

EXPLORING UNDERGRADUATE NURSING STUDENTS' UNDERSTANDING AND APPLICATION OF THE DUTY OF CARE

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DECLARATION

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

Date: March 2018

ABSTRACT

Background

The core of nursing practice is caring and if nurses do not care they failed to uphold the foundation that underpins nursing practice. A duty of care is required from all nurses and it is both an ethical and statutory obligation. If nurses negligently omit their duty of care or standards of practice, it could have detrimental consequences for the patient, nurse and employer.

Rationale

The researcher observed careless behaviours amongst nurses with reference to their fundamental duties, compelling the researcher to explore undergraduate nursing students' understanding and application of their duty of care.

Research question

The research question which guided the study was: What is the undergraduate nursing students' understanding and application of the duty to care?

Research aim

The aim of the study was to explore the undergraduate nursing students' understanding and application of the duty of care.

Research objectives

The objectives were as follows:

1. Understanding and application of caring in nursing practice
2. Understanding and application of the duty to care
3. Understanding and application of ethics in nursing practice
4. Understanding and application of standards in nursing practice
5. Understanding and application of legalities in nursing practice
6. Understanding of negligence in nursing practice.

Research design

A qualitative explorative-descriptive design was applied to explore the undergraduate nursing students' understanding and application of the duty of care.

Sampling

A purposive sampling method was applied to recruit participants from a nursing education institution in the Cape Metropolitan area.

Ethical consideration

Ethical approval was obtained from the Health Research Ethics Committee of Stellenbosch University (S16/10/230) and the nursing education institution (CPUT/HW-REC 2016/H15) where the study was conducted.

Inclusion criteria

Inclusion criteria consisted of fourth year undergraduate nursing students, following the BTECH degree programme in Nursing Science at the specific nursing education institution.

Exclusion criteria

Undergraduate nursing students in their first, second and third year of study at the specific nursing education institution were excluded from the study.

Pilot study

A pilot study was conducted with one participant from the target population.

Trustworthiness

Lincoln and Guba's (1985) four criteria: credibility, dependability, confirmability and transferability were applied in this study, to ensure the trustworthiness of the study.

Data collection

A self-formulated interview guide was used during data collection. Ten semi-structured interviews were conducted. The interviews were recorded on a digital voice recording device.

Data analysis

Transcribed data was analysed applying the Terreblanche, Durheim and Painter's model (2006). Eleven themes emerged from the data.

Results

The findings of the study suggest that the undergraduate nursing students do not entirely comprehend aspects of the duty of care. As stated by one student: *"Carrying out the orders as prescribed that is your duty...call the doctor and make a way so the patient can get the best health possible."* (Participant 9)

Recommendations

Recommendations include that health departments and nursing education institutions urgently address shortages of staff, uncaring nursing behaviours and knowledge gaps as identified in this study.

Key words: caring, duty of care, ethics, standards, legalities and negligence.

OPSOMMING

Agtergrond

Die kern van die verplegingspraktyk gaan oor versorging en indien verpleegsters dit nie uitdra nie, ondermyn hulle die basis wat onderliggend aan die verplegingspraktyk is. Daar word van alle verpleegsters verwag om 'n versorgingsplig te hê en dit is beide 'n etiese en statutêre verpligting. Indien verpleegsters as gevolg van nalatigheid hul plig versuim om te versorg of die standaarde van die praktyk nie nakom nie, kan dit skadelike gevolge vir die pasiënt, verpleegster en werkgewer tot gevolg hê.

Rasionaal

Die navorser het die nalatige gedrag onder verpleegsters ten opsigte van hulle fundamentele pligte waargeneem en was genoop om ondersoek in te stel na hoedat die voorgraadse verpleegstudente hulle versorgingspligte verstaan.

Navorsingsvraag

Die navorsingsvraag wat die studie gerig het, was: Hoe verstaan en pas voorgraadse verpleegstudente hul plig om te versorg toe?

Navorsingsdoelwit

Die doel van die studie was om te bepaal hoe die voorgraadse verpleegstudente hul plig om te versorg, verstaan.

Navorsingsdoelstellings

Die doelstellings was as volg:

1. Verstaan en toepassing van versorging in die verplegingspraktyk
2. Verstaan en toepassing van die plig om te versorg
3. Verstaan en toepassing van die etiek in die verplegingspraktyk
4. Verstaan en toepassing van standaarde in die verplegingspraktyk
5. Verstaan en toepassing van wettighede in die verplegingspraktyk
6. Verstaan en toepassing van nalatigheid in die verplegingspraktyk.

Navorsingsontwerp

'n Kwalitatiewe eksploratiewe-beskrywende ontwerp om te bepaal hoe die voorgraadse verpleegstudente hul plig om te versorg verstaan, was toegepas.

Steekproefneming

‘n Doelgerigte steekproefmetode was toegepas om deelnemers van ‘n verpleegkunde instansie in die Kaapse Metropolitaanse gebied te werf.

Oorweging vir etiek

Goedkeuring vir etiek was verkry van die Gesondheidsnavorsingsetiekkomitee aan die Universiteit van Stellenbosch (S16/10/230) en die verpleegkunde instansie (CPUT/HW-REC 2016/H15) waar die studie uitgevoer is.

Insluitingskriteria

Die insluitingskriteria het bestaan uit vierdejaar-ondergraadse verpleegstudente wat die BTech-graad program in Verpleegkunde by die spesifieke verpleegkunde instansie volg.

Uitsluitingskriteria

Voorgraadse verpleegstudente in hulle eerste, tweede en derde jaar van studie aan die spesifieke verpleegkunde instansie was van hierdie studie uitgesluit.

Loodsprojek

‘n Loodsprojek met een deelnemer van die teikengroep was uitgeoefen.

Betroubaarheid

Lincoln en Guba (1985) se vier kriteria: geloofwaardigheid, betroubaarheid, bevestigbaarheid en oordraagbaarheid was in die studie toegepas om die betroubaarheid van die studie te verseker.

Data-insameling

‘n Selfgeformuleerde onderhoudsgids was gedurende data-insameling gebruik. Tien semi-gestruktureerde onderhoude was gehou. Die onderhoude was deur middel van ‘n digitale stemopname-toestel opgeneem.

Data-analise

Getranskribeerde data was deur middel van Terreblanche, Durheim en Painter se model (2006) geanaliseer. Elf temas het uit die data voortgespruit.

Resultate

Die bevindinge van die studie suggereer dat die voorgraadse verpleegstudente nie die aspekte rondom hul versorgingsplig ten volle verstaan nie. Soos een student dit gestel het: ‘Om opdragte soos voorgeskryf uit te dra, is jou plig... ontbied die dokter en maak dit moontlik dat die pasiënt die beste gesondheidsorg moontlik ontvang.’ (Deelnemer 9)

Aanbevelings

Daar word aanbeveel dat gesondheidsdepartemente en verpleegkunde instansies die tekort aan verpleegsters en die verplegingsgedrag om nie te versorg nie, asook die kennisgapings soos geïdentifiseer in die studie, indringend aanspreek.

Sleutelwoorde: versorging, versorgingsplig, etiek, standaarde, wettighede en nalatigheid

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TABLE OF CONTENTS

Declaration	ii
Abstract	iii
Opsomming	vi
Acknowledgements	ix
List of Tables	xv
List of Figures	xvi
CHAPTER 1: FOUNDATION OF THE STUDY	1
1.1 Introduction	1
1.2 Rationale	2
1.3 Significance of the study	4
1.4 Research problem.....	4
1.5 Research question.....	4
1.6 Research Aim	4
1.7 Research objectives.....	4
1.8 Conceptual framework	5
1.9 Research methodology	6
1.9.1 Research design.....	6
1.9.2 Population and Sampling	6
1.9.2.1 Inclusion criteria	7
1.9.2.2 Exclusion criteria	7
1.9.3 Pilot study	7
1.9.4 Interview guide.....	7
1.9.5 Trustworthiness	7
1.9.6 Data collection	7
1.9.7 Data analysis	7
1.10 Ethical considerations	7
1.10.1 Right to self-determination	8
1.10.2 Right to autonomy and confidentiality	8
1.10.3 Right to protection from discomfort and harm.....	8
1.11 Conceptual definitions.....	8
1.11.1 Breach of duty.....	8
1.11.2 Caring	8
1.11.3 Causation	9
1.11.4 Damages	9

1.11.5	Duty of care	9
1.11.6	Negligence.....	9
1.11.7	Vicarious liability	9
1.12	Study layout	9
1.13	Summary	10
1.14	Conclusion	10
CHAPTER 2: LITERATURE REVIEW		11
2.1	Introduction	11
2.2	Duty of care	11
2.3	Nursing: A caring ethos.....	12
2.4	Ethical underpinnings in nursing	13
2.4.1	Codes of ethics	13
2.4.2	The role of professional organizations.....	14
2.4.2.1	The International Council of Nurses (ICN)	14
2.4.2.2	The American Nurses Association (ANA)	14
2.4.2.3	The Democratic Nursing Organization of South Africa (DENOSA)	15
2.4.3	Regulatory bodies	15
2.4.3.1	The Nursing and Midwifery Council (NMC).....	15
2.4.3.2	The South African Nursing Council (SANC).....	15
2.5	Legislation	16
2.5.1	Nursing Act 33 of 2005	16
2.5.2	National Health Act 61 of 2003	16
2.5.3	Constitution Act 108 of 1996	17
2.5.3.1	Patients' Rights Charter and Batho Pele Principles	17
2.6	The legal underpinnings of the duty of care	19
2.7	Negligence.....	20
2.7.1	The aims of the laws of negligence	20
2.7.2	Impact of negligence for the nursing professional	21
2.7.3	Costs of negligence	21
2.7.4	Factors contributing to negligence	22
2.7.4.1	Organizational failures.....	22
2.7.4.2	Public awareness	23
2.7.4.3	Inadequate training.....	23
2.7.4.4	Role expansion	23
2.8	Standards of nursing practice	25
2.9	Enhancement of the role of nursing professionals.....	26
2.10	Recommendations for safe practice	27

2.11	Summary	28
2.12	Conclusion	28
CHAPTER 3: RESEARCH METHODOLOGY		29
3.1	Introduction	29
3.2	Goal	29
3.3	Objectives	29
3.4	Study setting	29
3.5	Research design	30
3.6	Population and sampling	31
3.6.1	Inclusion criteria	32
3.6.2	Exclusion criteria	32
3.7	Instrumentation	32
3.8	Pilot study	33
3.9	Trustworthiness	34
3.9.1	Credibility	34
3.9.1.1	Reflexivity	34
3.9.1.2	Member checks	34
3.9.2	Dependability	34
3.9.3	Confirmability	35
3.9.4	Transferability	35
3.10	Data collection process	35
3.11	Data analysis	37
3.12	Summary	38
CHAPTER 4: RESULTS		39
4.1	Introduction	39
4.2	Section A: Biographical data	39
4.3	Section B: Themes emerging from the data	39
4.3.1	Theme 1: Patient care	40
4.3.1.1	Subtheme: Holistic care	40
4.3.2	Subtheme: Rendering a service	41
4.3.3	Subtheme: barriers to caring	41
4.3.4	Theme 2: Being there for the patient	42
4.3.4.1	Subtheme: Performing nursing tasks	42
4.3.4.2	Subtheme: Communication	43
4.3.4.3	Subtheme: Lack of care	43
4.3.5	Theme 3: Obligation	44
4.3.5.1	Subtheme: Responsibilities	44

4.3.5.2	Subtheme: Scope of practice.....	44
4.3.6	Theme 4: Legalities of the duty of care	45
4.3.6.1	Subtheme: Rules and Regulations	45
4.3.6.2	Subtheme: SANC	45
4.3.7	Theme 5: Caring for the patient	46
4.3.7.1	Subtheme: Respect.....	46
4.3.8	Theme 6: Ethical principles	46
4.3.8.1	Subthemes: Non-maleficence	46
4.3.8.2	Subtheme: Guidance.....	47
4.3.9	Theme 7: Legalities of nursing practice.....	47
4.3.9.1	Subtheme: SANC	47
4.3.9.2	Subtheme: Nursing Act	48
4.3.9.3	Subtheme: Ethical codes.....	48
4.3.9.4	Subtheme: Standards of practice	48
4.3.10	Theme 8: Decision making.....	49
4.3.10.1	Subtheme: Outweigh harm and benefits.....	49
4.3.10.2	Subtheme: Patient Autonomy	49
4.3.11	Theme 9: Carelessness	50
4.3.11.1	Subtheme: Omit care	50
4.3.11.2	Subtheme: Disciplinary action	50
4.3.12	Theme 10: Legalities of negligence.....	51
4.3.12.1	Subtheme: SANC	51
4.3.12.2	Subtheme: Criminal law.....	51
4.3.12.3	Subtheme: Vicarious liability.....	52
4.3.13	Theme 11: Increase in clinical negligence.....	52
4.3.13.1	Subtheme: Lack of knowledge.....	52
4.3.13.2	Subtheme: Lack of caring.....	53
4.4	Summary	53
CHAPTER 5: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS		55
5.1	Introduction	55
5.2	Discussion	55
5.2.1	Objective 1: Understanding and application of caring in nursing practice	55
5.2.2	Objective 2: Understanding and application the duty of care.....	56
5.2.3	Objective 3: Understanding and application of ethics in nursing practice	56
5.2.4	Objective 4: Understanding and application of standards in nursing practice ..	57
5.2.5	Objective 5: Understanding and application of legalities in nursing practice ...	57
5.2.6	Objective 6: Understanding of negligence in nursing practice	58

5.3	Conclusions	60
5.4	Limitations	60
5.5	Recommendations	60
5.5.1	Appreciation.....	60
5.5.2	Compliance.....	60
5.5.3	Renewal of commitment	61
5.5.4	Reviews	61
5.5.5	Education.....	62
5.5.6	Whistleblowing.....	62
5.6	Future research	63
5.7	Conclusion	63
	REFERENCES	64
	APPENDICES.....	68
	Appendix 1: Ethical approval from Stellenbosch University	68
	Appendix 2: Ethical approval from Cape Peninsula University of Technology	69
	Appendix 5: Interview guide	77
	Appendix 6: Transcribed interview	78
	Appendix 7: Declaration by language editor	96
	Appendix 8: Letter of technical editor	97

LIST OF TABLES

Table 4.1: Emerging themes and sub-themes	39
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LIST OF FIGURES

Figure 1.1: Schematic illustration of the conceptual framework by the researcher.....	6
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CHAPTER 1: FOUNDATION OF THE STUDY

1.1 INTRODUCTION

The study is based on obtaining information about the undergraduate nursing students' understanding and application of the duty of care. Chapter one introduces the foundation of the study, also the significance, rationale, conceptual framework, research problem, research question, aim and objectives and a short description of the research methodology which was followed.

According to Pera and Van Tonder (2011:2) the core of nursing practice is caring, and they assert further, that if nurses do not care they let go of the basis of being a nurse. Young (2009:3071) states that a duty of care is required from all nurses and it is both an ethical and statutory obligation. Moreover, the courts are of opinion that the duty of care originated due to the relationship between healthcare users and healthcare personnel.

This obligation had been differently described by law as a duty of care, a duty to take care or a duty to be careful (Griffith, 2014:234). In addition, the duty of care introduces a lawful responsibility for nurses to practise in accordance with standards prescribed by the legal system (Griffith, 2014:234-235). Nurses have thus an obligation not to cause injury to patients under their care through careless attitudes. If nurses negligently omit their duty of care or standards of practice they could be held liable for clinical negligence (Miola, 2009:756).

The Bill of Rights, Chapter 2 of the Constitution of the Republic of South Africa, (Act 108 of 1996) describes the fundamental rights of the population of South Africa, inclusive of the right of access to health, dignity and equality. The government and all healthcare professionals should focus on fulfilling, protecting, promoting and respecting the rights of the people of South Africa as stipulated in the Bill of Rights. Furthermore, the National Health Act, 2003 (Act 61 of 2003) stipulates that the government must produce the most excellent healthcare practices within the available budget for healthcare services. It is imposed on nurses and other healthcare personnel in the public sector to provide such services.

Section 3 in terms of the Nursing Act, 2005 (Act 33 of 2005) stipulates that it is dishonourable or shameful behaviour of nurses to consciously omit to sustain the health status of a patient under their care. The South African Nursing Council (SANC) code of ethics demands that nurses perform their duties with the expected respect for human rights, which is inclusive of civil rights, the right to life, self-determination and dignity.

Thus, nurses have to perform their duties without prejudice. Further, SANC stipulates that nurses have a responsibility towards the person, significant others, associations and society to safeguard, improve health, prevent disease, conserve life and relieve suffering (SANC, 2013:1).

In addition, the Office of Health Standards Compliance (OHSC) has been created through the National Health Amendment Act No.12 of 2013 in terms of Section 78 of the Act. The responsibility of the OHSC is to enforce and monitor health services, also private hospitals to comply with the principles and standards stipulated by the health minister. The OHSC enforces health services to comply with the following national core standards:

- Patient's rights
- Patient safety, clinical governance and care
- Provision of clinical support services
- Promote public health
- Strategic guidance by leadership and corporate governance
- Operational management
- Requirements for safe and secure facilities and infrastructure

Dhai and McQuoid-Mason, (2011: 92- 94) are of the opinion, that a case of negligence may be instituted against a nurse if he/she fails to deliver a high level of care to healthcare users and omits the duty of care. Similarly, if a nurse breaches any of her/his duties, causing harm to a patient, the patient may bring in a claim of negligence and sue for damages against the nurse and the employer (McQuoid – Mason & Dada 2011:8).

Equally important, Regulation 767 of 1 October 2014, Acts and Omissions, clearly specifies that the SANC can take disciplinary steps against a professional nurse who wilfully and negligently omit to maintain the health status of a patient under his/her care.

As a clinical facilitator, over a period of 11 years, the researcher observed in numerous wards in public hospitals, a careless attitude amongst the nurses while performing their fundamental duties. Fundamental duties included, monitoring of vital signs, intravenous therapy and patient identification, as well as keeping accurate records. A careless attitude of nurses towards their duty of care may lead to clinical negligence in nursing practice.

1.2 RATIONALE

Nursing is identified as having compassion and care for the sick and vulnerable (Fry, Macgregor, Ruperto, Jarret, Wheeler, Fong & Fetchet, 2013: 37-44). Furthermore, the patient is to be seen at the center of nursing care. Equally important, excellent nursing practices

involve supervised care with effective delivering of care, surroundings that are free from danger, a positive friendly culture and excellent teamwork (Fry et al., 2013: 37-44).

In addition, caring is arguably the most descriptive feature of nursing practice. Caring requires physical, mental and emotional energy on the part of the nurse to care for, respond to and support healthcare users. Fry et al. (2013:37-44) state that compassion includes the purposeful involvement in another person's afflictions and not only identifying the illness but also being able to relate to it.

According to Pera and Van Tonder (2011: 16-17) the concept of caring had been the topic of many discussions, and one outcome of such discussions is that healthcare professionals had come to the realization that, after all, a high standard of health care exists in caring. More specific, caring is an important indicator of the standard of health care and the will to care is a descriptive attribute of the healthcare profession. Sebopa (2010:48) states that when nurses take care of ill individuals, it is critical for them to follow benchmarks and policies of care. A case of negligence may be instituted against nursing personnel who violate their legal obligation to care for their patients (Miola, 2009:756).

However, evidence needs to be provided to the court by the claimant, that the nursing professional was under obligation to provide a duty of care, that the duty was omitted, the care was of low quality and that this violation had caused him/her injury (Cornock, 2011:21). The courts emphasize that the forming of a relationship between nurse and patient is the foundation for establishing that the nurse is under obligation to provide a duty of care to the patient (Klepatsky, 2006:15).

The National Health Service (NHS) hospitals reported a loss of two billion dollars annually due to adverse events resulting in 10% or in 850,000 of all admissions (Tingle, 2010:298).

From a South African point of view according to Dhai (2016:2), the costs paid by the public because of clinical negligence, litigation cannot be overlooked. The defense for patients with regard to their rights in the Constitution and the Consumer protection Act, together with an increase in patient anticipation and better comprehension of their health care, although beneficial, have also added to the increase in the regularity of lawsuits (Dhai, 2016:2).

The Minister of Health in South Africa summoned a medico-legal summit where it was concluded that inherently organizational failures in the public health department were highlighted as contributing to the increase in the regularity of malpractice and negligence claims against the government (Dhai, 2016:2). Healthcare professionals are to display caring behaviours and handle patients and their significant others with courtesy and empathy.

Healthcare professionals are to care for healthcare users in a way that enhances wellbeing, dignity and confidentiality (SANC, 2013:1).

1.3 SIGNIFICANCE OF THE STUDY

By scientifically investigating and exploring existing practices regarding the duty of care, the risk of adverse events in nursing practices may be limited. If student nurses and healthcare workers have an improved understanding of the duty of care, it may lead to an improvement in quality and safe nursing care for healthcare users and communities. Ultimately, it may decrease costs for the state as a result of clinical negligence litigation in nursing practice.

