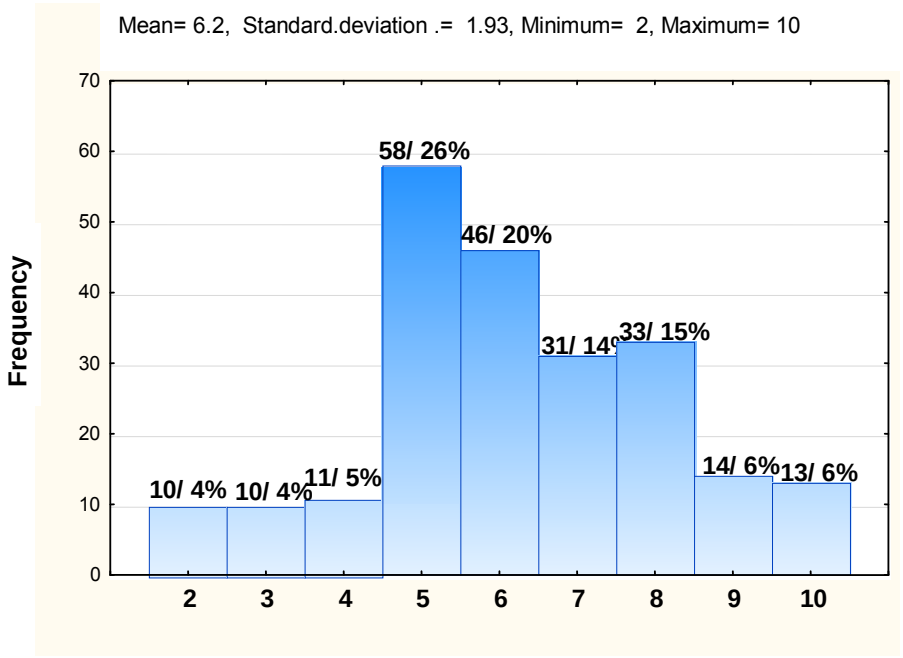


Figure 4.4: Knowledge of acts, regulations and policies

4.4.3.4 Question C4: Describe the political factors that are influencing your nursing practice

In this question respondents were asked to report the political factors influencing their nursing practice. Analysis of the data highlighted the emergence of five major themes. 122 comments were provided by respondents and were grouped and exemplified with verbatim quotations (n = 122).

Table 4.14: Political factors influencing nursing practice (n = 122)

Theme	Sub-themes
Treatment of nurses and changing nursing profession	Nursing is more administration Educational system Rights of nurses
Racism in nursing practice	
Appointment of staff	Unfairness of affirmative action Appointment not according to skill Nepotism with appointment of staff
Influence of unions in nursing practice	Disparity between unions Influence of unions
Administration	No consideration of work done on ground level Allocation of funding
Low involvement of practising nurses in decision making	

Theme 1: Treatment of nurses and changing nursing profession

The first major theme was the "allocation and treatment of nurses and changing nursing profession" (n = 30) (25%). This theme comprises of three sub-themes that is supported by responses by respondents:

Sub-theme 1: Nursing is more administration

Respondents experience that nursing is more focused on the administrative responsibilities of the nurse than nursing care:

> "The administration is more than nursing care" (respondent 52)
>
> "Nursing became more administration than nursing care" (respondent 55)

The respondents also reported that nursing is more focussed on protocols and rules than the nursing care of patients:

> "Nursing is more handling of protocols and rules than nursing care" (respondent 58)

Sub-theme 2: Educational system

These respondents felt that the changes in the educational system, the curriculum and also the opening of private nursing schools also have a great effect on their nursing practice:

> "Change in education system, change in curriculum, opening of private schools for nursing" (respondent 117)

Sub-theme 3: Rights of nurses

Indicated was respondents' discontentment that the rights of nurses are not considered and that the rights of patients are more important than the rights of the nurses:

> "Human rights are more important than the rights of health workers" (respondent 73)
>
> "Rights of nurses not taken into consideration due to lack of enough information regarding the needs of nurses and individuals" (respondent 80)

Theme 2: Racism in nursing practice

Respondents reported that "racism and discrimination in nursing practice" is a major political factor affecting nursing practice (n = 27) (22%). Respondents mostly indicated reversed racism in the workplace, between colleagues, individuals, but also with the appointment of staff. This can be seen in these responses:

> "Reverse racism" (respondent 179)
>
> "Racism between colleagues" (respondent 125)
>
> "Individual racism" (respondent 178)
>
> "Racial differences" (respondent 223)
>
> "Racism with appointment of staff" (respondent 151)

It was alarming that one respondent indicated that discrimination is also accompanied with intimidation:

> "Discrimination and intimidation" (respondent 158)

Theme 3: Appointment of staff

Respondents indicated that "appointment of staff" have an effect on nursing practice (n = 24) (20%). Three sub-themes were identified, labelled "unfairness of affirmative action", "appointment not according to skill" and "nepotism with appointment of staff" illustrated with verbatim quotations.

Sub-theme 1: Unfairness of affirmative action

Respondents indicated that to their opinion affirmative action is creating unfairness during staff appointment:

> "Transformation not always fair – diversity is a scam" (respondent 4)
>
> "Equity brings unfairness" (respondent 5)
>
> "Appointment according to race – the country has to look beyond the past (respondent 220)

Sub-theme 2: Appointment not according to skill

Appointment of staff was not only seen as unfair by respondents, but they also indicated that the appointment of staff is not according to the level of skill of the respondents and subsequently not the best person is appointed for a position:

> "Equity ensures that in some instances not the best person is appointed, rather the weakest person with the correct skin colour" (respondent 68)
>
> "Appointment according to the EE plan requirements and not according to skills" (respondent 74)

Sub-theme 3: Nepotism with appointment of staff

It was alarming that a number of respondents reported that nepotism occurs during the appointment of staff, it was seen with this response:

> "...preference to people that knows people in authority positions" (respondent 173)

Theme 4: Influence of unions in nursing practice

Respondents reported "influence of unions in nursing practice" as a political factor effecting nursing practice. Analysis of responses highlighted two sub-themes, labelled as "disparity between unions" and "influence of unions".

Sub-theme 1: Disparity between unions

It was evident in responses that respondents are of the opinion that the different unions do not convey the same messages:

> "Unions that communicate different messages" (respondent 6)
>
> "Too many unions that is contradicting another" (respondent 8)

Sub-theme 2: Influence of unions

It was indicated that respondents feel that the influence of the unions is not always positive. This was indicated with this response by a respondent:

> "Union interference" (respondent 210)

A number of respondents indicating the effect of unions during strikes as this ensure that nurses do not come on duty:

> "....strikes and not coming on duty" (respondent 29)

This respondent also indicated the ineffectiveness of unions:

> "Unions do not address problems successfully" (respondent 58)

Theme 5: Administration

"Administration" was perceived as a political factor affecting nursing practice. Two sub-themes evolved from the responses, branded as "no consideration of work done on ground level" and "allocation of funding".

Sub-theme 1: No consideration of work done on ground level

Respondents reported that the work responsibilities of nurses on ground level are not considered during administration:

> "...services are allocated to clinics, without any consideration for the infrastructure, level or amount of personnel and work load at clinic" (respondent 108)
>
> "Regulations do not accommodate additional tasks" (respondent 53)

With these responses a sense of helplessness and under appreciation is portrayed:

> "....rules and regulations are made and nurses must just comply with it" (respondent 20)
>
> "Top management have no idea what is going on ground level" (respondent 116)

This low recognition and consideration is alarming incognisance of Herzberg's theory of motivation that implicates relationship with the employer function as a hygiene factor that leads to dissatisfaction (Training and development solution, 2001 – 2011).

Sub-theme 2: Allocation of funding

This sub-theme encompasses responses reporting that funding does not always support the needs of nurses; these include funding to appoint more staff and the competition with other programs and provinces:

> "Budget too little to employ more people and posts are frozen" (respondent 47)
>
> "....posts are frozen that leads to burnout of staff" (respondent 108)
>
> "Competition with other programs and provinces for sufficient funding" (respondent 73)

Theme 6: Low involvement of practicing nurses in decision making

The final major theme for this question was the "low involvement of practising nurses in decision making". This can be seen in these responses:

> "Low consideration of personnel on ground level with decision making" (respondent 53)
>
> "Decision making is done on national level without insight from ground level" (respondent 115)
>
> "Personnel on ground level are not made part of decision making" (respondent 193)

4.4.4 Section D: Socio-economic factors

4.4.4.1 Question D1: Do you feel that you are receiving remuneration according to the level of work you deliver?

Depicted in Figure 4.7 67% of respondents (n = 158) is of the opinion that the remuneration is not according to the level of the work delivered, whereas 33% of respondents (n = 79) feel that the remuneration is correct according to level of their work delivered. This question was not completed by eight (n = 8) respondents. Remuneration is a form of recognition by the employer and recognition identified by the motivational theory of Herzberg (Training and development solution, 2001 – 2011) as a motivator that leads to satisfaction by employees.

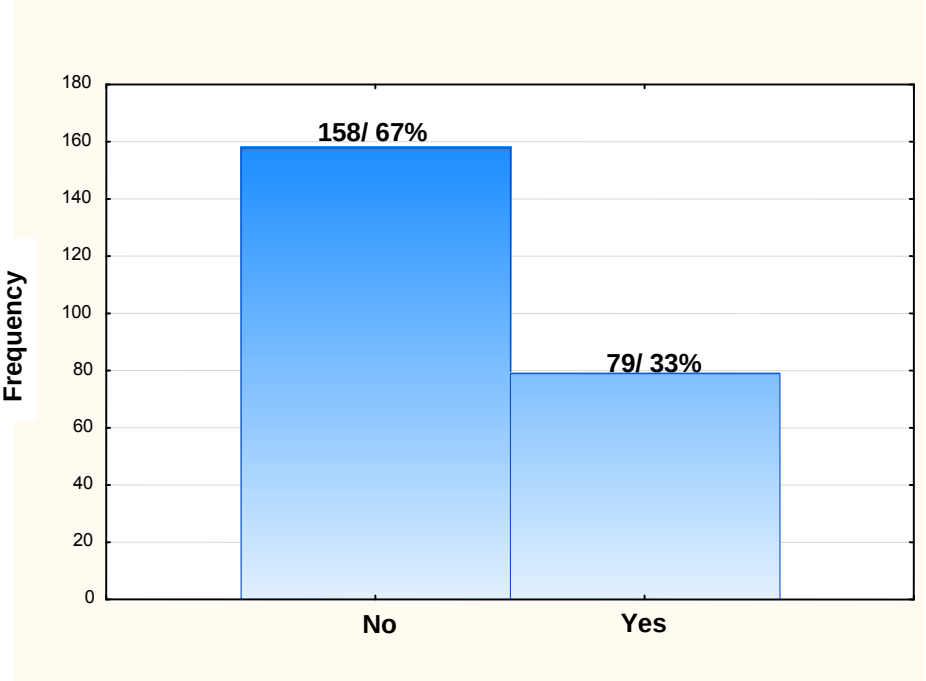


Figure 4.5: Remuneration according to the level of work delivered

4.4.4.2 Question D2: Can you keep up with the financial demands of life?

Five respondents (n = 5) did not answer this question. As seen in Figure 4.8 of the respondents that answered this question 168 (n = 168) (70%) cannot keep up with the financial demands of life, while 72 respondents (n = 72) (30%) can. Salary is a hygiene factor according to the motivational theory by Herzberg (Training and development solution, 2001 – 2011) which is problematic because more than half of respondents report that they are of the opinion that

remuneration is not according to the level of work delivered as this can lead to dissatisfaction and low motivation.

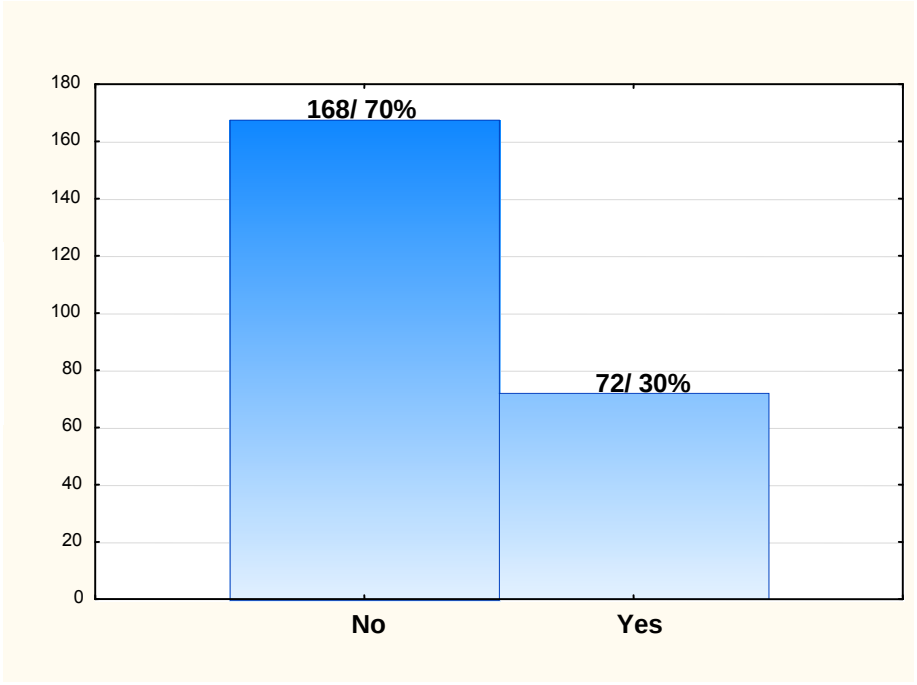


Figure 4.6: Keeping up with financial demands

4.4.4.3 Question D3: Do you feel that if your salary level were higher you would have been better motivated towards nursing care?

Figure 4.9 indicates that the majority of respondents (n = 163) (68%) indicated that they will be better motivated towards nursing care with an increase in salary level with the minority (n = 76) (32%) indicating that higher salary levels will have no influence on the care they delivered. This question was unanswered by six (n = 6) respondents. This corresponds with the motivational theory of Herzberg (Training and development solution, 2001 – 2011) that indicate salary as a hygiene factor, which indicates that if the needs of an employee is not satisfied it can lead to dissatisfaction and de-motivation.

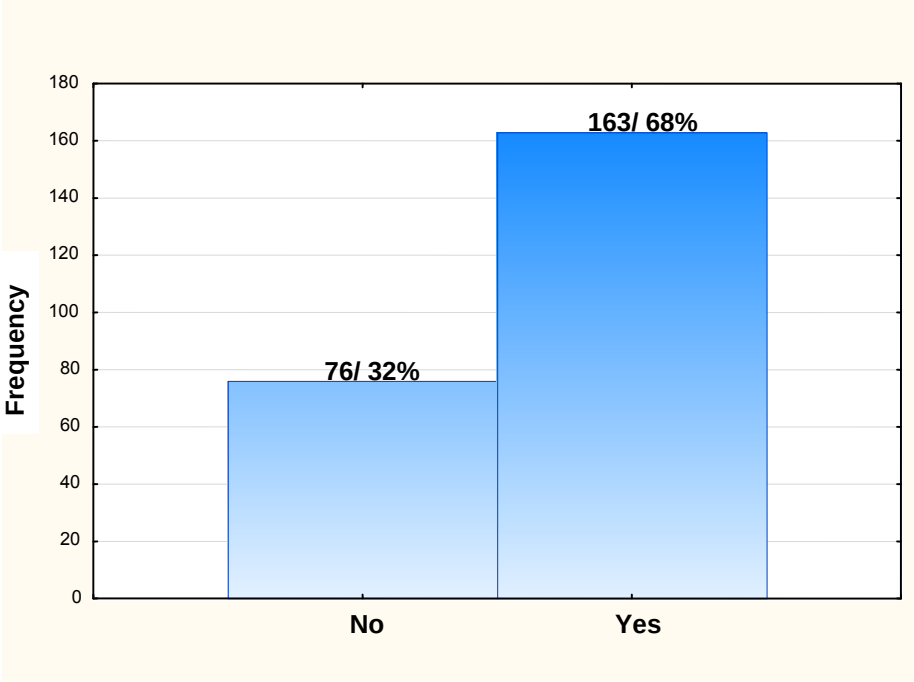


Figure 4.7: Would a higher salary lead to better motivation towards nursing care?

4.4.4.4 Question D4: Did you receive a significant salary increase during Occupation Specific Dispensation (OSD)?

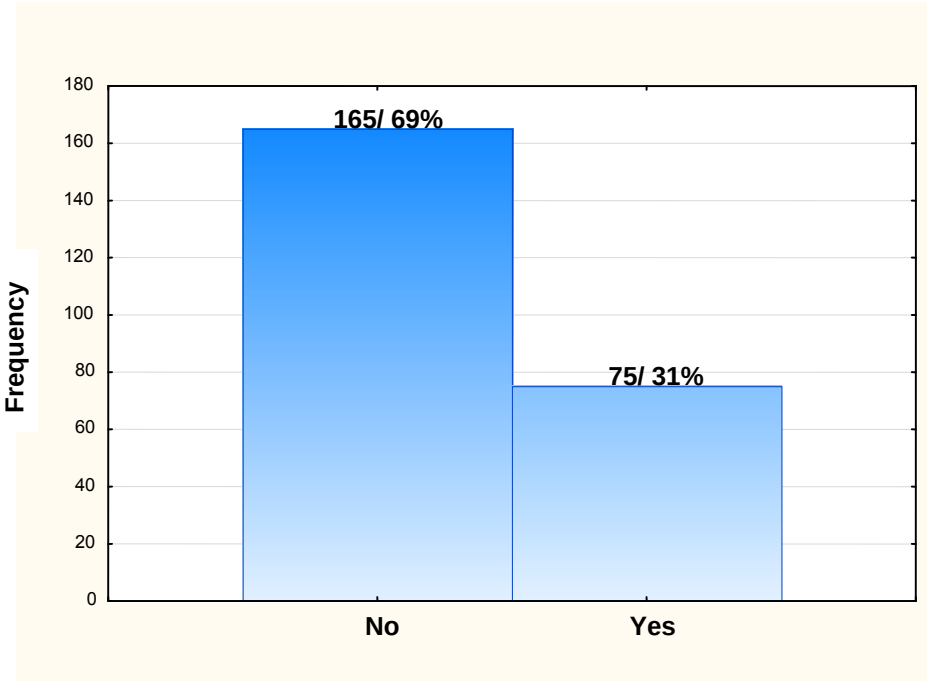


Figure 4.8: Did participants receive OSD?

More than half of the respondents were not significantly compensated during OSD (n = 165) (69%) with the minority receiving a significant salary increase during OSD (n = 75) (31%). Five respondents (n = 5) did not reply to this question.

4.4.4.5 Question D5: Do you think that the institution employs enough personnel to deliver proper nursing care?

Nearly all respondents (n = 230) (95%) was of the opinion that the institution where they work do not employ enough personnel to ensure delivery of proper nursing care. Four respondents (n = 4) did not complete this question. This is also reflected in 4.4.4.9 with responses by 17% of respondents indicating that staff shortages cause conflict in the department.

