LEGAL AND ETHICAL ASPECTS OF NURSING PRACTICE IN SELECTED PRIVATE HOSPITALS IN THE WESTERN CAPE METROPOLITAN AREA

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ABSTRACT

The current shortage of nurses has reached crisis proportions in South Africa and the effects of decreased numbers of health professionals are enormous. This results in far-reaching consequences for the health industry. An increased use of less-skilled personnel, in an attempt to meet the health care needs, impacts negatively on quality care. Personnel are often utilised outside their scope of practice, creating a high-risk therapeutic environment for the patients and health care workers alike.

Consequently, the nursing managers and employers of nurses are currently faced with major challenges in ensuring that the nurses practise their profession within a safe and healthy environment, and within the legal and ethical framework of the nursing profession.

For the purpose of this study the researcher decided to explore legal and ethical aspects influencing the clinical practice of the nurse.

Specific objectives were set for the study.

- Are nurses functioning outside their scope of practice?
- Do nurses exercise their nursing right?
- Do nurses function within ethical and legal guidelines?
- Do caregivers function as nurses?
- Do nurses still believe in the nursing philosophy?
- Are nurses exploited in their area of work?
- How much overtime do nurses work?

These objectives were met through an in-depth explorative descriptive research design with a quantitative approach to explore legal and ethical aspects in the nursing practice. A stratified sample was drawn of all categories of nurses in selected private hospitals in the Western Cape Metropolitan area. Through the use of a questionnaire, data was collected personally by the researcher.

Data analysis techniques that were used were based on descriptive and explorative procedures. Data was compressed in frequencies, percentages, means and standard deviations. The Chi-square test was applied.

Findings include the following:

- 53% of enrolled nursing assistants do not function under indirect supervision.
- 40% of caregivers assist nurses with interventional nursing care.
- Nurses still believe in the philosophy of the nursing profession.
- The nurse's rights are in contradiction with the patient's rights ($p = 0.08$).
- Nurses feel exploited in certain areas of work, depending on their qualifications.
- Nurses do recommend the profession ($p = 0.043$).
- Enrolled nursing assistants do not respect other religions ($p = 0.04$).
- Nurses feel free to discuss the patient's progress with the doctor depending on the nurses' years of experience ($p = 0.03$).
- 23% of nurses love to care for their patients.

Recommendations were made based on the findings.

- The patient approach should be respectful, not judgemental, accepting the patient's right to self-autonomy.
- Nurses should realise their autonomous role in addressing concerns.
- A staff mix should be utilised that facilitates safe and professional nursing care.
- Unfavourable or unsociable working conditions in some units such as the theatre should be addressed.
- Managers should match the work load with a proper skills mix and competency.
- Nursing practice should take place within the professional and statutory scope of practice of the nurse.
- Nurses should keep up to date with knowledge through continuous professional development.
- Caregivers should be regulated, installing the nursing philosophy and ethics into their practice.

OPSOMMING

Die huidige tekort aan verpleegpersoneel in Suid-Afrika het kritieke afmetings aangeneem en die gevolge van die verminderde getalle professionele gesondheidswerkers is enorm, met verreikende gevolge vir die gesondheidswese. ’n Toenemende gebruik van minder opgeleide personeel om in die behoeftes van gesondheidsdienste te voorsien, het ’n negatiewe uitwerking op die gehalte van die gesondheidswese. Personeel word dikwels buite die bestek van hul praktyk aangewend, wat ’n hoërisiko- terapeutiese omgewing vir sowel die pasiënte as die gesondheidsorgwerkers skep.

Gevolglik word verplegingsbestuurders en werkgewers van verpleegpersoneel aan ingrypende uitdagings blootgestel in ’n poging om te verseker dat verpleegpersoneel hul beroep binne ’n veilige en gesonde omgewing beoefen, asook binne die wetlike en etiese raamwerk van die verplegingsberoep.

Vir die doeleindes van hierdie studie het die navorser die wetlike en etiese faktore ondersoek wat die kliniese praktyk van verpleegpersoneel beïnvloed.

Bepaalde doelwitte is vir die studie gestel:

- Funksioneer verpleegpersoneel buite die bestek van hul praktyk?
- Oefen verpleegpersoneel hul verplegingsregte uit?
- Funksioneer verpleegpersoneel binne die etiese en wetlike riglyne?
- Funksioneer hulpversorgers as verpleegpersoneel?
- Glo verpleegpersoneel nog in die verplegingsfilosofie?
- Word verpleegpersoneel op hul werksterrein uitgebuit?
- Hoeveel oortyd werk verpleegpersoneel?

Hierdie doelwitte is bereik deur ’n kwantitatiewe benadering met ’n beskrywende verkennende navorsingsontwerp om wetlike en etiese faktore in die verpleegpraktyk te ondersoek. ’n Gestratifiseerde monster is getrek uit alle kategorieë van verpleegpersoneel in geselekteerde privaat hospitale in die Wes-Kaapse Metropolitaanse gebied.: Data is persoonlik by wyse van ’n vraelys deur die navorser ingesamel.

Die tegnieke wat vir dataontleding gebruik is, is op beskrywende en verkennende werkwyses gegrond. Data is in frekwensies, persentasies, gemiddeldes en standaard-afwykings verwerk. Die Chi-kwadraattoets is toegepas.

Beviindings sluit die volgende in::

- 53% van die geregistreerde verpleegpersoneel funksioneer nie onder indirekte toesig nie.
- 40% van hulpversorgers help die verpleegpersoneel met indringende verplegingsorg.
- Verpleegpersoneel glo nog in die filosofie van die verplegingsberoep.
- Verplegingsregte is in teenstelling met die regte van die pasiënte ($p = 0.08$).
- Verpleegpersoneel voel dat hulle op sekere werksterreine uitgebuit word, afhangende van hul kwalifikasies.
- Verpleegpersoneel beveel hul beroep aan ($p = 0.043$).
- Geregistreerde verpleegassistente respekteer nie ander geloofsoortuigings nie ($p = 0.04$).
- Verpleegpersoneel het die vrymoedigheid om pasiënte se vordering met die dokter te bespreek, afhangende van hul diensjare ($p = 0.03$).
- 23% van die verpleegpersoneel hou daarvan om hul pasiënte te versorg.

Aanbevelings is op grond van die bevindinge van die studie gemaak:

- Die benadering van die pasiënt moet respekvol geskied en nie veroordelend wees nie, en die pasiënt se reg op outonomiteit moet in ag geneem word.
- Die verpleegpersoneel moet bewus wees van hul outonome rol wanneer probleme hanteer word.
- ’n Kombinasie van personeel moet gebruik word wat veilige en professionele verpleegsorg vergemaklik.
- Ongunstige of sosiaal onbevredigende werksomstandighede in sommige eenhede, soos in die teater, moet aandag ontvang.
- Bestuurders moet die werkslading in ooreenstemming bring met die regte kombinasie van vaardighede en bekwaamhede.
- Werk binne die professionele en statutêre bestek van die praktyk.
- Bly op hoogte van die jongste kennis deur middel van volgehoue professionele ontwikkelling.
- Hulpversorgers moet gereguleer word om te verseker dat hulle die verplegingsfilosofie en etiek in hul praktyk toepas

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LIST OF ABBREVIATIONS

ANA	American Nursing Association
BCOE	Basic Conditions of Employment
CG	Caregiver
EN	Enrolled nurse
ENA	Enrolled nursing assistant
ICN	International Council of Nurses
ICU	Intensive Care Unit
NNA	National Nurse Association
NQF	National Qualifications Framework
OT	Operating theatre
RN	Registered nurse
SA	South Africa
SANC	South African Nursing Council
SD	Standard deviation
SE	Standard error
USA	United States of America
V	Variable
WHO	World Health Organisation

CHAPTER 1
SCIENTIFIC FOUNDATION FOR THE STUDY

1.1 INTRODUCTION

1.1.1 Rationale

The current shortage of nurses has reached crisis proportions in South Africa and the effects of losses of health professionals are numerous, having far-reaching consequences for the health industry. An increased used of less-skilled personnel, in an attempt to meet the health care needs, impacts negatively on quality patient care. Personnel are often utilised outside their scope of practice, creating a high-risk environment for the patients and health care workers alike, as well as for the employing body who carries the vicarious liability for any adverse incidents.

The demand for critical care nurses in particular has led to competition among hospitals. A heavy work load has become one of the reasons why many nurses leave the nursing profession, or suffer from fatigue and burn-out. All institutions are drawing upon the same pool of nursing expertise, which contributes to the negative cycle of overwork and burn-out. As a result of the brain-drain and shortages of skills, there are high levels of job-hopping as the few skilled people move between the many positions available, demanding higher salaries. Consequently, the nursing managers and employers of nurses are currently faced with major challenges in ensuring that the nurses practise their profession within a safe and healthy environment, and within the legal and ethical framework of the nursing profession.

The noble tradition of the nursing profession has always been the foundation of the nursing profession. Sloppy ethics and poor professional standards receive media coverage, damaging the image of this ‘noble’ profession.

The researcher believes that nurses have the power to make a difference by practising according to the underlying principles that govern their practice. Nurses need to fully understand their roles and responsibilities within a legal and ethical framework.

Despite nurses’ legal accountability and responsibility for the promotion of health care in nursing services, their fundamental rights need to be respected and not exploited in the work place. Nurses are more informed about their rights than ever before, as demonstrated by the recent government strike of June 2007.

This strike of 25 days cost the National Department of Health R24.9 million in patient bills, which could have been prevented. Even more provoking is the report (Medical Chronicle News 2007) about the deaths of 43 babies at Frere Hospital in the Eastern Cape, which was directly attributed to poor staffing and equipment. It has been established that this was as a result of a poor staffing ratio of one professional nurse and one assistant nurse for a 32-bed ward.

In an attempt to curb the exodus of nurses from the public sector, and possibly attract nurses to the public sector, health minister Manto Tshabalala-Msimang announced a salary increase of at least 20% for public nurses, including improved medical coverage and housing subsidies (Medical Chronicle 2007). Tshabalala-Msimang's reason for procuring this increase was an attempt to keep nurses in the public sector.

However, it has been shown that nurses are not only attracted by high salaries, but by overall job satisfaction and good working conditions (Erasmus & Brevis, 2005:51).

According to Muller (2001:37), midwives and nurses are exploited as a result of the disparities in the system and a lack of clarity on how systems work. In addition, these nurses are forced to deliver the service without the required legislation or legal procedures in place and often without the necessary training to perform these services, with a lack of equipment, and insufficient stock.

The patient expects nursing actions to be thorough, since total caring is the defining characteristic of the patient-nurse relationship. The nurse promises to offer holistic care to the best of his or her ability (Cherry & Jacob, 2002:203).

As individual practitioners, nurses take responsibility for their actions and behaviour according to the Nursing Act 1978 (Act No. 50), while the Occupational Health and Safety Act 1993 (Act No. 85) emphasises the duty of the employer.

Ethics is the foundation of committed service to humankind, and every professional nursing practitioner takes pride in his or her profession (Pera & Van Tonder, 1996:21).

The legislative framework within which nurses and midwives practise with regard to safe nursing care is stipulated in the Nursing Act 1978 (Act No. 50). The Scope of Practice, Regulation 2598 and Acts and Omissions Regulation 387, as promulgated

by the Nursing Act 1978, guide the practice of the professional registered nurse. In the event of the registered nurse contravening these regulations, such nurse may be held legally accountable for his or her actions or omissions. The registered nurse should adhere to the nursing regulations guiding his or her clinical practice to provide safe nursing care.

The exodus of nurses from the country is aggravated by factors such as high crime levels and affirmative action. According to the World Health Report (2006), 13 500 South African nurses are working overseas while there are 32 000 vacancies in South Africa. Consequently, the nurses who remain in the country have to work long hours with poor staffing levels, trying to provide the care that patients require. This practice places the nurse in a most vulnerable and precarious situation, resulting in exploitation and abuse.

One of the major challenges facing nurses in the health care system in South Africa and the world at large is that managers are urged to reduce staffing as they are a high-cost resource, and considerable savings can be made by reducing the number of personnel (Mason & Chandley, 1999:82).

In an attempt to reduce costs, subcategories of staff are being utilised to deliver basic care. The introduction of care givers into the clinical environment, to assist nurses with non-nursing tasks, should be guarded against, as exploitation of this group may result. Cognisance should be taken that these caregivers are not regulated, which poses challenges to the profession. Inadequate skilled staffing levels give rise to medico-legal hazards and litigation. If non-nursing personnel are utilised well, nursing staff can use their time more efficiently for nursing duties (Booyens, 1997:228).

Nursing is regarded as a caring profession and the nurse continuously strives to give good care. Both the doctor and the nurse seek to do their best for the patient, and both seek to exercise their skills and knowledge in the best possible way. Doctors are critical of nurses who do not carry out their orders, while nurses accuse doctors of not considering the patient's point of view. Doctors believe they are ultimately responsible for medical care, and at the same time nurses seek recognition for their nursing contribution to total patient care (Brown, Kitson & McKnight, 1997:820). Therefore nurses and doctors should consistently work together, guided by policies and procedures that are designed to be in the best interest of the patient.

Caring is not a feeling; it is a way of behaviour, and nurses should not only care for the patient, but also for one another. The researcher has observed that there are times when unacceptable strain between the nurses and between the nurses and doctors occur, creating a tense clinical environment that impacts negatively on patient care. Ethical and morally acceptable behaviour as a result of working situations can easily be de-harmonised by burn-out and poor quality of work life.

The nursing pledge and the meaning of the lamp are part of the ethos of the nurse, committed to serving humanity, and many ethical decisions are based on these values. It is often questioned whether nurses still respect and believe this. In the current climate of unemployment, many students enter the profession merely searching for a 'job'.

The position of women in the work place has changed significantly since the implementation of a new dispensation in South Africa in 1994. The new constitution paved the way for women to take their rightful place in the work place as equal partners of men and their participation in the labour market has increased significantly during the past few years. The fact that women are joining organisations as managers and professionals has prompted studies on various aspects of the importance of their contribution in general (Erasmus & Brevis, 2005).

Considering the factors currently impacting on the nurses' clinical practice, the researcher poses the question whether it is still possible for nurses to fulfil their role in promoting health, preventing illness, restoring health and alleviating suffering in a clinical environment characterised by inadequate staffing, poor working conditions and unskilled staff. According to Searle (2000:364), nurses have the right to expect the type of support from management and colleagues in the health team that will earn them the trust of the public, because they ensure that they provide the same type of support to management, colleagues in the health team, the patient and the public at large.

1.2 PROBLEM STATEMENT

In the light of the above, the researcher believes that nurses are utilised outside their scope of practice, while a lower category of staff is taking on more responsibilities than they are skilled for. The following questions come to mind:

- Are nurses compelled to function beyond their scope of practice?
- Do nurses adhere to the professional code of ethics?

1.3 AIM OF THE STUDY

The aim of the study is to explore the ethical and legal aspects in the practice of the nurse in selected private hospitals in the Western Cape Metropolitan area.

1.4 OBJECTIVES

- To determine whether nurses function within their scope of practice.
- To determine whether nurses know and exercise their nursing rights.
- To determine whether nurses are being exploited in the work place.
- To determine whether nurses function within the legal parameters.
- To determine whether caregivers contribute to nursing care.
- To determine whether nurses work more than ten hours overtime a week.
- To determine whether nurses still believe in the nursing philosophy.
- To determine whether nurses act ethically.

1.5 RESEARCH METHODOLOGY

1.5.1 Research design

The research design is a blueprint for the conduct of a study that maximises control over factors that could interfere with the desired outcomes of studies. The design study is the end result of a series of decisions made by the researcher concerning how the study will be implemented (Burns & Grove, 1997:246).

Quantitative research is a formal, objective, systematic process to describe and test relationships, and to examine cause and effect interactions among variables (Burns & Grove, 1997:27).

The formal objective systematic process was used, collecting numerical data to obtain information. This type of research provides a “sounder knowledge base to guide nursing practice” (Burns & Grove, 1997:2). To decrease the possibility of error, certain rules referred to as design were adhered to for the control of the study. Logistic and deductive reasoning were used to analyse questions and answers, with a view to achieving excellence in results.

An explorative and descriptive research design with a quantitative approach was used to explore the ethical and legal aspects of the nurse in selected private hospitals in the Western Cape Metropolitan area. The scope of the project is therefore to explore and investigate the ethical and legal aspects in the nursing

profession, obtaining information to ascertain whether nurses function within legal and ethical guidelines.

The literature was explored to gain valuable insights into the clinical practice and theory of nursing. The legislative guidelines in the nursing profession are very clear, steering the nurse in the right direction, and were used as a map and baseline.

No hypothesis was formalised; however, factors were identified and recommendations made.

1.5.2 Population and sampling

Burns and Grove (1997:293) refer to population as the entire set of individuals or elements defined by the sampling criteria established for the study. The sample is then chosen from the study population, which is commonly referred to as the target population.

'Sampling' defines the process of making the selection, while 'sample' defines the selected group of elements. A sampling plan is developed to increase representation, decrease the systematic basis and decrease the sampling error (Burns & Grove, 1997:205, 294).

A random stratified sample was drawn to obtain a representative sample of nurses in selected private hospitals in the Western Cape Metropolitan area. The sample consisted of all professional and non-professional nursing staff in permanent employment. A sample of 5% (3 030 nurses) was taken from each selected hospital as identified from the staff register. Every tenth nurse on the staff register was identified to participate in this survey. Questionnaires were handed out personally to maintain confidentiality, and participants were asked to give informed consent.

Table 1.1 Hospital sample distribution

Hospital	Population	Sample
1. Life Vincent Pallotti	400	20
2. Life Kingsbury/Claremont	450	15
3. Vergelegen Medi-Clinic	300	15
4. Stellenbosch Medi-Clinic	240	12
5. Cape Town Medi-Clinic	400	20
6. Panorama Medi-Clinic	500	25
7. Durbanville Medi-Clinic	400	20
8. Constantia Medi-Clinic	300	15
9. N1 City		14
10. Blaauwberg		10
Total		**159**

1.5.3 Reliability and validity

The reliability and validity were ensured through a pilot study conducted under circumstances similar to those of the actual study to test the instrument for any ambiguity and inaccuracies. Alterations were made based on scientific expertise advice. Experts in nursing and research methodology, including a statistician, were consulted on the design of the questionnaire throughout the study. The reliability and validity were further supported by the researcher who collected the data personally.

1.5.4 Ethical consideration

The survey was done voluntarily with informed written consent from each participant. Participants had the option of contacting the researcher for any information. All staff employed at the hospital of choice had a fair and equal opportunity to be selected.

The proposal of the research project, together with proposed informed consent document and questionnaire, was submitted to the Ethics Committee of the Medical Faculty, Stellenbosch University, for ethical evaluation. Corrections were required and therefore the document was prepared for use.

Permission was obtained from ethics committees, hospital managers and nursing managers. Confidentiality was maintained and questionnaires were distributed and returned in sealed envelopes. Data was captured by the data capturer.

Participants were treated with respect and all questions were answered objectively.

1.5.5 Instrumentation

A structured questionnaire with predominantly closed questions was used to collect the data.

The instrument was designed according to the following sections:

- Background details: age, qualifications, position, area of work, overtime hours, practising years.
- Ethical practice was divided into three categories, namely patient, profession and company.
- Legal practice, which refers to practices in the work place.

The initial page of the questionnaire contained a brief outline of the study, assured confidentiality of responses and contained a statement of signed consent for participation in the study.

Background questions required basic information or a simple yes/no answer to some questions. The legal and ethical questions were structured according to a seven-point Likert scale, varying from ‘most strongly agree’ to ‘most strongly disagree’. This was created to make response meaningful and prevent central tendency.

In total, 88 explorative questions were asked, exploring professional ethics, quality of work life, legal practice, biography and attitude.

1.5.6 Pilot study

Four per cent (15) of the actual sample were obtained for a pilot study conducted under circumstances similar to those of the actual study at one of the private hospitals, Life Vincent Pallotti. These participants were not included in the actual study. The instrument was tested for any inaccuracies and ambiguity and supported the reliability and validity. The pilot study also assisted in refining the data-collection instrument and addressing grammar or spelling errors.

1.5.7 Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or specific objectives, questions or hypothesis of the study (Burns & Grove, 1997:778).

The survey was analysed with the use of computerised statistical programs with the assistance of a statistician. The analysed data also included inferential statistics. Numerical data was obtained from the Likert scale questions and organised in a way to facilitate computer entry.

1.5.8 Data analysis and interpretation

Data analysis was conducted to reduce, organise and give meaning to the data. Analysis techniques used in this quantitative research were based on descriptive and explorative procedures. Frequencies, percentages, means and standard deviations were used. Chi-square tests using the 95% confidence interval were done to determine associations for significance between various variables.

