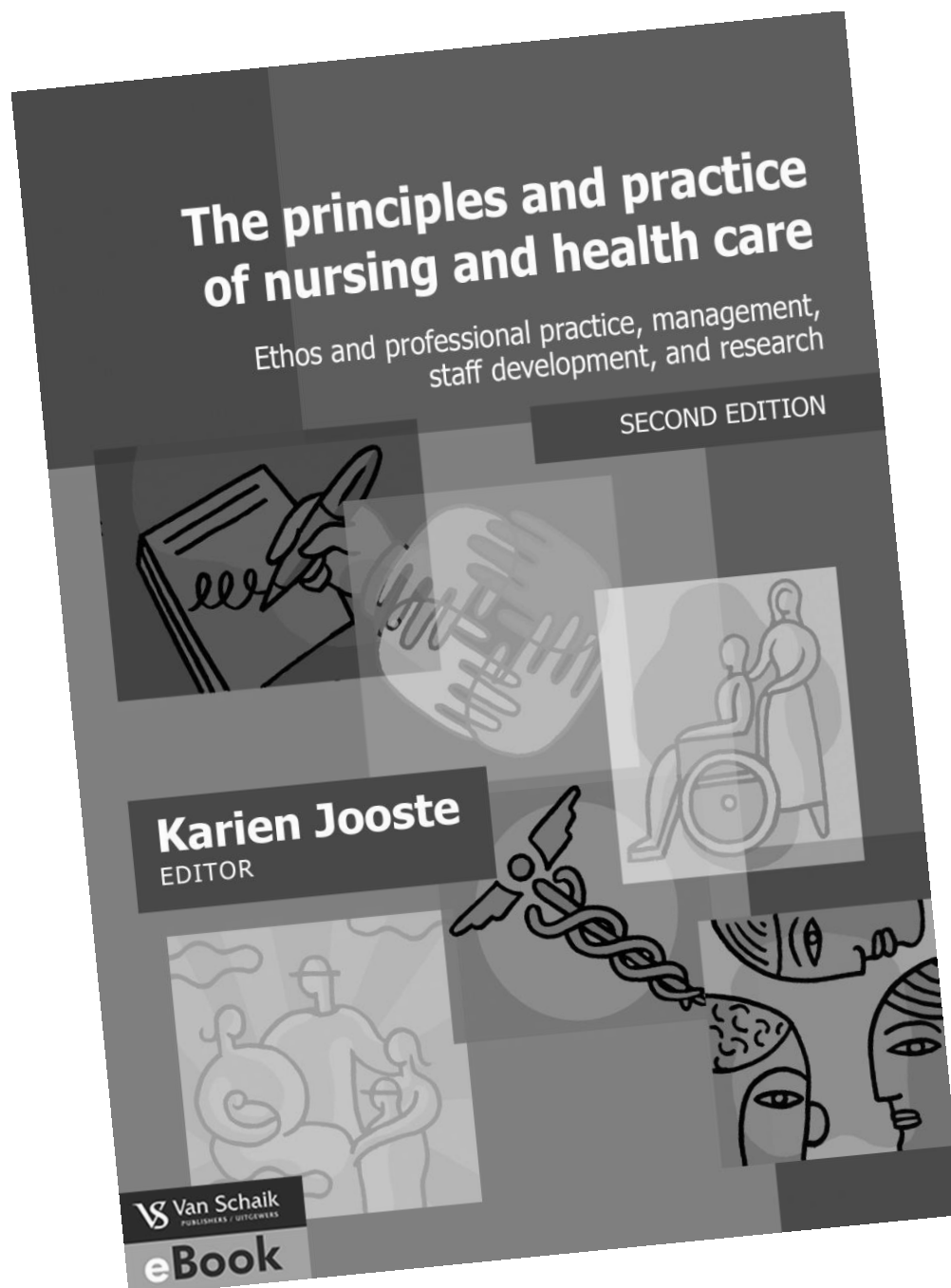


The principles and practices of nursing and health care

Additional information and activities



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Chapter 1: Nature and parameters of nursing practice

Anita Serdyn van der Merwe

Activity 1.1: Scenario (Textbook page 3)

Trigger points

You have read the scenario carefully and should analyse the following:

- The concerns and needs of the health care providers at the hospital
- The concerns and needs of the very ill clients in the medical ward
- The concerns and needs of Carey, the senior student nurse
- The history of nursing and its influence on nursing practice
- The philosophy of nursing as a basis for nursing practice
- The behaviours expected of a “professional” as they emerge in this scenario
- The difficulties of truly “living by” (consistently applying) an ethos of caring

Activity 1.2: Concerns in health care (Textbook page 4)

About 18.4 per cent of these nurses no longer practise nursing or practise in related fields, for example in pharmaceutical and medical insurance organisations (Worrall-Clare 2005a; HASA 2006).

Statistics indicate a loss of experienced nurses over time. More than 60 per cent of all nurses are between the ages of 40 and 64 years, with an alarming 66.54 per cent of professional nurses falling within this age bracket (SANC 2006).

Moreover, 13 496 nurses from South African (about 7 per cent of the local workforce) work in the OECD countries, which excludes countries in the Middle East (WHO 2006: 99). The OECD countries are Australia, Canada, Finland, France, Germany, Ireland, New Zealand, Portugal, the UK and the US. This brain drain represents a significant financial loss in the sense that the cost of educating these professionals is not offset by the benefit of utilising their skills to meet the country’s health care needs. It also severely affects the health care system in the country – the so-called “fatal flows” (WHO 2006).

McGrath (2003) reports a 25 per cent nurse post vacancy rate in the public health system in South Africa. This represented 32 000 vacant nursing posts in the country’s public hospitals in 2005. On the other hand, it is projected that a shortfall of nearly 19 000 nurses will exist in 2011 (Venter 2005).

The health care environment with which the public health sector deals has changed dramatically due to urbanisation, the proliferation of informal settlements and the HIV/Aids pandemic. Added to these are a challenging and often failing system of referrals from primary health care clinics, the disempowerment of clinicians, strained labour relations, perceived dysfunctional relationships between hospitals and head offices, and dysfunctional management structures within hospitals.

In South Africa, the private sector industry has about 25 638 beds compared to the public sector's 104 559 (Steyn 2005). This industry is proud of its highly skilled nursing workforce, and is committed to providing high quality nursing care. However, the reality and impact of making a profit are daunting. Medical schemes in effect determine the length of stays in hospital, and the reality of making client care decisions on the basis of cost impoverishes compassionate care (Von Dietze & Orb 2000). Nurses in private health care institutions often bear the brunt of saving costs for the provider, dealing with clients who are seeking value for money and satisfying the need for additional documentation.

Health care risk management is a critical concern – errors related to fire hazards, medication errors, allergic reactions, poor communication, insensitivity to clients (such as laughing and talking outside a ward), limited privacy, limited information, staff not introducing themselves, and the lack of emotional support for clients are common (*Adaptation model* 2005).

Nurses are disillusioned and frustrated. The shortage of staff (in all health categories, including their own) means they have to work harder to make up for the lack of capacity. They end up with numerous non-nursing duties, doing others' work, and limited time to be truly with the client – as DENOSA (2006) puts it, “extra workload hurts”. In a study involving 924 respondents, more than 60 per cent of nurses were dissatisfied with their workloads and 80 per cent of them complained of greater workloads, stressful conditions and limited support from management (HASA 2006; HSRC 2003 in Worrall-Clare 2005b ; Venter 2005).

The work environment is also hurting – in Sweden the highest risk of workplace violence is in the health care sector (WHO 2006), most frequently physical violence, assaults and bullying. In Canada, nurses have the highest sick leave rate of all workers, while in Zambia death among female nurses in two hospitals increased from 2 per 1000 in 1980 to 26.7 per 1000 in 1991. Botswana lost about 17 per cent of its health workforce to Aids between 1999 and 2005 (WHO 2006).

Activity 1.3: The “off-label” use of nurses (Textbook page 5)

“Supposedly good has become more bad than good”

Such usage triggers a number of ethical questions, for example is it experimentation, does it conform to standards of care, does it leave the prescriber open to a malpractice suit, what are the duties of the prescriber and how controllable are such practices (Mehlman 2005)? Nurses in both private and public practice are working in short-staffed environments and are then also used for activities and responsibilities that are not necessarily part of what they are

meant to do and or what they do best. What nurses do best is the skilful rendering of the most intimate personal and competent service. As a way of survival, nurses have to resort to functional task-oriented nursing; failing the client is then not so clear, and it becomes easier to blame others for failures. In more ways than one, it has become better to be *safe* than *sorry*. It becomes a difficult challenge to consistently provide compassionate care, and for health carers, suffering from compassion fatigue has become a sad reality that is not often acknowledged or dealt with.

Activity 1.4: Nursing profession (Textbook page 6)

The history of and current status of the nursing profession in South Africa

Florence Nightingale, the pioneer of the nursing profession, showed through her compassion, integrity and dedication that she too embraced the universal values that we call *Ubuntu*. It is in the spirit of Florence Nightingale and ancient wisdom that nurses need to strengthen nursing care delivery, based on the moral tradition of fairness, social justice, compassion and care. Through human solidarity and the restoration of human dignity and self-respect, nurses contribute to building a healthy, prosperous and peaceful nation.

Florence Nightingale portrayed a heroic image of nursing and this was kept alive in South Africa by leaders in the nursing profession such as Henrietta Stockdale and Cecelia Makiwane, who portrayed a nurse as someone who could do something important. As we know, the history of nursing in this country has a rich heritage despite the setbacks that were caused by apartheid. Stalwarts of the nursing profession like Cecilia Makiwane laid a solid foundation of providing selfless nursing care to the poor.

Nursing education

Henrietta Stockdale saw to it that the nursing profession became autonomous when, through her efforts, South Africa became the first country to register nursing as a profession. As an Anglican nun of the Order of Saint Michael and All Angels, she became the first matron of the new Kimberley hospital in 1881. The nurses she trained were much sought after to establish new hospitals throughout the country. In 1891 Sister Henrietta secured legal recognition of the profession when, through her efforts, an Act was passed by the Cape Parliament which made South Africa the first country in the world to institute compulsory state registration of nurses.

Another objective she strove to achieve was to make nursing education a part of the country's system of higher education, wishing it to enjoy equal status with the training of teachers and so to qualify for public funding support. *Nursing education* at the degree level was introduced in 1956, and has expanded to such an extent that 13 universities in South Africa now prepare nurses at baccalaureate, honours, masters and doctoral levels.

In acknowledgement of Sister Henrietta's vision and endeavours, a fully-fledged nursing college established in the Northern Cape in July 1980 was named the Henrietta Stockdale Nursing College. The *McCord School of Nursing* has also contributed much to the development of the nursing profession in South Africa. The focus of the school has always been to respond to the needs of the people. It had its origins in a hospital for Zulu people founded by Dr James

McCord, who came to South Africa as a medical missionary in May 1909. There was no one to employ as a nurse, so his wife initially carried out this task. Eventually Dr McCord employed Katie Makhanya as a general assistant and interpreter for the consulting rooms and examination room, after which the hospital was more cheerful and the clinic ran more smoothly. As the load of work increased in the hospital and dispensary, it became necessary to start training nurses who would care for the clients. A Miss MacNeille was engaged for this task. Four students were trained in the first group in 1910. However, the hospital was not yet registered as a training school.

Dr Alan Taylor joined Dr McCord in 1921, and contributed to the improvement of nurse training. He applied to the government to recognise the Mission Nursing Home as a hospital, fully qualified to train nurses, but his application was turned down. In the next few years, the hospital underwent considerable expansion, and after an inspection in 1924 it was approved as a training hospital. The nursing training programme was also approved. From 1924 onwards, the McCord Hospital nurses wrote the same examinations as white nurses, and on passing were registered with the Medical and Dental Council.

In 1927 the hospital was officially recognised as a training school for midwives. Midwifery educators were also products of McCords. Midwives visited many areas of Durban to do deliveries, and travelled in pairs for protection. The midwives in freshly starched uniforms with delivery bags in their hands became a common sight in the poorer and outlying areas of Durban.

With each enlargement of the hospital, it became necessary to increase the number of nurses and midwives in training to care for the increasing number of clients. Developments included the Advanced Midwives Programme (decentralised) in 1989, the training of facilitators for Advanced Midwifery for all South African provinces, the training of bridging course students in 1990 and the training of primary health care nurses (decentralised) in 1999.

Our nursing leaders made a drastic decision in the mid-1980s to *decentralise control of nurse training* and to delegate this responsibility to the universities. At the same time the training was changed from individual diploma or degree courses in general nursing, midwifery, psychiatric and community health nursing, which on average would take between five and six years to complete, to a comprehensive course that would allow students to obtain all these qualifications within four years. Each university sets its own standard and there is a strong emphasis on academic achievement, often to the detriment of clinical practice, as the duration of the course does not allow time for the consolidation of clinical skills.

In 2008 The Nursing Standard Generating Body of the SANC recommended that post-basic qualifications be pitched at master's certificate level, namely level eight of the National Qualifications Framework (NQF). The core of the proposal is that the programmes should have a single basic qualification with multiple entry and exit points. While these qualifications would elevate the nursing profession to higher education levels, this is by no means the most cost-effective way to train the increasingly large numbers of nurses needed to face the national crisis. The professional nurse will have a Bachelor's degree, which eliminates the current four-year diploma.

However, this qualification will confront public nursing colleges with a huge challenge, since they will not be in a position to offer degrees without some type of collaborative agreement between themselves and a university. South Africa has a drastic shortage of specialist nurses and a university course will only work if it encourages more students to specialise in clinical fields rather than focusing on management and academic positions. There are opportunities for staff nurses to specialise as the course will have exit points to ensure a good mix of theory and experience.

Against this backdrop, the pegging of post-basic qualifications at master's, certificate and higher diploma levels appears to pose additional challenges, given the dire need for specialised nurses. The suggestion that clinical programmes be introduced at master's levels may unwittingly reduce these numbers further. Registered nurses who may not cope with such a demanding programme may choose to remain where they are. Nonetheless, this does encourage the continuing professional development of nurses.

The educational standards should be the same in public and private hospitals, irrespective of where the individual is trained. There should be a nursing education model for training nurses for South Africa based on sound partnerships. Criteria for recruitment and selection should be standardised. The clinical accompaniment of nurses should be revisited as students must be groomed to adopt good clinical practice in order to deliver quality client care. Qualified nurses should be role models for young people entering the profession. The set of qualifications must be developed to address the needs of the country without dropping our internationally recognised standards.

The critique is that students are given very little clinical responsibility during their training and this impacts negatively on their functioning once they are registered. Student nurses are no longer paid a salary during training and are given a bursary, so there is no pressure on them to perform as they are not employed. Since nursing is a practical profession, if the trainees are not compelled to nurse during training, they will be ill equipped to nurse when qualified. This may be the reason why they are found in the nurses' station instead of at the bedside, as they lack the confidence to carry out their duties.

The number of registered nurses being trained is limited by the ability of the universities and nursing colleges to accommodate them, and with the shortage of experienced staff South Africa now has to import nurses to meet its national demands.

In 2008, the SANC did not accredit certain courses and this problem was taken up by other institutions in order to address the demand for nurses:

- Courses are being designed and implemented by NGOs and NPOs to train nursing auxiliaries and care-workers, often at quite a cost to the student.
- Some private hospitals have been offering post-registration training to meet their own needs, especially for theatre and intensive care, although some companies also train nursing auxiliaries and enrolled nurses, and offer bridging courses. The Hospital Association has been approached to accredit courses in the private hospital sector so that there is a national standard for the training of post-registration courses in that sector.

- The Associated Psychiatric Hospitals in the Western Cape have reintroduced training for the Diploma in Psychiatric Nursing as a one-year course.
- The Western Cape Provincial Department of Health is offering a course in the training of mentors.

More nurses need to be trained to support the present weak workforce and to prepare for the future. Ways of involving experienced nurses who have retired or taken packages in training and mentoring should be devised.

Military nursing

Military nursing is also part of the history of nursing in South Africa. Military nurses served in South Africa as far back as the Anglo-Boer War, and before that in the Zulu Rebellion. With the Union in 1910 came many changes and problems for the newly formed Union Defence Force. One of the necessities was the establishment of a South African Military Nursing Service. In August 1914, South Africa found itself at war. Matron ER Creagh of Weskoppies Hospital in Pretoria was appointed Matron-in-Chief (till 1925) and called upon to establish and organise a military nursing service.

Government Notice No. 1937 dated 18th December, 1931, provided for pension benefits for matrons, who to all intents and purposes, held permanent status in the force. The total strength of the service in 1931 was a mere 18 members, which included the Matron-in-Chief, a matron, two masseuses and a probationer.

For a period of five or six years immediately preceding World War II there were no nursing assistants in the service. In February 1940, the attestation of nursing assistants again took place. They were designated “female probationer nurse”. This remained unchanged until 1944 when the present term (nursing assistant) was adopted.

The service reached its peak during World War II. In 1944 the strength was recorded as being between 1886 and 2500 nurses, more than 1000 of whom were nursing assistants. In August 1964, the service celebrated its 50th anniversary of unbroken service to South Africa. It can claim to be not only the first organised independent women’s service, but the only one that endured to celebrate that memorable occasion.

The year 1964 was a memorable one for nurses throughout South Africa, for both the South African Military Nursing Service (SAMNS) and the South African Nursing Association celebrated their Golden Jubilees. The two are completely different bodies but all military nurses must be members of the Nursing Association. The two organisations first became linked when the South African Trained Nurses’ Association petitioned the Minister of Defence for the establishment of a Defence Nursing Council. This was to obviate a repetition of the difficulties under which nurses enlisted for military service during World War I. The petition was successful and in October 1921, the first meeting of the South African Defence Council was held. Two seats on the Council were allocated to representatives of the Trained Nurses’ Association.

In 1965 it was decided that nurses would wear the same badges of rank as those worn by the officers of the South African Army. The principal matron now holds the rank of colonel, senior matrons are commandants, junior matrons

are majors, grade one sisters are captains and grade two sisters are field cornets. Depending on their service, grade one sisters may be ranked as either captains or majors. The principal matron previously ranked as a commandant.

Nursing legislation

The history of nursing in South Africa teaches us that the previous generation of nurses spent much of their time structuring the nursing profession. Our task is to perfect it. Our predecessors created the Nursing Council and Association and were instrumental in moulding the many qualifications we have today. They also developed the scope of practice and all the regulations that govern our nursing practice. When we look at this legacy now, we can summarise it in these words:

- Structured qualification
- Regulated practice
- Ethical consideration
- Organised independent profession

The nursing profession has seen many legislative changes in the past few years, including proposed qualification changes. The Nursing Act No. 33 of 2005 makes provision for the following new categories of nurses:

- Professional Nurse – comprehensively qualified registered nurse. This will require a four-year training programme pegged at NQF level seven.
- Staff Nurse – equivalent to current registered nurse with no additional qualifications. This is an exit at second year of the four-year programme with NQF level six.
- Enrolled Nursing Auxiliary (ENA). This will require a certificate for enrolment at NQF level three.

The new Nursing Act must be fortified to open new opportunities for the nursing profession. The scope of practice should empower nurses to act other than limiting their practice to irrelevant situations based on client complexities.

The Nursing Act No. 33 of 2005 replaces the Nursing Act No. 50 of 1978 which was passed during the apartheid era. The passage of the new Nursing Act created a new regulatory framework which marked a fresh beginning for the nursing profession in the post-1994 democracy in South Africa.

The Nursing Act No. 33 of 2005 ensures that

- the nursing profession and its members are accountable to society
- the scope of practice of nurses is aligned to health service delivery needs
- members of the nursing profession will be competent through the introduction of mandatory continuing professional development requirements
- a notion of community service is instilled among new recruits through compulsory community service
- nurses are accountable for providing a high standard of professional and ethical nursing
- nursing education is aligned to the provisions of the NQF.

The 2005 Act created an enabling environment for the formulation of new regulations and a review of the existing regulations that govern the practice of nursing.

In response to the new Act the SANC

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

The SANC will strive to ensure that nurses are safe and competent practitioners who provide a high standard and professional nursing care to the inhabitants of South Africa.

The history of labour and unionism in South Africa

When Jan van Riebeeck landed in the Cape he brought with him a system of slavery whereby workers sold their labour for a plate of food and a place to stay. The Master/Servant Act of 1934 referred to a paternalistic employment relationship in which the employer prescribed the rules with no consultation with any other party. “Hard labour” or imprisonment of up to one month was introduced for transgressions such as disobedience, unauthorised absenteeism, late coming and refusal to obey an order.

Labourers were imported from India to work on the sugar cane plantations. With the discovery of diamonds in 1870 and gold in 1872 more skilled labourers were imported, many of them from the UK and Europe. They brought with them the concept of unionism, which had grown very strong during the course of the Industrial Revolution. The Joiners and Carpenters Union – South Africa’s first trade union – was formed in December 1881, and when the first strike took place in 1884, 40 people were injured. The first strikes among mineworkers took place on the Rand in 1897 following a cut in wages. Many strikes on the mines followed and many had a racial undertone.

World War I (1914 – 1918) led to a decrease in the gold price and the subsequent Depression of 1922. This ended in the Rand Rebellion – a strike that lasted 70 days and during which 400 people were injured and 144 died. With the defeat of the Smuts government came the introduction of the Industrial Conciliation Act of 1924.

The Industrial and Commercial Union was formed in 1919 under the leadership of Clements Kadane. This union had 100 000 members by 1927. In 1920, 71 000 workers went on strike in protest against the Group Areas Act. The police force soon defused this strike.

A Wage Act was introduced in 1925, which determined minimum salaries and conditions of service for industries, and the principle of negotiation for such. The National Party came into power in 1948 and introduced a system of racial segregation – a sin for which the country is still paying today. Legislation was promulgated to ban communism and

many communist leaders, supported by various trade unions and the African National Congress (ANC), were deported from South Africa.

The Kliptown Freedom Charter of 1956 articulated and upheld the basic rights and freedoms of South African citizens. The Pan African Congress (PAC) was formed in 1959. On 21 March 1960 leaders of unregistered unions were banned. This led to a decrease in union activities, which stabilised the labour market.

About 60 000 workers took part in strikes about conditions of service and salaries in 1973 in Natal. Major strikes in the transport industry brought the transport industry to a standstill. Following the 1975 Soweto riots, which were sparked by the introduction of Afrikaans as the language medium in black schools, the Wiehahn Commission presented proposals to the government which changed the labour scene and approach in South Africa for good. Some of these proposals were as follows:

- The inclusion of all races under the definition of “worker”
- The exclusion of racial discrimination
- The introduction of a Labour Court
- The entrenchment of freedom of association
- Learner/artisanship opportunities for all races
- The formation of a National Manpower Commission to investigate and monitor changes in labour relations
- Recognition of trade unions as role players in the workplace
- Revision and description of the role of government in labour dispute resolution (i.e. labour legislation)

In 1984 a tri-cameral parliament was introduced giving recognition to blacks, whites, coloureds and Indians. The Congress of South African Trade Unions (COSATU) was formed on 30 November 1985 with 33 unions and 450 000 members. Although there were some instances of increased harassment of trade unions, these organisations enjoyed greater recognition and became more active from the middle 1980s onwards. More work-hours were lost between 1985 and 1990 than in the preceding 75 years.

The release of Nelson Mandela from prison in 1990 set the scene for creative labour relations, and in 1991 a Labour Appeal Court was established. With the ANC coming into power in 1994, South Africa has seen the introduction of a good deal of advanced labour legislation.

The South African Constitution of 1996 introduced further changes, demands and opportunities in the labour/employment market – to take Chapter 2 of the Constitution, the Bill of Rights, as but one example.

In the nursing environment we have also felt the impact of labour problems and unionism – something we never knew before. The Constitution and relevant labour legislation changes have made it necessary for our own professional organisations to adapt to the demands of the time. The South African Nursing Association (SANA), originally a professional organisation, has become a fully-fledged trade union with its amalgamation with the previous “homeland” nursing organisations in 1996/7.

Membership of SANA had been compulsory for all South African nurses. This has changed to voluntary membership of DENOSA. With the freedom of association principle, nurses started to join general unions like the Health and Other Service Personnel Trade Union of South Africa (HOSPERSA), the National Education Health and Allied Workers (NEHAWU), the South African Democratic Nurses Union (SADNU), the Independent Municipal and Allied Trade Union (IMATU) and others.

The role of the trade union in nursing

The role of trade unions and workers' organisations has become more prominent over the past two decades, and negotiations about conditions of service and salaries have become standard practice – a far cry from the prescriptive and autocratic position taken by health care management in earlier times. Nurses have thus come to have a stronger voice. The negotiator for nursing in the PSCBC (Public Service Co-ordinating Bargaining Council) proved to be taking into account the interests not only of nurses but also those of clients – so much so that the medical practitioners in the public sector sided with DENOSA and for once the doctors are now dependent on the mercy of the nursing negotiators.

The health care industry also had its share of industrial action. The determination in 1997/8 of nursing as an essential service in the public sector, but not in the private sector, has its own implications for the health care industry, particularly section 100 of the 1996 Labour Relations Act.

Because of the changes in labour legislation and the focus on fairness and unfairness with regard to discipline and dismissal, procedurally and substantively wrong practices of employers are now also being sternly dealt with and rectified. Nurses have been seeking, and finding, legal remedies for perceived unfair labour practices.