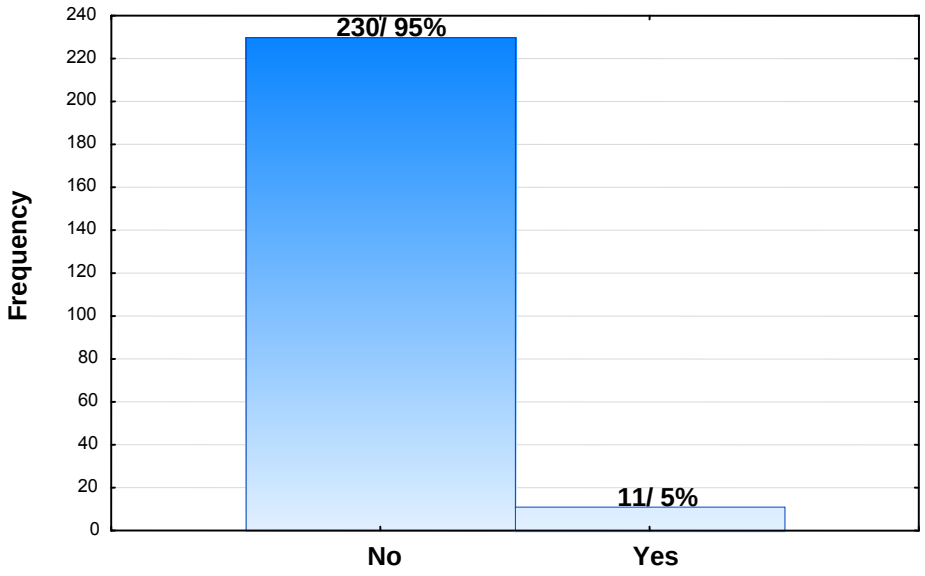


Figure 4.9: Do you think the institution employs enough personnel to deliver proper nursing care?

4.4.4.6 Question D6: Can you keep up with the demands of work and still ensure proper care?

Five respondents (n = 5) did not complete this question. Figure 4.12 indicates that 56% of respondents (n = 134) cannot keep up with the demands of their work and still provide proper

care, whereas 44% (n = 106) responded positively to this question. Work conditions form part of the hygiene factors stated in the motivational theory by Herzberg (Training and development solution, 2001 – 2011), again this can lead to de-motivation of employees.

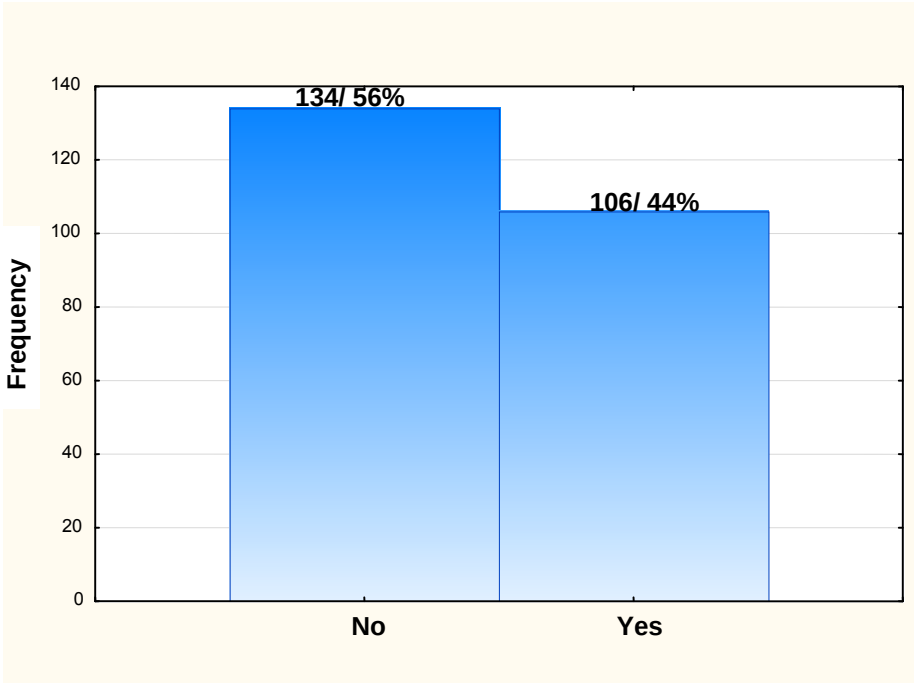


Figure 4.10: Can you keep up with demand of work and still ensure proper care?

4.4.4.7 Question D7: How motivated are you to deliver proper care?

In this question respondents had to rate their level of motivation towards proper care on a scale of 0 to 10. According to Figure 4.13 the median level of motivation was 7, the mean was 6.7319, with a standard deviation of 2.2015, and the outlier for this question was 0. Nursing is defined by the SANC (see paragraph 2.3) as a caring profession. Pera and Van Tonder (2005:7) identify that the primary goal of nursing is to provide optimal care for every client, as indicated the sentiment of respondents is in agreement with this opinion. With the mean motivational level for proper nursing care being 6.7319 it is a concern that this motivational level is not the maximum for all respondents.

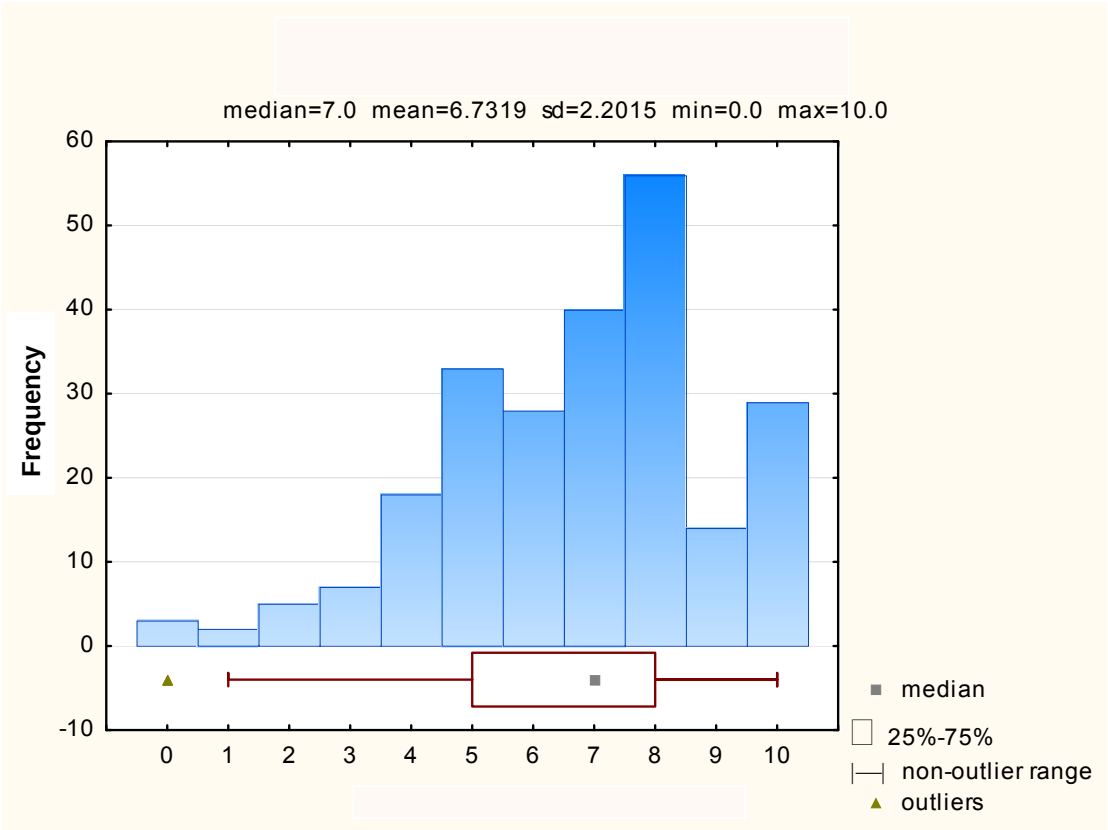


Figure 4.11: Level of motivation

4.4.4.8 Question D8: What is the level of conflict in the department you are working at?

According to Figure 4.14 the mean level of conflict in the departments where respondents worked was 5.4292, the median 5, with a standard deviation of 2.5352 on a scale of nil to ten, and there were no outliers in this question. Conflict influence work conditions and relationships with peers, which forms part of the hygiene factors in Herzberg's motivational theory, leading to dissatisfaction (Training and development solution, 2001 – 2011)

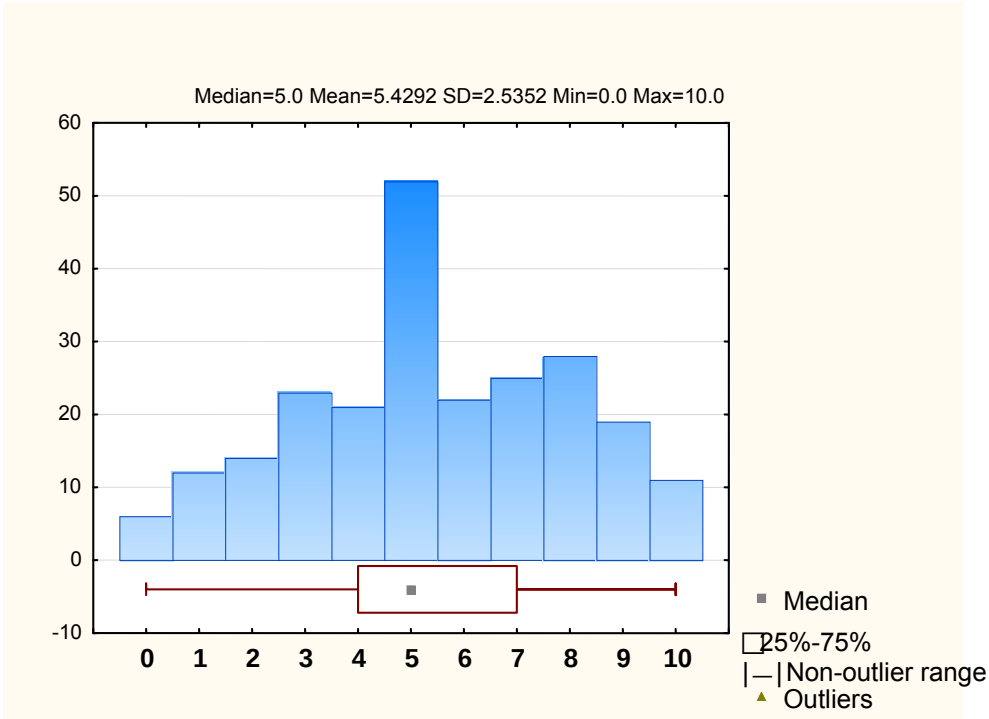


Figure 4.12: Level of conflict in the department

4.4.4.9 Question D9: What is causing the conflict in the department?

Table 4.15: Causes of conflict in the departments (n = 174)

Theme	Sub-themes
Work relations	Poor cooperation
	Relationships
Personnel shortages	
High workload	
Management	
Shifts and leave planning	
Unfairness	
Poor communication	
Relieving in other departments	
Work conditions and shortage of consumables	
SPMS, OSD and salaries	

Respondents were requested in this open-ended question to provide qualitative data on the causes, in their opinion, of conflict in the department. 174 responses were provided to this question (n =174). The comments of respondents could be placed in ten major themes and the responses are exemplified with verbatim quotations.

Theme 1: Work relations

The first major theme reported was "work relations" (n = 70) (25%). Two sub-themes were identified from the responses, labelled as "poor cooperation" and "relationships".

Sub-theme 1: Poor cooperation

Respondents identified that conflict arises when there is poor cooperation in this department, this included laziness and poor group work:

> "Poor cooperation, poor group work" (respondents 22)
>
> "Personnel that does not want to work under authority" (respondent 5)
>
> "Laziness of some staff" (respondent 64)
>
> "Personnel attitude towards work and staff (respondent 107)

Sub-theme 2: Relationships

A number of respondents indicated that the personal relationships in the department are not optimal and therefore leads to conflict, when personnel have friendship relationships it was indicated as leading to conflict. This included a number of respondents indicating that professional jealousy influences the level of conflict in the department:

> "Personal relationships in departments need attention" (respondent P10)
>
> "Friendship relationships create unfairness" (respondent 28)
>
> "Professional jealousy" (respondent 228)

This lack of good relationships is a matter of concern when the humanistic nursing practice model is taken into consideration. This model highlights that human interaction is an important part of nursing practice, it identifies interaction between humans, the meeting of people, relationships between humans and sharing between individuals, signifying that nursing occurs in the context of relationship (George, 2002:558). However, these comments by respondents signify unsatisfactory relationships.

Relationship with peers is indicated in the theory of motivation by Herzberg as a hygiene factor (Training and development, 2001 – 2011). The lack of good relationships with peers can lead to

dissatisfaction. This is a real concern which came to light in the responses by these respondents.

Theme 2: Personnel shortages

Respondents reported "personnel shortages" as one of the major causes of conflict in the departments (n = 47) (17%). Respondents reported that this shortage of staff leads to higher workload that consequently leads to conflict. This is motivated by these responses by respondents:

"Too much work, too little staff" (respondent 48)

"Staff shortages leads to high workload" (respondent 40)

"Shortage of staff increase the workload and result in poor patient care" (respondent 124)

"Too little staff on duty leads to overtiredness and work pressure" (respondent 23)

A number of respondents reported that staff levels on night duty is not sufficient and that it should correspond with the staff levels on day duty, as the patient levels stay constant on day and night duty, this could lead to conflict:

"Very little nurses on night duty with the same patients as on day duty" (respondent 233)

This staff shortage was also reported for non-nursing staff:

"Cleaning and administrative staff shortages" (respondent 199)

"...shortages of doctors" (respondent 37)

Theme 3: High workload

"High workload" was indicated as a leading theme causing conflict in the department (n = 37) (13%). This cause of conflict includes the amount of patients and greater responsibility due to additional work. This was indicated by these responses by respondents:

"High turnover" (respondent 217)

"....implementation of new programs and more responsibilities without considerations of staff" (respondent 97)

"Staff shortages leads to high workload" (respondent 40)

"Higher patient numbers" (respondent 192)

"Workload is too high" (respondent 164)

Theme 4: Management

Respondents indicated "management" as creating conflict in departments (n = 27) (10%). It was identified from responses that it was not only the use of inappropriate management styles

and decision making by managers, but also the managers' lack of knowledge about the function of the department:

> "Autocratic management style" (respondent 143)
>
> "Autocratic decision making" (respondent 139)
>
> "Unit manager has too little knowledge of what is happening in the department" (respondent 128)
>
> "Department heads that want to manage you and want to make your decisions" (respondent P4)

Theme 5: Shift and leave planning

"Shifts and leave planning" were indicated as a major theme for this question (n = 23) (8%). Following are responses that indicated this:

> "Leave and night duty planning, requesting for shifts" (respondent 26)
>
> "Sometimes unfair treatment with regard to off duties..." (respondent 57)
>
> "Adapting of off duties" (respondent 75)

Theme 6: Unfairness

Respondents identified "unfairness" as a leading cause of conflict in nursing facilities (n = 22) (8%). This included unfairness with regard to work responsibilities and treatment of staff. Examples of responses that motivate this theme are:

> "More work allocated to one person than another...unfair division of work responsibilities" (respondent 113)
>
> "Unfair treatment by supervisors" (respondent 86)
>
> "Favouring of personnel" (respondent 103)
>
> "Unfair work and leave division" (respondent 148)

Theme 7: Poor communication

"Poor communication" was indicated as a source of conflict for respondents (n = 20) (7%). This included communication with nurses, colleagues and patients. Responses that motivated this are:

> "Poor communication between nurses" (respondent 209)
>
> "Mistaken communication" (respondent 21)
>
> "Patient-nursing staff communication not well understood....doctor-nurse communication" (respondent 80)

"Communication is poor, the supervisor will give an order, but not all staff knows about it" (respondent 121)

Theme 8: Relieving in other departments

Respondents reported "relieving in other departments" as creating conflict in departments (n = 15) (5%). It was indicated that relieving in other departments can cause burnout. This major theme is exemplified by these responses:

"The fact that you have to relieve in other departments, above all your other responsibilities" (respondent 15)

"Relieving in other departments leads to burnout" (respondent 56)

"Due to staff shortages relieving in other departments" (respondent 215)

Theme 9: Work conditions and shortage of consumables

"Work conditions and shortage of consumables" was indicated as a major theme in this question (n = 13) (5%). Respondents reported a lack of personal space and not having the necessary consumable as major causes of conflict, as indicated:

"Fight for territory, little resources, everybody fights to receive the best" (respondent 73)

"Unfavourable conditions, continuously in each other's personal space" (respondent 86))

"Very slow supply of stock" (respondent 220)

Theme 10: SPMS, OSD and salaries

The last of the major themes indicated by respondents experience "SPMS, OSD and salaries" create conflict in the departments (n = 8) (3%). Some respondents reported unfairness with regard to SPMS. This is motivated by these responses:

"Unfair allocation and evaluation of SPMS" (respondent 163)

"OSD, SPMS and salary levels" (respondent 44)

"OSD and SPMS" (respondent 152)

"SPMS unfairness" (respondent 67)

4.4.4.10 Question D10: Describe the social factors that are influencing your nursing practice

The social factor indicated by respondents as having an influence on their nursing practice identified eight themes. 181 responses were provided for this question (n = 181). Responses by respondents were reported as verbatim as support for each theme or sub-theme:

Table 4.16: Social factors influencing nursing practice (n = 181)

Theme	Sub-themes
Influence of nursing practice on personal life	Influence on family life Influence on social life
Social circumstances in the department	Lack of good working conditions Social relationships
Personal and social problems affecting nursing practice	Illness Living conditions Family life Transport
The community	Poverty of the community Unemployment Education of the community
Alcohol and drug abuse	
Health status of the community and their responsibility towards their health	
Violence and crime	
Growth in population and urbanization	

Theme 1: Influence of nursing on personal life

The first major theme that evolved from this question was the "influence of nursing on personal life" (n = 52) (29%). Two sub-themes advanced from the responses, labelled as "influence on family life" and "influence on social life".

Sub-theme 1: Influence on family life

Analysis of responses indicated that respondents experience that their work has an influence on their family life. A vast amount of respondents indicated that the shifts they work influence their family life greatly:

> "Personnel on night duty are not accommodated with regard to crèches" (respondent P1)
>
> "Overtired and irritated at home due to shifts" (respondent 40)
>
> "....I cannot attend children's' activities" (respondent 56)

This respondent indicated her concern about her children when she is at work:

> "I am worrying about the level of care my children are receiving when I am at work" (respondent 212)

Sub-theme 2: Influence on social life

Identified from the responses was respondents' expression of their poor involvement in any form of social activity, it was cited that they are too tired to attend and that the shifts influence their involvement in social activities:

"Too tired to be social" (respondent 15)

"I cannot attend social activities" (respondent 28)

"Difficult to plan social life due to short notice of shifts" (respondent P8)

Theme 2: Social circumstances in the department

Respondents made reference of the "social circumstances in the department" (n = 35) (19%) as having an effect on their nursing practice. From the responses two sub-themes became evident, labelled "lack of good working conditions" and "social relationships".