Research is not complete until the findings have been communicated, therefore a research report was developed for the appropriate audience in the health industry. The research findings and recommendations will also be published.

1.6 OPERATIONAL DEFINITIONS

- *Nurse:* A registered nurse is a practising, registered nurse who is registered with the South African Nursing Council (SANC) in terms of the Nursing Act (South Africa, 2005).
- *Accountability:* An ethical duty stating that one action's should be answerable legally, morally and ethically (Creasia & Parker, 2001:278).
- *Caring:* A form of involvement with others that creates concern about how other individuals experience their world (Creasia & Parker, 2001:279).
- *Beneficence:* An ethical principle stating that one should do good and prevent or avoid harm (Creasia & Parker, 2001:280).
- *Duty:* A duty is a legal obligation toward the patient (Creasia & Parker, 2001:265).
- *Autonomy:* Personal freedom and the right to make choices (Creasia & Parker, 2001:281).

- *Ethics:* Expected standard and behaviour of a group as described in the group's code of professional conduct (Creasia & Parker, 2001:273).
- *Negligence:* Failure to do something reasonable or the failure to exercise ordinary care under normal circumstances (Creasia & Parker, 2001:264).
- *Burn-out:* Burn-out, as described by Tappen (1995:454), refers to a state of emotional exhaustion, a depletion of energy that seems to be a particular problem for people in helping professions.
- *Right:* Justified claims that individuals and groups can make upon others or upon society (Beauchamp, 1994:71).

1.7 STUDY OUTLAY

- *Chapter 1*: The scientific foundation of the study is described including the problem, the problem statement and a brief literature review identifying the research objectives.
- *Chapter 2*: The literature study consists of legal and ethical guidelines used to form the basis of the clinical practice of the nurse. Sources are selected to build a case and reflect the current knowledge of the topic.
- *Chapter 3:* The methodology used to conduct the survey, includes the approach, design, objectives, population, sampling, instrumentation, pilot study and data analysis.
- *Chapter 4*: Results of the final processed data is analysed to reach a conclusion. Discussions of some results which are meaningful are discussed.
- *Chapter 5*: Recommendations are made based on deductive and inductive thought processes ,regarding the clinical practice of the nurse.

1.8 CONCLUSION

In this chapter the researcher described the purpose of the study as an attempt to gain a better understanding of the legal and ethical behaviour of the nurse. The scientific foundation included the background and aim of the study. The conceptual framework was included to guide the researcher in understanding the clinical practice of the nurse.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

It is the responsibility of nursing management to ensure that high quality patient care is achieved through the optimum performance of each member of the nursing staff. Optimum performance by the nursing staff presupposes that the abilities of each incumbent of a post will correspond with the requirements for that particular post. To achieve such a match between incumbent and post it is necessary to analyse the contents of the different jobs in the organisation, to arrive at effective job descriptions, and to evaluate jobs properly in order to pay the incumbents of the different posts according to the expected performance for each post (Booyens, 1998:235).

2.1.1 Ethics

Ethics is the expected standard and behaviour of a group as described in the group's code of professional conduct (Creasia & Parker, 2001:273).

The manner in which nursing practice is carried out constitutes an experience for patients and their families. Does the reality of nursing practice meet the legal and ethical criteria for professional practice? Is the reality of nursing practice what the patient expected? It is well known that some neglect of patients occurs daily and that slovenly, indifferent and even ignorant practice exists at times. Is the nursing profession looking the facts squarely in the face and admitting that nursing practice is not all that it should be in all medical care environments? (Searle, 2000:13).

Searle furthermore states that ethical codes for professions set the parameters of the responsibilities that nurses owe to their patients. Professional ethics are moral dimensions of attitude and behaviour based on values, judgment, responsibility and accountability, which practitioners take into account when weighing up the consequences of their professional actions (Searle, 2000:97).

The ethical foundation of the nursing profession in South Africa is vested in the Nurses' Pledge. This pledge is derived from the Nightingale Pledge and has been in use since the institution of nurses' training in South Africa. When taking the pledge, the nurse/midwife enters into a verbal agreement with the community. The question,

however, arises as to whether this pledge reflects the dominant views of nurses in South Africa (Muller, 1997:14).

Muller (1997:15) also refers to Searle's Nursing Credo, which is a summary of the South African nurses' beliefs and convictions about nursing. This credo was compiled in 1969 by Professor Charlotte Searle, and was described as the philosophical light beacons. Some light beacons are written in a neutral form, while others are clearly rooted in the Christian philosophy. The philosophical light beacons are as follows:

- *Nursing is a belief*: A belief in the essential worth of every human life and in the divine reason for the existence of this life. It is a belief in the uniqueness and irreplaceability of every human being, and it is a belief that the Creator charged mankind with the serious responsibility for his or her own personal well-being, and for the well-being of his or her fellow man. For nurses, this belief has a deep significance. This is something from which nurses derive support when their burden has become almost unbearable, and it makes the work and existence meaningful.
- *Nursing is faith*: Faith is a continual source of inner strength that will assist the nurses in doing what is expected of them, and that will guide their behaviour.
- *Nursing is a yearning*: A yearning to be a worthy servant of humanity and an effective instrument of medical science.
- *Nursing is acceptance*: Acceptance of the fact that every human being is unique, acceptance of the need to employ all health aids to provide for the health needs of this unique being; it is acceptance of the fact that there really are no patients, and that disease viewed as a separate entity really does not exist, but that there are only sick people or people with health needs. It is acceptance of the fact that nursing consists not only of a series of tasks that has to be performed or a set or procedures that has to be followed, but that it is a professional service to mankind that includes instrumental and expressive functions.
- *Nursing is transcending*: The so-called nurse-patient relationship to a relationship between human beings.
- *Nursing is conservation and change*: The conservation of a previous human life through change, for nursing seeks to prevent, promote, reverse or balance in order to conserve.
- *Nursing is assistance and support*: Not only to those who are dependent on the health of staff, but also to those who render the service. In its application

of scientific skills during the treatment and care of the human being, nursing is a technology.

- *Nursing is the therapeutic use of the self*; it is love which is made visible.

2.1.1.1 The ICN code of ethics

The ICN (International Council of Nurses) Code of Ethics for Nurses has four principal elements that outline the standards of ethical conduct (International Council of Nurses, 2007).

a) Nurses and people:
   - The nurse's primary professional responsibility is to people requiring nursing care. In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.
   - The nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment.
   - The nurse holds in confidence personal information and uses judgement in sharing this information.
   - The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.
   - The nurse also shares responsibility to sustain and protect the natural environment from depletion, pollution, degradation and destruction.

b) Nurses and practice:
   - The nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continuous learning.
   - The nurse maintains a standard of personal health such that the ability to provide care is not compromised.
   - The nurse uses judgement regarding individual competence when accepting and delegating responsibility.
   - The nurse at all times maintains standards of personal conduct which reflect well on the profession and enhance public confidence.
   - The nurse, in providing care, ensures that use of technology and scientific advances are compatible with the safety, dignity and rights of people.

c) Nurses and the profession:
   - The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education.
   - The nurse is active in developing a core of research-based professional knowledge.
   - The nurse, acting through the professional organisation, participates in creating and maintaining safe, equitable social and economic working conditions in nursing.

d) Nurses and co-workers:
   - The nurse sustains a co-operative relationship with co-workers in nursing and other fields.
   - The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person.

According to Searle (2000:120), the profession must accept certain basic premises and obligations such as:

- Nurses are concerned with human health care from birth to death.
- Nurses/midwives are concerned with the human beings as holistic beings within their culture, social milieu and total health status, with due regard for their dignity and vulnerability in the health care situation, with particular reference to the safety of their person, their name and the property they have with them in the health care situation.
- Nursing/midwifery is a profession practiced within legal and ethical parameters.
- Nursing/midwifery encompasses a wide variety of scientifically planned actions based on biological, physical, chemical, psychological, social, educational, medical and technological knowledge and skills ranging from the simple to the highly complex.
- Nursing/midwifery is not a series of procedures, but an individualised form of treatment, care and support unique to each person in a health care relationship with the nurse/midwife.
- Nurse/midwives are accountable for their professional acts and omissions.

- Nurses/midwives must have the necessary knowledge to perform all the acts relating to the various aspects of the scope of their practice.
- Nurses/midwives must maintain standards of care, continue to develop their knowledge and skills and practice their profession within the ethical norms of their profession and the legal constraints of the practice of nursing.
- Nurses/midwives are practitioners in their own right with duties towards their patient, society, employer and the other members of the health team, and with the right to perform their nursing acts in accordance with their judgement, knowledge and skills.
- Nurses/midwives are accountable for all their actions and must exercise their professional right and duty of accountability.

Burkhardt and Nathaniel (2002:408–413) refer to seven primary values that are central to ethical nursing:

- *Health and well-being*: Nurses value health and well-being and assist persons to achieve their optimum level of health in situations of normal health, illness, injury or in the process of dying.
- *Choice*: Nurses respect and promote the autonomy of clients and help them to express their health needs and values, and to obtain appropriate information and services.
- *Dignity*: Nurses value and advocate the dignity and self-respect of human beings.
- *Confidentiality*: Nurses safeguard the trust of clients, in that information learned in the context of a professional relationship is shared outside the health care team only with the client's permission or as legally required.
- *Fairness*: Nurses apply and promote principles of equity and fairness to assist clients in receiving unbiased treatment, and a share of health services and resources proportionate to their needs.
- *Accountability*: Nurses act in a manner consistent with their professional responsibilities and standards of practice.

Practice environments are conducive to safe, competent and ethical care. Nurses advocate practice environments that have the organisational and human support systems and the resource allocations necessary for safe, competent and ethical nursing care.

Obligation to the institution has a legal and moral obligation to the institution. This obligation, however strong, does not suggest that the nurse should jeopardise personal integrity or submit to subordinate loyalty. To succeed in the age of technological advancement, competition and litigation, institutions need the service of nurses who express the professional characteristics of autonomy, integrity and ethically-based practice. Conflicts arise when the institution's goals are focused more on 'bottom-line' economics than on moral responsibility and patient welfare. Conflict is inevitable when nurses, whose primary loyalty is to the welfare of patients, are employed by institutions that eliminate important programmes, employ poorly qualified staff or inadequate numbers of staff and are otherwise ill-equipped to meet the needs of the patient (Burkhardt and Nathaniel, 2002:158) .

2.1.2 The Nursing Act 33 of 2005

Nursing practice in Southern Africa is controlled by the Nursing Act of 1978 (Act No. 50). Unless nurses observe the provision of the Nursing Act, they become criminally liable, and unless they observe other health-related legislation and the laws governing all citizens, they may become civilly or criminally liable. It is the law and only the law that authorises nurses to practise nursing. They depend on the law for every aspect of their professional role and function. The law includes the act and its regulations, as well as decisions given by the courts on the interpretations of the law (Searle, 2000:39).

Once promulgated, the new Nursing Act of 2005 (Act no 33) will create an enabling environment for the creation of new regulations that govern the practice of nursing. In response to the new imminent legislative framework, the South African Nursing Council

- has reviewed the scope of practice of all categories of nurses and developed a competency framework to ensure that the practice of nurses is in line with the developments and needs of the health sector;
- is currently aligning the educational requirements for nurses to the revised scope of practice to ensure that persons entering the nursing profession are skilled, competent and safe practitioners;
- has reviewed the ethical rules and practice standards for nursing practice; and
- is developing a system for implementing mandatory continuing professional development to ensure that nurses maintain their level of competence. (South African Nursing Council, 2007)

Chapter 2, The Nursing Act of 2005 (Act no 33) section 30 refers to the scope of practice of nursing and highlights the following:

- A professional nurse is qualified and competent to independently practise comprehensive nursing.
- A midwife is qualified and competent to independently practise midwifery.
- A staff nurse is educated to practise basic nursing care.
- An auxiliary nurse or auxiliary midwife is educated to provide elementary nursing care.
- The minister may allow for other categories of nurses.

2.1.2.1 ICN position on the scope of nursing practice

The nursing practice is responsible for articulating and disseminating clear definitions of roles nurses engage in, and the profession's scope of practice. National professional organisations bear the responsibility of defining nursing and nurses' roles that are consistent with accepted international definitions articulated by the ICN, and relevant to their national health care needs. While nurses, through professional, labour relations and regulatory bodies, bear primary responsibility for defining, monitoring and periodically evaluating roles and scope of practice, the view of others in society should be sought and considered in defining scope of practice.

The scope of practice is not limited to specific tasks, functions or responsibilities but includes direct care giving and evaluation of its impact, advocating for patients and for health, supervising and delegating to others, leading, managing, teaching, undertaking research and developing health policies for health care systems. Furthermore, as the scope of practice is dynamic and responsive to health needs, development of knowledge and technological advances, a periodic review is required to ensure that it continues to be consistent with current health needs and supports improved health outcomes.

National nurses' associations (NNAs) have a responsibility to seek supportive legislation which recognises the distinctive and autonomous nature of nursing practice, including a defined scope of practice.

2.1.3 The Nursing Act 50 of 1978

Terms such as diagnostic, treatment, caring, prescribing, collaborating, co-ordinating and patient advocacy need to be defined so that nurses understand their role.

In principle the scope of practice for the enrolled nurse encompasses certain acts and procedures that have been planned and initiated by a registered nurse or registered midwife and are carried out under his or her direct or indirect supervision as part of the nursing regimen (Searle, 2000:131).

According to Searle (2000:118) the scope of practice is an authorisation of what the nurse may do.

This service directedness further implies that the nurse will always put the patient first, in other words, his or her own interest will always come second (Muller, 1997:15).

This makes it clear that enrolled nurses may not carry out professional functions. It is therefore important that registered nurses and registered midwives understand this, for they have to teach and prepare enrolled nurses for their role and functions, prepare a nursing regimen, decide whether enrolled nurses are functioning beyond their scope of practice, supervise this practice, take responsibility for the delegated duties and be accountable for the fact that they allow enrolled nurses to act beyond their scope of practice, for allocating them functions beyond their knowledge and skill and for inadequate supervision (Searle, 2000:131).

The scope of practice of the enrolled nursing auxiliary is limited and restricted to assisting the registered nurse, registered midwife, and enrolled nurse with those acts and procedures that are part of the nursing regimen, planned and initiated by a registered nurse or registered midwife for a patient or a group of patients. His or her functions relate to the provision of basic nursing care and to the performance of elementary nursing procedures, all of which is carried out under supervision of a registered person. The auxiliary nurse works under the direct or indirect supervision of the registered nurse or midwife. The range of activities encompassed by the scope of practice of the nurse is very extensive. It deals with the activities of the registered nurse from preparation for conception though all the stages of a person’s lifespan, including death (Searle, 2000:131).

2.1.4 The Bill of Rights Act 200 of 1993

Constitution of the Republic of South Africa (Act No. 108 of 1996)

The constitution of the country obliges the employer to provide a safe and healthy working environment. Section 24(a) states that everyone has the right to an environment that is not harmful to their health or well-being.

The Bill of Human Rights is a legal document in which the fundamental values and needs of the population or nation are entrenched against violation by the government. It may also specify certain actions that are desired by government (Pera & Van Tonder, 1996:43).

The confirmation of the rights of the nurse is therefore not an end in itself (Chenevert, 1993:115), but a means to ensuring improved services to patients. To enable nurses to practise safe, adequate nursing care, they have the right to

- practise in accordance with the scope that is legally permissible for their specified practice;
- a safe working environment that is compatible with efficient patient care and equipped with at least the minimum physical, material and personal requirements;
- proper orientation and goal-directed in-service education in respect of the modes and methods of treatment, and procedures relevant to their working situation;
- negotiation with the employer for such continuing professional education as may be indirectly related to their responsibilities;
- in the case of a registered person, equal and full participation in such policy-determined planning and decision making as may concern the treatment and care of the patient; and
- advocacy for and protection of patients and personnel for whom they have accepted responsibility.

Conscientious objection provided that

- the employer has been timeously informed in writing;
- it does not interfere with the safety of patients and/or interrupt their treatment and nursing;
- they refuse to carry out a task reasonably, if regarded as outside the scope of their practice for which they have insufficient training, or for which they have insufficient knowledge and skills;
- they do not participate in unethical or incompetent practice;

- they follow written policy guidelines and prescriptions concerning the management of their environment;
- they refuse to implement a prescription or participate in activities which, according to their professional knowledge and judgement, are not in the interest of the patient;
- the doctor has disclosed to them the diagnoses of patients for whom they accept responsibility;
- they enjoy a working environment that is free of threats, intimidation and/or interference; and
- there is medical support or a referral system to handle emergency situations responsibly.

In terms of the above, nurses are entitled to their rights in terms of the Constitution of the Republic of South Africa and relevant labour legislation, provided that the exercising of such rights does not put at risk the life or health of patients.

The ICN (International Council of Nurses, 2007) position on Nurses and Human Rights state the following:

> The ICN views health care as a right of all individuals, regardless of financial, political, geographical, racial or religious considerations. This right includes the right to choose or decline care, including the right to accept or refuse treatment or nourishment, informed consent, confidentiality and dignity, including the right to die with dignity. It involves both the rights of those seeking care and the providers.

Nurses have the right to practise in accordance with the nursing legislation of the country in which they work, and to adopt the ICN Code of Ethics for nurses or the country's own national ethical code. They also have a right to practise in an environment that provides personal safety, freedom from abuse and violence, threat or intimidation. Nurses individually and collectively, through their national nurses' association, have a duty to speak up when there are violations of human rights, particularly those who have access to essential health care and patient safety. National nurses' associations need to ensure an effective mechanism through which nurses can seek confidential advice, counsel, support and assistance in dealing with difficult human rights situations (International Council of Nurses, 2007).

Nurses deal with human rights issues daily, in all aspects of their professional role, such as they may be pressured to apply their knowledge and skills in ways that are detrimental to patients and others. There is a need for increased vigilance, a requirement to be well informed about how new technology and experimentation violate human rights. Furthermore, nurses are increasingly facing complex human rights issues, arising from conflict situations within jurisdictions, political upheaval and wars. The application of human rights protection should emphasise vulnerable groups such as women, children, elderly, refugees and stigmatised groups. ICN endorses the Universal Declaration of Human Rights and addresses human rights issues through a number of mechanisms including advocacy lobbying and position statements (International Council of Nurses, 2007).

Many authors have attempted to determine whether or not nurses have any rights. Most of the current resolutions with regard to the rights of nurses refer to “the rights and responsibilities of nurses”. This seems to indicate that there is some confusion between the terms ‘rights’, ‘duties’ and ‘responsibilities’. It could also indicate that no rights can be exercised without their concomitant duties and responsibilities. It is a well-known and commonly accepted fact that nurses may make conscientious objections to participate in an abortion procedure or to implement a procedure for which the nurse is not trained. This, however, is a negative right. It is imperative that professional nursing looks beyond this negative right and the right to refuse to do something. More positive rights that will enable nurses to fulfil their roles better must be ensured (Van Tonder, 1992:44).

Searle (2000:363) describes the rights of the nurse who is an employee as the following:

- A job description.
- A fair salary/wage arrived at by agreement with his or her professional association or union, and reasonably salary increases as near as possible to the increases in the cost of living index.
- Remuneration that is equivalent to that of other categories of health workers with similar qualifications and service demands.
- Remuneration that takes into account the classification of functions and responsibilities.
- Remuneration for overtime duties, and for unsociable hours where these are not compensated for by additional vacation leave.

- Social security in respect of maternity leave, sick leave, workmen's compensation, permanent disability through the nature of service performed and retirement.
- Working hours and rest periods that are clearly defined, and that are not longer than those set for other health workers.
- Vacation leave in accordance with the grade of service occupied. The nurse should have the right to accumulate some of this leave for diverse purposes.
- The determination of working schedules a reasonable period in advance, except in the case of necessity of emergency where this does not apply.
- Confidentiality as to his or her health status and personal problems known to the employer.
- The protection of his or her health as a worker.
- Equivalent pro rata status for part-time employment.

To summarise the professional practice of the nurse, Searle (2000:364) says that nurses/midwives have the right to expect conditions of employment and practice that enable them to practise in a knowledgeable, competent, legal and ethical manner, and provide the optimal type of care possible in a particular situation. They have the right to expect the type of support from management and colleagues in the health team, which will earn them trust of the public, because they ensure that they provide the same type of support to management, colleagues in the health team, the patient and the public at large.

The nursing managers in supervisory positions know the abilities of their nursing staff (Searle, 2000:249). They must be alert to the risks involved in deficiencies in knowledge and skills, in negative attitudes to the work situation and in antagonisms between nurses and patients, and among the various members of the health team. At the same time they have to impress on their personnel that employer liability does not relive the nurse/midwife of personal liability, nor does it relieve the practitioner of professional accountability.