Furthermore, it could contribute to health policies, as well as adherence to standards in patient care. Information provided by participants during the study, might add to the existing body of knowledge in nursing science.

1.4 RESEARCH PROBLEM

As discussed above, quality health care resides in caring. According to Pera and Van Tonder (2011:2-3) caring is an important indicator of quality care and the willingness to care a defining characteristic of the healthcare profession. In the Western Cape Province, at a nursing education institution, the researcher observed in clinical practice, that student nurses lacked an understanding and application of the duty of care. Based on the rationale, it has thus become essential to investigate the undergraduate nursing students' understanding of the duty and application of care.

1.5 RESEARCH QUESTION

The research question which guided the study was: What is the undergraduate nursing students' understanding and application of the duty to care?

1.6 RESEARCH AIM

The aim of the study was to explore the undergraduate nursing students' understanding and application of the duty of care.

1.7 RESEARCH OBJECTIVES

The objectives of the study were to explore undergraduate nursing students':

- Understanding and application of caring in nursing practice
- Understanding and application of the duty to care
- Understanding and application of ethics in nursing practice
- Understanding and application of standards in nursing practice
- Understanding and application of legalities in nursing practice
- Understanding of negligence in nursing practice.

1.8 CONCEPTUAL FRAMEWORK

The ideas of a researcher can be used to develop a foundational framework for a proposed study. According to Burns and Grove (2011:227) the framework of the study indicate the researcher's logical reasoning of the study whilst he/she plans for the study. Sometimes in qualitative studies, the researcher attempt to determine any consistency between their findings and their expectations or any consistency between the literature and their findings (Burns & Grove, 2011:227).

In addition, researchers utilize a map or a model as a technique to express a study framework. A map or a model graphically demonstrates the relationships between statements and concepts. Sometimes the map is referred to as a conceptual framework. The researcher construct the conceptual framework to describe how concepts contribute to causing or partially causing an outcome. All the essential concepts are included in the study framework. Arrows link the concepts to express the proposed linkages between concepts (Burns & Grove, 2011:233).

Furthermore, qualitative studies researchers sometimes develop a conceptual framework from the literature or data. Sometimes in qualitative studies a theory can emerge as a result of the study. These theories can be utilized as a foundation for nursing practice or as a framework for other research studies (Burns & Grove, 2011:244).

In this study the researcher constructed the conceptual framework below to illustrate conceptual relationships as described in the literature. The five characteristics below, with reference to the duty of care were explored to determine the undergraduate nursing students' understanding and application of the duty to care. As stated by Young (2009:3071-3078), to ensure quality patient care and prevent negligence, nurses should not omit their duty of care or standards of nursing practice.

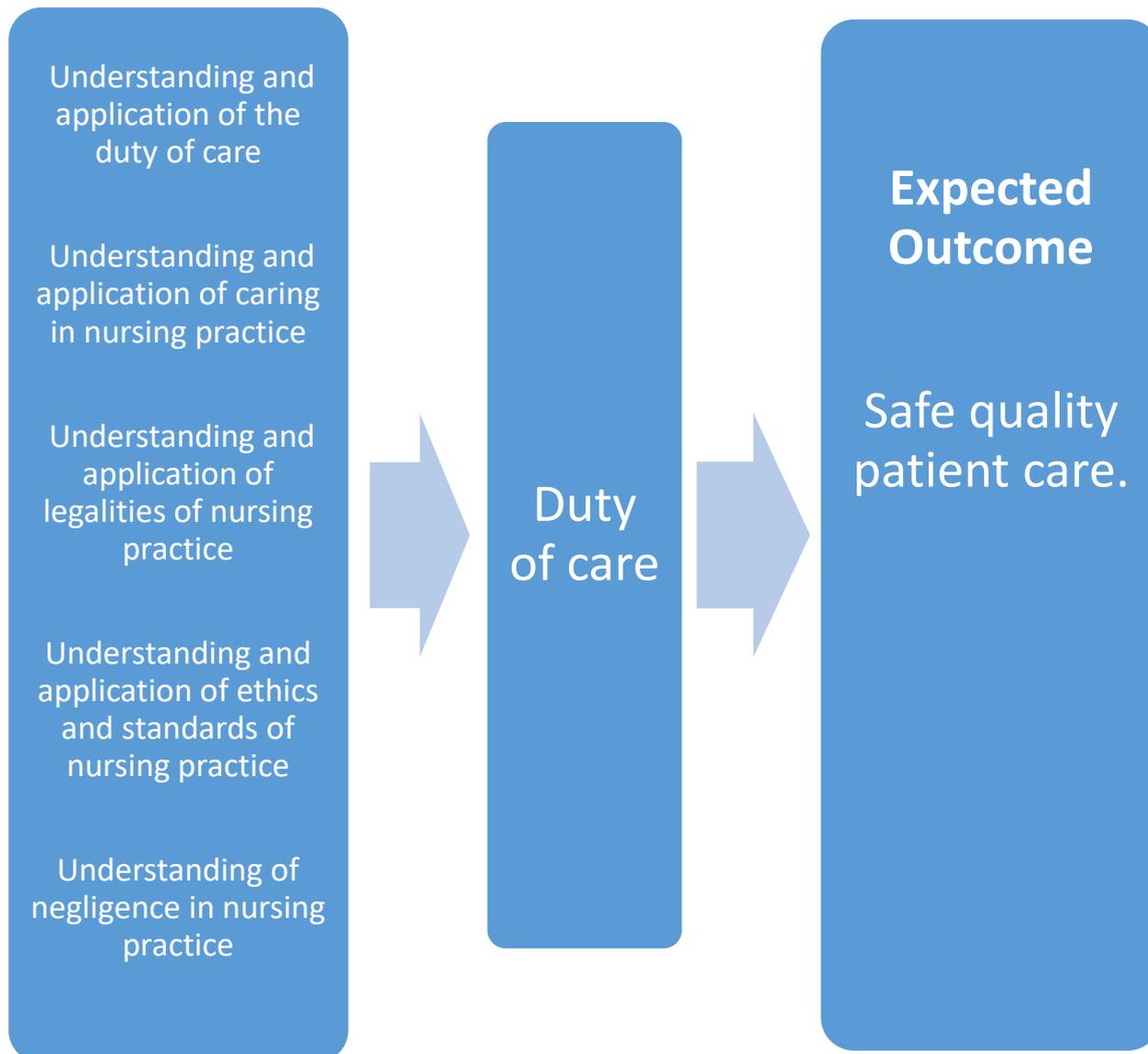


Figure 1.1: Schematic illustration of the conceptual framework by the researcher

1.9 RESEARCH METHODOLOGY

1.9.1 Research design

For the purpose of this study a qualitative explorative-descriptive design was applied to explore the undergraduate nursing students' understanding of their duty of care, as well as the application thereof.

1.9.2 Population and Sampling

The target population to research the objectives of this study included the entire group of students who were in their fourth year of study of the undergraduate R425 programme at a

nursing education institution in the Cape Metropolitan area. Purposive sampling, a non-probability sampling method was applied to select participants, who were able to provide in-depth information about the aim of the study as described.

1.9.2.1 Inclusion criteria

Fourth year undergraduate nursing students, who followed the BTECH degree programme in Nursing Science at the specific nursing education institution were included.

1.9.2.2 Exclusion criteria

Undergraduate nursing students in their first, second and third year of study at the specific nursing education institution were excluded.

1.9.3 Pilot study

A pilot study was conducted with one participant from the target population, after permission was obtained from the nursing education institution's ethics committee. (Appendix 2)

1.9.4 Interview guide

A self-formulated semi-structured interview guide based on the objectives of the study was used by the researcher during the interviewing process.

1.9.5 Trustworthiness

Lincoln and Guba's (1985) four criteria: credibility, dependability, confirmability and transferability were applied in this study, to ensure the trustworthiness of the study (Polit & Beck, 2010: 322-331).

1.9.6 Data collection

The researcher collected the data with the use of an interview guide. Data was gathered after permission for data collection was obtained from the training institution's ethics committee.

1.9.7 Data analysis

Terreblanche, Durheim and Painter's (2006:322) model was applied in this study to analyse the data. A series of steps for examining the data were used during data analysis. The researcher applied bracketing and reflectivity to exclude any biases.

1.10 ETHICAL CONSIDERATIONS

Ethics approval to conduct the study was obtained from the Health Research Ethics Committee at the University of Stellenbosch, (Appendix 1), as well as from the nursing education institution in the Cape Metropolitan area where the study was conducted. (Appendix 2)

1.10.1 Right to self-determination

The right to self-determination is based upon the ethical principle of respect for individuals (Grove, Burns & Gray, 2013:164). Participants were informed that participation in the study was voluntarily, and no form of coercion was employed by the researcher. The researcher respected the participants' autonomy, by informing them about the nature and purpose of the proposed study and allowing them to decide individually whether to participate or not. In addition, participants had the right to remove themselves from the study without any disadvantage (Grove et al., 2013:164). Thus, informed individual consent was requested from the participants and an informed consent form was signed by each participant before the data-collection process. In addition, special permission was sought from the participants specifically to record the interview.

1.10.2 Right to autonomy and confidentiality

The participants' right to anonymity and confidentiality was respected, and they were assured that data obtained will be kept secret. Pseudonyms were used to protect the participants' identification. Participants voluntarily decided to participate in the study (Grove et al., 2013:171-172). Electronic notes and data was saved in a password protected file and only the researcher had access to the data. The files will be kept and stored for a maximum of five years. Information was thus kept confidential (Grove et al., 2013:172).

1.10.3 Right to protection from discomfort and harm

The right to protection from discomfort and harm is based on the ethical principle of beneficence and non-maleficence (Grove et al., 2013:174). No inherent risks were foreseen for this study. No psychological difficulties or any unforeseen events emerged during interviewing, thus no counselling services were required for any of the participants. Data will be kept for five years and only the researcher and supervisor will have access to data.

1.11 CONCEPTUAL DEFINITIONS

1.11.1 Breach of duty

Breach of duty refers to an overall obligation, enforced by the legal system that gives rise to clinical negligence litigation or the lawsuit of the person who suffered harm (Dhai & McQuoid-Mason, 2011:52).

1.11.2 Caring

Care and caring are interconnected with the word nursing. Caring can be defined as an emotion that displays consideration, empathy and compassion to other individuals (Lachman, 2012:112-114).

1.11.3 Causation

Factual causation means to determine if the nurse's negligence has caused the damage, and legal causation determine if it is significant to regard the factual causation to be the reason for the damage (Turnton, 2009:825-827).

1.11.4 Damages

The legal concept of damages means the decrease in the worth of an individual's personal rights, financial or worldly goods. Damages also signify injury or losses resulted from violation of the duty of care (Mcquoid-Mason & Dada, 2011:122).

1.11.5 Duty of care

The duty of care is a specifically all-inclusive obligation, and its span necessitates that lawful and ethical obligations are to be applied by nurses during patient care (Griffith, 2014:234-235).

1.11.6 Negligence

Negligence occurs where a duty of care is expected from a healthcare worker towards a healthcare user, but that duty had been omitted or the healthcare professional failed to attain the required standard of care (Young, 2009:3071-3078).

1.11.7 Vicarious liability

Vicarious liability is a legal concept which moves the culpable employee's accountability over to the organization he/she is employed by (Nemie, 2009:54-59).

1.12 STUDY LAYOUT

Chapter 1

The scientific foundation of the study is described in chapter one.

Chapter 2

In chapter two the literature review process is described.

Chapter 3

The research methodology applied in this study is described in chapter three.

Chapter 4

The findings of the study are discussed in chapter four.

Chapter 5

Discussions on the study findings are presented in chapter five.

1.13 SUMMARY

Chapter one provided the foundation of the study, which is inclusive of the rationale, significance, ethical considerations and a brief description of the methodology of the study. A more detailed presentation of the methodology of the study is described in chapter three. A brief outline of the different chapters of the study is also presented in chapter one.

1.14 CONCLUSION

The observations made by the researcher in the clinical setting with regard to the caring aspect in nursing practice led to the researcher exploring undergraduate nursing students' understanding and application of the duty of care. An in-depth discussion of the literature review with regard to the duty of care is presented in chapter two.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

In chapter 2 the literature review regarding the duty of care will be discussed as obtained from literature. A literature review means to read, analyse and synthesise scientific content regarding a particular topic. Moreover, review of the scientific material is of great importance to develop comprehension and obtain facts about a topic under study (Garrard, 2011:4).

The purpose of the literature review was to gain insight about what is currently known about the topic of a duty of care. Definitions of a duty of care, as well as an overview of existing literature regarding the duty of care are presented. Relevant, existing literature includes the concepts of negligence, standards, and codes of ethics, case law and human rights.

The literature review placed the current study in the context about what is known about the topic. Furthermore, it assists in the development of a theoretical framework for the study. Moreover, the broad search of literature increased the researcher's understanding regarding the concepts of a duty of care.

The scientific databases, PubMed, Cinahl and Google Scholar, as well as textbooks were used to obtain literature for the research project. Articles obtained from the academic databases ranged from the year 2006-2017. Key words used during the search were duty, care, and duty of care, negligence, adverse events, standards, ethics and law.

2.2 DUTY OF CARE

Young (2009:3071) states that the duty of care is concerned with ethics and laws of the nursing profession. While McQuoid-Mason and Dada (2011:173) define the duty of care as the responsibilities enforced on healthcare practitioners not to injure healthcare users through negligent acts. According to Young (2009:3071) the duty of care is a constitutional issue and it is inevitably concerned with guidelines and operations of the nursing profession.

Moreover, the duty is extensive; it includes all the facets of nursing care, physical as well as psychological treatment (Young, 2009:3071-3078). Cornock (2011:21) corroborates that the duty of care emerges as an issue of legalities, when nurses are taking care of patients and accept duties as part of ordinary and official responsibilities.

Griffith (2014:234-235) is of the opinion that judiciary had diversely explained the duty as a duty of care, a duty to take care and a duty to be careful. Thus, the legal system demands a duty of care from all healthcare professionals, including nurses and it has been referred to as

an obligatory situation. In the same way the duty of care is a particularly all-inclusive obligation, and its span necessitates those lawful and ethical obligations to be employed by nurses during clinical decision making in patient care.

According to Kline and Khan (2013:7) duty of care refers to the responsibilities a healthcare professional owes a healthcare user. Duty of care provides the foundational standards of practice for healthcare practitioners.

2.3 NURSING: A CARING ETHOS

Caring is the central ethic, not only in nursing but also in other healthcare services (Pera & Van Tonder, 2011:4). Similarly, the core of nursing practice is caring behaviours and if nurses let go of caring, they let go of the essence of being a nurse. Fry et al. (2013:37-44) state that nursing can be identified as having compassion and caring for the sick and vulnerable, and that caring is arguably the most descriptive feature of nursing practice. In addition, compassion includes the purposeful involvement in another person's afflictions and not only identifying the illness, but also being able to relate with it.

Watson (2006:21-21) supports the idea that caring is the essence of nursing. Furthermore, caring may be considered as the nurses ethical epitome, to preserve the honour of humanity, by helping the patient to gain significance in sickness and distress in order to restore and promote the individuals overall peace. The most recent work of Watson brings divine elements of the work of caring, making more absolute, that in life the experiences of human beings are events with metaphysical, transcendent, virtues and moralistic elements (Watson, 2006: 21-21).

Caring is essential to moral standards in the ethics of care, which is strongly associated with virtue ethics (Dhai & Mcquoid-Mason, 2011:13). However, the particular order of today's culture is one of the obstacles in achieving an ethos of care undertaking. Thus, the social setting is not favourable to step out of this reality to contemplate on caring relations, in zealous trades where egotistical behaviour is pre-eminent (Dhai & McQuiod-Mason, 2011:13).

A qualitative study done in England found that in the healthcare environment nurses may encounter external obstacles to caring, as well as obstacles to caring that come from within themselves (Dobrowolska & Palese, 2016:305-313). Therefore, National Health Services (NHS) Commissioner advised that nursing leadership and superiors should find innovative ways that will bring changes to the healthcare system that will enhance caring at the patient's bedside.

2.4 ETHICAL UNDERPINNINGS IN NURSING

Ethics can be defined as the analysis of norms and principles, a carefully and systematically reflection on, and studying of moral decision making and conduct, whether in previous times, current or in times to come (Moodley, 2011:3). Furthermore, ethics is concerned with what people are supposed to do in specific circumstances; it is an issue of what the correct thing is to be done (Moodley, 2011:3). To be ethical means to act or behave in a right or good manner (Pera & Van Tonder, 2011:5).

Ethics and professionalism form the foundation of the healthcare establishment with the public and place an obligation on nurses to consider the needs of the patient above their own. Therefore, nursing professionals should be knowledgeable regarding the field of ethics and consider norms and principles to guide them during ethical decision making (Pera & Van Tonder, 2011:9).

In addition, the ethical responsibility of a nurse to render care to patients originates from the ethical principles of doing what is right and the principle to cause no injury (Schroeter, 2008:3-4). These ethical principles describe the ethical duties of all nursing practitioners to promote the good health of all healthcare users in their care (Schroeter, 2008:3-4). Principles of ethics which mainly apply to clinical care currently are: autonomy, non-maleficence, beneficence and justice. These principles are largely applied today in health care and form the guidelines for ethical dilemmas in clinical care overall (Luba, Ivanov & Oden, 2013:231-237).

Furthermore, ethical codes supply a structure of overall rights, norms, protocols and responsibilities of nursing care services and impose on nurses to adhere to the moral position of their profession (Pera & Van Tonder, 2011:9).

2.4.1 Codes of ethics

Ethical codes are the moralistic rules that oversee the practice of workers of a specific profession, for example the practice of healthcare workers like doctors, nurses, social workers, psychologists and dentists (Mcquiod-Mason & Dada, 2011:77).

In the 4th century BC, Hippocrates, the father of Western medicine, pointed out essential ethical matters in healthcare practice. Consequently, the first written record, the Hippocratic Oath which pertained to the ethical practice of medicine was introduced by Hippocrates (Moodley, 2011:3). Likewise, more than a century ago the Nightingale's pledge was brought in as an oath for the practice of nursing (Pera & Van Tonder, 2011:4).

In addition, all healthcare professionals inclusive of nurses are to adhere to the moral principles of their profession. The codes of ethics are the basis for direction in instances of

ethical dilemmas in nursing practice. The aim of ethical codes is to inform society of the moral principles that apply to nursing practitioners in the performance of their duties (SANC, 2013:1).

Codes of ethics are directives, put together into several different oaths which nursing professionals can employ when they are faced with ethical dilemmas in nursing practice. Subsequently, professions depend on the good moral character of their workers to perform their tasks with great consideration for those who are in their care (Pera & Van Tonder, 2011:9).

According to Young (2009:3071-3078) the duty of care is prominent to regulating healthcare, enhances standards and responsibilities in the healthcare system. Moreover, regulatory bodies in the nursing profession stipulate more specific and focalized principles in the form of regulations to give guidance to its members, as well as for regulatory purposes (Searle, Human & Mogotlane, 2009:155).

A study done by Stellenberg and Dorse (2014:7) found that 91% of nurses consider the nurse's pledge of service. Regardless of the fact that most of the respondents suggested that they protect the healthcare user from unethical practice it was not the same for some of the respondents. However, it may lead to serious consequences for the nursing profession if only a few respondents do not attend to the nurse's pledge of service.

2.4.2 The role of professional organizations

2.4.2.1 *The International Council of Nurses (ICN)*

The ICN, the largest influential global nursing organization introduced ethical codes for nursing professionals in the year 1953. Since then ethical codes had been reviewed and reaffirmed on several different occasions. The most recent review and the completion thereof were in 2012. The ICN states that the four basic obligations of nurses are to promote health, prevent disease, restore health and alleviate suffering. According to the ICN code of ethics inherently to nursing practice is the consideration of human rights, inclusive of the right to life, dignity, respectful treatment, autonomy and cultural rights. Furthermore, the ICN asserted that nursing is to be practised without discrimination with regard to nationality, political affiliation, sexual orientation, social standards, culture, sex, age or colour (ICN, 2012:1).

2.4.2.2 *The American Nurses Association (ANA)*

The second provision of the ANA code provides information regarding the duty of care, relevant to relations between the healthcare practitioner and the healthcare user (Brown & Finnel, 2015:37-43). Similarly, the ANA code imposes an ethical responsibility on nursing professionals to be committed and to provide prudent, compassionate care to all healthcare

users with whom they come into contact with in the healthcare setting. More specific, nurses are to be accountable for their actions, respecting the dignity of patients and keep up to date with evidence-based practices. Also, the ANA code describes concise interpretations of the norms and responsibilities for anybody who aspires to become a nursing professional (Brown & Finnel, 2015:37-43).