Sub-theme 1: Lack of good working conditions

It was indicated by respondents that the conditions they work in are not supportive of good nursing practice. They identified that the facilities are not conducive; this was especially indicated to clinics:

"Precarious working conditions, no proper facilities for breaks at clinic" (respondent 90)

"No restrooms" (respondent 96)

Respondents reported that a lack of sufficient staff levels and resources also affect the nursing care they provide:

"Personnel shortage, with addition to absenteeism and personnel on study leave" (respondent 101)

"Shortage of staff leads to exhaustion at the end of the shift" (respondent 232)

"Lack of resources" (respondent 116)

Sub-theme 2: Social relationships

Responses reflected respondents' discontentment with the social relationships in the different departments. They indicated no support between nurses, that relationships are not cooperative and more effort should be made to create teambuilding:

"No support with personal problems" (respondent P5)

"Poor cooperative relationships between colleagues" (respondent 52)

"Teambuilding opportunities not held" (respondent 53)

Respondents cited that the lack of involvement of the multi-disciplinary team also reduces the level of nursing care provided:

> "Lack of multi-disciplinary team involvement, e.g. occupational therapist, counsellors" (respondent 147)

Indicated by a number of respondents was the lack of interaction and support from management:

> "No interaction between management and ground level" (respondent 227)
>
> "Lack of staff and not getting enough support from management" (respondent 226)

According to the motivational theory by Herzberg (Training and development solution, 2001 – 2011) working conditions is a hygiene factor. These statements by respondents directly indicate that they feel dissatisfied and this can conclude to feelings of de-motivation.

Theme 3: Personal and social problems effecting nursing practice

Respondents indicated "personal and social problems effecting nursing practice" as a social factor that has an influence on nursing practice as the third most important theme (n = 31) (17%). Four sub-themes were identified from the responses by respondents, labelled as illness, living conditions, family life and transport.

Sub-theme 1: Illness

The first of the sub-themes that could be identified from the responses was the influence of illness of nurses as a social factor affecting nursing practice:

> "Stress due to illness" (respondent 29)
>
> "Depression of staff due to domestic problems" (respondent 190)

Subtheme 2: Living conditions

Respondents reported that their own living conditions or that of their colleagues affects their nursing practice:

> "Poor conditions at home" (respondent 100)
>
> "Living conditions has the biggest contribution to absenteeism that affects level of care" (respondent 138)

Sub-theme 3: Family life

Cited by respondents was the effect that family life has on their nursing practice, mostly referenced was the financial responsibilities and also marriage conflict:

> "My financial implications of home responsibilities" (respondent 125)

"Conflict in marriage" (respondent 203)

Sub-theme 4: Transport

Respondents indicated transport problems as social factor affecting nursing practice, a number of respondents indicated the unreliability of public transport that they make use of:

"...transport problems" (respondent 2)

"Public transport not always reliable" (respondent 215)

Theme 4: The community

Respondents reported "the community" as a social factor influencing nursing practice (n = 20) (11%). Respondents' responses were grouped in three sub-themes, labelled as "poverty of the community", "unemployment" and "level of education of the community":

Sub-theme 1: Poverty of the community

Poverty of the community was viewed by respondents as having a great effect on their nursing practice as it can also lead to increase in the medical care required:

"Poverty of the community serviced" (respondent 57)

"Poverty leads to malnutrition leading to medical care" (respondent 117)

"Working in low socio-economic areas" (respondent 198)

Sub-theme 2: Unemployment

Respondents reported that unemployment leads to crime and violence that increase the requirement for medical care:

"Unemployment leads to crime and violence" (respondent 37)

"Poverty and low level of education" (respondent 60)

Sub-theme 3: Education of the community

Educational level of the community was identified as also affecting nursing practice:

"Low standard of education, poor career guidance" (respondent 117)

Theme 5: Alcohol and drug abuse

A major theme respondents indicated was "alcohol and drug abuse" (n = 14) (8%) as one of the leading social factors influencing nursing practice. Alcohol and drug abuse of the community and nurses' family members are supported by these responses:

"Alcohol and drug abuse of community" (respondent 88)

"Alcohol and drug abuse of nurses and family of nurses" (respondent 181)

> "Alcohol abuse, misuse of tobacco and negative responsibility of the community (respondent 89)
>
> "Drug abuse" (respondent 64)

It was alarming that one respondent reported the increase of drug abuse amongst nurses:

> "Drug abuse is increasing amongst nurses" (respondent 138)

Theme 6: Health status of the community and their responsibility towards their health

"Health status of the community and their responsibility towards their health" was shown to be a major theme as social factor effecting nursing practice (n = 12) (7%). Respondents reported the influence of HIV and Tuberculosis and other chronic diseases:

> "HIV and TB pandemic" (respondent 107)
>
> "High rate of contagious diseases, e.g. HIV/AIDS and TB and other chronic illnesses" (respondent 233)

It was also the respondents' experience that patients have a negative responsibility towards their health, with patients not cooperating, defaulting on medication and continuous readmission of patients:

> "Patients that do not give their full cooperation with regard to their health" (respondent 108)
>
> "Defaulting in the use of medication" (respondent 120)
>
> "Continuous re-admissions of patient due to non-compliance...Non-involvement of family members in caring for their family" (respondent 147)

Theme 7: Violence and crime

Respondents reported "violence and crime" (n = 9) (5%) as a social aspect affecting nursing practice. This involved family-, woman- and child abuse-, indicated with the following responses:

> "Family violence" (respondent 138)
>
> "Woman and child abuse" (respondent 139)
>
> "Violence and crime" (respondent 64)
>
> "Molesting of women and children" (respondent 108)

Theme 8: Growth in population and urbanization

The final major theme for this question indicated "growth in population and urbanization" (n = 8) (4%) as a social factor affecting nursing practice. Respondents focused on the language

barriers and level of care influenced by this theme. This theme is supported by the following responses:

> "Influx from homelands and other countries makes it difficult to apply proper quality care as most clients are incompliant to their treatment" (respondent 114)
>
> "Overpopulation" (respondent 109)
>
> "High growth in population" (respondent 107)
>
> "Urbanization, high influx from the Eastern Cape, communication barriers" (respondent 111)
>
> "Language barriers especially with season workers" (respondent 119)

4.4.4.11 Question D11: Comments

In this question respondents were asked to provide any additional information that was not addressed in the questionnaire, which is important for them. Only 38 responses were provided to this questions (n = 38). The comments of respondents could be placed in five major themes and the theme is exemplified with verbatim quotations.

Table 4.17: Comments

Theme	Sub-themes
Working conditions	Management
	Staffing
	Unfavourable work conditions and poor attention to nurses' needs
	Education of nurses
Positivity towards the research	
Nursing profession changed	
Unfairness of OSD and SPMS	
Positive opinion about nursing	

Theme 1: Working conditions

The first major theme of responses refer to those that focus on "work conditions" (n = 23) (61%). Four sub-themes evolved from this theme. These sub-themes labelled "management", "staffing", "unfavourable work conditions and poor attention to nurses' needs" and "education".

Sub-theme 1: Management

"Management" was reported as the most important aspect affecting working conditions. Respondents indicated their unhappiness with regard to management style and managements' low understanding and support:

> "I am still very glad that I chose nursing as profession, but you work hard with little amount of personnel and we receive very little appreciation for what we do. Management follow up very quickly on complaints, but give little appreciation for good care. Only staff in high posts ever goes on teambuilding weekends, the rest are not acknowledged. In the past we all received fair SPMS increases." (respondent P1)

> "Bigger salaries will not increase the morale or motivation of personnel. The employer does not show that he appreciates his employees and their hard work." (respondent 87)

> "Nursing is my passion, it just frustrates me when there is now consideration from management, with regard to illness or deaths in the family, or children's important days that you as staff member really want to attend, but it does not suite the department (understandably) or you just hope for nothing." (respondent 106)

Sub-theme 2: Staffing

The respondents indicated that "staffing" is also affecting their nursing practice. Staff shortages were indicated as having a negative influence, especially on the workload, these responses exemplify this theme:

> "Too little personnel in the department to handle the load." (respondent P7)

> "I enjoy nursing. To help my fellow human being in need is my passion. Nowadays it is impossible to live out my passion, due to personnel shortage and higher workload." (respondent P10)

> "I enjoy my work; this is my passion and calling from God. I just feel that more personnel must be appointed to make the workload less for personnel." (respondent 9)

> "Appointment of more personnel to relief workload. Give nurses more insight into acts, regulations and protocols." (respondent 41)

> "Due to shortage of staff there is unnecessary pressure on those on duty, thus there is a high sick leave record and I think there must be looked at appointment of staff." (respondent 230)

> "Provide more nurses on night duty because it is just as busy on night as on day duty." (respondent 232)

One respondent indicated that more personnel and revised salaries will ensure that more people enter the nursing profession, which is revealed below:

> "I hope more personnel are appointed and that salaries will be revised to ensure more people apply for the profession." (respondent 175)

Sub-theme 3: Unfavourable working conditions and poor attention to nurses' needs

"Unfavourable working conditions and poor attention to nurses' needs" was the third subtheme that was indicated. Respondents indicated the provision of staffing, the morale and recognition of nurses and their needs, as reported below:

> "We are only two nurses at the clinic, it means that if one must go relieve where there is only one nurse, the one that stays behind must handle the whole clinic alone. This is so unfair. Often I do not like to go to work, just due to the relieving." (respondent 15)

> "Excellent and good nursing care can be delivered if they look better after nursing, especially at the morale, more recognition must be given to us." (respondent 21)

> "I feel that the rights of the nurses are decreased. Our humanity is neglected. Employ more personnel to lighten the workload, then quality of care will increase. No acknowledgement of those for who it is due, it will increase the morale. Take in consideration the social circumstances, for example nurses are put on night duty, but have no one to help with children." (respondent 40)

> "Nursing standards is not always on standard, because personnel do not have the necessary driving force. Hope this study can have a positive influence to lift the morale." (respondent 53)

> "Hope more attention will be given to the needs and problems of nurses as well. Affordable houses must be build for nurses and better salaries. Danger allowances for each department especially Casualty and Psychiatric department." (respondent 80)

> "I studied nursing because I wanted to help people and enhance the medical profession, but due to underlying conflict in the department, nursing is not a pleasure any more. Most of my colleagues and I are not motivated towards nursing any more. People are in posts that are not qualified for it." (respondent 165)

"I hope that there are real actions implemented. I hope that there are changes coming, to ensure that it is a pleasure again to come to work." (respondent 179)

"I received this high post (PHC) but did not expect to work in such a place that was not kept up to standard. Now I must do my regular work plus catch up. It is very difficult for me. My co-workers are negative and say they have asked for the same things I am asking for - like apparatus or things to be corrected but they did not get any reaction. I did not receive proper induction; I try to find things out from co-workers." (respondent 197)

"Too many disciplines are transferred to PHC. Too little personnel and time. Too many persons visit the clinic. People are more conscious about their rights and loose all respect and values towards nursing." (respondent 200)

Sub-theme 4: Education of nurses

A number of respondents indicated that the "education of nurses" also affects nursing. Reference was made to nurses not getting a chance to further educate themselves, the prerequisites for doing nursing and the opening of more nursing schools, as stated below:

"It becomes more difficult to educate yourself further in nursing. I am a staff nurse for nine years now – stagnation. There is a lot of people that want to study, but is not given the opportunity." (respondent 52)

"More personnel must be educated. A lot of children want to do nursing, but does not have maths as a subject and is therefore unsuccessful. Please exclude Maths as a compulsory subject. Do training where nurses receive money because they come from poor households and want to make a contribution to the household, because parents cannot give their children the privilege to study." (respondent 55)

"In order to improve quality of nursing care Government should revise the educational system for nurses, considering opening training colleges which were used before." (respondent 117)

"The shortage of staff is a problem. The department must open nursing schools." (respondent 155)

Theme 2: Positivity towards the research

The second major theme focused on responses indicating respondents' "positivity towards the research" (n = 6) (16%). Views expressed indicated that the research was a good institution and should be regularly done, as stated below:

> "I feel this survey is a good institution and must be done regularly. There can be worked on improvements and new ideas to make our work more efficient. I feel we can do a lot if we work as a team." (respondent 3)

> "Questionnaires like this can be more regularly completed. Personnel in management positions do not know the work pressure on lower levels." (respondent 12)

> "I think the survey was good" (respondent 129)

> "I hope the research is positive and that the Department of Health improve the condition we work in." (respondent 178)

> "Hope the research improves the nursing profession." (respondent 211)

Theme 3: Nursing profession changed

Respondents' comments was focussing on respondents identifying that the nursing profession changed (n = 4) (11%). The following comments support this category:

> "Nursing is not like previously." (respondent 7)

> "Nursing is not seen as a professional service any more. A lot do nursing because there is no other work. They see it as the last resort." (respondent 54)

> "Patient care is not like in the past. Service weakens and nursing salaries are not as desired." (respondent 99)

> "The profession of nursing lost its values. Nursing is not the same." (respondent 151)

Theme 4: Unfairness of OSD and SPMS

From the respondents' point of view there were "unfairness of OSD and SPMS" reported (n = 3) (8%). The following comments by respondents indicate this category:

> "A lot of personnel were well lifted out with OSD, but there are personnel that were poorly lifted out or not at all. SPMS is also unfair, because personnel do not all write, usually the good ones, but the weak personnel write and get money." (respondent 47)

> "SPMS – just the seniors are favoured. SPMS is a sham, because the same persons get SPMS every time." (respondent 77)
>
> "OSD – I received a good increase, but it is still unfair. I received the same salary scale as a person with only three months experience after 15 years of service." (respondent 156)

OSD was introduced with the main aim to improve the salaries and conditions of service to ensure the attracting and retaining of skilled employees (Public Service Co-ordinating Bargaining Council, 2007:3). OSD brought about salary adjustment in accordance to speciality and re-calculation of experience, based on the years of experience and aspired to ensure "fair, equitable and competitive remuneration structures for all categories of employees" (Department of Health, 2007). More than half of the respondents were not significantly compensated during OSD (69%) with the minority receiving a significant salary increase during OSD (31%) (Paragraph 4.4.4.4). These responses indicate that respondents do not view OSD as fair and equitable, thus not meeting the aspirations for introducing OSD.

Paragraph 4.4.3.2 shows a substantial majority of respondents feel that Staff Performance is not evaluated fairly (95%); this sentiment is supported in the responses provided to this question. Staff Performance was introduced with the aim to plan, manage and improve the performance of employees and to improve motivation (Department of Public Service and Administration, 2007). With the majority of respondents indicating that SPMS is not done fairly the risk might occur that employees' performance is not properly maintained and enhanced, decreasing the level of nursing care provided.

Theme 5: Positivity opinion about nursing

The final theme suggested by respondents indicated a "positive opinion about nursing" (n = 2) (5%). The following comments support this category:

> "Nursing is a wonderful profession." (respondent P4)
>
> "Nursing is the profession were you can life out humanity." (respondent 48)

4.5 ANALYSIS OF QUANTITATIVE DATA

In this section only the statistical significant correlation statistics are discussed in order to describe the relationship between them, concerning the following variables:

- Values influencing behaviour as a nurse and biographical data
- Values important to provide proper patient care and biographic data

- Values often used in ethical decision making and biographic data

4.5.1 Values influencing behaviour as a nurse and biographic data

The Spearman's correlation was used to determine the relationship between values influencing behaviour as a nurse and age group, number of years of experience and highest qualification obtained. The appropriate ANOVA test was used to determine the relationship between the professional values which influence behaviour as a nurse, current job description and current department.

4.5.1.1 Values influencing behaviour as a nurse and highest qualification

The results from a Spearman's correlation indicated a weak negative relationship (*rho* = -0.20) between the highest qualification obtained and confidence (*rho* of between 0.1 and 0.29 indicated a weak relationship (Burns and Grove, 2007:424)). The probability (p = <0.01) was smaller than 0.05 indicating a statistical significant relationship. This signifies that the importance of the value of confidence decreases when nurses obtain higher qualifications. This result does not support the findings by McNeese-Smith and Crook (2003:265) and Rassin (2008:625). Mc Neese-Smith and Crook (2003:265) indicate that aesthetics has higher ratings of importance for nurses with a bachelor's degree, than for associated-degree nurses, whilst Rassin (2008:624) identified that aesthetics has the least importance for academic nurses. Mc Neese-Smith and Crook (2003:265) also identified that non-graduate degree nurses rated the values altruism, associates, economic returns, security, supervisory relations and surrounding higher than nurses with a master's qualification.

4.5.1.2 Values influencing behaviour as a nurse and current job description

An appropriate ANOVA showed a statistical significant relationship between the value of accountability and current job description (F (3, 210) = 3.8374, p=0.01). Fisher Least Significant Difference (LSD) post-hoc test revealed a significant difference (p = 0.002) between Assistant nurses (mean = 3.3333) and Professional nurses (3.6961) and also a significant difference (p = 0.02) between Assistant nurses (mean = 3.3333) and Operational Managers (mean = 3.7647). This indicates that Professional nurses and Operational managers place higher importance on the value of accountability than Assistant nurses.

Rassin (2008:625) found that the value of excellence received the highest importance from operating room nurses, followed by nurses working in an emergency room, labour ward, theatre and medical ward.

4.5.2 Values important to provide proper patient care and biographical data

The Spearman's correlation was used to determine the relationship between values important to provide proper patient care and age group, number of years of experience and highest qualification. The appropriate ANOVA test was used to examine the relationship between the values important to provide proper patient care and current job description and current department.

4.5.2.1 Values important to provide proper patient care and age group

The results from a Spearman's correlation depicts that there is a positive correlation (*rho* = 0.23, *p*<0.01) between age group and the value of respect for dignity and autonomy. The significant relationship can be reported as weak, as indicated by Burns and Grove (2007:424).A value between 0.1 and 0.29 indicates a weak relationship. Implying that with an increase in age the value of respect for dignity and autonomy becomes more important.

According to a Spearman's correlation there is a weak positive correlation between age group and the value of responsibility (*rho* = 0.23) and a statistical significant probability exists (*p* = <0.01). This depicted that with an increase in age the importance of the value responsibility increases.

A Spearman's correlation indicated that there is a statistical significance and weak (value between 0.1 and 0.29) positive correlation (*rho* = 0.21, *p* = <0.01) between age group and trustworthiness, signifying an increase in the importance of the value of trustworthiness which increases with an increase in age.