Husted (1995:198) says the nurse/patient agreement is not problematic. The central term is the patient's life and well-being. The following has to be considered:

- Life is the precondition of all of a patient's other values.
- Life is the precondition of a patient's rights. To respect a patient's right to autonomy, freedom, etc., and not to be concerned for his or her life and well-

being is, very much, to miss the point. At the same time, to be concerned with a patient's life and well-being and not respect his or her right to autonomy, freedom, etc., is to have lost one's ethical direction.

- Life is the purpose of the patient in entering the health care environment. Patients' concern for their life must be shared by their nurse, or else there is no easily understood reason for him or her being their nurse. Life is the central term of the agreement that a nurse makes with his or her patient.
- A patient's motivation in entering the health care environment is the fact that his or her capacities and potentialities are radically circumscribed. When a patient regains his or her capacities and potentialities, his or her life is very much expanded.
- A patient, except in the most extreme circumstances, can have no rational desire before his or her desire for life. At the same time, in extreme circumstances, a desire for death is not an irrational desire.

As a practical necessity, hospitals and other health care institutions, having physicians as their clients, must provide qualified staff to carry out physicians' orders. Furthermore, those nurses are required to be autonomous when making these independent nursing judgements. The exercise of independent nursing judgement should be welcomed by institutions because of the safeguards that are afforded. It is not unusual to hear about a nurse who refuses to carry out a physician's order that is later found to be incorrect. Such action protects patients from physicians' negligence, and thus prevents litigation against the nurse, the physician and the institution. The fact that nurses are often found legally negligent for following questionable orders by physicians, or failing to follow through with the hierarchical chain of command when questioning or disagreeing with acts or omissions of physicians or others, proves that the courts not only recognise, but expect nursing autonomy (Burkhardt & Nathaniel, 2002:42).

According to Burkhardt and Nathaniel (2002:166), nurses' relationship with physicians is an important factor in the quality of patient care. Ideally the work of nurses and physicians should be complementary and synergetic.

Because both professions hold claim to the primary goal of patient health, one would expect a sense of collegiality and collaboration between nurses and physicians. When this type of relationship exists, it is rewarding and productive. When there is conflict between nurses and physicians, the relationship is stressful and damaging to

nurses, physicians and patients alike. Because nurses and physicians work in close proximity, conflict that occurs between them is a strong contributor to the lack of job satisfaction for nurses (Burkhardt & Nataniel, 2002:166).

The traditional nurse was expected to obey the physician, much as the wife was expected to obey her husband. Physicians demanded obedience and nurses hesitated to disagree with physicians, even if there was good reason to do so. What course should be followed by the nurse who questions or disagrees with any order or action of a physician? The nurse must remember that the primary obligation is to the patient and not to the physician. Nurses are autonomous practitioners who have the knowledge, experience and the legal and ethical responsibility to make independent judgements, even when carrying out physicians' orders. If medical care constitutes incompetent, unethical or illegal practice, the nurse is clearly obligated to disobey orders (Burkhardt & Nathaniel, 2002:166).

Burkhardt and Nathaniel (2002:395) reflect on the nurse's accountability for the assignment of nursing responsibilities to other nurses and the delegation of nursing care activities to other health care workers. The nurse must make reasonable efforts to assess individual competency when assigning selected components of nursing care to other health care workers. This assessment involves evaluating the knowledge, skills and experience of the individual to whom the care is assigned, the complexity of the assigned tasks, and the health status of the patient. The nurse is also responsible for monitoring the activities of these individuals and evaluating the quality of the care provided. Nurses may not delegate responsibilities such as assessment and evaluation, though they may delegate tasks. The nurse must not knowingly assign or delegate to any member of the nursing team a task for which that person is not prepared or qualified.

The confirmation of the rights of the nurse is therefore not an end in itself, but a means to ensuring improved services to patients (Chenevert, 1993:115).

In terms of the Constitution of the Republic of South Africa and relevant labour legislation, nurses are entitled to rights. Nurses are both legally and ethically required to practise autonomously (Burkhardt & Nathaniel, 2002).

Autonomous practice serves as a safeguard for the patient, nurse, physician and institution. Nursing codes of ethics support the nurses' autonomous decision making

and responsibility. Both the American Nurses' Association (ANA) Code for Nurses with Interpretative Statement (1985) and the subsequent ANA Code of Ethics for Nurses (2001) explicitly and implicitly call for autonomous action of nurses, particularly with regard to assuming responsibility and accountability for individual nursing judgements and actions, and in respect of protecting the safety of patients. Similarly, the Canadian Nurses' Association Codes of Ethics for Registered Nurses (1997) and the ICN Code of Ethics for Nurses (2000) implicitly and explicitly reflect nursing autonomy and responsibility. The purpose of autonomy, as described in these codes, is to protect the patient from harm, and allow for the full benefit of professional nursing care (Dumpel, 2005).

2.1.5 The Occupational Health and Safety Act 85 of 1993

Patient safety is fundamental to quality health and nursing care. ICN (International Council of Nurses, 2007) believes that the enhancement of patient safety involves a wide range of actions in the recruitment, training and retention of health care professionals, performance improvement, environmental safety and risk management, including infection control, the safe use of medicines, equipment safety, safe clinical practice, a safe environment of care, and accumulating an integrated body of scientific knowledge focused on patient safety and the infrastructure to support its development.

Nurses address patient safety in all aspects of care. This includes informing patients and others about risk and risk reduction, advocating patient safety and reporting adverse events. The ICN further states that the early identification of risks is a key to preventing patient injuries, and depends on maintaining a culture of trust, honesty, integrity, and open communication among patients and providers in the health care system. ICN strongly supports a system-wide approach, based on a philosophy of transparency and reporting – not on blaming and shaming the individual care provider – and incorporating measures that address human and system factors in adverse events. ICN is deeply concerned about the serious threat to the safety of patients and quality of health care resulting from insufficient numbers of appropriately trained human resources. The current global nursing shortage represents such a threat.

ICN believes nurses and national nurses' associations have a responsibility to

- inform patients and families of potential risks;
- report adverse events to the appropriate authorities promptly;

- take an active role in assessing the safety and quality of care;
- improve communication with patients and other health care professionals;
- lobby for adequate staffing levels;
- support measures that improve patient safety;
- promote rigorous infection control programmes;
- lobby for standardised treatment policies and protocols that minimise errors;
- liaise with the professional bodies representing pharmacists, physicians and others to improve packaging and labelling of medications;
- collaborate with national reporting systems to record, analyse and learn from adverse events; and
- develop mechanisms, for example through accreditation, to recognise the characteristics of health care providers that offer a benchmark for excellence in patient safety.

ICN (International Council of Nurses, 2007) firmly believes that violence in the health work place threatens the delivery of effective patient services and, therefore, patient safety. If quality care is to be provided, nursing personnel must be ensured of a safe work environment and respectful treatment. Excessive work loads, unsafe working conditions and inadequate supervision can be considered as forms of violence, and are incompatible with good practice.

Traditionally, customer complaints in any domain other than the clinical have been ignored, because they were not viewed as customer complaints, but as unavoidable staff disgruntlement that should be accepted and tolerated rather than given serious consideration. Furthermore, these staff complaints did not receive serious consideration because health care organisations had abundant resources of time, money, personnel and patients at their disposal. This abundance gave rise to the cavalier attitude of believing that health care workers were ‘a dime a dozen’ and that there would always be sickness, trauma, death, and a surplus of physicians and auxiliary staff members (Katz & Green, 1997:62).

When registered nurses offer their service to an employer and patient/client and take up their place in the health team, the fact that they do so as registered nurses implies that they have reasons to take legal action when it is to the student’s benefit (Mellish & Wannenburg, 1998:75).

The following list supplies a few factors influencing the patient's safety as stated by Mellish and Wannenburg (1998:189):

- Unsafe acts on the part of the personnel.
- Unsafe acts on the part of patients, clients or relatives.
- An unsafe environment.

Knowledge, skills and sound attitudinal qualities will enable the nurse to be an effective, safe practitioner. It is not possible for nurses to have knowledge about every need or situation arising in the domain of nursing care, but registration implies that the newly qualified nurse practitioner is competent to deal with all those medical, surgical, psychiatric/mental health, paediatric and community health conditions that occur most commonly in the country in which they are practising. In such cases it is their ethical duty to obtain expert help as quickly as possible in the interest of their patient. This is an ethical and, in some countries, also a legal responsibility (Searle, 1988:154).

Searle (1988:248) also states that the role of professional nurses in the years ahead will be determined by the nurses themselves, and not by health care authorities. How they acquit themselves in the difficult role they have grown into, will determine whether the authorities will continue to see them as the lynchpin in the provision of health care. It is up to the profession as a whole to ensure that the individual professional nurse is equipped to accept the challenges of the times and of the future.

Searle furthermore states that there is no room for complacency. Much has to be done to improve the contribution made by nurses and to retain nurses in the nursing profession. There is a need for innovation, assertiveness and the use of negotiating skills and power pressure by the profession, and there is a need for nurses to have faith in themselves and in their future. Professional nurses have good reason to be proud of their achievements, but must nevertheless be aware of their failings. All in all, they have reason to walk tall among health professionals and in the nation (Searle, 1988:218).

The factor that influences the success and functioning of the health system is its human resources. The composition, training, education and dedication of human resources are of vital importance in rendering a comprehensive state, private or any kind of health service to meet all the health care requirements of the population. The

provision of human resources should be considered with great concern. The provision of adequate and competent manpower for a health service requires health service managers to plan cautiously with a vision of the future. Manpower is usually the most expensive item on the budget (Booyens, 1997:24).

Although the main responsibility of professional nurses in charge lies in the organisation of nursing personnel, they must also organise non-nursing personnel in their unit. If non-nursing personnel are utilised well, the nursing personnel can use their time more efficiently for nursing duties (Booyens, 1997:228).

2.1.6 The Labour Relations Act 66 of 1995

The purposes of the act are the following:

a) To develop the skills of the South African workforce
   - to improve the quality of life of workers, their prospects and labour mobility;
   - to improve productivity in the work place and the competitiveness of employers;
   - to promote self-employment; and
   - to improve the delivery of social services.

b) To increase the levels of investment in education and training in the labour market and to improve the return on that investment.

c) To encourage employers
   - to use the work place as an active learning environment;
   - to provide employers with the opportunities to acquire new skills;
   - to provide opportunities for new entrants to the labour market to gain work experience; and
   - to employ persons who find it difficult to be employed.

d) To encourage workers to participate in learnership and other training programmes.

e) To improve the employment prospects of persons previously disadvantaged by unfair discrimination and to redress those disadvantages through training and education.

f) To ensure the quality of education and retaining in and for the work place.

g) To assist
   - work seekers in finding work;
   - retrenched workers in re-entering the labour market; and
   - employers in finding qualified employees.

h) To provide and regulate employment services.

The measure of productivity is usually made from the bottom-line of the salaries and benefits budget sheet with no consideration for service, practice or governance outcomes. An unfortunate perception is that the least costly staff is the best staff mix. However, there is, as yet, no yardstick to measure the impact of a poor staff mix on service, practice or governance outcomes. Health care organisations continue to believe they are saving money by decreasing the number of staff members who are the higher paid 'experts' and replacing them with inexperienced 'two-fers'. Two-fers are defined as two lower paid employees for the price of one highly paid, knowledgeable worker with specific expertise. In many organisations, top management believe that this will produce a lower cost of operation, while increasing the number of people who can perform the requisite tasks (Katz & Green, 1997:284).

No one can feel comfortable in an environment that does not provide the material and fiscal support necessary for staff members to act responsibly upon decisions. A fertile environment for performance excellence involves valuing the staff's administrative responsibilities for measuring and improving the results of services, as much as it values the provision of that care. Commitment of resources also involves recognising and rewarding accomplishments. A strong recognition programme is necessary to keep the fires of staff enthusiasm burning brightly for the performance management system, and it motivates staff members to reach ever higher levels of excellence (Katz & Green, 1996:100).

According to Olivier (1999:x), developing human resources is the most important means that any country, business or government department should capitalise on, not only to enhance economic growth, but also to provide the much needed advancement of its people. Decisions on how much should be invested on education and training of people are always controversial boardroom issues, since the cost benefit of conventional ways of education and training is not always that visible. With outcomes-based education and training, the learning achievements are more tangible and the results thereof can be validated against the needs of the real world, the world of work and ways of earning an income. It is therefore imperative that decision makers should take cognisance of the impact of education and training on development, should the education and training adhere to the basic principles of the outcomes-based learning approach.

Respect, trust, recognition and empowerment are the key ingredients to worker satisfaction in a health care organisation, and therefore to the success of its performance management system. Does anyone begin a new job with a negative attitude? No. They are filled with anticipation, excitement and ambition. But employees in health care organisations with little regard for the satisfaction of their employees find that their enthusiasm and open-mindedness are soon replaced by apathy and bitterness (Katz & Green, 1997:299).

Deep holistic lifelong learning is a dynamic process during which the learner intentionally approaches the learning environment in an active search for meaning through interaction. The learner, by demonstrating critical thought and reflection, allows a qualitative perception of learning to manifest itself. The learning approach is related to learning outcomes, which implies that the learner should show a motivated attitude. The learner accepts responsibility for his or her own learning. Deep holistic lifelong learning takes place through continuity and articulation that represent democratisation, and can occur in formal, non-formal and informal education. Deep holistic lifelong learning can be represented on a continuum, from a lesser degree to a higher degree of involvement (Klopper, 1998:6).

McClaskey and Grace (1994:295) discuss the importance of nursing's contribution to improving quality in a managed care revolution. Nurses are at the centre of the managed care revolution in health care delivery. Indeed, they are more critical now than they were under traditional fee-for-service settings. With the influence of managed care, nursing leadership has never before been more crucial to the future of the health care delivery system. Nurses are the professionals at the nerve centres of managed health care, and in those roles they have extraordinary influence to bring patient advocacy and quality of care priorities to the centre of the health care delivery system. Nurses have a marked influence in two particular roles, namely that of prevention and primary care.

Mellish and Wannenburg (1998:186) discuss nurses as facilitators of patient care. Nurses must have knowledge of their subject, especially related to the type of work handled in their unit. In the nursing field, if they are to continue as competent practitioners and facilitators of patient care, registered nurses have to constantly strive to remain abreast of development in nursing and medicine.

If nurses do not do so, they cannot provide good patient care, cannot supervise the giving of care, cannot teach good patient care, and cannot facilitate the giving of care (Mellish & Wannenburg, 1998:186).

Since much of the care revolves around the management of hazards, trust work involves apprising patients about hazards, while at the same time demonstrating competence in their management. This is done not only by possessing technical competence and judgement, but also by evincing calmness, steadiness and self-confidence. Of course, apprising patients of potential risks has recently gained in emphasis as a result of the patients' rights movement and the subsequent use of informed consent, along with concern over the legal consequences of not informing patients. Trust work occurs within the context of busy fast-moving wards, where many workers interact with each patient. Uncontrolled and invisible events can decrease mutual trust (Fagerhaugh, 1987:180).

Human sources of error made by health workers include lack of skills, skills involving not only the knowledge necessary to make errorless judgements, but also technical, manipulative skills necessary to carry out tasks. Both sets of skills are often based on experiential knowledge. Other sources of error consist of very human ones like carelessness or forgetfulness, being physically exhausted or being distracted by other ongoing work, or by personal pressures (Fagerhaugh, 1997:26).

Fiscal resources and budgetary constraints are a growing concern in every area of health and social service provision as we move into the next century. It is often the case that health care workers, attempting to allay fears and effectively operate therapeutic programmes of activity, will automatically call for an increase in staff as though quantity equates with safety. On the other hand, managers are urged to reduce staffing as it is a high-cost resource and considerable savings can be made by reducing the number of personnel. However, the idea of having staffing levels as high as possible to attain safety is one that has inconclusive support in the literature and is contrary to fiscal reasonableness. The common consensus is that there is an optimum quantity of staffing that a given population requires, but this is not a static measurement, as it changes over time and varies according to the context. The staffing level therefore has to reflect a need, and this is something that will fluctuate. The nurse has a clear professional duty to report to an appropriate person or authority, having regard for the physical, psychological and social effects on patients

and clients, and any circumstances in the environment of care that could jeopardise standards of practice (Mason & Chandley, 1999:82).

In order to plan effectively for future care, we must adopt a new and radical approach to how we work in the process of health care planning. A goal must be to work within a more collaborative framework in which design professionals work closely with each other, and with the user or client group for a particular facility. This will lead to health care environments that are better designed, take greater account of capital and revenue cost considerations, and that are more flexible to changing needs over time. A collaborative approach will ensure that expenditure represents value for money, both in the medium and long term (Valins & Salter, 1996:152).

According to Tappen (1995:414), both the organisation's management philosophy and budget have a great deal of influence on its staffing policies. Staffing is a complex function that does not yield to easy or consistent formulas, especially those that are borrowed from other organisations.

According to Marie Muller (2001:37), the Labour Relations Act made provision for protected strike action by employees, subject to certain conditions, procedures and negotiated agreements. This has led to the removal of the strike clause in the Nursing Act as amended (South Africa, 1992). The labour rights of all citizens are entrenched in the Constitution of the Republic of South Africa (1996). Participation in strike action by the nurse and midwife, regardless of the legal requirements and specifications, does, however, pose an ethical question. It is therefore necessary to conduct a value clarification on strike action by nurses in South Africa.

2.1.7 The Basic Conditions of Employment Act 75 of 1997, as amended in 2002

a) Chapter 2.2, Section 9 of the act refers to ordinary hours of work which shall not exceed
   - 45 hours in any week;
   - nine hours in any day if an employee works for five days or less in a week; or
   - eight hours in any day if an employee works on more than five days in a week.

b) Chapter 2.3, Section 9 of the act refers to overtime. An employer may not require or permit an employee
   - to work overtime except by an agreement; or

- to work more than ten hours' overtime per week.

c) Sections 63–81 of the act state the following:
   - Labour inspectors must advise employees and employers about their rights and obligations in terms of employment laws. They may conduct and remove records and other relevant documents.
   - An inspector may serve a compliance order on an employer who is not complying with a provision of the act. The employer may object to the order to the Director-General: Labour who, after receiving representations, may confirm, modify or set aside an order. This decision is subject to appeal to the Labour Court.

Clinical mentorship is a term used to describe the relationship between an expert practitioner within an area of practice, and a person who is new to that area. Most often this is a relationship between a qualified professional and a 'student professional', and that relationship often embraces the tripartite role of teacher, assessor and critical friend (Hyde & Cook, 2004:161).

Promoting continuous professional development, as stated by Hyde and Cook (2004:26), is important in lifelong learning, and the authors urge and encourage practitioners to obtain user feedback in order to achieve quality service. Work-based learning enables both these aims to be achieved.

Salary levels might be influenced due to the need for limiting the growth of health care costs and the restructuring thereof. The results of Havers' 1995 research revealed that 73% of the respondents (n = 183) from a randomised national survey reported implementing changes in staffing that targeted altering the use of registered nurse resources. This restructuring initiative has generally involved using a smaller core of professional staff with re-designed roles, supported by a larger grade of non-professional assistant care personnel (McClaskey & Grace, 1994:495).

The nursing manager should be sensitive to nurses' feeling of self-worth, and should continually strive to improve it. This can be achieved, for example, by listening intently to employees when discussing what they are satisfied or dissatisfied with regard to their career, or when discussing their career goals (Booyens, 1998:468).

Traditionally hospitals have been content to make do with whatever nurses they have on hand. If it happened that an adequate number of nurses were not available,

hospital staff simply sat back, waiting for prospective employees to wander in. Until the new 'stock' arrived, the old staff was prodded to work longer and harder, take on double shifts, forego days off and increased patient loads. Under the strain, many loyal, long-term nursing employees resigned. The nurse shortage escalated and desperation increased. Hospitals tried to maintain their high standards for hiring nurses. Apart from attracting new nurses, they realised the necessity of holding onto existing staff. Nurses had become more astute at reading advertisements. It is a known fact that 'competitive salaries' meant they paid exactly the same salary as every other institution in the area. 'Challenging positions' meant twice the work for the same salary (Chenevert, 1993:43).

Katz and Green (1997:95) define job descriptions as structured standards, because they outline the requisite knowledge, skills, attitudes, responsibility and scope of authority of a specific position within an organisation for the organisation to function at maximum performance.

By ignoring the job description in hiring practices, the organisation may end up with unqualified staff or individuals without the necessary experience to fulfil the specification of the job. Some individuals never achieve the level of performance expected, and problems arise from the constant lack of skill (Katz & Green 1997:95).