To understand why employees join and terminate union membership, one needs to understand what trade unions do for their members. Of course, different unions have different goals and objectives and thus offer different benefits to their members.

Employees join unions for the following reasons:

1. Economic reasons – members can negotiate better working conditions and salaries and can also take advantage of discounts and other financial benefits, such as indemnity insurance and medical aid, that a union may be able to offer.
2. Safety reasons – even in this day and age subtle victimisation and intimidation take place between unions. In addition, unions are seen to be protecting employees from losing their jobs. Many employees are reaching for any kind of security to survive in current conditions.
3. Social reasons – people hope to develop personally and professionally by joining a union and to obtain a certain status and standing in the community and industry.
4. Work security – union officials are extremely knowledgeable about the latest legislation and the availability of skills in the labour market, and can assist their members to do what is in their best interests.

5. Political reasons – union members may obtain a political objective and make contributions to legislation.
6. Procedural reasons – union officials are highly skilled at negotiating and resolving disputes, and this often poses a threat to uninformed employers.

Employees, in our case nurses, refrain from joining unions for the following reasons:

1. Affordability – although union membership is reasonably affordable, one needs to consider the value of our currency. There might also be times when it is more important to buy bread and milk than to join a union.
2. Ignorance – many nurses do not really know how they will benefit from union membership and what they will get for their money.
3. Need – if you haven't had a labour problem yet, you might not be aware of or interested in the services of a union.
4. Culture – there may be a non-union culture in the organisation, and this may be very successful provided the employees are well looked after. However, many of the old school or “silent generation” nurses do not want to be associated with what they regard as non-professionalism – a stance of ignorance, I would say.
5. Service delivery – if the services employees get from their unions are not satisfactory with regard to availability, knowledge, assistance, and so on, employees will look for alternatives. (The obverse is also true: if an employee does not like the assistance or even the hard truths the union is presenting, he or she will just go to another union that might do as he or she expects.)

Employers may also be ignorant of the added value a trade union can bring to an organisation.

The role of the trade union in the past has been to promote general socio-economic change. Given the current political dispensation in South Africa and the active interaction between unions and management, the role is shifting to that of business unionism. Unions are tending to become business partners in our industry, with some unions even having shares in the major health care companies in which they organise members. More important is the buy-in from some unions to improved productivity.

In addition, the competition between unions for membership strength (and thus power) in a particular industry has led unions to become more business focused. Unions now have shares on the stock exchanges and pension funds for their members, and are being run as major financial companies.

Given that nurses work in a people's business, and in the current competitive era, the power balance between employer and trade union is likely to be decided by which of the two provides the best customer care to employees. Adherence to the basic principles of customer care will be what persuades the employee to join a trade union or terminate her or his membership, and employers or managers to support or discourage union membership.

Unions should not be seen as a watchdog for or an alternative to a peaceful working environment. Input and cooperation with unions can go a long way towards establishing good working relationships. However, the approach,

integrity, knowledge and credibility of individuals on both sides, and the respect with which they treat one another, will ultimately determine the level of cooperation with both the union and the employer.

Whether a nurse or health care worker is a manager/employer or a union official, it is always important to remember that his or her conduct and behaviour are taken as personifying the company or union he or she represents. The union is only as good as its previous case success; the company is only as fair as its last dispute management.

Community service

The introduction of community service started in 2007 but is restricted to students doing a four-year degree/diploma. Nurses have a limited licence to practice during the community service year, making it impossible to moonlight.

Impact of HIV/Aids on growth

Nurses, positioned as they are at the frontline of the health care sector, are at the centre of this situation. They have to care for the seemingly unending number of terminally ill victims of Aids, and this impacts negatively on their emotional and physical wellbeing. The chronic pressure on hospitals and nurses is threatening to undermine the capacity of countries such as South Africa to provide a comprehensive health safety net for the rest of the population. This is a national priority that we all need to pay attention to. Health care workers need to speak openly about the disease and educate as many people as possible, especially the young, about its prevention and treatment. It is also important that nurses take responsibility for their own health.

Quality and standards

Quality improvement changes revolutionise our focus on the health care industry and require a fundamental change in the way that we work together. The emphasis on delivering quality client care and the need for accreditation by international organisations underline the importance of quality within health care – especially private health care. Quality initiatives empower and educate people to maximise their involvement and mobilise their energies towards caring for their clients. If we all focus on improving the quality of client care we will help to reduce the number of client complaints and will ultimately promote the nursing profession. The profession must focus on what needs to be done in the future. Quality starts with each health care professional.

Challenges

Nurses who work in either the private or public health care sector are faced with the challenges posed by increased health care costs, growing client numbers and changes in disease profiles. They can make a difference to the health care system in their own way. It is not the expensive medications and equipment that make clients happy – it is the little things that count. The kindness and care shown, a listening ear and the desire to genuinely help an individual are key to a client's recovery.

Nurses today have more opportunities than ever before in terms of career development, jobs, areas of speciality and assuming executive or political positions within both the public and private sectors. At the same time, however, the

profession is grappling with the challenges posed by the scourge of HIV/Aids, changes in legislation, socio-economic demands and educational and professional changes. Nurses in South Africa choose to leave the profession for a variety of reasons, including the promise of better salaries elsewhere. South Africa has a shortage of at least 32 000 nurses in the public sector. South Africa needs nurses who are competent and highly skilled, caring and empathic, and who are critical thinkers.

South African nurses have been sought after internationally for decades due to our high standards of theory and practice. Ours was the first country in the world to legislate nurse training and practice, thereby setting, maintaining and controlling standards. Every nursing course was centrally examined and registered, enrolled or certificated by the SANC as a quality control measure.

South African nurses are now globe-trotting to the UK, America, Canada, Australia, New Zealand, the Middle East and up into Africa itself.

Our nurses are sought after because of their propensity for hard work, their ability to fulfil the roles of any other member of the multidisciplinary team, their ability to use their own initiative in a crisis, their ability to function in a team or independently, their inherent professional discipline and their retention of professional accountability. However, because so many of our more experienced nurses have taken voluntary severance packages and gone overseas, our young nurses have been left without mentors.

General questions (Textbook page 11)

Question 2: Evaluate yourself by answering the following questions to ascertain your level of professionalism

1. Do I have a personal code of nursing ethics and behaviour?
2. Do I consistently act as a professional?
3. Do I positively defend nursing and speak proudly of being a nurse?
4. Do I lead by example so that others can follow?
5. Am I a mentor, and do I share my professional knowledge with others?
6. Do I always listen to my conscience regardless of who is watching and even when no one is watching?
7. Do I work to my highest potential?
8. Am I a contributing representative member of my staff, profession, community and society as a whole?
9. Do I continuously strive for personal and professional growth and development?
10. Do I set personal and professional goals and accomplish them?
11. Do I belong to and participate in my professional nursing organisations?

Question 5 Criteria of a profession

There are certain basic criteria that nursing must and does meet in order to be regarded as a profession. They are as follows:

1. Nursing has a large body of specialised theory with well-developed technical skills based on theory, such as the scientific nursing process:
 - Assessment of situation
 - Requires intelligent judgement and specialised theoretical knowledge
 - Planning of action
 - Establishment of priorities
 - Determining of short and long-term objectives
 - Implementation of planned action
 - Self or by delegating to followers
 - Requires technical skills
 - Necessitates guiding and directing of delegated tasks
 - Evaluation
 - Was the desired effect achieved?
 - Is an amended plan necessary?
 - Recording
 - Scientific and legal format
 - Specific language and nursing jargon
2. Theory from sciences and other fields of learning is relevant to practice:
 - Ethos; anatomy; physiology; chemistry; microbiology; pharmacology; pathology; social science; etc.
3. Long periods of specialised preparation are required at recognised educational institutions. All institutions delivering nursing education as well as the curriculum of the nursing course must be accredited by the SANC.
4. Professional competence must be tested before admission to the ranks of the profession:
 - Successful completion of an SANC, university or college examination on theory and practice is required.
 - Qualified examiners and moderators are appointed by the examining body.
5. There must be a recognised form of registration and licensing:
 - Qualified nurses, nurses doing community health service and nursing students are registered on the registers of the SANC.
 - The SANC determines distinguishing devices for each category of nursing.
6. Self-organisation leading to the formation of professional associations is necessary, as is a self-governing body (SANC) which controls the professional standards:
 - Ethical codes and standards are determined by the SANC.
 - The training institutions set specific admission criteria which candidates must satisfy to enter the profession (e.g. senior certificate with mathematics, biology and natural science as well as the psychometric testing of the aptitude of the candidate).

7. Ethical control of professional conduct by members of the profession is required:
 - Scope of practice is determined by the SANC.
 - Peer review takes place in cases of professional misconduct.
8. The motive for service is clients' need for professional assistance, irrespective of their ability to pay; the welfare of the client is the overriding consideration.
 - Nursing has a collective philosophy to serve the community.
 - It meets the basic needs of clients.
 - Staff are rewarded in adequate monetary terms (salaries of nursing staff).
9. A high degree of accountability for professional acts to the public, client, employing body and other members of the profession is necessary.
 - Nurses are independent practitioners responsible for their own acts and/or omissions.
 - Legal (e.g. courts) and disciplinary action (SANC and employer) is possible.
 - Nurses take accountability for professional competence and judgement.
10. There should be a feeling of exclusiveness.
 - Admission requirements to the profession must be met before entering.
 - Uniforms are specific and there are distinguishing devices.
 - Specific nursing language and jargon are used.
 - Ways of socialising are established.
 - There is a common bond among nurses.
11. Professionals should have a recognised status in law.
 - Nursing in South Africa has been governed by national legislation since 1891. South Africa was the first country in the world to have state registration for nurses.
 - The Nursing Act is an act of parliament.
 - Nursing regulations and legislation are in place.
12. Nursing has a high social standing and considerable social power:
 - Nursing is respected by the public.
 - Nursing has a trust relationship with the public.
 - Performance of activities is based on an understanding of what is involved in these activities, so that the results of acts and omissions can be predicted.
13. The nursing profession, through the SANC, determines the curriculum and subjects required for educational programmes, in order to realise its objectives.
14. There is constant critical analysis of activities leading to the modification of practice in the light of this analysis. The nursing profession is never static, but is subject to change and development – discarding what is no longer relevant in favour of what is of more use in carrying out activities related to the nature of the profession.
 - Nursing research is a very important component of the profession.
15. Members must be able to select, in a responsible manner, the activities that are of intrinsic importance to its practice. These activities must be realistically attainable by members of the profession.
 - Basic training is followed by post-basic training.

- Short courses are followed for CPD (continuous professional development).
16. Individual members are allowed the maximum use of their own discretion and initiative in practice. Independent functions and accountability for performance are inherent.
 17. Members have an obligation to use their best endeavours at all times in meeting the needs of the client.
 - The client's life depends on nurses' actions and/or omissions.
 18. There must be a continuous striving for excellence – competence is not enough!

Conclusion

Nursing continues to be a female-dominated profession and all the challenges that women in the broader society are facing therefore also apply to this profession. Nursing continues to be a route of access to the health sciences profession for all sections of our society. Nursing is not independent of the mores of society. A new orthodoxy has developed which has brought fragmentation to the nursing profession, with each nurse being taught to become a wholly autonomous practitioner. Thus the ward sister no longer inducts her charges into a (nursing) tradition but rather takes on the role of a detached business manager.

One of the most important changes that has occurred in nursing is that it has expanded from a client-centred approach to family-centred and community-oriented care.

The nurse has been an important, dynamic force in the history of the development of a care model and in the wellbeing of the South African population.

In the present era, nursing is prominent in the struggle against disease conditions such as HIV/Aids and pulmonary tuberculosis, and in assisting all our communities in the prevention of illness and achieving their maximum health potential.

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Chapter 2: Nursing theories and philosophy

Agnes Makhene and Karien Jooste

Activity 2.1: Philosophy (Textbook page 15)

A *philosophy* is a way of thinking about the world, the universe and people. A philosophy is a group of ideas, worked out by a philosopher (someone who has studied ways of thinking about the world). The ideas in philosophy are abstract, which means that they are “things that cannot be touched.” Philosophy can be divided into different groups, based on the types of questions that are being asked.

In ethics the following questions could be posed:

- What is right and wrong, good and bad?
- Should people do some things and not others?
- What is justice?

Humanism

Humanism is a broad category of ethical philosophies that affirm the dignity and worth of all people, based on the ability to determine right and wrong. Humanism may be regarded as a process by which truth and morality are sought through human investigation, focusing on the capacity for self-determination. Although humanists share many fundamental principles, there is a great deal of variety among them. The ancient Greeks placed importance on understanding human relationships, especially in the context of social order. Socrates (470–399 BCE), Plato (384–345 BCE) and Aristotle (384–322 BCE) believed that we can obtain an understanding of human nature by studying what humans do and the way they interact, especially from interactions that are directed towards doing good or evil to others. The Greeks elaborated on the concepts of free choice and responsibility for one’s actions relative to those “free” choices.

In nursing, human-centred thinking is easily recognised in the views of the earliest nursing professionals, who described nursing as personalised, humanistic care, or a way of caring for the patient as a unique person (Henderson 1964; Nightingale 1946). Florence Nightingale (1946) claimed that the essence of nursing rested on the nurse’s capacity to provide humane, sensitive care to the sick, which she believed would allow healing. Hildegard Peplau (1965) later introduced her Theory of Interpersonal Relations, which focused on the human connection between nurse and patient. Henderson (1964), in turn, characterised her own view of modern nursing as embracing “self understanding and a universal sympathy for an understanding of diverse human beings” (Kleiman & Kleiman 2005).

The humanistic perspective views human nature as basically good, with an inherent potential to maintain healthy, meaningful relationships and to make choices that are in the interest of oneself and others. The humanistic therapist focuses on helping people free themselves from disabling assumptions and attitudes so that they can live fuller lives.

Architects of the humanistic approach include Abraham Maslow and Carl Rogers.

Shared beliefs in the humanistic perspective are as follows:

- People are essentially good and growth-oriented.
- If people depart from their basic nature, they may commit bad or destructive acts.
- If a relationship is characterised by acceptance, caring, trust and respect, a person may regain his or her emotional and spiritual equilibrium.

Basic assumptions in the humanistic perspective are the following:

- Experience and the understanding of personal experience are the prime concerns.
- Every individual is unique.
- Growth orientation: people have a tendency towards growth and actualisation.
- Free choice: people can choose what they become.

Humanistic existentialist

Some humanists hold existentialist views as well, according to which there is no meaning to life or human existence apart from the meaning that we make up or invent. Some religions do not agree with the beliefs of existentialism.

The humanistic existentialist is interested in helping the client find philosophical meaning in the face of anxiety by choosing to think and act authentically and responsibly. According to existential therapy, the central problems people face are embedded in anxiety over loneliness, isolation, despair and, ultimately, death. Creativity, love, authenticity and free will are recognised as potential avenues towards transformation, enabling people to live meaningful lives in the face of uncertainty and suffering. Everyone suffers losses (e.g. friends die, relationships end), and these losses cause anxiety because they are reminders of human limitations and inevitable death. The existential therapist recognises that human influence is shaped by biology, culture and luck.

Existential humanism assumes that people's problems come from not exercising choice and judgement enough, or enough to forge meaning in their lives, and that each individual is responsible for making meaning out of life.

Existential humanism may be understood in several different ways. It expresses the power of human beings to make freely willed choices, independent of the influence of religion or society. The best use of our capacity for making choices is to freely choose to live a fully human life that incorporates traditional human structures such as marriage. Some of us may choose to be heroic, even knowing that it will bring us neither reward nor salvation, and embracing our own personal freedom requires us to fight for the freedom of all humanity.

Existential theory is

- based in philosophy
- helps people examine issues of personal meaning

- less about theory and more about offering a perspective on the human condition.

Existential principles are as follows:

- Self-awareness: you live in the now.
- Isolation: we are born alone and die alone.
- Personal meaning: what is the purpose of living?
- Freedom: people have a fear of freedom because with freedom comes choice and the possibility of making bad decisions.
- Responsibility: we are responsible for our own lives.

Behaviourism

Behaviourism is also known as the learning perspective, and is a philosophy of psychology based on the proposition that all physical actions which individuals do, including acting, thinking and feeling, can and should be regarded as behaviours. Strictly speaking, behaviourism is a doctrine. A behaviourist is a psychological theorist who demands behavioural evidence. For such a person, there is no knowable difference between two states of mind unless there is a demonstrable difference in the behaviour associated with each state. Behaviourism, the doctrine, is committed in its fullest and most complete sense to the truth of the following three sets of claims:

- Psychology is the science of behaviour. Psychology is not the science of mind.
- Behaviour can be described and explained without making reference to mental events or to internal psychological processes. The sources of behaviour are external (in the environment), not internal (in the mind).
- In the course of theory development in psychology, if, somehow, mental terms or concepts are deployed in describing or explaining behaviour, then either (a) these terms or concepts should be eliminated and replaced by behavioural terms or (b) they can and should be translated or paraphrased into behavioural concepts.

Behaviourism originated with the work of John B Watson, an American psychologist. Watson claimed that psychology was not concerned with the mind or with human consciousness. Instead, psychology should be concerned only with behaviour. In this way, humans could be studied objectively, like rats and apes.

Watson's work was based on the experiments of Ivan Pavlov, who had studied animals' responses to conditioning. In Pavlov's best-known experiment, he rang a bell as he fed some dogs several meals. Each time the dogs heard the bell they knew that a meal was coming, and they would begin to salivate. Pavlov then rang the bell without bringing food, but the dogs still salivated. They had been "conditioned" to salivate at the sound of a bell. Pavlov believed, as Watson was later to emphasise that humans react to stimuli in the same way.

Behaviourism is associated today with the name of BF Skinner, who made his reputation by testing Watson's theories in the laboratory. Skinner's studies led him to reject Watson's almost exclusive emphasis on reflexes and conditioning. People respond to their environment, argued Skinner, but they also operate on the environment to produce certain consequences.

Skinner developed the theory of “operant conditioning” – the idea that we behave the way we do because this kind of behaviour has had certain consequences in the past. For example, if your girlfriend gives you a kiss when you give her flowers, you will be likely to give her flowers when you want a kiss. You will be acting in expectation of a certain reward. Like Watson, however, Skinner denied that the mind or feelings play any part in determining behaviour. Instead, our experience of reinforcement determines our behaviour.

The presuppositions of behaviourism are as follows:

- Behaviourism is naturalistic. The material world is the ultimate reality, and everything can be explained in terms of natural laws. The human being has no soul and no mind, only a brain that responds to external stimuli.
- Humans are no more than machines that respond to conditioning.
- We are not responsible for our actions. If we are mere machines, without minds or souls, reacting to stimuli and operating on our environment to attain certain ends, then anything we do is inevitable.

Behaviourism is manipulative. It seeks not merely to understand human behaviour, but to predict and control it. Behaviourism could be the basis for manipulating patients, students and whole societies.

Christianity

The Christian religion accepts that our past experiences and our environment do affect the way we act, but it holds that these factors cannot account for everything we do. The Christian Bible teaches that we are basically covenantal creatures, not biological creatures. Our nearest environment is God Himself, and we respond most fundamentally to Him. We respond either in obedience to or rebellion against His Word.

Altruism

The word “altruism” (French, *altruisme*, from *autrui*: “other people”, derived from Latin *alter*: “other”) was coined by Auguste Comte, the French founder of positivism, to describe the ethical doctrine he supported. He believed that individuals had a moral obligation to renounce self-interest and live for others.

Altruism is a selfless concern for the welfare of others, and can be distinguished from feelings of loyalty and duty. Altruism focuses on a motivation to help others or a desire to do good without reward, while duty focuses on a moral obligation towards a specific individual (e.g. God, a monarch), a specific organisation (e.g. a government), or an abstract concept (e.g. patriotism). Some individuals may feel both altruism and duty, while others may not. Pure altruism is giving without regard to reward or the benefits of recognition and need. Altruism is an ethical doctrine that holds that individuals have a moral obligation to help, serve or benefit others, if necessary at the sacrifice of self-interest.

The ethical doctrine of altruism generally revolves around a moral obligation to benefit others or the pronouncement of moral value in serving others rather than oneself. It is a special obligation to benefit others, a duty to relieve the distress and promote the happiness of our fellows.

Egoism

Ethical egoism contrasts with ethical altruism, which holds that moral agents have an obligation to help and serve others. Ethical egoism does not, however, require moral agents to disregard the wellbeing of others; nor does it require that a moral agent should refrain from considering the wellbeing of others in moral deliberation, for what is in an agent's self-interest may be incidentally detrimental, beneficial or neutral in its effect on others. Individualism allows for the possibility of any of these, as long as what is chosen is efficacious in satisfying the self-interest of the agent.

Nor does ethical egoism necessarily entail that, in pursuing self-interest, one ought always to do what one wants to do, since in the long-term the fulfilment of short-term desires may not be in the agent's interest.

Dualism

Moral dualism is the belief in the great balance (in eastern and naturalistic religions) or conflict (in western religions) between the "benevolent" and the "malignant". Most religious systems have some form of moral dualism – in western religions, for instance, this dualism is found in the belief that good and evil are in conflict.

Activity 2.2: Types of theory (Textbook page 17)

Theories are classified according to their purpose or scope, breadth or level of abstraction. The different types of theory that one can find are the following:

- Grand theory
- Meta-theory
- Middle range theories
- Narrow range (micro-theory)
- Factor theory

Read any literature, for example, the book by Van der Walt, C. and Van Rensburg, G. 2006. *Fundamentals of research methodology for health care professionals*, as well as other related literature to expand on these theories.

Activity 2.3: Orem's theory (Textbook page 17)

Self-care system

The self-care theory is based on four concepts, namely self-care, self-care agency, self-care requisites and therapeutic self-care demand.

Self-care refers to the activities an individual performs independently throughout life to promote and maintain personal wellbeing. This aspect refers to a client who independently does self-care activities that promote and maintain her or his healthy state. An example would be a client who comes to a health service for preventive and

promotive care (e.g. a baby clinic). The role of the nurse is to facilitate and maximise the self-care abilities of the individual. Self-care is not instinctive or reflexive, but is performed rationally and intentionally in response to a known need which is learnt through the individual's interpersonal relations and communication.

Self-care agency refers to an individual's ability to perform self-care activities. It consists of two agents: the self-care agent (an individual who performs self-care independently) and a dependent care agent (a person other than the individual who provides the care). The individual is seen as a self-care agent who possesses the capability to carry out self-care actions. Deliberate actions are undertaken to meet the therapeutic self-care demands arising out of known needs for care. This varies throughout life. If the self-care demands are not met, a self-care deficit exists, which calls for nursing intervention. Most adults care for themselves, whereas infants and people who are weakened by illness or disability require assistance with self-care activities.

Self-care requisites are also called self-care needs. These are measures or actions taken to provide self-care and are divided into three categories, namely universal, developmental and health deviation requisites.

Every human being has universal requisites. They have to do with physiological needs. They include maintenance of intake and elimination of air, water and food, balancing rest, solitude and social interaction, preventing hazards to life and wellbeing and promoting normal human functioning.

Developmental requisites result from maturation or are associated with conditions or events such as adjusting to a change in body image or to the loss of a spouse. An example would be seen in a client who has just had a mastectomy and the grieving processes that she goes through after the loss of the breast and the adjustment to her body image.

Health deviation requisites result from illness, injury or disease or its treatment. They include actions such as seeking health care assistance, carrying out prescribed therapies and learning to live with the effects of illness or treatment, for example a newly diagnosed diabetic who is adjusting to a change in life style and the use of insulin as treatment.

Therapeutic self-care demands refer to all self-care activities that are required to meet existing self-care requisites or actions to maintain health and wellbeing.

Self-care deficit system

The self-care deficit system is the core of Orem's general theory of nursing. It explains when nursing is required and how people can be helped through nursing. A self-care deficit comes about when self-care agency is not adequate to meet self-care demands. Orem explains not only when nursing is needed but also how people can be assisted through five methods of assistance: acting or doing for, guiding, teaching, supporting and providing an environment that promotes the individual's abilities to meet current and future demands.

Nursing systems

Nursing systems are a series of actions a nurse takes to meet a client's self-care requisites. They are determined by the person's self-care requisites and self-care agency and there are three types of system for meeting the client's self-care requisites. The three types of system are the following:

- Wholly compensatory systems that are required for individuals who are unable to control or monitor their environment and cannot process information (e.g. a mentally ill client)
- Partly compensatory systems, which are designed for individuals who are unable to perform some, but not all, self-care activities (e.g. a client who has had a back operation)
- Supportive educative (developmental) systems, which are designed for persons who need to learn to perform self-care measures and need assistance to do so (e.g. teaching a paraplegic client self-catheterisation)

Activity 2.4: Henderson's theory (Textbook page 18)

The 14 needs

Physiological needs

- Breathe normally
- Eat and drink adequately
- Eliminate body wastes
- Move and maintain desirable postures
- Sleep and rest
- Select suitable clothes – dress and undress
- Maintain body temperature within normal range by adjusting clothing and modifying environment
- Keep the body clean and well groomed and protect the integument
- Avoid dangers in the environment and avoid injuring others

Psychological aspects of communicating and learning

- Communicate with others in expressing emotions, needs, fears or opinions
- Learn, discover or satisfy the curiosity that leads to normal development and health and use the available health facilities

Spiritual and moral needs

- Worship according to one's faith

Sociologically oriented to occupation and recreation

- Work in such a way that there is a sense of accomplishment
- Play or participate in various forms of recreation

Henderson's theory and the four major concepts

Individual

- Individuals have basic needs that are components of health.
- They require assistance to achieve health and independence or a peaceful death.
- Mind and body are inseparable and interrelated.
- The theory takes into consideration the biological, psychological, sociological and spiritual components.
- The theory presents the client as a sum of parts with bio-psychosocial needs, and the client is neither client nor consumer.