Rassin (2208:624) found a significant difference with regard to the value of privacy, with younger nurses rating this value as more important than older nurses.

4.5.2.2 Values important to provide proper patient care and number of years of experience

Depicted was a statistically significant relationship and weak positive correlation (*rho* = 0.21, *p* = <0.01) between the value of independence and the number of years of experience. An increase in years of experience shows an increase in the importance of the value of independence.

The Spearman's correlation showed a statistical significant, weak positive correlation (*rho* = 0.21, *p* = <0.01) between the values of respect for dignity and autonomy and number of years of

experience. This implies that the value of respect for dignity and autonomy becomes more important with an increase in years of experience.

The results of a Spearman's correlation showed a probability of less than 0.05 (p = <0.01), between trustworthiness and the number of years of experience. The relationship was between 0.1 and 0.29 indicating a weak positive relationship (*rho* = 0.25). This signifies that the value of trustworthiness increases with an increase in number of years of experience.

Rassin (2008:627) found that nurses with a maximum of two years working experience rated dignity lower than nurses with additional experience, while the group with additional experience rated privacy lower than the nurse with a maximum of two years experience. Mc Neese-Smith and Crook (2003:266), revealed that entry level nurses place higher value on economic returns than persons with greater experience and that experienced nurses showed lower value for altruism than entry level nurses.

4.5.2.3 Values important to provide proper patient care and current department working in

The Kruskal-Wallis test indicated a statistical significant relationship between the value of confidentiality and the current department working in (F (3, 197) =.88534, p = 0.09). Fisher LSD post-hoc test reveals that a significant difference (p = 0.005) exists between nurses in Medical (mean = 3.4211) and Midwifery (mean 3.8857) departments, with nurses working in Midwifery departments placing higher importance on the value of confidentiality than nurses working in Medical departments. The Fisher LSD post-hoc test also revealed a significant difference (p = 0.005) between nurses in the Medical (mean = 3.4211) and Primary Health Care (mean = 3.8545) departments. This implies that nurses working in Primary Health Care places higher importance on the value of confidentiality than nurses working in Medical departments.

Rassin (2008:625) found that the value of excellence received the highest importance from operating room nurses, followed by nurses working in an emergency room, labour ward, theatre and medical ward.

4.5.2.4 Values important to provide proper patient care and current job description

A Kruskal-Wallis test indicated that a positive relationship exists between the value of responsibility and the current job description of the respondents (F (3, 187) = 2.2201, Kruskal-Wallis p = 0.05). Fischer LSD post-hoc test revealed that a significant difference exists between Operational managers and Assistant nurses, staff nurses and also professional nurses. A

probability of less than 0.05 (p = 0.04) indicated that a significant difference occurred between Assistant Nurses (mean = 3.4773) and Operational managers (mean = 3.8125). A significant difference (p = 0.01) occurred between Staff nurses (mean = 3.3953) and Operational managers (mean = 3.8125). A probability of less than 0.05 (p = 0.03) indicated a significant difference between Professional nurses (mean = 3.5) and Operational managers (mean = 3.8125). The Fischer LSD post-hoc test implies that Operational managers view the value of responsibility more important than Assistant Nurses, Staff Nurses and Professional nurses.

The findings by Mc Neese-Smith and Crook (2003:265) indicate that managers and staff nurses place greater importance on the value of aesthetics than advanced practice nurses. Staff nurses showed significantly higher scores than managers for the importance of the value of security, surroundings, supervision and economic returns (Mc Neese-Smith & Crook, 2003:265).

4.5.3 Values often used in order to make ethical decisions and biographic data

The Spearman's correlation was used to examine the relationship between the values often used in order to make ethical decisions and age group, number of years of experience and highest qualification. The appropriate ANOVA and Kruskal-Wallis tests were applied to test the relationship between the values often used in order to make ethical decisions and current job description and current department.

4.5.3.1 Values often used in order to make ethical decisions and number of years of experience

A Spearman correlation indicated that there exists a weak positive correlation (with a value between 0.1 and 0.29) and statistical significance (rho = 0.25, p = <0.01) between the value of quality care and excellence and number of years of experience. This signifies that with an increase in number of years of experience the importance of the value of quality care and excellence increases.

Rassin (2008:627) found that nurses with a maximum of two years working experience rated dignity lower than nurses with additional experience, while the group with additional experience rated privacy lower than the nurse with a maximum of two years experience. Mc Neese-Smith and Crook (2003:266) revealed that entry level nurses place higher value on economic returns than persons with greater experience and that experienced nurses showed lower value for altruism than entry level nurses.

4.5.3.2 Values often used in order to make ethical decisions and highest qualification obtained

Depicted by a Spearman's correlation was a statistically significant relationship and weak negative correlation (*rho* = -0.20, *p* = <0.01) between the value of freedom and highest qualification obtained, signifying that when the qualification obtained becomes higher, the importance of the value of freedom decreases.

This result does not support the findings by Mc Neese-Smith and Crook (2003:265) and Rassin (2008:625). Mc Neese-Smith and Crook (2003:265), indicate that aesthetics has higher ratings of importance for nurses with a bachelor's degree, than for associated-degree nurses, whilst Rassin (2008:624) identified that aesthetics has the least importance for academic nurses. Mc Neese-Smith and Crook (2003:265) also identified that non-graduate degree nurses rated the values altruism, associates, economic returns, security, supervisory relations and surrounding higher than nurses with a master's qualification.

4.5.3.3 Values often used in order to make ethical decisions and current department

A Kruskal-Wallis test indicated a relationship between the value of confidentiality and current department (*F* (7, 185) = 1.5399, *p* = 0.05). Fisher LSD post-hoc test revealed a significant difference (*p* = 0.006) between nurses working in Medical (mean = 3.3750) and Midwifery (mean = 3.9032) departments. The Fisher LSD post-hoc test also revealed a significant difference (*p* = 0.01) between nurses working in Surgical (mean 3.4800) and Midwifery (mean = 3.9032) departments. This signifies that nurses working in Midwifery Departments places higher importance on the value of confidentiality than nurses working in Medical and Surgical departments.

Rassin (2008:625) found that the value of excellence received the highest importance from operating room nurses, followed by nurses working in an emergency room, labour ward, theatre and medical ward.

4.5.3.4 Values often used in order to make ethical decisions and current job description

An ANOVA test indicated a relationship between the value of accountability and current job description (*F* (3, 184) = 2.9420, *p* = 0.03). Fisher LSD post-hoc test revealed a significant difference (*p* = 0.01) between assistant nurses (mean = 3.3556) and professional nurses (mean = 3.6353) and also a statistical difference (*p* = 0.028593) between assistant nurses (mean =

3.3556) and Operational managers (mean = 3.7500). This post-hoc test indicates that Assistant nurses place less importance on the value of accountability than Professional nurses and Operational managers do.

The findings by Mc Neese-Smith and Crook (2003:265) indicate that managers and staff nurses place greater importance on the value of aesthetics than advanced practice nurses. Staff nurses showed significantly higher scores than managers for the importance of the value of security, surroundings, supervision and economic returns (Mc Neese-Smith & Crook, 2003: 265).

4.6 CONCLUSION

In this chapter the demographic data of the respondents were presented in frequency tables. The responses to the quantitative data were presented in the form of histograms and frequency tables. Section B determined the nursing values of respondents, while Section C estimated the political and legal factors affecting values and Section D estimated the socio-economic factors affecting values. Qualitative data were grouped and quantified and the most common proposals were presented by reporting verbatim to exemplify the theme or sub-theme. Spearman *rho*, Analysis of Variance and Kruskal-Wallis tests were used to investigate the statistical significant relationship between the demographic data and selected research variable.

In Chapter 5 the empirical findings are discussed and compared with the findings of previous studies. Conclusions are drawn from the findings and recommendations originating are discussed, and recommendations for further studies are made. The limitations of the current study are also discussed.

CHAPTER 5: DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

From the literature it is clear that there are different views between different authors with regard to the core nursing values and limited research data available on the factors influencing them (Chapter 2). This poses a problem as South Africa is a country that has undergone vast political and social changes and also presents immense diversity.

The aim of the study was to do an in-depth study into the factors influencing nursing values of nurses working in Nursing Facilities in the Paarl district and employed by the Provincial Administration of the Western Cape in the West Coast Winelands Region of the Western Cape. The study was directed by its objectives, as specified in Chapter 1 (paragraph 1.6).

The objectives for the study were to

- determine the main reason for entering the nursing profession for nurses working in these facilities
- identify the most important part of nursing practice for nurses working in these facilities
- identify the core nursing values of the nurses working in these facilities
- determine the factors influencing nursing values
- determine the factors influencing the nursing care of the patient.

In this chapter, the findings from this study are discussed and conclusions are drawn from the research outcomes. Recommendations are presented that arose from the objectives and recommendations for further studies are made.

5.2 DISCUSSION AND CONCLUSIONS

The study findings, according to the research objectives, are discussed. The conclusions represent a discussion of the findings in order to create a comprehensive presentation of the information that was generated through the data analysis and the findings of previous studies (Burns & Grove, 2007:437).

5.2.1 The main reason for entering the nursing profession

Objective 1: Determine the main reason for entering the nursing profession for nurses working in these facilities

The first objective was to determine the main reason for entering the nursing profession for nurses working in the nursing facilities where the research was conducted. The most prominent reason indicated by respondents for entering the nursing profession was that respondents entered nursing because they wanted to help people (57%). The second most significant reason was indicated as career opportunity and stability (24%), followed by respondents indicating that it was a way of receiving an income and good incentives were offered (9%) and the minority of respondents indicated since one of their family members was a nurse they decided on nursing as a profession (5%) (paragraph 4.4.2.1). The majority of respondents indicated that they are still in nursing for the same reason that they entered the profession (paragraph 4.4.2.2).

Shaw and Degazon (2008:45), indicated (paragraph 2.2) that the primary motivator for persons entering the nursing career is assumed to be the value of altruism, yet identified that nurses in the modern era are attracted to nursing due to "the financial incentives and career mobility and stability". The altruistic view can be defined as the "regard for the welfare of others" (Altun, 2002:271). The findings from this study disagree with Shaw and Degazon (2008:45) by identifying respondents' main reasons which encompass a sense of altruism, thus agreeing with the historic view that the main reason for entering the nursing profession is 'wanting to help others'.

In conclusion, the findings from this study suggested that:

- The main reason for entering the nursing profession for respondents' of this study was because they wanted to help people and this encompasses an altruistic viewpoint.

5.2.2 The most important part of nursing practice

Objective 2: Identify the most important part of nursing practice for nurses working in these facilities

The second objective of this study was to identify the most important part of nursing practice for nurses working in the facilities where the research was conducted. Paragraph 4.4.2.3 indicates that for the majority of respondents (49%) of this study the most important part of nursing is seeing a patient progress towards healing. The rest of the responses were divided as follows:

interaction with other professionals (1%), caring for the patient (13%), job stability and receiving the monthly remuneration (8%), gaining of new knowledge, getting clinical experience and being a competent nurse (27%) and other parts of nursing (2%).

The findings of this study support the definition of nursing by the SANC (see paragraph 2.3). As indicated in table 4.10 the majority of the respondents specified the most important part of nursing which entails a caring and patient directed service. Pera and Van Tonder (2005:7) identified that the primary goal of nursing is to provide optimal care for every client. As indicated, the sentiment of respondents corresponds with this opinion. This viewpoint by respondents also corresponds with the focus of the South African health system, of delivering quality health care in a caring environment (Department of Health, 1997b).

In conclusion, the findings from this study suggested that:

- The most important part of nursing practice for respondents of this study was seeing a patient progress towards healing, consequently focussing on care as the aim of their nursing practice.

5.2.3 The core nursing values of nurses

Objective 3: Identify the core nursing values of the nurses working in these facilities

Mellish and Paton (2003:122) depicts that values can be divided into professional values and social values. Ethical decision making is a vital part of the ethical conduct of a nurse and are influenced by the legal framework, common law principles, human rights charter and the country's professional Acts and Regulations (Mellish & Paton 2003:123). Yet, it could not be established through previous research whether nurses apply different values in their behaviour, to provide proper patient care and to make ethical decisions. The findings of this study indicated that a difference exists between the values influencing nursing behaviour, values important to provide proper patient care in daily work as a nurse, and values used in ethical decision making.

The values that were predominantly indicated as influencing nursing behaviour (paragraph 4.4.2.4) were: confidence (72%), quality care and excellence (68%), accountability (67%), integrity (63%), competence (59%), a co-operative relationship with co-workers (55%), compassion and humanity (54%), privacy (52%), responsibility (52%), respect for the rights of people (51%), confidence (51%), truth and honesty (49%), respect for dignity and autonomy (48%) and trustworthiness (47%).

The values most important to provide proper patient care in daily work as a nurse (paragraph 4.4.2.5) as indicated by respondents were confidentiality (78%), quality care and excellence (65%), accountability (61%), competence (59%), responsibility (53%), privacy (52%), integrity (50%) and value of personhood (48%).

Values used in ethical decision making (paragraph 4.4.2.6) as indicated by respondents were confidence (69%), accountability (59%), truth and honesty (57%), integrity (54%), compassion and humanity (52%), respect for the rights of people (49%), responsibility (49%), competence (49%) and quality care and excellence (47%).

Nursing practice cannot be seen in isolation and involves the behaviour of the nurse, patient care and ethical decision making. The most prominent values influencing nursing behaviour, values most important to provide proper patient care and values used to make ethical decisions were combined to form the core nursing values for respondents, namely:

- Confidentiality
- Quality of care and excellence
- Accountability
- Integrity
- Competence
- Co-operative relationship with co-workers
- Compassion and humanity
- Privacy
- Responsibility
- Respect for the rights of people
- Confidence
- Truth and honesty
- Respect for dignity and autonomy

- Trustworthiness
- Confidentiality
- Value of personhood

The findings of this study correspond with overarching values identified by the Provincial Government of the Western Cape on the importance of competence, accountability and integrity (Western Cape Government, 2011).These findings also correspond with the International Council of Nurses on the importance of the values of confidentiality, responsibility, accountability, rights of people and a co-operative relationship with co-workers as important values (International Council of Nurses, 2000). However, the findings disagree that the provision of safe and competent nursing care, maintaining standards of personal conduct, safety and dignity are core professional values (International Council of Nurses, 2000). The values indicated as most important by respondents of this study, are not in agreement with the findings of Shaw and Degazon (2008:45) on the importance of the values of altruism, human dignity, social justice, autonomy and integrity, but agree on the importance of the value of truth. The findings of this study agree with Altun (2002:271) on the importance of the value of truth, but disagree on the importance of altruism, human dignity and social justice, but include aesthetics, equality and freedom. The values indicated as important by the respondents of this study does not necessarily agree with Fagermoen (1997:438) on the importance of the value of human dignity, autonomy, value of personhood, reciprocal trust, security, but agrees that integrity and privacy are important nursing values.

In conclusion, the findings from this study suggested that:

- The core nursing values for respondents of this study were indicated as confidentiality, quality of care and excellence, accountability, integrity, competence, a co-operative relationship with co-workers, compassion and humanity, privacy, responsibility, respect for the rights of people, confidence, truth and honesty, respect for dignity and autonomy, trustworthiness, confidentiality and value of personhood.

5.2.4 Factors influencing nursing values

Objective 4: Determine the factors influencing nursing values

This objective was to determine the factors influencing nursing values. The demographic factors that were examined in this study is age group, number of years of experience, highest

qualification obtained, current job description and current department and all possess a significant relationship with a certain nursing value. No statistical correlations could be drawn between gender, ethnic group or religion and values due to poor representation in the different categories.

5.2.2.1 Age group and values

The findings of this study indicated that with an increase in age the value of respect for dignity and autonomy, the value of responsibility and the importance of the value of trustworthiness become more important as values important to provide proper patient care (paragraph 4.5.2.1).These findings are not supported by the finding of Rassin (2208:624) who identified a significant difference with regard to the value of privacy, with younger nurses rating this value as more important than older nurses, however no literature could be found on why these relationships occur.

5.2.2.2 Number of years of experience and values

Results of this study depicted that with an increase in years of experience the importance of the value of independence, the value of respect for dignity and autonomy and the value of trustworthiness as an important value to provide proper patient care increase (paragraph 4.5.2.2). Findings also showed that with an increase in number of years of experience the importance of the value of quality care and excellence increase as value often used to make ethical decisions (paragraph 4.5.3.1).

These findings are not supported by the finding of Rassin and Mc Neese-Smith and Crook, and no literature could be found on why these relationships occur. Rassin (2008:627) found that nurses with a maximum of two years working experience rated dignity lower than nurses with additional experience, while privacy was less important for the group with additional experience. Mc Neese-Smith and Crook (2003:266), revealed that entry level nurses place higher value on economic returns than persons with greater experience and that experienced nurses showed lower value for altruism than entry level nurses.

5.2.2.3 Highest qualification obtained and values

The findings from this study indicated that the importance of the value of confidence, as value influencing behaviour as a nurse, decreases when nurses obtain higher qualifications (paragraph 4.5.1.1). It was also indicated by results that when the qualification obtained becomes higher, the importance of the value of freedom, as value often used to make ethical

decisions, decreases (paragraph 4.5.3.2). The reasons for these relationships could not be established through previous research findings.

This result is not supported by the findings by Mc Neese-Smith and Crook (2003:265) and Rassin (2008:625). Mc Neese-Smith and Crook (2003:265) indicated that aesthetics has higher ratings of importance for nurses with a bachelor's degree, than for associated-degree nurses, whilst Rassin (2008:624) identified that aesthetics has the least importance for academic nurses. Mc Neese-Smith and Crook (2003:265) also identified that non-graduate degree nurses rated the values altruism, associates, economic returns, security, supervisory relations and surrounding areas higher than nurses with a master's qualification.

5.2.2.4 Current job description and values

From results that were obtained in the analysis of findings it clearly indicated that professional nurses and Operational Managers place higher importance on the value of accountability, as a value that influences behaviour as a nurse, than Assistant nurses (paragraph 4.5.1.2). The findings indicated that Operational Managers view the value of responsibility, as value important to provide proper patient care, more important than Assistant Nurses, Staff Nurses and professional nurses (paragraph 4.5.2.4). Also reported was that Assistant nurses place less importance on the value of accountability, as an important value to make ethical decisions, than professional nurses and Operational Managers do (paragraph 4.5.3.4).

The findings of this study do not concur with the findings of Mc Neese-Smith and Crook (2003: 265), that indicated managers and staff nurses place greater importance on the value of aesthetics than advanced practice nurses. In the study by Mc Neese-Smith and Crook (2003: 265) staff nurses showed significantly higher scores than managers for the importance of the value of security, surroundings, supervision and economic returns.