Table 2.1 A comparison between research done in 1998 and 2003

1998 study	Ranking order	2003 study	Ranking order
Problems at work			
• Better remuneration needed	1	• Better remuneration needed	1
• Better benefits needed	2	• Better benefits needed	2
• Too much stress	3	• Too much stress	3
Possible changes for a better work place			
• Being paid according to extra experience, responsibility and qualifications	1	• Improving pay scales • Being paid according to extra experience, responsibility and	1 2

• Improving pay scales • On-the-job training opportunities	2 3	qualifications • On-the-job training opportunities	3
Barriers in the work place • Low salaries that cannot support child care payments • Lack of recognition and respect for work completed • Restriction on type of work given, thus limiting experience	 1 2 3	 • Lack of recognition and respect for work completed • Low salaries that cannot support child care payments • Little allowance made for family commitments	 1 2 3
Career expectations and goals • Job satisfaction • Recognition • Professional support	 1 2 3	 • Job satisfaction • Recognition • Balanced profess-sional/private life	 1 2 3
Suggestions to SA Nursing Council • Annual refresher courses • Discussion groups • Greater discounts on membership fees	 1 2 3	 • Annual refresher course • Network group of professional women mentors • Greater discounts on membership fees	 1 2 3

(Erasmus & Brevis, 1998:55)

Burn-out, as described by Tappen (1995:454), refers to a state of emotional exhaustion, a depletion of energy that seems to be a particular problem for people in helping professions. It begins with frustrations, disillusionment, or doubts about one's work and leads to the loss of ideals, purpose and energy. The burnt-out individual may feel apathetic, alienated or exhausted. Stress-related physical symptoms such as headaches, backaches, indigestion and lowered resistance to infection may be experienced. Family difficulties and social problems may also occur, and like reality

shock, the cost of burn-out to individuals, their families, employing organisations and clients is enormous.

According to Tappen (1995:454), the following factors contribute to burn-out:

- Low pay
- Long working hours
- Too much paper work
- Client losses
- Lack of appreciation and understanding
- Lack of support
- Unresponsiveness to client needs
- Powerlessness
- Discrimination
- Inadequate advancement opportunities

Identifying what constitutes a ‘safe’, a ‘minimum’ or an ‘effective’ staffing level in nursing remains a contentious issue. Some commentators have argued that a vicious cycle can arise where ‘understaffing’ in relation to work load leads to more nurses leaving, which then compounds the problem of understaffing. The conventional wisdom tends to be that staffing levels are best left to local level management, taking account of local work load and resources. This ‘bottom-up’ philosophy has now been challenged by a fundamentally different approach – the use of ‘top-down’ standardised and mandatory nurse:patient ratios (Tappen, 1995:454).

The pressures of an increased work load, the need to improve staffing efficiency and effectiveness, and the growing recognition of the linkages between effective staffing levels and outcomes (including patient safety) have led to attempts to identify the ‘best’ methods of determining staffing levels. The challenge of using ‘off-the-shelf’ or bespoke systems of work load assessment and staffing determination is that their application can all too easily become a ‘numbers game’ – an end in itself rather than a decision-support mechanism. These systems can also be time-intensive to use, can be ‘data hungry’, and can fall into disrepute if their recommended staffing levels are not consistently implemented by the organisation. The other major point to note when selecting a system is that there is no single ‘right’ answer to the question: “What is the best staffing level?” Research has demonstrated that different systems

applied in the same care environment will give different staffing ‘answers’ (World Health Organisation, 2006).

Empowerment within the profession requires a renewed vision of nursing. As nurses we need to redefine nursing according to our vision, rather than accepting the definition imposed by the dominant groups in health care, which are physicians and institutions. When nurses draw pictures of their vision of nursing, what emerges are images of caring, light, comfort and love. These images reflect the heart of the vision of nursing amongst nurses. Making choices based on the vision and values of the profession fosters congruence between nursing, knowing and doing, which again strengthens personal and professional effectiveness (Burkhardt & Nathaniel, 2002:371).

The trend of increasing ethnic diversity raises issues of nursing care that is culturally congruent. This asks a lot of any health delivery system that has difficulty in even finding language interpreters as a minimum approach to meeting the needs of ethnic groups. In addition, the nursing literature raises the related issue of dealing with marginality, referring to people with all kinds of differences, whether based on ethnic, gender, class or other social conditions. Again, the knowledge and skills demanded for competent nursing care is extensive (Roy, 2000:119).

2.1.8 The South African Nursing Council

ICN (International Council of Nurses, 2007) and national nurses’ associations have a responsibility to promote professional practice models that support the appropriate delegation of nursing care to assisting nursing personnel. In addition, educational programmes should focus on the proper preparation of nurses to undertake the responsibilities of health team supervisors and the delegation of care.

ICN advocates national nurses’ associations and other nursing organisations to

- assure that the nursing profession is an active participant in reviews and decision making on the roles and required competencies of nursing personnel;
- investigate what nursing can do cost-effectively;
- adopt a proactive role in identifying and proposing areas of nursing care that can be delegated to assistive nursing personnel; and
- monitor health human resources policy changes and evaluate the impact of practice and the delivery of services.

A SANC (South African Nursing Council, 2007) states the following:

- The nursing profession and its members are accountable to society.
- The scope of practice of nurses is aligned to health service delivery needs.
- The members of the nursing profession will be competent through the introduction of mandatory continuous professional development requirements.
- A notion of community service is instilled amongst new recruits through compulsory community service.
- Nurses are accountable for providing a high standard of professional and ethical nursing.
- Nursing education is aligned to the provisions of the National Qualifications Framework (NQF).

SANC (South African Nursing Council, 2007) declared their mission as the following. "We excel in quality humane nursing care for all through:

- restoring dignity in the nursing profession and instilling hope in the community;
- good governance;
- balancing cost-effectiveness and quality;
- providing evidence-based information;
- developing our personnel and counsellors;
- promoting accessible, equitable and excellent service delivery;
- policy formation and implementation, in line with applicable legislation;
- enhancing community participation and development through structured programmes;
- intersectional collaboration and partnering with relevant stakeholders;
- ensuring public protection by regulating nursing practice, and formulating and monitoring nursing practice standards;
- quality assurance of nursing education and training.

Mellish and Wannenburg (1998:90) believe nurses have an obligation to keep themselves informed, and to know what is happening in the world of nursing and medicine. This can be done by reading professional literature, attending meetings, symposiums and seminars, and making sure that they are aware of all the health facilities available in the area.

Nursing as a profession has a professional behaviour component on which practice is based. There are internal and external controls on this professional practice. Apart from the values and norms inherent in the practice of nursing, legal requirements have to be adhered to (Mellish & Wannenburg, 1998:90).

2.2 CONCLUSION

In this chapter the researcher presented the ethical and legal guidelines underlying the nursing profession. Current legislation guides nurses in their clinical practice and the researcher examined the ethical and legal framework within which nurses practise.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

The purpose of this chapter is to describe the research methodology that was applied to investigate the legal and ethical practice of the nurse.

Research design is the blueprint for the conduct of a study that maximises control over factors that could interfere with the desired outcomes of studies. The design study is the end result of a series of decisions made by the researcher concerning the way in which the study will be implemented (Burns & Grove, 1997:246).

Quantitative research is a formal, objective, systematic process to describe and test relationships and examine cause and effect interaction among variables (Burns & Grove, 1997:791).

3.2 RESEARCH DESIGN

A quantitative approach with an explorative research design was chosen in order to obtain a big sample of the target population. The scope of this project was to explore the legal and ethical aspects of nursing in the clinical practice in selected private hospitals in the Western Cape Metropolitan area. The survey was conducted during a time when the country experienced grave nurse shortages. Questions asked are relevant in the clinical practice of nurses today.

According to Mouton and Marais (1992:33), the aim of the research design is to plan and structure a given research project in such a manner that the eventual validity of the research findings is maximised. A research design therefore implies rational decision making before and during the research process. It includes decisions made about the type, strategy and content of the research.

A literature research of both an empirical and theoretical nature proved that the ethical and legal guidelines are the foundation of the nursing profession. Nursing ethics is the basis of clinical practice and important in health care. Nurses make decisions in the daily implementation of their practice and should be knowledgeable about the legal implications in their profession.

A formal objective systematic process was used for obtaining numerical data at a specific time. The truth was measured through structured closed-ended questions. Statistics were organised to be meaningful and give insight into matters such as frequency distribution and to measure central tendency and dispersion.

3.3 OBJECTIVES

The research goal provides a broad indication of what researchers wish to attain in their research (Mouton & Marais, 1990:42). The purpose statement (objectives) establishes the general direction of the inquiry and provides a synopsis of the overall goal (Polit & Hungler, 1997:72).

Objectives of this study were to determine

- whether nurses function within their scope of practice;
- whether nurses know and exercise their nursing rights;
- whether nurses are being exploited in the work place;
- whether nurses function within the legal guidelines;
- whether caregivers contribute to nursing care;
- whether nurses work more than ten hours overtime a week;
- whether nurses still believe in the nursing philosophy;
- whether nurses act ethically; and

3.4 INSTRUMENTATION

A structured questionnaire with predominantly closed-ended questions was used to determine legal and ethical factors in the nursing profession.

The questionnaire consisted of the following:

- *Section A*: Biographical data such as age, qualifications, position and area of work. Overtime was also determined to assess the average overtime that nurses work.
- *Section B*: This section focused on three main areas, namely profession, company and patient. The nurses' perception and knowledge were tested regarding these ethical factors.
- *Section C*: To conclude the questionnaire, various questions were asked about the legal framework within which nurses practise.

The initial page of the questionnaire contained a brief outline of the study, assured confidentiality of responses and contained a statement of signed consent for participation in the study.

Background questions required basic information or a simple yes/no answer to some questions. The legal and ethical questions were structured according to a seven-point Likert scale, varying from ‘most strongly agree’ to ‘most strongly disagree’. These questions were created to make the response meaningful and prevent central tendency.

A pre-tested questionnaire was used, which had been corrected for bias, on the suggestions of the ethical committee.

In total, 88 explorative questions were asked, exploring professional ethics, quality of work life, legal practice, biography and attitude. The questionnaire consisted of four pages, including the consent form.

Questions were identified and based on an in-depth literature study and the clinical and managerial experience of the researcher. Aspects addressed in the questionnaire included the following:

- Legal aspects in the nursing profession.
- Ethical code of the profession.
- World Health Report.
- ICN view on various aspects of the nursing profession.
- Abuse in the work place.
- Training and evidence practice.
- Core functions of nursing.
- Managed health care and cost implications.
- Nursing theory.
- Patient needs and expectations.
- The role of the employer and governing body.
- Strike and disputes.
- Migration of nurses.
- Nursing leadership role and responsibility.
- Current nurse registrations in South Africa.

- Articles and surveys on contemporary nursing issues.
- Research methodology.

3.5 POPULATION AND SAMPLING

Burns and Grove (1987:206) refer to population as the entire set of individuals or elements defined by the sampling criteria established for the study. The sample is then closed from the study population, which is commonly referred to as the target population.

Sampling defines the process of making the selection, while a sample defines the selected group of elements (Burns & Grove, 1997:794).

A 5% sample of 2 990 nurses were drawn from the nursing population identified. The population included professional and non-professional nurses in permanent employment in selected private hospitals in the Western Cape Metropolitan area. All disciplines and areas of specialty were included to obtain a fair distribution and sample size. Nurses on duty were selected at random to participate. Questionnaires were placed in sealed envelopes and treated with confidentiality. Questionnaires were handed out and collected between 28 September 2007 and 5 October 2007. Questionnaires were handed to the data capturer for processing. No hospitals of the Netcare group were involved because of a delay in receiving approval for the study from their ethics committee and the time constraints of the study.

Table 3.1 Hospital sample distribution

Hospital	**Population**	**Sample distributed**	**Sample received**
1. Life Vincent Pallotti	400	20	20
2. Life Kingsbury/Claremont	450	15	10
3. Vergelegen Medi-Clinic	300	15	15
4. Stellenbosch Medi-Clinic	240	12	12
5. Cape Town Medi-Clinic	400	20	16
6. Panorama Medi-Clinic	500	25	23
7. Durbanville Medi-Clinic	400	20	14
8. Constantia Medi-Clinic	300	15	14
Total	**2 990**	**142**	**124**

3.6 PILOT STUDY

A pilot study is a smaller version of a proposed study conducted to develop and/or refine the methodology, such as the treatment, instrument or data-collection process (Burns & Grove, 1997:791).

A pilot study was conducted under circumstances similar to those of the actual study at one of the private hospitals, namely Life Vincent Pallotti. These participants were not included in the actual study. The instrument was tested for any inaccuracies and ambiguity and supported reliability, validity and confidentiality. The pilot study assisted in refining the data-collection instrument and addressed grammar and spelling errors.

According to Krejcie and Morgan (1970) a sample of 384 (0.04%) participants is required for a population of one million in any scientific study. In this study, a sample of 157 (0.05%) was drawn from a population of 3 030.

3.7 VALIDITY AND RELIABILITY

The strength of a design to produce accurate results is determined by examining statistical conclusion validity, internal validity, construct validity and external validity (Burns & Grove, 1997:795).

Reliability represents the consistency of the measure obtained (Burns & Grove, 1997:793). Reliability was obtained through the investigation of recent national and international literature as primary and secondary sources from well-known nursing organisations and authors.

Experts in research methodology, statistics and computer science programming evaluated the instrument. A nursing science specialist evaluated the content of the instrument, while participants in the pilot study recommended grammar changes to the instrument. Further feedback received proved the questionnaire to be clear and understood by all.

Participants had to read questions in detail as the Likert scale, varying from ‘most strongly agree’ to ‘most strongly disagree’, prevented central tendency. Therefore feedback was more meaningful.

3.8 ETHICAL CONSIDERATIONS AND ETHICAL APPROVAL FROM THE UNIVERSITY

Participants had the option of contacting the researcher for any information. All staff employed at the hospitals of choice had a fair and equal opportunity to be selected.

The proposal of the research project, together with the proposed informed consent document and questionnaire, was submitted to the Ethics Committee of the Medical Faculty, Stellenbosch University, for ethical evaluation. Corrections were required after which the document was prepared for use.

Permission was obtained from the National Nursing Managers of both Life Healthcare and Medi-Clinic. Nursing managers of selected private hospitals were involved in the fair selection of participants. Confidentiality was maintained and questionnaires were distributed and returned in sealed envelopes. Data was captured by the data capturer.

Participants were treated with respect and all questions were answered objectively. The participation was voluntary and nobody was intimidated or threatened.

3.8.1 Confidentiality and anonymity

Any information that a participant divulged was not made public or available to other people, therefore confidentiality was maintained throughout the survey. The anonymity of the institution was protected by making it impossible to link the specific data to the participant and institution. Anonymity was safeguarded as all raw data was destroyed after the compilation of the final thesis. No participant was referred to by name. The independent data capturer received the raw data for capturing.

3.8.2 Privacy and consent

The researcher ensured that participants were anonymous and could participate voluntarily. Participants were also free to withdraw at any time.

Written consent was obtained from each participant and was voluntary. Consent was treated with confidentiality.

3.9 DATA COLLECTION

Data was collected from selected private hospitals in the Western Cape Metropolitan area in September 2007. The structured English questionnaire, with a consent form,

was received in sealed envelopes. Each hospital had a designated person collecting the completed questionnaires, as off-duties made it difficult to contact participants. Respondents were from all nursing categories and disciplines. There was no discrimination against male nurses or certain age groups. The aim of the study was to represent the entire population of nurses in the private hospital industry.

Questionnaires were then handed to the data capturer who captured data on a spreadsheet. The researcher treated data confidentially. The statistician then analysed the data.

3.10 DATA ANALYSIS

Assisted by a statistician and computer science expert, the researcher analysed the quantitative data by means of a computer program. Experts in research methodology assisted the researcher in analysing data by refining and clarifying literature. The raw data was examined for completeness and accuracy, using the conceptual framework in inductive reasoning.

An inductive argument with genuine supporting evidence can lead to highly probable conclusions and lend gradual support to the conclusion.

Data analysis was conducted to reduce, organise and give meaning to the data. For the purpose of this study, the analysis techniques used in this quantitative research were based on descriptive and explorative procedures. Frequencies, percentages, means and standard deviations were used. Chi-square tests using the 95% confidence interval were done to determine associations for significance between various variables.

Descriptive statistics are used to describe and summarise data. Examples of measurements used in descriptive statistics are percentages and measures of central tendency namely mean, mode and standard deviation.

Inferential statistics may be used to make conclusions about a population from the sample that has been studied. Inferential statistics is used when there is a wish to generalise research findings from a sample of a given population to the whole of that population.

Research is not complete until the findings have been communicated, therefore a research report was developed for the appropriate audience in the health industry. The research findings and recommendations will also be published.

3.11 LIMITATIONS

The study was only conducted in selected private hospitals with a sample of 142 participants. The public sector was not included and therefore no data exists for nurses in this industry. Duo to time constraints, Netcare was not included in the study. Small clinics were excluded but could also have given valuable information with regard to their specific practices.

Caregivers are not regulated by SANC, therefore the study had to focus on nurses in general and not merely the nursing profession. Caregivers play an important role in the hospitals and the researcher had to find a way to include them, gaining valuable information.

Agency nurses were not included, yet they are a critical resource for hospitals, and between 30% and 40% is used in private hospitals, according to statistics of Life Healthcare.

Some questions with regard to doctor abuse in the work place were rephrased on the suggestion of the Ethics Committee. No true reflection was received although the researcher believes that nurses experience verbal abuse by doctors.

3.12 CONCLUSION

In this chapter, the researcher described the methodology of the study. The various steps of the research process as applied in the study were discussed. This includes the research design, sampling, pilot study, ethical consideration, instrumentation, reliability and validity.

CHAPTER 4
DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

In this chapter the researcher proceeds to describe the analysis and interpretation of the data obtained in this study, which was of a quantitative nature. The analysis and interpretation of the data obtained are presented simultaneously. Assisted by a statistician and computer science expert, the researcher analysed the quantitative data by means of the Statistica 7.1 computer program. Experts in research methodology assisted the researcher in analysing the data by refining and clarifying the literature. The raw data was examined for completeness and accuracy, using the conceptual framework in inductive reasoning.

4.2 DATA ANALYSIS AND INTERPRETATION

Data analysis was conducted to reduce, organise and provide meaning to the data. Analysis techniques that were used in this quantitative research were based on descriptive and explorative procedures. Data was expressed in frequencies, percentages, means and standard deviations. The following tests were done to determine statistical significance between the various variables using the 95% confidence interval: Chi-square test, Man-Whitney and Kruskal-Wallis tests and the Spearman correlation test.

The Chi-square test is used to analyse nominal data to determine significant differences between observed frequencies within the data and frequencies that were expected (Burns & Grove, 1997:774).

The Spearman correlation test is used when data might not be normally distributed (Blanche & Durrheim, 2004).

The Mann-Whitney U test is the most powerful of nonparametric tests with 95% of the power of the *t* test to detect differences between groups of normally distributed populations (Burns & Grove 1997:458).

The Kruskal-Wallis test is the most powerful non parametric test for examining three independent groups (Burns & Grove, 1997:477).

Standard deviation is a measure of dispersion that is calculated by taking the square root of the variance (Burns & Grove 1997:794). Mean is the value obtained by summing all the scores and dividing that total by the number of sores being summed (Burns & Grove, 1997:786).

4.2.1 Section A: Biographical data

Abbreviations used:

N - Total sample
RN - Registered nurse
EN - Enrolled nurse
ENA - Enrolled nursing assistant
CG - Caregiver
SD - Standard deviation
SE - Standard error
V - Variable
OT - Operation theatre

4.2.1.1 Variable 1–6: Age group

Table 4.1 shows the number of nurses who participated in the study. In total, 87% (69) of the nurses were between the ages of 30 and 49. The age group 40–49 consisted of the most nurses: RN-24, EN-7, ENA-1, CG-3, and management-6. Management was predominantly in the age group 50–59, while registered nurses were in the age group 40–45. Enrolled nursing assistants were mainly in the age group 50–55.

Table 4.1 Age group (n = 124)

Age range	**N**	**%**
≤21	1	1
≥22<30	12	10
≥30≤39	43	34
≥40≤49	44	35
≥50≤59	23	19
≥60	1	1
TOTAL	**124**	**100**

4.2.1.2 Variable 7–11: Position

Table 4.2 below shows the number of nurses in different positions. The registered nurses formed the largest sample, which was 48% (59).

Table 4.2 Position (n = 124)

Position	**N**	**%**
RN	59	48
EN	20	16
ENA	9	7
CG	9	7
Management	27	22
TOTAL	**124**	**100**

4.2.1.3 Variable 12–17: Area of work

Table 4.3 below shows the area of work for different nurse categories. “Management” could consist of unit managers while “other” could consist of educators, paediatric, gastro-intestinal or trauma units. The sample seemed to have a fair representation of all areas.