Environment

- The environment consists of settings in which an individual learns unique patterns for living.
- It includes all external conditions and influences that affect life and development.
- Individuals are seen in relation to families.
- The theory minimally discusses the impact of the community on the individual and family.
- Society wants and expects nurses to act for individuals who are unable to function independently.
- In return nurses expect society to contribute to nursing education.

Health

- Health is defined based on the individual's ability to function independently as outlined in the 14 components.
- Nurses need to stress promotion of health and prevention and cure of disease.
- Good health is a challenge.
- Health is affected by age, cultural background, physical and intellectual capacities, and emotional balance

Nursing

- This consists of temporarily assisting an individual who lacks the necessary strength, will and knowledge to satisfy one or more of the 14 basic needs.
- Assists and supports the individual in life activities and the attainment of independence.

Activity 2.5: Caring theory (Textbook page 19)

Jean Watson (2005) asserts that the practice of caring is central to nursing. Caring is the unifying focus for practice. Watson's assumptions are as follows:

- Human caring in nursing is not just an emotion, concern, attitude or benevolent desire. Caring connotes a personal response.
- Caring is an inter-subjective human process and is the moral ideal of nursing.
- Caring can be effectively demonstrated only interpersonally.
- Effective caring promotes health and individual or family growth.

- Caring promotes health more than does curing.
- Caring responses accept a person not only as they are now, but also for what they may become.
- A caring environment offers the development of potential while allowing the person to choose the best action for the self at a given point in time.
- Caring occasions involve action and choice by the nurse and client. If the caring accession is transpersonal, the limits of openness expand as well as human capacities.
- The most abstract characteristic of a caring person is that the person is somehow responsive to another person as a unique individual, perceives the other's feelings, and sets one person apart from another.
- Human caring involves values, a will and a commitment to care, knowledge, caring actions and consequences.
- The ideal and value of caring is a point of departure, a stance and an attitude that has become a will, an intention, a commitment and a conscious judgement that manifests itself in concrete acts.

Watson (2005) has described nursing interventions related to human care and refers to them as the clinical *caritas* processes. These interventions are said to be the following:

- Formation of humanistic-altruistic system of values is said to be “practice of loving-kindness and equanimity within the context of caring consciousness”.
- Instilling of faith–hope becomes “being authentically present, enabling and sustaining the deep belief system and subjective world of self and one-being-cared-for”.
- Cultivation of sensitivity to one's self and others is said to be “cultivation of one's own spiritual practices and transpersonal self, going beyond ego self”.
- Development of a helping, trusting, human caring relationship becomes “developing and sustaining a helping, trusting, authentic caring relationship”.
- Promotion and acceptance of expression of positive and negative feelings are said to be “being present to and supportive of the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared-for”.
- Systematic use of a creative problem-solving caring process becomes “creative use of self and all ways of knowing as part of the caring process, to engage in artistry of caring-healing practices”.
- Promotion of transpersonal teaching–learning is viewed as “engaging in genuine teaching–learning experience that attends to unity of being and meaning attempting to stay within other's frame of reference”.
- Provision of a supportive, protective and/or corrective mental, physical, societal and spiritual environment, becomes “creating healing environment at all levels – physical and non-physical, subtle environment of energy and consciousness, whereby wholeness, beauty, comfort, dignity and peace are potentiated”.
- Assistance with gratification of human needs is seen as “assisting with basic needs, with an intentional caring consciousness, administering human care essentials which potentiate alignment of body, mind and spirit, wholeness and unity of being in all aspects of care, tending to both embodied spirit and evolving spiritual emergence. Allowance for existential-phenomenological-spiritual-mysterious and existential dimensions of one's own life-death, souls care for self and the one-being-cared-for”. (<http://www.en.wikipedia.org/wiki/Behaviorism>)

Activity 2.6: Philosophical assumptions (Textbook page 20)

The philosophical assumptions of the culture care, diversity and universality theory are as follows:

- Care is the essence and central focus of nursing.
- Caring is an action or activity directed towards providing care.
- Caring is essential for health and wellbeing, healing, growth, survival as well as facing illness or death.
- Culture care is a broad, holistic perspective to guide nursing care practices.
- The central purpose of nursing is to serve human beings in health, illness and death.
- Culture care concepts have both different and similar aspects among all cultures of the world. Every human culture has its own folk remedies, professional knowledge and professional care practices. The nurse has a duty to identify and address these factors consciously with each client in order to provide holistic and culturally congruent care.
- Cultural care values, beliefs and practices are influenced by worldview and language, as well as religious, spiritual, social, political, educational, economic, technological, ethno-historical and environmental factors.
- Beneficial, healthy, satisfying, culturally-based nursing care enhances the wellbeing of clients. Culturally beneficial nursing care can only occur when cultural care, values, expressions or patterns are known and used appropriately and knowingly by the nurse providing care.

A culturally competent nurse will do the following:

- Consciously address the fact that culture affects the nurse–client transaction.
- Ask each client she or he interacts with, compassionately and clearly, what his or her cultural practices and preferences are.
- Incorporate the client's personal, social, environmental and cultural needs/beliefs into the plan of care wherever possible.
- Respect and appreciate cultural diversity and strive to increase knowledge and sensitivity associated with the essential nursing concern.

Nurses who understand and are sensitive to cultural diversities are able to provide culturally congruent care. To share a cultural identity the nurse is required to have knowledge of transcultural nursing concepts and principles, together with an awareness of current practices. The nurse needs to incorporate clients' beliefs and values into nursing care plans thoughtfully and skilfully.

Activity 2.8: Roy's adaptation model (Textbook page 21)

Adaptation, according to Roy (n.d.), is defined as the process and outcome whereby the thinking and feeling person uses conscious awareness and choice to create human and environmental integration. The focus of Roy's model is on the increasing complexity of the self-organisation of person and environment, on the relationship between and among people, and between the universe and what can be considered a supreme being or God. The assumption is that persons

and the earth are one, and that they are in God and of God. According to Roy the individual is a bio-psychosocial adaptive system that involves a feedback cycle of input seen as a stimulus, a throughput which is said to be a control process, and an output that manifests as behaviours or adaptive responses. The individual and the environment are said to be sources of stimuli that require modification in order to promote adaptation. This takes place on a continuous basis. Adaptive responses contribute to health which, according to Roy, is a process of being and becoming integrated, whereas maladaptive responses do not contribute to health. Each person's adaptation level is unique and dynamic.

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Chapter 3: Professional-ethical practice

Josephine Elizabeth de Villiers, Catarina Magdeline Erasmus and Karien Jooste

Activity 3.2: Autonomy (Textbook page 27)

- Respect for clients' autonomy requires that the nurse practitioner empowers clients to make decisions.
- Nurse practitioners ensure that clients understand all the relevant information to enable the client to provide informed consent for health care interventions.
- Promoting client autonomy becomes precarious when the nurse practitioner realises that clients do not have the ability or capacity to reason and take autonomous decisions. Non-autonomous clients are more vulnerable than other clients and this obliges the nurse practitioner to become a client advocate who protects the autonomy of the vulnerable client. Respect for client autonomy takes into account the life or world of the client.
- Cultural values often prescribe clients' ability to engage in autonomous decision making. The nurse practitioner cannot assume that autonomous adult clients are able to make their own decisions, because it might be a cultural requirement to deliberate with significant others about the decision.
- Respect for autonomy also considers the wish of the client to deliberate with others in exercising autonomy.

Activity 3.3: Caring (Textbook page 29)

Compassion

Compassion refers to sympathy and concern for the suffering and misfortune of others (Soanes & Hawker 2005: 196). A compassionate nurse acts in a humane manner, is kind to clients and devoted to meeting their needs. A client's life world matters to the compassionate nurse, and such a nurse shares a relationship with clients in which she or he shows a willingness to be available for the client and to listen to him or her. Compassion is expressed by involvement in the care of clients; by touching others, not only physically, but also spiritually and emotionally. Compassion requires the nurse practitioner to have the courage to do what is right and to show a genuine interest in whatever matters to the client. Compassion as a character trait is not something that can be acquired by skill or technique (Searle & Pera 1995: 136). It is a value that originates from a deeper understanding of one's purpose as a nurse practitioner.

Commitment

Commitment refers to dedication to and engagement with a cause, activity or duty, knowing that some personal sacrifices are needed in fulfilment of the commitment. The committed nurse practitioner undertakes to protect clients from harm, provide high quality nursing care and alleviate suffering; shares the burden of clients in the health care situation; and provides a calm, meaningful presence by being available to clients. Commitment means that the nurse practitioner engages in professional duties, shows respect and concern to others, considers the interests of clients and identifies and addresses nursing challenges effectively.

Conscience

Conscience refers to a person's moral sense of right and wrong and gives human beings the capacity to decide how to behave, guided by their conviction of right and wrong (their conscience). A conscientious nurse practitioner is diligent. She or he shows great care in the performance of nursing duties and provides complete, thorough and holistic nursing care. Reflection and dialogue with others give the nurse practitioner the opportunity to consider what is important in human life and therefore the conscientious nurse engages with others to grow morally and to develop self-knowledge. When nursing care needs conflict with the moral convictions of the nurse practitioner, it is the obligation of the nurse to protect the interests of the client by handing the client over to other nurse practitioners. The nurse practitioner cannot be forced to act contrary to her or his moral convictions, but should take the necessary steps to manage care according to the needs of clients.

Activity 3.4: Self-confidence (Textbook page 29)

- A self-assured nurse practitioner believes that nursing practices that are founded on scientific knowledge and skills and a positive attitude, enhance safe nursing care and facilitate the achievement of the goals of quality nursing practice.
- A confident nurse practitioner is assertive. He or she recognises his or her own personal and professional needs and has the ability to communicate these needs effectively and clearly, while also taking cognisance of the needs of others.
- A confident nurse does not allow others to undermine the genuine desire to do well to others and to practise nursing effectively and professionally.

Activity 3.5: Nursing pledges and code of conduct (Textbook page 30)

Examples of ethical codes, nursing service pledges and oaths

Ethical codes *guide nurse practitioners* and are used in conjunction with nursing legislation and professional nursing standards to provide quality nursing care. Most ethical codes and pledges are collective statements of the profession. The individual nurse practitioner nevertheless has the responsibility to reflect on and evaluate whether nursing conduct is in accordance with the ethical code of the profession. At the same time, since these codes and pledges are collective statements of intent of ethical conduct by the nursing profession, the individual nurse practitioner realises that individual conduct should coincide with the intention of the profession as a whole. Aberrant conduct of individual nurses tarnishes the image of the whole profession. The public perceives the nursing profession as an entity with goals as declared by all the nurses, and unacceptable conduct of the individual nurse practitioner therefore defeats the objects of the profession at large.

While most nurses attempt to practise ethically, the requirement of ethical conduct is often challenged for a variety of reasons and in many nurse care situations. Moral conflict situations in nursing practice often arise because of the intention of nurse practitioners to practise with moral forethought, and these conflicts are not always easy to address.

The International Council of Nurses code of ethics for nurses

An international code of ethics for nurses was first adopted by the International Council of Nurses (ICN) in 1953. It has been revised and reaffirmed at various times since, most recently with a review and revision completed in 2005. The 2005 ICN code is reproduced below.

PREAMBLE

Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal. Inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, color, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status. Nurses render health services to the individual, the family and the community and co-ordinate their services with those of related groups.

THE ICN CODE

The ICN Code of Ethics for Nurses has four principal elements that outline the standards of ethical conduct.

Elements of the code

1. Nurses and people

The nurse's primary professional responsibility is to people requiring nursing care.

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

The nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment.

The nurse holds in confidence personal information and uses judgement in sharing this information.

The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.

The nurse also shares responsibility to sustain and protect the natural environment from depletion, pollution, degradation and destruction.

2. Nurses and practice

The nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning.

The nurse maintains a standard of personal health such that the ability to provide care is not compromised.

The nurse uses judgement regarding individual competence when accepting and delegating responsibility.

The nurse at all times maintains standards of personal conduct which reflect well on the profession and enhance public confidence.

The nurse, in providing care, ensures that use of technology and scientific advances is compatible with the safety, dignity and rights of people.

3. Nurses and the profession

The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education.

The nurse is active in developing a core of research-based professional knowledge.

The nurse, acting through the professional organization, participates in creating and maintaining safe, equitable social and economic working conditions in nursing.

4. Nurses and co-workers

The nurse sustains a co-operative relationship with co-workers in nursing and other fields.

The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person.

(International Council of Nurses 2006)

Nursing service pledge – University of Namibia

- I solemnly declare that my ultimate responsibility as a nurse is to protect and safeguard the total wellbeing of my clients, their families and the community at large.
- My practice will be founded on respect for my clients' humanity, dignity and individuality.
- I undertake to treat my clients equally, and will not allow that social, economical, political, religious or cultural differences influence the care I render.
- To fulfill the need of my clients, I will endeavour to understand and address it with compassion and

empathy.

- I accept it as my duty to protect the interest of my clients and to maintain professional secrecy.
- I will comply with all moral, legal and professional standards in the execution of my duties and inspire others in achieving our shared vision.
- Finally, I pledge to maintain the highest level of knowledge and skills and to contribute towards the development of my profession.

(University of Namibia 2001)

Activity 3.6: Challenges in nursing practice (Textbook page 30)

Moral challenges

A moral challenge, often also referred to as a moral dilemma, is encountered when moral values are in conflict and there is uncertainty about how the situation should be addressed. A moral challenge is difficult to resolve because of the uncertainty about what might be the right or wrong decision or action in a particular situation. Conflicting values create a situation where it is difficult to find an answer to the challenge, because enough evidence or reasons exist for the justification of more than one option to address the challenge, yet it is not possible to carry out all of these actions.

For instance, it is not possible to both save the life of a client on a ventilator and to cease life supporting measures in a situation where one has to decide about the termination of life supporting measures in the case of a brain dead client. In such a situation there is sufficient moral justification to switch off the ventilator, but there is also sufficient evidence not to withdraw life supporting measures. It is, however, impossible to satisfy both these requirements. The conflicting moral values also challenge the decision makers, because most virtuous persons have a sincere desire to act according to their moral values, and it becomes very challenging when these values are in conflict.

Bioethics as a discipline originated from the many challenges inherent in health care and those disciplines related to human conduct. In the discussion of the nursing values above, reference is made to the four ethical principles that are often used in bioethical decision making, namely autonomy, beneficence, non-maleficence and justice. The application of these ethical principles optimises objective moral decision making and prevents the taking of moral decisions based only on emotion and feeling.

Clinical challenges

A clinical nursing challenge arises in nursing care situations when clients develop nursing needs which should be addressed through clinical nursing care interventions. The nurse practitioners utilise the nursing process to identify nursing needs and plans and initiate nursing care based on scientific knowledge and skills and sound professional judgment. Clinical challenges include the holistic fulfilment of clients needs and cannot be seen as only facilitating the

physical nursing needs of clients. A clinical challenge may be present when a child, for instance, develops fever (or anxiety or respiratory distress) which should then be addressed after proper scientific assessment, nursing diagnosis, planning, appropriate nursing intervention by the nurse practitioner and evaluation of the chosen nursing intervention.

Professional ethical challenges

Transgression of the ethical code of the nursing profession gives rise to professional ethical challenges (University of Namibia, 2001: 30). Non-compliance with the expected behaviour as declared by the profession often creates challenging situations in clinical nursing care, as well as in the personal lives of nurse practitioners. Unlike moral challenges, professional ethical challenges do not leave any doubt in the minds of nurses that the unethical conduct is wrong and it is clear that this type of behaviour cannot be condoned by the profession. Professional ethical challenges may occur when a nurse steals medicine from a nursing unit to sell to the public, or when a nurse is involved in publicly known incidents of assault or alcohol abuse, while not practising in a nursing unit. Nurses who become aware of unprofessional conduct on the part of other nurses often find it difficult to address this type of challenge, because the consequences of professional discipline are known to nurses. Therefore, addressing professional ethical challenges may create a moral challenge for those who are required to act upon the unprofessional conduct of others.

Activity 3.7: Nursing dilemmas, nursing ethics and ethical problems (Textbook page 30)

Scenarios regarding moral challenges in the health care environment

Josephine Elizabeth de Villiers

Consider the following scenarios in nursing care practice and attempt to identify and justify the conflicting ethical principles in each of these situations.

Scenario 1

Mr X is 55 years old, blind and a diabetic. He is suffering from acute renal failure and has suffered three cardiac arrests in the last month while hospitalised. On all three occasions Mr X was successfully resuscitated. Mr X is under your care and asks you not to resuscitate him again in the event of a further cardiac arrest.

Should Mr X be resuscitated in a further cardiac arrest?

Scenario 2

Babies M and M were born as conjoined twins sharing one heart and one liver. Should separating surgery be performed on the newborns?

Scenario 3

Your sister phones you to tell you about her new boyfriend, who she feels is her partner for life. When you are introduced to him, you realise that you counselled him the previous week because he is HIV positive.

Do you tell your sister about the status of her new boyfriend?

Scenario 4

Ms Y is 23 years old, and is a repetitive drug addict who is now on a ventilator after a suicide attempt. She is being nursed by you in the intensive care unit. As the nurse in charge of the ICU you are requested for a bed to admit a 62-year-old woman who has suffered severe injuries in a motor vehicle accident and who also needs mechanical ventilation. Your unit is equipped to ventilate only one client at a time.

Which of the two clients should be ventilated?

Scenario 5

Mr P is 35 years old and was admitted to the medical unit three weeks ago with pneumonia. He has received four courses of antibiotics, but the pneumonia is persisting. Mr P is HIV positive and the doctor is considering stopping his curative treatment.

Should Mr P's treatment be stopped?

Scenario 6

Ms W, who is 12 years old and fourteen weeks pregnant, is admitted to the unit where you care for clients. She is fearful of her parents who do not know about her pregnancy and has been admitted because she has requested a legal abortion.

Should the abortion be performed on Ms W? Should a nurse become involved in the performance of legal abortions?

Consider each of the above scenarios and reflect on its moral challenge. These situations should not be addressed clinically but morally. Make use of the moral decision-making process set out in Chapter 3, section 3.6.2, to assist in the objective consideration of the moral challenge.

Activity 3.9: Labour organisations and legislation (Textbook page 35)

Catarina Magdeline Erasmus

The mobilising of workers goes as far back as when Moses approached the Pharaoh to release the workers from their slavery. However, unionism as we know it today had its origins during the Industrial Revolution (1760–1850) when humans were replaced by machines, which dramatically increased the unemployment rate with all its socio-economic complications (e.g. poverty, malnutrition, increase in communicable diseases, increased crime rate). A clear split between capital and labour took place and work processes started to focus on productivity. Factories emerged and cities developed. People were forced to leave their loved ones and family behind to earn a living in another town. An employee was regarded as no more than a production factor and remuneration was the only means of motivation. Child labour was introduced in the 1700s. On a more positive note, a normal work day was decreased from 14 to 12 hours in 1776.

Robert Owen (1771–1858), the owner of a cotton factory, was one of the first employers to be concerned about the wellbeing of his employees. He refused to employ children under the age of 10 and reduced the working day further

from between 13 and 10 hours to 5 hours. He saw his employees as an asset and is often described as the father of human resources management.

In 1891 Henry Towne and Frederick Halsey pleaded for guaranteed remuneration on a regular basis with their Gain Sharing campaign. They encouraged the determination and payment of a day fee, which should be performance related.

The scientific management approach to not only the business or corporation but also to employees or workers developed at the beginning of the 20th century when Frederick Taylor (1856–1915) introduced time and motion studies. Employers started looking at employees in a different light and identified the potential for development of the employee as an added value to his or her labour potential.

The notion of the division between labour and management was formally introduced in 1916 when Henry Fayol proclaimed his 14 management principles. The principles are:

- Labour division – this emphasised the employer/manager as the superior party and the employee as the submissive, dependent party in the employment relationship.
- Power and responsibility – employers were seen as having power over employees.
- Discipline – this was the employer's prerogative as he paid for performance.
- Unit of command – employees had to report to one employer only.
- Unit of leadership – a good leader had to possess good leadership skills and be able to influence others to accept responsibility.
- Submission of own interests to general business interests – employees' interests had to conform with those of the company.
- Remuneration of staff – this should be done according to performance.
- Centralisation – this was preferred for ease of decision making and communication.
- Hierarchy – the employer or manager was placed at the higher level and employees at the lower.
- Order – this was necessary for the management of equipment and supplies.
- Fairness – to achieve the best from followers, persons in authority positions needed to be friendly but fair.
- Stability of personnel – labour turnover, then as now, was very costly and should be kept at the lowest level. A steady average employee was preferred over a more skilled one who was forever moving on to greener pastures.
- Initiative – people at all levels should be allowed to contribute to the production process.
- Esprit de corps – team-building should be given a high priority.

Max Weber (1864–1920) placed greater emphasis on the hierarchy and introduced his bureaucratic management model which classified employers and employees in different social classes with according differences in decision-making powers and remuneration packages. Employees started developing a feeling of tremendous oppression.

Chris Agyris of Harvard University predicted in 1957 that the effect of authoritarian management would ultimately be revealed in a workforce that was submissive, dependent, passive and incapable of creative problem solving. The

reason, he said, was that mature and competent personnel were under authoritarian rule and were being forced to behave in immature and incompetent ways in order to stay in their organisations. Over time, workers could be expected to adapt themselves to organisational pressures and to become the compliant, unthinking and compliant children top management always wanted. Numerous studies have confirmed these words of Agyris, that traditional authoritarian managers ultimately fail.

Power means money, and money has, therefore, over the years, brought about many forms of conflict between employer and employee. Mary Parker Follet (1868–1933) felt that conflict should be dealt with collectively between employers and employees by sharing ideas and reaching a compromise. She encouraged a process of discussion, explanation and sharing of power, which led to the introduction of the process of negotiation between unions and employers as we know it today.

Unionism is often viewed as the individualism of the workers in opposition to the capitalism of the employer. This viewpoint was, perhaps, most powerfully expressed by Karl Marx (1818–1883).

Labour legislation relevant to nursing practice

- The Labour Relations Act No. 66 of 1996 is the most important piece of South African labour legislation and applies to all employees, including nurses and health care workers.
- The Occupational Health and Safety Act No. 85 of 1993 covers health and safety issues in all areas of employment affecting both workers and members of the public who could be injured.
- The Compensation for Occupational Diseases and Injuries Act No. 130 of 1993 makes provision for compensation for employees who are injured in accidents or contract an occupational disease during the normal course of employment. Benefits may be temporary or permanent, or may be granted to the family of a deceased employee.
- The Unemployment Insurance Act No. 63 of 2001 provides for unemployment benefits and their collection.
- The Basic Conditions of Service Act No. 75 of 1997 provides for minimum standards of employment on issues such as working hours, leave and remuneration.
- The Skills Development Act No. 97 of 1998 and the Skills Development Levies Act No. 9 of 1999) deal with the training and development of employees and the funding thereof.
- The Employment Equity Act No. 55 of 1998 promotes equal employment opportunities and fair treatment in employment through the elimination of unfair discrimination and by implementing affirmative action measures by designated employees.

Martello (1999) states that a contract for a service to be performed upon a client may be either expressed or implied. Once this relationship is established, the duty to the client becomes a legal responsibility. This duty to care is owed to the client and the contract cannot be broken unless it is terminated in one of three ways:

1. By mutual agreement. No written communication is needed if there is no further necessity for treatment and the client is informed of the completion of treatment.
2. At the client's request.

3. At the request of the caregiver. A prerequisite here is that reasonable notice of termination of the relationship is given. The client then has the opportunity to seek alternative sources of care if she or he so wishes (Martello 1999: 10).

Professional organisations

A professional nursing organisation represents all nurses at all levels.

The Democratic Nursing Organisation of South Africa (DENOSA) is a voluntary organisation for South Africa nurses and midwifery professionals. DENOSA aims to safeguard and promote the dignity, rights and socio-economic status of members in the nursing profession. Its professional and union solidarity impacts beyond the borders of South Africa on the rest of the world.

DENOSA champions the rights of professionals and helps to ensure that members have an acceptable working life and balance between their career demands and social requirements. To uplift the health of the South African population, DENOSA operates through a network of quality nurses and midwives and ensures an effective health service system. DENOSA also participates in policy-making bodies affecting health at district, provincial, national and international levels (www.denosa.org.za).

What are the benefits of belonging to DENOSA?