2.4.2.3 The Democratic Nursing Organization of South Africa (DENOSA)

The DENOSA was instituted on 5 December 1996 as a professional body and trade union representing nursing professionals and nursing practice in South Africa. DENOSA is the largest professional body for nurses and its aim is to empower, educate, unite and support nursing practitioners. Furthermore, the nursing profession's focal point to care, serve and advocate for the community are supported by DENOSA. In addition, DENOSA aims to influence healthcare policies regionally, nationally and globally. Professional development of its members and to unite nurses to pursue a high level of care in service delivery is another objective of the DENOSA (DENOSA, 2012:1).

2.4.3 Regulatory bodies

2.4.3.1 The Nursing and Midwifery Council (NMC)

The NMC is the regulatory body of nursing practice in the United Kingdom. The NMC ethical codes for nursing practice are derived from the ICN code. It informs nursing professionals, institutions of employment, other healthcare practitioners including society, about the guidelines acceptable of ethical behaviours for nursing practitioners. Moreover, to develop professional liability and practice is one of the goals of the NMC (Dobrowolska, Wronska, Fidecki & Wysokinski, 2007:171-180). In addition, essential principles of the NMC code for nurses include, respecting healthcare users as unique beings, safeguarding patient confidentiality, obtaining official permission for therapy from healthcare users. Other important elements of the NMC code are collaboration with the multi-disciplinary team, pointing out and foreseeing hazards, being trustworthy and demonstrating uprightness in nursing practice (Dobrowolsaka et al., 2007:171-180).

2.4.3.2 The South African Nursing Council (SANC)

The South African Nursing Council is the regulatory body of nursing practice in South Africa. It is an autonomous body which was initially introduced by the Nursing Act, 1944 (Act No.45 of 1944). Currently, the SANC operates under the Nursing Act, 2005 (Act No. 33 of 2005). SANC's ethical codes guide all nursing professionals regarding their responsibilities with relation to healthcare users, their relatives, communities and society. The code of conduct reminds all nurses to, without prejudice, safeguard, and advances and encourages the well-

being of all patients under their care. Prevention of diseases, maintaining human life and relieving pain and distress are fundamentals of the ethical code. At the same time, not only do the ethical codes give direction to nursing professionals, but it is an official record whereby nurses should comply with (SANC, 2013:1-9).

2.5 LEGISLATION

2.5.1 Nursing Act 33 of 2005

The concept legal is concerned with the official system of rules and regulations of a country, whereby a society is bound, as promulgated by that government (Pera & van Tonder, 2011:6). After consultation with SANC, the Minister of Health under section 58 (1) (q) of the Nursing Act (No. 33 of 2005) promulgated the regulations applicable to the nursing profession. The rules, regulations and codes made in terms of the Act provide the ethical and legal constructs for the practise of nursing in South Africa. The scope of practice, for registered nurses, however not exclusively, states that nurses should completely be accountable and responsible when practising nursing. Further, their practices must be underpinned by the professional and ethical obligations of their profession. In addition, registered nurses should provide comprehensive care for society, as well as for the individual healthcare user (DoH, 2013:1-6).

However, Regulation 767 of 1 October 2014, Acts and Omissions as promulgated through the Nursing Act 2005 (Act 33 of 2005) clearly specifies that the SANC can take disciplinary steps against nursing professionals who negligently omit to maintain the health status of a patient under their care.

Section 3 in terms of the Nursing Act, 2005 (Act 33 of 2005) stipulates that it is dishonourable or shameful behaviour of nurses to consciously neglect to sustain the health status of a patient in their care.

2.5.2 National Health Act 61 of 2003

The National Health Act, 2003 (Act 61 of 2003) stipulates that the government must produce the most excellent healthcare practices within the available budget for healthcare services. It is imposed on nurses and all other healthcare professionals in the public and private sector to provide such services. Moreover, the objectives of the Office of Health Standards Compliance (OHSC) created through the National Health Amendment Act of 2013 in terms of section 78 emphasise the protection and promotion of the health and safety of all healthcare users.

2.5.3 Constitution Act 108 of 1996

The Constitution, Act 108 of 1996 has placed an obligation on the government to encourage, highly regard and safeguard the Human Rights of all people. Clinical practitioners, including nurses, should avoid anything that will negatively influence the rights of healthcare users.

The following Human Rights relate to health care as stipulated in the Bill of Rights, in chapter 2 of the constitution:

- Access to health care including reproductive health care
- No one may be refused emergency medical care
- Right to life
- Respect and protection of human dignity
- Access to information
- Respect for culture, religion and choice
- Freedom of movement
- Right to privacy
- Right to freedom and security of the person
- To bodily and psychological integrity
- Not to be subjected to medical or scientific experiments without informed consent
- To be free from all forms of violence
- To an environment that is not harmful to health or wellbeing.

2.5.3.1 *Patients' Rights Charter and Batho Pele Principles*

The Patients' Rights Charter and Batho Pele Principles were introduced by the public services department of government in association with clinical professionals to initiate Human Rights (McQuiod-Mason & Dada, 2011:38). In addition, healthcare users can place a demand on the state for the rights pointed out in the Patients' Rights Charter and Batho Pele Principles (London & Baldwin-Ragavin, 2008:83-84).

(a) Patients' Rights Charter

A large number of South Africans had for many years undergone refusal or infringement of basic human rights, inclusive of the right to health care. Therefore, the Constitution of the Republic of South Africa (Act No. 108 of 1996) stated the right of access to health care. Hence, the Department of Health is dedicated to protect, promote and uphold this right; therefore the Patients' Rights Charter was introduced to achieve this right. Moreover, all healthcare professionals should comply with the specifications of the Patients' Rights Charter (HPCSA, 2008:2).

Patient Rights include the following:

- A healthy and safe environment.
- Participation in decision-making.
- Access to health care.
- Knowledge of one's health insurance/medical aid.
- Choice of health services.
- Treated by a named health care provider.
- Confidentiality and privacy.
- Informed consent.
- Refusal of treatment.
- A second opinion.
- Continuity of care.
- Complaints about health services.

(b) Batho Pele Principles

To transform and improve public service delivery, the White Paper on Transforming Public Service Delivery has introduced the eight Batho Pele Principles in 1997. This approach is summed up in the name Batho Pele, which means "people first". The Batho Pele Principles serve as a structure for all public servants during service delivery. Thus, public servants have to be mindful that the purpose of their employment is to provide society access to services which are their rights. Furthermore, public servants should always be polite and willing to help the community, Public Service Act, (No 103 of 1994).

Batho Pele is based on the following eight principles:

- Consultation: Citizens should be consulted about their needs and the level of quality of the public service they received.
- Standards: All citizens should know what service to expect.
- Redress: All citizens should be offered an apology and solution when standards were not met.
- Access: All participants should have equal access to services.
- Courtesy: All citizens should be treated courteously.
- Information: All citizens should be given full, accurate information about the public services they are entitled to receive.
- Openness and transparency: All citizens should know how decisions are made and departments are run.
- Value for money: All services provided should offer value for money.

Human rights may be described as general ethical entitlements, owned impartially to every individual, solely because of being human; they do not need to be gained on merits, be an heir to it or be purchased. Individuals have uniformly a right to these rights regardless of their gender, ethnicity, mother tongue, nationality, age, social status, religion or political affiliation (Dhai & McQuoid-Mason, 2011:36).

2.6 THE LEGAL UNDERPINNINGS OF THE DUTY OF CARE

The duty of care is commented on directly and indirectly in a number of current protocol records, and has gained a noticeable level of consideration in the news (Young, 2009:3071-30780). According to Klepatsky (2006:16) the courts and not healthcare professionals determine the constituents of the duty of care. If the court finds that during clinical litigation that a duty of care does exist, the court then decides on the conduct required to satisfy the duty.

According to Nemie (2009:54-59) the court has indisputably determined that a duty of care exists due to the relationship between healthcare worker and healthcare user. Thus, the court as a mechanism of public governance has determined the legal rights of healthcare users. In addition, the courts have shown that nursing professionals are obligated to a duty of care towards healthcare users (Nemie, 2009:54-59).

Furthermore, nurses are to carry out their duty of care with an acceptable level of competency and carefulness. Nurses are obligated to make patients aware of any hazards regarding health care and healthcare interventions (Young, 2009:3071-30780).

Similarly, Cornock (2011:21) states that duty of care arises as an issue of law when a nursing professional takes care of a patient and undertakes duties as part of routine work. A breach of the duty of care and failure to uphold the required standard of practice can lead to legal proceedings against a nurse practitioner.

Therefore, it is required that the court should decide on matters that will lessen disputes and difficulties taking place in nursing practice (Nemie, 2009:54-59).

According to Tingle (2010:297-299), the legal system advises on issues regarding the suitability of the behaviour of nursing professionals. It influences all disciplines of the nursing profession, thus, it needs to be considered in combination with principles and regulations of the profession. Evidently, nurses are held legally responsible for patients in their care.

Griffith (2014:234-235) emphasizes that the judiciary, regulatory bodies or an employer may take legal action against nursing professionals who negligently omit their duty of care. Griffith (2014:234-235) asserts that, normally the concept of the duty of care is viewed with reference to negligence.

2.7 NEGLIGENCE

Negligence takes place when clinical-care professionals neglectfully omit to employ the level of competence and care of a reasonably skilful professional in their area of work (Dhai & McQuiod-Mason, 2011:92). According to Fullbrook (2008:1420-1421) negligence falls under civil law and it is a violation which can be prosecuted. In addition, negligence is particularly relevant to matters of benchmarks in the nursing profession. Unless a nursing professional acted in a manner that was not of a level of quality as anticipated, one cannot claim a violation of a duty of care, lest there is evidence against the nurse who is accused of causing the injury (Fullbrook, 2008:1420-1421).

Similarly, Cornock (2011:21) suggests that negligence occurs when healthcare users had been subjected to injuries because of the treatment they received or had not received from a nursing professional. Thus, such users need to be reimbursed if any damage was incurred. However, Cornock (2011:21) points out that four components are needed to prove negligence. Firstly, it must be evident that the nurse owed the patient a duty of care, secondly infringement of the duty has occurred, thirdly the patient was subjected to injury and fourthly the nurse's negligent behaviour has caused the injury.

While Young (2009:3071-3078) states that a case of negligence may be instituted where a duty of care is expected from the nursing professional towards the health care user, but that duty had been violated, or rather the accused nursing professional failed to attain the required level of nursing care. Consequently, harm occurred which could have been foreseen. However, the judicial system should at all times judge the violation of a duty of care according to evidence presented to them duly; judgement should be exercised in consideration of current information and practices (Young, 2009:3071-3078). Based on the evidence from numerous lawsuits against nursing professionals, nurses do not get sued alone, but also the employer (Nemie, 2009:54-59). This is because of the role of vicarious liability. According to Tingle (2010:297-299) it is presumed that the accused healthcare worker was performing his/her task whilst in service at the place of employment where the adverse incident occurred.

2.7.1 The aims of the laws of negligence

The aim of the laws associated with negligence is to reimburse those who were subjected to injury and hardships brought on by other individuals. The person who was subjected to harm

or experienced any unnecessary expenses or problems may claim for reimbursement to make up for the damage they had to withstand (Foley & Christensen, 2016:7-10). Moreover, its intention is also to prevent healthcare professionals from becoming involved in unlawful behaviour (Foley & Christensen, 2016:7-10).

2.7.2 Impact of negligence for the nursing professional

The employer of the nursing professional or the governing councils may discipline a nurse if found guilty of negligence (Tingle, 2010:297-299). Likewise, the guilty nursing professional does not get acquitted even though being charged jointly with the employer. Regulatory bodies may expel the culpable nurse or strike her/his name from the roll or register. The employer has legal entitlement to immunity against the nursing professional at fault (Nemie, 2009:54-59). In addition, the laws associated with professional negligence hold healthcare workers, including nurses, accountable for their conduct (Foley & Christensen, 2016:7-10).

Equally important, if a healthcare user dies due to gross negligence, the guilty nurse may be charged with a criminal offence, and if found guilty the nursing professional may be sentenced to a maximum of life in prison (Huxley-Binns, 2009:892-893). Furthermore, Dhai (2016:2) states that the cost paid by the public because of clinical negligence cannot be overlooked.

2.7.3 Costs of negligence

A study done in America found that the number of nursing professionals being disciplined and the number of lawsuits against them are escalating (Klaassen, Smith & Witt, 2011:85-90). The number of nursing professionals being disciplined escalated from 3 000 in 1996 to nearly 8 000 in 2006. Damages paid out to plaintiffs against nursing professionals escalated from 10 000 dollars in 1997 to 94 million dollars in 2009 (Klaassen et al., 2011:85-90).

Furthermore, The National Health Service Litigation Authority (NSHLA) in England reports claims of professional negligence to the amount of 56 billion pounds as at 31 March 2016 (Tingle, 2017:296-297). The Medical Defense Union (MDU) claims that they received an increase in complaints about negligence against nursing professionals (Tingle, 2017:296-297). Due to the negligence of nursing professionals, the MDU had paid out an amount of two million dollars in compensation to a claimant. In addition, in the year 2015 there were twenty five newfound professional negligence lawsuits with respect to nursing professionals who had membership with the MDU, in comparison with only two ten years earlier (Tingle, 2017:296-297).

In the same way in South Africa clinical negligence lawsuits are rapidly increasing, involving the state, as well as private entities (Malherbe, 2013:83-84). The medical protection society

(MPS) states that professional negligent litigation has multiplied in the past 2 years (Malherbe, 2013:83-84). Damages awarded escalated from 1 million rand 10 years earlier to 5 million rand in the past five-year period, from a 550% increase to 900%. Consequently, the Gauteng Department of Health awarded damages for professional negligence to the amount of R573 million in the year 2009 – 2010. The Health Professions Council of South Africa (HPCSA) received 2 403 statements of dissatisfaction with healthcare services between April 2011 – March 2012 (Malherbe, 2013:83-84).

2.7.4 Factors contributing to negligence

2.7.4.1 Organizational failures

The Minister of Health in South Africa summoned a medico-legal summit, where it was concluded that inherently, organizational failures in the public health department were highlighted as contributing to the increase in the regularity of malpractice and negligence claims against the state (Dhai, 2016:2).

In addition, 141 mentally ill patients died after the Gauteng Health Department in South Africa terminated their contract with the Life Esidimeni Rehabilitation Centre (Nicolson, 2017:1). Cutting costs to save on the health budget was the reasoning behind the government ending their contract with Life Esidimeni. The patients were transferred from Life Esidimeni to unlicensed Non-Governmental Organizations (NGOs). Patients were transferred without proper medical records and identification. Furthermore, the NGOs did not have adequate resources to care for the patients and the personnel at the NGOs were unqualified and inexperienced. Most of the patients died because they were neglected, starved and also due to hypothermia (Nicolson, 2017:1). Thus, organizational procurement matters and budget pressures of government greatly contributed to the deaths of the 141 mentally ill patients.

Furthermore, in the UK, Robert Francis, Care Quality Commissioner (CQC) made an investigation into the needless passing of 1 200 healthcare users at Midstaffordshire Hospital in England (Kline & Khan, 2013:1-2). He came to realize that for the majority of healthcare users the fundamental constituents of care was omitted. The Midstaffordshire Hospital Public Inquire Report revealed serious shortcomings at the hospital, but concluded that those failures may reoccur at other hospitals as well. The CQC suggests that to make a high standard of care the main fundamental norm, the State, NHS senior management, healthcare personnel and regulators should bring transformation to the whole healthcare setting (Kline & Khan, 2013:1-2).

2.7.4.2 Public awareness

According to Dhai (2016:2), the defense for patients with regard to their rights in the Constitution of the Republic of South Africa (Act No. 108 of 1996) and the Consumer Protection Act (No.108 of 2008) has led to an increase of cases of professional negligence. In addition, an increase in patient anticipations and a better comprehension of healthcare, although beneficial, has also added to the increase in the regularity of clinical negligence lawsuits.

At the same time Fullbrook (2008:650-652) claims that the public is no longer to just submissively and without question receive the healthcare decisions made for them by healthcare professionals. The public is more bold and knowledgeable and they will challenge the judgements made for them by healthcare workers.

2.7.4.3 Inadequate training

A study conducted in America reported that the increase in the number of nurses being disciplined and the increase in the number of clinical negligence litigation indicate that student nurses, as well as registered nurses are not adequately trained for lawful matters of the clinical environment. Consequently, nursing training institutions have included a legal nursing module in their curriculum to better equip nurses regarding legal matters of nursing practice. (Klaassen et al., 2011:85-89).

2.7.4.4 Role expansion

Another contributing factor to clinical negligence litigation is the expansion of the roles of nursing professionals (Tingle & Mchale (2009:38-39). Nursing professionals will not be found guilty of negligence if they act in accordance with a practice accepted by a responsible body of professional opinion (Griffith, 2014:234-235).

The Bolam Test, applicable to all healthcare professionals will illustrate the above- mentioned statement.

(a) A case of clinical paternalism: The Case of Bolam

Paternalism refers to a healthcare worker, doctor or nurse, which overrides a patient's preferences, based on the judgement of the healthcare worker (Moodley, 2011:59).

This landmark case was between Bolam, the claimant and Frien Hospital Management Committee, the defendant (1957) WLR 582 (Miola, 2009:756-757). In this case the judge concluded that the hospital was not guilty of any negligence. Furthermore, the court decided that a clinical practitioner will not be found to be negligent if she/he carries out a task according to a praxis truly believing to be right by an authoritative reliable council of clinical expertise.

However, the Bolam test has been continuously judged by scholars, analysts and consortiums. They proclaim that the Bolam test acts in favouritism towards clinical practitioners (Young, 2009:3071:3078). In addition, the Bolam test creates the idea that if a nursing professional or any other healthcare worker could prove that they cautiously carried out their tasks as any other healthcare worker would do in a similar position, they will not be found guilty of negligence (Miola, 2009:756-757).

However, the Bolam test has been changed and adapted in many clinical negligence trials that have followed. It is no longer enough to act in accordance with a practice accepted by a responsible body of professional opinion (Griffith, 2014:234-23). The main authoritative contemporary clinical negligence trial that indicated a change in judiciary judgement was the case of *Bolitho*.

(b) A Doctrinal Shift

The case that suggests a change from the customarily Bolam ruling was the case between *Bolitho* as the claimant, and *City and Hackney* as the defendant HA 1997 & all ER 771 as the defendant (Young, 2009:3071-3078). In the case of *Bolitho*, judiciary suggested that they would place the viewpoint of the medical expert under close scrutiny if appropriate. In the *Bolitho* case, the courts took on the stance of a professional practice which was logical, prudent and accountable and their viewpoint had to have a sound and rational foundation. It appears as if the courts are more eager to confront healthcare practitioners and to analyse their work more closely if under question (Tingle, 2010:297-298). Also, it had been illustrated in a series of trials after *Bolitho* that the Bolam test which was in support of clinical professionals had become weaker and weaker, and is not a powerful shield for clinical professionals anymore as it once was (Young, 2009:3071-3078).

A South African case illustrating the change in clinical paternalism is the case of *Esterhuizen* as the plaintiff and administrator, *Transvaal* the defendant. In this trial, the judge found in favour of the plaintiff and dismissed the defendant's claim that the therapy was favourable for the plaintiff (Chima, 2013:1-3).

In an Australian case where the Bolam test was declined, was the case between *Rogers and Whitaker*, *Rogers* as the defendant and *Whitaker* the plaintiff. In this case the claimant had an operation to her right eye which would have presumably improved her sight, as well as her physical image. However, the result of the operation was disastrous. In the end the plaintiff could virtually no longer see. Judiciary rejected the Bolam test and ruled in the interest of the plaintiff and ordered reimbursement to the amount of 800, 54 dollars (Dingwall, 2007:85-89).

Tingle and Mchale (2009:38-39) suggest to prevent lawsuits of clinical negligence nurses should pay close attention to patients' rights, healthcare developments, regulations, policies and standards.

2.8 STANDARDS OF NURSING PRACTICE

The National Health Act (No. 61 of 2003) as amended by the National Health Act (No. 12 of 2013) has introduced the Office of Health Standards Compliance (OHSC). The OHSC is to make sure that healthcare institutions observe the necessary healthcare standards. The National Core Standards (NCS), introduced by the National Department of Health in 2011, can be used to generally defy quality health care. The NCS should be available to all healthcare institutions and be used as guidelines for managerial boards and personnel alike. In addition, the NCS can be applied to evaluate if institutions and staff are compliant with standards.

In addition, Searle, Human and Mogotlane (2009:312-313) state that nursing professionals should be mindful about benchmarks for practice, prescribed by their profession. Further, records that give guidance and protocol documents of standards are available in a well-organized clinical care institution. Searle, et al. (2009:312-313) assert that benchmarks for nursing practice should always be achievable, comprehensible, logical, assessable, economical and patient orientated. Also, nursing professionals should assess benchmarks on a regular basis and stay up to date with enhancements in nursing practice.