Table 4.3 Area of work (n = 124)

Area of work	**N**	**%**
Management	15	12
ICU	26	21
Ward	35	28
Theatre	17	14
Maternity	14	11
Other	17	14
TOTAL	**124**	**100**

4.2.1.4 Variable 18– 2: Overtime

Table 4.4 below shows the average amount of overtime worked a month per nurse. There has always been an assumption that nurses work more overtime stipulated by the Basic Conditions of Employment Act, which in fact is not true. Only 5 (4%) of the nurses worked more than the 40 hours per month overtime as stipulated in the act. According to the Spearman test, there was a correlation between age and overtime

worked (p = -0.05). The age group 40–49 worked more overtime and RNs proved to work the most overtime.

Table 4.4 Overtime (n = 124)

Overtime worked	N	%
Less than 10 hours a month	71	57.3
10–19 hours a month	24	19.4
20–29 hours a month	15	12.1
30–39 hours a month	9	7.3
More than 40 hours a month	5	4
TOTAL	**124**	**100**

4.2.1.5 Variable 23– 7: Current position

Table 4.5 below shows the number of years in current positions. The largest sample in this section is 59% (73) of the nurses who have been in their current positions between 1–5 years. Nurses in positions indicating more than 16 years are mostly enrolled nursing assistants.

Table 4.5 Current position (n = 119)

Current position	N	%
1–5	70	59
6–10	23	19
11–15	10	9
16–20	10	9
More than 20	6	4
TOTAL	**119**	**100**

4.2.1.6 Variable 28–32: Years in nursing

Table 4.6 below shows the nurses' years of experience in the nursing profession. It shows that 35% (41) nurses have 20 years and more experience in the nursing profession.

Table 4.6 Years in nursing (n = 119)

Years in nursing	**N**	**%**
1–5	9	8
6–10	18	15
11–15	18	15
16–20	33	28
More than 20	41	35
TOTAL	**119**	**100**

4.2.1.7 Variable 33: Are you qualified in your area of specialty?

Table 4.7 below shows that the majority, namely 96 (83.5%), of the participants have indicated that they are qualified for the area of speciality. It was also shown statistically that the nurses working in the area of speciality were qualified to work in the particular area (Spearman test p = 0.0827).

Table 4.7 Are you qualified in your area of specialty? (n = 115)

	Yes – 83%	**No – 16%**
RN	49	9
EN	14	2
ENA	4	2
CG	8	0
Management	21	6
Total	**96**	**19**

4.2.1.8 Variable 34: Are you currently studying towards another degree?

Table 4.8 below shows that the majority, namely 91 (83%), of the participants have indicated that they are not studying towards another degree. Results further show that 46 (85%) of the registered nurses did not study towards another degree.

Table 4.8 Are you currently studying towards another degree? (n = 110)

	Yes – 17%	**No – 83%**
RN	8	46
EN	4	11
ENA	0	7
CG	3	4
Management	4	23
Total	**19**	**91**

4.2.1.9 Variable 35: Do you belong to a professional trade union?

Table 4.9 below shows that the majority, namely 66 (60%), of the participants have indicated that they do not belong to a union. These results could be attributed to the fact that many private hospitals make use of employee forums. Therefore the staff is indirectly discouraged from joining trade unions. Registered nurses 23 (43%) and management 11 (44%)) are more inclined to join unions than any other category of nurse.

Table 4.9 Do you belong to a professional trade union? (n = 110)

	Yes – 40%	**No – 60%**
RN	23	31
EN	6	11
ENA	2	5
CG	2	5
Management	11	14
Total	**44**	**66**

4.2.1.10 Variable 36: Do you recommend nursing as profession?

Table 4.10 below shows that the majority, namely 85 (73%), of the participants have indicated that they will recommend nursing as a profession. A statistical association has been obtained between position and whether they will recommend nursing as a profession (Chi-square test p = 0.043).

Table 4.10 Do you recommend nursing as profession? (n = 116)

	Yes – 73%	**No – 27%**
RN	35	21
EN	15	2
ENA	6	2
CG	5	3
Management	24	3
Total	**85**	**31**

4.2.1.11 Variable 37: Do you function in your area of specialty?

Table 4.11 below shows that the majority of nurses, namely 95 (89%), function in their area of speciality. No statistical significance was identified.

Table 4.11 Do you function in your area of specialty? (n = 107)

	Yes – 89%	**No – 11%**
RN	45	7
EN	11	2
ENA	6	1
CG	8	0
Management	25	2
Total	**95**	**12**

4.2.1.12 Variable 38: Are you thinking of changing your profession?

Table 4.12 below shows that the majority of the participants, namely 79 (70%), have indicated that they were not thinking of changing their profession, while 30% indicated that they were thinking of changing their profession. In total, 21 (40%) of RNs were thinking of changing their profession, which may have an adverse effect on the profession if it does happen. A statistical significant association has been identified between position and whether nurses were thinking of changing their profession (Chi-square test p = 0.05).

Table 4.12 Are you thinking of changing your profession? (n = 114)

	Yes – 30%	**No – 70%**
RN	21	32
EN	4	16
ENA	0	8
CG	3	5
Management	7	19
TOTAL	**35**	**80**

4.2.1.13 Variable 39: Are you thinking of emigrating?

Table 4.13 below shows that the majority of the participants, namely 87 (77%), have indicated that they were not thinking of emigrating, but it is cause for concern to note that 26 (23%) have indicated that they were thinking of emigrating. Should 23% (696) of the target population of 3 030 nurses working in the private hospitals, as defined for the purpose of this study, leave the country it will have an adverse effect on the patient care in these hospitals. A statistical significant association has been identified between position and whether nurses will emigrate elsewhere (Chi-square test p = 0.0024).

Table 4.13 Are you thinking of emigrating? (n = 113)

	Yes – 23%	**No – 77%**
RN	17	37
EN	4	13
ENA	0	8
CG	4	4
Management	1	25
TOTAL	**26**	**87**

4.2.2 Section B: Ethical practice

Data was collapsed to ‘agreeing’ or ‘disagreeing’. ‘Most strongly agree’, ‘strongly agree’ and ‘agree’ were collapsed to ‘agree’ while ‘most strongly disagree’, ‘strongly disagree’ and ‘disagree’ were collapsed to ‘disagree’. Neutral feedback was ignored. This was done to analyse and interpret data effectively.

4.2.2.1 Variable 40: You do not respect all religions

The Nurses' Pledge (Muller, 1997:14) states "I will not permit considerations of religion, nationality, race or social standing to intervene between my duty and my patient" therefore one would expect all nurses to adhere to this principle.

Table 4.14 below shows that the majority of the participants, namely 98 (84%), have indicated that they respect all religions, while it is a cause for concern to note that 19 (16%) nurses do not respect all religions.

A statistical association was identified with the number of years in current position and respect for all religions (Spearman test p = 0.04). Results indicate that registered nurses disagreed with the statement that nurses do not respect other cultures (mean = -2.12; SD = 1.68; SE = 0.22). Enrolled nursing assistants agreed (mean = -1.00; SD = 2.07; SE = 0.73).

Table 4.14 You do not respect all religions (n = 117)

Mean = -1.75; SD = 2.00; SE = 0.18 (Position/V40)

Response	**%**	**N**
Agree	84	98
Disagree	16	19
TOTAL	**100**	**117**

4.2.2.2 Variable 41: You always assure patient privacy

Table 4.15 below shows that the majority of the participants, namely 116 (96%), have indicated that they always assure patient privacy, while it is a cause for concern to note that 5 (4%) nurses do not always assure patient privacy. Theatre nurses assure the most patient privacy (mean = 2.76; SD = 0.43; SE = 0.10).

Table 4.15 You always assure patient privacy (n = 121)

Mean = 2.38; SD = 1.21; SE = 0.11 (Area of Work/V41)

Response	**%**	**N**
Agree	96	116
Disagree	4	5
TOTAL	**100**	**121**

4.2.2.3 Variable 42: You do not acknowledge patient autonomy

Table 4.16 below shows that the majority of the participants, namely 94 (88%), have indicated that they disagree with the statement that they do not acknowledge patient autonomy. It is a cause for concern to note that 13 (12%) do agree with this statement. Caregivers least acknowledge patient autonomy (mean = -2.14; SD = 0.89; SE = 0.34), which could be attributed to their lack of training. The Bill of Human Rights is very clear on the autonomy of every human being, and according to the Constitution of the Republic of South Africa (Act 200 c2) this should at all times be adhered to.

Table 4.16 You do not acknowledge patient autonomy (n = 107)

Mean = -1.80; SD = 1.55; SE = 0.14 (Position/V42)

Response	**%**	**N**
Agree	12	13
Disagree	88	94
TOTAL	**100**	**107**

4.2.2.4 Variable 43: You experience verbal abuse by the patient

Table 4.17 below shows that the majority of the participants, namely 60 (56%), have indicated that they experience verbal abuse from patients. Caregivers experience most verbal abuse by patients (mean = -2.14; SD = 0.89; SE = 0.34). This could be attributed to the fact that patients do not realise the role of the caregivers in the health industry, as they belong to a relatively new category of health worker.

Table 4.17 You experience verbal abuse by the patient (n = 107)

Mean = 1.80; SD = 1.55; SE = 0.34 (Position/V43)

Response	**%**	**N**
Agree	56	60
Disagree	44	47
TOTAL	**100**	**107**

4.2.2.5 Variable 44: You do not respect all cultures

Table 4.18 below shows that the majority of the participants, namely 114 (96%), have indicated that they do not agree with the statement that they do not respect all cultures. A statistical association shows older nurses to be more respectful of other cultures (p = .04). The nurse, however, is not in a position to be judgemental, but to

alleviate suffering regardless of belief, culture or social standing. Enrolled nursing assistants were the most disrespectful of other cultures (mean = -1.12; SD = 2.10; SE = 0.74), while registered nurses most definitely respected other cultures (mean = -2.43; SD = 1.24; SE = 0.16).

Table 4.18 You do not respect all cultures (n = 119)

Mean = -2.20; SD = 1.34; SE = 0.12 (Position/V44)

Response	**%**	**N**
Agree	4	5
Disagree	96	114
TOTAL	**100**	**119**

4.2.2.6 Variable 45: You always provide safe and committed care for your patient

Table 4.19 below shows that the majority of the participants, namely 116 (95%), always provide safe and committed care for their patients. Results show that safe and committed care was mostly given by registered nurses (mean = 2.67; SD = 0.73; SE = 0.09), and the least by caregivers, which is below the mean (mean = 2.00; SD = 1.32; SE = 0.44). Maternity nurses stood out amongst the units as being committed to care (mean = 2.69; SD = 0.48; SE = 0.13). The Occupational Health and Safety Act is very clear on guidelines pertaining to patient safety.

Table 4.19 You always provide safe and committed care for your patient (n = 122)

Mean = 2.45; SD = 1.13; SE = 0.10 (Position/V45)

Mean = 2.46; SD = 1.14; SE = 0.10 (Area of work/V45)

Response	**%**	**N**
Agree	95	116
Disagree	5	6
TOTAL	**100**	**122**

4.2.2.7 Variable 46: You do not always act as your patient's advocate

Table 4.20 below shows that the majority of the participants, namely 93 (80%), disagree with the statement that they do not always act as patient advocates. Patient advocacy is a primary role of the nurse, and regardless of age or experience, should be always executed. Results show that the RNs demonstrated the highest advocacy for patients (mean = 1.56; SD = 1.95; SE = 0.25). The CGs demonstrated the least

advocacy (mean = -1.75; SD = 1.58; SE = 0.55). This could be attributed to the fact that CGs are not trained nurses. The participants in the wards demonstrated the most advocacy for the patients (mean = -0.94; SD = 1.95; SE = 0.33).

Table 4.20 You do not always act as your patient's advocate (n = 116)

Mean = -1.43; SD = 1.83; SE = 0.16 (Position/V46)

Mean = -1.44; SD = 1.84; SE = 0.16 (Area of work/V46)

Response	**%**	**N**
Agree	20	23
Disagree	80	93
TOTAL	**100**	**116**

4.2.2.8 Variable 47: You love to care for your patient

Table 4.21 below shows that the majority of the participants, namely 120 (99%), love to care for their patients. Results show that ENs love to care for their patients the most (mean = 2.95; SD = 0.22; SE = 0.05). Nurses working in maternity love to care for their patients the most above all other areas (mean = 2.92; SD = 0.27; SE = 0.07). These results show that nurses are still in the caring business.

Table 4.21 You love to care for your patient (n = 122)

Mean = 2.72; SD = 0.63; SE = 0.05 (Position/V47)

Mean = 2.71; SD = 0.63; SE = 0.05 (Area of Work/V47)

Response	**%**	**N**
Agree	99	120
Disagree	1	2
TOTAL	**100**	**122**

4.2.2.9 Variable 48: You are not always honest with the patient

Table 4.22 below shows that the majority of the participants, namely 74 (65%), disagree with the statement that they are not always honest with the patient. Results show that nurses working in maternity were the most honest with patients (mean = -2.000; SD = 1.29; SE = 0.35). The ward nurses show less honesty towards the patients (mean = -0.352; SD = -0.35; SE = 0.35). An alarming factor, although not statistically significant, is that 32% (39) of nurses were not always honest with patients.

Table 4.22 You are not always honest with the patient (n = 113)

Mean = -0.82; SD = 1.98; SE = 0.18 (Position/V48)

Mean = -0.83; SD = 1,99; SE = 0.18 (Area of Work/V48)

Response	**%**	**N**
Agree	35	39
Disagree	65	74
TOTAL	**100**	**113**

4.2.2.10 Variable 49: You safeguard the patient from unethical practice

Table 4.23 below shows that the majority of the participants, namely 109 (94%), safeguard the patient from unethical practice. Results between the participants show that registered nurses show the highest result in safeguarding the patient from unethical practice (mean = 2.50; SD = 0.86; SE = 0.11), the lowest being the ENs (mean = 1.68; SD = 1.88; SE = 0.43). Nurses in ICU mostly safeguarded patients from unethical practice (mean = 2.59; SD = 0.15; SE = 0.77), and those in the wards, the least (mean = 1.78; SD = 1.88; SE = 0.32).

Table 4.23 You safeguard the patient from unethical practice (n = 116)

Mean = 2.18; SD = 1.34; SE = 0.12 (Position/V49)

Mean = 2.20; SD = 1.33; SE = 0.12 (Area of Work/V49)

Response	**%**	**N**
Agree	94	109
Disagree	6	7
TOTAL	**100**	**116**

4.2.2.11 Variable 50: You do not assure patient confidentiality

Table 4.24 below shows that the majority of the participants, namely 99 (84%), disagree with the statement that they do not assure patient confidentiality. Results among the participants show that registered nurses (mean = -1.94; SD = 1.73; SE = 0.22) and management (mean = -2.00; SD = 1.26; SE = 0.24) mostly assured patient confidentiality. Enrolled nursing assistants did not assure patient confidentiality (mean = -0.50; SD = 2.00; SE = 0.70). Cognisance should be taken that patients are protected in this regard in accordance with the Bill of Human Rights.

Table 4.24 You do not assure patient confidentiality (n = 118)

Mean = -1.75; SD = 1.70; SE = 0.16 (Position/V50)

Mean = -1.75; SD = 1.79; SE = 0.16 (Area of Work/V50)

Response	**%**	**N**
Agree	16	19
Disagree	84	99
TOTAL	**100**	**118**

4.2.2.12 Variable 51: Nursing is not a caring and compassionate profession

Table 4.25 below shows that the majority of the participants, namely 107 (89%), disagree with the statement that nursing is not a caring and compassionate profession, while 13 (11%) agree that nursing is not a caring and compassionate profession. Maternity staff perceive nursing as a caring profession (mean = -2.846; SD = 0.37; SE = -3.07), while theatre staff do not (mean = -1.58; SD = 1.93; SE = 0.47). Enrolled nursing assistants also denied the statement (mean = -2.500; SD = 0.75; SE = 0.26).

Table 4.25 Nursing is not a caring and compassionate profession (n = 120)

Mean = -2.09; SD = 1.52; SE = 0.13 (Position/V51)

Mean = -2.08; SD = 1.52; SE = 0.13 (Area of Work/V51)

Response	**%**	**N**
Agree	11	13
Disagree	89	107
TOTAL	**100**	**120**

4.2.2.13 Variable 52: You believe in the Nurses' Pledge of service

Table 4.26 below shows that the majority of the participants, namely 113 (95%), believe in the Nurses' Pledge of service. However, the caregivers did not share this oath with the nurses (mean = 1.88; SD = 1.72; SE = 0.61), which could be attributed to the fact that they are not trained nurses and are not regulated by SANC.

Table 4.26 You believe in the Nurses' Pledge of service (n = 119)

Mean = -2.22; SD = 1.27; SE = 0.11 (Position/V52)

Response	**%**	**N**
Agree	95	113
Disagree	5	6
TOTAL	**100**	**119**

4.2.2.14 Variable 53: You are not loyal to the profession

Table 4.27 below shows that the majority of the participants, namely 109 (93%), disagree with the statement that they are not loyal to the profession. Results between the areas show that the nurses working in maternity (mean = -2.69; SD = 0.48; SE = 0.13) and the wards (mean = -2.54; SD = 0.75; SE = 0.13) were most loyal to the nursing profession. Caregivers (mean = -1.87; SD = 1.72; SE = 0.61) and ICU nurses (mean = -1.76; SD = 1.80; SE = 0.37) are the least loyal to the profession. This is attributed to the fact that the caregivers are not regulated by SANC.

Table 4.27 You are not loyal to the profession (n = 117)

Mean = -2.22; SD = 1.27; SE = 0.11 (Position/V53)

Mean = -2.21; SD = 1.28; SE = 0.22 (Area of Work/V53)

Response	**%**	**N**
Agree	7	8
Disagree	93	109
TOTAL	**100**	**117**

4.2.2.15 Variable 54: You market the profession positively

Table 4.28 below shows that the majority of the participants, namely 98 (94%), market the profession positively. Results show that enrolled nurses (mean = 2.10; SD = 1.04; SE = 0.24) market the profession positively, and registered nurses the least (mean = 1.61; SD = 1.39; SE = 0.18). Results also show that theatre nurses did not market the nursing profession positively (mean = 1.17; SE = 1.42; SE = 0.34).

Table 4.28 You market the profession positively (n = 104)

Mean = 1.73; SD = 1.26; SE = 0.11 (Position/V54)

Mean = 1.73; SD = 1.26; SE = 0.11 (Area of Work/V54)

Response	**%**	**N**
Agree	94	98
Disagree	6	6
TOTAL	**100**	**104**

4.2.2.16 Variable 55: You do not respect the noble tradition of the profession

Table 4.29 below shows that the majority of the participants, namely 108 (95%), disagree with not respecting the noble tradition of the profession. Results show that most nurses respect the noble tradition of the nursing profession, except for caregivers (mean = -1.12; SD = 2.16; SE = 0.76) and ICU staff (mean = -1.95; SD = 1.58; SE = 0.32).

Table 4.29 You do not respect the noble tradition of the profession (n = 114)

Mean = -2.05; SD = 1.23; SE = 0.11 (Position/V55)

Mean = -2.06; SD = 1.23; SE = 0.11 (Area of Work/V55)

Response	**%**	**N**
Agree	5	6
Disagree	95	108
TOTAL	**100**	**114**

4.2.2.17 Variable 56: Your right to privacy is respected

Table 4.30 below shows that the majority of the participants, namely 88 (81%), indicated that their privacy was respected. Results also show that caregivers indicated that their right to privacy was not respected (mean = 0.03; SD = 2.12; SE = 0.70), while management indicated it was respected (mean = 1.33; SD = 1.49; SE = 0.28). Subordinates and patients will easily respect management as they are in a more superior position, while the caregivers are not nurses and belong to the lowest rank in the clinical environment.

Table 4.30 Your right to privacy is respected (n = 108)

Mean = 1.08; SD = 1.57; SE = 0.14 (Position/V56)

Response	**%**	**N**
Agree	81	88
Disagree	19	20
TOTAL	**100**	**108**

4.2.2.18 Variable 57: You are loyal and committed to your company

Table 4.31 below shows that the majority of the participants, namely 114 (97%), indicated that they are loyal and committed to their company. Management (mean = 2.33; SD = 0.67; SE = 0.13) seems most loyal to their company, whereas ICU staff seem least loyal to their company (mean = 2.04; SD = 1.05; SE = 0.21). This is, however, not statistically significant.