- Salary negotiations on behalf of nurses
- Free international indemnity insurance
- Assistance in statement writing
- Legal representation (at DENOSA'S discretion)
- Free advice regarding professional and work-related issues
- Special group scheme packages
- Receiving issues of DENOSA's magazine, *Nursing Update*
- Grievances and disciplinary representation
- A 10 per cent discount on cash purchases of books sold by DENOSA
- Bursaries
- Access to training and seminars at special rates
- Special tariffs for individuals and group scheme insurance
- DENOSA family funeral scheme

The responsibilities of a professional organisation include the following:

- To promote the professional progress of nurses
- To adapt to health care change
- To provide a framework within which the profession can develop
- To play a role in setting nursing standards, developing health policies, focusing on quality assurance and standards of nursing practice

- To promote economic advantages for nurses
- To act as a spokesperson for nurses particularly on service problems, and to consult with other relevant health care groups
- To promote quality care and the status of nursing
- To promote the educational and professional development of nurses through a problem-solving approach
- To act as a facilitator in addressing problems in nursing education
- To assist in mediation in grievances and dismissal of members
- To provide representation in disciplinary hearings
- To secure economic benefits for members through funds and bursaries
- To play a role in research through a research committee, publications and forums
- To look after the socio-economical wellbeing of members through negotiations for salaries, labour relations functions, indemnity policies, advice regarding labour issues

(The above is quoted and/or adapted from policy statements of DENOSA.)

General Questions (Textbook page 31)

Question 4 Examples of values

Table 3.1 Examples of values

Personal values	Social values	Cultural values	Professional values
Self-esteem/self-respect	Recognition	Respect for beliefs, norms and customs	Respect for human dignity and autonomy
Self-actualisation	Appreciation of beauty (nature and art)	Tolerance	Equality
Self-sufficiency	Liberty	Cultural awareness	Justice
Happiness	Equality	Cultural sensitivity	Beneficence
Wisdom	Prosperity	Sharing	Non-maleficence
Companionship	Peace (national and personal)	Open mindedness	Prevention of suffering
Ambition to achieve and excel	Security (family and economic)	Non-judging	Quality care
Fulfilled intimacy (sexual and spiritual)		Expressive	Compassion
Salvation		Understanding	Confidence
Courage		Ethno relativity	Commitment
Politeness		Acceptance	Conscientiousness
Honesty		Creativity	Competence
Responsibility			Honesty
Intelligence			Loyalty/trust
Ability to forgive			Excellence
			Altruism

Self-discipline			Responsibility Independence Privacy Assertiveness Advocacy
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Chapter 4: Legal rights and responsibilities

Joyce Desia Mokoena and Karien Jooste

Activity 4.1: Nurses and human rights (Textbook page 41)

For a comprehensive text on nurses and human rights visit <http://icn.ch/pshumrights.htm> and read more on the subject.

Health and human rights in South Africa

The Constitution Act No. 108 of 1996, lays a solid foundation for a culture of human rights in health care in South Africa. The Bill of Rights spells out these rights. London and Baldwin-Ragaven (2008) divide the rights into four main categories, namely health care services, underlying conditions needed for health, special populations (more vulnerable than others) and foundational rights affecting health. The Client's Rights Charter, launched in 1999 by the Department of Health, spells out the rights of clients as well as their responsibilities. The charter is displayed in all health care settings.

Activity 4.2: Advocacy: the rights of clients (Textbook page 43)

The fundamental aim of advocacy is to ensure that the rights of clients are met and are not violated. Advocacy for the rights of clients is in line with the demands based on national and international instruments. Provision for the health rights of clients is articulated in the 1948 Universal Declaration of Human Rights by the United Nations. The International Council of Nurses (ICN) views health care as a right of all individuals regardless of financial, political, geographical, racial or religious considerations. This right to health care includes the following:

- The right to choose or decline care
- The right to accept or refuse treatment and nourishment
- Informed consent
- Confidentiality
- The right to die with dignity

The ICN also states that nurses have an obligation to safeguard people's rights at all times and in all places.

Advocacy as perceived by practicing nurses

The advocacy role of the nurse manifests within the context of the nurse–client relationship. Nurses have diverse and also similar perceptions about the practice of client advocacy in nursing.

In a study conducted among practising nurses, Negarandeh et al. (2006) report that client advocacy is a contextually complex, controversial and risky component of nursing practice. These authors also report that nurses have identified several aspects in nursing practice as either barriers to or facilitators of client advocacy. These are summarised in Table 4.1 below. The table suggests that there are more barriers than facilitators. However, professional development can help eradicate some of the perceived barriers. A more concerted effort to strengthen the facilitators will add more value to the role of the nurse as the client's advocate.

Table 4.1: Barriers to and facilitators of client advocacy

Barriers	Facilitators
Powerlessness	Nurse–client relationship
Lack of law and code for nurses	Recognising and meeting client's needs
Doctors as leaders	Nurses' responsibility
Time constraints	Doctors as colleagues
Limited communication	Knowledge and skills
Risks involved in advocacy	
Loyalty to peers	
Lack of motivation	

(Adapted from Negarandeh et al., 2006)

Mallik (1997: 310) identifies consequences of advocacy which may include negative repercussions for the individual nurse, ranging from harassment by doctors to victimisation by nurse managers. Empowering nurses with more knowledge and skills will enable them to overcome these obstacles and ensure that the rights of clients are met and are not violated. The section below focuses on advocacy of the rights of clients.

General Questions (Textbook page 46)

Question 7 Additional activities on advocacy

Read the following case study and, with a fellow student, work out the discussion questions below.

On Christmas Eve in 2006, a young man in his early twenties was admitted to the orthopaedic ward of a public tertiary hospital. He had been knocked down by a speeding motorcar whose driver did not even stop. He sustained an open fractured tibia and fibula on his right leg. He was seen by the admissions doctor at casualty. Three days after admission he had not been seen by an orthopaedic surgeon, nor had his fracture been set. He lay on his hospital bed, groaning in pain, with a bandaged open fracture that was still bleeding. The attending registered nurse gave him paracetamol for pain. Upon enquiry by the relatives as to why the doctor had not yet seen the client, the sister responded that the client had to wait his turn as there were other clients who had been waiting to see the doctor for

over a week. The client had not been given any information in this regard. She concluded by saying that the doctor was busy at a private clinic. The relatives had the client transferred to a private hospital the same day, and he was operated on immediately.

Discussion questions

- Which rights of the client were violated?
- What was the advocacy role of the registered nurse in this regard?
- Discuss specific regulations of the SANC which have a bearing on the advocacy role of the registered nurse.

Chapter 5: Professional regulation: an organised profession

Karien Jooste

Activity 5.2: Self-responsibility (Textbook page 53)

Safeguarding the self-regulation of the nursing profession

Nurses can

- learn more about self-regulation and
 - use and promote the use the standards of practice and the code of ethics to guide nursing practice
 - read nursing publications to increase knowledge and awareness of regulatory and ethical issues
- take advantage of any opportunity that may develop nursing competencies
- consider further training in the field of nursing
 - work in partnerships to create a quality nursing practice environment that supports professional practice and clients' safety
- become informed about professional liability protection (CNA 2007: 4).

Chapter 6: Professional competencies, responsibilities and accountability

Catarina Magdeline Erasmus and Karien Jooste

Activity 6.1: Scope of nursing (Textbook page 57)

Meaning of the scope of practice

Nurses need to practise within the parameters of their scope of practice as prescribed by the SANC. The ICN defines the scope of practice as “the range of roles, functions, responsibilities and activities, which a registered/licensed professional is educated for, competent in, and is authorized to perform. It defines the accountability and limits of practice” (ICN 1997).

As the legal definition of the scope of nursing has expanded, so have the responsibility, the absolute duty, the accountability and the liability of the nurse. The scope of practice refers to the process of subdividing the major deliverables into smaller, more manageable components. Defining the scope helps clarify those areas over which influence, power and/or authority extend. One must not be confused with what the scope of practice is/is not:

- It is not a job description of what a nurse or midwife should or should not do when working in a specific area. The scope of practice should encompass all that nurses could possibly do.
- It is not a protocol of best practices which states what the public can expect of a nurse – it is insufficiently detailed to do this.
- It is not a complete list of what nurses are allowed to do. Professionals are allowed to do anything they are trained and experienced in, except for those things particularly prohibited by the Nursing Act.

Nurses cannot refuse to do something because it is not specifically mentioned in the scope of practice. The scope is dependent on the nursing and health care needs of the community. These needs are entrenched in the educational programmes prescribed for nurses, which shape practitioners to be able to address the needs. The practice of nurses is grounded in the ethical principles embodied in the codes of practice and is based on the nature and extent of their education, knowledge and experience.

The role players, support network and available community and health resources vary according to circumstances, and influence the nature of professional interaction and the decision making and actions of nurses. The ultimate determinants of practice in the profession are the self-direction, decision-making ability and professional integrity of the individual practitioner. It is the duty of each nurse, as a professional practitioner, to determine the parameters of personal practice in a given situation and to accept responsibility for it.

Gumbi (2000: 2) further describes the scope of practice in South Africa as a document which lists the following acts:

- The diagnosing of health needs and the prescribing, provision and execution of a nursing regimen to meet those needs, where necessary, by referral to another registered person
- The diagnosing of health needs and the facilitation and attainment of optimum physical and mental health of the mother and child
- The provision of nursing care to fulfil the health needs of a client
- Caring for a client and executing a scientific nursing care plan for the client which includes the monitoring of vital signs and observation of reaction to medication and treatment
- The promotion and maintenance of the health of the client, the family and the community
- The promotion and maintenance of the hygiene of a client
- The promotion and maintenance of the physical comfort, rest, sleep, exercise and reassurance of the client

Critical elements for the scope of practice are as follows:

- It should be in line with the health service paradigm of the country, including the economic and technological context.
- Practice should be research-based and should follow a scientific problem-solving and epidemiological approach.
- It must be set within an ethical and legal framework and the culture must be sensitive to rights and gender.
- It should be dynamic and sensitive to changing health care, social and technological environments.
- It should be comprehensive enough to make provision for a variety of practice settings, roles and competence.
- Terminology should be defined clearly as it must ensure the safety of the nurse and the client.
- There should be regular reviews of the scope of practice document.
- There should be a preamble to the scope of practice document, which states the objectives. It should address the autonomy of the profession and the overlap between professions, and should involve mandatory updating and external peer evaluation.
- It should be competency-based.
- It should address teamwork (Gumbi 2000).

In 2004 the SANC revised the scope of practice, which is still to be promulgated by the South African parliament. In that document, “nursing” is regarded as a regulated profession comprising a body of scientific knowledge and skills practised within a legal and ethical framework. The practice of nursing is a dynamic process that provides and maintains the care of individuals, groups and communities that are faced with actual or potential health problems.

Nursing is a dynamic process which

- promotes, supports and restores health status
- assists a health care user to maintain the basic activities of daily living
- requires judgement within a caring therapeutic relationship, informed by the context in which it is practised
- maintains continuity and coordination of health care
- provides continuous support and care to health care users irrespective of their state of health and through all stages of life
- provides and maintains a safe and conducive environment for health care.

Scope of practice of the three categories of nurses in South Africa

According to the Nursing Act No. 33 of 2005, nursing in South Africa has three categories of nurses: professional, staff and auxiliary nurses.

The professional nurse

A professional nurse is a person who

- is educated and competent to practise comprehensive nursing
- assumes responsibility and accountability for independent decision making in such practice
- is registered and licensed as a professional nurse under the Nursing Act.

Comprehensive nursing means integrated nursing interventions that apply the scientific process of the full range of nursing care (i.e. in the areas of general, obstetric and mental health) and which promote and maintain the health status of health care users; or where this is not possible, palliative care and a peaceful and dignified death.

The *scope of the professional nurse* is to provide comprehensive nursing, and the primary responsibilities entail the following:

- The provision of comprehensive nursing treatment and care of persons in all health care settings
- Taking responsibility and accountability for the management of nursing care of individuals, groups and communities
- Providing emergency care
- Ensuring safe implementation of nursing care
- Taking responsibility and accountability for the care of persons who have unstable and complicated health conditions
- Ensuring that nursing care is delegated only to competent practitioners

The staff nurse

A staff nurse is a person who

- is educated and competent to practise basic nursing
- assumes responsibility and accountability for independent decision making in such practice
- is registered and licensed as a staff nurse under the Nursing Act.

Basic nursing care means fundamental nursing interventions that promote and maintain the health care user's status or, where this is not possible, palliative care and a peaceful and dignified death.

The *scope of the staff nurse* is to provide basic nursing care, and the primary responsibilities entail the following:

- The provision of basic nursing care and treatment of persons with stable and uncomplicated health conditions in all settings
- Providing basic emergency care

- Assessing and developing a plan of nursing care for persons with stable and uncomplicated health conditions
- Taking responsibility for the nursing care of persons whose health condition is stable and uncomplicated in a unit of an overall health facility or service

A staff nurse may not take responsibility and accountability for managing overall nursing care in a health facility or service. A staff nurse may, however, provide nursing care and treatment to persons who have complicated health problems or are in an unstable condition under the supervision of a professional nurse.

The nursing auxiliary

A nursing auxiliary who is a person who

- is educated and competent to practise elementary nursing
- assumes responsibility and accountability for independent decision making in such practice
- is registered and licensed as a nursing auxiliary under the Nursing Act.

Elementary nursing means practical self-care and activities of daily living interventions that assist health care users to promote and maintain their health status through the application of prescribed standards of care.

The *scope of the nursing auxiliary* is to provide elementary nursing care, and the primary responsibilities entail the following:

- Providing assistance and support to a person for the activities of daily living and self-care
- Providing nursing care as prescribed or directed by a professional nurse or staff nurse
- Providing nursing care in accordance with a standardised plan of care
- Rendering basic first aid

Activity 6.4: Job description (Textbook page 63)

Responsibility areas of most job descriptions

- Communicating (in relation to whom, what, how)
- Planning and organising (what of)
- Managing information or general administration support (what of)
- Monitoring and reporting (what of)
- Self-development
- Health and safety
- Evaluating and decision-making (what of)
- Financial budgeting and control (what of)
- Producing things (what)
- Maintaining/repairing things (what)

- Quality control (what of)
- Using equipment and systems (what)
- Creating and developing things (what)

Questions to ask to clarify whether a new activity or procedure can be incorporated into your job description

- Is it consistent with my professional scope of practice?
- Is it consistent with statutory or regulatory laws?
- Is it consistent with my education in the specialty?
- Is it consistent with the scope of my recognised title or does it evolve into another advanced practice requiring additional formal education and legal recognition?
- Is it consistent with the standards of nursing practice?
- Is it consistent with evidence-based care?
- Is it consistent with reasonable and prudent practice?
- Am I willing to accept accountability and liability for the activity and outcomes?

Chapter 7: Professional and legal aspects

Catarina Magdeline Erasmus

Malpractice

Not every medical mistake or failure to diagnose justifies a medical malpractice case. More and more nurses are being named as defendants in malpractice and negligence lawsuits. The trend shows no sign of stopping despite the efforts of nurse educators to inform nurses and students of their legal and professional responsibilities and limitations. A charge of negligence against a nurse may arise from almost any action or failure to act that results in the injury of a client – most often, an unintentional failure to adhere to a standard of clinical practice (Croke 2003: 54). According to Beckman (1995: 7), nursing malpractice suits are on the increase. The nursing literature extensively addresses what should be done to provide safe and effective nursing care, and these interventions and actions are based on sound scientific principles. The literature does not, however, describe the pitfalls and problems associated with the delivery of sub-standard care.

Bad medical outcomes, whether due to negligence, mistakes, errors or the more common complications of illness or treatment, are often thought to be someone's fault. This thinking has led to serious problems with malpractice. In the UK, practitioners thought to be guilty of malpractice can be charged with committing a criminal act, and the frequency of such charges is increasing. There is evidence of medical practitioners serving prison sentences after administering an overdose of an intravenous drug into the spine of a teenager (Criminalising medical errors 2004: 4). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines malpractice as “improper or unethical conduct or unreasonable lack of skill by a holder of a professional position”.

Activity 7.1: Malpractice (Textbook page 66)

There are situations in which it is not possible to demonstrate clearly the true nature of the problem and how the health care practitioner's action or inaction caused significant harm to the client. The courts of law have examined the many varied settings in which professional misconduct has occurred and from these cases principles have been formulated which provide some guidance in relation to the notion of professional misconduct. The conduct may be compared with negligent acts but is usually coupled with indifference on the part of the practitioner, or lack of concern or even gross negligence, before the behaviour will amount to misconduct (Griffiths 2003: 5). The International Council of Nursing (ICN) identifies five levels of adverse outcomes to clients to distinguish mishaps from real mistakes that indicate incompetence:

Level 1: An accident which occurs independently from or by a person's decision or action

Level 2: A well-justified decision that turns out bad (e.g. a client's reaction to medication prescribed); does not necessarily indicate incompetence of the nurse

Level 3: Situations where professionals disagree (no consensus on what is the “right” thing to do) and someone’s decision later results in harm to the client, (e.g. not reporting troubling symptoms or reactions)

Level 4: When the health care professional exercises poor although not “bad” judgement or skill (e.g. missing signs of physical abuse in a child)

Level 5: True violations of expected quality of care (e.g. giving the wrong dose of medication) (Fry & Johnstone 2006: 157)

Activity 7.2: Human error (Textbook page 66)

A report

In 2001 Harvard University’s Institute of Medicine (IOM) shook the health care industry with the release of a report entitled “To error is human”. According to this report, health care errors caused between 44 000 and 98 000 deaths in America each year. Over half of these errors were preventable. Aside from the deaths, the report further outlined significant disabilities, injuries and harm caused by adverse events (Bernsten 2004: 1). Nurses were also indicted in criminal charges.

Understandably, nurses are reluctant to report health care errors. Yet the only way to lessen the number of health care errors is to document and analyse the problems and contributing factors. This can only be done in a non-punitive culture. The IOM reports that most errors in nursing are the result of failures in health care systems rather than of human recklessness (Kany 2000: 86).

Activity 7.3: Misconduct (Textbook page 67)

Many different acts and omissions may be deemed to be misconduct. Examples are as follows:

- Performing or causing or permitting to be performed or conniving at any act which is to the prejudice of the administration, discipline or efficiency of any department, office or institution of the state
- Disobeying, disregarding or making wilful default in carrying out a lawful order given to him by an authoritative person or by word or conduct displaying insubordination
- Negligence or insolence in carrying out of duties
- Undertaking, without permission, any private work in any matter connected with the performance of one’s official functions or duties
- Publicly commenting to the prejudice of the administration of any department
- Making use of one’s position to promote or to prejudice the interests of any political party
- Attempting to secure intervention from political or outside sources in relation to his position and conditions of service
- Conducting oneself in a disgraceful, improper or unbecoming manner, or, while on duty being grossly discourteous to any person

- Using intoxicants or stupefying drugs excessively
- Getting into financial trouble unless it can be shown that this was due to unavoidable misfortune
- Disclosing information other than in the carrying out of one's official duties, without first having obtained permission of the head of the department or for any other purpose than the carrying out of official duties
- Misappropriating or making improper use of the property of the employer or its clients
- Committing an offence
- Absenting oneself from one's office or duty without leave or valid cause
- Making a false or incorrect statement with a view to obtaining any privilege or advantage in relation to one's official position or one's duties aimed at prejudice or injury to employer or its clients
- Contravening any rule of the constitution of a medical aid fund or aid scheme of which he/she is required to be a member in terms of the regulations or failing to comply therewith
- Contravening any provision of a prescribed code of conduct, or failing to comply with any provision thereof

Activity 7.4: Incompetence (Textbook page 68)

Incompetent practice and unacceptable behaviour have traditionally been defined by the courts and professional regulatory boards as misconduct. The focus of the disciplinary process has been to identify inappropriate conduct and then to sanction the individual concerned. This is an indirect method of protecting the public (Griffiths 2003: 2). We are not to blame if a colleague commits criminal behaviour: we are to blame if we deny the possibility. We are even more to blame if we ignore the warning signs and permit the event to occur. We have a responsibility to our clients, colleagues and society to identify individuals with malicious intent and to prevent them from harming others. It is a professional responsibility to take cognisance of a colleague's inability to practise adequately by reason of physical or mental illness or even just lack of skill. Failure to report such a colleague is unprofessional conduct and gives enough grounds for discipline. If a known impaired practitioner injures a client, the professional who fails to make the mandatory report may be held liable for the injury. Silence and inaction of medical staff may be construed as violation of ethical standards.

Incompetence is performance beyond the individual's control and often arises from misunderstanding, ignorance or inability to meet the job requirements. The incompetent employee should be re-educated, transferred or demoted. In the case of discharge of incompetent workers, employers must demonstrate that the employee was told that his or her performance is inadequate; that plans and measures, which include reassessment of progress and failure, were put in place to breach the incompetence; that performance standards have been uniformly applied; and that equally poor performers have been treated in the same way.

Incompetence – a problem faced by most managers – probably poses the most difficult area of discipline. Negligence also fits into this category. Incompetence may be a result of physical illness, psychological problems (loss of memory, inability to concentrate), drug or alcohol abuse, or inappropriate screening or hiring by management. No employee is hired as an incompetent worker and, if this does occur, a probation period should eliminate such employees.

Nurses must fulfil the professional obligation to keep abreast of developments and techniques. Someone who qualified ten years ago and has done no further development would not be qualified to treat an Aids client as this disease did not exist then (Padayachee 2002). Maintaining competence is important because if a person is acting in accordance with a particular practice, he or she is not negligent merely because there is a body of opinion that would take a contrary view. At the same time, that does not mean that a medical person can “obstinately and pigheadedly carry on with old techniques if it had been proven to be contrary to what is really substantially the whole of informed medical opinion” (Hunter v. Hanley 1955: SL 200: 213, 217).

The International Confederation for Midwives states, in its position paper on the governance of midwifery practice, that it is imperative not to give a license to practice “for life”. A set of criteria or requirements must be instituted for accreditation and re-accreditation of practitioners for fixed periods of time. These should be based on the ability of the practitioner to demonstrate that she or he has the required skills to practise the profession safely according to the national requirements (ICN 2005: 1).

Nurses must act responsibly and not engage in practices prohibited by law or delegate to others activities prohibited by practice acts of health care personnel or by other laws. Nurses determine the scope of their practice in light of their education, knowledge, competence and extent of experience. If the nurse concludes that she or he is lacking in competence or is inadequately prepared to carry out specific functions, she or he has a responsibility to refuse that work and seek alternative sources for care, based on concern for the client’s welfare. In that refusal, both the client and the nurse are protected. Inasmuch as the nurse is responsible for the continuous care of clients in health care settings, the nurse is frequently called upon to carry out components of care delegated by other health professionals as part of the client’s treatment regimen. The nurse should not accept these interdependent functions if they are so extensive as to prevent her or him from fulfilling the responsibility to provide appropriate nursing care to client (American Nursing Association 2004: 4).

We tend to turn our backs on instances of incompetence. We even cover up for each other in these matters (Rosenthal, 1995: 25). If a nurse does not understand the basic legal, ethical, physical, biological, therapeutic, social and physiological elements of safe and considerate nursing care; if she does not understand her own rights as a nurse; if she does not understand and comply with the fundamental principles underlying professional conduct; if she does not understand and observe the nature of her responsibilities as a colleague of the doctor; if she does not understand or accept that a client is her client as well as the client of the doctor; if she does not understand or accept the rights of the client in a care situation and if she has no confidence in herself as a practitioner – we cannot call her a professional practitioner, no matter what the law says. Professional practice is based on sound knowledge. Understanding and acceptance of a role, responsibility and accountability: if the nurse does not know or observe these principles, there is no professional practice. Under such circumstances practice is an illusion and reality is shrouded in ignorance, while professional responsibility is negated.

In order to prove negligence, the reasonable man test should answer positively on certain evaluations.

Forseeability

Would a reasonable man in the circumstances in which the alleged accused found himself have foreseen the possibility that the particular circumstances might exist or that the particular consequences might result from his act? This question is regarded as the keystone for the negligence test. A finding of negligence can be made if the mere possibility of the consequences was reasonably foreseeable even though the exact manner in which it resulted was not. The facets of the human body are many, and death and injury may come to mortals through a variety of hurts and derangements. The fundamental factor is the extent of risk created by the wrongful conduct and this comprises two elements: (1) the degree of probability that the damage will happen and (2) the seriousness of the possible consequences. The question remains whether the potential harmful consequences were reasonably foreseeable or if it is only the plaintiff's position that could be prejudiced (Claasen & Verschoor 1992: 10).

Caution

Would the reasonable man have guarded against these possibilities? In other words, did the reasonable man implement steps against the manifestation of the harmful consequences? Often precautions are so difficult, inconvenient or expensive that the reasonable man would not have guarded against the possibility of an accident. It is expected that he will only guard against damages in cases where a reasonable possibility exists that the harmful consequence may occur. A person is not negligent when he caused an accident in a sudden situation, which he did not create himself (Claasen & Verschoor 1992: 10).

Deviation of conduct

Did the conduct deviate from what the reasonable man would have done in the circumstances? The reasonable man may sometimes take moderate risks in the interests of another and act peculiarly or irrationally in a sudden predicament. There are four basic considerations which influence the reactions of the reasonable man in a situation that holds foreseeable risk (Claasen & Verschoor 1992: 12):

1. The degree of risk created by his conduct
2. The seriousness of the risk and possible consequences
3. The benefit of the actual conduct
4. The nuisance or inconvenience of eliminating the risk or prejudice

The extent of the risk, which must be weighed against the benefit of the conduct and the effort, expense and/or disadvantages flowing from not doing it; if the risk outweighs the benefit, steps should be taken to prevent the occurrence.