According to Fullbrook, (2008:1420-1421) the matter of standards fall under common law and it gives direction to nursing professionals on how to adhere to the law in the prevention of adverse events. It is the duty of regulatory bodies to provide standards, approve standards, and to point out those standards which are not acceptable. The conduct demonstrated at present in the deliverance of healthcare and the required standards of healthcare are partially the expectations of professional bodies (Fullbrook, 2008:538-539).

In the same way Miola (2009:756) states that nursing professionals should uphold required standards of nursing care to avoid disciplinary action and being held accountable for professional negligence. Equally important, Sebopa (2010:48-49) states that whenever nursing professionals are taking care of healthcare users, it is of great importance to conform to guidelines and standards of the profession. Moreover, failure on the part of nurses to uphold these standards, will lead to endangering healthcare users, with horrendous consequences for the nurse, patient as well as the employer.

Furthermore, a violation of the nursing standards linked to the issue of professional negligence would take place if nursing professionals omit to perform their task according to that of an

ordinary competent professional (Fullbrook, 2008:1420-1421). Foley and Christensen (2016:7-10) are of the opinion that adhering to the approved standards of the nursing profession assists nursing professionals, ensuring them that they are fulfilling their lawful duties.

Tingle (2010:297-299) suggests that the enhancement of the functions of the nursing professional brought on more responsibilities, thus nurses should become more knowledgeable regarding developments in the standards of their profession.

2.9 ENHANCEMENT OF THE ROLE OF NURSING PROFESSIONALS

Experienced, skilful nurses are undergoing extensions of their nursing functions universally (Boris, 2010:1761-1762). Currently, nursing professionals at large are performing duties which were normally the tasks of clinicians. Subsequently, the expansion of the functions of the nursing professional, with increased independence resulted in added responsibilities which, without fail brought about increased medico-legal hazards and liability (Boris, 2010:1761-1762).

Tingle and Mchale, (2009:38-39) state that the enhancement of the functions of nursing professionals in the clinical setting and in the communities have caused nurses to become more apprehensive with reference to the legalities of the provision of healthcare. Since changes were made to the scope of practice of nursing professionals, it has never been more important for them to keep up to date with the statutory laws and with the fast rate at which laws are changing (Tingle & Mchale, 2009:38-39).

The functions of nurses in Malaysia have been enhanced to supplement the care provided by other clinical practitioners (Nemie, 2009:54-59). In a continuous evolving clinical setting, nurses in Malaysia have been forced to perform tasks that may have radical personal statutory implications due to the expansion of their functions. Thus, it is only appropriate to assume that the expansion of the functions of nursing professionals will cause them to be accountable for any ramifications of their conduct. Furthermore, nurses are also accountable to the organization they work for, their co-workers, and healthcare users and in the end accountable to a court of law (Nemie, 2009:54-59).

However, to deal with the complicated ethical and statutory matters that confront nursing practices at present, it is vitally important that nursing professionals equip themselves with the necessary knowledge pertaining to their profession (Griffith, 2014:234-235).

2.10 RECOMMENDATIONS FOR SAFE PRACTICE

Clinical negligence litigation can be an unsettling issue for nursing professionals. On the contrary, if they practise according to the approved guidelines, they do not need to be fearsome with regard to litigation and complaints (Cornock, 2011:21). Folley and Christensen (2016:7-10) reiterated that nursing professionals can be certain that if they comply with statutory laws of their profession, if they adhere to accepted benchmarks of nursing practice, then they can prevent themselves from being sued for negligence.

Tingle and Mchale (2009:38-39) reaffirm that the routine task that nurses perform each day should display insight and understanding with regard to the laws that underpin their profession. In doing so, the result will be a considerate, sound and prudent nursing practitioner. Hence, statute law can be seen as a strategy to safeguard healthcare users, but nurses will also protect themselves with regard to claims of negligence if their practice is informed by legal knowledge.

In the same way Boris (2010:1761-1762) acknowledges that to grow safe practicing customs that decrease hazards, the nursing professional should have knowledge with regard to the status-quo of present statute law. For example, a relative useful way in understanding the legal implications intrinsic to an individual's profession is to read published papers, analyse case law, be involved with ongoing educational projects and understand the fundamentals of professional misconduct. This also means, being knowledgeable regarding the scope of practice, analysing the country's parliamentary laws and having insight into standards and protocols of service delivery. In addition, Boris (2010:1761-1762) suggests a recordkeeping strategy should be established that consists of current meaningful information.

Moreover, the Midstaffords NSH Trust Public Inquire Report suggests, to openly speaking the truth, being transparent and candid are needed characteristics for institutions that provide clinical care to society (Mellor, 2013:36-43). Nursing professionals are to fully explain and apologize to their employers and healthcare users if an adverse incident occurs in the clinical environment (Griffith, 2015:407-409).

At the same time, concerns for safe practices to be communicated publically and honestly by healthcare executives and healthcare professionals and they should be open with healthcare users regarding preventable injuries. Furthermore, health care professionals should not give evasive information to regulatory bodies, society and government administrators. On the contrary, the Midstaffords NSH Trust Public Inquire Report noted that candour and unambiguity are not presently observable in different areas of healthcare services where it is required (Mellor, 2013:36-43).

Essentially, Young (2009:3071-3078) states that the duty of care is a situation of lawful aspects and its concern is for society, therefore judiciary, not clinical practitioners to establish benchmarks for the duty of care. Griffith (2016:155-158) reaffirms that even though judiciary is usually satisfied to permit the health care system to establish their benchmarks for practice, it still holds the entitlement to dismiss standards if it is not of a logical base.

2.11 SUMMARY

An in-depth discussion regarding the duty of care was provided in this chapter. The obtained literature immensely suggests that the duty of care is a matter of legal and ethical obligations (Young, 2009:3071-3078). Furthermore, the law which is a mechanism of public governance imposes a duty of care on healthcare professionals, due to the relationship between healthcare worker and healthcare user (Nemie, 2009:54-59). Equally important, if healthcare workers breach their duty of care or do not uphold standards of practice they may be held liable or be charged with clinical negligence (Griffith, 2014:234-235).

2.12 CONCLUSION

The scientific literature regarding duty of care demonstrates the researcher's review of the published literature. The concepts of the duty of care were debated and relevant aspects relevant to the duty of care were presented. In chapter 3 the research methodology applied in this study will be discussed.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter provides a detailed discussion of the research methodology that was followed to explore undergraduate nursing students' understanding and application of the duty of care. Research methodology refers to the research process which basically means the methods used by the researcher to resolve problems (De Vos, Strydom, Fouche, Delport, 2011:61).

3.2 GOAL

The goal refers to something which the researcher intends to accomplish (De Vos et al., 2011:94). The aim of the study was to explore the undergraduate nursing students' understanding and application of the duty of care.

3.3 OBJECTIVES

The objective means to clearly and concisely declare statements in the present tense which states the focus of the inquiry (Grove et al., 2013:138).

The objectives of the study is to explore undergraduate nursing students' understanding and application of

- caring in nursing practice
- the duty of care
- the legalities of nursing practice
- ethics in nursing practice
- standards of practice
- negligence in nursing practice.

3.4 STUDY SETTING

Qualitative researchers normally gather their data in existing, genuine life environments (Polit & Beck, 2014: 267). However, obtaining entry to the setting required the researcher to negotiate with gatekeepers who had the control to allow for entrance to the setting (Holloway & Wheeler, 2010: 54).

Furthermore, it is essential for the researcher to consider the contextual and customs in which the research will occur (Holloway & Wheeler, 2010: 5). Thus, not only do participants have their own norms and belief system, but they also connect with their surroundings and this may affect their relations with the researcher (Holloway & Wheeler, 2010: 5). Yet, if the researcher considers the contextual aspects in which the research will occur, it is easier for them to comprehend the expressions and behaviours of the participants.

For instance, the inquiry may occur in a healthcare setting, academic environment, and a participant's home or in a public area. Thus, if data collection occurs in a familiar environment, participants are more at ease and in a degree of control; the researcher then may obtain more detailed information during the data collection process (Holloway & Wheeler, 2010: 93).

However, the researcher should decide on an area that is private, quiet, convenient, comfortable and nonthreatening to the participants (Grove et al., 2013:271). Seating can be arranged in such a manner that will promote communion (De Vos et al., 2011:350). Water or other drinks can be offered before interviewing to build rapport with participants or for social interaction (Grove et al., 2013:272).

This study was conducted in a quiet vacant room at a nursing education institution in the Cape Metropolitan area. After permission was obtained from gatekeepers, the researcher informed participants with regard to the research setting.

Since individuals connected with their environment the researcher chose an area which was familiar, safe and convenient for the participants. Moreover, if participants are interviewed in a familiar environment, they are in a degree of control, are more relaxed which might cause them to interact with ease with the researcher. Thus, more in-depth information can be obtained from the study participants (Holloway & Wheeler, 2010:93).

The room was furnished with comfortable chairs and seating was arranged in a manner which promoted social interaction.

3.5 RESEARCH DESIGN

Qualitative researchers concentrate on the viewpoint and understanding of the individuals participating in the study (Holloway & Wheeler, 2010:3). Similarly, Grove et al. (2013:57) state that qualitative research explains human experiences from the viewpoint of the individuals taking part in the study; it gives meaning to their subjective life experiences and it provides insight to direct practices of the nursing profession.

Also, exploratory descriptive qualitative research is carried out to explore matters or problems that need to be resolved or to be understood (Grove et al., 2013:27). In addition, exploratory descriptive qualitative researchers point out a particular shortcoming of information that can be dealt with only by means of getting the point of view of the individuals involved (Grove et al., 2013:27).

Thus, qualitative nursing researchers are exploring matters or problematic areas by applying a variety of qualitative techniques with the intention of explaining phenomena and to promote

insight and comprehension. The aim is to develop a system or ways that are advantageous to society (Grove et al., 2013:66).

According to Polit and Beck (2014:343) the main objective of exploratory descriptive designs in nursing is to explore in detail phenomena or principles which are not clearly comprehended.

Thus, in this study a qualitative exploratory descriptive design was applied to explore 4th year undergraduate nursing students' understanding and application of the duty of care. This design was found to be most applicable for the purpose of the study, because it will give the 4th year nursing students an opportunity to express and speak freely about how they understand the duty of care and how to apply it.

3.6 POPULATION AND SAMPLING

A population refers to all the elements that have the same characteristics or meet the inclusion criteria for a study (Polit & Beck, 2014:387). A sample is a unit or part of the population which the researcher selects to take part in an inquiry (Polit & Beck, 2014:391). Sampling refers to the process the researcher applies to select a group of individuals from the population for representation of the population (Polit & Beck, 2014:391).

Unlike quantitative research, qualitative researchers gather more in-depth data from a smaller number of participants (Harding, 2013:8). Thus, the sample of a rigorous qualitative inquiry is not as huge as the sample size of a rigorous quantitative study.

However, the specific sample size of a qualitative study is dependent upon whether data saturation has occurred (Grove et al., 2013: 261-268). Data saturation has occurred when there is a repetition in the new data of what has already been determined. Thus, patterns start to come to light in the data and the researcher has the information required to explain the research question (Grove et al., 2013:267-268).

In addition, numerous qualitative researchers make use of purposive sampling, a method of non-probability in which researchers purposefully decide on those individuals who will add in-depth value to the inquiry (Polit & Beck, 2014:285).

For the purpose of this study the target population to research the objectives of this study, included the entire group of students who are in their 4th year of study of the undergraduate R425 programme at a nursing education institution in the Cape Metropolitan area. The researcher applied the use of purposive sampling, a technique of non-probability sampling to recruit participants for the study. A sample of 11 individuals was recruited for participation in this study, consisting of one pilot study and ten individual interviews.

The researcher decided on the 4th year nursing students because they were in their final year of study. These students have gained a good measure of clinical experience over the four years and were thus able to respond to the objectives of study.

During the sampling process the researcher applied reflexivity strategies by means of bracketing past experiences and relationships. Reflexivity in sampling refers to the capability of being conscious of your biases and previous experiences that may have an impact on the process and outcome of the research study (Grove et al., 2013: 268).

The researcher worked as a clinical educator at the specific nursing education institution where the research study was done. The main function of the researcher was to mentor first year nursing students at a public hospital in the Western Cape metropolitan area. Thus, the researcher excluded those individuals whom she accompanied during her/his first year study.

3.6.1 Inclusion criteria

Inclusion criteria refer to the attributes participants need to have to be included in the target population (Grove et al., 2013:353).

Inclusion criteria in this study included:

- Fourth year undergraduate nursing students enrolled for the R425 programme at the specific nursing education institution whom were not mentored by the researcher during their first year of study.

3.6.2 Exclusion criteria

Exclusion criteria refer to those attributes an individual has which exclude her/him from the target population (Grove et al. 2013:353).

Exclusion criteria in this study excluded:

- All undergraduate nursing students enrolled for the R425 programme at the specific nursing education institution whom were mentored by the researcher during their first year of study.
- All other students in their 1st, 2nd or 3rd year of study.

3.7 INSTRUMENTATION

Qualitative researchers make use of an interview guide to collect data from participants (Polit & Beck, 2014:290). Furthermore, the interview guide is used to make sure that all questions are covered during interviewing.

According to Holloway & Wheeler (2010:89), an interview guide is compiled by the researcher to address aspects of the inquiry and also to give guidance during interviewing. The interview guide ensures consistency and that the same information is gathered from all the participants. Thus, the researchers can construct their own questions and make their own choices as to which avenues to investigate. In addition, the interview guide focuses on specific questions with regard to the research topic; however the questions may be modified after many interviews because of theories that emerge (Holloway & Wheeler, 2010:90).

For the purpose of this study, a self-formulated semi-structured interview guide based on the objectives of the study was used by the researcher during data collection. The researcher applied the use of an interview guide to ensure that all the questions related to the topic were covered.

Moreover, the interview guide gave structure to the interviewing process, however questions were modified as interviewing continued because new data emerged. Equally important, the interview guide ensured that more or less the same data were obtained from the participants.

3.8 PILOT STUDY

A pilot study is a smaller inquiry performed by the researcher to prepare for the actual study to determine if the major study is feasible (Polit & Beck, 2014:387). The goal is also to detect the possibility of mistakes in the methodology of the proposed study.

According to De Vos et al. (2011:395) the aim of a pilot study is to detect if significant information can be gathered from the study participants. Questions tested during piloting may be modified to ensure a high standard of interviewing during the actual inquiry. Furthermore, by carrying out a pilot study the researcher may estimate the timing and expenses of a study and also prevent any difficulties that may occur during the main interviewing process (De Vos et al., 2011:395).

For the purpose of this study, the researcher conducted a pilot study at the particular nursing education institution with one of the fourth year undergraduate nursing students. The length of the pilot interview was one hour and 10 minutes.

It enabled the researcher to test the appropriateness and feasibility of the methodology of the study, as well as testing the interview guide, interview skills of the researcher and the timing of the interview.

After the pilot study the researcher modified certain questions for improved understanding and clarification on behalf of the study participants.

3.9 TRUSTWORTHINESS

The criteria for the development of trustworthiness in a qualitative study are: credibility, dependability, confirmability and transferability (Polit & Beck, 2014: 322). These four criteria were introduced by Lincoln and Guba (1985) for qualitative researchers and it is similar to the criteria of reliability and validity in quantitative research (Polit & Beck, 2014: 322). The abovementioned criteria were applied to enhance trustworthiness in this study.

3.9.1 Credibility

Credibility involves confidence in the truthfulness of the obtained information and the meanings and understanding of it (Polit & Beck, 2014: 322). For the enhancement of credibility in this study the researcher applied the following:

3.9.1.12 Reflexivity

The researcher applied reflexivity strategies in this study, which relates to being aware that researchers as unique human beings bring to the study their own morals and principles, as well as their social and professional backgrounds which could influence the research proceedings. By means of maintaining reflexivity in the study before and after the interviewing process, the researcher were mindful of the researcher's influence with regard to data gathering, data analysis, as well as meanings of the information obtained.

Bracketing was done by the researcher with reference to previously read literature about the topic and considering any prior life experiences. Thus, the researcher remained neutral during the research proceedings.

3.9.1.23 Member checks

Member checking refers to the researcher giving feedback to participants with reference to their interpretations of the data and for the participants to check the truthfulness of the researcher's meanings of the data (Polit & Beck, 2014:322). Member checking was conducted in this study during the interviewing process when the researcher purposefully repeated and paraphrased participants' words to them to confirm that the researcher accurately interpreted the interviewee's meanings (Polit & Beck, 2014: 322).

3.9.2 Dependability

Dependability is based on the consistency and accuracy of the research findings (Holloway & Wheeler, 2010: 302). For the enhancement of dependability in this study the researcher kept record, drew a decision trail of conclusions and categorised data during the research process (Polit & Beck, 2014:328). Thus, the researcher described the context of the research proceedings in detail (Holloway & Wheeler, 2010: 303).

3.9.3 Confirmability

Confirmability is concerned with the principle of corroboration between two or more researchers, whether the data provided by one researcher is correct, relevant and accurately interpreted (Polit & Beck, 2014: 323). In addition, these criteria involved in determining that the information presented by the researcher is indeed the data that was given by the participants and that the meaning of the information was not assumed by the researcher. To enhance confirmability in this study the expert knowledge of the supervisor of the research was employed to check the data collected and the data analysis processes of the principal investigator, thus through collaboration any biases and discrepancies were excluded.

3.9.4 Transferability

Transferability refers to whether the research outcomes are applicable or can be generalized to other contexts (Polit & Beck, 2014:323). Lincoln and Guba (1985) suggest that the researcher is responsible to give enough in-depth information for readers to assess if the gathered information could be applied to other settings (Polit & Beck, 2014: 323).

In this study the researcher enhanced transferability by providing thick descriptions of the research settings, proceedings and verbatim quotes of study participants, as well as demographic data with regard to study participants (Polit & Beck, 2014:323).

3.10 DATA COLLECTION PROCESS

In qualitative research data collection and data analysis may be carried out at the same time (Grove, et al., 2013:268). According to Polit & Beck (2014:290) detailed interviewing is commonly used as a strategy for gathering qualitative data.

In addition, data in qualitative research consist of the words spoken by the participants, as well as the nonverbal cues observed by the researcher (Grove, et al., 2013:271). According to De Vos, et al. (2011:342) the interview is a social interaction constructed for exchanging data between interviewer and interviewee.

Semi-structured interviews are used when the researcher has a number of open-ended questions he/she wants to address (Polit & Beck, 2014: 290). Semi- structured interviewing is utilized by researchers to obtain an in-depth understanding of the interviewees' descriptions and viewpoints of a specific phenomenon (De Vos et al., 2011: 351). This technique was flexible, as it allowed the researcher to probe specific emerging issues that came to light and it enabled the participants to provide more detailed information.

Usually, qualitative researchers are knowledgeable from whom they want to collect data, before entering the research setting, yet not forgetting other sources that may emerge as data gathering continues (Polit & Beck, 2014: 290).

In this study the researcher obtained ethical approval from the higher education institution, (Appendix 2) to gain access to one of their satellite campuses, before gathering the data. In addition the researcher had to obtain permission from the gatekeeper, who was the head of campus, to gain access to the fourth year students (Appendix 3). The researcher then met with a lecturer, teaching the fourth year students, to arrange for a meeting with the fourth year undergraduate nursing students. After a date and time was set the researcher met with the fourth year students in their classroom to recruit participants for the study. The purpose of the study was explained to the students. In addition, the researcher informed the students that participation in the study was voluntarily. Eleven students indicate that they were interested to participate in the study. With permission from the lecturer, the researcher removed the 11 participants to another classroom. The researcher explained to them in more detail the purpose of the study, as well as their responsibilities. The researcher also informed the participants about the area where interviews will be conducted, as well as the estimated duration of an interview, so that participants could plan their day accordingly. The researcher emphasised that participation was voluntarily and that participants may withdraw from the study without any detrimental actions towards them.

Before commencement of the interviews the demographic data were obtained and consent forms were completed by participants. The researcher offered beverages and had general conversations with participants before interviewing, as a means of building rapport.

Interviews were conducted in a pre-arranged room at the identified nursing education institution. Interviews were conducted in English. The duration of the interviews were between 50 - 90 minutes.

Anonymity and confidentiality of students were retained during data collection. After permission was obtained from the participants including recording of the interview, the interview commenced and was recorded. The researcher recorded the interviews on a digital voice recording device which was saved on a computer for later transcription (Grove, et al., 2013:2720). Ten semi-structured interviews were carried out in order to gain a detailed picture of the participants' understanding or accounts of the duty of care (De Vos et al., 2011:351).

In order to calm the participants and prevent distraction the researcher placed the recorder in a manner where it was not easily visible (De Vos et al., 2011:359).

Utilizing the use of a voice recording device the researcher could save the accurate statements of the participants, as well as questions and it allowed the researcher not to forget essential aspects (Holloway & Wheeler, 2010: 95). The researcher could also maintain eye contact with the participants and carefully attend to the words of the participants. In addition, the researcher could follow and focus on the interviewing process (De Vos et al., 2011: 359).