Table 4.31 You are loyal and committed to your company (n = 118)

Mean = 2.15; SD = 1.09; SE = 0.09 (Position/V57)

Mean = 2.15; SD = 1.10; SE = 0.10 (Area of Work/V57)

Response	**%**	**N**
Agree	97	114
Disagree	3	4
TOTAL	**100**	**118**

4.2.2.19 Variable 58: You feel exploited in your area of work

Table 4.32 below shows that the majority of the participants, namely 51 (54%), indicated that they are exploited in their area of work. Results show that staff working in maternity (mean = 0.36; SD = 2.06; SE = 0.57), theatre (mean = 0.43; SD = 2.06; SE = 0.51) and management (mean = 0.40; SD = 1.88; SE = 0.48) are more exploited in their area of work. The results show that enrolled nurses (mean = -0.10; SD = 1.72; SE = 0.39) are not exploited, although assumptions were made that enrolled nurses functioned as registered nurses. This has proven the assumption in this regard as incorrect.

Table 4.32 You feel exploited in your area of work (n = 94)

Mean = -0.05; SD = 1.86; SE = 0.17 (Position/V58)

Mean = -0.04; SD = 1.87; SE = 0.17 (Area of Work/V58)

Response	**%**	**N**
Agree	54	51
Disagree	46	43
TOTAL	**100**	**94**

4.2.2.20 Variable 59: There is openness and transparency in your company

Table 4.33 below shows that the majority of the participants, namely 71 (77%), indicated that there is openness and transparency in their company, depending on the years in position (Spearman test p = 0.03) and years in the nursing profession (Spearman test p = 0.06 Management mostly agrees to transparency in the company (mean = 1.18; SD = 1.03; SE = 0.19), while ICU disagrees (mean = 0.20; SD = 1.25; SE = 0.25).

Table 4.33 There is openness and transparency in your company (n = 92)

Mean = 0.71; SD = 1.34; SE = 0.12 (Position/V59)

Mean = 0.72; SD = 1.34; SE = 0.12 (Area of Work/V59)

Response	**%**	**N**
Agree	77	71
Disagree	2317	21
TOTAL	**100**	**92**

4.2.2.21 Variable 60: Your salary does not match your responsibility

Table 4.34 below shows that the majority of the participants, namely 92 (83%), indicated that their salaries did not match their responsibility. Results also show that nurses with longer years in the nursing profession felt their salaries did not match their responsibility. This has been shown statistically significant (Spearman test p = 0.08). Nineteen (17%) were satisfied with the salaries they earned, which included caregivers (mean = 2.00; SD = 1.06; SE = 0.37). Registered nurses felt their salaries did not match their responsibilities (mean = 1.29; SD = 1.62; SE = 0.21).

Table 4.34 Your salary does not match your responsibility (n = 111)

Mean = 1.47; SD = 1.56; SE = 0.14 (Position/V60)

Response	**%**	**N**
Agree	83	92
Disagree	17	19
TOTAL	**100**	**111**

4.2.2.22 Variable 61: You function in an area where there is trust and common purpose

Table 4.35 below shows that the majority of the participants, namely 94 (92%), indicated that they functioned in an area where there is trust and common purpose. Results also show that caregivers indicated that they did not function in an area where there is trust and common purpose (mean = 0.50; SD = 2.07; SE = 0.73). Management agreed that there was trust and common purpose (mean = 1.66; SD = 1.04; SE = 0.27).

Table 4.35 You function in an area where there is trust and common purpose (n = 102)

Mean = 1.34; SD = 1.22; SE = 0.11 (Area of Work/V61)

Response	**%**	**N**
Agree	92	94
Disagree	8	8
TOTAL	**100**	**102**

4.2.2.23 Variable 62: You are unhappy in your area of work

Table 4.36 below shows that the majority of the participants, namely 91(93%), indicated that they disagreed with the statement that they were unhappy in their area of work. Results show that caregivers (mean = 0.12; SD = 2.29; SE = 0.81) and nurses working in the wards were mostly unhappy in their area of work (mean = -1.09; SD = 1.65; SE = 0.29). Management was least unhappy in their area of work (mean = -1.81; SD = 0.87; SE = 0.16).

Table 4.36 You are unhappy in your area of work (n = 98)

Mean = -1.22; SD = 1.56; SE = 0.14 (Position/V62)

Mean = -1.22; SD = 1.57; SE = 0.14 (Area of Work/V62)

Response	**%**	**N**
Agree	7	7
Disagree	93	91
TOTAL	**100**	**98**

4.2.3 Section C: Legal practice

4.2.3.1 Variable 63: There is a team approach from the multidisciplinary team

Table 4.37 below shows that the majority of the participants, namely 91 (89%), indicated that there was a team approach from the multidisciplinary team. Results also show that enrolled nursing assistants (mean = 0.50; SD = 1.77; SE = 0.62), as well as theatre nurses (mean = 0.88; SD = 1.36; SE = 0.33), did not agree there was a multidisciplinary approach. Theatre nurses agreed with this statement.

Table 4.37 There is a team approach from the multidisciplinary team (n = 102)

Mean = 1.23; SD = 1.34; SE = 0.12 (Position/V63)

Mean = 1.23; SD = 1.35; SE = 0.12 (Area of Work/V63)

Response	**%**	**N**
Agree	89	91
Disagree	11	11
TOTAL	**100**	**102**

4.2.3.2 Variable 64: You do not function within your scope of practice

Table 4.38 below shows that the majority of the participants, namely 94 (82%), disagreed about not functioning within their scope of practice**.** Results also show that enrolled nursing assistants (mean = 0.25; SD = 2.12; SE = 0.75) and caregivers (mean = 0.88; SD = 2.08; SE = 0.69) did not always function within their scope of practice.

Table 4.38 You do not function within your scope of practice (n = 114)

Mean = -1.41; SD = 1.72; SE = 0.15 (Position/V57)

Response	**%**	**N**
Agree	18	20
Disagree	82	94
TOTAL	**100**	**114**

4.2.3.3 Variable 65: You take responsibility and accountability for your actions

Table 4.39 below shows that all the participants, namely 122 (100%), indicated that nurses took responsibility and accountability for their actions. Overtime, responsibility and accountability for their own actions in nursing have been shown as statistically significant (Spearman test p = 0.05).

Table 4.39 You take responsibility and accountability for your actions (n = 122)

Response	**%**	**N**
Agree	100	122
Disagree	0	0
TOTAL	**100**	**122**

4.2.3.4 Variable 66: You feel free to discuss your patients' progress with the doctor

Table 4.40 below shows that the majority of the participants, namely 107 (96%), indicated that they felt free to discuss their patients' progress with the doctor. Results show statistical significance (Spearman test p = 0.04) between the years of experience and nurses who felt free to discuss patients' progress with the doctor. Management felt at ease (mean = 2.33; SD = 0.78; SE = 0.15), but caregivers felt least likely to do so (mean = 1.66; SD = 1.73; SE = 0.57). Theatre nurses did not feel free to discuss patients' progress with the doctor (mean = 1.29; SD = 1.15; SE = 0.28).

Table 4.40 You feel free to discuss your patients' progress with the doctor (n = 111)

Mean = 1.95; SD = 1.21; SE = 0.11 (Position/V66)

Mean = 1.96; SD = 1.21; SE = 0.11 (Area of Work/V66)

Response	**%**	**N**
Agree	96	107
Disagree	4	4
TOTAL	**100**	**111**

4.2.3.5 Variable 67: You function within the legal guidelines of your profession

Table 4.41 below shows that the majority of the participants, namely 113 (97%), indicated that they functioned within the legal guidelines of their profession. Results also show that enrolled nurses (mean = 1.21; SD = 1.84; SE = 0.42) in ICU did not always function within the legal guidelines of the profession, although it is not statistically significant. Maternity staff felt they did function within legal guidelines (mean = 2.29; SD = 0.51; SE = 0.14).

Table 4.41 You function within the legal guidelines of your profession (n = 117)

Mean = 2.06; SD = 1.22; SE = 0.11 (Position/V67)

Mean = 2.07; SD = 1.22; SE = 0.11 (Area of Work/V67)

Response	**%**	**N**
Agree	97	113
Disagree	3	4
TOTAL	**100**	**117**

4.2.3.6 Variable 68: You do not understand your scope of practice

Table 4.42 below shows that the majority of the participants, namely 113 (97%), indicated that they disagreed with not understanding their scope of practice. Results also show that the enrolled nursing assistants least understood their scope of practice (mean = -1.00; SD = 1.91; SE = 0.72) and ward nurses (mean = -1.93; SD = 1.41; SE = 0.24). Although only 3 % (4) nurses claimed they did not understand their scope of practice, it is alarming, as nurses need to be familiar with their legal and ethical framework.

Table 4.42 You do not understand your scope of practice (n = 120)

Mean = -2.15; SD = 1.24; SE = 0.11 (Position/V68)

Mean = -2.16; SD = 1.24; SE = 0.11 (Area of Work/V68)

Response	**%**	**N**
Agree	5	6
Disagree	95	114
TOTAL	**100**	**120**

4.2.3.7 Variable 69: You adhere to the patient's rights at all times

Table 4.43 below shows that the majority of the participants, namely 114 (95%), indicated that they adhered to the patient's rights at all times. Results also show that caregivers least adhered to the patient's rights (mean = 1.66, SD = 1.22; SE = 0.40) in contrast with the maternity staff who mostly adhered to the patient's rights (mean = 2.46; SD = 0.66; SE = 0.18). Caregivers are not trained nurses and are only trained in a specific task, and not comprehensively, and will therefore not have the understanding and insight into the practice of providing holistic patient care.

Table 4.43 You adhere to the patient's rights at all times (n = 120)

Mean = 2.11; SD = 1.07; SE = 0.09 (Position/V69)

Mean = 2.12; SD = 1.07; SE = 0.09 (Area of Work/V69)

Response	**%**	**N**
Agree	95	114
Disagree	5	6
TOTAL	**100**	**120**

4.2.3.8 Variable 70: Nurses' rights are respected in your area of work

Table 4.44 below shows that the majority of the participants, namely 75 (73%), indicated that the nurses' rights are respected in their area of work. Results also show that caregivers' rights are the least respected (mean = 0.44; SD = 1.87; SE = 0.62), and those of management the most (mean = 1.25; SD = 1.50; SE = 0.29). Theatre nurses indicated that their rights are not respected (mean = -0.00; SD = 1.87; SE = 0.45). In the nursing profession the lowest rank tends to receive the least respect, while the highest ranks score highest in this regard. Caregivers are not part of the nursing profession and form the lowest rank in the work environment.

Table 4.44 Nurses' rights are respected in your area of work (n = 103)

Mean = 0.79; SD = 1.65; SE = 0.15 (Position/V70)

Mean = 0.78; SD = 1.66; SE = 0.15 (Area of Work/V70)

Response	**%**	**N**
Agree	73	75
Disagree	27	28
TOTAL	**100**	**103**

4.2.3.9 Variable 71: Nurses' rights are in contradiction with patients' rights

Table 4.45 below shows that the majority of the participants, namely 57 (65%), disagree that nurses' rights are in contradiction with patients' rights. It is, however, a cause for concern that 31 (35%) of the participants agree that nurses' rights are in contradiction with patients' rights. Results also show that enrolled nurses agreed with nurses' rights being in contradiction with patients' rights (mean = 0.17; SD = 1.84; SE = 0.44). Results show statistical significance between whether the nurses' rights are in contradiction with the patients' rights and years of experience (Spearman test p = 0.01); between the years in current position (Spearman test p = 0.09) and between age groups (Spearman test p = 0.08).

Table 4.45 Nurses' rights are in contradiction with patients' rights (n = 88)

Mean = -0.45; SD = 1.60; SE = 0.14 (Position/V71)

Response	**%**	**N**
Agree	35	31
Disagree	65	57
TOTAL	**100**	**88**

4.2.3.10 Variable 72: Your working environment is unsafe for the optimal functioning of nurses

Table 4.46 below shows that the majority of the participants, namely 102 (87%), agreed that the working environment was unsafe for their optimal functioning. According to the results, enrolled nursing assistants agreed that the working environment is unsafe to function in (mean = 0.00; SD = 2.13; SE = 0.75), while ICU nurses agreed on a lesser scale (mean = -1.20; SD = 2.08; SE = 0.42).

Table 4.46 Your working environment is unsafe for the optimal functioning of nurses (n = 117)

Mean = -1.59; SD = 1.60; SE = 0.14 (Position/V72)

Mean = -1.58; SD = 1.60; SE = 0.14 (Area of Work/V72)

Response	**%**	**N**
Agree	87	102
Disagree	13	15
TOTAL	**100**	**117**

4.2.3.11 Variable 73: Your company adheres to all legislative regulations

Table 4.47 below shows that the majority of the participants, namely 90 (88%), agree that their company adheres to all legislative regulations. Results also show that enrolled nursing assistants felt that their company did not adhere to legislative regulations (mean = 0.75; SD = 2.18; SE = 0.77).

Table 4.47 Your company adheres to all legislative regulations (n = 102)

Mean = 1.47; SD = 1.47; SE = 0.13 (Position/V73)

Response	**%**	**N**
Agree	88	90
Disagree	12	12
TOTAL	**100**	**102**

4.2.3.12 Variable 74: You are not participating in continuous professional development

Table 4.48 below shows that the majority of the participants, namely 95 (86%), disagreed to the statement that they did not participate in professional development**.** Results also show that ward nurses were not involved in continuous professional development (mean = 0.72; SD = 1.73; SE = 0.30), but that enrolled nurses showed the highest involvement in this regard (mean = -1.00; SD = 1.69; SE = 0.38).

Table 4.48 You are not participating in continuous professional development (n = 110)

Mean = -1.39; SD = 1.58; SE = 0.14 (Position/V74)

Mean = -1.39; SD = 1.59; SE = 0.14 (Area of Work/V74)

Response	**%**	**N**
Agree	14	15
Disagree	86	95
TOTAL	**100**	**110**

4.2.3.13 Variable 75: You feel you are skilled and competent to perform your duties

Table 4.49 below shows that the majority of the participants, namely 95 (86%), agreed that they were skilled and competent to perform their duties. Results show that enrolled nursing assistants were least the skilled and competent (mean = 1.37; SD = 2.06; SE = 0.73). This is not statistically significant.

Table 4.49 You feel you are skilled and competent to perform your duties (n = 120)

Mean = 2.10; SD = 1.14; SE = 0.10 (Position/V75)

Response	**%**	**N**
Agree	95	114
Disagree	5	6
TOTAL	**100**	**120**

4.2.3.14 Variable 76: You do not have a formal contract with your employer

Table 4.50 below shows that the majority of the participants, namely 108 (92%), agreed that they had no formal contracts with their employers. A statistical result of significance was obtained between not having a formal contract and overtime worked (Spearman p = 0.06).

Table 4.50 You do not have a formal contract with your employer (n = 118)

Response	**%**	**N**
Agree	92	108
Disagree	8	10
TOTAL	**100**	**118**

4.2.3.15 Variable 77: Your basic conditions of employment are met

Table 4.51 below shows that the majority of the participants, namely 98 (88%), agreed that their basic conditions of employment are met. Results also show that nurses working in theatre felt their basic conditions were not met (mean = 0.82; SD = 1.94; SE = 0.47). The researcher believes that theatre nurses' working hours impact negatively on their social lives, which might lead to unhappiness or a feeling that basic conditions were not met. Results show a statistical association between basic conditions of employment, age (Spearman test p = 0.08) and overtime (Spearman test p = 0.05).

Table 4.51 Your basic conditions of employment are met (n = 111)

Mean = 1.54; SD = 1.44; SE = 0.13 (Area of Work/V77)

Response	**%**	**N**
Agree	88	98
Disagree	12	13
TOTAL	**100**	**111**

4.2.3.16 Variable 78: You do not address patient safety in all aspects of care

Table 4.52 below shows that the majority of the participants, namely 105 (88%), disagreed with the statement that they do not address patient safety in all aspects of care. Results also show that registered nurses disagreed (mean = -2.10; SD = 1.31; SE = 0.17), and enrolled nursing assistants agreed (mean = -1.00; SD = 1.77; SE = 0.62). This is not statistically significant.

Table 4.52 You do not address patient safety in all aspects of care (n = 119)

Mean = -1.89; SD = 1.50; SE = 0.13 (Position/V78)

Response	**%**	**N**
Agree	12	14
Disagree	88	105
TOTAL	**101**	**119**

4.2.3.17 Variable 79: You inform patients and families of potential risks

Table 4.53 below shows that the majority of the participants, namely 92 (87%), inform patients and families of potential risks. A statistical association was identified between nurses informing patients of potential risks and the years of experience (Spearman test p = 0.02). The results also show that maternity nurses were most

concerned about this aspect (mean = 1.92; SD = 1.18; SE = 0.32), and theatre nurses the least (mean = 1.06; SD = 1.94; SE = 0.48).

Table 4.53 You inform patients and families of potential risks (n = 106)

Mean = 1.46; SD = 1.40; SE = 0.12 (Area of Work/V79)

Response	**%**	**N**
Agree	87	92
Disagree	13	14
TOTAL	**100**	**106**

4.2.3.18 Variable 80: You promote and support infection control

Table 4.54 below shows that the majority of the participants, namely 114 (95%), promote and support infection control. Results also show that management mostly promoted infection control (mean = 2.46; SD = 0.83; SE = 0.21).

Table 4.54 You promote and support infection control (n = 120)

Mean = 2.16; SD = 1.08; SE = 0.09 (Area of Work/V80)

Response	**%**	**N**
Agree	95	114
Disagree	5	6
TOTAL	**100**	**120**

4.2.3.19 Variable 81: As an enrolled nursing assistant, you function under direct supervision

Table 4.55 below shows that the majority of the participants, namely 40 (87%), indicated that enrolled nursing assistants functioned under direct supervision (mean = 1.66; SD = 1.50; SE = 0.61). In total, 26 (65%) of registered nurses were the least in agreement (mean = 0.653; SD = 1.19; SE = 0.23) with the perception of enrolled nursing assistants. It was statistically significant (Spearman test p = 0.05) that this depended entirely on the age of the nurses.

Table 4.55 As an enrolled nursing assistant, you function under direct supervision (n = 46)

Mean = 1.12; SD = 1.34; SE = 0.16 (Position/V81)

Response	**%**	**N**
Agree	87	40
Disagree	13	6
TOTAL	**100**	**46**

4.2.3.20 Variable 82: As an enrolled nursing assistant, you function under indirect supervision

Table 4.56 below shows that the majority of the participants, namely 23 (53%), indicated that enrolled nursing assistants functioned under indirect supervision. Results indicated that enrolled nursing assistants who participated felt they did not function under indirect supervision (mean = -2.00; SD = 1.00; SE = 0.44), although registered nurses felt they did (mean = 0.12; SD = 1.36; SE = 0.22). Statistical results of significance were obtained between enrolled nursing assistants functioning under indirect supervision and years in current position (Spearman test p = 0.06) and years in nursing (Spearman test p = 0.00).

Table 4.56 As an enrolled nursing assistant, you function under indirect supervision (n = 43)

Mean = 0.01; SD = 1.74; SE = 0.22 (Position/V82)

Response	**%**	**N**
Agree	53	23
Disagree	47	20
TOTAL	**100**	**43**

4.2.3.21 Variable 83: As an enrolled nurse, you function under direct supervision

Table 4.57 below shows that the majority of the participants, namely 40 (87%), indicated that enrolled nurses functioned under direct supervision. Results show that enrolled nurses (n = 18) who participated agreed that they functioned under direct supervision, although registered nurses (n = 24) disagreed (mean = 0.68; SD = 1.24; SE = 0.24). Enrolled nurses in maternity wards functioned under direct supervision (mean = 1.80; SD = 1.30; SE = 0.58), while enrolled ward nurses did not (mean = 0.95; SD = 1.43; SE = 0.31).

Table 4.57 As an enrolled nurse, you function under direct supervision (n = 46)

Mean = 1.07; SD = 1.36; SE = 0.16 (Position/V83)

Mean = 1.07; SD = 1.37; SE = 0.17 (Area of Work/V83)

Response	**%**	**N**
Agree	87	40
Disagree	13	6
TOTAL	**100**	**46**

4.2.3.22 Variable 84: As an enrolled nurse, you function under indirect supervision

Table 4.58 below shows that the majority of the participants, namely 24 (55%), indicated that enrolled nurses functioned under indirect supervision. Results also show that enrolled nurses (n = 15) who participated felt that they functioned under indirect supervision. Registered nurses (n = 24) who participated felt that enrolled nurses did not function under indirect supervision (mean = 0.33; SD = 1.83; SE = 0.47). Enrolled nurses work under indirect supervision mostly in maternity wards (mean = 0.80; SD = 2.48; SE = 1.11) and least in ICU (mean = 0.84; SD = 1.77; SE = 0.49). Because of staff shortages in the ICUs, other categories of staff assist with nursing functions. Statistical results of significance were obtained between enrolled nurses functioning under indirect supervision and years in current position (Spearman test p = 0.03).