Activity 7.6: Professional conduct hearings (Textbook page 75)

The disciplinary committee can decide that the whole or a part of the proceedings be conducted in camera. Similarly the defendant must be seen to be dealt with in a just and fair manner. These hearings are also conducted with decorum and a deep sense of the consequences of actions for a professional colleague. It is indicative of the maturity of the

nursing profession and of its highly developed professionalism that both the public and the profession have a high regard for the disciplinary powers of the Council and with the manner in which these are exercised. Council wishes to convey the message clearly, that its aim is not to prosecute and punish nurses, but rather to establish and enhance the standards of nursing care. Ultimately, the Council strives to maintain a balance between the rights of the public and the rights of the nurse as it has the protection of the public at heart.

Preliminary investigating committee

The terms of reference of the Preliminary Investigating Committee are that it will

1. Consider cases which arise from
 - courts and inquest proceedings
 - complaints lodged with the SANC
 - matters that come to the attention of the council in any manner.
2. Following on a complaint lodged against a practitioner, the committee must determine
 - whether there is prima facie proof of the conduct
 - whether the committee regards the conduct complained of as unprofessional conduct

The committee then, depending on whether the circumstances as contemplated in (1) and (2) above are established, recommends that the case should be referred to

- the Professional Conduct Committee for an inquiry in terms of section 28 of the Nursing Act No. 50 of 1978
 - the Professional Conduct Committee with the recommendation that the practitioner be afforded the opportunity of an admission of guilt and the payment of a predetermined fine
 - any other professional council or board where health practitioners other than nurses are involved.
3. If it is decided that a professional conduct hearing will be held, the Preliminary Investigation Committee may
 - direct the professional conduct department to call for further information from the complainant
 - carry out any investigation as may be considered necessary; and/or
 - inform the defendant of the nature of the complaint/s and ask him/her whether he/she desires to give a written explanation, but warning him/her that such explanation may be used in evidence against him/her (SANC 2003c: 13–14).

A case is not heard by the Professional Conduct Committee before the preliminary committee has resolved that there is prima facie support for the charge.

Professional Conduct Committee

The Professional Conduct Committee is one of the most essential committees of the Nursing Council and has to fulfil its mandate within the sphere of fair administrative action. It is essential that the members of the committee are equipped with a working knowledge of the legal framework and of what would constitute administrative unlawfulness or illegality. This committee (and the Council) are now functioning in a culture which is dominated by justification, a

requirement that government tribunals must respect, protect, promote and fulfil according to the Bill of Rights (Lamley & Gouws 2005: 3). This committee is totally different from the Preliminary Investigation Committee and no member that serves on the Preliminary Investigation Committee may serve on the Professional Conduct Committee. The terms of reference of this committee are that it shall

- hold inquiries at which it hears evidence under oath or affirmation and decides whether the facts alleged against a person whose name appears on the SANC's registers or rolls are proven on a balance of probabilities
- consider proven facts in context and decide whether, in professional terms, they constitute unprofessional conduct
- hear information regarding the defendant's previous personal and professional history and any other submissions in mitigation or aggravation of penalty
- impose a suitable order or penalty in terms of section 29 of the Nursing Act (SANC 2003c: 16).

Committee members must recuse themselves from a hearing if there is a conflict of interests (e.g. a member knows the defendant or works/worked with him or her in the same institution). The office must be notified in order to enable them to replace the member on the committee (SANC 2003a: 8).

The pro forma complainant

The pro forma complainant is the prosecutor of the Nursing Council. It is her or his duty to investigate the complaints, formulate the charges and present the case on behalf of the Nursing Council. The pro forma complainant is independent from the Professional Conduct Committee. When she or he is prosecuting the alleged complainant she or he is dominus litis (SANC v. Makwela 2002).

Lodging a complaint

Regulation 373 of the Nursing Act No. 50 of 1978, sets out the terms and conditions for the investigation of alleged misconduct and the conduct of inquiries. It dictates in section 4 that a person lodging a complaint, charge or allegation of disgraceful or improper conduct, shall do so in writing, wherever possible in the form of an affidavit, setting out the specific acts or omissions complained of. The person must be prepared, if required, to bring evidence in support thereof. Rosenthal (1995: 36) states that problem colleagues and mistakes seem to emerge in the following ways:

- Clear mishaps or mistakes by someone who is professionally competent
- Clear mishaps or mistakes by someone who is professionally suspect
- Suspect characteristics
- Unprofessional behaviour

It is imperative that the accused be informed of the complaint as soon as possible (Lamley & Gouws 2005: 4).

Media reports

The Nursing Act describes the powers of the Council, in other words what it may do when it receives a complaint. When the SANC is made aware of unprofessional conduct of nurses, or when it comes to the attention of Council via the newspaper that nurses are misbehaving themselves, Council, as the custodian of the public, has the obligation to

investigate any such allegation. It must, however, see to it that the stipulations of the regulations regarding the statement or affidavit are complied with. In this regard Council may ask the authorities of the institution to supply it with sworn statements and/or client documentation, to verify, and possibly prosecute, any allegations.

The inquiry or hearing

The appropriate management of cases is very important as the professional and personal future of the nurse charged with misconduct is affected, whatever the outcome of the hearing (SANC 2003a: 1). The Council is given quasi-judicial powers to inquire into charges of misconduct and to impose sanctions (penalties) in cases of established misconduct. It is a very serious matter for a nurse to be subjected to disciplinary proceedings since the outcome may have serious economic and social consequences for him or her (Searle 2000: 45).

There are two legs to an inquiry: to establish the facts and then, upon those facts, to conclude whether or not the proved conduct falls short of the required standard. The committee must determine whether sufficient facts have been proven to support the charge and, in doing so, the committee is bound by the rules of evidence. Charges are never presumed but must be proven and the party who must prove them is the party that brings them – the pro forma complainant (*De La Rouviere v. the South African Medical and Dental Council* 1977 1 SA 85). In professional conduct hearings, the principles of natural justice must be applied. The principles of natural justice serve three purposes, namely to

- facilitate accurate and informed decision-making
- ensure that decisions are made in the public interest
- cater for important process values (SANC 2003a: 1).

Timing is vital. Hearings should not be delayed too long: peer review rendered to accommodate administrative convenience may be perceived as placing the employee in double jeopardy. The Constitution, Act No. 108 of 1996, section 33, provides for a constitutionally entrenched right to administrative action which must be lawful, reasonable and procedurally fair (Lamley & Gouws 2005: 2).

Formulating charges

The charge sheet forms the substratum of the case against the accused and determines what case the accused has to meet and what the pro forma complainant has to prove on a balance of probabilities. It determines what will be relevant evidence to adduce in order to prove the content of the charges and what evidence will be relevant. It is not a prerequisite to allege negligence in a charge sheet. An allegation of improper or disgraceful conduct is the cause of action. It involves a normative decision in the eyes of the profession whether any act or omission constitutes unprofessional conduct. The concept of negligence is irrelevant in these proceedings and reference is rather made to improper or disgraceful conduct (Lamley & Gouws 2005: 8,11).

Section 17 of the SANC Regulation for investigation of alleged misconduct and the conduct of enquiries determines that the charge must be in the following standard format:

“You are hereby summoned to appear at ... upon ... (date) at 09:00 before the Professional Conduct Committee of the South African Nursing Council when the following allegations which have been preferred against you by the pro forma complainant will be considered: that you, being a ... (qualifications) in terms of the Nursing Act No. 50 of 1978 are guilty of improper or disgraceful conduct or conduct which when regard is had to your profession is improper or disgraceful in that on or about ... (date of incident) at (place of incident), you ... (specific misconduct charges).” (SANC R373).

Amendment of the charges

There is no explicit regulatory provision for the amendment of charges; this aspect will therefore be guided by what is regarded as fair in terms of administrative justice. Guidance can also be taken from the Criminal Procedure Act (Lamley & Gouws 2005: 12). It is procedurally unfair for the pro forma complainant to add or change charges at the hearing. The defendant has the right to be informed of all the charges timeously in order to prepare testimony. The dropping of charges can also not happen at the hearing. The charges are formulated by the Preliminary Investigation Committee and only this committee, or the registrar of the Council, after thorough consultation with and on instruction of the Preliminary Investigation Committee, may drop charges. In the case of an application for dropping of charges, the whole case is referred back to the preliminary investigation for re-investigation.

Summons and subpoenas

The summons is sent by registered post to a defendant, at the address on the Council’s database, a minimum of eight weeks before the hearing. It may also be personally delivered by a courier company or by any other form of delivery. The summons is further followed up by means of faxing it to the manager of the institution where the defendant works. Proof or return of service is obtained from the post office. A subpoena is a legal directive to a witness to testify at a hearing and will be issued six weeks before the date of the hearing. The defence may also request the Council to subpoena witnesses on their behalf (SANC 2003a: 6). The defendant or their representative may request further documents from the pro forma complainant. This request must be done in writing and must be specific. The defendant can only demand what she or he must account for, namely content of the charge which could include statements from the witnesses. The defendant is not entitled to know exactly how the pro forma complainant will prove his case (Lamley & Gouws 2005: 21).

Attendance of the defendant

Section 16 of the Regulation for investigation of misconduct, R373, of the Nursing Act No. 50 of 1978, as amended, determines that any person who fails to attend and give evidence relevant to the inquiry at the time and place specified by the summons, or refuses to be sworn or make an affirmation, or refuses to produce any book, record, document or thing which is required by summons to produce, shall be guilty of an offence and liable on conviction to a fine. Section 18 (1) paragraph (b), of the Nursing Act No. 50 of 1978, as amended, serves to remedy the situation should a person be considered a danger to the public while the hearing or the case is still pending against her or him. It reads as follows:

“The Council may direct the Registrar to remove from the Register or Roll the name of any person, who has failed to notify the Registrar within a period of three months as from the date of the written enquiry sent by the Registrar to the address appearing in the register or roll in respect of such a person of his present address. “

In these cases the name of the defendant is administratively removed from the register /roll of the SANC. If he or she contacts the SANC for any reason thereafter, probably to renew their annual licensing fee, they will be informed of the removal. The professional conduct review can then take place as previously planned.

Representation for the defendant

Section 16 of the Regulation for investigation of misconduct, R373, of the Nursing Act No. 50 of 1978, as amended, makes provision for the defendant to be represented by a member of a trade union or a professional organization such as DENOSA, or a lawyer. The procedure followed by the representative corresponds with that of a court case or ordinary disciplinary hearing in the workplace. The cost of representation must be borne by the defendant. Although it is advisable for nurses to make use of a representative at these proceedings, because of the emotional stress and anxiety they will undergo, they need to be careful when selecting a representative. Representatives can often do more harm than good if they are not familiar with nursing issues. A union’s customary tactics of delay, for example, are not tolerated in these proceedings, which are held with the same decorum as those of the court. SANC is also expected to apply processes fairly and to ensure administrative correctness.

Pleading

The procedure requires a plea to be entered by or on behalf of the defendant on the charges. Should the defendant refuse or fail to plead, the Professional Conduct Committee holding the inquiry must make a note thereof and all oral evidence to be led must be under oath or affirmation. While a plea of guilty is acceptable, it leads to problems in sentencing unless some evidence is led to guide the committee in this regard, and the committee may ask either party to lead evidence in this regard (SANC 2003a: 11). There is an onus on the Nursing Council to prove guilt. The Constitution, section 35, warrants and guarantees that nobody may be compelled to make any confession or admission that could be used in evidence against that person and that any person is presumed innocent until proven otherwise.

Leading of evidence

Section 12 of Regulation 373 of the Nursing Act No. 50 of 1978, as amended, determines that all verbal evidence shall be taken on oath or affirmation, which shall be administered by the chairperson. Evidence admitted must be relevant to the case. Relevance means that any two facts presented must be related to one another so that if one were to be removed, the existence of the other would be improbable. Relevant facts must be proved through documentation of witnesses. If both parties (pro forma complainant and defence) agree to a fact, it is considered to be proven and becomes common cause. The evidence presented should relate to the specific charges, should be presented in a way that proves or disproves the case and should give the facts that underlie these issues. Hearsay evidence is evidence given by a person who recounts an event in which he or she was not personally involved, but about which he or she

was told by somebody else. Hearsay evidence is not allowed as there is no way of checking its reliability (SANC 2003a: 2).

A document or evidence is authentic if it is what it is alleged to be by the party tendering it. Proof of authenticity is usually supplied by the author of or a signatory to the document. A witness is not allowed to prepare evidence in written form and to read it out or hand in the written document as a transcript of her or his evidence, with the exception of the expert witness. An affidavit made by a witness must be in a written statement sworn to or confirmed before a commissioner of oaths, and is only admissible if it contains evidence of a formal nature or is non-contentious (Lamley & Gouws 2005: 27, 30).

Witnesses

Witnesses can be subpoenaed to give evidence and failure to comply constitutes contempt of court, which is a very serious offence. When this occurs in a disciplinary matter, the Council hands the matter over to the courts (Searle 2000: 186). The witness is always allowed, when giving evidence about relevant facts, to embellish his or her narrative with detail of the surrounding circumstances so as to give life and colour to the evidence, even if the detail has no bearing on the probabilities relating to the facts in issue. This is not to say that the surrounding detail is necessarily irrelevant; it often supplies the means by which the internal consistency of the case can be tested. The word “relevant” means that any two facts to which it is applied are so related to each other that according to the common course of events one either taken by itself or in connection with other facts, proves or renders probable the past, present or future. The committee may at any stage of the proceedings call or recall any person to give evidence (Searle 2000: 339). The first few minutes of testimony are critical in establishing rapport with the committee (Beckman 1995: 35). After being sworn in and on instruction to be seated, the witness should sit in an attentive position with both feet on the floor and with hands folded on the lap. Eye contact with each committee member during testimony is vital and projects a positive and confident attitude.

Questions and answers to questions should be articulate, factual and to the point. A witness should answer only what is asked and should not volunteer information, elaborate, lecture or editorialise. Witnesses should be prohibited from providing an explanation as in “yes, but...”. They should answer slowly and thoughtfully to be in control of the questioning process, but should also be aware that hesitating too long before replying may create the impression that they are not knowledgeable or are being evasive. It is, however, permissible to say “I do not know” or “I have no comment”. Witnesses should speak directly, confidently and at the appropriate volume (not too loud) so that they are heard easily. Testimony by deposition at a trial is a serious matter. Witnesses are sworn to tell the truth and nothing but the truth. Anything said at the trial or hearing is an open record and such statement will remain with the nurse for the rest of her or his career (Beckman 1995: 34, 37). All evidence must be direct, relevant and admissible. Circumstantial evidence is seldom taken into account. All evidence must be logical and legally relevant to the facts of the case and must be used for proving or disproving the case against the defendant. Documentary evidence must be presented in its original form (Searle 2000: 185).

Expert witness

An expert witness is a professional person who devotes at least 75 per cent of her or his professional time to the active practice of the medical specialty involved in the action. It is a person who has specialised knowledge and skills and may be able to draw better inferences than the committee members, who may not be familiar with the issues. This expert will be present when all evidence is led by other witnesses and will then be led by either the pro forma complainant or the defendant, depending on whose witness she or he is (SANC2003a: 4). Expert witnesses are usually the most important role players in defending and/or proving a malpractice case. A percipient witness tells the jury what happened and an expert witness tells the jury what should have happened (Gargaro 2004: 4). The expert witness must be thoroughly familiar with all the reviewed documents but does not have to memorise medical records or related materials. It is permissible to refer to these documents during the trial. The expert should organise the documents before the trial so that relevant sections can be accessed rapidly during testimony (Beckman 1995: 34).

Cross-examination

While the discovery phase is the dress rehearsal, the trial, and specifically the cross-questioning, is the opening night (Showers 1999: 27). The opposing attorney or representative will apply various techniques and may, for example, deliberately rephrase answers to questions to include inaccuracies or to twist the respondent's meaning, in a bid to make the witness lose his or her composure, to distract them, to shake their confidence and to attack their character. Such tactics should not be taken personally. Witnesses should not become angry or argumentative, and should remain calm, polite and professional (Beckman 1995: 37). Impeachment of a witness is an important goal of the opposition. Impeachment calls into question the veracity (truthfulness) of a witness. This may be done by demonstrating bias, prior inconsistent statements, contradictions of fact or poor character. A witness is identified and called to testify because the information the pro forma complainant obtained from him or her, would strengthen and help prove the case of the pro forma complainant. If a witness of the pro forma complainant gives testimony that contradicts what was clarified during prior discussions and it seems clear that the witness is now testifying in favour of the defence, the pro forma complainant will apply to the chairperson of the hearing to declare the witness a hostile witness, in which case no evidence given by the witness will be considered in decision making. Examination of the credibility of a witness involves questioning not only his or her honesty, but also his or her powers of perception, inferences, memory and accuracy in telling his or her story (Lamley & Gouws 2005: 35).

Witnesses and defendants must always remember that they have the advantage of having been at the right place at the right time; in other words, they were there when the incident happened and they can therefore provide accurate information. They know better about the incident and perhaps the nursing that took place at the time than the pro forma complainant. As long as they speak the truth and stick to just that, there should be no problem. In cross-examination, both the pro forma complainant and the defendant or his or her representative will seek to damage the credibility of one another's witnesses by trying to show that their version of the events is inaccurate, biased or illogical. Lawyers call this "destructive cross-examination". As already indicated, this is done using various techniques and tactics (Mandell 1993: 22).

Firstly, the memory of the witness will be questioned, especially if the nurse (witness) testifies that something was done but was not recorded. They will be asked how and specifically why they remember something so well without it being recorded. Witnesses may refresh their memories from contemporaneous notes, for example a diary or other notes made while the facts were still fresh in memory (Lamley & Gouws 2005: 34). While leading questions may not be asked in direct examination, this is allowed in cross-examination. Neither the pro forma complainant nor the defence may therefore ask leading questions of their own witnesses. A leading question is one that leads the respondent to answer in a particular way, or that suggests the answer. If any inconsistencies between the statements of the trial and any other statements are picked up by an alert pro forma complainant, attorney, representative and member of the disciplinary committee, the defendant and the witness can be very sure that these inconsistencies will be pursued to establish the real and correct version of the facts.

The possibility of bias will be tested. The pro forma complainant will, for example, ask the defendant why and how it is possible that the witness will testify on acts or omissions of the defendant that could cause the defendant to land in trouble, if there is no bad blood between them. If the defendant now claims that there is a conspiracy against her or him, she or he will have to prove it beyond reasonable doubt. In the rehearsed answer tactic, which is the oldest tactic in the book, there will be an attempt from either the pro forma complainant or the defence to demonstrate that the witness rehearsed his or her testimony before the trial (Mandell 1993: 23). If a witness's answers have been rehearsed, the logic in the content of these answers will often not be consistent with the rest of the evidence led in the case.

A member of the committee may question a witness of the defendant through the chairperson but may not make statements, intimidate the witness, repeat questions already asked, make accusations, pre-empt the outcome or make speeches (SANC 2003a: 1).

Standard of proof

In professional conduct hearings, the committee must be certain, on the balance of probabilities, that the person is guilty of such a finding. This will mean that the version of the pro forma complainant is more probable than the version of the defendant or her or his representative. It is not necessary for the case to be proven beyond reasonable doubt, as is required in a criminal case (SANC 2003: 4).

Absolution or discharge of the allegations

In an inquiry like this, which is a quasi judicial inquiry, there are no clear-cut rules about procedure. Therefore, it would be pertinent to look at both civil and criminal procedure, as an inquiry of this nature has elements of both. It is a generally accepted principle of procedural law that at the end of the plaintiff's case, or at the end of the state's case in a criminal matter, the defendant/accused is entitled to request absolution or discharge, should the evidence not disclose a *prima facie* case against the defendant/accused. In determining whether the plaintiff or the state has succeeded in disclosing or proving a *prima facie* case, the following test should be applied: is there sufficient evidence before the court so as to enable a reasonable man, based on the evidence, to find in favour of the plaintiff or in favour of the state (State v. Heller 1979 (1) SA 824 (A), as well as State v. Khanyapa 1979 (1) SA 824 (A)). If the defendant refuses to testify in his or her own defence, the committee has to rely on the available evidence or call other witnesses (State v.

Shuping 1983 (2) SA 119 (B)). The committee should be careful not to assume that the defendant is guilty or has something to hide if she or he refuses to testify. In cases where the pro forma complainant and the defence have closed their cases and the committee needs more evidence, the committee can call witnesses and ask for documentation and, at any stage of the proceedings, call or recall any persons to give evidence (SANC 2003: 11, 12). Complete verbatim records of each hearing are kept and must include all papers presented and numbered as evidence.

Mitigation or aggravation

There is no rule entitling first convicted offenders to a lesser penalty just because there is no proof of previous convictions (State v. Victor 1970(1) SA 427). Punishment should fit the criminal as well as the crime, to be fair to the state and to the accused, but it should also be blended with mercy (Sparks 1972(2) SA 396). The sanction or penalty must be appropriate taking into consideration the offence committed (e.g. improper or disgraceful conduct). A more serious offence will be met with heavier penalties. A penalty must take the following into account:

- The personal circumstances of the defendant (e.g. age, experience and training, family situations)
- The interest of the community which is served by the defendant
- The image and interest of the profession
- The circumstances of the misconduct
- The consequences of the misconduct (Lamley & Gouws 2005: 64)

Finding

The outcomes of these hearings provide guidance to the profession and the public on acceptable nursing practice. Nursing practice is also influenced and regulated by processes other than disciplinary activity. The decisions establish and reinforce acceptable conduct and practice for the entire nursing profession. Peer review forms the substance of the profession's self-regulation (Griffiths 2003: 1).

Decisions taken by the Council's Professional Conduct Committee have far-reaching implications for the status of the individual practitioner, his or her reputation and career opportunities. The committee should thus guard against taking administrative action that is not fair and just (Lamley & Gouws 2005: 3). At the end of a hearing or enquiry the committee deliberates in camera to consider whether to find the accused guilty or not guilty on the basis that sufficient facts have been proven to support the charge. After hearing mitigation, it considers, again in camera, what an appropriate sanction would be.

All decisions are based only on the evidence led and should consider the principle of the reasonable nurse. Each member of the committee should get a chance to express his or her opinion. The chairperson chairs the discussion, ensures that all members are given an adequate opportunity to speak and sums up the discussions. Decisions are taken by consensus of all committee members and written down on prescribed forms. Decisions must include brief explanations of the reasons for the finding as well as any aspects of professional conduct which the committee wishes to highlight in relation to the case (SANC 2003: 16).

If a practitioner's offence is a grave one, this will lead to an adverse decision by the Council and the responsibility of the Council cannot be measured only by the effect of its decision on the individual. The high reputation of the nursing profession as a whole depends in no small measure on excluding from it those whose professional misconduct makes them unworthy to belong to it and undermines the confidence which the public are accustomed to (General Medical Council v. Spackman 1943 A (627)). This is intimately connected with the assurance that those who practise the art of nursing are, in all relations with their clients, individuals of the highest honour. The conduct alleged against the respondent is conduct from which the public has every claim to be protected, and there would be none more ready to afford such protection than the members of the profession itself. No tribunal is better qualified to draw deductions from the proved conduct than the experienced body of men (and women) who sat on the (professional conduct committee). It is left to the Professional Conduct Committee to decide what acts or omissions should, in its opinion, render a member of the profession liable for punishment. The members of this committee are the custodians of the honour and rectitude of the profession, and it is left to them to say to what standard of honour the members of the profession should conform. Much depends upon their opinion whether the standard of personal or professional honour of its members is a high and acceptable one or not. The courts will be slow to interfere with a decision honestly arrived at by the committee, if the appeal or application for review is not on a procedural aspect.

In the absence of clear reasons and principles, expected standards will not enhance transparency and consistency in decisions. Nor will such decisions provide guidance for the profession and its clients. The disciplinary committee's determination on the nurse's reputation and his or her ability to continue to work as a registered nurse, reinforces the need for these cases to be more readily accessed, the profession informed and efforts made to familiarise the profession with the determinations (Griffiths 2003: 6).

The more information detailing the disciplinary committee's determination, the easier it is to comprehend and extrapolate the arguments and subsequent findings. This allows for greater transparency of decisions and highlights whether determinations, particularly where there are similar cases, are consistent. Furthermore, when an adverse finding is made, the choice of determination commonly includes counselling and further education of the nurse. Provided appropriate educational topics are recommended, such determinations are suggestive of a balancing interest. It ensures professional standards are maintained, as the nurse is directed to upgrade her or his knowledge and educational qualifications, which in turn should impact on improved client care and ultimately on the protection of the public (Griffiths 2003: 7).

Sanction and sentencing

There are three elements which the committee considers when imposing an appropriate sanction: firstly, the seriousness of the charges of which the defendant has been convicted; secondly, the personal circumstances of the defendant; and thirdly, the interest of the community. It is one of the purposes of punishment or sentencing that it must fulfil one of the following functions: individual deterrence and generalised deterrence. The sentence the committee imposes should proclaim to the community that the Professional Conduct Committee, and therefore the South African Nursing Council, has the interests of the public at heart. It is also important that the Professional Conduct Committee should note that the people who are receiving care in any situation rely solely on the advice of the nurse or midwife.