During interviewing the voice recording device provided a more detailed report than written statements. However, during interviewing the researcher wrote words and phrases in order to have a clear mind about specific instances that transpired in the field (De Vos et al., 2011: 407). After interviewing the researcher also wrote notes with regard to certain aspects of the interview soon after completion of the interview, while the interview was still clear in the mind of the researcher (Holloway & Wheeler, 2010: 97).

3.11 DATA ANALYSIS

In qualitative studies researchers follow a series of steps to examine and interpret data in order to understand and obtain ideas for the development of knowledge (Grove et al., 2013:279-281). In this study a series of steps according to Terreblance, Durheim and Painter (2006:322) were followed during analysis of the data.

Step 1: Familiarization and Immersion

Familiarization means that the researcher took time to listen to the voice recordings, reflected on experiences that transpired during data collection and read and reread the transcript over and over again (Grove et al., 2013:281). Immersion refers to the researcher spending much time, energy and effort to read and reflect on the data and to be completely immersed in the data.

In this study the researcher spent much time listening to the audio recordings of the interviews and read and reread notes that were made during the interviewing process. In addition, the researcher read and reread the transcripts, recalled observations and reflected on the information that was collected during data collection.

Step 2: Inducing themes

Comparing similarities and characteristics within the data and through immersion the researcher was able to induce themes. The researcher recognized underlying themes in the data as it could be pointed out repeatedly within the data.

Step 3: Coding

Coding refers to the naming and labelling of phrases and text within the data as it relates to a theme. At the same time as the theme developed the researcher coded the data. The data were highlighted with different colours as it related to the different themes.

Step 4: Elaboration

During the elaboration phase the researcher explored the themes more closely, comparing more intensely the themes in the data that appeared to have a connection with one another. During the comparison of themes, subthemes emerged and information that were not noticed before were pointed out within the data. The researcher continued with elaboration and coding until no new meaningful aspects appeared within the data.

Step 5: Interpretation and checking

Interpretation and checking refer to the researcher's written account with regard to themes and subthemes. Interpretations were closely checked by the researcher to identify whether it was only a written summary of the data. Interpretations made by the researcher were placed into context, related to the research question and the objectives of the inquiry. The researcher bracketed any preconceived ideas with regard to previous life experiences, previously read literature and the professional role the researcher played in gathering and analysis of the information.

3.12 SUMMARY

In chapter three the researcher described in depth the methodology that was followed to achieve the objectives of the study and to be able to answer the research question. The qualitative research design, as well as the recruitment process, data analysis and rigor of qualitative studies were discussed in detail. In chapter four the results of the study will be discussed.

CHAPTER 4: RESULTS

4.1 INTRODUCTION

In chapter 4 the data collected are analysed, interpreted and presented, with reference to the participants' understanding and application of the duty of care, participants' understanding and application of ethics and legalities of nursing practice, as well as their understanding of negligence.. Themes and subthemes that emerged from the data are presented in table 4.1. Themes and subthemes will be elaborated on after presentation of the biographical data.

4.2 SECTION A: BIOGRAPHICAL DATA

Interviews were conducted with 11 participants who met the inclusion criteria. Participants were in their fourth year of training. All of the participants were English speaking, while some of them spoke a second language, either English or Afrikaans. Two of the participants were married, while the rest was single, and most of them resided in the residence at the college. Ages of the participants ranged from 22-35 years and all of the participants were females. During recruitment of participants, no male participants were interested to participate in the study.

4.3 SECTION B: THEMES EMERGING FROM THE DATA

Themes and subthemes which emerged from the interviews were used as a structure within which to present the findings. A number of 11 themes emerged from the data and subthemes varied from 1-4 per theme. The emerging themes and subthemes are displayed in table 4.1

Table 4.1: Emerging themes and sub-themes

Theme	Subtheme
Patient Care	<ul style="list-style-type: none"> • Holistic care • Rendering a service • Barriers to caring
Being there for the patient	<ul style="list-style-type: none"> • Performing nursing tasks • Communication • Lack of care
Obligation	<ul style="list-style-type: none"> • Responsibilities • Scope of practice
Caring for the patient	<ul style="list-style-type: none"> • Respect
Ethical principles	<ul style="list-style-type: none"> • Non-maleficence • Guidance

Legalities of nursing practice	<ul style="list-style-type: none"> • SANC • Nursing Act • Ethical codes • Standards of practice
Decision making	<ul style="list-style-type: none"> • Outweigh harm and benefits • Patient autonomy
Carelessness	<ul style="list-style-type: none"> • Omit patient care • Disciplinary action
Legalities of negligence	<ul style="list-style-type: none"> • SANC • Criminal law • Vicarious liability
Increase in clinical negligence	<ul style="list-style-type: none"> • Lack of knowledge • Lack of caring

4.3.1 Theme 1: Patient care

4.3.1.1 Subtheme: Holistic care

Most of the participants associated caring with taking care of patients in a healthcare setting. The taking care of patients surfaced boldly as a theme during interviewing. Furthermore, most participants described holistic care as an essential component of taking care of a patient in nursing practice. In addition, most participants asserted that not only the physical aspect of the patient needs to be addressed, but all the dimensions of being human. Based on the participant's statements below, the researcher concluded that participants related their understanding of caring with taking care of patients holistically.

One participant mentioned: *“Caring is looking at a patient as a whole; you must first see the patient for who he is in all aspects, physical needs, psychological need, and spiritual needs.”* (Participant 1)

Some verbalised: *“Caring is that you have to care holistically... taking to consideration the emotional wellbeing, social wellbeing, psychological wellbeing of the patient care.”* (Participant 6)

In addition, one participant was of the opinion that caring means to assist people, because you wanted to.

“Caring is to help people, something that you want to do.” (Participant 2)

Another participant described caring as having compassion and empathy for patients suffering from illness.

“Caring is being compassionate, showing empathy and sympathy towards our patients.”
(Participant 3)

Furthermore, a participant also explained that the essence of nursing practice is to assist people.

“The core of nursing practice is basically just for me to help people.” (Participant 2)

4.3.2 Subtheme: Rendering a service

Provision of nursing services was another aspect which participants associated with patient care, with reference to their understanding of caring. Some participants explained that they provided a service to the patients by assisting them with activities of daily living. Thus, the participants also related their understanding of caring with providing a service to the patient.

“Caring means acknowledging the patient’s need and ensuring that you deliver a service in order to meet those needs.” (Participant 1)

“Caring means when you give support and also render services.” (Participant 6)

However, one participant stated time constraints caused them not to care for patients, thus only to perform essential duties.

“You don’t have much time...so you just do your work not actually getting to depth in caring.” (Participant 4)

Another participant stated that nurses can work on their attitudes when they are providing care to patients.

“We can definitely change our attitude or the way we talk to the patients.” (Participant 10)

According to another participant, caring was taking care of the patients according to benchmarks stipulated for the nursing profession.

“You go according to your scope of patients...and care for them according to that guidelines.” (Participant 2)

4.3.3 Subtheme: barriers to caring

Moreover, most participants expressed that in the clinical setting they find barriers to effectively care for patients. Shortage of staff was a major factor that emerged during interviewing. The following verbatim quotes express participant’s views.

“There are always shortage of staff so it is impossible to provide the quality care that we supposed to.” (Participant 6)

“I experienced is the shortage of staff...it takes up our time.” (Participant 2)

Some participants also mentioned that language was another barrier to caring, because sometimes they find it difficult to communicate with patients.

“Language is the biggest barrier.” (Participant 8)

“Sometimes language is the biggest barrier.” (Participant 9)

In addition, participants mentioned that negative staff attitudes place a barrier on caring for the patient adequately.

“Staff behaviours...most of the wards...sister shouting...and they talking at you with very aggressive tone.” (Participant 10)

“Senior attitudes towards junior nurses...there is no mutual respect.” (Participant 3)

“Conflict in the workplace and not being treated well by your superiors.” (Participant 7)

4.3.4 Theme 2: Being there for the patient

4.3.4.1 Subtheme: Performing nursing tasks

Being there for the patient often emerged as a theme during each interview with reference to the application of caring in nursing practice. Most of the participants associated the performance of nursing tasks with being there for the patient. Bathing of patients, assistance with feeding and hydration were mentioned by participants as means of applying care in nursing practice. It is clear from the participants' comments that they will apply caring by carrying out nursing care duties.

“Making sure they are well fed, they are clean.” (Participant 3)

“Make sure the patient is safe ... basic needs of the patient are met.” (Participant 5)

In contrast, one participant mentioned that in practice they sometimes forgot about caring for the patient and just carried out duties as expected from them.

“We supposed to care for every patient but it doesn't happen like that so basically we just sometimes, we forget, put the caring aside and you just do what we supposed to do.” (Participant 2)

4.3.4.2 Subtheme: Communication

Most participants also related being there for the patient by communicating with the patient to apply caring. Thus, they will also apply care by communicating with the patient by asking them about their well-being. The researcher concluded that participants view communication as an important factor in application of caring in nursing practice.

“Find out from the patient what the patient needs.” (Participant 7)

One participant voiced about applying the therapeutic touch on a patient’s hand or shoulder which will indicate to the patient that the nurse is caring.

“The therapeutic touch...on the hand...by communicating and say are you okay?”
(Participant 9)

Furthermore, some participants verbalised that they will reassure the patients with reference to their health care.

“We are here for you as nurses.” (Participants 3)

However, one participant mentioned that they were reprimanded for having conversations with patients.

“We get scolded for just talking to the patients.” (Participant 10)

4.3.4.3 Subtheme: Lack of care

The majority of the participants mentioned that during their clinical placement they did not observe caring towards patients in nursing practice. Furthermore, participants asserted that nurses are just carrying out their duties for the mere fact of getting the work done. Based on participants’ responses the researcher concluded that compassionate, empathetic caring is fading in nursing practice.

“The nurses I’ve been working with, some they don’t show compassion... they just do things because it need to be done.” (Participant 8)

“They not showing they care they just doing for the sake of carrying out their work.”
(Participant 11)

However, one participant stated that she did see caring for the patients in nursing practice, but it was not visible amongst nursing personnel.

“I have seen caring for patients, but amongst the staff...they still need to work on it.”
(Participant 6)

Another participant voiced that caring varies from ward to ward in the hospital, but the community clinics operated like a business.

“It varies in the hospital, in some wards there is caring but then in the clinic...it’s sort of a business.” (Participant 3)

4.3.5 Theme 3: Obligation

4.3.5.1 Subtheme: Responsibilities

The main theme that emerged from the data with reference to participants’ understanding of the duty of care were the statements they raised that nurses have an obligation to take care of patients. A large number of participants verbalised that it was the responsibility of a nursing professional to take care of a healthcare user. It is evident from the data below that participants associate their understanding of the duty of care with the obligations of a nursing professional.

“The duty of care, I think it’s what is expected of us, the responsibilities.” (Participant 4)

“You just have to know that your responsibility is your patients.” (Participant 3)

One participant related the duty of care with the skills and abilities a nurse should have in carrying out nursing tasks.

“It include your abilities and competence in performing a particular task.” (Participant 1)

Another participant related the duty of care with caring for a person because she chose nursing as a career.

“My understanding is just that when I care for someone I do it...because it is what I really apply for.” (Participant 2)

4.3.5.2 Subtheme: Scope of practice

Furthermore, some participants related their understanding of the duty of care with their scope of practice. Some of them were of the opinion that their scope of practice formulated the duties which they were obligated to provide to patients. The following quotations illustrate the views of the participants with reference to their understanding of the duty of care.

“My understanding is to do according to my guidelines, like the scope of practice.”
(Participant 2)

“Duty of care is providing care based on your scope of practice.” (Participant 7)

4.3.6 Theme 4: Legalities of the duty of care

4.3.6.1 Subtheme: Rules and Regulations

According to most participants' understanding, the duty of care was a legal issue because regulations and policies direct nursing practice. The verbatim quotes below indicate participants understanding with reference to the legalities of the duty of care and nursing practice.

“There is policies and regulations that are binders that the nurses do to do this duty of care.” (Participant 5)

Another participant mentioned that a nurse should perform nursing duties according to the scope of practice

“Caring for the patient according to scope of practice.” (Participant 1)

One participant associated the legalities of the duty of care with the regulatory bodies of the nursing profession.

“Duty of care is a legal issue... because there is governing bodies that governs the nursing professional.” (Participant 4)

Another participant stated that the duty of care was about correlating nursing practice with theory.

“It includes you knowing your theory and how to apply it when you present with a certain situation.” (Participant 10)

4.3.6.2 Subtheme: SANC

Most of the participants related their understanding of the legalities of the duty of care with the SANC. Participants were of the opinion that SANC imposes the duty of care on nursing practitioners. The remarks from the participants indicated that they were not certain about who imposes the duty of care on nurses.

“SANC, I think.” (Participant 3)

“SANC, because the scope of practice is from SANC.” (Participant 7)

One participant verbalised that the nurses themselves placed the duty of care on them because they have chosen nursing as a career.

“Ourselves, because...you make the decision to take care of sick people.” (Participant 2)

Another participant stated that a doctor imposed the duty of care, because patients require clinical care from the doctor:

“A doctor...you require health care from the doctor.” (Participant 4)

4.3.7 Theme 5: Caring for the patient

4.3.7.1 Subtheme: Respect

Respect for the patient was a frequent response which emerged with reference to applying the duty of care. Most of the participants mentioned that they would demonstrate respect for the patient when carrying out their nursing tasks. Hence, the researcher concluded that participants would apply the duty of care by treating the patient with respect when caring for them. The statements below are evident of the researcher’s interpretation.

“Ensuring that everyone is respected, dignity is ensured, make sure patients are taken care of correctly.” (Participant 3)

“Respecting the patient’s values, taking into consideration the patient’s rights.” (Participant 11)

Two participants mentioned that in carrying out the duty of care they would not infringe on the rights of the patients.

“Make sure the rights of the patient are not violated.” (Participant 5)

4.3.8 Theme 6: Ethical principles

4.3.8.1 Subthemes: Non-maleficence

Ethical principles emerged frequently with reference to participants’ understanding of ethics in nursing practice. Most participants related their understanding of ethics in nursing practice with the ethical principle of non-maleficence. Two participants mentioned the ethical principles of justice and confidentiality in their understanding of ethics. It became clear that participants predominantly related their understanding of ethics with ethical principles of nursing practice.

“You don’t cause harm to the patient.” (Participant 4)

“Not doing harm, injustice and everything.” (Participant 7)

One participant verbalised that ethics was concerned with doing what was right and avoid doing wrong.

“Ethics has to do with what is right and what is wrong.” (Participant 11)

However, one participant stated that many times they do not consider ethical principles and just do what was expected of them.

“Most of the time we don’t really strive to uphold those principles, we just do what we are supposed to do.” (Participant 10)

4.3.8.2 Subtheme: Guidance

According to most participants ethical principles directed the practice of nursing professionals. Guidance of nursing practice was another factor which surfaced boldly as participants’ understanding of ethics in nursing practice. In addition, some participants’ stated that ethics ensured that ethical codes and standards of practice were followed in nursing practice. The following verbatim quotes demonstrate the participants’ understanding of ethics in nursing practice.

“It’s to guide our practice.” (Participant 6)

“Rules we should follow as nurses that we follow and that we practice.” (Participant 5)

“They will guide you into knowing what you do for a patient.” (Participant 7)

4.3.9 Theme 7: Legalities of nursing practice

4.3.9.1 Subtheme: SANC

When the researcher asked about the role of the SANC in nursing practice, some participants were aware of the role of SANC. Some participants asserted that SANC oversees all fields of the nursing profession.

“SANC is the governing body that overlooks all aspect of nursing.” (Participant 1)

However, one participant voiced that SANC refers to the people who governs the Nursing Act.

“SANC is just the people that are behind the Act we see and read.” (Participant 2)

Another participant stated that both SANC and the Nursing Act were about caring for the patient.

"I think it's caring for the patient they are both striving for a caring for the patient."
(Participant 8)

4.3.9.2 Subtheme: Nursing Act

All of the participants had different views about the Nursing Act. According to participants' statements, the researcher concluded that participants do not understand the function of the Nursing Act.

"Nursing Act is a written document that simply states how the nurses should conduct themselves." (Participant 3)

"I don't have much knowledge about the Nursing Act." (Participant 10)

"SANC is the people who wrote the Nursing Act." (Participant 2)

4.3.9.3 Subtheme: Ethical codes

When asked about the prescription of ethical codes in nursing practice, some participants mentioned that SANC prescribed ethical codes, while other participants gave various opinions. From the statements below it can be interpreted that participants were not certain about the prescription of ethical codes in nursing practice.

"I think its people that experienced it and researched it...and some of the ethical guidelines come from the department of health." (Participant 2)

"The facilities which we work for." (Participant 7)

4.3.9.4 Subtheme: Standards of practice

Most participants are of opinion that standards of practice guide their nursing practice. Furthermore, participants voiced that it cannot be applied when faced with an ethical dilemma in nursing practice. The following verbatim quotes illustrate participants' understanding of standards of practice.

"Those policies are just to guide us." (Participant 1)

"It's a way of improving our decision-making process." (Participant 10)

Another participant stated that standards of practice can be applied by behaving in a professional manner.

"You can apply this... behaving in a professional way." (Participant 5)

However, the participants stated that they do not read policies in the wards, because they do not have time to read it or policies are too extensive to read, or they only read it when they had an assignment to complete.

“You don’t get the time to read them when you expected to work.” (Participant 6)

“They are long ... folder you are going to take out and read and read and read and read.”
(Participant 7)

“When we need to have an assignment... and just pass through all the rest” (Participant 2)

4.3.10 Theme 8: Decision making

4.3.10.1 Subtheme: Outweigh harm and benefits

Most participants asserted that in their application of ethics in nursing practice, they would outweigh harm and benefits during ethical decision making. Most of the participants verbalized that they would do what was best for the patient and would by all means prevent any harm to the patient. Based on participants’ comments the researcher concluded that participants will apply ethics in nursing practice by outweighing harm and benefits of patient care.

“Weighing the benefits and making sure no harm is done.” (Participant 3)

“Outweigh the harm and the benefits.” (Participant 4)

One participant asserted that in applying ethics she would rather consider the consequences of health care than being concerned with ethical principles.

“It’s more about...what effect the outcome would have on the patient rather than thinking too much about the principles that you are supposed to uphold” (Participant 10)

Another participant verbalised that ethics could be applied by educating people with reference to ethics in nursing practice.

“Having this ethical codes of standards maybe on a notice board...take a group of people and teach them about this ethics.” (Participant 8)

4.3.10.2 Subtheme: Patient Autonomy

Patient autonomy was another factor which emerged often in the application of ethics in nursing practice. Most of the participants asserted that they would respect and uphold the patient’s right to self-determination during healthcare practice. Furthermore, some of the

participants voiced that they will include the patient in their health care and do what was best for the patient. It is clear from the responses below that most participants will apply ethics in health care by having respect for patient autonomy.

“Allowing the patient to also be involved in decision making.” (Participant 1)

“Respect patient confidentiality and autonomy.” (Participant 8)

4.3.11 Theme 9: Carelessness

4.3.11.1 Subtheme: Omit care

Omission of patient care was a major factor which emerged during interviewing with regard to participants’ understanding of negligence. One participant also stated that negligence was when a nurse delays to take action when needed. According to the participants’ responses it can be concluded that participants associate their understanding of negligence with breach of duty.

“Not doing something that you are supposed to do or not doing it the correct way.”
(Participant 4)

“You don’t abide to the right way, you don’t care.” (Participant 11)

Some participants mentioned that a nurse was negligent in patient care when procedures were not carried out accurately.

“You don’t carry out the treatment as you should...would have a negative outcome for the patient.” (Participant 9)

4.3.11.2 Subtheme: Disciplinary action

Most of the participants stated that carelessness in patient care could lead to disciplinary action against a nurse. Most participants voiced that SANC was “the people” who will institute disciplinary action against a nurse on a charge of negligence. Some participants mentioned that nurses will lose their license to practise if SANC found them guilty of negligence. It is evident from the participants’ comments below that they were of the understanding that disciplinary action could be taken against nurses if they omit patient care.

“According to SANC she would... be called in for a disciplinary hearing... even a nursing license with-held, depend on the degree of negligence.” (Participant 9)

One participant stated: *“The hospital managers must take the nurse for disciplinary hearing and SANC is also going to be involved...the nurse might lose her license.”* (Participant 1)

Another participant stated with reference to negligence that the doctor would be held accountable for patients in his care, but it was not the same for nursing professionals.

“Patient...in the doctor’s care...the family members...would take further steps...whereas in nursing it’s not like that.” (Participant 10)

Furthermore, one participant stated that if an adverse event occurred in nursing practice she was not certain about who would be held accountable.

“I don’t know who is held responsible for nurses who don’t do their job.” (Participant 8)

However, one participant said that a nurse could go to jail on a charge of negligence and that the family of the patient, who had suffered the negligence could take civil action against the nurse.