Table 4.58 As an enrolled nurse, you function under indirect supervision (n = 44)

Mean = 0.04; SD = 1.75; SE = 0.22 (Position/V84)

Mean = 0.03; SD = 1.76; SE = 0.22 (Area of Work/V84)

Response	**%**	**N**
Agree	55	24
Disagree	45	20
TOTAL	**100**	**44**

4.2.3.23 Variable 85: As a registered nurse, you take responsibility for delegating functions

Table 4.59 below shows that the majority of the participants, namely 97 (99%), indicated that registered nurses took responsibility of delegating functions. In total, 57 (54%) of the registered nurses who participated felt they did take responsibility for delegating functions (mean = 2.47; SD = 0.82; SE = 0.10). Statistically significant

association was identified between registered nurses delegating functions and the years in their current position (Spearman test p = 0.06).

Table 4.59 As a professional nurse, you take responsibility for delegating functions (n = 98)

Mean = 2.31; SD = 0.97; SE = 0.09 (Position/V)

Response	**%**	**N**
Agree	99	97
Disagree	1	1
TOTAL	**100**	**98**

4.2.3.24 Variable 86: Caregivers assist the nursing staff with interventional nursing care

Table 4.60 below shows that the majority of the participants, namely 53 (60%), indicated that they disagreed about caregivers assisting the nursing staff with interventional care. However, it is still a cause for concern that 36 (40%) of respondents agree that caregivers do assist with interventional procedures. Results also show that caregivers did assist with interventional care in the wards (mean = 0.14; SD = 2.13; SE = 0.40). Registered nurses disagreed that caregivers assisted with interventional care (mean = -1.02; SD = 1.83; SE = 0.26), but enrolled nurses felt they did assist with interventional care (mean = 0.56; SD = 2.15; SE = 0.53). Statistical significance was identified between caregivers assisting nursing staff with interventional nursing care and their years of service (Spearman test p = 0.05) and age groups (Spearman p = 0.03). As non-nurses, caregivers should function within their scope of practice. Medico-legal actions and the safety of patients are at risk. The researcher feels that caregivers should be regulated, because they are associated with nursing.

Table 4.60 Caregivers assist the nursing staff with interventional nursing care (n = 89)

Mean = -0.605; SD = 2.03; SE = 0.19 (Position/V86)

Mean = -0.62; SD = 3.03; SE = 0.30 (Area of Work/V86)

Response	**%**	**N**
Agree	40	36
Disagree	60	53
TOTAL	**100**	**89**

4.2.3.25 Variable 87: Caregivers do not perform nursing duties

Table 4.61 below shows that the majority of the participants, namely 90 (88%), indicated that caregivers did not perform nursing duties. Results also show that enrolled nursing assistants (mean = -0.714; SD = 1.49; SE = 0.56) and enrolled nurses (mean = -0.26; SD = 1.96; SE = 0.45) agreed that caregivers did assist with nursing functions. Nurses working in the wards also indicated that caregivers did assist with nursing functions (mean = 0.27; SD = 2.11; SE = 0.39). Management (mean = 1.03; SD = 1.70; SE = 0.33) and registered nurses (mean = 1.03; SD = 1.84; SE = 0.26) indicated that caregivers did not perform nursing duties.

Table 4.61 Caregivers do not perform nursing duties (n = 102)

Mean = 0.63; SD = 1.89; SE = 0.17 (Position/V87)

Mean = 0.63; SD = 1.90; SE = 0.18 (Area of Work/V87)

Response	**%**	**N**
Agree	88	90
Disagree	12	12
TOTAL	**100**	**102**

4.2.3.26 Variable 88: You feel free to follow the grievance procedure

Table 4.62 below shows that the majority of the participants, namely 86 (86%), feel free to follow the grievance procedure. Results also show that there is a statistical significance between nurses following the grievance procedure and years in current position (Spearman test p = 0.07) and between age (Spearman test p = 0.04).

Table 4.62 You feel free to follow the grievance procedure (n = 100)

Response	**%**	**N**
Agree	86	86
Disagree	14	14
TOTAL	**100**	**100**

4.3 CONCLUSION

An extensive analysis of the factors influencing the clinical practice of the nurse has been completed. The quantitative data was analysed using frequency tables for applying statistical tests.

The objectives that were set for the study were compared to the results of the survey, and recommendations were made based on the scientific evidence obtained in this study.

The questions that were posed as a point of departure for this study are summarised below. The outcome is also briefly discussed.

The following objectives and results are discussed briefly.

- *Whether nurses function within their scope of practice*: Enrolled nursing assistants do not function within their scope of practice. It was statistically significant (Spearman test p = 0.05) that this depended entirely on the age of the nurses. Statistical results of significance were obtained between enrolled nursing assistants functioning under indirect supervision and years in current position (Spearman test p = 0.06) and years in nursing (Spearman test p = 0.00).
- *Whether nurses know and exercise their nursing rights*: The nurses' rights are not respected in some areas, depending on qualification and status. Results also show that caregivers' rights were least respected and those of management the most.
- *Whether nurses are being exploited in the work place*: The majority of the participants, namely 51 (54%), indicated that they are exploited in their area of work**.** Results show that caregivers and enrolled nursing assistants are most often exploited in their area of work.
- *Whether nurses function within the legal guidelines*:The majority of the participants, namely 113 (97%) indicated that they functioned within the legal guidelines of their profession. Results also show that enrolled nurses in ICU did not always function within the legal guidelines of the profession, although it is not statistically significant.
- *Whether caregivers contribute to nursing care*: Statistical significance was identified between caregivers assisting nursing staff with interventional nursing care and their years of service (Spearman test p = 0.05) and age (Spearman test p = 0.00).
- *Whether nurses work more than ten hours overtime a week*:Nurses work more than 40 hours overtime a month. According to the Spearman test there was a correlation between age and overtime worked (p = -0.05).

- *Whether nurses still believe in the nursing philosophy*:Results show that most nurses respect the noble tradition of the nursing profession, excepting caregivers.
- *Whether nurses act ethically*:Nurses need to re-affirm the ethical guidelines of the profession. Ethics and legal guidelines are like a mother and baby, and cannot be separated.A statistical association was identified between the number of years in current position and respect for all religions (Spearman test $p = 0.04$).

CHAPTER 5
RECOMMENDATIONS

5.1 INTRODUCTION

In the light of the findings of this study, the researcher believes that nurses are utilised outside their scope of practice, while a lower category of staff is taking on more responsibilities than they are skilled for. Nurses need to adhere to the ethical and legal guidelines of their profession. Inadequate staffing can result in poor nursing care and burn-out among nursing staff.

The legislative framework within which the nurse and midwife practise with regard to safe nursing care is stipulated in the Nursing Act (1978). The Scope of Practice, Regulation 2598 and Acts and Omissions, Regulation 387 as promulgated by the Nursing Act (Act No. 50 of 1978), guide the practice of the professional registered nurse. In the event of registered nurses contravening these regulations, such nurses may be held legally accountable for their actions or omissions. Registered nurses should adhere to the nursing regulations guiding their clinical practice in order to provide safe nursing care.

The researcher believes that staff shortages cause nurses to act unethically and illegally, resulting in medical errors. As individual practitioners, nurses need to take responsibility and accountability for their actions, addressing concerns with nurse leaders and forums, and giving quality care. Unprofessional conduct and sloppy ethics are a shame to the profession and should be guarded against. The patient's and nurse's rights should not be in contradiction with each other, but should be treated with respect.

5.2 RECOMMENDATIONS

5.2.1 Recruitment

According to statistics the average age of nurses registered in South Africa is 40 (South African Nursing Council, 2007) and 53 000 nurses will be retiring in 2016 (South African Nursing Council, 2007). Another challenge nursing recruiters face is presenting the job in an appealing way. Since the shortage has placed nurses in such high demand, the job prospects for nurses are certainly better than many other current job opportunities. The South African government does not support the recruitment of health professionals from any developing country, for ethical reasons.

Some experts estimate that the enrolment numbers for younger people entering nursing programmes would have to increase exponentially to meet the demand for nurses as older registered nurses retire from the work force. These retired registered nurses need to be recruited to return to the profession, provided they are evaluated physically and mentally. The country needs nurses and nursing managers should be creative in the packages they offer to older nurses. Flexible working hours could once again attract retired nurses to the work force.

Another challenge nursing recruiters face is that of presenting the job in an appealing way. The wages of nurses are often in stark contrast with the work pressure and risks they face. Benefits such as remuneration for overtime, night duty, specialisation allowances, adequate accommodation, travel or car allowances and subsidised meals during long working hours are often not adequately provided.

5.2.2 Overtime

The research has indicated that nurses work more overtime than stipulated by the Basic Conditions of Employment Act. The Spearman test determined that there was a correlation between age and overtime worked ($p = -0.05$). The age group 40–49 worked more overtime, with registered nurses working the most overtime. Nurses taking their statuary leave work overtime through nursing agencies at other hospitals. Nurses work in 12-hour shifts, sometimes back to back. This has serious consequences for both the hospital and patient care. Nurses working long hours and overtime become weary, as their jobs require them to care for more patients than would have been the case if the hospital had an adequate supply of nurses. The researcher believes that the nursing shortage is increasing the risk of medical errors, because there are simply not enough nurses present to provide safe care for all the patients.

Recommendation

Overtime should be managed by the employer. Management cannot simply ignore the fact that nurses work more overtime than stipulated. Nursing agencies must ensure that employees do not abuse the system in order to earn more money. Statutory leave is to be taken as stipulated to prevent burn-out of staff.

5.2.3 Specialised units

The inadequate staffing in ICUs is a major concern. The researcher believes that the majority of medical errors occurring in ICUs are a result of the nursing shortage,

which again results in a lack of competency. Statistics (South African Nursing Council, 2005) indicate that in 2005 there were 2 593 trained ICU nurses and 2 962 trained OT nurses. These ICU nurses are hardly enough for the private sector with its 1 871 specialised beds.

Recommendation

Twenty-seven per cent of the nurses indicated that they would not recommend the nursing profession, of which theatre had the highest score (Table 4.10). Theatre staff work unsociable hours, and are often called out for cold cases and not for emergencies. Although theatres generate more income, management has to establish ways to utilise theatres more efficiently during the day, limiting the numbers of call-out.

Nursing managers are responsible for determining the staffing requirements for the units, based on the competency of staff and acuity of patients. Team nursing could be implemented successfully for the high-care patients by reducing the work load. In a team nursing approach, the team leader is the registered nurse, with other nurses supporting and providing the care needed by the patient. The team leader is responsible for a group of patients and should delegate patient care. The team approach can be very successful, provided that the registered nurse takes responsibility for his or her team by guiding and supporting them.

The advantages of team nursing are

- the registered nurse develops his or her leadership skills;
- individual skills and knowledge of each nurse are emphasised;
- patients are, on the whole, more satisfied with the care, because more nurses are taking care of them; and
- an adequate staffing and skills mix has a significant impact on the quality and safety of health care.

5.2.4 Career development

The majority of the participants, namely 70%, have indicated that they were not thinking of changing their profession, while 30% of the total sample indicated that they were thinking of changing their profession (Table 4.12). A statistical significant association has been identified between nurses' position and whether nurses were thinking of changing their profession (Chi-square test $p = 0.05$). With so many nurses leaving their current positions or retiring because of job burn-out, attracting more

nurses to these positions can be a daunting task. Career develoment planning on staff, developing their skills and knowledge for career advancement should be done at all staff levels.

Recommendation

There is a big need to revise qualifications for the future, in order to meet the demands of new programmes. Nurses need to be aware of different career paths, accommodating their individual interests. Continuous professional development must be encouraged and facilitated by the employers, stimulating adult learning. Nursing managers should know their staff's competencies and utilise them safely, preventing burn-out.

Retention strategies are very important for retaining staff that have been recruited.The failure of retention strategies result in the following:

- Increased provider cost
- Threatened quality of care
- Disrupted organisation function
- Decreased team efficiency
- A loss in institutional knowledge

5.2.5 Emigration

The decision of health workers to emigrate is influenced not only by their social and financial circumstances, but also the economic and political environment surrounding them. Nurse emigration is facilitated by active recruitment of some receiving countries due to domestic shortage of health personnel. Many recruitment agencies make the travel arrangements and organise employment and accommodation in the receiving countries.

In this study, 23% of nurses are thinking of emigrating. (Table 4.13). A total of 13 500 nurses are currently working overseas, while there are 32 000 vacant positions locally (WHO, 2006). Although the emigration of nurses is affecting South Africa, additional training and specialisation are gained, which are valuable when nurses return to South Africa.

Table 5.1 Registered nurse numbers

	Registered nurses	**23% emigrating**	**30% change profession**
RN	101 295	23 297	30 388
EN	39 305	9 040	11 791
ENA	56 314	12 952	16 894
Total	**196 914**	**45 289**	**59 073**

(South African Nursing Council, 2007)

Recommendation

Huge recruitment drives are needed to market nursing positively, recruiting South African nurses to return to South Africa. Many health care groups have opportunities for staff to work abroad, and nurses need to be aware of these opportunities. Much effort is required to improve the image of nursing.

Policies have to be implemented to attract RNs back to South Africa. A joint effort between the private sector and the Department of Health should be initiated, encouraging nurses to return to the country. Retaining RNs should consist of a continuous drive to address concerns relating to the quality of nurses' work life. Indian nurses currently being introduced to the health care in South Africa fill many gaps. The South African rand cannot compete with the British pound, but a more sustained effort can be made to remunerate nurses for what they are worth.

The factors that lead to the emigration of health workers are often categorised into push and pull factors. Push factors are those factors that encourage health care workers to leave their place of work. Pull factors are those factors at the place of destination that attract health workers.

5.2.6 Staff burn-out

Burn-out, as described by Tappen (1995:454), refers to a state of emotional exhaustion, a depletion of energy that seems to be a particular problem for people in helping professions.

Nursing is not a nine-to-five job and consists predominantly of female nurses. The strain placed on family lives influences all family members. Female nurses, however, feel a bigger responsibility for their personal life and are less inclined to abandon

their families. Odd working hours and long shifts place extra strain on marriages and play a part in the high divorce rate amongst nurses. According to research it is estimated that 7 to 10% of nurses become chemically dependent in an effort to cope.

Recommendation

Much of the responsibility for enhancing the environment of the work place rests with upper level management, consisting of people who have the authority and resources to encourage organisation-wide growth and change. Special incentives for reward and recognition should be implemented to keep the fires of staff enthusiasm burning. Safe working conditions should be the manager's primary responsibility, focussing on staffing levels, competencies and skills. No one feels comfortable in an environment where there is no support, therefore it is essential to invest in mentoring and coaching programmes.

There should be a balance between work, leisure and family life. Reduced hours or part time positions may be offered. Creativity in the offering of flexible working hours is a big attraction for mothers with children.

Succession planning revolves around evaluating future leadership or unlocking talent in potential candidates, and should be managed properly. Equity and fairness are principles attracting staff and portray the image of the organisation.

5.2.7 Trade unions

The data analysis indicated that 60% of the nurses in private health care do not belong to professional trade unions (Table 4.9). These results could be attributed to the fact that private hospitals make use of employee forums. In an indirect way staff are not encouraged to join trade unions, but to utilise the employee forums for addressing concerns.

Recommendations

Employee forums should be established to encourage staff to discuss concerns at work, ensuring quality of work life, equity and fairness in the work place. Companies should realise the worth of sound relationships in the work place. All employees, notwithstanding their roles and responsibilities, should strive for productive working relationships in order to achieve both personal and company objectives.

The following is recommended (Booyens, 1998:674):

- Promote the interests of all employees at the work place.
- Increase efficiency in the work place.
- Engage in consultation on certain matters .
- Ensure joint decision making on issues such as disciplinary codes and procedures.
- Introduce rules regarding conduct and behaviour.
- Take measures to protect individuals against discrimination.
- Make changes to the rules applicable to social benefits.

The nursing service manager has a legal obligation to prevent strike action by means of quality human resource management. The nursing staff have certain professional-ethical and legal responsibilities regarding the promotion of health care in a nursing service, but they also have fundamental human rights that need to be respected. The protection of these human rights has to be included in the human resource management strategy. Industrial relations policies must, however, operate within a value system that is acceptable to all stakeholders, employees, customers, shareholders and the community.

5.2.8 Ethical practice

5.2.8.1 Culture and religion

Ethical rules of conduct must ensure that actions of individuals do not cause harm to others. A statistical association was identified with the number of years in current position and respect for all religions (Spearman test p = 0.04). Nurses need to be non-judgemental, respecting the autonomy of the patient (Table 4.14).

Recommendation

A yearning to care, regardless of colour, religion, culture or social standing, should be the nurses' first consideration, regardless of their years of experience. Diversity culture workshops can be arranged, making staff aware of different cultures and religion and teaching them be more tolerant of others. Every person has an inherent dignity and a right to have their dignity respected and protected, as stated by the Bill of Human Rights (c 2).

In providing care, the nurse promotes an environment in which human rights, values, customs and beliefs of the individual, family or community are respected. Nurses

need to safeguard the trust of the patients and act in a manner consistent with their professional responsibilities.

Diversity enriches our lives and brings together the resources and talents of many people. People may fear diversity simply because they are accustomed to the way things used to be, and because change makes them uncomfortable.

Key principles to improve employee relationships:

- Treat others with respect.
- Avoid using stereotypes.
- Make it clear that prejudice is wrong.
- Do not allow bigoted comments by others, even friends or family members.
- Teach children to resist bias – be a role model.

5.2.8.2 Patient autonomy

The majority of the participants (88%) have indicated that they acknowledge patient autonomy, and 12% do not acknowledge autonomy. Caregivers least acknowledge patient autonomy.

Recommendation

The principle of autonomy is one enjoying particular prominence in modern health care. Autonomy is the principle by which a client is given sufficient information about health care and then permitted to decide for him- or herself about treatment. Adults without mental health problems should be able to understand the benefits and drawbacks of their planned treatment and care.

Health care is a right of all individuals, regardless of financial, political or other factors. The public outcry against incidences of adverse effects in hospital environments and clinics are reported by the media on a daily basis, and demonstrates the nature of society. The autonomy of the patient is stipulated in the Constitution of the Republic of South Africa (Act No. 108), the “Patient’s Right Charter”. All patients need to be respected.

5.2.8.3 Abusive patients

Statistics show that the majority of the participants, namely 56%, have indicated that they experience verbal abuse from patients (Table 4.17). Although the patient

generates income for the hospital, patients need to understand their responsibilities as well.

Recommendation

The rights of the nurse include an environment that is free of threats, intimidation and/or interference. Patients sometimes feel threatened and fearful of health care institutions, and the nurse needs to understand the patient in totality. Junior nurses are not competent and confident enough to address situations like these and senior staff should be of assistance in finding solutions.

The principle of ubuntu implies the following (Haegert, 2007):

- Compassionate caring that is ethical, showing respect and dignity to patients and students.
- Maintaining group solidarity (i.e. working with the community, having a united teaching approach/capacity).
- Sustaining justice through fairness and tolerance.
- Community survival (i.e. enabling communities to be self-sustaining/health promoting through the training and education of competent practitioners).

5.2.8.4 Patient advocacy and doctor involvement

The majority of the participants, namely 96%, indicated that they felt free to discuss their patient's progress with the doctor. Results show a statistical significance (Spearman test $p = 0.04$) between the years of experience and nurses who felt free to discuss the patient's progress with the doctor (Table 4.20).

Recommendation

A nurse must always act within her scope of competence, and record everything he or she does. Nurses' responsibility is toward the patient and family, and is always aimed at protecting the patient against harm, abuse, neglect and deprivation. The nurse has a duty to develop confidence in order to provide effective caring, and should therefore not be intimidated by colleagues or medical practitioners. The nurse and doctor should form a skilled and knowledgeable team, seeking to do their best for the patient.

Doctors expect nurses to give quality, competent and skilled care, while nurses need doctors to acknowledge them and be available for advice and guidance.

Hospitals need to create a stable agency in the workforce, functioning hand in hand with permanent employees. Not only do these nurses know the policies of the company, but they also become confident and skilled in the area of work. It is in the patient's interest if the nurse develops a relationship with the doctor and other health professionals involved in patient care.

The nurse, however, has the right to intervene in any situation that may jeopardise the well-being of the patient, or is unethical. These actions must be reported to the doctor, manager or senior, and all errors must be reported to the doctor. When in doubt about a prescription or treatment, the nurse must seek advice or clarification. Where a diagnosis is doubtful, the nurse needs to ask for further investigation to safeguard the patient.

However, experienced nurses need to encourage and advise young inexperienced staff of the importance of establishing a relationship with the doctor, never hesitating to contact the doctor when needed. Doctors need to respect nurses and ensure that instructions are understood and clear. The nurse is not the servant of the doctor, but should confer with the doctor with actual knowledge based on facts.

5.2.8.5 Caring and compassion

This study indicated that 99% of nurses love to care for their patients (Table 4.21).