The nurse or midwife is entrusted with the client's life because of her or his position of trust in relation to the client. This position of trust is a very noble position and it must not in any way be undermined.

Types of sentences

Section 29 Section 29(1) of the Nursing Act No. 50 of 1978 states clearly that the Professional Conduct Committee may impose the following sanctions: a reprimand or caution; suspending the practitioner from practising nursing for a specified period; removal of name from the register or roll; and a fine up to a maximum of R2000. It also states that the Committee may, in the case of a student, extend the period of training of that particular student.

Appeals and review

A review is a limited re-hearing, with or without additional evidence or information, to determine, not whether the decision under appeal was correct or wrong, but whether the arbiters/committee exercised their powers and discretion honestly and properly. The meaning of the word "appeal" is

- a complete re-hearing of and fresh determination on the merits of the matter with or without additional evidence or information
- the re-hearing of the merits of the evidence or information on which the decision under appeal was given in which the only determination is whether that decision was right or wrong.

Grounds for appeal are effective if the respondent is of the opinion and can prove the following:

- That one or more members of the committee exhibited bias against the appellant having regard to the manner in which questions were asked of witnesses and the nature of such questions
- That the committee admitted certain inadmissible and irrelevant evidence which resulted in prejudice to the appellant
- That the committee and the respondent should not have found the appellant guilty of the offences charged because there was no evidence upon which they could reasonably come to that conclusion (*Tikly and Others v. Johannes, N.O. and Others* 1963 (2) SA 588 (T) p590)

Activity 7.7: Disgraceful and improper conduct (Textbook page 76)

In professional conduct cases the committee must make a value judgement and determine whether the conduct of a nurse is to be regarded as disgraceful or improper in a professional respect, and in doing so the committee must have regard to what the common knowledge is in the branch of the profession to which the nurse or midwife belongs and whether or not the nurse or midwife applied the necessary skill and care. The committee must also consider the individual's conduct in relation to what the common knowledge and practice of nurses or midwives was at that time.

"A general practitioner is not expected to have the same degree of knowledge and skill and experience as a specialist has" (*Esterhuizen v. Administrator of Transvaal* 1957 (3)). The question is, what is the common knowledge in the branch of the profession to which the defendant belongs? Consideration must be given to his or her actions in relation

to what common knowledge and practice was at that time and not to what a specialist might have known or done. Common knowledge in the profession is evidence on which reliance may be placed, because the practitioner is expected to possess the knowledge which is common in the profession and that of an average nurse/midwife in the case in question, who is reasonably skilled. Nurses and midwives must perform their services with such technical skill as the average nurse or midwife in South Africa possesses. They have a duty to apply reasonable skill, care and judgement. They are not expected to bring to bear on a case entrusted to them the highest possible professional skill, but are bound to employ reasonable skill and care and are liable for the consequences if they do not do so (*Esterhuizen v. Administrator of Transvaal* 1957 (3)).

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Chapter 8: The management process: an overview

Ansie Minnaar

Activity 8.1: Case study Behaviour patterns of a unit manager (Textbook page 94)

It is important to look at how the unit manager should comport her or himself in the unit. There are certain behaviour styles which a unit manager should display in the unit to ensure quality client care. These behaviour styles are discussed below.

1. *Set a good example*

The way the unit manager speaks to people and the way the work is carried out will be observed by clients, their families, staff members and other health professionals. The unit manager is, in a way, “on show” the whole time. Other nurses and students will learn from the unit manager’s behaviour how to give client care and how to be a professional nurse. So it is important for a unit manager to send out the correct message by behaving in an appropriate way. It also means that the unit manager must know and adhere to health care policies and procedures. She or he must be aware of the image that she or he projects and it must always conform to the role of a unit manager in charge of a health care unit.

2. *Know all the clients in the unit*

The unit manager should have a sincere interest in her clients and in other staff members. She should display a caring attitude towards clients by knowing their names, what illnesses they are suffering and what their everyday needs are. She should show the same interest in the other staff members. Thus she should know her staff by name and be aware of their special personal needs as well as their training and professional needs. Clients should never be referred to as “the client in bed five” or “the Aids client”. The unit manager must ensure that nurses are competent to render quality client care at all times within their scope of practice and within their competencies.

3. *Be available and approachable at all times for everyone in need*

A unit manager must always be friendly even if the going gets hard. Clients indicate that a smile makes a big difference to the way they feel in a hospital or when using health care services. The unit manager must also aim to be available to clients, their relatives and staff and other health care professionals. He should work actively with nurses, showing an interest in what they are doing in the client care environment. The unit manager must ensure that he spends time with each and every client at the beginning of the shift to ensure quality client care.

The unit manager must acquaint himself with the unit by doing the following:

1. Assessing each client’s needs
2. Assessing the state of the ward
3. Assessing the nursing workload
4. Ensuring that clients are in a position to ask questions

5. Giving and receiving information to and from clients and their relatives
6. Assessing the need for in-service education and support to nurses

The unit manager should never give the impression that he is in a hurry when doing the daily ward round.

4. *Be consistent in all duties*

The unit manager should be consistent in mood and should not be cheerful the one day and bad-tempered the next. She should be consistent in decision making, behaviour and attitude to clients and colleagues, and should handle all matters in a mature way, never being childish in her dealings with staff or clients. She could ensure consistency in the unit by doing the following:

- Ensuring that all nurses know what is expected from them when they start their day or shift
- Clarifying procedures correctly, following the policies, procedures principles and standards of client care
- Being available for consultation, advice and support, and supervising effectively (as described later on in the chapter)
- Ensuring two-way communication between clinicians and staff
- Ensuring a philosophy of nursing in the unit that complements the philosophy of the health services

5. *Show compassion and be sensitive to the needs of others*

The unit manager must be aware of the needs of both clients and staff and must show compassion. A compassionate approach is one which shows understanding of the position of others and a willingness to help them.

6. *Be receptive to new ideas*

The unit manager should be receptive to suggestions of other team members, and should allow everyone to contribute towards working well as a team. He should create an environment that encourages questions, especially if nurse training is offered in the health institution. He should be forward thinking (strategically) and willing to change, and should not feel threatened by new methods and technology or suggestions for improvement in the unit. His attitude should be flexible and he should treat constructive feedback as a priority in the unit.

7. *Show competence as a nurse*

The unit manager must be a competent nurse who is able to render quality client care and who can demonstrate her ability through in-depth discussions regarding client care. The unit manager must be in contact with the clients and during her contact time she should display expertise by showing other nurses how to position the client, teaching them how to give medicine and injections, demonstrating aseptic techniques and modelling how to talk to distressed clients and their relatives.

The reason so many things are expected of a unit manager is that many people are involved in the proper functioning of the unit. It is not just nursing tasks that need to be undertaken; there is a continuing presence of other health professionals and ancillary staff who all render a part of the care and services. A happy unit also depends on the relationships and coordination in the unit. Ultimately the unit manager's main aim is to create a ward atmosphere and environment in which clients receive a high level of client care.

Characteristics of a “good nurse”

The notion of a good nurse and good nursing is alive and well, but exactly what it means is a good question. Perhaps the term has been used so often that a simple shared meaning is assumed, but in fact it is obvious that the notions of a good nurse and good nursing are complex and that we need to look into them more closely. A research study done by Smith and Godfrey (2002) on being a good nurse and doing the right thing identified seven characteristics of a good nurse and good nursing. Let’s look at each characteristic carefully and re-think our own practices in nursing.

1. *Personal characteristics*

These are the attributes the nurse brings into nursing by virtue of the person he or she is and how these are manifested in everyday life. They include caring, compassion, respect for self and others and communication patterns. The *good nurse* truly cares about people, is flexible, has outstanding interpersonal skills and listens to and respects the feelings of others.

2. *Professional characteristics*

Professional characteristics relate to a nurse’s practice and include commitment to services as reflected in the nursing code of conduct, nursing acts and regulations, standards of care, own philosophy of care and ethics, role modelling and acts within the scope of practice.

- Knowledge base. The nurse must have all the facts, information and skills necessary to be recognised as competent. The knowledge includes both professional knowledge and situational knowledge. Professional knowledge is attained through basic training and continuing education and experience. Situational knowledge is client or disease-specific and includes an openness to the enhancement of skills and knowledge.
- Client centredness. The nurse should always give clients’ needs and desires first priority in her tasks.
- Advocacy. The good nurse acts on the principle of empowering others and intervening on behalf of clients or clients’ interests.
- Critical thinking. Here the nurse must be able to do reflective analysis and make the right judgements or decisions and to plan the outcome of care. The nurse should continually ask questions, clarify information and consider a variety of options, by looking at all sides of the situation at hand.
- Client care. Client care is the actual application or performance of safe, competent nursing care. The good nurse focuses on addressing the individual needs of every client. Communication and teaching for and about clients are also important (Smith & Godfrey 2002: 301–307)

Activity 8.3: Strategic planning (Textbook page 96)

There are many ways of doing strategic planning. However, most strategic planning processes follow certain logical steps, which in essence are based on the problem-solving cycle. Strategic planning has many definitions. It means different things to different people. The meaning of strategic planning depends on one’s past experience, present job, value system, type of organisation in which one is involved, and so on. For example, a community development

worker's understanding of strategic planning may differ from that of a business person. However, there are certain events, elements and processes that are common to most strategic planning contexts.

Definition of strategic planning

Strategic planning is the process by which an organisation establishes its purpose and objectives, formulates actions designed to achieve these objectives in the desired time frame, and establishes monitoring and evaluation mechanisms to assess progress and results.

Strategic planning is characterised by the following:

- It is long-term planning (three to five years) usually with an extended time frame and often spanning more than five years in reality.
- Strategic plans focus on the entire organisation's resources.
- Strategic plans look at reconciling the organisation's resources with threats and opportunities in the external environment.
- Strategic plans take synergy into consideration.
- Strategic planning is about being proactive, flexible, responsive and agile.
- Emphasis is placed on aligning and reconfiguring an organisation continuously, based on external and internal forces.
- Strategic planning is not about crisis management and reactivity.

When strategic planning is effective, it leads to the achievement of strategic objectives within the allocated time, budget, defined quality and performance standards. Some strategic plans succeed while others fail. The reasons for the success and failure of a strategic plan are complex and depend on the nature and context of the organisation.

The main phases and steps of the strategic management cycle are as follows:

- Consultation process
 - Pre-planning
 - Stakeholder management
- Planning
 - Purpose, vision, mission development
 - Analysis of internal environment
 - Analysis of external environment
 - Formulation of strategic issues, goals, objectives and action plans
- Implementation and monitoring
- Evaluation and review
- Analysis of needs, interests and power base
- Deciding on a tactic to involve followers constructively

Activity 8.4: Organisational structure (Textbook page 96)

Max Weber and organisation

Max Weber was a German scientist and is generally referred to as the father of organisational theory and bureaucracy (Marquis & Huston 2006: 270). During the early nineteenth hundreds, Weber stated that organisations have the following characteristics:

- A clear division of labour with all work divided into units that can be undertaken by individuals
- A well-defined hierarchy of authority in which supervisors are separated from subordinates
- Impersonal rules and relationships where supervisors provide control over subordinates
- A system of procedures for dealing with work-related matters
- A system of rules covering the rights and duties of each position
- Selection of employees and promotion based on technical competence

Since Weber did his analysis, nearly a hundred years ago, management has learnt much about behaviour, and organisations have modernised their structures and made the working environment more personal and relationships more humane.

It is usually a pleasure to work in a well-organised organisation or health care unit. Organisation also refers to the orderly structure and division of tasks and responsibilities for the smooth running of the service and units. The organisation in a unit is divided into four elements, namely specialisation, standardisation, coordination and authority.

Activity 8.5: Delegation (Textbook page 97)

Gofer and stewardship delegation

Gofer delegation essentially entails telling someone to “go for this, go for that, do this, do that, no don’t do that, do it before then” (Covey 1994: 173). The leader or manager expects the work to be produced exactly as instructed. When the person does not produce the delegated work as expected, mental models about the person being incompetent or not trustworthy enough are entrenched even further.

Stewardship delegation focuses on results instead of methods. People choose the method that will elicit the desired result. In this way, the person is placed in a position of responsibility and trust. Stewardship delegation will take more time in the beginning. It involves clear, mutual understanding of what needs to be accomplished and focuses on what, not on how, on results, not on methods. Stewardship delegation demands time and patience on the part of the supervisor. The supervisee needs to see the desired results. Stewardship delegation involves five processes between the supervisor and the supervisee.

1. Desired results involve a clear and mutual understanding of what needs to be achieved (and as stated above not of the how). The supervisee will have to devise her or his own method to ensure that the desired results are achieved. The supervisor needs to ensure that both parties are operating in harmony by asking the supervisee to explain and describe how she or he sees the desired outcome, proposing realistic periods and keeping a record of the discussion.
2. The parameters or framework in which the supervisee should operate need to be identified. These should not be too restrictive, so that the supervisee can explore his or her own methods of achieving the desired output. If the supervisor knows the failure paths of the job, they should be identified so that other supervisees are made alerted to them and the risk of failure is minimised.
3. The human, financial, technical and/or organisational resources required to ensure that the supervisee achieves the desired results must be identified.
4. Supervisees need to be made accountable by establishing the standards of performance that will be used to evaluate the results and specify when the reporting and evaluation should occur.
5. The consequences should be spelt out. Supervisees need to know what the outcomes of the evaluation will be – both positive and negative, such as financial rewards, promotion, further projects or disciplinary action (Covey 1994: 171–179).

Activity 8.6: Performance management (Textbook page 106)

There are a number of different approaches to performance management. Some of these are discussed below.

- Performance management as an individual assessment tool is the most common approach. Using different rating scales, an individual is assessed against generic criteria. These criteria rarely measure results and more commonly focus on behaviour and attitude. In that context, performance management amounts to an occasional meeting between a supervisor and an employee.
- Performance management as a development tool has the primary objective of determining an individual's development needs and mapping out a plan to address those needs. The focus is on the development of competencies. This approach does not necessarily make a link between pay (guaranteed and variable) and performance.
- Organisational performance management refers to the process of strategic planning and control. It helps to translate strategic direction into operational plans and objectives for each department. These are then cascaded down the organisation, to sections, teams and, ultimately, the individual.
- Individual performance management translates organisational objectives and plans into individual performance plans. Actual performance is discussed and reviewed, and individuals are rewarded appropriately for their achievements.

Integrated view of performance management

Government legislation and regulations clearly demand an integration of all these approaches. Part of the mandate arises from the new Finance Management Act, which requires that the employment contract of an accounting officer

for a department, trading entity or constitutional institution must be in writing and, where possible, should include performance standards. Integrating performance management demands bringing together the following management disciplines.

Strategic management is about setting goals and objectives, then tracing and influencing their progress. Performance management from this point of view is mainly concerned with how well the organisation and its various units function.

The primary interest of performance management from the human resource perspective is to establish how well individuals work, and to develop and reward them accordingly. In this discipline, performance management is commonly known as performance appraisal.

In quality management, production and service standards are constantly measured against set targets. If there is a deviation, corrective action will be initiated. Teams play an important role in problem solving. Performance management in this context concentrates on the assessment of quality, customer satisfaction, team and organisational performance.

The focus of financial management in the public sector is moving away from knowing how the money is being spent to knowing how to spend the money so that it has the greatest impact. This requires information that shows the results of expenditures. Tracing these results can only be done if the appropriate performance management systems are in place.

A greater integration of all these management functions affects every aspect of an organisation. All elements of the organisation should be aligned to make sure that they support each other:

Information systems need to keep records of the progress with all the major goals and indicators related to the performance of individuals, groups or organisational units. Ideally, they should be able to link human, financial, service delivery and strategic information. These systems should also be able to produce reports that are timely and user friendly. The current information systems are ill-suited to support the management of performance. Therefore, any performance system introduced now should be simple and should not depend on complicated technological solutions.

Processes, policies and procedures must be aligned. This means the work must be organised in such a way that the integration of this function can actually take place. For example, strategic planning must be linked to financial planning to make sure that the organisation does not set goals that it cannot fund. It also means that there are clear guidelines and timetables to make certain that the new appraisal systems are actually implemented.

To perform effectively requires appropriate skills. The design of training programmes should therefore be informed by the needs identified during performance appraisals. Performance management in itself requires certain skills to

carry out tasks such as the counselling of an employee. Training therefore needs to be part of a programme of rolling out a new performance management system.

Performance-driven organisations have a culture of excellence. Everyone strives to achieve his or her best. In order for performance management to function effectively a culture of openness and learning is required. People are free to give and receive feedback and then seek to correct themselves.

Performance management makes sense when it becomes part of everyday decision making. Are we pursuing the goals that we have set ourselves? Where are potential obstructions to their achievement? How can we overcome them? Unfortunately performance management is often seen as a cumbersome bureaucratic exercise that needs to be endured once a year, rather than as an integral part of strategic leadership.

The design of a performance management system depends on the structure of the organisation. For example, an organisation that encourages decentralisation requires the setting and local monitoring of the performance goals. Processes need to be put in place to allocate goals to each structural unit and, likewise, reporting mechanisms that consolidate the achievement of each unit.

Strategic planning is a prerequisite for performance management. Before we can measure how far we have travelled, we need to determine where we want to go, whether it is worthwhile and whether we have the necessary resources. Once realistic strategic plans have been developed, one can then develop indicators that reflect those plans. Performance management should be viewed as an instrument for translating an abstract mission and strategy into specific measures and goals.

A major goal of the government's transformation strategy has been to improve the quality of service delivery. Improving quality is a continuous process that involves assessing the current standards of service delivery, raising the bar higher, implementing initiatives that promise enhancements and reviewing how far the set standards have been achieved – only to start again to raise the standards even higher. Quality management, like performance management, inherently involves the setting of goals and the appraisal of how they have been achieved. Performance management does not only set standards, but also defines who is in what way responsible for their achievement. By assigning personal accountability, linking it to rewards and support, government departments can ensure that better quality service is not an elusive ideal.

Performance management seems to be a fairly straightforward process: agreeing on each person's responsibilities, determining the extent to which they have been achieved by evaluating the indicators, and rewarding or disciplining people depending on their performance. On the other hand, the practical experience in many organisations, including the South African public service, has proven that performance management is not as easy as it appears.

Implementing performance management

Despite the problems, the existence of a good performance management system can be of great value to an organisation. This section gives clear guidelines on how to develop such a system. In contrast, the Performance Management and Development Guide of the Department of Public Service and Administration stresses the unique situation of each government department and therefore avoids being prescriptive.

Of course, every organisation is somewhat different. Every organisation is located in a particular context and may have some unique goals. However, all the reviews of the South African public sector have highlighted the same critical issues, irrespective of where the departments are located or what they are mandated to do? Therefore, we can conclude that the fundamentals of developing a performance management system in the public sector are the same. This section therefore gives detailed guidelines.

The most important aspect of implementing any organisational change is a sense of urgency. Trying to develop a performance system that pre-empts all possible shortcomings will probably only overwhelm those charged with developing it, and its implementation may never get off the ground. Having no performance management system is worse than having a faulty one, because it deprives the organisation of the opportunity to learn. It must be realised that the implementation of any performance management system is plagued by problems, because human behaviour is difficult to predict. The challenge here is to move forward and improve the system as the organisation learns from its mistakes

Performance management implementation

A performance management system can be implemented in five phases, namely initiating the process, designing suitable forms and procedures, rolling out and implementing (applying), training supervisors regarding the process, and improving as you go along.

- Initiating is the first phase and is concerned with securing the necessary commitment from stakeholders, putting into place the project mechanisms that will be needed for the implementation, and building a common understanding of the approach.
- Designing the system is the second phase. All the elements that are needed for the operation of a performance system are developed. This includes policies, processes, forms and integration with other organisational systems that need to be linked.
- The roll-out phase takes place when the system is ready to be introduced to the organisation at large. This includes training and communication.
- Applying or implementing is the phase in which the system comes into use. Regular performance reviews and appraisals take place.
- Improvement is ongoing. Specific improvements are also made to resolve any problems that may be experienced and to make changes that will enhance the system.

Balanced Scorecard approach

This approach is a strategic performance management tool for measuring whether small scale operational activities of an institution are aligned with the vision and strategy of the institution. The dimensions are called value drivers and include aspects such as client or community needs, capacity needs, operational needs and financial drivers (budget). The planning process should answer some of the following questions.

Customer value drivers. The questions to ask here are: Whom do we serve? Who are our customers? What are the needs of the public and the communities? What service standards have we set ourselves? What service improvement initiatives (Batho Pele) will we undertake?

Capacity value drivers. Do we have adequate capacity? What shortcomings exist? How can we overcome them? What learning needs to take place? What people's issues are we facing? How do the different regulations affect us (e.g. the Skills Development Act, the Employment Equity Act and the new Public Service Regulations)? In the light of the available skills, are our plans realistic?

Operational value drivers. How can we improve our efficiency? Could we organise our workflows (processes) more effectively? Could we work smarter? Could we possibly eliminate non-productive functions or services altogether? What systems do we need to put in place?

Financial value drivers. Do we have the necessary financial means? Where do we use them best? How could we achieve savings? Huge sums are lost because of wastage or poor financial management: how could we generate more income? Typically, government assumes that most of its funding should come from the budget allocation because it has no ability to generate fees. This is, however, a faulty assumption. Large amounts of money are lost in hospitals, for example, due to poor debt collection or not charging fees at all.

One does not, however, set goals in isolation. These perspectives are all closely interrelated and need to be aligned with one another. Improvement in one area can't be achieved without changes in the others. The ultimate purpose of the public service is to meet the needs of the nation, its communities and citizens. We start therefore from the customer perspective. However, to achieve these goals requires sufficiently skilled people (capacity perspective). These people will, however, only succeed if the work is properly organised and the necessary systems are in place (operational perspective). For all of that, sufficient financial resources are necessary (financial perspective).

For example, the Department of Health has set itself the goal of reducing waiting time in response to customer complaints. Starting out at the top of the organisation, goals are developed taking into consideration each one of the perspectives.

The Price Model

PINPOINT

Pinpoint the value drivers (functional roles and behavioural roles)

Set up the improvement/development plan

	Career planning
RECORD	Record and diagnose current performance levels Compile “ticklist” of factors affecting the performance of the individual
INVOLVE	Involve direct reporting by agreeing on the performance
COACH/COUNSEL	Coach/counsel and set objectives (proactive behaviour)
CONDUCT THE INTERVIEW	Direct and influence behaviour and state the expectations of the individual Involve, understand, inspire, envision and obtain buy-in Set objectives, discuss, review and set up a developmental plan; follow up!
EVALUATE	Evaluate performance of supervisee Give feedback and follow up Reinforce improvements, counsel on lack of improvement

Chapter 9: Legislation and policy frameworks in planning a health care unit

Nobesuthu Effie Sokhela, Nomathemba Faith Nonkelela, Rose Valencia Noxolo Sikuza and Buyiswa Monica Sitole

Activity 9.1: Terminology and critical nursing policy issues (Textbook page 110)

Ansie Minnaar

Terminology

Health care policy is formulated and implemented at six levels. It is initially formulated at the legislative level, then it goes to the national health level, thereafter to the provincial level, which sends it to the health services organisational level and from there it goes to departmental level, after which it reaches you at unit level. The government's policy is promulgated in the form of acts of parliament by means of a democratic process. Policies direct individual behaviour towards the goals, vision, mission and philosophy of a service. Health policy creates the context for nurses and other health professionals to practise quality client care. Therefore nurses and others need health care policies to guide their practice.

Policies and procedures are a means of accomplishing the goals and objectives set by government and strategically by the organisation in which a health care worker is employed. Policies explain goals and procedure manuals guide our actions in health care delivery.

There is often confusion about the *differences* between a policy, a programme and a project.

- Policy in its most general definition is a set of guidelines for meeting certain goals.
- Programmes are regarded as a structured process for meeting those goals. Programmes consist of a portfolio of projects.
- Projects are a more specific way of meeting the goals of a programme and, ultimately therefore, the goals of a policy.