“Where they are found guilty...the nurse can go to jail or to court...or the family take them to court.” (Participant 3)

4.3.12 Theme 10: Legalities of negligence

4.3.12.1 Subtheme: SANC

When the researcher asked participants about who finds the nurse guilty of negligence, most of the participants mentioned the SANC, while some participants had different viewpoints. The following statements demonstrated the participants’ understanding of the organization responsible to find a nurse guilty of negligence.

“It’s the nursing council.” (Participant 6)

“SANC.” (Participant 5)

Whereas, two participants mentioned that an employer or a nurse’s colleagues can find a nurse guilty of negligence.

“The supervisor also the colleagues.” (Participant 4)

“The institution you are working for.” (Participant 10)

4.3.12.2 Subtheme: Criminal law

When the researcher asked participants which law negligence was affiliated to, most participants mentioned criminal law, while other participants indicated different laws. Due to

the participants' suggestions the researcher came to the conclusion that those participants' were not knowledgeable about the law affiliated with negligence.

"I would say under domestic law." (Participant 6)

"I think it's within criminal law, I'm not sure." (Participant 1)

"Criminal law because...the nurse intend harm to the patient." (Participant 3)

4.3.12.3 Subtheme: Vicarious liability

With reference to the concept of vicarious liability, some participants mentioned that the nurse, as well as the employer could be sued in a case of clinical negligence. However, some participants had different views. The participants' statements below indicate that they do not fully understand the concept of vicarious liability.

"The employer because she must make sure that the nurse do what is required of her."
(Participant 6)

"The shift leader or the manager." (Participant 9)

"The sister will be held responsible." (Participant 8)

4.3.13 Theme 11: Increase in clinical negligence

4.3.13.1 Subtheme: Lack of knowledge

Some participants asserted that a lack of knowledge was one of the reasons for the increase of clinical negligence litigation. One participant stated that in the clinical setting nursing professionals were unable to assist them with skills which were in their practical skills book. Moreover, some participants verbalised that nursing professionals in the clinical setting were to update their knowledge in accordance with advancement and developments of the nursing profession. The following statements illustrate participants' opinion with reference to the increase in clinical negligence in nursing practice.

"You show them your prac book and they can't help you with what is in your prac book, their knowledge is not up to current standard." (Participant 1)

"Sometimes we don't always have the necessary skill...we need to attend courses, make sure that we have the right knowledge." (Participant 6)

In addition, some participants' voiced that nurses sometimes do not follow the correct procedure when carrying out their duties.

“She didn’t even wash her hands when she was wanted to do wound care.” (Participant 2)

4.3.13.2 Subtheme: Lack of caring

Some participants expressed that the increase in clinical negligence was also due to a lack of caring in nursing practice. They asserted that nurses were not caring and compassionate, that they only do the work for monetary benefits. Another participant verbalised that nurses were judgmental towards patients, and that they cared less for the underprivileged patient. The verbatim quotes below illustrate participants’ views with reference to the increase in clinical negligence:

“It’s just about not having the caring essence in you...not having that caring feeling in you.”
(Participant 4)

“I’ve noticed they tend to really neglect other patient...like those people who don’t know their rights...the uneducated patients.” (Participant 5)

One participant mentioned that nurses were losing the core or essence of nursing practice.

“They don’t care, they losing the core of nursing, we are losing it.” (Participant 11)

In addition, some participants also mentioned that a shortage of staff also contributed to the increase in clinical negligence.

“There are always shortage of staff, so it’s impossible to provide the quality care that we suppose to.” (Participant 6)

4.4 SUMMARY

In chapter 4 the research question was answered: What is the undergraduate nursing students’ understanding and application of the duty to care? The goal to explore undergraduate nursing students’ understanding and application of the duty of care was successfully investigated. In addition, the objectives were met, namely:

- Understanding and application of caring in nursing practice
- Understanding and application of the duty to care
- Understanding and application of ethics in nursing practice
- Understanding and application of standards in nursing practice
- Understanding and application of legalities in nursing practice
- Understanding of negligence in nursing practice

Themes as well as subthemes were presented in this chapter. In chapter 5 discussion, conclusions and recommendations will be presented.

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CHAPTER 5: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In chapter one the researcher described the goal and rationale of the study. A comprehensive literature review was given in chapter two. The research methodology was presented in chapter three and the data analysis was described in chapter four. The goal and objectives of the study have been scientifically and successfully explored. In this chapter a discussion on the findings and recommendations based on the objectives of the study, as well as the conclusions will be presented.

5.2 DISCUSSION

Interpretation refers to the process of giving meaning to the results of the study (Polit & Beck, 2014:52). Meaning of the data was acquired by relating the results of the study to the broader study literature.

5.2.1 Objective 1: Understanding and application of caring in nursing practice

Holistic care was the essence of most of the participants' understanding of caring in nursing practice. However, the findings indicate that essentially most participants mentioned caring with reference to patient care, and being there for the patient: *"caring is...taking care of your patients and being there for them."* (Participant 4)

Also some participants stated that they rendered a service to the patient by means of taking care of their basic needs: *"You just care for that person, by helping that person to eat...or wash that's it about caring."* (Participant 5) Further, most participants stated that they would apply caring by performing routine nursing tasks, referred to by Dobrowolska and Palese, (2016:36) as instrumental caring. Dobrowolska and Palese (2016:36) state that instrumental caring is concerned with the physiological aspects; the nursing and medical interventions of patient care support the researcher's findings.

Even though most participants verbalized holistic care, the emotional factors of caring like compassion, empathy, being present, dedication and consideration were not related to their nursing practice, described by Dobrowolska and Palese (2016:36) as expressive caring. However, most participants also mentioned that they would apply caring by means of communicating with the patient.

Furthermore, the results of the data analysis show a lack of caring in nursing practice. In addition, the research data also revealed that in the clinical setting most participants

experienced barriers to caring specifically, language, negative staff attitudes and shortage of staff.

The researcher concluded that participants generally related their understanding and application of caring with the instrumental element of caring, for example, assisting the patient with activities of daily living. However, participants displayed poor knowledge about the expressive element of caring which is concerned with emotional factors, such as empathy, sympathy, compassion, attentiveness and commitment.

5.2.2 Objective 2: Understanding and application the duty of care

The results of the data analysis suggest that most participants related the duty of care with the obligation to take care of patients. According to McQuoid-Mason and Dada (2011:173) the duty of care is concerned with the responsibility enforced on healthcare workers not to cause injury to patients through careless behaviours. However, the data indicate that participants were unable to associate the duty of care with negligence.

In addition, the results also suggest that participants are of the opinion that the SANC imposes the duty of care on nurses. In contrast, Griffith (2014: 234-235) asserts that the courts impose a duty of care on all healthcare professionals, including nursing practitioners. Furthermore, most participants associated the duty of care with the duties they had to perform, because it was expected from them as nurses. Most participants also related the duty of care with their scope of practice; because the scope of practice describes the duties they ought to carry out in nursing practice. According to Young (2009:3071-3078) the duty of care is extensive, it includes all the facets of nursing care, physical as well as psychological treatment. Participants correctly associated the duty of care with the scope of practice; however participants were not aware that psychological aspects are inclusive of the duty of care.

The conclusion can be made that most participants do not entirely grasp the concept of duty of care. The legal implications of the duty of care are not fully understood by participants as stated by Young (2009:3071). The duty of care is a constitutional issue. However, participants correctly understood that they have an obligation to carry out their task according to their scope of practice.

5.2.3 Objective 3: Understanding and application of ethics in nursing practice

It is evident from the research that most participants related their understanding of ethics with ethical principles. Ethical principles of non-maleficence and autonomy were the main features of most of the participants' understanding of ethics. According to Moodley (2011:3) ethics is the studying of moral decision making and the analysis of norms and principles. It is evident

from the data that most participants could not associate ethics with the analysis of norms and values as described by (Moodley, 2011:3).

However, two participants related their understanding of ethics with doing what is right and preventing the wrong, which corroborated with Schroeter (2008: 3-4), who states that the ethical responsibility of a nurse to render care to patients, originates from the ethical principles of doing what is right and the principle to cause no injury.

In addition, the data indicate that most of the participants were not knowledgeable about the origination of ethics in nursing practice, revealed by one participant: "It (ethics) originated when a patient started complaining that the nurses are rude and everything." (Participant 7)

Furthermore, the data suggest that participants acknowledged ethical principles as guidelines for nursing practice. Moreover, some participants stated that they would apply ethics during an ethical dilemma by outweighing the harm and benefits of healthcare treatment. The findings corroborate with Pera and Van Tonder (2011: 9) who assert that ethical codes supply a structure of overall rights, norms, protocols and responsibilities for nursing practitioners.

The researcher concluded that most participants lacked knowledge with reference to their understanding of ethics in nursing practice. Participants mainly referred to the ethical principle of non-maleficence and autonomy as their understanding of ethics. However, participants were cognizant that ethical principles could be applied during ethical decision making.

5.2.4 Objective 4: Understanding and application of standards in nursing practice

It is evident from the data that most participants understood that standards of practice give guidance during patient care. The data concur with Fullbrook (2008: 1420-1421) stating, the matter of standards relates to common law and it gives direction to the practice of nursing professionals. However, participants revealed that they do not read policies in the clinical setting, because it is too lengthy. They also stated that they did not have time or they only read policies when it was applicable content for an assignment. *"When we need to have an assignment...I will pass through all the rest and just look what I am looking for."*

The researcher concluded that participants are aware that standards of practice guide nursing practice. However, participants are not knowledgeable about different policies, because participants stated that they do not read the policies in the clinical setting.

5.2.5 Objective 5: Understanding and application of legalities in nursing practice

The findings of this study concur with the findings of a study done by Klaassen et al. (2011:85) who found that nursing students are not knowledgeable about legal aspects of nursing

practice. The researcher found that some participants acknowledged that SANC is the regulatory body of nursing practice. In contrast, some stated that “SANC is the people that are behind the Nursing Act.” Some participants also suggested that SANC is a committee that does all the acts in the nursing profession and that the function of SANC is to strive for caring of all patients. The data suggest that some participants had poor knowledge about the function of the SANC.

In addition, it is evident from the data that some participants believed that ethical codes and standards are prescribed by the department of health. Some mentioned an employer: “*The facilities we work for*” (Participant 7) and people who carried out research prescribed ethical codes and standards of practice. As stated by one participant: “*I think its people that experienced it and researched it*” (Participant 2) However, SANC is the council that establishes and sustains the standards of nursing practice and nursing education (SANC, 2017:1).

The results further reveals that all participants had inaccurate and different viewpoints about the Nursing Act. Furthermore, some participants incorrectly understood that the Nursing Act is a document that simply states how nurses should behave and that SANC is “*the people who wrote the Nursing Act.*” (Participant 1) Furthermore, one participant stated that “*the Nursing Act is a written document that simply states how the nurses should conduct themselves.*” (Participant 3) The Nursing Act (No. 33 of 2005) actually governs the nursing practice as authorized by the parliament of the Republic of South Africa.

Furthermore, the analysis indicates that participants inaccurately relate the legalities of the duty of care with the rules and regulations of the nursing profession as prescribed by SANC. According to Nemie (2009: 54-59) the courts which is a mechanism of public governing had determined the legal aspects of the duty of care of healthcare users, due to the relationship between healthcare worker and healthcare user.

Based on the findings it can be concluded that participants had very poor knowledge with reference to the legalities of nursing practice.

5.2.6 Objective 6: Understanding of negligence in nursing practice

Research findings indicate that participants essentially understood that negligence occurs when nurses omit patient care. This was stated by most participants: “*When she was supposed to do something for the patient and you don't.*” In addition, some participants were of the opinion that nurses are negligent when they carry out procedures inaccurately. Most participants accurately relate negligence with omission of care; however, infringement,

damage and causation were not mentioned in relation to negligence as stated by Cornock (2011:21).

According to Dhai and McQuoid-Mason (2011:92) negligence takes place when clinical care professionals negligently omit to apply the level of competence and care of a reasonably skillful professional in their area of practice. Furthermore, negligence occurs when nursing professionals do not observe and follow the standards of practice of their profession (Fullbrook, 2008: 1420-1421). However, the findings revealed that all participants were not able to relate negligence with the issue of standards in nursing practice.

The data also revealed that participants wrongly understood that the SANC found nurses guilty of negligence. According to Foley & Christensen (2016:7-10), laws associated with negligence held nurses accountable for their conduct and negligence is a violation that can be prosecuted. Furthermore, the judicial system passes judgement with reference to, negligence, based on the evidence presented (Young: 2009:3071-3078).

Some participants inaccurately suggested that the shift leader, registered nurse or the manager will be sued in the event of clinical negligence litigation. While some participants accurately understood that nurses, as well as the employer could be sued for negligence. This is supported by Tingle (2010:297-299) who states that the healthcare worker, as well as the employer will be sued in a case of negligence. It is presumed that the healthcare worker was performing her/his tasks whilst in service of the employer.

In addition, some participants believed that negligence was affiliated with criminal law. The findings do not reveal whether participants were able to relate the concept of negligence with civil law.

Furthermore, the data analysis suggests that participants were of opinion that the increase in clinical negligence litigation was due to a shortage of staff, lack of care and lack of knowledge.

A number of references support these findings. Kline and Khan (2013:1-2) found that organizational failures contribute to clinical negligence, similarly supported by Malherbe (2013:83-84) that shortcomings in healthcare services contribute to clinical negligence. Furthermore, clinical negligence also results from inadequately trained staff (Klaassen et al., 2011: 85-89), patient awareness (Dhai, 2016:2) and expansion of the role of nursing professionals (Boris, 2010:1761-1762).

The researcher came to the conclusion that most participants also lacked knowledge about negligence and the laws associated with negligence in health care.

5.3 CONCLUSIONS

The research was directed by the research question: What is the undergraduate nursing students' understanding and application of the duty of care? The findings of the study indicate that most of the participants did not entirely understand the duty of care. Shortcomings were also identified with reference to ethics and standards of practice. Furthermore, the findings revealed that most of the participants had very poor knowledge about the legalities of nursing practice. In addition, most of the participants also lacked knowledge about negligence and the laws of negligence. Thus, the findings confirm that the research question had been answered and the study objectives had been met.

5.4 LIMITATIONS

Limitations refer to methodological and theoretical shortcomings in a study causing the findings of the study not to be easily generalized to other settings (Grove et al., 2013:699). In this study, after ethics approval from Stellenbosch University, the study was delayed due to obtaining a second ethics approval from the institution where the study was conducted. Thereafter, the researcher experienced further delays awaiting for permission from the head of the college to enter the research setting. After permission from the head of college the research started with data collection. The researcher were delayed by a period of six months before he /she could begin the data collection process.

5.5 RECOMMENDATIONS

5.5.1 Appreciation

The researcher recommends that clinical mentors and registered nurses in the clinical environment should encourage students and demonstrate appreciation for their caring practices. According to Dobrowska and Palese (2016:312) students' see caring as a rewarding experience and feel pleased when their caring endeavours are valued and acknowledged in the clinical setting. As mentioned by participant 7: "Staff are not very nice to us...I'm not going to do it (care) because the sister does not appreciate it anyway". Nevertheless, it is necessary to motivate students to attain their caring duties, without needing to be esteemed, thus growing as caring professionals.

In addition, Watson's (2006:21) "ten caritas processes" should be used as a guideline to enhance caring in nursing practice.

5.5.2 Compliance

The researcher recommends that nursing professionals should practise according to the required legal standards of the profession. In addition, compliance measurement tools should

be developed to assess compliance of caring duties. Furthermore, policy makers in the clinical environment and healthcare departments should develop policies and protocols which address shortages of staff, uncaring staff behaviours and language barriers as identified in this study. Nursing education institutions should make teaching and learning of the duty of care a priority in an effort to prevent clinical negligence. As asserted by Griffith (2014: 234) that nurses should ensure that their practices comply with applicable common law, statute law as well as with professional benchmarks when fulfilling their duty of care.

Furthermore, The Human Rights Commission Act (No. 54 of 1994) has imposed on government and health care professionals not to infringe the human rights of health care users. Consequently, a variety of responsibilities had followed, which now underlie the duty of care for healthcare professionals.

5.5.3 Renewal of commitment

The researcher recommends that nurses should advocate for the vulnerable patients in their care and recommit themselves to the Nurse's Pledge of Service. In addition, Batho Pele Principles should be realized in combination with the Nurse's Pledge of Service to successfully enhance nursing practice. Nurses should respect patients as sole individuals and consider them as their main concern. Therefore, when nurses are polite, careful and considerate towards patients they shall add to the restoration of the work ethic that is currently fast fading in nursing practice (Jali, 2010:29).

According to Stellenberg and Dorse (2014:2) the public anticipate that nurses consider and respect the moral principles of society. However, nursing practice in South Africa is deteriorating and it could be due to the general moral decay seen currently in the country (Jali, 2010:29). In addition, patients who were transferred from government institutions to unlicensed organizations led to enormous repercussions, only because of the government's endeavour to save on their healthcare budget (Nicolson, 2017:1). Budget constraints should not compromise the safety and quality of patient care. However, nursing professionals should use their autonomy to positively influence circumstances by practising in accordance with the norms and values that underpin their profession (Stellenberg & Dorse, 2014:7).

5.5.4 Reviews

It is also recommended that policies should be reviewed regularly to ensure contemporaneous practice. Nemie (2009, 54) states that more and more legal and ethical benchmarks are developed and surfacing in nursing practice, internationally and nationally.

Moreover, nurses should be encouraged to uphold required legal standards of nursing practice to prevent a claim of negligence. Failure to uphold standards will lead to endangering patients with horrendous consequences for the nurse, patient, and the employer (Sebopa, 2010:49). Also nurses are frequently faced with ethical dilemmas in the clinical setting. In addition, ethical codes of professional nursing practice stipulate the ethical obligation of nursing professionals.

5.5.5 Education

The researcher recommends that legal aspects of the nursing profession be a focal point in nursing curricula as much as clinical theory is. Nursing education institutions highlight comprehension of theory, as well as clinical competencies and do not adequately acknowledge the importance of legalities in directing sound practices (Klaassen et al., 2011:85).

In addition, lecturers and clinical educators should encourage nurses to read published papers, analyse case law, as well as their country's parliamentary laws to equip them with the knowledge for sound and considerate nursing practice. Nurses should also have insight into standards and protocols of service delivery, their scope of practice and the fundamentals of professional misconduct (Boris, 2010:1761-1762).

Klaassen et al. (2011:85) found that the majority of nurses, including student nurses are not effectively trained to deal with legal instances in the clinical environment. Furthermore, the development and advancement of the healthcare system with increased governance has caused an increase in the legal obligations for both student nurses and professional nurses.

5.5.6 Whistleblowing

The researcher recommends that nurses should identify and report unsafe practices and take appropriate action to ensure a safe healthcare environment. Also, nurses should be educated with reference to the laws related to negligence. According to Klepatsky, (2006:15) judiciary and not healthcare professionals decides on the matters regarding the element of duty in a negligence claim.

Furthermore, the predominant ethical principles of nursing of do no harm and promote good, should always be a priority for nurses during patient care (Schroeter, 2008:3-4). Non-maleficence is not only concerned with the prevention of harm but also, not to cause the patient to be subjective to needless harm. However, clinical negligence litigation is on the increase and if nurses negligently cause harm to a patient, they will be held individually and legally liable for their acts and omissions (Tingle, 2017:296-297). In addition, the injured patient or his family can institute legal action against nurses in a court of law.

5.6 FUTURE RESEARCH

It is recommended that future research be conducted to explore effective teaching and learning strategies with reference to educating student nurses the legalities of nursing practice. In addition, similar studies can be conducted at other nursing education institutions, as well as in clinical settings, including other nursing categories, to determine their understanding about the aspects of their duty to care.

5.7 CONCLUSION

In this chapter the research findings were discussed with reference to the study objectives. The goal and objectives to explore undergraduate nursing students' understanding and application of the duty of care were successfully explored. The research findings revealed that most of the fourth year nursing students have poor knowledge about the aspects of the duty of care. Thus, it could lead to horrendous consequences for the patient, nurse and the healthcare department. Therefore, the healthcare department, including nursing education institutions should urgently address the problems identified in this study. If failed to do so the moral decay currently experienced in health care will deteriorate even further, affecting the quality and safety of patient care. In addition, continuous professional development and evidence-based practice should be of pre-eminence for both healthcare department and nursing education institutions.