The impact of the nursing shortage crisis, in combination with the high patient acuity, is a vital concern for any nursing manager, specifically relating to balancing staffing need with patient needs. Nurses need time to spend with patients, to establish a relationship, and not purely focus on the tasks.

This study, however, indicated that nurses still love to care for their patients, and do in fact respect the noble tradition of the profession in private health care. It is interesting to note that ENAs mostly agreed that nursing is a caring and compassionate position, while theatre staff least agreed with this statement. Looking at the environment in which the ENA functions, the difference in dynamics in both these areas can be understood.

Recommendation

The committed, caring nurse needs to understand the philosophy of nursing, making it meaningful and understanding the person-to-person service. Caring is not

something the nurse does for the patient, but something that is co-created and negotiated in interaction with the patient. Somehow in this modern world many nurses have forgotten that taking care of people is the greatest honour one could have. Nurses have to renew their professional ethic and their ethos of caring and healing.

If our values are not congruent with our actions, we may conclude that nursing is no longer the caring profession. Caring is about people, is done with people, done for people, done to people, and as people (Geyer, 2005b:55).

Compassion is a way of living that is born out of an awareness of one's relationship to all living creatures. It is understood mainly in terms of empathy, which is our ability to enter into and, to some extent, share others' suffering. Compassion is unconditional, undifferentiated and universal in scope, which often consists of a gut feeling to a situation of great need – a specific act to a specific need (Geyer, 2005b:52).

5.2.8.6 The right to privacy

Nurses have a right to privacy as much as patients have, and this is contravened in many instances. Senior staff and doctors need to adhere to this regulation when dealing with sensitive information. Caregivers indicated that their right to privacy are not respected, and this could be attributed to the fact that caregivers are not regulated by the profession, and include young, inexperienced workers. Subordinates and patients will readily respect management as they are in a more superior position, while the caregivers are not nurses and belong to the lowest rank in the clinical environment.

Recommendation

This practice is unacceptable, as every person is included in the Constitution. The code of conduct of the nurse as stipulated by SANC is very clear. Privacy and confidentiality go hand in hand and are defined as characteristics of the professional person, as regulated by SANC.

Managers who wish to be seen as role models and leaders need to promote privacy and confidentiality, and should bear in mind that communication is not limited to encouraging employees to speak up, but also involves a willingness to share knowledge.

5.2.8.7 Conditions of employment

Seventeen per cent of the nurses indicated that their salaries did not match their responsibilities, which were supported by most RNs. Results also show that nurses with more years in the nursing profession felt their salaries did not match their responsibility. This has been shown to be statistically significant (Spearman test p = 0.08). The competition among hospitals to fill vacant positions has a negative effect on market-related salaries. Nurses who have been in positions for a long time do not earn the same as new staff, which is an unfair practice that needs to be addressed on a yearly basis (Table 4.34).

Nurses have become more astute at reading advertisements, knowing that 'competitive salaries' mean exactly the same as other competitive hospitals, while 'challenging positions' mean working twice as hard (Chenevert, 1993:43).

Recommendation

Searle (2000:364) says that nurses/midwives have the right to expect conditions of employment and practice that enables them to practise in a knowledgeable, competent, legal and ethical manner, and to provide the optimal type of care that is possible in a particular situation. They have the right to expect the type of support from management and colleagues in the health team that will earn them the trust of the public, because they ensure that they provide the same type of support to management, colleagues in the health team, and the patient at large.

5.2.9 Legal practice

5.2.9.1 Nurses' rights

Results show a statistical significance (Table 4.44) between whether or not the nurses' rights are in contradiction with the patients' rights, and the years of experience in nursing (Spearman test p = 0.01).

Although adequate staffing was not explored, statistics also show that the majority of the participants, namely 54%, indicated that they are exploited in their area of work (Table 4.32).

Research indicated that caregivers were not respected in the nursing profession (Table 4.30). The lowest rank tends to receive the least respect, while the highest ranks scored highest in this regard. Caregivers are not part of the nursing profession and fill the lowest ranks in the work environment.

Recommendation

The confirmation of the rights of the nurse is not an end in itself, but a means of ensuring improved service to patients. To enable nurses to provide safe, adequate nursing, they have the right to use the Nurses' Rights as the basis of their practice. Older nurses seem more mature and more confident to rely on the nurses' rights, guidelines and principles, and should guide young nurses in understanding their rights. Nurses need to familiarise themselves with the Nurses' Rights and should not accept unethical and illegal practices.

Nurses have the right to practise in accordance with the scope that is legally permissible for their specific practice. Nurses have the right to refuse to carry out a task reasonably regarded as outside the scope of their practice, and for which they have insufficient training, or for which they have insufficient knowledge and/or skills.

5.2.9.2 Continuous professional development

As indicated in the research, 14% of nurses do not attend in-service training (Table 4.48). The researcher believes that due to big work loads and short staffing in the units, nurses do not attend in-service training programmes. Nurses have the right to proper orientation and goal-directed in-service education in respect of the modes and methods of treatment and procedures relevant to their working situation.

Recommendation

Nurses have an obligation to keep informed and to know what is going on in the world of nursing. They can do this by reading professional literature and attending meetings, symposiums and seminars (Mellish & Wannenburg, 1998:90).

Educators need to keep in-service training sessions short in order for staff to be released from wards. Training should be stimulating and interesting, benefiting the clinical practice of the nurse. Much focus should be on identifying potential risks and the prevention thereof.

It is therefore important for managers to explore with staff all avenues of learning opportunities. The new Nursing Act (Act No. 33 of 2005) indicates that SANC will promulgate a new legislative framework that will include developing a system for implementing mandatory continuing professional development, to ensure nurses maintain their level of competence.

5.2.9.3 Scope of practice: The Nursing Act 33 of 2005

This study indicated that ENAs are not functioning within their scope of practice. It was statistically significant (Spearman test p = 0.05) that this depended entirely on the age of the nurses (Table 4.38).

Statistical results of significance were obtained between ENAs functioning under indirect supervision (Table 4.55) and years in current position (Spearman test p = 0.06) and years in nursing (Spearman test p = 0.00).

Statistical significance was identified between caregivers assisting nursing staff with interventional nursing care (Table 4.60) and their years of service (Spearman test p = 0.05) and age groups (Spearman p = 0.03).

Fourteen per cent of the nurses do not feel competent and sufficiently skilled to perform their duties, which is a serious concern, as it represents 424 staff members in private health care in the Western Cape (Table 4.49).

Recommendation

Chapter 2, Section 30 of the new Nursing Act refers to the scope of practice of nursing, and highlights the following:

- A professional nurse is qualified and competent to independently practise comprehensive nursing.
- A midwife is qualified and competent to independently practise midwifery.
- A staff nurse is educated to practise basic nursing care.
- An auxiliary nurse or auxiliary midwife is educated to provide elementary nursing care.
- The minister may allow for other categories of nurses.

All nurses are becoming ‘registered nurses’, accountable for their actions and omissions. New terminologies for nurses are:

- Registered nurse becomes the registered professional nurse.
- Enrolled nurse becomes the registered staff nurse.
- Enrolled nursing assistants become the registered nursing auxiliaries.

Caregivers should function within their scope of practice. Medico-legal actions and the safety of patients are at risk. The researcher feels that caregivers should be regulated. Chapter 2, Section 30 of the new act states that the minister may allow for

other categories of nurses – therefore the possibility exists to include caregivers into the professional nursing body.

Data analysis indicates the following:

- Caregivers are not respected.
- Caregivers do not function within their scope of practice depending on ther years of experience.
- Caregivers assist nurses with interventional actions depending on years of experience.
- Caregivers do not acknowledge patient autonomy.
- Caregivers demonstrated the least advocacy for patients.

Nurses need to take ownership of their professional development, and ensure that they are competent to perform their duties. As individual practitioners, each nurse is accountable for his or her actions. Proper job descriptions should be in place, outlining the required knowledge, skills, attitudes and responsibility. Nurses need to understand their distinctive tasks, and can no longer be obedient, unthinking instruments of doctors and administrators (Hunt, 1994:137).

5.2.9.4 Patient safety

Nurses are the facilitators of patient care and must have knowledge of their subject, especially related to the type of work handled in their unit. To remain abreast of development, nurses constantly have to strive to increase their knowledge. In recent times we have seen a bigger emphasis on patient safety and quality of care. In spite of statistics showing that nurses are qualified in their area of specialty (Spearman test $p = 0.0827$), many errors occur, according to media reports (Table 4.7).

Recommendation

Health and safety are vital to the delivery of quality care, including all aspects of nursing care and therapy. The safe administering of drugs, prevention of slips and falls, prevention of pressure sores, adequate staffing and management of infection control risks are only a few risk factors pertaining to the hospital environment.

Burkhardt and Nathaniel (2002:395) reflect on the nurse's accountability for assigning nursing responsibilities to other nurses and delegating of nursing care activities to other health care workers. The nurse must make a reasonable effort to assess individual competency when assigning selected components of nursing care to other

health care workers. This assessment involves evaluating the knowledge, skills and experience of the individual to whom the care is assigned, the complexity of the assigned tasks, and the health status of the patient. The nurse is also responsible for monitoring the activities of these individuals and evaluating the quality of the care provided. Nurses may not delegate responsibilities such as assessment and evaluation, but they may delegate tasks. The nurse must not knowingly assign or delegate to any member of the nursing team a task for which that person has not been prepared or qualified.

(International Council of Nurses, 2007) believes nurses and national nurses' associations have a responsibility to

- inform patients and families of potential risks;
- report adverse events to the appropriate authorities promptly;
- take an active role in assessing the safety and quality of care;
- improve communication with patients and other health care professionals;
- lobby for adequate staffing levels;
- support measures that improve patient safety;
- promote rigorous infection control programmes;
- lobby for standardised treatment policies and protocols that minimise errors;
- liaise with the professional bodies representing pharmacists, physicians and others to improve packaging and labelling of medications;
- collaborate with national reporting systems to record, analyse and learn from adverse events; and
- develop mechanisms, for example through accreditation, to recognise the characteristics of health care providers that offer a benchmark for excellence in patient safety.

5.2.9.5 Privacy and confidentiality

Six per cent of nurses did not ensure patient confidentiality (Table 4.24). Trust is the key to the contractual relationship between nurse and patient. This implies trust in the integrity of nurses and the vital role they play within the legal and ethical parameters of their practice. Trust implies moral obligations for the nurse, which should not be abused and misused. Nurses should not engage themselves in gossip or entertain other nurses on patient matters.

Recommendation

Like doctors, nurses are enjoined to keep in confidence anything that they see, hear or surmise about a patient. At times, nurses and doctors are inclined to discuss patient problems. Except during legitimate discussions on patient diagnosis, treatment or care, health personnel who are not involved in the care of particular patients should not be told about matters that do not concern them (Searle, 2000).

Confidential information relating to the condition or treatment of patients must not be made available or shared to anyone other than the doctor treating the patient concerned, unless duly authorised in writing by the patient. Should a nurse not adhere to the patient's right to privacy, he of she might be held accountable. The Access to Information Act no 2 (2000) is very clear on how confidential information should be managed.

5.2.9.6 Organisational climate

The majority of the participants, namely 77%, indicated that there is an openness and transparency in their company depending on the years in position (Spearman test p = 0.03), and years in nursing profession (Spearman test p = 0.06) have been shown to be statistically significant (Table 4.33).

Recommendation

According to research done in 1998 and 2003 (Erasmus & Brevis, 2005), staff need the following:

- Better remuneration
- Better benefits
- On-the-job training
- Recognition
- Job satisfaction
- Balanced professional/private lives
- Allowance made for family commitments

5.3 CONCLUSION

The professional status of the nurse depends solely on the manner in which he or she promotes the profession and ethical code. The image of nursing has lately been portrayed in a bad light in the media and by the public.

The relationship of medical practitioners with the patient is short in duration and is usually characterised by an intermediary tool, such as a stethoscope, tests results or a scalpel. The nursing relationship involves more long-term and intimate care (Geyer, 2005b:52).

The professional conduct of the nurse according to the ICN (International Council of Nurses, 2007) should be to:

- promote health;
- prevent illness;
- restore health; and
- alleviate suffering.

The organisation's policies and attitude can largely influence the climate and ethics in the work place, creating transparency and a culture of high standards. These are crucial facts in terms of attracting staff and ensuring effective human resource management.

Consumers of health care in South Africa have basic rights that have to be protected, and because of the availability of the nurse for 24 hours per day, the nurse becomes the guardian of these rights. This makes the nurse the patients' primary advocate, with the responsibility of being alert to conditions that may prevent a successful outcome for patients, and to intervene on the patients' behalf (Geyer, 2006a).

It is encouraging that the law recognises the rights of health workers, as experienced some unfortunate instances where staff are either physically or verbally abused by patients and their visitors. Making patients aware of the rights of health workers will hopefully reduce these incidents (Worral-Clare, 2005).

“What will nursing be,
what will nursing become?
How will nursing be redefined,
when the systems that have defined it,
controlled it, and given it its identity,
are no longer there, standing behind it?”
(Watson, 2002)

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Comment: This is a state. Which town/city?

Comment: This is a country. Which town/city?

APPENDIX A: PARTICIPANT CONSENT FORM

Tel: 021 506 5158
Fax: 021 506 5187
E-mail: alta.dorse@lifehealthcare.co.za

12 September 2007

Dear Colleague,

In order to gain valuable information regarding the nursing profession, I wish you to complete this questionnaire

Title of the study: Legal and ethical aspects of nursing practice in selected private hospitals in the Western Cape Metropolitan area

1. **The nature and purpose of the study**
   You are being asked to participate in a research study. The aim is to evaluate the nurse's perceptions of the nursing profession. By doing so, we wish to learn more about factors influencing nurses from performing their duties.

2. **Explanation of the procedure to be followed**
   The study involves answering some questions regarding legal and ethical perceptions of the profession.

3. **Risk and discomfort involved**
   There are no risks or discomfort involved in completing this questionnaire.

4. **Possible benefits**
   There are no personal benefits, but the results will be published.

5. **Conditions**
   You may at any time withdraw from this study and will not be discriminated against.

6. **Information**
   If you have any questions concerning this study you should contact Alta Dorse at the above contact numbers.

7. **Confidentiality**
   All questionnaires obtained in this study will be regarded as confidential

8. **Consent to participate in this study**
   I have read and understand the above information before signing this consent form. The content and information are clear to me. I have been given the opportunity to ask questions and I am satisfied that they have been answered satisfactorily. I understand that if I do not participate, I will not be discriminated against in any way. I hereby volunteer to take part in this study.

Signature **Date**

I appreciate your cooperation
Alta Dorse
M.Cur
SU: 14986744 – 2006

APPENDIX B: RESEARCH QUESTIONNAIRE

Choose the most appropriate response.

A. Biographical

	Age	
1.	≤21	
2.	≥22<30	
3.	≥30≤39	
4.	≥40≤49	
5.	≥50≤59	
6.	≥60	

In which position are you currently?

7.	RN	
8.	EN	
9.	ENA	
10.	CG	
11.	Management	

In which area do you work?

12.	Management	
13.	ICU	
14.	Ward	
15.	Theatre	
16.	Maternity	
17.	Other	

How many hours overtime do you work on average per month?

18.	< 10	
19.	10–19 hours a month	
20.	20–29 hours a month	
21.	30–39 hours a month	
22.	40 and more a month	

How many years have you been in your current position?

23.	≤1–5 years	
24.	6–10 years	
25.	11–15 years	
26.	16–20 years	
27.	More than 20	

How many years have you been in the nursing profession?

28.	≤ 1–5 years	
29.	6–10 years	
30.	11–15 years	
31.	16–20 years	
32.	More than 20	

	Please select your preferred choice.	**Yes**	**No**	**N/A**
33.	Are you qualified in your area of specialty?			
34.	Are you currently studying towards another degree?			
35.	Do you belong to a professional trade union?			
36.	Do you recommend nursing as a profession?			
37.	Do you function in your area of specialty?			

38.	Do you think of changing your profession?			
39.	Are you thinking of emigrating?			

B. ETHICAL PRACTICE		**most strongly agree 3**	**strongly agree 2**	**agree 1**	**neutral 0**	**disagree -1**	**strongly disagree -2**	**most strongly disagree -3**
PATIENT: Choose the most appropriate response								
40.	You do not respect all religions.							
41.	You always assure patient privacy.							
42.	You do not acknowledge the patient autonomy							
43.	You experience verbal abuse by your patient.							
44.	You do not respect all cultures.							
45.	You always provide safe and committed care for your patient.							
46.	You do not always act as your patient's advocate.							
47.	You love to care for your patient.							
48.	You are not always honest with the patient.							
49.	You safeguard the patient from unethical practice.							
50.	You do not assure patient confidentiality at times							
PROFESSION: Choose the most appropriate response								
51.	Nursing is not a caring and compassionate profession.							
52.	You believe in the Nurses' Pledge of service.							
53.	You are not loyal to the profession.							
54.	You market the profession positively.							
55.	You do not respect the noble tradition of the profession.							
COMPANY: Choose the most appropriate response								
56.	Your right to privacy is respected.							
57.	You are loyal and committed to your company.							
58.	You feel exploited in your area of work.							
59.	There is openness and transparency in your company.							
60.	Your salary does not match your responsibility.							
61.	You function in an environment where there is trust and common purpose.							
62.	You are unhappy in your area of work.							

	C. LEGAL PRACTICE	most strongly agree 3	strongly agree 2	agree 1	neutral 0	disagree -1	strongly disagree -2	most strongly disagree -3
63.	There is a team approach from the multidisciplinary team.							
64.	You do not function within your scope of practice.							
65.	You take responsibility and accountability for your actions.							
66.	You feel free to discuss your patient's progress with the doctor.							
67.	You function within the legal guidelines of your scope of practice.							
68.	You do not understand your scope of practice.							
69.	You adhere to the patient's rights at all times.							
70.	Nurses' rights are respected in your area of work.							
71.	Nurses' rights are in contradiction with the patient's rights.							
72.	Your working environment is unsafe to function in.							
73.	Your company adheres to all legislative regulations.							
74.	You are not participating in continuous professional development.							
75.	You feel you are skilled and competent to perform your duties.							
76.	You do not have a formal contract with your employer.							
77.	Your basic conditions of employment are met.							
78.	You do not address patient safety in all aspects of care.							
79.	You inform patients and families of potential risks.							
80.	You promote and support infection control programmes.							
81.	As an enrolled nursing assistant you function under direct supervision.							
82.	As an enrolled nursing assistant you function under indirect supervision.							
83.	As an enrolled nurse you function under direct supervision.							
84.	As an enrolled nurse you function under indirect supervision.							
85.	As a professional nurse, you take responsibility of delegating functions.							
86.	Caregivers assist the nursing staff with interventional nursing care.							
87.	Caregivers do not perform nursing duties.							
88.	You feel free to follow the grievance procedure.							

APPENDIX C: ORGANISATIONAL CONSENT FORM

Western Cape Region
Suite 302, Building 20, Waverley Business Park
Wycroft Road, Mowbray, 7700
Private Bag X14, Rondebosch 7701
Telephone +27 21 402 1500
Facsimile +27 21 402 1560
www.lifehealthcare.co.za

13 September 2007

Alta Dorse
Nursing Management
Life Vincent Pallotti Hospital
Alexandra Road
Pinelands
7405

RE: PERMISSION FOR RESEARCH SURVEY

Dear Alta,

Your letter dated 12 September 2007 is acknowledged with thanks.

We are comfortable for you to go ahead with this research, provided that the confidentiality of the participating hospitals (Life Kingsbury, Life Claremont and Life Vincent Pallotti Hospitals) is maintained within the study, and not only that of the participants.

All the best with your research.

Kind regards,

Jonathan Lowick
Regional Hospital Manager
Western Cape Regional Office

MEDI-CLINIC
LIMITED

Medi-Clinic Offices, PO Box 456, Stellenbosch 7599 • T +27 21 809 6500 • F +27 21 809 6756
Strand Road, Stellenbosch 7600 • www.mediclinic.co.za

Mrs A Dorse
Nursing Manager
Vincent Pallotti Hospital
P O Box 103
HOWARD PLACE
7405

13 September 2007

Dear Alta

RE: Permission for research survey.

Your letter dated 12 September 2007 is acknowledged with thanks.

We are comfortable for you to go ahead with this research and we will load it onto our research register, provided that the confidentiality of the participating hospitals is maintained within the study, and not only that of the participants.

The contact people at the hospitals are:

- Vergelegen – Ms R Jacobs (the nursing manager, Ms H Louw, is on leave)
- Stellenbosch – Ms M Herbst
- Panorama – Ms A Siebrits
- Cape Town – Ms M McNamara
- Constantiaberg – Ms F Redfern
- Durbanville – Ms M Rix

All the best with your research.

Kind regards

Estelle Jordaan
Nursing Director