5.2.2.5 Current department and values

The findings of this study designated that nurses working in Primary Health Care departments place higher importance on the value of confidentiality, as an important value to provide proper patient care, than those nurses working in medical departments (paragraph 4.5.2.3). The analysis of results indicated that nurses working in midwifery departments place higher importance on the value of confidentiality, as an important value to provide proper patient care, than nurses working in medical departments (paragraph 4.5.2.3).The results obtained in the analysis also indicated that nurses working in midwifery departments place higher importance

on the value of confidentiality as a value often used to make ethical decisions, than nurses working in medical and surgical departments(paragraph 4.5.3.3). The results obtained in this study show no relation with the findings obtained in the study by Rassin (2008:625) which found that the value of excellence received the highest importance from operating room nurses, followed by nurses working in the emergency room, the labour ward, theatre and medical ward.

5.2.2.6 Conclusions of outcome

The focus of this study was directed by Leininger arguing that values, beliefs and norms are shaped by the "world view, language, religion, social, political, educational, economical, technological, ethnohistorical and environmental context" of the group (George, 2002:491; Tjale & De Villiers, 2004:22). From the findings of this study it could be identified that the educational and environmental (department working in) contexts influence values and also indicated age, years of experience and job description as factors that affect nursing values

In conclusion, the findings from this study suggested that:

- With an increase in age:
    - The value of respect for dignity and autonomy becomes more important, as values important to provide proper patient care
    - The importance of the value of responsibility increase, as important value to provide patient care
    - The importance of the value of trustworthiness, as important value to provide proper patient care, increases.
- An increase in years of experience shows
    - an increase in the importance of the value of independence, as an important value to provide proper patient care
    - the value of respect for dignity and autonomy, as a value to provide proper patient care, becomes more important
    - the importance of the value of trustworthiness increasing as a value to provide proper patient care

- the importance of the value of quality care and excellence increases, as a value often used to make ethical decisions.

- When a nurse obtains a higher qualification
  - the importance of the value of confidence, as value influencing behaviour as a nurse, decreases
  - the importance of the value of freedom, as value often used to make ethical decisions, decreases.

- The differences in importance of values between different job descriptions are as follows:
  - Professional nurses and Operational Managers place higher importance on the value of accountability as a value that influence the behaviour of a nurse, than an assistant nurse
  - Operational Managers view the value of responsibility, as a value important to provide proper patient care of more importance than assistant nurses, Staff Nurses and professional nurses
  - Assistant nurses place less importance on the value of accountability, as an important value to make ethical decisions, than professional nurses and Operational Managers do.

- Difference in importance of values between nurses working in different departments:
  - Nurses working in midwifery departments place higher importance on the value of confidentiality as an important value to provide proper patient care, than nurses working in medical departments
  - Nurses working in Primary Health Care place higher importance on the value of confidentiality as important value to provide proper patient care, than nurses working in medical departments
  - Nurses working in midwifery departments place higher importance on the value of confidentiality as value often used to make ethical decisions, than nurses working in medical and surgical departments.

5.2.5 The factors influencing the nursing care of the patient

Objective 5: Determine the factors influencing the nursing care of the patient

The aim of this objective was to determine the factors that affect the respondents nursing practice in view of the literature review that identified that the values of a person determine the care delivered and to identify the factors influencing nursing care with reference to Leininger's Culture-care diversity and universality theory.

5.2.3.1 Political and legal factors

Leininger identified that political factors have an effect on nursing care; the aim was to identify what the specific political factors are that affect the respondents' nursing practice. The study revealed that there exist five major themes indicated as political factors affecting the respondents' nursing practice (paragraph 4.4.3.4).

The respondents identified that the "treatment of nurses and a changing nursing profession" affect their nursing practice. This specifically referred to the fact that "nursing is more administration" and that the "educational system" creates a negative reaction to nursing practice; this was motivated by the reporting of the changes in the education system, changes in the curriculum and opening of private nursing schools. Indicated also were respondents' discontentment that the "rights of nurses" are not considered and that the rights of patients are more important than the rights of the nurses.

Respondents reported that "racism and discrimination in nursing practice" is a major political factor affecting their nursing practice. Respondents indicated reversed racism in the workplace, racism between colleagues, between individuals, but also with the appointment of staff. It was alarming that reference was made about a correlation between discrimination and intimidation. It was also reported that "appointment of staff" has an effect on nursing practice. Respondents identified "unfairness of affirmative action", "appointment not according to skill" and "nepotism with appointment of staff".

The "influence of unions in nursing practice" was identified as a political factor affecting nursing practice. It was evident in responses that respondents are of the opinion that the different unions do not convey the same messages. It was also indicated that respondents feel that the influence of the unions is not always positive and a number of respondents indicated the effect of unions during strikes as this ensures that nurses do not come on duty. A respondent also indicated the ineffectiveness of unions.

"Administration" was perceived as a political factor affecting nursing practice. Two sub-themes evolved from the responses, branded as "no consideration of work done on ground level" and "allocation of funding". Respondents reported that the work responsibilities of nurses on ground level are not considered during administration. With these responses a sense of helplessness and under-appreciation are portrayed:

> "....rules and regulations are made and nurses must just comply with it" (respondent 20)
>
> "Top management have no idea what is going on on ground level" (respondent 116)

This sentiment could support why only a minority of respondents reported their knowledge of acts, regulations and policies as being excellent (n = 13) (6%) (paragraph 4.4.3.4). The fact that respondents reported that they feel unrecognised by management is alarming in view of Herzberg's theory of motivation that implicate relationship with the employer function as a hygiene factor that leads to dissatisfaction (Training and development solution, 2001 – 2011)."Allocation of funding" encompassed responses reporting that funding does not always support the needs of nurses; this includes funding to appoint more staff and the competition with other programmes and provinces for sufficient funding.

5.2.3.2 Social factors

Leininger identified that social factors have an effect on nursing practice. The social factors indicated by respondents of this study as having an influence on their nursing practice identified eight themes.

The study revealed the social factor mostly affecting nursing practice was the "influence of nursing on personal life". Respondents reported that nursing has a great "influence on family life" and an "influence on social life". "Social circumstances in the department" was identified as having an effect on their nursing practice reported as "lack of good work conditions" and "social relationships". It was indicated by respondents that the conditions they work in are not supportive of good nursing practice. They identified that the facilities are not conducive. This was especially with reference to clinics. Respondents reported that a lack of sufficient staff levels and resources also affect the nursing care they provide. Responses reflected respondents' discontent with the social relationships in the different departments. They indicated no support between nurses, also that relationships are not cooperative and more effort should be made to create team-building. Respondents cited that the lack of involvement of the multi-disciplinary team also reduces the level of nursing care provided. Indicated by a number of respondents was the lack of interaction and support from management. These opinions are a

matter of concern in view of the motivational theory by Herzberg (Training and development solution, 2001 – 2011) that indicate the standard of work conditions as a hygiene factor, which can create feelings of dissatisfaction. These statements by respondents directly indicate that they feel dissatisfied and this can lead to feelings of demotivation.

Respondents indicated “personal and social problems affecting nursing practice” as a social factor that has an influence on nursing practice. Responses indicate that illness of nurses and their own living conditions or that of their colleagues affect their nursing practice. Cited by respondents was the effect that family life has on their nursing practice. Mostly referenced was the financial responsibilities and also marriage conflict. Respondents indicated transport problems, as a number of respondents indicated the unreliability of public transport that they make use of.

Respondents reported “the community” as a social factor influencing nursing practice. Poverty of the community was viewed by respondents as having a great affect on their nursing practice as it can also lead to an increase in the medical care required. Respondents reported that unemployment leads to crime and violence which increases the requirement for medical care.

Analysis revealed “alcohol and drug abuse” as one of the leading social factors influencing nursing practice; this includes alcohol and drug abuse of the community and nurses’ family members. It was however very alarming that it was reported that the drug abuse amongst nurses is increasing.

The “health status of the community and their responsibility towards their health” was shown to be a major social factor affecting nursing practice. Respondents reported the influence of HIV and Tuberculosis and other chronic diseases. It was also the respondents’ experience that patients have a negative responsibility towards their health, with patients not cooperating, defaulting on medication and the continuous readmission of patients.

Respondents reported “violence and crime” as a social aspect affecting nursing practice. This involved family-, woman- and child abuse.

The “growth in population and urbanization” was indicated as a social factor affecting nursing practice. Respondents focused on the language barriers posed by respondents that have become urbanized especially those from the Eastern Cape and the level of care influenced by this.

5.2.3.3 Motivation

The literature study (Chapter 2) revealed that good performance and consequently nursing care are greatly influenced by the motivational level of workers (Franco, Bennett and Kanfer, 2002:1256; Jooste, 2010:200).

This study revealed that the mean level of motivation to deliver proper nursing care was 6.7319(paragraph 4.4.4.7), thus indicating a moderate level of motivation towards caring for patients. This identifies that the respondents' sentiment towards patient care concur with the definition of nursing's a caring profession by the SANC (see paragraph 2.3). Pera and Van Tonder (2005:7) identified that the primary goal of nursing is to provide optimal care for every client, which indicates that the sentiment of respondents is in correspondence with this opinion.

Some of the possible contributors to the motivational level towards patient care being moderate and not high, can possibly be contributed to 67% respondents identifying that the remuneration is not according to the level of the work delivered (paragraph 4.4.4.1). Remuneration is identified by Herzberg's motivational theory's a form of recognition by the employer (Training and development solution, 2001 – 2011). This form of recognition is a motivator that leads to satisfaction by employees (paragraph 2.6). This concurs with the findings that 68% of respondents indicated that they will be better motivated towards nursing care with an increase in salary level (paragraph 4.4.4.3). The dissatisfaction of respondents can be seen in the findings that 70% of respondents indicated that they cannot keep up with the financial demands of life (paragraph 4.4.4.2). This corresponds with the motivational theory of Herzberg (Training and development solution, 2001 – 2011) that indicates salary as a hygiene factor, which indicates that if the needs of an employee are not satisfied it can lead to dissatisfaction and de-motivation. Financial incentives function as an extrinsic motivator and should therefore be optimal to ensure proper motivation of personnel (Jooste, 2003:56).Franco et al. (2002:1256) recommend that economic strategies can contribute greatly to enhance the motivational level of health care workers.

The Public Service introduced OSD for nursing in 2007. This brought about salary adjustments in accordance with speciality and a re-calculation of experience, based on the years of experience and had as its goal "fair, equitable and competitive remuneration structures for all categories of employees" (Department of Health, 2007). More than half of the respondents were not significantly compensated during OSD (69%). Comments by respondents indicated that respondents do not view OSD as fair and equitable thus not meeting the aspirations for

introducing OSD (paragraph 4.4.4.9 and 4.4.4.10). In reference to the Motivational theory by Herzberg (Training and development solution, 2001 – 2011) this discontent with salary adjustment can increase de-motivation of personnel. Jooste (2003:56) identifies that motivation is determined by extrinsic conditions, for example financial incentives. These findings identify that the extrinsic conditions do not support the motivation of personnel. Economical strategies should be developed to enhance the motivational level of health care workers (Franco et al., 2002:1256).

A substantial majority of respondents feel that Staff Performance is not evaluated fairly (95%) (Figure 4.5). The Staff Performance Evaluation plan was introduced with the aim to plan, manage and improve the performance of employees and to improve motivation (Department of Public Service and Administration, 2007). With 95% of respondents indicating that this is not done fairly, the risk might occur that employees' performance is not properly maintained and enhanced. However in paragraph 4.4.4.7, the mean score for motivational level towards proper care is 6.7319, thus indicating that respondents are moderately motivated towards patient care.

"SPMS, OSD and salaries" were also referred to by respondents when they were identified by respondents as creating conflict in the departments; more specifically indicated by respondents as unfairness with regard to SPMS. This was also indicated by additional comments by respondents. The following comments by respondents indicate this:

> "A lot of personnel were well lifted out with OSD, but there are personnel that were poorly lifted out or not at all. SPMS is also unfair, because personnel do not all write, usually the good ones, but the weak personnel write and get money." (respondent 47)
>
> "SPMS – just the seniors are favoured. SPMS is a sham, because the same persons get SPMS every time." (respondent 77)
>
> "OSD – I received a good increase, but it is still unfair. I received the same salary scale as a person with only three months experience after 15 years of service." (respondent 156)

Working conditions form part of the hygiene factors as stated in the motivational theory by Herzberg (Training and development solution, 2001 – 2011).Again this can lead to de-motivation of employees. Findings of this study indicate that respondents view working conditions as not optimal. Nearly all respondents (95%) were of the opinion that the institutions where they work do not employ enough personnel to ensure delivery of proper nursing care.

This is also reflected in 4.4.4.9 with responses by respondents indicating that staff shortages cause conflict in the department. Figure 4.12 indicates that 56% of respondents cannot keep up with the demands of their work and still provide proper care.

According to Figure 4.14 the mean level of conflict in the departments where respondents worked was 5.4292. Conflict influences working conditions and relationships with peers, which form part of the hygiene factors in Herzberg's motivational theory, which can lead to dissatisfaction (Training and development solution, 2001 – 2011). With this moderate level of conflict it is important to ensure that the areas of conflict get attention to ensure that this level does not rise, as this can lead to an even higher level of de-motivation. Franco et al., (2002:1256) identified that with the implementation of organisational developmental, human resource management and sociological strategies the motivational level of health care workers can increase. Indicated by responses to an open-ended question, respondents indicated reasons for conflict in the department. The comments of respondents could be placed in ten major categories, but all concluded that a need for these strategies exists.

The findings indicate that "work relations" create conflict, and specifically "poor cooperation" and "relationships". A number of respondents indicated that the personal relationships in the department is not optimal and therefore leads to conflict when personnel have friendship relationships it was indicated as leading to conflict as well. This included a number of respondents indicating that professional jealousy influences the level of conflict in the department.This lack of good relationships is concerning when the humanistic nursing practice model is taken into consideration. This model highlights that human interaction is an important part of nursing practice this identifies interaction between humans, the meeting of people, relationships between humans and sharing between individuals, signifying that nursing occurs in the context of relationship (George, 2002:558). However, these comments by respondents signify unsatisfactory relationships.Relationship with peers is indicated in the theory of motivation by Herzberg as a hygiene factor (Training and development, 2001 – 2011). The lack of good relationships with peers can lead to dissatisfaction; this is a real concern in terms of the responses by respondents.

Respondents reported "personnel shortages" as a major cause of conflict in the departments. Respondents reported that this shortage of staff leads to higher workload that consequently leads to conflict. A number of respondents reported that staff levels on night duty are not sufficient and that it should correspond with the staff levels on day duty, as the patient levels

stay constant on day and night duty, which could lead to conflict. This staff shortage was also reported for non-nursing staff, specifically doctors, admin- and cleaning staff.

“High workload” was indicated as a leading factor causing conflict in the department. This cause of conflict includes the amount of patients and greater responsibility due to additional work allocated. Findings also indicated that “management” is a cause of conflict in the departments. Identified from responses was the use of inappropriate management style and decision making by managers, but also the managers’ lack of knowledge about the function of the department. “Shifts and leave planning” was indicated as a major cause of conflict in departments. Specific reference was made to leave planning, requesting of shifts, night duty allocation and adapting of off duties. Respondents identified “unfairness” as a leading cause of conflict in nursing facilities. This included unfairness with regard to work responsibilities and treatment of staff. “Poor communication” was indicated as a source of conflict for respondents. This included communication with nurses, colleagues and patients. Reported was that “relieving in other departments” create conflict in departments. It was indicated that relieving in other departments can cause burnout and that it is caused by staff shortages. “Work conditions and shortage of consumables” was indicated as a major cause of conflict. Respondents reported a lack of personal space and not having the necessary consumables as major causes of conflict. The last of the major causes of conflict indicated by respondents was “SPMS, OSD and salaries”.

In conclusion, the findings from this study suggested that:

Respondents reported that the main political factors affecting their nursing practice are:

- The influence of nursing practice on personal life, with specific reference to the negative influence on family life and influence on social life being perceived as negative

- Social circumstances in the department were identified and respondents identified the lack of good working conditions and poor social relationships

- Personal and social problems affecting nursing practice were identified as illness of nurses, living conditions, family life and transport

- The community where respondents work was also identified as a political factor affecting nursing practice, specific references were made to the poverty of the community, unemployment and education of the community

- Alcohol and drug abuse also influence nursing practice according to the experience of the respondents
- Health status of the community and their responsibility towards their health
- Violence and crime as it can lead to an elevated need for health care
- Growth in population and urbanization also influence nursing care.

Respondents reported that the following social factors affect nursing practice:

- Treatment of nurses and changing nursing profession, with respondents reporting that nursing is more administration, that the education system is not supportive of teaching good patient care and the lack of attention to the rights of nurses
- Racism in nursing was identified as a social factor affecting nursing practice and is a deep concerning factor
- Appointment of staff was identified as a factor by a number of respondents in the form of unfairness of affirmative action, appointment not according to skill and nepotism with appointment of staff
- The administration in nursing also functions as a social factor affecting nursing practice with respondents identifying no consideration for work done on ground level and allocation of funding
- Low involvement of practising nurses in decision-making was also identified as a social factor affecting nursing practice.

From the literature it was identified that poor motivation of staff can decrease the level of care delivered by respondents. A moderate level of motivation was reported (mean = 6.7319). The majority of the respondents indicated that the remuneration is not according to the level of work they deliver, that they cannot keep up with the financial demands of life and will be more motivated towards patient care with a higher salary. 95% of respondents identified that the institutions where they work do not employ enough staff and a majority of respondents (95%) reported that SPMS is not rated fairly. This sentiment was also reflected in the open-ended question as the reasons for conflict in the departments and the extra comments by respondents stating that SPMS, OSD and salaries are not fair and effective. Conflict influences the

motivational level of respondents and in retrospect also the level of care delivered. Respondents reported a moderate level of conflict in the department (mean = 5.4292) and the main reasons reported for this conflict was:

- Work relations signified as poor cooperation and relationships
- Personnel shortages
- High workload
- Management
- Shift and leave planning
- Unfairness
- Poor communication
- Relieving in other departments
- Work conditions and shortage of consumables
- SPMS, OSD and salaries

Although respondents made reference to economical factors and kinship, responses were not substantial to make statistical findings. Responses of economic factors were made with regard to the inadequacy of salaries. Kinship was referred to during responses about social factors affecting nursing care, by the reference made of the influence of nursing on family life and also the lack of involvement in social activities.

5.3 RECOMMENDATIONS

From abovementioned findings it was identified that the core values identified from this study is not in essence supported by any other previous study. It was indicated by respondents that SPMS is not viewed in a positive light and that numerous factors exist that are not conducive to the motivation of nurses. Finally, it became evident through the responses that nursing staff is not successfully supported by the management structure of nursing. The recommendations of this study are focussed on developing a good value structure to ensure that the caring nature of the nursing profession is upheld.

5.3.1 Clear value structure for nursing in South Africa

Values are an essential human reality, it directs the priorities individuals live by and outline an individual's world view (Mc Neese-Smith & Crook, 2003:260). Each individual's thoughts, feelings, actions and perceptions are determined by the well-known values a person holds and determines what a person attaches value to (Mohr, Deatrick, Richmond & Mahon, 2001: 31). Brown (2003:58) conceptualizes that values function as guiding principles for individuals and the organization; therefore it is necessary to understand the values that govern the practice of each nurse, facility and organization.