Nursing policy issues

Practical examples of how nursing policy issues may be addressed in nursing practice are as follows:

- Weak governance
- Disjuncture between discourse and practice
- Policy frameworks and strategies not translated into action
- Generic frameworks used rather than practical plans
- Developed policies not implemented
- Very slow policy processes
- Required regulations not enacted

- Good policies undermined by poor implementation process
- Policies do not have the intended impact
- Inadequate attention to policy and planning systems
- Poor coordination between related policy sub-systems
- Lack of collective governance and leadership of sector
- Disempowerment at all levels
- Alienation of frontline nurses from nursing policy processes
- Caring discourse does not reflect current reality of frontline care
- Significant changes in current nursing practice – but by default rather than intention
- Inadequate preparation for nursing practice in the real world
- Preoccupation with traditional concerns rather than contemporary challenges (Blaauw 2008)

Activity 9.2: The use of supplies and equipment (Textbook page 115)

Particular emphasis should be placed on the following;

- Safety – ensuring equipment is used safely and, when not in clinical use, stored in a safe condition
- Security – ensuring that equipment is secure at all times
- Information – ensuring that the equipment inventory associated with the unit is accurate
- Maintenance – following and overseeing the maintenance schedules
- Contingency planning – developing an appropriate contingency plan in case of equipment failure
- Record keeping – maintaining a log book for larger items of equipment and ensuring proper records are kept for other items; maintaining of a database of all equipment and its maintenance; reporting problems with usage in such a way that all relevant parties are able to learn from them
- Hygiene – ensuring that equipment in the unit is clean and decontaminated as far as practicable before it is stored or leaves the unit; following proper procedures when equipment is decommissioned
- Suitability – ensuring that equipment and supplies are suitable for their intended purpose
- Disposal – following correct disposal procedure, whatever the value of the asset, to maintain health and safety

Activity 9.3: Meetings (Textbook page 116)

Terminology used in connection with meetings

Amendment	alteration, change
Adjournment	postponement
Agenda	things to be done or discussed
Ad hoc	arranged for a special purpose

Addendum	an appendix
Apology	formal notification of inability to attend meeting
Chairperson	the person who presides at a meeting
Co-opt	elect by votes of existing members
Ex officio	a member by virtue of position
Mandate	instruction given by members
Minutes	record of meeting proceedings
Motion	a proposal moved at a meeting
Precedent	a parallel case in the past which would tend to allow similar action in future
Point of order	an appeal to the chairperson for his or her ruling on a matter concerning the conduct of a meeting; a member who breaks the formal rules of a meeting is called to order by the members
Quorum	minimum number of members present to make the meeting valid (50% + 1)
Resolution	a formal decision taken at a meeting

Preparing for a meeting

Adequate preparation for any meeting is essential to the effectiveness of a meeting and ensures the appropriate use of resources and time management (i.e. consider its cost to the organisation).

Preparation by the chairperson

The chairperson needs to be clear about the purpose of the meeting, who has to be invited and the appropriate time for holding it. A meeting where complex decisions will be taken should be held in the morning rather than in the afternoon, since participants are likely to be more active early in the day. Give necessary background information and support data relating to the agenda topics.

Preparation of the agenda

The agenda is the blueprint of any meeting. It must clearly indicate the purpose of the meeting and all the topics to be covered. Agenda items must be organised in order of priority under headings and subheadings. Items that need more mental energy, creativity and clear thinking should be placed high on the agenda. The agenda should be neither too long nor too brief. Too long an agenda has a negative psychological effect on participants.

Preparation of the venue

The physical environment should be organised well in advance. The venue should be quiet, with a reasonable temperature, good lighting and ventilation and comfortable seating. Conference tables are usually appropriate so that participants are in full view of each other. Additional equipment such as microphones or projectors should be checked to make sure it is working properly and that the chairperson is able to use it. How people are seated has an impact on the meeting proceedings.

Preparation of participants

The notice of the meeting and the agenda should be circulated to all participants before the meeting. Minutes of the previous meeting should be circulated together with any relevant material to be used during the meeting. Members are requested well in advance if they are required to bring additional material or information to the meeting so that they have enough time to prepare. If a specialist is to be invited, or a specific topic discussed, the role of such a person and the time he or she will be allowed must be made clear.

Managing time and ensuring cost-effectiveness

Various time management strategies should be used before and during the meeting. The duration of the meeting should be estimated, taking into account that both the chairperson and the participants have other commitments. The meeting should start on time, and the chairperson should use various facilitation strategies and be able to deal with different personality types.

The meeting structure

Opening the meeting. The person who calls the meeting should have the authority to do so. Members should arrive at the venue before the scheduled time. If the chairperson (facilitator) has not taken the chair 15 minutes after the meeting was due to begin, the meeting should elect another chairperson from among the members present to act temporarily. The meeting begins after the chairperson declares a quorum and the meeting is opened. The quorum is 50% + 1. If a quorum cannot be declared within 30 minutes of the designated starting time, the meeting should be rescheduled.

The chairperson opens the meeting with a few general remarks, introduces and welcomes all members. Rules of the meeting and time frames are set. The meeting is conducted according to the agenda. If members do not have copies of the agenda, the secretary reads it aloud and it is adopted by the members.

Apologies. The names of those unable to attend the meeting are read. Such persons must have followed the correct procedure of tendering apologies for their apology to be accepted and they will be bound by the resolutions of the meeting.

Presentation of minutes. Minutes of the previous meeting are read by the secretary and the chairperson asks members to adopt the minutes. If members disagree on their accuracy, changes may be suggested and corrections made. If there are a few minor corrections, the chairperson may ask members to accept the minutes with the corrections. Once the minutes are adopted, the chairperson signs them and hands them to the secretary for filing.

Business or matters arising from the previous meeting. These are usually listed on the agenda. Any reports, pieces of information or other matters of substance that were requested at the previous meeting are debated and resolutions taken on the appropriate action.

Correspondence. Any letters, facsimiles and the like which have been sent to the meeting are tabled and debated if the meeting wishes to do so. Correspondence which covers similar issues may be summarised and discussed as a single issue. The chairperson presents the correspondence to the meeting by putting a motion that the meeting “receives the correspondence”. This is an acknowledgement by the meeting that the correspondence has been formally received and that it may be discussed and acted upon if necessary.

Reports. Reports and submissions that are prepared for the meeting are tabled and discussed. A motion is required for a report to be received. Motions may be put for or against the recommendations of the report.

General business. Items listed on the agenda are announced singly by the chairperson, followed by a discussion or debate. The debate usually begins with the chairperson calling on someone to move a motion. A seconder is someone who agrees that a motion should be debated. This is typical of formal meetings. Once a motion receives a majority of votes, it becomes a resolution. If the chairperson has a motion or an item to present, she or he vacates the chair and somebody else takes over the chair for that specific period of time.

Any other competent business. When all items on the agenda have been debated, the chairperson may call for items not listed on the agenda. If an urgent matter is to be discussed, the chairperson should be informed before the meeting and a revised agenda drawn up. No extremely important or complex issues should be raised unannounced at this point. For complex or troublesome issues, the chairperson may call for another meeting or place them on the agenda for the next scheduled meeting.

Closure of the meeting. The chairperson should summarise the discussions and evaluate the process of the meeting. Participation and contribution of members should be acknowledged. The date and time of the next meeting is announced. After closure has been proposed and seconded, the chairperson declares the meeting officially closed.

Facilitating participation in a meeting

Participation is the soul of a successful meeting. A meeting that works is characterised by participants’ freedom to express their thoughts without fear of ridicule or intimidation. To be an active and effective member of any meeting one should (1) be well prepared, (2) be aware of the topics for discussion (i.e. the agenda), (3) be involved, (4) be a good listener, and (5) approach the meeting with a positive attitude.

The quality of interaction in a meeting is greatly influenced by its chairperson. Whether or not one succeeds depends on two factors: the meeting environment and getting the most from participants. Therefore, the chairperson has to create an atmosphere conducive to participation by doing the following:

- Displaying open-mindedness. Preconceptions and assumptions must be left behind.
- Starting on a positive note. A smile and a greeting don’t cost a cent. Non-verbal communication and an appropriate dress code impact on the members.

- Recognising individual expertise and talent and giving credit where it is due. Give members a chance to share expert knowledge. When members are not given the credit due to them they feel disheartened, particularly the junior members of the profession.
- Respecting the differences among members. Remember that people have different personalities, some are loud and others quiet, some are not easy to work with; but accept them and encourage their participation.
- Accepting the challenge of others. Level-headed managers accept criticism of their ideas, as long as the criticism is directed at actions or opinions rather than at the person.
- Responding to non-verbal cues. Members' facial expressions will indicate when there is dissatisfaction or when people are exhausted. Always keep eye contact. Even those who appear to be wall flowers may be willing to say something, so respond to signals.
- Being sincere. A good chairperson should display impartiality, firmness, tact, common sense, courtesy, transparency, patience and tolerance. These are the attributes that will help her or him to remain focused on the purpose of the meeting. A chairperson needs to be a good observer and should not lose control of the situation.
- Striving to get the most from participants. Know the rules of debate including those of the organisation and ask relevant questions.
- Allowing one speaker at a time and avoiding interruptions. There are some exceptions to the latter, for example when the discussion loses its focus, or when there is intimidation, ridicule or any unprofessional behaviour.
- Being time conscious. Try to work within the scheduled time. The time spent in a meeting must be balanced against the cost and real productivity.
- Being able to deal with conflict. Sometimes there may be "reasonable" conflict, so it is important to understand group dynamics.
- Making decisions based on the principle rather than on personality. Avoid bias. Communicate with members of the meeting. Summarise the proceedings as you go and insist on conclusions and action. Speak clearly for the sake of the secretary.
- Remember that any healthy process has its don'ts. Avoid (1) dominating the discussion, (2) embarrassing yourself or others, (3) losing your temper, (4) being personal, (5) interrupting, (6) being rushed, (7) losing control, and (8) conflict.

The effectiveness of a meeting will be determined by the achievement of its purpose through the active participation of its members. The above strategies are not exhaustive but may be used as guidelines when conducting meetings. The chairperson or manager should also use her or his communication skills and creativity.

Chapter 10: The planning process in a health care unit

Eleonora Anchen du Rand

Activity 10.1: Beliefs and values (Textbook page 119)

Personal values

Value judgements play a part in a person's decision making, consciously or subconsciously. Understanding our own beliefs and feelings helps us understand the decisions that we take. McNally (in Marquis and Huston 2006: 153) describes a "true value" as having four characteristics:

1. It was freely chosen from a set of alternatives after reflection on the alternatives.
2. It is prized and cherished.
3. It is consciously and consistently repeated.
4. It is positively affirmed and carried out.

If it does not meet all four criteria, it is not a true value, only a "value indicator". In explaining this, Marquis and Huston (2006: 153) give the example of nurses who state that they value their national nursing organisation, but then fail to pay the membership fees or participate in the activities of the organisation. This is then a value indicator and not a true value.

Values may change over time, when experience or new knowledge is gained. Let's take beliefs regarding the termination of pregnancy (TOP) as an example. A nurse may at one stage have believed that it was immoral to terminate a pregnancy, but may later decide that it is acceptable.

- Evaluate your list of basic beliefs about nursing as being true values or value indicators.
- If they are true values, then you would probably choose nursing as your career again.

Activity 10.2: Plans (Textbook page 120)

Complete the following table:

Item	Present situation
1 Relationship with family 2 Relationship with friends 3 Use of spare time 4 Hobbies 5 My career	

For each of the items listed above, complete the following table:

Item	Goals for next year	Objectives for the goals	Action plans
------	---------------------	--------------------------	--------------

1			
2			
3			
4			
5			

Activity 10.3: Progress with plans (Textbook page 122)

Evaluate each objective according to the **K I S S** and **S M A R T** criteria.

Activity 10.4: Addressing job dissatisfaction in a health care unit (Textbook page 126)

Researcher	Year	>70% Satisfaction	>80% Dissatisfaction
A Provincial hospital	2003	Working hours	Workload Communication Salary Acknowledgement Professional development
B Private hospital	2004	Professional development Leadership Communication Participation	Workload
C Day hospital	2004	Communication	Salary Workload Safety Professional development Leadership
D Clinic	2005	Safety Acknowledgement Autonomy Professional development Communication Safety	

Activity 10.5: Job satisfaction (Textbook page 127)

Characteristics	Research findings	
	Yes	No
Participatory decision making Communication with staff Effective use of resources Opportunities for professional development Autonomy and responsibility Strong leaders High quality care Community involvement A high level of general satisfaction		

Do you have any practical suggestions to make that could align job satisfaction with the above characteristics?

General questions (Textbook page 128)

Question 4 Case study

Having to go and assist in another unit is often a problem in practice, and those who are sent to assist usually say that as soon as they arrive the staff of that unit then “rest”, and they have to do all the work.

Sister Knight, the unit manager, should consider the following aspects.

- Is there a policy available on “floating”, and if so, what does it say?
- The specific needs of the medical unit should be identified:
 - Are there specific days on which there is a shortage?
 - Are there specific shifts for which there is a shortage?
 - Is there a shortage of specific categories of nurses, and when?
- Based on the above, she should inform her staff of these needs.
- She should also identify which of her staff are available, according to her duty roster, for the needs identified.
- They should then be allocated on a rotational basis.

The allocation in future of more staff to the medical unit, and possibly fewer to the isolation unit, should then become the responsibility of the person responsible for the change list, who should be informed of this by the area supervisor.

Do you have any other suggestions?

Chapter 12: Change and project management

Lunic Base Khoza

Activity 12.1: Emotional phases (Textbook page 141)

An outline of the literature; and the ten emotional phases of the change process described by Marquis and Huston (1992: 72).

Resistance to change

Change imposed by others feels threatening rather than exciting. The removal of choice leads to a sense of powerlessness resulting in stress and defensive behaviour. People are open to change and they continually change themselves. If change comes from within, it feels good; if it is imposed from outside it can feel like a threat, because it is unknown. It should be no surprise that health professionals are defensive when threatened. Indeed, it is irresponsible not to defend oneself against a threat. Managers in a health care unit should note that communicating as much information as possible about proposed changes helps to alleviate these feelings. People need to be given the chance to react and voice their mixed feelings about change; and the change process should respect the autonomy of the different kinds of experience brought by the group (Marquis & Huston 1992: 71; Smit et al. 2007: 221–222). Marquis and Huston (1992) further state that the level of resistance depends on the type of change proposed. It is generally perceived that technological changes encounter less resistance than changes that are social or that are contrary to established customs and norms because these threaten individual self-esteem and the sense of security within the group.

Marquis and Huston's ten emotional phases

These phases should form the basis of any change intervention discussions in a health care unit.

1. *Equilibrium*. This phase is characterised by high energy and emotional and intellectual balance. Critical thinking is applied and issues are closely interrogated. Personal and professional goals are synchronised. As the change becomes more and more complex in nature, individuals start to experience disillusionment.
2. *Denial*. Individuals deny the reality of the change. Negative changes occur in physical, cognitive and emotional functioning.
3. *Anger*. Energy is manifested in rage, envy and resentment. “Why the need for change? Those who want change should go for it. Who bothers anyway?”
4. *Bargaining*. In an attempt to eliminate change, energy is expended on bargaining. “I agree that there is a need for change in the future – but not now. Our positions will be affected; the change in social norms will affect my self-esteem.”
5. *Chaos*. This phase is characterised by diffused energy, feelings of powerlessness, insecurity and loss of identity. “Change is not meant for people like us. I will just wait and see what the new strategy brings in.”

6. *Depression.* Defence mechanisms are no longer operable. No energy is left to produce results. Self-pity sets in. “Let others take charge. I have ulcers; and headaches. Wish I wasn’t working in this unit.”
7. *Resignation.* Change is accepted passively but without enthusiasm. “I’ll just try to participate in the process, but it seems the strategy won’t work in this unit.”
8. *Openness.* Some renewal of energy is seen in implementing new roles that have resulted from the change. “If it wasn’t for this team nothing would have been achieved. Thanks to them, we can now see some light at the end of the tunnel. It is a reality.”
9. *Readiness.* There is a willing expenditure of energy on exploring new events. “I feel the mental readiness and I am physically fit to move with change.”
10. *Re-emergence.* The individual once again feels empowered and begins initiating projects and ideas. “I think we need to work as a team and respect one another in the project. We are all change agents, and working together will always bring success.”

Activity 12.2: Commitment to change (Textbook page 142)

Questions to ask in order to identify ways of gaining a commitment to change.

- What personal benefit do you gain as change agent?
- What is the view of your leaders of the work groups involved in change?
- What fresh, objective information is available about the need for change?
- To what extent are facts pertinent to the change process generated from within the work groups?
- To what degree can those involved in the change influence the change process?
- How attractive is the work group to its members?
- Does the change process involve bringing individuals from different groups together, off the job, in temporary groups?
- How open are the communication channels relating to the need for, plans for and consequences of change?

In the change process, taking into account the needs, attitudes and beliefs of individual health care professionals and workers will increase the level of their active participation. Individuals will feel part of a change process that respects their own decisions. Full participation by all the members of the affected work groups is likely to be the most effective approach. In order to mobilise change in others, leaders need to be personally open to change themselves. Managers should be seen moving around, when appropriate, like all other staff. They should use symbols and language to manage the meaning of change and create the energy for change. Close relationships with staff members promote concern for their development. It needs to be noted that diagnostic data that has been identified, gathered, analysed and interpreted by the groups involved in change are more likely to be understood and accepted than data presented by outside experts (Mabey et al. 2000: 442–443).

When change is being proposed, group cohesiveness becomes high if the group satisfies the needs of its members, and this operates to reduce resistance to change if the group sees the changes as beneficial. This is because strong group

membership tends to lead to greater individual conformity to group norms. Change programmes that involve individuals within the context of their immediate job situations are likely to be more successful because this group has more psychological meaning to an individual than does a group with only temporary membership (Mabey et al. 2000: 442–443). Lastly, it needs to be observed that change processes that provide specific knowledge on the progress to date, specify the criteria against which improvement is to be measured and continuously sustain the group's momentum are most successful in establishing and maintaining change.

Activity 12.3: Learning organisations (Textbook page 144)

Learning organisations

(The following has been adapted from Lles & Sutherland 2001: 63–64; Mabey et al. 2000: 310–320; Davies & Nutley 2000: 998–1001.)

Learning organisations have the following characteristics:

- | | |
|--------------------------|--|
| Structure | <ul style="list-style-type: none"> – Managerial hierarchies are flat and enhance opportunities for employee involvement. – Members are empowered to make decisions. – Structures support teamwork. – There are both internal and external networks, such as project teams. – There is a strategy for information sharing and opening up to information necessary for organisational learning. – Members have a high level of trust in each other. – There is sufficient discipline and cohesion among members to implement decisions upon which they have agreed. – The organisation has the capacity to discuss and understand both long and short-term issues. – Interpersonal relationships are good and there is an understanding of each other's values. |
| Information systems | <ul style="list-style-type: none"> – Learning organisations require information beyond that which is used in traditional organisations. – Sophisticated information systems are required for transformational change. |
| Human resource practices | <ul style="list-style-type: none"> – Learning organisations focus on provision and support of individual learning. – Appraisal and reward systems are concerned with measuring long-term performance. – The acquisition and sharing of new skills and knowledge is promoted. – The development of the individual is stressed, since everyone brings a range of experience, knowledge and emotional investment to the learning. |

- Members bring to their learning expectations about the way in which learning occurs and about their learning capabilities.
 - The pace and direction of learning and change may vary from individual to individual, but all are actively engaged in a dynamic process of change.
 - Devaluing or ignoring what members bring to their learning undermines and rejects their whole identity.
 - It is acknowledged that members come from a complete social environment. They bring their learning demands and needs influenced by parents, community, friends as well as working colleagues. Learning should consider this background.
 - Members tend to have preferred learning styles.
- Organisational culture
- Organisations, just like health care units, are composed of people (staff), products (clients), facilities, strategies, processes, procedures and technological innovations.
 - Every organisation has its own personality, which is called the corporate culture.
 - Learning organisations have strong cultures that promote openness, creativity and experimentation among members.
 - Members are encouraged to acquire, process and share information.
 - Innovation is nurtured and the freedom to try new things is provided.
 - There is a willingness to risk failure and learn from mistakes.
 - Cultures are significant because they define and encourage established skills, habits, taken-for-granted ways of thinking and behaving.
 - Cultural factors are questioned: What kinds of factors are operating that militate against change? What beliefs, habits, actions are perceived as good and what are seen as unacceptable? How is learning achieved, and problems solved, reviewed and reported?
- Leadership
- Organisational learning depends heavily on effective leadership.
 - Leaders model the openness, risk taking and reflection necessary for learning.
 - They communicate a compelling vision of the learning organisation.
 - Empathy, support and personal advocacy are needed to lead others towards the learning organisation.
 - Leaders are approachable and willing to receive feedback and criticism, implying the ability to give and receive feedback in an impersonal and objective manner.
 - They discuss issues openly without arousing undue sensitivity or tension.
 - They provide a safe environment for the risk and openness required for reflective practice.
 - They define their own roles and responsibilities, rather than being essentially isolated individuals. They are members of a professional community of co-learners.

- They recognise the positive value of the conflicts arising from multiple agendas and diverging perceptions.

Action research

Action research is a process that involves systematically collecting research data about an ongoing system relative to some objectives, needs or goal of that system; feeding these data back into the system; taking action by altering selected variables; and evaluating the results by collecting more data.

Action research is the foundation of many approaches to change. It involves a researcher working as a consultant with a group of participants. The principle is that if participants are engaged in understanding their situation more fully, they design actions that they themselves will take, which will move them towards the aim of their change programme (Lles & Sutherland 2001: 66).

Activity 12.4: Decision making (Textbook page 145)

The 5 Cs of decision making in project management

- | | |
|-------------|---|
| Consider | <ul style="list-style-type: none"> – Clarify the nature of the project. – Identify objectives. – Ask yourself and others what information is needed. – Clarify time and other constraints like human resources, finance and facilities. |
| Consult | <ul style="list-style-type: none"> – Gather the maximum amount of information needed. – Organise meetings and workshops of those involved in the change process. – Brainstorm issues of interest. |
| Crunch | <ul style="list-style-type: none"> – Review all the options and take a decision. – Write down your implementation plan. |
| Communicate | <ul style="list-style-type: none"> – Provide briefings on that will happen. – Tell people whom the decision affects and why. – Give back-up briefing with written conformation of the decision. – Make sure everyone understands when the decision will be implemented. |
| Check | <ul style="list-style-type: none"> – Check that the briefing is carried out. – Use spot checks to monitor effectiveness. – Review the impact of the decision and take any corrective action. |

Chapter 14: Organisation and coordination of a health care unit: teams and groups

Elizabeth Matseliso Yako and Karien Jooste

Activity 14.1: Teams and the management approach (Textbook page 160)

Many organisations are moving away from the traditional, rigid autocratic approach in dealing with employees and adopting a more humanistic approach. Harsh, rigid managers are being replaced with a new brand of managers who are more open, show genuine interest in the needs of employees and involve them in decision making (Muller et al. 2006: 205). This humanistic approach promotes trust among employees and management. The organisation is perceived positively, as a caring organisation. This boosts the morale of the employees and creates a desire among them to be identified with it.

For teams to succeed, their members need to develop a sense of conscientiousness, which is a broad and abstract term that includes “a feeling of competency, achievement striving, self-discipline and dutifulness” (Costa et al., in English et al. 2004: 646). Team members who are conscientious have been found to be creative, organised and more focused in their jobs. This conscientiousness among team members leads to higher team performance.

Activity 14.2: Teamwork (Textbook page 161)

Team effectiveness criteria are as follows:

- On effective teams, team members understand and agree on the team’s goals and objectives, and on what it is trying to accomplish. Ineffective teams usually lack commonly understood goals and objectives, and its members pull in different directions.
- In effective teams, trust is evident. Although conflict may not be absent or avoided, it is dealt with openly and worked out in a constructive manner.
- Effective teams share leadership roles among members. All members feel responsible for team leadership. Ineffective teams often have one person dominating.
- Team members’ resources are recognised and used fully in effective teams. Under-use of some members is one of the greatest sources of frustration for people stuck in ineffective work groups. For some people, not being used to their full potential is worse than being overworked.
- Effective teams pride themselves on open, participatory communication among members. Members generally know what is going on. Ineffective teams are often marked by guarded communication.
- Effective teams have procedures to guide team functioning and the members support these procedures and regulate themselves.
- Approaches to problem solving and decision making are well established for effective teams.

- Well-functioning teams often experiment with different ways of doing things and encourage creativity. Ineffective teams are often bureaucratic and rigid.
- Effective teams regularly evaluate their functions and processes.
- An effective team's members clearly understand their roles, responsibilities and degree of authority.

Activity 14.4: Groups and communication (Textbook page 162)

Why would you want to join a group?

There are several reasons why people join groups. The two main reasons why groups are formed in a health care organisation are as follows:

- Groups can provide a mechanism for the provision of quality care. In modern times, one client is taken care of by a number of specialists. These provide expert knowledge which would not be available with the services of one person.
- They may provide a forum where people can gain personal and professional growth through sharing of knowledge, exchange of ideas and critiquing situations.

Other reasons why groups should be established in an organisation include the following:

- People who belong to a powerful group develop a sense of power, elevated status and boosted self-esteem.
- Groups offer an opportunity for individuals to discuss and debate issues, which results in a better understanding of the organisation and other factors which affect the client.
- Groups promote interaction, professional linkages and social networks (Huber 2006: 566).

Aspects that need attention during group communication are group planning and group dynamics.

Group planning

Thorough planning should be done in respect of identifying the purpose of the group, selecting members and the venue and meeting times of the group. Aspects such as privacy, confidentiality, respect for members' time and preferences, language, and culture as well as the cognitive abilities of members should be taken into consideration.

Group dynamics and concepts

The group leader should have insight into and awareness of group dynamics. Group dynamics are the "powers" that change and form groups, and influence the effectiveness of the group.

- *Trust* is an important facet of group dynamics. It relates to the degree to which self-disclosure takes place and the level of risk taking in the group.
- Other factors that influence group dynamics are *group size*, *power structures*, *interaction patterns* and *group norms*.
- *Group atmosphere* also forms part of group dynamics. The atmosphere in a group could, for example, be tense, agitated, calm or excited. The group leader should not ignore the group atmosphere, but should rather

demonstrate respect and use it to achieve the purpose of the group. She or he might, for example, comment: “We all feel excited about the client’s improvement. Let’s talk about further treatment.”