REFERENCES

- Boris, L. L. 2010. Commentary on Young, A (2008) The legal duty of care for nurses and health professional. *Journal of Clinical Nursing*, 19: 1761-1762.
- Brown, C. S & Finnel, D. S. 2015. Provisions of the Code of Ethics for Nurses: Interpretive Statements for Transplant Nurses. *Nephrology Nursing Journal*, 42(1): 37-43.
- Burns, N & Grove, S. K. 2011. Understanding nursing research. Building an evidence-based practice. 5th ed. Texas: Elsevier Saunders Publishers.
- Chima, S. C. 2013. Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study. *BMC Medical Ethics*, 14(1): 1-3.
- Cornock, M. 2011. A legal commentary on negligence. *Legal Issues*, 23(1): 21-22.
- Democratic Nursing Organization of South Africa. 2012. [Online]. Available: www.denosa.org.za [2017 November 10]
- Department of Health. 2013. Regulations Relating to the Scope of Practice of Nurses and Midwives, R786 of 2013. Pretoria: Government Printer.
- Department of Public Service and Administration. 1997. *Batho Pele-People First*. Pretoria: Government Printer.
- De Vos, A. S., Strydom, H., Fouche, C. B. & Delport, C. S. L. 2011. *Research at grass roots for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik Publishers.
- Dhai, A. & Mcquiod – Mason, D. 2011. Bioethics, Human Rights and Health Law. *Principles and Practice*. Cape Town: Juta & Company Ltd.
- Dhai, A. 2016. Medical Negligence: Alternative claims resolution an answer to the epidemic? *South African Journal of Bioethics and Law*, 9(1): 2-3.
- Dingwall, C. 2007. Case: Sympathetic ophthalmia following elective surgery. *Clinical Risk*, 13: 21-22.
- Dobrowolska, B., Wronska, I., Fidecki, W. & Wysokinski, M. 2007. Moral obligations of nurses based on the ICN, UK, Irish and Polish codes of ethics for nurses. *Nursing Ethics*, 14(2): 171-180.
- Dobrowolska B. & Palese, A. 2016. The caring concept, its behaviours and obstacles: perceptions from a qualitative study of undergraduate nursing students. *Nursing Inquiry*, 23:305-314.
- Foley, M. & Christensen, M. 2016. Negligence and the duty of care: A case study discussion. *Singapore Nursing Journal*, 43(1):7-10.

- Fry, M., Macgregor, C., Ruperto, K., Jarret, K., Wheeler, J., Fong, J. & Fetchet, W. 2013. Nursing Praxis, compassionate caring and interpersonal relations: An observational study. *Australasian Emergency Nursing Journal*, 16:37-44.
- Fullbrook, S. 2008. Contemporaneous nursing: a conclusion to the 2008 series. *British Journal of Nursing*, 17(22):1420-1421.
- Fullbrook, S. 2008. Duty of care and political expectations. Part 3 law and the new code. *British Journal of Nursing*, 17(8):650:652.
- Fullbrook, S. 2008. Duty of care and political expectations. Part 5: standards and clinical outcomes. *British Journal of Nursing*, 17(10):538-539.
- Garrard, J. 2011. *Health Sciences Literature Review Made Easy. The Matrix Method*, 3rd Edition. Minnesota: Jones & Barlet Learning, LLC.
- George, J.B. 2011. *Nursing Theories: The base for professional nursing practice*, 6th Edition. New Jersey: Pearson Education.
- Griffith, R. 2014. Duty of care is underpinned by a range of obligations. *British Journal of Nursing*, 23(4): 234-235.
- Griffith, R. 2015. Understanding the code: the duty of candor. *British Journal of Community Nursing*, 20(8):407-409.
- Griffith, R. 2016. Repercussions of negligence in community nursing practice. *British Journal of Community Nursing*, 21(3): 155-158.
- Grove, S.K. Burns, N. & Gray, J.R. 2013. *The Practice of Nursing Research. Appraisal, Synthesis and Generation of Evidence*. 7th Edition. St Louis: Elsevier Saunders Publishers.
- Harding, J. 2013. *Qualitative data analysis from start to finish*. London: SAGE Publications Ltd.
- Health Professions Council of South Africa. 2008. National Patients' Rights Charter. [Online]. Available: <https://www.safmh.org.za/documents/policies/-and.../patient%20Rights%20Charter> [2017 November 5]
- Holloway, I. & Wheeler, S. 2010. *Qualitative research in nursing and healthcare*. 3rd ed. United Kingdom: Blackwell Publishing Ltd.
- Huxley-Binns, R. 2009. When is negligence a crime? *British Journal of Nursing*, 18(14):892-893.
- International Council of Nurses. 2012. *The ICN code of ethics for nurses*. [Online]. Available: <http://www.icn.ch/images/stories/documents/about/icncode-english.pdf> [2017 October 23]
- Jali, M. N. 2010. Respect for human life. *Nursing Update*. 26-29

- Klaassen, J., Smith, K.V. & Witt, J. 2011. The New Nexus: Legal Concept Instruction to nursing Students, Teaching-Learning Frameworks, and high fidelity human simulation. *Journal of Nursing Law*, 14(3&4):85-90.
- Klepatsky, A.D. 2006. Duty: A historical perspective. *Journal of Legal Nurse Consulting*, 17(1).
- Kline, R. & Khan, S. 2013. *The duty of care of healthcare professionals*. London: Public world.
- Lachman, V. D. 2012. Applying the ethics of care to your nursing practice, *MEDSURG Nursing*, 21(2):112-114.
- London, L. & Baldwin-Ragaven, L. 2008. Human rights and health: challenges for training nurses in South Africa. *Curationis*, 31(1):5-18.
- Luba, L., Ivanov, R. N & Oden, T. L. 2013. Public health nursing ethics and human rights. *Public health nursing*, 30(3):231-238.
- Malherbe, J. 2013. Counting the cost: The consequences of increased medical malpractice litigation in South Africa. *South African Medical Journal*, 103(2):83-84.
- Mcquiod-Mason, D & Dada, M.2011. *A-Z of Nursing Law*. 2nd Edition. Cape Town, Juta & Company Ltd.
- Mellor, C. 2013. A duty of candor: A change in approach. *Clinical risk*. 20 (1-2):36-46.
- Miola, J. 2009. Negligence and the legal standard of care: What is reasonable conduct? *British Journal of Nursing*, 18(12):756-757.
- Moodley, K. 2011. *Medical ethics, law and human rights: A South African perspective*. Pretoria, Van Schaik Publishers.
- Nemie, J. K. P. 2009. Challenges for the Nursing Profession in Malaysia: Evolving Legal and Ethical standards. *Journal of Nursing Law*, 13(2):54-62.
- Nicolson, G. 2017. *Life Esidimeni: Arbitration highlights government culpability*. [Online]. Available: <https://www.dailymaverick.co.za/.../2017-10-31-lifeesidimeni-arbitration-highlights-...>[2017November 3]
- Pera, S & van Tonder, S. 2011. *Ethics in Healthcare*. 3rd Edition. Cape Town, Juta & Company Ltd.
- Polit, D.F. & Beck, C. T. 2014. *Essentials of Nursing Research: Appraising evidence for Nursing Practice*. 7th ed. Philadelphia: Lippincott Williams & Wilkens.
- Republic of South Africa. 1996. Constitution of the Republic of South Africa Act 108 of 1996. Pretoria: Government Printer.
- Republic of South Africa. 2003. National Health Act 61 of 2003. Pretoria: Government Printer.
- Republic of South Africa.2005. Nursing Act 33 of 2005. Pretoria: Government Printer.

- Republic of South Africa. 2013. National Health Amendment Act 12 of 2013. Pretoria: Government Printer.
- Republic of South Africa. 2014. Regulations setting out the acts and omissions in respect of which the council may take disciplinary steps, R767 of 2014. Pretoria: Government Printer.
- Republic of South Africa. 2015. Procedural regulations pertaining to the functioning of the Office of Health Standards Compliance and its Board, R110 of 2015. Pretoria: Government Printer.
- Schroeter, K. 2008. Duty to care Versus Duty to Self. *Journal of Trauma Nursing*, 15(1):3-4.
- Searl, C., Human, S. & Mogotlane, S. M. 2009. *Professional practice. A southern African nursing perspective*. 5th ed. Johannesburg: Heinemann Publishers Ltd.
- Sebopa, D. Basic Human Needs. *Nursing Update*. Pp 48-49.
- South African Nursing Council. 2013. Code of ethics for nursing practitioners in South Africa. [Online]. Available: www.sanc.co.za [2017 October 20]
- Stellenberg, E.L. & Dorse, A.J. 2014, Ethical issues that confront nurses in private hospitals in the Western Cape Metropolitan area. *Curationis*, 37(1):1-9.
- Terreblanche, M, Durrheim, K, Painter, D. 2006. *Research in practice: Applied methods for Social Sciences*. Cape Town: University of Cape Town Press Ltd.
- Tingle, J. & Mchale, J. 2009. Specialist healthcare law for nurses: an introduction. *British Journal of Nursing*, 18(1):38-39.
- Tingle, J. 2010. Commentary on a young (2009) Review: the legal duty of care for nurses and other health professionals. *Journal of clinical nursing*, 18:297-299.
- Tingle, J. 2017. The high cost of clinical negligence litigation in the NHS. *British Journal of Nursing*, 26(5):296-297.
- Turton, G. 2009. Factual and legal causation - their relation to negligence in nursing. *British Journal of Nursing*, 18(13):825-827.
- Watson, J. 2006. Carative factors, Caritas Processes guide to professional nursing. *Danish Clinical nursing Journal*, 20 (3):21-27.
- Young, A. 2009. Review: The legal duty of care for nurses and other health professionals. *Journal of Clinical Nursing*, 18:3071-3078.

APPENDICES

Appendix 1: Ethical approval from Stellenbosch University



UNIVERSITEIT-STELLENBOSCH-UNIVERSITY
jou kennisvenoot • your knowledge partner

Approval Notice Response to Modifications- (New Application)

24-Jan-2017
Stolenkamp, Thabita T

Ethics Reference #: S16/10/230

Title: Exploring undergraduate nursing student's understanding and application of the duty to care.

Dear Mrs Thabita Stolenkamp,

The **Response to Modifications - (New Application)** received on **15-Nov-2016**, was reviewed by members of **Health Research Ethics Committee 2** via Expedited review procedures on **24-Jan-2017** and was approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: **24-Jan-2017 -23-Jan-2018**

Please remember to use your **protocol number** (S16/10/230) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372

Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics

approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit:

Appendix 2: Ethical approval from Cape Peninsula University of Technology



HEALTH AND WELLNESS SCIENCES RESEARCH ETHICS COMMITTEE (HW-REC)
Registration Number NHREC: REC- 230408-014

P.O. Box 1906 • Bellville 7535 South Africa
Symphony Road Bellville 7535
Tel: +27 21 959 6917
Email: sethn@cput.ac.za

29 June 2017
REC Approval Reference No:
CPUT/HW-REC 2016/H15

Dear Ms Thabita Stollenkamp

Re: APPLICATION TO THE HW-REC FOR ETHICS CLEARANCE

Approval was granted by the Health and Wellness Sciences-REC on 15 June 2017 to Ms Stollenkamp ethical clearance. This approval is for research activities related to research for Ms Stollenkamp at the University of Stellenbosch.

TITLE: Exploring undergraduate nursing student's understanding and Application of the duty to care
Supervisor: Prof EL Stellenberg

Comment:

Approval will not extend beyond 30 June 2018. An extension should be applied for 6 weeks before this expiry date should data collection and use/analysis of data, information and/or samples for this study continue beyond this date.

The investigator(s) should understand the ethical conditions under which they are authorized to carry out this study and they should be compliant to these conditions. It is required that the investigator(s) complete an **annual progress report** that should be submitted to the HWS-REC in December of that particular year, for the HWS-REC to be kept informed of the progress and of any problems you may have encountered.

Kind Regards

A handwritten signature in black ink, appearing to read "N. Naidoo".

Mr. Navindhra Naidoo
Chairperson – Research Ethics Committee
Faculty of Health and Wellness Sciences

Appendix 3: Permission by Head of Campus

Dear Thabita

Permission has been granted that you will conduct the interviews on the 4th year students at Metro west.

We wish you well with your process.

Thanks

Mrs Rafferty
HEAD OF CAMPUS METRO WEST
Western Cape College of Nursing
Tel: (021) 684-1211 /1235

Appendix 4: PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: Exploring undergraduate nursing students understanding and application of the duty of care.

REFERENCE NUMBER: 15513890

PRINCIPAL INVESTIGATOR: Stollenkamp, T

ADDRESS: 11 Maryn close, Sirrocco Village, Bellville

CONTACT NUMBER: 0715154436

SUPERVISOR: 021 938 9297/ 021 938 9823

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

The project aims to explore undergraduate nursing students understanding of the duty of care.

The study will be conducted at the Western Cape College of Nursing. The total number of participants will be 10.

Why have you been invited to participate?

You have been invited because I believe you will be able to provide the best answers to questions because of your experience.

What will your responsibilities be?

Your responsibility will be to answer the questions that will be posed to you about the duty of care.

Will you benefit from taking part in this research?

The student participation in the study could contribute to the scientific body of knowledge in nursing. No personal benefits, namely, being paid for participation in the study will not be implemented by the researcher.

Are there in risks involved in your taking part in this research?

There will be no risks involved in the study.

If you do not agree to take part, what alternatives do you have?

Participants will partake voluntarily in the study. There will be no repercussions if participants withdraw from the study.

.

Who will have access to your collected information?

Interviews will be recorded and data will be securely kept for 5 years, with access limited to the researcher and supervisor.

Information collected will be kept confidential.

What will happen in the unlikely event of some form of injury occurring as a direct result of your taking part in this research study?

There is no inherent risks in the study.

Will you be paid to take part in this study and are there any costs involved?

You will not be paid if you participate in the study. The investigator will not be paid for the study. The investigator will be responsible for any costs of the study.

Is there anything else that you should know or do?

You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by the researcher.

You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I agree to take part in a research study entitled (*insert title of study*).

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*)on (*date*)
2016.

.....
Signature of participant

.....
Signature of witness

Declaration by investigator

I (*name*) declare that:

- I explained the information in this document to
.....
- I encouraged him/her to ask questions and took adequate time to answer them.

- I am satisfied that he/she adequately understands all aspects of the research,
-
- as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*)on (*date*)
2016.

.....
Signature of investigator

.....
Signature of witness

Declaration by interpreter (Not applicable for this study)

I (*name*) declare that:

- I assisted the investigator (*name*) to explain the information in this document to (*name of participant*) using the language medium of Afrikaans/Xhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) on (*date*)
.....

.....
Signature of interpreter

.....
Signature of witness

Appendix 5: Interview guide

The following questions based on the objectives will be posed to the participants:

1. Describe to me what is your understanding and application of caring in nursing practice?
2. Explain to me what is your understanding and application of the duty of care?
3. What is your understanding and application of ethics in nursing practice?
4. What is your understanding and application of standards in nursing practice?
5. Explain to me your understanding and application of legalities in nursing practice?
6. What is your understanding of negligence in nursing practice?

Appendix 6: Transcribed interview

Interviewer: Good morning.

Participant: Good morning miss

Interviewer: How are you today?

Participant: I'm good and yourself?

Interviewer: I'm fine thank you.

Interviewer: I like to thank you for your participation in this research, I do appreciate it. Let me just tell you what this research is about, it's about exploring undergraduate nursing students' understanding and application of the duty of care. The interview is going to be 60-90 minutes, thank you for signing the informed consent form, and the interview is going to be recorded, is that ok with you?

Participant: Yes it's fine.

Interviewer: Everything that we are going to discuss here is confidential, it's only my supervisor who is going to check my work, to see whether I have done it correctly. Tell me what do you, see the word duty is there in the duty of care, in that phrase, so what is your understanding of a duty?

Participant: Must I relate it to nursing mam?

Interviewer: No just the duty.

Participant: A duty is when you have to do stuff that is assigned to you, or like maybe I have a duty as a community worker to just take care of the people in the community, to do my best to enable them to be at the level where they want to be. Maybe in the health care system, or like I have a duty where I like help school children with their homework when they struggle, it's just something that you do to help others and to help them progress and come where they want to be.

Interviewer: Tell me what you think is the essence of nursing practice?

Participant: Ok.

Interviewer: Or the core of nursing practice?

Participant: The core of nursing practice is basically just for me to help people to a certain extent where you know that they are able to take care of themselves afterwards. To help them to understand that, how can I now say, you help them when they can't help themselves. At the end your goal is to make sure that you, make sure that they can take care of themselves or be independent. Know that they can't rely on other people as much as they want to, ja It's basically just to help other people.

Interviewer: I'm not sure whether I can take that as your understanding of caring?

Participant: Ok.

Interviewer: Or what is your understanding of caring?

Participant: Of caring, is to help people and to like not to help them where you know that you going to gain something. Help them where you really want something that you want to do and so you go according to your scope of practice and you remember all the things that the guidelines that they set out for you. You care for them according to that guidelines but yet keep in your mind like the person you are and your values and morals and you just care for other people in this profession, is it much better or?

Interviewer: You said asked me a question now, you said is it much better?

Participant: Yes, (laugh).

Interviewer: It's not about giving me right or wrong answer, it's more about your experience. How do you relate compassion and empathy with caring?

Participant: Compassionate and empathy ok, so empathy for me is you start, you feel what that person is feeling. You don't show them that you know what they going through and stuff, but you treating them in a way where they will know, ok she does understand. When you not judging them in that same sense and then you are compassionate by caring for them. You not, like some people they care like, ok, in practical I came across people that are long time nurses, and then I looking at them and thinking, why can't you help that patient when they ask you for a bedpan. Even though I'm the student, but you also have compassion for what you do, cause that's why you a nurse. They would like say, no, the patient must help themselves or something and I'm thinking ok so why are you doing this job when you don't have compassion for it? Then I'm like there and I'm thinking, the reason why I'm doing this is that I really love what I'm doing and I want to help this person so I'm going to help this person. Then I feel like I'm more compassionate then this registered nurse that is there for 12 years or something, so ja.

Interviewer: So what would you say, do you see caring compassion and empathy in practice?

Participant: Honestly, not everywhere. Like the majority of my placements I don't see it at all and it depends from person to person like each nurse or sister is different but overall I don't see it.

Interviewer: Do you think your character as a person or your attributes as a person, do you think it influence you're caring?

Participant: Yes, I think it does, because as a person maybe I'm too young now and I'm still fresh in this. For me I feel like, I really want to do this nursing and caring for people, so when I get into services I feel like I'm going to do my best to where I can't anymore. Then you see people they are in this profession but then it's mostly about the money or they are in this profession and they had the compassion and the desire to be a nurse, but now that they are there, they don't want to be there anymore or they just do it for a living and just to survive from it so ja.

Interviewer: I do hear you. Do you think in nursing practice, there is barriers or obstacles to caring, or do you find it maybe in practice obstacles or barriers to caring?

Participant: There is a lot. The most, the one that is the problem where I experience, is the shortage of staff. I think that is a major barrier, because it takes up our time and like when you must give health education to a patient we can't even provide enough health education to a patient. We just scatter all that information in a short period of

time and we don't even ask the patient to clarify or to make sure that they understand. They go away out of the facility with that information. Another thing is, I think that, the some of us in the health care profession, we think that, we underestimate the patients, we think we know too much. I think that is a barrier because, when the patient ask us something, we think that the patient is asking stupid questions or wasting our time. Then we don't really take our time to communicate with the patient, to just make sure where is he coming from, even though we don't know what they are trying to ask us, stuff like that. Then a shortage of equipment, it is a big problem, because when you have to do observations, you have to improvise. Some people, they write results in when they didn't even do the stuff, because there are no equipment or that is really a big problem.

Interviewer: Did you experience that?

Participant: Yes a lot and I'm thinking we don't even have a thermometer, where did you now do the temperature, how did you get the results, but then it's there.

Interviewer: Do you think caring is an indicator of our standard of health care?

Participant: Can you just repeat the question mam.

Interviewer: Do you think caring is an indicator of our standard of health care? Do you think caring indicates, maybe the quality of care in ward A is a high quality than then in ward B? Do you think caring plays a role there?

Participant: I think so yes, but in general we, I'll don't look at how much there is caring in this facility then that facility. We just look at the statistics and the outcomes of how many patients is healed in that ward. How many patients is injured in that ward? How many do us safe in the ICU ward then looking at caring overall.

Interviewer: Do you think caring indicate the standard of care or the quality of care?

Participant: I think yes, it does it does indicate, to a certain extent.

Interviewer: Meaning?

Participant: What I can say, is cause even if we care, we suppose to care for every patient, but it doesn't happen like that, so basically we just sometimes we forget, put the caring aside and you just do our, what we supposed to do. Just do, accomplish that, according to our scope of practice. We just do it, because we have to do it and we forget the caring part of it.

Interviewer: Ok, now tell me, how do you think we should apply caring in our practice?

Participant: Ok, it differ from person to person, but for me it like listening and like having respect for the individual you treating. Basically when the person is in need, I'm not saying be there constantly for the patient, when the patient is asking for help we must help them. If you can't help them, tell them, listen, I'm going to assist you, just give me a moment, I'm busy with another patient. Some of them are unreasonable, but we have to explain it to them, to be humble and you just explain to them. Bring them to, we have to come to their level and explain to them. We are here, like there is shortage of staff and that we are here, uhm have to treat like maybe 18 people. Then we had to let them know that we will get back to them. We have to listen to them when we have time and ja. Respect is basically also a thing that you care for them and show them when you nurse them, you don't judge them and that you don't compare them to other patients and ja that's basically it.