From the literature search (Chapter 2) it is concluded that no literature could be found that identifies the core nursing values directing the nursing practice of South Africa. With regard to nursing values in South Africa it is recommended:

- That the core nursing values that guide nursing are established and should be underpinned by the South African Nursing Council.

5.3.2 Staff performance and management

The Department of Public Service implemented a strategy aimed at achieving "individual excellence and achievement" by introducing the Employee Performance Management and Development System (EPMDS) (Department of Public Service, 2007). EPMDS was introduced with the aim to plan, manage and improve the employees' performance to ensure the overall performance and service delivery of Government Departments, also aimed at improving the motivation of employees. The implemented EPMDS programme is called the Staff Performance Management System (SPMS) (Department of Public Service and Administration, 2007).

Respondents identified their discontent with SPMS, citing unfairness in the evaluation and awarding of this form of recognition. From the findings of the study it is recommended that the implementation and evaluation of staff performance and management should receive attention and the following recommendations are made:

- Attention should be given to ensure fair evaluation of nurses through the SPMS process, by incorporating evaluation of persons doing assessment during the SPMS process.

- Processes should be implemented to create fairness, by making the evaluation tools user friendly and also providing good instructions for evaluators.

5.3.3 Enhancing motivation of nursing staff

Jooste (2010:200) identifies that motivation is one of the main components to ensure effective work being delivered. The findings of Franco et al., (2002:1255) coincide and state that the performance of the health sector critically depends on the motivational level of the healthcare workers. This motivation is determined by different conditions, namely extrinsic conditions, for example financial incentives, and intrinsic responses, for example personal growth (Jooste, 2003:56). To enhance the motivational level of health care workers various strategies should be included, such as economical-, psychological-, organisational developmental-, human resource management- and sociological strategies (Franco et al., 2002:1256).

From this research it was identified that an effort should be made to ensure better motivation of respondents, the researcher therefore recommends that special attention should be given to improve the motivation of respondents:

- Including strategies to improving working conditions, including resource availability and better facilities, such as restrooms for clinics
- A vast amount of responses indicated that the salary levels should be revised to ensure the motivation of respondents
- As stated Staff Performance should be evaluated fairly and should support the motivation of respondents
- Relieving of staff shortages, as it will reduce work pressure and the need for relieving in other departments, consequently decreasing conflict and enhancing motivation
- The appointment of staff, by focussing on the best person for the position rather than the ethnic representation.

5.3.4 Management-for-Nurse strategy

The two factor content theory by Herzberg identifies the relationship with the employer as a hygiene factor that leads to dissatisfaction if it is not met (Training and development solution, 2001 – 2011). From the finding of this study the inadequacy of management was indicated as a common topic. It was identified that respondents did not feel supported and protected by management. Respondents indicated their unhappiness with regard to management style and managements' low understanding and support of nurses, but also the managers' lack of knowledge about the function of the department. It is therefore recommended:

- That a Management-for-Nurse strategy is developed that encompasses reach-out by management to nurses by including nurses in decision making, planning and incorporating their opinion and expertise.

5.4 RECOMMENDATIONS FOR FURTHER STUDIES

5.4.1 Expansion of research

It would be informative if a similar study targeting a variety of nursing institutions in the country were done, to get a good representation of the nursing population. This would allow generalisation of findings to nursing in South Africa. These studies should include private nursing facilities, to evaluate the difference between nurses working in government facilities and private nursing facilities with regard to important nursing values and factors influencing it, but also to get a good representation of the nursing population of South Africa.

5.4.2 Influence and effectiveness of unions

Respondents identified that the influence of unions is not necessarily optimal. Findings identify disparity, interference and ineffectiveness of unions in nursing. It is recommended from the findings of this study that a research is undertaken to determine nurses' opinion about the influence and effectiveness of unions in nursing practice.

5.4.3 Implementation of Occupation Specific Dispensation in nursing

The main aim of OSD was to improve the salaries and conditions of service, by adjusting salaries in accordance to speciality and re-calculation of experience, based on the years of experience and aspired to ensure "fair, equitable and competitive remuneration structures for all categories of employees" (Department of Health, 2007; Public Service Co-ordinating bargaining council, 2007:3). OSD affected all nurses working in the public sector. Findings from this study identified that OSD is not perceived as fair, it creates conflict in the departments and it does not meet the aspirations for introducing OSD. It is recommended from the finding of this study that further studies are undertaken to evaluate the effectiveness of OSD and to establish if nurses experience the remuneration as fair, equitable and competitive, with possible recommendations.

5.4.4 Staff performance management as motivator and promoting performance

It is recommended from the findings of this study that the Staff Performance Management System should be evaluated, with specific reference to the implementation of it in the workplace to determine the ease and fairness of the evaluation process and its contribution to motivation and performance of employees, with possible recommendations for adjustment.

5.4.5 Political factors affecting nursing practice and nursing values

Leininger identifies that political factors affect nursing practice (George, 2002:491; Tjale & De Villiers, 2004:22). It is recommended in view of the political changes South Africa underwent and the findings from this study that further research specifically of political factors affecting nursing practice and nursing values are undertaken.

5.4.6 Social factors affecting nursing practice and nursing values

Leininger identified that social factors affect nursing practice (George, 2002:491; Tjale & De Villiers, 2004:22). This study identified a number of findings with regard to social factors affecting nursing practice and nursing values, which refer to social factors in personal life and social factor in the work setting. From these findings it is recommended that this is further explored.

5.5 LIMITATIONS OF THE STUDY

The limitations of a study can reduce the credibility and may reduce the ability to generalise research findings to a larger population (Burns & Grove, 2007:37). Several limitations regarding this study were identified that should be considered when interpreting the results.

Due to time and financial constraints the study was limited to the Paarl district and facilities of the Provincial Administration of the Western Cape. The convenience sample used in the study, may not have been representative of all nurses, and may reduce the applicability of the findings.

A self-report, anonymous questionnaire was used which enhances truthfulness and generally reduces bias by an interviewer, but it can also limit opportunity to elaborate on responses, possibly resulting in less depth and it might give a limited overview of the problem (Burns & Grove, 2007:382). The self-report method of data collection may have the possibility of a false positive result. The self-reported questionnaire posed another limitation in respondents providing incomplete demographic data and consequently not completing all closed-ended questions andseveral respondents not completing open-ended questions. This was indicated with the discussion of each question. A limitation in the questionnaire was a lack of a definition of each value, as values unknown to respondents could have let to respondents not rating those values, leading to the high level of missing data. This limitation was not identified during the pilot study, due to the researcher being available for questions from the respondents during the completion of the questionnaire during the pilot study. This omission by the researcher was due to the researcher's perception that respondents will ask for clarification of the definition of values

when questionnaires were completed after the information sessions and respondents were also provided a telephone number of the researcher for any queries.

A further limitation during data collection was members of the population's previous experience with research that was conducted in the nursing facilities and reconstructed opinions about research. The workload in the different departments constituted to nursing personnel feeling that they did not have the time to complete the questionnaire.

5.6 SUMMARY

A quantitative, descriptive research was conducted to do an in-depth study into the factors influencing nursing values of nurses working in Nursing Facilities in the Paarl district employed by the Provincial Administration of the Western Cape, in the West Coast Winelands Region of the Western Cape. The population included all nurses permanently employed by the Provincial Administration of the Western Cape, from nursing facilities in the Paarl district. These nurses represented all nursing departments, namely casualty, theatre, surgery, medical, midwifery, orthopaedic, high care, paediatric department, administration, education and primary health care departments.

The objectives for the study were to

- determine the main reason for entering the nursing profession for nurses working in these facilities
- identify the most important part of nursing practice for nurses working in these facilities
- identify the core nursing values of the nurses working in these facilities
- determine the factors influencing nursing values
- determine the factors influencing the nursing care of the patient.

The rationale, problem statement and aim of the study, as well as the ethical consideration were discussed in Chapter 1. An extensive literature review guided this research and was presented in Chapter 2. Chapter 3 explored a broad discussion of the methodology, population, sampling and instrumentation of this study. In Chapter 4 the data analysis and interpretation were presented, this included the quantitative data that was presented in frequency tables and histograms and qualitative data obtained in the open-ended questions. In the current chapter the empirical findings are discussed and compared with the findings of previous studies,

conclusions are drawn from the findings and recommendations originating from the objectives are discussed, recommendations for further studies are made and limitations of the current study are discussed.

The overall conclusion was that nurses enter nursing due to altruistic reasons and the most important part of nursing is seeing the patient progress towards healing. Respondents rated different values as important for behaviour as a nurse, patient care and ethical decision making. The most prominent values were:

- confidentiality
- quality of care and excellence
- accountability
- integrity
- competence
- co-operative relationship with co-workers
- compassion and humanity
- privacy
- responsibility
- respect for the rights of people
- confidence
- truth and honesty
- respect for dignity and autonomy
- trustworthiness
- confidentiality
- value of personhood.

It was concluded that age, years of experience, qualification obtained, job description and department influence different values. Findings from this study identified that political factors, social factors and motivation influence nursing practice. The overall recommendation is that a clear value structure for nursing in South Africa should be developed, the evaluation of the staff performance and management system should be improved, the motivation of staff should be enhanced with various strategies and a Management-for-nurse strategy should be developed. The further studies that were recommended was the expansion of the research, research into the influence and effectiveness of unions, exploring the implementation of OSD in nursing, research into Staff Performance Management as motivator and promoting performance, political factors affecting nursing practice and nursing values and social factors affecting nursing practice and nursing values. Finally, this study demonstrated the importance of establishing a good value base for nursing institutions and establishing supportive environments for proper patient care to ensure good health care for South African citizens.

LIST OF REFERENCES

Altun, I. 2002. Burnout and Nurses' Personal and Professional Values. *Nursing Ethics*. 9(3), pp. 269-278.

Babbie, E., Mouton, J., Vorster, P. & Prozesky, B. 2006.*The practice of social research.* Cape Town: Oxford University Press

Babbie, E. 2007.The practice of social research. 11th ed. Australia: Thomson Wadsworth.

Booysen, L., Erasmus, H.M. & Van Zyl, M.D. 2004. *The auxilliary nurse*. Cape Town: Juta.

Brink, H. 2006. (revised by C. Van der Walt & G. Van Rensburg). *Fundamentals of research methodology for health care professionals*. 2nd edition. Cape Town: Juta.

Brink, H. 2008. *Fundamentals of research methodology.* Lansdowne, Juta & Co.

Brown, C. 2003. Low morale and burnout: is the solution to teach a value-based spiritual approach? *Complementary therapies in Nursing & Midwifery.* 9. pp. 57 – 61.

Burns, N. & Grove, S. 2001. *The practice of nursing research: conduct, critique and utilization*. Philadelphia: WB Saunders.

Burns, N. & Grove, S. 2007. *Understanding Nursing Research Building an evidence-bases practice.* Fourth Edition. Missouri: Saunders Elsevier.

Burns, N. & Grove, S.K. 2009. *The Practice of Nursing Research:* Appraisal, Synthesis, and Generation of Evidence**.** Sixth Edition. Missouri: Saunders Elsevier.

Corbin, J. 2008. Is caring a lost art in nursing? *International Journal of Nursing Studies.* 45 (2008). pp. 163 – 165.

Cortis, J. D. & Kendrick, K. 2003. Nursing Ethics, Caring and Culture. *Nursing Ethics.* 10(1). pp. 77 – 88.

Davis, A.J. 1999. Global Influence of American Nursing: Some ethical issues. *Nursing Ethics.*6(2). pp. 118-125.

Department of Health. 1997a. The *Charter of the Public and Private Health Sectors of the Republic of South Africa*. [Online] Available from: http://www.doh.gov.za/docs/charter.f.html [Accessed 12 August 2009].

Department of Health.1997b. White *paper for the transformation of the health system in South Africa.* [Online] Available from: http://www.doh.gov.za/docs/index.html [Accessed 14 August 2009].

Department of Health. 2007. *All nurses to benefit from an agreement with unions.* [Online] Available form: http://www.doh.gov.za/docs/pr/2008/pr0115.html [Accessed 31 March 2010].

Department of Public Service and Administration. 1997a. *Code of conduct for public servants.* [Online] Available from: http://www.capegateway.gov.za/eng/pubs/public_info/C/61188 [Accessed 18 August 2009].

Department of Public Service and Administration. 1997b. *White paper on Transforming public service delivery.* [Online] Available from: http://www.dpsa.gov.za/documents/actsregulations/frameworks/white-paper/transform.pdf [Accessed 12 June 2009].

Department of Public Service and Administration. 1998. White Paper on Affirmative Action in the Public Service. *Government Gazette.*394 (18800). Pretoria: Government Printers.

Department of Public Service and Administration. 2007. *Employee Performance Management and Development System.* Pretoria: The Presidency.

De Vos, A.S, Strydom, H, Fouché, C.B & Delport, C.S.L. 2008. *Research at grass roots.* Pretoria: Van Schaik.

Fagermoen, M.S. 1997. Professional identity: values embedded in meaningful nursing practice. *Journal of Advanced Nursing*.25, pp.434 – 441.

Flynn, L. & Aiken, L.H. 2002. Does International Nurse Recruitment Influence Practice Values in U.S. Hospitals? *Journal of Nursing Scholarship.* 34(1). pp. 67-73.

Frish, N.C. & Frisch, L.E. 2002. *Psychiatric Mental Health Nursing.* Second Edition. New York: Delmar Thomson Learning.

Fry, S. T. & Johnstone, M. 2008. *International council of Nurse. Ethics in Nursing Practice. A guide to ethical decision making.* Third edition. United Kingdom: Blackwell Publishing.

Franco, L. M, Bennett, S. & Kanfer, R. 2002. Health sector reform and public sector health worker motivation: a conceptual framework. *Social Science & Medicine*. 54(2002). pp. 1255 – 1266.

George, J.B. 2002. *Nursing theories the base for professional nursing Practice*. Fifth edition. New Jersey: Prentice Hall.

Gillham, B. 2000. *Developing a questionnaire.* London: Continuum.

International Council of Nurses, 2000.ICN Code of Ethics for Nurses. International Council of Nurses, Geneva, Switzerland, [Online] Available from http://www.icn.ch/ethics.htm [Accessed 17/04/07].

Jooste, K. 2010. *The principles and practice of nursing and health care. Ethos and professional practice, management, staff development and research*. Pretoria: Van Schaik Publishers.

Jooste, K. 2003. *Leadership in Health Services Management*. Landsdown: Juta.

Jormsri, P, Kunaviktikul, W, Ketefian, S & Chaowalit, A. 2005.Moral Competence in Nursing Practice. *Nursing Ethics.* 12(6), pp. 582-594.

Kong, B. 2008. Levinas' Ethics of Caring: Implications and limits in Nursing. *Asian Nursing Research.* 2(4). pp. 208 – 213.

Kubsch, S, Hansen, G & Huyser-Eatwell, V. 2008. Professional Values: The Case for RN-BSN Completion Education. *The Journal of Continuing Education in Nursing.* 39(8). pp. 375-384.

LeSergent, C.M. & Haney, C.J. *Rural hospital's stressors and coping strategies: a survey*[Online], Volume 42, Issue 3, University of Northern British Columbia. Available from: http://www.sciencedirect.com.ez.sun.za/science? [Accessed 31 March 2007].

Maltby, J, Day, L & Williams, G. 2007. *Introduction to statistics for nurses.* England: Pearson Education.

Marks, S. 1994. *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession.* Johannesburg: Witwatersrand University Press.

Mc Donald, J.H. 2009.*Handbook of Biological Statistics (2nd ed.).* [Online] Baltimore: Sparky House Publishing. Available from: http://udel.edu.~mcdonald/statfruskalwallis.html [Accessed 13 October 2011].

Mc Neese-Smith, D & Crook, M. 2003. Nursing values and a changing Nurse workforce. *Journal of Nursing Administration*. 33(5) May, pp. 260-270.

Mellish, J.M. & Paton, F. 1999.*An introduction to the Ethos of Nursing a text for basic student nurses*. Second edition. Sandton: Heinemann.

Mohr, W.K., Deatrick, J, Richmond, T & Mahon, M.M. 2001.A reflection on Values in Turbulent Times. *Nursing Outlook.* 49 (30-6), pp. 30-36.

Mosby's Medical, Nursing, & Allied health dictionary. Sixth Edition. 2002. Missouri: Mosby.

Mouton, J. 2001. *How to succeed in your Master's & Doctoral Studies. A South African guide and resource book.* Pretoria: Van Schaik.

Mulaudzi, M. M, Makoena, J, Troskie, R. 2000. *Basic Nursing Ethics in Practice*. Sandown: Heinemann.

Neumann, J.A. & Forsyth, D. 2008. Teaching in the Affective Domain for Institutional Values. *The Journal of Continuing Education in Nursing.* 39(6), pp. 248-252.

Newhouse, R.P. 2005. Exploring Nursing Issues in Rural Hospitals. *JONA*, 35 (7/8) July/August, pp.350-358.

Pera, SA & Van Tonder, S. ed. 2005.*Ethics in health care*. Second edition. Cape Town: Juta.

Polit, D.F. & Beck, C.T. (2006) *Essentials of Nursing research*. Methods, Appraisal, and Utilization.6th edition.

Public Service Co-ordinating Bargaining Council. 2007. *Resolution No. 1 of 2007.* Pretoria, PSCBC. [Online]. Available from: http://www.pscbc.org.za [Accessed 12 January 2010].

Rassin, M. 2008. Nurses' Professional and Personal Values. *Nursing Ethics.* 15(5), pp. 614-630.

Rispel, L. & Schneider, H. 1991. Professionalisation of South African Nursing: Who Benefits? *International Journal of Health Services.* 21(1), pp 109 -126.

RSA (Republic of South Africa). 2005. *Nursing Act, No 33 of 2005.* Pretoria: Government Printer.

Schroeder, F. 24 April 2009. *Woman sues premier for R10m over birth.* Pretoria News, pp. 6.

Searle, C, Human, S & Mogotlane, S.M. 2009. *Professional practice. A South African nursing perspective*. Fifth edition. Johannesburg: Heinemann Publishers.

Shaw, H.K. & Degazon, C. 2008. Integrating the core Professional Values of Nursing: A

Profession, Not Just a Career. *Journal of Cultural Diversity.* 15(1) Spring, pp. 44-50.

Sidumo, Z. 24 April 2009. *Unabantu's family wait for MEC's report…and closure.* Cape Argus, pp. 3.

South African Nursing Council. 2009a. *Age distribution.* Pretoria, South African Nursing Council. [Online]. Available from: http://www.sanc.co.za/stats/stat2008/Age%20stats%202008_files/slide0025.htm [Accessed 11 June 2009].

South African Nursing Council. 2009b. *SANC Geographical Distribution 2008* [Online]. Pretoria, South African Nursing Council. Available from: http://www.sanc.co.za/stats/stat2008/Distribution%202008xls.htm [Accessed 11 June 2009].

Statistics South Africa. 2008. *Mid-year population estimates 2008* [Online]. Pretoria, Statistics South Africa. Available from: http://www.statssa.gov.za [Accessed 10 June 2009].

Terre Blanche, M., Durrheim, K. & Painter, D. (2006) *Research in Practice. Applied* Methods For The Social Sciences.1st ed. Cape Town, Cape Town University Press.

The English illustrated dictionary. 2005. Nottinghamshire: Award Publications Limited.

Tjale, A & De Villiers. 2004. *Cultural Issues in Health and Health Care*. Cape Town: Juta.

Training and development solution. 2001 – 2011. *Frederick Herzberg – Theory of motivation* [Online]. Available from: http://www.trainanddevelop.co.uk/article/frederick-herzberg-theory-of-motivation-a78 [Accessed 03 October 2011].

Western Cape Government. 2011. *Department of health: Overview* [Online]. Available from: http://www.westerncape.gov.za/eng/your_gov/305 [Accessed 18 November 2011].

ADDENDA

ADDENDUM A: CONSENT FORM

PARTICIPANT CONSENT FORM

INVESTIGATION INTO THE FACTORS INFLUENCING NURSING VALUES

PRINCIPAL INVESTIGATOR: MRS. T. VAN SCHALKWYK

CONTACT NUMBER: O834438372

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Committee for Human Research at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

Please ensure that you complete a consent form before you partake in the study.

Declaration by participant

By signing below, I ……..……. agree to take part in a research study entitled "*Investigation into the factors influencing nursing values"*.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2010.

.....

Signature of participant Signature of witness

Declaration by investigator

I *(name)* ……..…… declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.

- I am satisfied that he/she adequately understands all aspects of the research, as discussed above

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2010.

.....

Signature of investigator

Signature of witness

ADDENDUM B: PARTICIPATION INFORMATION LEAFLET

PARTICIPANT INFORMATION LEAFLET

AN INVESTIGATION INTO THE FACTORS INFLUENCING NURSING VALUES

PRINCIPAL INVESTIGATOR: MRS. T. VAN SCHALKWYK

CONTACT NUMBER: O834438372

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Committee for Human Research at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

The study will be conducted at Paarl Hospital, Sonstraal Hospital, TC Newman Community District Centre, E. De Waal clinic, J.J. du Preez clinic, Klein Drakenstein clinic, Klein Nederburg clinic, Patriot Plein clinic, Simondium clinic, Gouda clinic, Hexberg clinic, Huis Macrone clinic, Nieuwedrift clinic, Saron clinic, Soetendal clinic, Windmeul clinic, Mbekweni clinic, Phola Park clinic and Dalevale clinic.

A total of 460 nursing personnel will be invited to partake in the study

The aim of the study is to do an in-depth study into the factors influencing nursing values of nurses working in Government Nursing Facilities in the Paarl district, in the West Coast Winelands Region of the Western Cape.

The process of collection of data will require that you complete a structured questionnaire, by giving your honest opinion. There is no right or wrong answer.

Why have you been invited to participate?

Because you are working at either of the nursing facilities where the research will be conducted, you are invited to partake in the research. Your input would be valued information. All information you provide will be contribusive to the study.

What will your responsibilities be?

The completion of the questionnaire will take no longer than 15minutes. Please assure that you complete a consent form before you complete a questionnaire.

Will you benefit from taking part in this research?

South Africa is a diverse country with a diverse population which you as nurse serve, as well as the muticulturality and the political and social background of South Africa, it is of importance to do an investigation into the factors influencing nursing values. Through this information it will be possible to make recommendation to stakeholders in nursing to ensure a better understanding of the core nursing values, determine the factors influencing these nursing values and determine how the factors influencing the nursing values then affect the nursing care of the patient.

Are there in risks involved in your taking part in this research?

There are no foreseen risks for taking part in the research.

Who will have access to your questionnaire?

The information you provide will be used a thesis, but your identity will remain anonymous and at no stage will any name of respondent be provided. The researcher and the supervisor of the study are the only persons that will have access to the information you provide in the questionnaire.

ADDENDUM C: ENGLISH QUESTIONNAIRE

Investigation into factors influencing nursing values

Survey Questionnaire

Study Aim

The purpose of this study is to determine the factors influencing nursing values.

There are no right or wrong answers to these questions and your truthful response is of utmost importance for the success of this study.

All information will be treated as confidential and the researcher undertakes not to reveal any individual information that appears in this questionnaire.

To complete this 8 paged questionnaire will take no longer than 15 minutes.

All you need to do is to mark off with a cross (**x**) your most appropriate response.

The response scale is as follows:

1. No priority
2. Little priority
3. Moderate priority
4. High priority

A numerical value of 1, 2, 3 and 4 will be awarded to each response, with 1 being awarded to the most negative answer and 4 to the most positive answer.

An example follows:

For each of the statements below, indicate the extent of priority by placing a tick in the appropriate box.

Example

Value		High priority	Priority	Little priority	No priority
A	**Faithfulness**	**x**			
B	**Individuality**			**x**	

Please read the instructions carefully when answering the questions.

Thank you for agreeing to partake in this survey.

T. van Schalkwyk

Researcher

Tel: 083 443 8372

SECTION A: Biographical data

(Mark the most applicable block with an (**X**) or fill in the appropriate answer)

Gender	Male		Female		
Ethnic group	African	Coloured	Indian	White	
Religion	Islam	Christian	Jewish	Jehovah Witness	None
	Other:				
Age group	<30yrs	30-39yrs	40-49yrs	50-59yrs	60-65yrs
Nr of years of experience	<4yrs	4-10yrs	11-20yrs	21-30yrs	>31yrs
Highest qualification obtained	Certificate	Basic diploma	Degree		
	Post basic diploma	Post graduate degree	Other:		
Current job description	Assistant nurse	Staff nurse	Professional nurse		
	Operational manager	Assistant manager	Deputy manager		
	Other:				
Current department	Medical	Surgical	Theater	Midwifery (antenatal, intrapartum and postnatal)	
	Casualty	High Care	Pediatric	Orthopedic	
	Primary Health Care	Other:			

SECTION B: Nursing values

B1. Identify the MAIN reason you decided on nursing as a career

(Mark the applicable block with an (**X**), **only one reason can be selected)**

Reason		Answer
A	**Career opportunities**	
B	**I was looking for a work and it was a way to get money**	
C	**Good incentives and income**	
D	**I wanted to help people**	
E	**Career stability**	
F	**One of my family members was a nurse so I decided to do it**	
G	**I was pressured to do it**	
H	**Other:** (Give a description)	

B2.Do you feel that you are still in nursing practice due to the reason for entering the nursing career?

(Mark the applicable block with an (**X**))

Yes	No	Unsure

B3. Identify the part of nursing practice most important to you.

(Mark the applicable block with an (**X**), **only one answer can be selected**)

Part of nursing		Answer
A	**Job stability**	
B	**Seeing the patient progress towards healing**	
C	**Interaction with other professionals**	

D	**Gaining of new knowledge and getting clinical experience**	
E	**Receiving the monthly remuneration**	
F	**Caring for the patient**	
G	**Being a competent nurse**	
H	**Other:** (Give a description)	

B4. Prioritize each of the following professional values which influence your <u>BEHAVIOUR AS A NURSE</u>.

<u>A MAXIMUM OF 5 VALUES CAN BE IDENTIFIED AS HIGH PRIORITY</u>

(Mark the most applicable block with an (**X**), only one level of priority can be assigned to each value)

	Value	High priority	Moderate priority	Little priority	No priority
1	**Confidentiality**	4	3	2	1
2	**Accountability**	4	3	2	1
3	**Advocacy**	4	3	2	1
4	**Altruism (regard for the welfare of other individuals) /**	4	3	2	1
5	**Beneficence and Non-maleficence**	4	3	2	1
6	**Compassion / Humanity**	4	3	2	1
7	**Co-operative relationship with co-workers**	4	3	2	1
8	**Confidence**	4	3	2	1
9	**Courtesy**	4	3	2	1
10	**Competence**	4	3	2	1
11	**Equality (all persons have the same rights and privileges)**	4	3	2	1
12	**Freedom (the ability to exercise own choice or decide on**	4	3	2	1
13	**Independence**	4	3	2	1
14	**Integrity (nurses acting in accordance with an appropriate**	4	3	2	1
15	**Maintaining of standards of personal conduct**	4	3	2	1
16	**Privacy**	4	3	2	1
17	**Quality care / Excellence**	4	3	2	1
18	**Respect for dignity and autonomy**	4	3	2	1
19	**Respect for the rights of people**	4	3	2	1
20	**Responsibility**	4	3	2	1
21	**Safety / Security**	4	3	2	1
22	**Social justice (fair treatment through the upholding of moral**	4	3	2	1
23	**Trustworthiness**	4	3	2	1
24	**Truth (faithfulness to fact and reality) / Honesty**	4	3	2	1
25	**Value of personhood**	4	3	2	1

B5. What values are important to provide proper<u>PATIENT CARE</u> in your daily work as a nurse?

<u>A MAXIMUM OF 5 VALUES CAN BE IDENTIFIED AS HIGH PRIORITY</u>

(Mark the most applicable block with an (**X**), only one level of priority can be assigned to each value)

	Value	High priority	Moderate priority	Little priority	No priority
1	Confidentiality	4	3	2	1
2	Accountability	4	3	2	1
3	Advocacy	4	3	2	1
4	Altruism (regard for the welfare of other individuals) /	4	3	2	1
5	Beneficence and Non-maleficence	4	3	2	1
6	Compassion / Humanity	4	3	2	1
7	Co-operative relationship with co-workers	4	3	2	1
8	Confidence	4	3	2	1
9	Courtesy	4	3	2	1
10	Competence	4	3	2	1
11	Equality (all persons have the same rights and privileges)	4	3	2	1
12	Freedom (the ability to exercise own choice or decide on	4	3	2	1
13	Independence	4	3	2	1
14	Integrity (nurses acting in accordance with an appropriate	4	3	2	1
15	Maintaining of standards of personal conduct	4	3	2	1
16	Privacy	4	3	2	1
17	Quality care / Excellence	4	3	2	1
18	Respect for dignity and autonomy	4	3	2	1
19	Respect for the rights of people	4	3	2	1
20	Responsibility	4	3	2	1
21	Safety / Security	4	3	2	1
22	Social justice (fair treatment through the upholding of moral	4	3	2	1
23	Trustworthiness	4	3	2	1
24	Truth (faithfulness to fact and reality) / Honesty	4	3	2	1
25	Value of personhood	4	3	2	1

B6. Which values do you often use in order to make <u>ETHICAL DECISIONS</u> (decisions to decide between right or wrong)?

<u>A MAXIMUM OF 5 VALUES CAN BE IDENTIFIED AS HIGH PRIORITY</u>

(Mark the most applicable block with an (**X**), only one level of priority can be assigned to each value)

	Value	High priority	Moderate priority	Little priority	No priority
1	Confidentiality	4	3	2	1
2	Accountability	4	3	2	1
3	Advocacy	4	3	2	1
4	Altruism (regard for the welfare of other individuals) /	4	3	2	1
5	Beneficence and Non-maleficence	4	3	2	1
6	Compassion / Humanity	4	3	2	1
7	Co-operative relationship with co-workers	4	3	2	1
8	Confidence	4	3	2	1
9	Courtesy	4	3	2	1
10	Competence	4	3	2	1
11	Equality (all persons have the same rights and privileges)	4	3	2	1
12	Freedom (the ability to exercise own choice or decide on	4	3	2	1
13	Independence	4	3	2	1
14	Integrity (nurses acting in accordance with an appropriate	4	3	2	1
15	Maintaining of standards of personal conduct	4	3	2	1
16	Privacy	4	3	2	1
17	Quality care / Excellence	4	3	2	1
18	Respect for dignity and autonomy	4	3	2	1
19	Respect for the rights of people	4	3	2	1
20	Responsibility	4	3	2	1
21	Safety / Security	4	3	2	1
22	Social justice (fair treatment through the upholding of moral	4	3	2	1
23	Trustworthiness	4	3	2	1
24	Truth (faithfulness to fact and reality) / Honesty	4	3	2	1
25	Value of personhood	4	3	2	1

SECTION C: Political and legal factors

C1. Do you feel that appointment of nurses is done fairly?

(Mark the applicable block with an (**X**))

Yes	No

C2. Do you feel that Staff Performance (SPMS) is rated fairly?

(Mark the applicable block with an (**X**))

Yes	No

C3. Rate your knowledge of the acts, regulations and policies applicable to your work from 0 to 10.

(With 0 being no knowledge and 10 having excellent knowledge)

(Mark the applicable block with an (**X**))

0	1	2	3	4	5	6	7	8	9	10

C4. Describe the political factors that are influencing your nursing practice.

(This is an individual opinion; there is no right or wrong answer)

_____
_____
_____
_____
_____
_____
_____
_____
_____

SECTION D: Socio-economic factors

D1. Do you feel that you are receiving remuneration according to the level of work you deliver?

(Mark the applicable block with an (**X**))

Yes	No

D2. Can you keep up with the financial demands of life?

(Mark the applicable block with an (**X**))

Yes	No

D3. Do you feel that if your salary level were higher you would have been better motivated towards nursing care?

(Mark the applicable block with an (**X**))

Yes	No

D4. Did you receive a significant salary increase during Occupation Specific Dispensation (OSD)?

(Mark the applicable block with an (**X**))

Yes	No

D5. Do you think that the institution employ enough personnel to deliver proper nursing care?

(Mark the applicable block with an (**X**))

Yes	No

D6. Can you keep up with the demand of work and still ensure proper care?

(Mark the applicable block with an (**X**))

Yes	No

D7. On a scale of 0 to 10 how motivated are you to deliver proper care.

(With 0 being totally unmotivated and 10 being very motivated)

(Mark the applicable block with an (**X**))

0	1	2	3	4	5	6	7	8	9	10

D8. On a scale of 0 to 10 what is the level of conflict in the department you are working at?

(With 0 being no conflict and 10 being extreme conflict)

(Mark the applicable block with an (**X**))

0	1	2	3	4	5	6	7	8	9	10

D9. What is causing this conflict in the department?

(This is an individual opinion; there is no right or wrong answer)

_____

_____

_____

_____

_____

D10. Describe the social factors that are influencing your nursing practice.

(This is an individual opinion; there is no right or wrong answer)

D11. Comments

(This is an individual opinion; there is no right or wrong answer)

Addendum D: Afrikaanse vraelys

Ondersoek na die faktore wat verpleegwaardes beïnvloed

Studie Vraelys

Studie doelwit

Die doel van die studie is om die faktore the bepaal wat verpleegwaardes beïnvloed.

Daar is geen regte of verkeerde antwoord op enige van die vrae nie en jou eerlike antwoord is van belang vir die sukses van die studie.

Alle informasie sal as konfidensieël hanteer word en die navorser onderneem om geen individuele informasie wat in die vraelys verskynbekend te maak nie.

Om die 8 bladsy vraelys te voltooi sal nie langer as 15 minute neem nie.

Al wat jy moet doen is om die mees toepaslike antwoord met ‘n (**x**) te merk.

Die respons skaal is as volg:

1. Geen prioriteit
2. Min prioriteit
3. Matige prioriteit
4. Hoë prioriteit

‘n Numeriese waarde van 1, 2, 3 of 4 sal toegeken word aan elke anrwoord, met 1 toegeken aan die mees negatiewe antwoord en 4 tot die mees positiewe antwoord.

‘n Voorbeeld volg:

Vir elk van die stellings, dui die mate van belangrikheid aan deur die toepaslike spasie af te merk.

Voorbeeld

Waarde		**Hoë prioriteit**	**Matige Prioriteit**	**Min prioriteit**	**Geen prioriteit**
A	**Getrouheid**	**x**			
B	**Individualiteit**			**x**	

Lees asseblief die instruksies sorgvuldig wanneer die vrae beantwoord word.

Dankie dat jy bereid is om aan die studie deel te neem.

T. van Schalkwyk

Navorser

Tel: 083 443 8372

AFDELING A: Biografiese data

(Merk die mees toepaslike spasie met 'n (**X**) of vul die toepaslike antwoord in)

Geslag	Manlik		Vroulik		
Etniese groep	Swart	Bruin	Indiër	Wit	
Geloof	Islam	Christen	Joods	Jehovah Getuie	Geen
	Ander:				
Ouderdoms groep	<30jaar	30-39jaar	40-49jaar	50-59jaar	60-65jaar
Aantal jare ondervinding	<4jaar	4-10jaar	11-20jaar	21-30jaar	>31jaar
Hoogste kwalifikasie behaal	Sertifikaat	Basiese diploma	Graad		
	Na-basiese diploma	Na-basiese graad	Ander:		
Huidige pos beskrywing	Assistent verpleegster	Staf verpleegster	Professionele verpleegkundige		
	Operasionele bestuurder	Assistent bestuurder	Adjunkbestuurder		
	Ander:				
Huidige departement	Medies	Chirurgie	Teater	Verloskunde (antenataal, intrapartum & postnataal)	
	Ongevalle	Hoësorg	Pediatrie	Ortopedies	
	Primêre Gesondheid Sorg	Ander:			

AFDELING B: Verpleegwaardes

B1. Identifiseer die<u>HOOF</u>rede vir jou toetrede tot die verpleeg beroep

(Merk die toepaslike spasie met 'n (**X**), **slegs een antwoord kan aangedui work)**

	Rede	Antwoord
A	**Beroeps geleenthede**	
B	**Ek was opsoek na 'n werk en dit was 'n manier om geld te verdien**	
C	**Goeie voordele en inkomste**	
D	**Ek wou mense help**	
E	**Beroep stabiliteit**	
F	**'n Familie lid was 'n verpleegster, daarom het ek daarop besluit**	
G	**Ek was daarin forseer**	
H	**Ander:** (Gee 'n verduideliking)	

B2.Is jy steeds in verpleging vir die rede waarom jy die beroep gekies het?

(Merk die toepaslike spasie met 'n (**X**))

Ja	Nee	Onseker

B3. Identifiseer die aspek van die verpleeg praktyk wat vir jou die belangrikste is.

(Merk die toepaslike spasie met 'n (**X**), **slegs een antwoord kan geselekteer word**)

	Aspek van verpleging	Antwoord
A	**Werk stabiliteit**	
B	**Om te ervaar 'n pasiënt vorder tot genesing**	
C	**Interaksie met ander professionele persone**	
D	**Om nuwe kennis en ervaring te verkry**	
E	**Ontvang van die maandelikse vergoeding**	
F	**Versorging van die pasiënt**	

G	**Om 'n vaardige verpleegster te wees**	
H	**Ander:** (Gee 'n verduideliking)	

B4. Prioritiseer die volgende professionele waardes wat jou <u>GEDRAG AS 'N VERPLEEGSTER BEINVLOED</u>.