Interviewer: Do you think this duty of care is a legal issue or a legal matter?

Participant: I am not sure, I think, I don't think that if you don't care for someone it can become a court case. I think that because we, when you start in nursing and you read the ICN code of ethics and all that, but I think that you know that what you getting yourself into. You so are not expected to care for people, but it just benefits you as a nurse when you get into this profession. When you care for someone and like genuinely you want to do this and you, so I think that it depends on a person to person.

Interviewer: So what is your understanding then of this duty of care if, you say it is not a legal matter what is your understanding of the duty of care?

Participant: My understanding is just that when I care for someone, I do it because I know in the back of my mind it is what I really apply for. What I am willing to do according to my guidelines, like the scope of practice. Yet it's of me as a person, how I was brought up and but I don't. I'm not sure why people chose nursing when they not caring, so I think for me as a person I just know that caring is important in nursing. How you care for someone, it can go wrong and it can become a legal ethical thing but it really depends from person to person.

Interviewer: You said you don't know why people choose nursing and not be caring, what do you think is the reason then that people then come to nursing?

Participant: I think that because they now financially, they think the job is stable. Nowadays, people at school, I was in a group of girls and I always said I wanted to become a nurse. They had various occupations, which they wanted to become and then, nowadays, I just hear, ok my other friend is also now in nursing. The majority of them don't make it, because they don't really feel it. Then you get those, where I get in the services and I meet a sister that, that tell me that, she doesn't like this, that she get irritated with the patients. Then why are you there for like 12 years, but you don't care for people? It must be the financial stability, and some of them just want to belong somewhere, even though they don't do it out of their hearts for caring. Then sometimes, people are in nursing, I think they started off as caring, but somewhere along the way they get hard. It might, is probably because of the patients or where they are placed and what they experience. Overall, I don't think if you come in this for caring that you, is able that you can change so quickly.

Interviewer: What do you think this duty of care is inclusive, of what does it include this duty of care?

Participant: It includes, giving your all to do, to do a job, you now chose to do. You mustn't really think of it as just a job, but as something that you as a person, it's part of. You, you must just think that, ok I'm treating this person with this care because if that person was me, I would have wanted them to treat me like that. Well like they always say, that you must think of it, if it's going to be that person that treat your mother or your father. You want them to be treated with care and respect and that person must take them seriously. Help them to the extent that you know they are physically, they are stable and mentally and all that.

Interviewer: Was the topic the duty of care addressed in NPP?

Participant: The topic wasn't addressed like duty of care, it was just like, we did the ethics in nursing, like the autonomy, maleficence and the respect ja respect for autonomy. We did it like, we broke down the ICN code of ethics, we went into the scope of practice and regulation, but we didn't like focus on care.

Interviewer: Topic of duty of care?

Participant: Yes, we didn't.

Interviewer: Now, what did you, what do you think did give rise to this duty of care which are placed on us as nurses?

Participant: Like why did they?

Interviewer: You remember I say, or you say the duty, you give me your definition of duty, so what do you, what did give rise to this duty of care?

Participant: Ok, I think that because we dealing with people and no matter in what profession you are, there is always a duty mos. I think, the thing that give us the rise of the duty of care is because of the people that that put the policies. They were long in nursing that do research and they find that maybe if you care for people more the person tends to heal quicker. Like I think, they did research, then they find that some people they would care to their utmost best for this people and then that patients would tend out to be more successful. Then it make nursing better type of occupation, so I'm not sure where else it could come from.

Interviewer: You did hear about Batho Pele principles, right, patient's rights and human rights how does it relate to the duty of care?

Participant: In the Batho Pele Principles it says that every person, every patient has its own rights and have the right to the care. I think that, that is also a guidelines, like as I previously said, we have, we are working according to the guidelines, but it does not say that each person, patient has the right to be cared for by us nurses. But it also go both ways so, I think that basically the Batho Pele Principles is a guide, but it depend on the person or the individual if they chose to go according to that.

Interviewer: Now how does that relate to the duty of care?

Participant: It basically just tell that you have to respect for the patient, cause care, it means now having respect for the person and treating the person like someone, you would like some someone of your own, that you would like to be treated nicely and then you must give like it's a, I don't know.

Interviewer: Do you think, I do hear you what you say do you think the duty of care relates to ethics?

Participant: Yes.

Interviewer: Can you tell me what your understanding of ethics is?

Participant: My understanding of ethics is now, what I've learn in NPP, is that, when I think of ethics, is not doing harm to the patient and preventing harm. To have respect for the patient, by allowing the patient to make their own decisions. Telling them, ok you are now diagnose with TB and this is the medication, so it's your choice if you want to take the medication and just to allowing them to be part of making their decisions in healthcare. So that you know, that because, it goes both ways, the patients has their rights but they also has their responsibilities. On the other hand, the fairness, like treating patients equally. For instance, when there's a teenager that is 16 years old at your door by the family planning, then you now saying, but why, why are you on family planning now so early. We don't even, we don't even ask her what the reasons is, and we don't even need to know that, we only need to respect the fact that she is willing to take the responsibility and to use the family planning. When there is a person that is 35 year old, then we don't even question them for family planning, but the person isn't married. We just think, ok, because the 16 year old is too young, now we just going to discriminate against age. We can also, because, according to the Batho Pele, we have to be fair, we don't, we mustn't discriminate and all that. We it's just like stuff, like that, that make us more confusing. So ja, the ICN codes is that of fairness, the not doing harm, the, the respect for autonomy and then also to allow the patient to be part of the decision making.

Interviewer: Ok, if you find yourself you have to make an ethical decision, or you find an ethical dilemma in your practice, how will you deal with it?

Participant: Ok can I use an example?

Interviewer: mm.

Participant: Ok, so in my first year I was placed, I was placed in a medical ward. This patient was diagnosed with HIV and AIDS and TB. At first I was, like exiting in this nursing business, and at first when you see a patient crying you cry and all that, you get emotional. Then I was standing there and this patient ask me what was wrong with him. He was like terminally ill and I could tell this patient that everything is going to be

fine, but, I knew it's not going to be fine. So I chose to tell the patient, don't worry it's going to be fine. I told him the doctor is, will come and explain, because in my mind I was in an ethical dilemma where I had to tell according to what I know. I had to tell the truth to the patient, I want to include them in the decision making and I couldn't be the one that break that gyze heart to tell him it's not going to be ok. So, I just chose to tell the patient that it's going to be fine and then I walk off and I just watch from a distance, when the doctor came and tell him that he is going to die probably soon. I just felt like, that, if I had to do it again, I would. At that moment I lie to the patient, but I lie because I didn't want him to feel bad more than what he already is feeling, see.

Interviewer: What do you think is the purpose of ethical codes and standards and guidelines, what do you think is their purpose?

Participant: The purpose is to keep us, on a, like a path, where we know that, sometimes we can tend to go of it, but which, which shouldn't be. It's basically just a guideline for us to where we should work on. We should, just remember, everything we do, we must remember that the standards, that we must uphold. We must remember that, we have a scope of practice that we are supposed to act out on. It's just basically a guideline to assist us.

Interviewer: Where do you think, who do you think prescribed this standards and guidelines and ethical codes for us?

Participant: I think its people that experienced it and researched it and they worked in the medical field and as they pick up along the way. Some of the ethical guidelines come from the department of health and that is because they overall, they sit as a committee and now they discuss what's best for the patient and what's best for the nurse. They think that, it's almost like you have a goal and in order to reach that goal you have to make a certain steps and rules to reach that goal. I think basically, they just want us to work according to that steps and just to become a better South Africa and better health care system.

Interviewer: Do you think ethics should influence our relationship with our patients?

Participant: Yes.

Interviewer: Why you say it does influence our relationship with a patient?

Participant: It does influence, because some, like what I experienced now, sometimes you know that you have to be honest with a patient and you have to respect the patient but when you there and you can't like in a case where there is a TOP. The patient is there and you have your own values and morals, but know you come there and you maybe a Christian and you come there and this patient she doesn't want the baby anymore and you sit. You looking in her face, but you know that you don't believe in this that are going on. You don't want to take part in this, but according to your job description and all the codes and policies you have to treat this patient fair. But now, how do you put aside your own morals and values? That is basically why I think that is an ethical dilemma and then we dealing with it every day. Ethics is important when you dealing with a patient. It is something that's just like, in such a case, you have to remember that the ethics is more, what you as the nurse should do is more important than you as a person and individual think of the situation.

Interviewer: Does ethics influence our relationship with one another in the workplace?

Participant: Yes.

Interviewer: Should.

Participant: It should, but ja, it should, because, everyone is different now with their own morals and values. When we at work and then people think that their title is maybe, like for instance, when a registered nurse and a student is there, then someone ask her, the registered nurse a question, and she doesn't know it. For instance, but then the student says it, but then they wouldn't like give the student the credit or uh give the respect they give the registered nurse, just because he is just the student. Basically, I think, both two are on the same level and respect should be maintained, but then they just don't do that. They don't allow the students to take part in the meetings and stuff, but the student is also nursing the patient. They give them like in some work places, they don't just, they exclude some people, and they don't treat them on the same level.

Interviewer: So how should ethics influence that situation that you describing?

Participant: Ethics should basically just, like they should try to uphold it, like, the respect for one another, the autonomy include everyone. They should actually make more reasonable principles, like, I know of seven principles, but I think that like the, not doing harm, I think that is more applicable to patients then in the workplace. I think they should create more principles for co-workers also in nursing field.

Interviewer: Do you know where ethics originated from?

Participant: I honestly can't remember anymore.

Interviewer: What is the link between, what is the link between SANC and the Nursing Act?

Participant: SANC is the people that we work under, that gives us the majority of the guidelines that we now, they give us the right to practice as nurses, and we have to answer to them when something is wrong. I think with the Nursing Act, I think, SANC is the people that wrote the Nursing Act. That is what I think, is people part of the SANC department that wrote it, because they know what they want in this nursing field. They goes of seeing nursing like (college loudspeaker) like, I think they have this idea, this nice idea of what they think nursing should be. That's why they give us this Nursing Act. We can try and follow it, but yet try and do the best for the patient, so the link there. Both of them are guidelines, but SANC is just the people that are behind the act that we see and read.

Interviewer: Do you think professionalism and ethics there's a link?

Participant: Yes, because when you choose a profession, you can't just, because you come from which ever background and you brought up in a certain way, you can't just come in and be in a profession where you not ethically, you not write. You just like, talking like you talk at home and doing the stuff that you doing at home, but when you in your workplace, it shouldn't be like, then you are professional. You must, like change your tone of speaking, choose better words. At home you will just use the short cut, or you would speak in a different tone then what you would do at work. Like, this is my colleague, this is someone that I'm treating. I think at work ethics is very important as a professional.

Interviewer: So what is your understanding of professionalism?

Participant: Ok, as a professionalism, I think that you should uphold certain standards and according to your job prescription, we should go according to that. Also, do all that where you have respect for someone, where you do your job as what they want it to be like. As a profession you must just, sometime put aside your personal experiences, values and morals and just sometimes focus on what your job is entitle you to do depending on which job now.

Interviewer: Do you see professionalism in practice today, in nursing practice?

Participant: Not everywhere, it depends, but in the majority it doesn't really, but I think most of the people, they try. Most of the sisters, where I've been placed, try to uphold, but I've experience that the sister soma call, sometimes call us, the student, come we go, she now going on a smoke break. Then she talks about her personal stuff and then you think but I'm working with you and how do I become your friend. I was the student that you suppose to teach and all that and now I'm your friend and so I think that it's very confusing in today's life.

Interviewer: This standards, I do hear what you say, this standards and this ethical codes and this guidelines is it a lawful matter?

Participant: Yes.

Interviewer: Do you find standards and guidelines policies in the nursing setting?

Participant: Yes.

Interviewer: Where?

Participant: In front of every ward and in the clinics, there's like a few, like the Batho Pele principles. They give pamphlets out about the patient's rights, and then the, in every sisters office where I saw there's a, the guidelines and the regulation but it's in shortened and I don't think the patients read it, because it's now pasted on a sisters wall.

Interviewer: On the wall?

Participant: Yes.

Interviewer: And the policies for nurses?

Participant: The policy, I only saw the policy in the nursing tea room ja, nee. The nursing, it's like in a cupboard like in Karl Bremmer, ja in Karl Bremmer and then they, the sister always tell us that we can go read it and so.

Interviewer: Do you read it, or does nurses read the, the files where the policies and stuff is?

Participant: I don't think so, I don't think, but as us student sometimes when we need to have an assignment, honestly speaking, then I will go and just pass through all the rest and just look what I am looking for but then I skip all the other parts.

Interviewer: Now, if this standards and guidelines and laws is a lawful matter, do you think it is important for us to know what is written there?

Participant: Yes, it is important, because at the end of the day, if you know what is written in there, you could prevent it by not doing the stupid stuff, like, not recording and by treating the patient like what we should, according to the guidelines. Then avoid this law cases and losing our jobs for unnecessary, but sometimes I feel like people, we know this stuff and then we just tend to forget it depending on the situation and ja.

Interviewer: Do you think these guidelines and policies need to be updated from time to time?

Participant: Yes, very regularly, it should, but then they should also like inform us and not like with papers, but with videos, like maybe in the clinics or just like sending cd's. Honestly as a 22 year old, I'm thinking that, I don't like to read as much. If I had to choose, I will take DVD's of nursing and the policies and ethics and just listen to it rather than just open a book with 100 pages you see what I mean.

Interviewer: Who's going to pay for those?

Participant: If they have money for unnecessary stuff they can (laughter).

Interviewer: Unnecessary stuff like what?

Participant: Like too much, ok, I don't want to get into that politics and stuff.

Interviewer: Are you talking about politics?

Participant: Yes.

Interviewer: Ok. What can happen if we don't uphold the standards, does it relate to negligence?

Participant: Yes, I think.

Interviewer: Or first answer me, what can happen to a nurse if she don't uphold the standards of practice?

Participant: Ok, what can happen, she can be discontinued as a nurse by SANC she can lose her practice. Sometimes they put you of a certain period of time, until the nurse now acknowledges her mistake. I think that that is a bit harsh, but depending on what the nurse did. I think also, it's important that SANC has that type of rules, because nursing is something that is important and you can't get that life back if you lost someone, so ja.

Interviewer: What is your understanding of negligence?

Participant: Negligence is when you know the stuff, like, ok, I know the ICN code of ethics say this, I know that I pledge for this. Then I am place in front of a patient and I choose not to do what I know I must do and I do it half way just to get the job done, and I forget all the other things that I am supposed to do. I think that is like, because you know as a nurse you should care for a patient, you should explain the procedure to the patient, but because there is a shortage of staff you choose not to explain to the patient. You just say open your legs, I'm doing this and then you just go and you don't make sure that the patient is calm.

Interviewer: You talking about midwifery now?

Participant: Ja, but in general also, it's like you do something and you just forget that, that's a patient you are dealing with and you just think of what you must do to get the day through.

Interviewer: What do you think is the consequences of negligence?

Participant: In nursing?

Interviewer: mm.

Participant: I think that you can be fired from the job where you are, at the place where you work, the place permanent. SANC can discontinue you also and depending on what you did, but basically I just think that you can loss lose your license to practice nursing and ja that's all.

Interviewer: Do you know what is the criteria for finding a person guilty of negligence? For instance you did do this and this and that, now you guilty of negligence do you know that criteria?

Participant: I know what you talking about yes, but I can't now remember everything, but I know that they will uh put you in front of a, ok you are in front, place in front of people where they listen and they tell you, listen to your side of a story. Then they inform you how they feel and then they would discipline you like a disciplinary hearing. You can get that and then depending on the outcomes or what they found while they research the situation and investigate, then they would like maybe tell you ok, because of what you did and we think that you shouldn't practicing nursing anymore, or they would say you must be scrubbed for two years or something.

Interviewer: What do you think is the intention of this laws of negligence?

Participant: The intention is just to make us aware of what can go wrong, if we don't uphold our standards and what we pledge for. The other end, I think sometimes it's to make us scared and aware that, just to do the right thing. If you take your job seriously you would and to avoid all the law cases.

Interviewer: Now, the nurse was negligent or due to negligence a patient dies under the care of the nurse because of negligence. What do you think will be the implications of that?

Participant: Like what they should do?

Interviewer: The patient die now, yes, what's going to happen to the nurse, what will be the consequences?

Participant: consequences? I think they should now first listen to, interview the situation. How come, why is there negligence? I know that some people have stuff on their minds and their own problems, but it shouldn't be a problem. Maybe they should just like, first ask her how come, what was the reason that she did what she did. On the other hand, I think because the patient died, it's much more serious than just giving a disciplinary hearing. I think that they would probably just scrub her maybe, for maybe five years if they know that she could have save that patient. If she did the right thing and maybe just take her license, but depending on what her, her story also is. I don't think they are unreasonable, when it comes to us as nurses. They know we also people, but just the fact that they know that the patient is our first consideration, we should do our best, and it will be depending on what her reason is.

Interviewer: What do you think the family can do of the patient?

Participant: The family of the patient, like every family they will ask questions and they will sue the nurse and take it to an extent and require maybe an autopsy or require to see the patients records and stuff. If something goes wrong in that way, they can pick up, they can take, have a court a law case against this nurse and it will also cost her, her job. It will reflect bad on SANC and the nursing in general, as people don't only just go for court cases they put it in newspapers. SANC will just probably let her go, unless they know it was something that she couldn't, even though she didn't do neglect the patient, the patient would also die, they would stand up for her I think.

Interviewer: So who would held the nurse responsible then, I mean, in this case where the, it happen to be a case, our scenario our situation we did discuss now, who is held then responsible for the death of this patient in the court?

Participant: She in the court it will be the nurse that was helping the patient, but I don't feel that the nurse is the only person dealing with that patient. There is other people also as well, because we are part of a multidisciplinary team. Judging on how it got to that point, where she forgot to do what she should have done, I think that they should investigate everything and everyone and checks everyone notes. In the end it will be her, because she was dealing with the patient right, but the fact is they should also just try to listen to her as well.

Interviewer: So now we found that the nurse is guilty, right and the court decide now that the nurse is guilty what will be the outcome for the patient's family?

Participant: Some families see that justice took place, they are more happy and they relieve from the grieve and stuff like that. I don't think it will make a difference, because even though they see the nurse is losing her, she's guilty and she losing her practice and stuff, some of them they just get back to their house and they still get memories of the person. They went through all of that, the money lost and they went through all the stress, all this worrying about the nurse that they want to bring down. At the end of the day the grieve is still there they lost someone.

Interviewer: The laws of negligence, do you know under which law it falls, under criminal law under case law under civil law?

Participant: Isn't it under, not criminal, case law.

Interviewer: Ok, so what do you think can a nurse do to prevent herself from being sued for negligence?

Participant: She shouldn't be negligent, she should read up on the policy and the updates and keep updated. Try and give all she can in the nursing profession and do the best she can for each individual and not try to do shortcuts and ja.

Interviewer: In literature it says, I'm almost done, in literature it says that disciplinary actions against nurses is on the rise and cases of negligence against nurses is on the increase why do you think that is?

Participant: Cos nowadays there's people that are in nursing so long that they tend to know that they've experienced like, you are like, we come there, we learn this long procedure and then this nurse of twenty years, just there in two minutes, she do that long procedure. We do in an hour and then, we standing there, we see, ok, she didn't even wash her hands when she was wanted to do wound care. Aseptic technique is important, so I think because they think they know according to the years they gain so much experience they soma just going to do it quick, quick and nothing will happen. Nothing did happen before and I think they get too comfortable into the things, they are more competent and experienced so that is how the negligence happens I noticed.

Interviewer: Ok, well, thank you very much for your participation, appreciated. I come to the end of my interview, is there anything you want to ask or comment or you want to add?

Participant: No, thank you.

Interviewer: Thank you again.

Appendix 7: Declaration by language editor



Lona's Language Services

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Afrikaans/English

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* Preparation of Website Articles

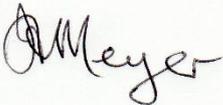
TO WHOM IT MAY CONCERN

This letter serves to confirm that the undersigned

ILLONA ALTHAEA MEYER

has proofread and edited the document contained herein for language correctness.

Signed



Ms IA Meyer

23 November 2017

FOR: THABITA STOLLENKAMP

**TITLE: EXPLORING UNDERGRADUATE NURSING STUDENTS'
UNDERSTANDING AND APPLICATION OF THE DUTY OF CARE**

Appendix 8: Letter of technical editor

To whom it may concern

This letter serves as confirmation that I, Lize Vorster, performed the technical formatting of Thabita Stollenkamp's thesis entitled:

Exploring undergraduate nursing students' understanding and application of the duty of care.

Technical formatting entails complying with the Stellenbosch University's technical requirements for theses and dissertations, as presented in the Calendar Part 1 – General or where relevant, the requirements of the department.

Yours sincerely

Lize Vorster Language Practitioner