<u>'N MAKSIMUM VAN 5 WAARDES KAN AS HOË PRIORITEIT AANGEDUI WORD</u>

(Merk die mees toespaslike spasie met 'n (**X**), slegs een vlak van prioriteit kan aan elke waarde toegeken word)

	Waarde	Hoë prioriteit	Matige Prioriteit	Min prioriteit	Geen prioriteit
1	**Konfidensialiteit**	4	3	2	1
2	**Aanspreeklikheid**	4	3	2	1
3	**Voorspraak**	4	3	2	1
4	**Altruisme / Deernis**	4	3	2	1
5	**Liefdadigheid & Nie-kwaadwilligheid**	4	3	2	1
6	**Medelye / Menslikheid**	4	3	2	1
7	**Samewerkende verhouding met kollegas**	4	3	2	1
8	**Selfvertroue**	4	3	2	1
9	**Hoflikheid**	4	3	2	1
10	**Vaardigheid**	4	3	2	1
11	**Gelykheid**	4	3	2	1
12	**Vryheid**	4	3	2	1
13	**Onafhanklikheid**	4	3	2	1
14	**Integriteit**	4	3	2	1
15	**Handhawing van 'n standaard van persoonlike gedrag**	4	3	2	1
16	**Privaatheid**	4	3	2	1
17	**Kwaliteit van sorg / Uitnemendheid**	4	3	2	1
18	**Respek vir waardigheid en outonomiteit**	4	3	2	1
19	**Respek vir die regte van mense**	4	3	2	1
20	**Verantwoordelikheid**	4	3	2	1
21	**Veiligheid / Sekuriteit**	4	3	2	1
22	**Sosiale geregtigheid / Regverdigheid**	4	3	2	1
23	**Betroubaarheid**	4	3	2	1
24	**Eerlikheid / Waarheid**	4	3	2	1
25	**Waarde van persoon**	4	3	2	1

B5. Dui die waardes aan wat belangrik is om goeie <u>VERPLEEGSORG</u> in jou daaglikse werk te lewer.

<u>'N MAKSIMUM VAN 5 WAARDES KAN AS HOË PRIORITEIT AANGEDUI WORD</u>

(Merk die mees toespaslike spasie met 'n (**X**), slegs een vlak van prioriteit kan aan elke waarde toegeken word)

	Waarde	Hoë prioriteit	Matige Prioriteit	Min prioriteit	Geen prioriteit
1	Konfidensialiteit	4	3	2	1
2	Aanspreeklikheid	4	3	2	1
3	Voorspraak	4	3	2	1
4	Altruisme / Deernis	4	3	2	1
5	Liefdadigheid & Nie-kwaadwilligheid	4	3	2	1
6	Medelye / Menslikheid	4	3	2	1
7	Samewerkende verhouding met kollegas	4	3	2	1
8	Selfvertroue	4	3	2	1
9	Hoflikheid	4	3	2	1
10	Vaardigheid	4	3	2	1
11	Gelykheid	4	3	2	1
12	Vryheid	4	3	2	1
13	Onafhanklikheid	4	3	2	1
14	Integriteit	4	3	2	1
15	Handhawing van 'n standaard van persoonlike gedrag	4	3	2	1
16	Privaatheid	4	3	2	1
17	Kwaliteit van sorg / Uitnemendheid	4	3	2	1
18	Respek vir waardigheid en outonomiteit	4	3	2	1
19	Respek vir die regte van mense	4	3	2	1
20	Verantwoordelikheid	4	3	2	1
21	Veiligheid / Sekuriteit	4	3	2	1
22	Sosiale geregtigheid / Regverdigheid	4	3	2	1
23	Betroubaarheid	4	3	2	1
24	Eerlikheid / Waarheid	4	3	2	1
25	Waarde van persoon	4	3	2	1

B6. Dui die waardes aan wat jy gebruik om<u>ETIESE BESLUITE</u> te neem (besluite tussen wat reg of verkeerd is)

<u>'N MAKSIMUM VAN 5 WAARDES KAN AS HOË PRIORITEIT AANGEDUI WORD</u>

(Merk die mees toespaslike spasie met 'n (**X**), slegs een vlak van prioriteit kan aan elke waarde toegeken word)

	Waarde	Hoë prioriteit	Matige Prioriteit	Min prioriteit	Geen prioriteit
1	Konfidensialiteit	4	3	2	1
2	Aanspreeklikheid	4	3	2	1
3	Voorspraak	4	3	2	1
4	Altruisme / Deernis	4	3	2	1
5	Liefdadigheid & Nie-kwaadwilligheid	4	3	2	1
6	Meedelye / Menslikheid	4	3	2	1
7	Samewerkende verhouding met kollegas	4	3	2	1
8	Selfvertroue	4	3	2	1
9	Hoflikheid	4	3	2	1
10	Vaardigheid	4	3	2	1
11	Gelykheid	4	3	2	1
12	Vryheid	4	3	2	1
13	Onafhanklikheid	4	3	2	1
14	Integriteit	4	3	2	1
15	Handhawing van 'n standaard van persoonlike gedrag	4	3	2	1
16	Privaatheid	4	3	2	1
17	Kwaliteit van sorg / Uitnemendheid	4	3	2	1
18	Respek vir waardigheid en outonomiteit	4	3	2	1
19	Respek vir die regte van mense	4	3	2	1
20	Verantwoordelikheid	4	3	2	1
21	Veiligheid / Sekuriteit	4	3	2	1
22	Sosiale geregtigheid / Regverdigheid	4	3	2	1
23	Betroubaarheid	4	3	2	1
24	Eerlikheid / Waarheid	4	3	2	1
25	Waarde van persoon	4	3	2	1

AFDELING C: Politieke en wetlike faktore

C1. Meen jy dat die aanstelling van verpleegsters regverdig gedoen word?

(Merk die mees toespaslike spasie met 'n (**X**))

Ja	Nee

C2. Meen jy Werknemer Prestasie (SPMS) word regverdig beoordeel?

(Merk die mees toespaslike spasie met 'n (**X**))

Ja	Nee

C3. Gradeer jou kennis van die wette, regulasies en beleide toepaslik tot jou werk tussen 0 en 10.

(Met 0 as geen kennis and 10 as uitstekende kennis)

(Merk die mees toepaslike spasie met 'n (**X**))

0	1	2	3	4	5	6	7	8	9	10

C4. Beskryf die politieke faktore wat jou verpleeg praktyk beïnvloed.

(Dit is 'n individuele opinie, daar is geen reg of verkeerde antwoord nie)

_____

_____

_____

_____

_____

_____

_____

AFDELING D: Sosio-ekonomiese faktore

D1. Meen jy dat jy vergoeding ontvang volgens die vlak van die werk wat jy lewer?

(Merk die mees toespaslike spasie met 'n (**X**))

Ja	Nee

D2. Kan jy by die finansiële vereistes van die lewe hou?

(Merk die mees toespaslike spasie met 'n (**X**))

Ja	Nee

D3. Indien jy 'n groter salaries ontvang het sou jy beter gemotiveerd gewees het tot verpleegsorg?

(Merk die mees toespaslike spasie met 'n (**X**))

Ja	Nee

D4. Het jy 'n noemenswaardige salaries verhoging ontvang tydens Beroepspesifieke Dispensasie (OSD)?

(Merk die mees toespaslike spasie met 'n (**X**))

Ja	Nee

D5. Neem die instansie genoeg personeel in diens om voldoende verpleegsorg te lewer?

(Merk die mees toespaslike spasie met 'n (**X**))

Ja	Nee

D6. Kan jy die eise van jou werk hanteer en steeds voldoende verpleegsorg lewer?

(Merk die mees toespaslike spasie met 'n (**X**))

Ja	Nee

D7. Op 'n skaal van 0 tot 10 dui jou motivering tot verpleegsorg aan.

(Met 0as totaal ongemotiveerd en 10 as baie gemotiveerd)

(Merk die mees toespaslike spasie met 'n (**X**))

0	1	2	3	4	5	6	7	8	9	10

D8. Op 'n skaal van 0 to 10 dui die vlak van konflik in die department waar jy werk aan?

(Met 0as geen konflik en 10 as baie konflik)

(Merk die mees toespaslike spasie met 'n (**X**))

0	1	2	3	4	5	6	7	8	9	10

D9. Wat veroorsaak die konflik in die department?

(Dit is 'n individuele opinie, daar is geen reg of verkeerde antwoord nie)

_____

_____

_____

_____

D10. Beskryf die sosiale faktore wat 'n invloed op jou verpleeg praktyk het.

(Dit is 'n individuele opinie, daar is geen reg of verkeerde antwoord nie)

_____

_____

_____

_____

_____

_____

_____

_____

D11. Kommentaar

(This is an individual opinion; there is no right or wrong answer)

_____

_____

_____

_____

_____

_____

_____

_____

_____

ADDENDUM E: ETHICAL APPROVAL

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot · your knowledge partner

30 April 2010 **MAILED**

Ms T van Schalkwyk
Department of Nursing
2nd Floor Teaching Block
Tygerberg Campus

Dear Ms van Schalkwyk

Investigation into the Factors Influencing Nursing Values

ETHICS REFERENCE NO: N10/03/091

RE : APPROVAL

It is a pleasure to inform you that a review panel of the Health Research Ethics Committee has approved the above-mentioned project on 30 April 2010, including the ethical aspects involved, for a period of one year from this date.

This project is therefore now registered and you can proceed with the work. Please quote the above-mentioned project number in ALL future correspondence. You may start with the project. Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary.

Please note that a list of funding opportunities are available from www.sun.ac.za/rds or roxanne@sun.ac.za

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.

Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences

Verbind tot Optimale Gesondheid · Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun · Division of Research Development and Support
Posbus/PO Box 19063 · Tygerberg 7505 · Suid-Afrika/South Africa
Tel.: +27 21 938 9075 · Faks/Fax: +27 21 931 3352

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot · your knowledge partner

Approval Date: 30 April 2010

Expiry Date: 30 April 2011

Yours faithfully

MS CARLI SAGER
RESEARCH DEVELOPMENT AND SUPPORT
Tel: +27 21 938 9140 / E-mail: carlis@sun.ac.za
Fax: +27 21 931 3352

Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences

Verbind tot Optimale Gesondheid · Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun · Division of Research Development and Support
Posbus/PO Box 19063 · Tygerberg 7505 · Suid-Afrika/South Africa
Tel.: +27 21 938 9075 · Faks/Fax: +27 21 931 3352

17 May 2011 **MAILED**

Ms T van Schalkwyk
Department of Nursing
2nd Floor Teaching Block
Tygerberg Campus

Dear Ms van Schalkwyk

Investigation into the Factors Influencing Nursing Values

ETHICS REFERENCE NO: N10/03/091

RE : PROGRESS REPORT

At a meeting of the Health Research Ethics Committee that was held on 16 May 2011, the progress report for the abovementioned project has been approved and the study has been granted an extension for a period of one year from this date.

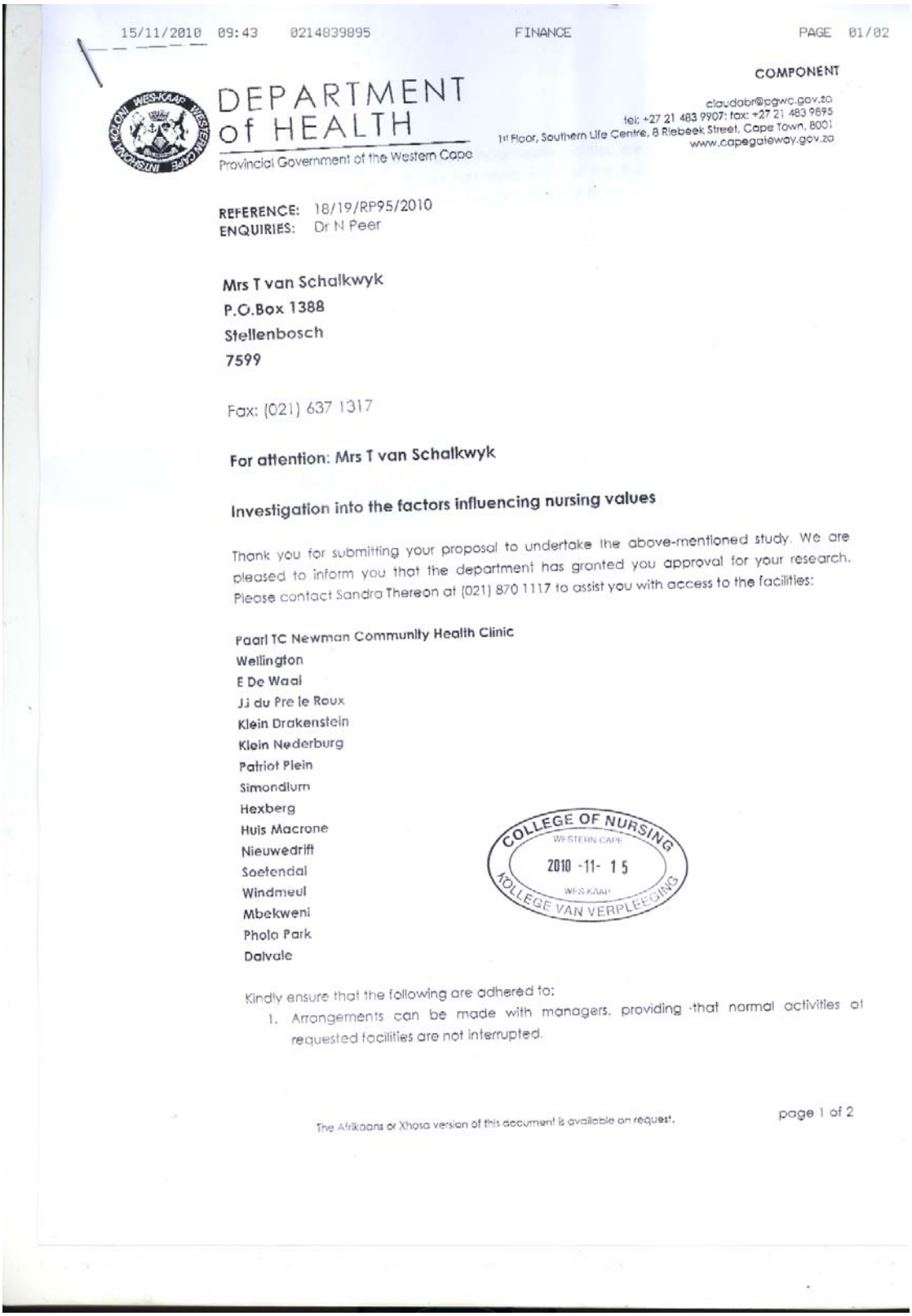
Please remember to submit progress reports in good time for annual renewal in the standard HREC format.

Approval Date: 16 May 2011 Expiry Date: 16 May 2012

Yours faithfully

MRS MERTRUDE DAVIDS
RESEARCH DEVELOPMENT AND SUPPORT
Tel: 021 938 9207 / E-mail: mertrude@sun.ac.za
Fax: 021 931 3352

ADDENDUM F: RESEARCH PERMISSION FROM DEPARTMENT OF HEALTH WESTERN CAPE



15/11/2010 09:43 0214839895 FINANCE PAGE 01/02

DEPARTMENT of HEALTH
Provincial Government of the Western Cape

COMPONENT
claudabr@pgwc.gov.za
tel: +27 21 483 9907: fax: +27 21 483 9695
1st Floor, Southern Life Centre, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: 18/19/RP95/2010
ENQUIRIES: Dr N Peer

Mrs T van Schalkwyk
P.O.Box 1388
Stellenbosch
7599

Fax: (021) 637 1317

For attention: Mrs T van Schalkwyk

Investigation into the factors influencing nursing values

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact Sandra Thereon at (021) 870 1117 to assist you with access to the facilities:

Paarl TC Newman Community Health Clinic
Wellington
E De Waal
Jj du Pre le Roux
Klein Drakenstein
Klein Nederburg
Patriot Plein
Simondium
Hexberg
Huis Macrone
Nieuwedrift
Soetendal
Windmeul
Mbekweni
Phola Park
Dalvale

COLLEGE OF NURSING
WESTERN CAPE
2010 -11- 15
WES-KAAP
KOLLEGE VAN VERPLEEGING

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.

The Afrikaans or Xhosa version of this document is available on request.

page 1 of 2

2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (healthres@pgwc.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

pp DR J CUPIDO
DEPUTY-DIRECTOR GENERAL
DISTRICT HEALTH SERVICES AND PROGRAMMES
DATE: 12/11/2010.

CC: DR L PHILLIPS DIRECTOR: CAPE WINELANDS DISTRICT

The Afrikaans or Xhosa version of this document is available on request.

DEPARTMENT of HEALTH
Provincial Government of the Western Cape

COMPONENT
claudabr@pgwc.gov.za
tel: +27 21 483 9907: fax: +27 21 483 9895
1st Floor, Southern Life Centre, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: 18/19/RP95/2010
ENQUIRIES: Dr N Peer

Mrs T van Schalkwyk
P.O.Box 1388
Stellenbosch
7599

Fax: (021) 637 1317

For attention: Mrs T van Schalkwyk

Investigation into the factors influencing nursing values

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact Sandra Thereon at (021) 870 1117 to assist you with access to the facilities:

Sonstraal Hospital	Matron Andrews	(021) 862 3176
Paarl Hospital	Sr A Smith	(021) 660 2589

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (healthres@pgwc.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

DR J CUPIDO
DEPUTY-DIRECTOR GENERAL

COLLEGE OF NURSING
COLLEGE VAN VERPLEGING
WESTERN CAPE
WES-KAAP
2010 -11- 16

The Afrikaans or Xhosa version of this document is available on request.

ADDENDUM G: PROOF OF LANGUAGE AND TECHNICAL EDITING

LONA'S LANGUAGE SERVICES

English/Afrikaans
** Translations*
** Editing*
** Proof-Reading*
** Academic Manuscript Preparation*
** Archival Research*
** Transcriptions from Archived Documents*

Member: South African Translators' Institute (SATI)

3 Beroma Crescent
Beroma
Bellville 7530

TO WHOM IT MAY CONCERN

This letter serves to confirm that the undersigned

ILLONA ALTHAEA MEYER

has proof-read and edited the document contained herein for language correctness.

(Ms IA Meyer)

SIGNED

Email: illona@toptutoring.co.za Tel: 27 21 9514257 Cell: 27 78 264 8484 Fax: 0865148540
3 Beroma Crescent Beroma Bellville 7530

Lize Vorster Communication

To whom it may concern

This letter serves as confirmation that I, Lize Vorster, have performed the technical formatting of Talita van Schalkwyk's thesis which entails ensuring its compliance with the Stellenbosch University's technical requirements.

Yours sincerely

Lize Vorster

Vygie street 9, Welgevonden Estate, Stellenbosch, 7600 * e-mail: lizevorster@gmail.com * cell: 082 856 8221