- *Group cohesion* is the spirit of common purpose within the group. Group cohesion is created through clear, mutually defined objectives and trust.
- *Group roles* relate to group leadership. Each member may contribute to the group and be a “group leader” in different facets of the group. Members could, for example, serve as task leaders or take the lead in building relationships. Destructive roles include self-directed roles where the focus is on fulfilling only individual needs that might be irrelevant to the objectives of the group. The group leader should encourage group-centred attitudes.
- *Speech communities* exist when people share norms about how to use talk and what purpose it serves. The scientific jargon used by the multi-professional team is an example of such a community. This shared understanding of how and what to communicate should not impede communication with groups or members outside the speech community, for example when explaining conditions to clients.

Activity 14.5: Disadvantages of group decision making (Textbook page 164)

Premature decision. If the group members do not want to spend time on an item, they may reach a decision without discussing the problem sufficiently. Members who may not agree with the decision may accept it for fear of being perceived as wasting everyone’s time.

Domination by certain members of the group. Group members with strong personalities may be argumentative and dominating. This behaviour may discourage others from making contributions. The end result will not be a group decision, but a decision of a few individuals.

Disruptive conflicts among members. Conflicts may emerge in a group as a result of a difference of opinion, personality issues or clashes in values. When these conflicts erupt, they will drain some of the energy that could have been used to solve the problem (Huber 2006: 568).

Dissemination of information. The manager may give members information that might affect them as employees, for example about organisational changes, policies or guidelines on client care. Participants are given an opportunity to ask questions and the answers are provided. For example, the manager may provide the group with the latest national guidelines on infant feeding in the context of HIV/Aids. This is a disadvantage because this was not a group decision and it could ultimately affect work output.

Seeking opinions. The manager may request group members to give their opinions on various issues. The members give information on their perspective of the issues. This information is then fed to the decision-making body, which will use it to make the final decision. However, their suggestions are not necessarily implemented.

Problem solving. The group may be requested to engage in more complex issues. They have to go through the steps of problem solving which include identifying the real problem, brainstorming, generating alternative solutions and coming up with the best solutions. For example, the group may be requested to come up with a solution to the problem of absenteeism among professionals in a unit. However, the solution may not necessarily be taken into consideration by top management.

Talkative group members. There may be members in a group who are very talkative. Unless such people are controlled, they may dominate a discussion, wanting only their viewpoints to be heard. The manager needs to tactfully thank such a member for her or his contribution, but move on to ask somebody else to make a contribution.

Quiet group members. The manager should make a conscious effort to ask those who are quiet to contribute. The manager could direct a specific question to a quiet person. This could encourage such a person to open up and make a contribution.

Members who display negative attitudes or unacceptable behaviour. Some members may interrupt others in a discussion. This kind of behaviour should not be tolerated, as it will prevent people from making their contribution. The interrupter should be stopped and the other person should be given an opportunity to continue.

Example: Some members may squash any new idea, arguing that it will not work. These are the members who do not want to change, but want to keep the status quo. The manager should encourage further discussion of the matter. In the discussion she should assist the members to see the potential benefits of what is being introduced. Other members may engage in disruptive behaviour such as going in and out of the meeting, answering cell phones and having side conversations. The manager should control this kind of behaviour. Even before the discussion starts, ground rules should be set (Huber 2006: 577–8).

Encouragement of a clash of ideas

The manager should encourage members to express their own perspectives about an idea. Different ways of dealing with an issue or problem should be looked into. The manager should guard against clashes of personalities. Members should not personalise issues.

Activity 14.7: Global workforce diversity (Textbook page 165)

The six core dimensions of diversity are age, ethnicity, gender, physical attributes, race and sexual orientation. These core elements of diversity have a life-long impact on the behaviour and attitudes of health care professionals. Lack of understanding of cultural practices and patterns may result in cultural biases, stereotypes and prejudices that may lead to the loss of meaningful communication, and the loss of highly competent staff or potential leaders.

There are four personal characteristics that leaders must develop in order to lead multicultural organisations:

- A long-range vision that recognises and supports a diverse organisational community
- A broad knowledge of the primary and secondary dimensions of diversity and awareness
- Encouragement of feedback from their employees
- Mentoring and empowerment of diverse employees

A sensitive organisational culture acknowledges that people are different and appreciates those differences. People differ in terms of nature, time orientation, how they relate to nature, how they relate to people in authority, their use of interpersonal space, modes of thinking and preferred leadership style.

Activity 14.8: Conflict sources in diversity (Textbook page 166)

Managing diversity

Match the do's of diversity management in Column A with the opposite don'ts in Column B.

Column A	Column B
a. Ensure fairness b. Support diversity as an integral part of the organisation's philosophy c. Recognise diversity d. Value diversity e. Develop informal supports	1. Pretend everyone is alike 2. Seek only the quick easy solutions 3. Expect everyone to conform to the prevailing culture 4. Develop different standards of performance 5. Expect one workshop, guest speaker or training film to solve the problem

Feedback

a. 4; b. 5; c. 1; d. 3; e. 2

Activity 14.9: Transcultural communication (Textbook page 167)

The gender gap in leadership should be narrowed. There is no one strategy that spells out the solution, but the following ideas could be helpful in addressing this dilemma:

- Change perceptions
- Lure more women into leadership positions
- Break down gender segregation by occupation
- Use objective performance criteria
- Develop mentor programmes
- Communicate competences – women must develop communication skills if they want to emerge as organisational leaders and superiors must recognise that women possess these skills

There are, whoever, a number of issues that are obstacles to effective leadership by women.

General questions (Textbook page 167)

Question 4 Literature on group dynamics

Principles of group dynamics

Objectives of the group

Each small group should identify the objectives it would like to reach. These identified objectives will help the group to stay focused on what it wants to achieve and thus make it more productive.

Allocation of responsibilities

It is necessary to compile a plan or plans of action according to the objectives set by the team and the functions should be divided between the members, taking into account each one's strengths and weaknesses. The general principles of participative decision making are followed (see Chapter 12) to avoid a bureaucratic approach.

Structuring of the group

The objectives of the group play an important role when a group is being structured. Where possible, group members should have the option to choose a project that they would like to work on. A person who is allocated to a project against his or her will is bound to offer resistance. It is advisable to obtain the commitment of the members to such projects on a one-on-one basis in the group. Availability and willingness of group members are sometimes better than knowledge and skills. It is, however, also necessary to evaluate the knowledge and skills of group members according to the demands that will be made upon them and the objectives that have to be achieved.

Positioning of group members

It is important to avoid creating a perception or impression of seniority or authority in the group and therefore it is important to position the group members in such a way that a classroom atmosphere is avoided, for example by letting members sit in a circle. The positioning of the members may have a significant influence on their participation and functioning.

The promotion of group cohesion

Group members need to learn to trust each other. Mutual trust will contribute to group cohesion. Cooperation and interaction between the group members are uncomfortable initially and icebreakers are therefore necessary to create a more relaxed, positive atmosphere. An icebreaker gives each member the opportunity to share his or her ideas or experiences with the rest of the group. Icebreakers are also necessary to introduce group members to one another. Self-disclosure on aspects that relate to the objectives of the group is also essential.

Management of group members

Different people within the group (or health care unit) may have their own hidden agendas that may come to the fore as the group starts functioning. Various internal variables, such as ethnic group, generation, personality and previous life experience, may prompt people to take on different roles or stances in a group. These variables should be identified by the group leader and he or she should manage these dynamics within the group positively, to the benefit of the project or the achievement of the set objectives.

Applicable principles are as follows:

- Group members should determine and agree upon guidelines for communication within the group. Doing this will give each member an equal opportunity to make a contribution, will prevent personal or derogatory remarks and will encourage members to focus on the problem instead of the person.
- The group leader disciplines the members when the code of conduct is transgressed.
- The group leader should
 - make sure that each group member is given an opportunity to make contribution
 - manage the “silent person” by deliberately involving him or her
 - ask the dominant person to give the other members of the group an opportunity to speak
 - avoid eye contact with this person, for example when it is not her or his turn to speak
 - let the senior persons speak last
 - if a person seems to be acting in her or his own, personal interests, highlight the group objectives
 - focus the discussion on the group objectives if there are obstructive group members (the aggressor, the one who looks for sympathy, the show-off).
- The group member should
 - come to the group discussion prepared, if required
 - make a professional contribution by participating in the debate
 - be willing to take part in project functions that have to be carried out
 - show respect through appreciation, mutual acceptance and regard for the ideas, uniqueness, cultural differences and generational views of other group members
 - be sincere, honest and reliable, especially in terms of feedback to colleagues
 - be open-minded and willing to consider new ideas and suggestions put forward by other group members
 - also accept the suggestions and new ideas of other group members
 - always control his or her own feelings, emotions and reactions when he or she disagrees with other group members, especially when negative emotions are unleashed
 - realise that every contribution is important in order to reach the group objectives, and members should therefore be reliable and display dedication by working towards these objectives with perseverance despite setbacks (make every problem a challenge)
 - display friendliness, patience and tolerance towards other group members.

Group dynamics will always play a major role in the attainment of set objectives in a complex system such as the health system of South Africa. It is essential for a group leader to have knowledge about the members of a group so that each member may be utilised according to her or his personal skills and knowledge, thus allowing her or him to make a positive contribution in reaching the set objectives. Interacting with others is a dynamic process.

Chapter 15: Information and knowledge management

Karien Jooste

Introduction

The implementation of effective information systems leads to the fulfilment of institutional goals. The problem experienced in the health sector is that the transformation efforts of the public and private health sectors to build effective, efficient, attainable, cost-effective, innovate, quality and customer-focused organisations, depend essentially on expert health care professionals for the implementation of information management principles in their departments. However, to achieve the outstanding quality service described above, hospitals, in particular public hospitals, should assist health care professionals through effective information systems and technology to become more focused in playing their part in information management.

Activity 15.3: Computer technology (Textbook page 176)

Today's computers are electronic, which means they use electronic pulses to function, and integrated circuits, called microprocessors. The computer has affected the way many different types of employees carry out their jobs. For example, some employees spend most of their working day sitting in front of a terminal screen and a keyboard. Before computerisation, they may have had significant interaction with a variety of other employees throughout the organisation.

Computers may be used as follows:

- They may perform a significant portion of employees' jobs.
- They may carry out a number of personnel functions, such as keeping employee and training records, expert systems, and in decision support systems, staffing, statistics, strategic planning, and so on.
- When decisions become routine, the various factors considered in making a decision can be developed into a computer model. By turning routine decision making over to the computer, humans now have more time to perform those functions that only they can perform.
- With work measurement processes, a computer can, for example, keep track of an employee's output during a given amount of time.
- Computers can determine whether an employee is working faster than expected, at the expected rate, or slower than expected.

The *data processing cycle* for which computers are used extensively involves five steps: origination, input, manipulation, output and storage. During the origination step, data are gathered for input into the system. The origination step is basically a data-collection step. In many cases, the documents used during the origination step are source documents.

In the next step, which is input, the data collected during the origination step are input into the system. The data may be input either manually, such as by keyboarding, or they may be input mechanically, such as by a scanning process.

During the manipulation step, one or more of a number of things may happen to the data. The data may be classified, sorted, subjected to arithmetic calculations and recorded. Of the various steps of the data processing cycle, more probably happens to the data during the manipulation step than during any of the other steps.

Once the data have been manipulated, they are ready for output. Output involves presenting the manipulated data in the format desired by the user. The output may be in the form of hard copy or “soft” copy that the user can access from his or her terminal.

The final step is storage. If the data are likely to be needed in the future, then they will need to be held in storage. Two considerations are critical: security of the data, and storage that facilitates quick and easy retrieval.

Activity 15.4: Telecommunications (Textbook page 177)

New technology that improves the telecommunications function is being introduced on a very regular basis. The signals comprising the data/information being transmitted are sent either as *digital signals* or as *analog signals*.

Digital signals are transmitted in a discrete, on–off manner. Analog signals, on the other hand, are transmitted as continuous signals. The digital mode is preferred when large quantities of data or information need to be transmitted at a high speed. The analog mode is typically used for voice communication. Increasingly, health care organisations are installing systems that use digital signals so that both data transmission and oral communication can readily take place.

In the future, most systems will probably digitise voice communication so that it can be sent in a digital mode. One advantage of using digital voice transmission is the ability to merge data, text and facsimile transmission, using the same communication devices and equipment. Another advantage, although less important for most businesses, is the increased security that digital voice transmission provides. The most significant disadvantage is that digital voice transmission is more costly than analog voice transmission.

Another new development in telecommunications technology is the use of *fibre optics*. Using either analog or digital transmission, fibre optics function by sending light signals through glass threads. The technology uses a laser that converts either analog or digital signals into light impulses that travel through the glass threads.

Another transmission mode that has received a fair amount of attention over the years is *satellite communication*. When compared with ground-based systems, such as copper wire systems, satellite communication is much more efficient. In addition, satellite systems are faster and more cost-effective than copper wire systems. One of the distinct

advantages of satellite communication is the ability to communicate from any location where earth stations are available. Compared with earth-based systems, satellite communication is much more accurate and is considerably faster.

Telecommunication today is also making extensive use of *networking*. This simply means that various components in an office are interconnected so they can communicate with one another. Networks exist at two levels: local and long distance. Local networks facilitate communication within a limited geographical area. However, the local network can also be connected to long-distance communication systems, such as satellite communication systems. The integrated nature of local networks facilitates communication between word processors, computers, video terminals, printers, and so forth. Regarding services, local networks facilitate the accessing of databases, communicating by means of electronic mail, and voice communication. Generally, in fully-fledged networks, voice, word, data and video transmission are all supported.

Telecommunication is used extensively in *teleconferencing*. Teleconferencing refers to the use of telecommunications to support the oral, video or digital communication between individuals at two or more locations. Several types of teleconferencing are found, including audio conferencing, video conferencing and computer conferencing. Audio conferencing involves oral but not visual signals. This means the participants can be heard but not seen. At the low-end level, audio conferencing is simply a conference call between two or more individuals. Audio conferencing may be supplemented by such devices as electronic blackboards that transmit material written on the device from one location to another.

Telecommunication is also used extensively in supporting the *Internet*, which is a network of networks and is the fastest growing means of communication today. The Internet supports a variety of communication services, including communication by e-mail, by Internet telephone, by Internet fax, and by such other services as discussion lists, newsgroups, list servers and social networks like YouTube, Facebook and Twitter. Not only are individuals using the Internet extensively as they carry out various personal activities, but companies are also making extensive use of it in supporting their activities. Of the various Internet services, the two that individuals probably use most often are e-mail and the World Wide Web. With regard to e-mail, one needs to remember to use it carefully. Because it is not a private messaging system, you should avoid sending messages by e-mail that you would be reluctant to send on a postcard. Legislation is in place that makes all e-mail messages the property of the owner of the system.

A final example of how telecommunication is changing how we communicate is *Telnet*, which is used to provide a connection between a remote computer and a host computer. Thus, once connected, an individual can use the host computer in much the same way as he or she can when directly connected to the host.

A knowledge management system

What is a knowledge management system used for?

- To know where particular expertise resides in the health organisation
- To know what expertise is being lost when an employee leaves
- To know which individuals could perform a task as a team member
- To understand how knowledge flows within the health organisation
- To track the loss or acquisition of a particular competence or proficiency
- To locate documents and other media on particular topics
- To assist in planning for training
- To assist in planning for recruiting
- To access anecdotal material on customer accounts, problem solving, etc.

Knowledge management programs typically involve one or more of the following activities:

- Appointment of a knowledge leader – to develop a framework for the knowledge management program
- Creation of knowledge teams – people from all disciplines should assist with developing the methods and skills needed to implement knowledge management
- Development of a knowledge base – best practices, market intelligence, etc.
- Development of an interactive intranet portal – a “one-stop-shop” that gives access to explicit knowledge as well as connections to experts
- Creation of a knowledge centre with focal points for knowledge skills and facilitating knowledge flow
- Development of knowledge sharing mechanisms, such as facilitated events that encourage greater sharing of knowledge than would normally take place
- Effective management of intellectual assets, with methods to identify and account for intellectual capital

The *value of knowledge* is to enhance quality health care services. The following trends should be noted:

Globalisation and competition. Many organisations rely on knowledge to create their strategic advantage. With available knowledge widely dispersed and fragmented, organisations often waste valuable time and resources “reinventing the wheel” or failing to access the highest quality knowledge and expertise that is available.

Knowledge may command a premium price in the market. Applied know-how may enhance the value (and hence the price) of products and services.

Restructuring and downsizing. Without effective mechanisms in place to capture the knowledge of experienced employees, organisations make costly mistakes or have to pay again for knowledge they once had on tap.

Sharing of best practices. Organisations can save financially by taking the knowledge of their best performers and applying it in similar situations elsewhere.

Successful innovation. Health care organisations that apply knowledge management methods have found that through knowledge networking they can create new products and services faster and better.

These and other benefits, such as improved customer service, faster problem solving and more rapid adaptation to market changes, have resulted from an explicit focus on corporate knowledge as a strategic resource.

One of the prime areas in which this knowledge management approach could be applied is the field of project management. Knowledge is generated within a project and then sometimes lost. Failure to transfer this knowledge within the organisation or along the complexities of the supply chain leads to wasted activity (i.e. “reinventing the wheel”) and impaired project performance.

Knowledge management problems may be linked to discrete events in the evolution of a health organisation’s organisational environment, such as downsizing and other large reorganisation initiatives or significant health organisation growth.

The key challenges of managing knowledge in a project environment are briefly described below.

Knowledge ownership. The construction of a knowledge base necessitates mechanisms to attach knowledge ownership to individuals and/or groups. Where ownership structures and rights are in place, transfer of knowledge is usually feasible.

Life-cycle management of knowledge. Knowledge has a life cycle. A new form of knowledge is created; it is refined through different business applications until it reaches a usefulness peak, after which its usage decreases until it is replaced by a more novel form of knowledge. A key challenge when building a collective knowledge base is to reach a strategic balance between stability and innovation.

A challenge facing health care organisations is the management of *tacit knowledge*. This type of knowledge is the personal, embedded, nebulous form of knowledge that is nevertheless essential for effective operations. Knowledge experts are needed in the creation and diffusion of tacit knowledge.

Employees and managers deal with different *grades of organisational knowledge* when involved in projects. One form of knowledge is akin to the core competencies of a health organisation. This type of knowledge, labelled kernel knowledge, includes forms of knowledge that need to remain and be nurtured within a health organisation in order to sustain high project performance in the long term. On the other hand, the completion of a project also requires access to project-specific knowledge, which is knowledge that is useful for one project but has a low probability of ever

being used again. This form of knowledge is labelled *ephemeral knowledge*, as it is only active and useful during the lifetime of a project.

Kernel knowledge is a project-generic form of knowledge that is applied to all the projects that a health organisation deals with. Thus, a key issue is to ensure the consistency of the application of kernel knowledge, that is, to avoid the emergence of altered team cultures and work philosophies.

The challenges of deploying the knowledge assets of an organisation

Competitive advantage is becoming more crucial as a result of the following:

- The marketplace is increasingly competitive and the rate of innovation is rising, so that knowledge must evolve and be assimilated at an ever faster rate.
- Organisations are organising their services to be focused on creating customer value. There is a need to replace the informal knowledge management of the staff function with formal methods in customer aligned organisational processes.
- Competitive pressures are reducing the size of the workforce which holds this knowledge.
- Knowledge takes time to experience and acquire. Employees have less and less time for this.
- There are trends for employees to retire earlier and for increasing mobility, leading to loss of knowledge.
- A change in strategic direction may result in the loss of knowledge in a specific area. A subsequent reversal in policy may then lead to a renewed requirement for this knowledge, but the employees with that knowledge may no longer be there.

Therefore the following core knowledge management activities should be implemented:

- The health care organisation should focus its attention on specific knowledge domains that offer direct service benefits.
- Knowledge management initiatives require dedicated funding to design, implement and sustain the process.
- Knowledge needs to be identified as an essential *component of the organisation's strategy*.
- The organisation's *knowledge-intensive work processes* must be identified and analysed (e.g. product design, strategic planning, organisational development, proposal development).
- Definitive *goal-setting* for what knowledge management is to achieve should be performed.
- Data should be *collected* from different systems and data *tagged* for future use. Knowledge should be made *visible* organisation wide.

A number of social concerns are developing as a result of the widespread use of computers. For example, computer crime is becoming an increasingly significant concern. An example of computer crime is embezzlement of data or information alteration. Health care organisations are vulnerable to computer crimes and will need to take special precautions to prevent their occurrence.

Other concerns include the following:

- Computer viruses may be introduced into a program for the purpose of either destroying or altering data.

- The right to privacy. A vast amount of data about citizens of this country is stored in a wide variety of computers. Of that stored data, a portion is likely to be confidential. As citizens of this country, we have the right to expect that these data will remain private and out of the hands of individuals who have no right to their use.
- Job security. Because an increasing number of jobs are being done by computers or tasks are being consolidated so that they can be performed by computers, some administrative employees are having to contend with diminished job security.
- The health and safety of people is a serious concern, especially when considering electronic equipment and its potential impact on an employee's health.
- Carpal tunnel syndrome is experienced by some employees who use the keyboard for extensive periods each work day.

The following are factors that may influence *knowledge management*:

- Getting employees on board in the process
- Not having specific organisational goals
- Understanding that not all information is management information

Management should think outside the boundaries of current practices, products, services, organisations and industries as they fall behind the treadmill of faster and more rapid pace of change. The new health care environment puts a greater premium on creativity and innovation than ever before. The more complex technologies and their applications impose a greater responsibility on the humans using them to create outstanding performance. Ongoing learning and unlearning of technologies and organisational practices should take place in the ever changing health care environment.

General questions (Textbook page 178)

Question 5 Read more on knowledge management

Knowledge management process

Knowledge management is the acquisition and use of resources to create an environment in which information is accessible to individuals and in which they acquire, share and use that information to develop their own knowledge and are encouraged and enabled to apply their knowledge for the benefit of the organisation (<http://www.kmnetwork.com/whatis.htm>).

In its simplest form, knowledge management is about encouraging people to share knowledge and ideas to create value-adding products and services.

Effective knowledge management can only be accomplished by creating a supportive, collaborative culture that eliminates all the traditional rivalries. Knowledge creation and production require continuous interaction with each

other and faith in all social actors, therefore trust is a critical prerequisite for the successful implementation of knowledge management.

An effective knowledge management program should help a health care organisation to do one or more of the following:

- Foster innovation by encouraging the free flow of ideas.
- Improve customer service by streamlining response time in services provided.
- Enhance employee retention rates by recognising the value of employees' knowledge and rewarding them for it.
- Streamline operations and reduce costs by eliminating redundant or unnecessary processes in human and financial resources management.

Characteristics of an organisational culture suffering a lack of knowledge

Characteristics of an anti-knowledge culture are as follows:

- There are no motivations or endorsements to promote sharing information and insights among employees.
- Little time or attention is given to identifying lessons learnt from project failures and successes.
- Assumptions about new projects or activities are not challenged.
- The organisation hires and promotes individuals based on technical expertise alone.
- Management is hesitant to talk about project failures.

Bibliography

<http://www.kmnetwork.com/whatis.htm>

Chapter 16: Staffing

Karien Jooste, Carine Johanna Prinsloo and Gedina Eureka de Wet

Activity 16.1: Standard setting organisations (Textbook page 181)

The SANC provides all health care training institutions with the regulations to guide and train students, as well as with the scope of practice of practitioners.

All health care facilities in all provinces have standard criteria and protocols on how to deliver health care in specific clinical areas. As the HIV/Aids infection rate increases, the demand for quality health care rises, especially in relation to the care of babies and mothers after delivery. Staffing changes will have to be made to accommodate these demands in the health care environment.

Health care service standards should take into account the philosophy and objectives of the service, specialty, department or health care unit, its staffing composition and the management and development plans for personnel (Jooste 2009: 272).

Guidelines and policies published by the National Health Department and contained in the Constitution of the country are available to lead the professional conduct of health care professionals.

The South African Qualifications Authority (SAQA) prescribes the minimum standards of qualifications and competencies needed by health care professionals.

Activity 16.3: Use of agency staff (Textbook page 183)

Your answer could include the following:

- Many agency nurses do not update or upgrade their clinical skills and this places clients at risks.
- Usually, nurses are hired from a health care agency during sudden, unexpected personnel shortages, when there are too few regular personnel to adequately orientate the agency nurses to the unit's layout and to its clients, personnel, protocols, equipment and supplies.
- Agency nurses are prone to making errors and omissions and unsatisfactory performance.
- Because the agency nurse's affiliation with the health agency is short term, she or he lacks strong commitment to the health care organisation's goals, personnel and clients.
- Although agency nurses may be committed to their work, some clients may nevertheless receive poor quality care, particularly if the nurses are working in unfamiliar wards or specialities.

- The safeguards applicable to full-time employees in terms of pre-employment qualification and registration checks do not apply to agency nurses.
- Some health care agencies do not ensure that agency nurses are qualified to work in the requesting speciality; inductions to the work area are often inadequate or non-existent; and many agency nurses' skills and knowledge have not been clinically updated.

Health care organisations should have policies to address the use of health care recruitment agencies; however few health care organisations have a policy on evaluating agency nurses' competence and performance, and the number of consecutive shifts worked.

One of the driving forces for the increase in the use of the service provided by these agencies has been the demand from health care organisations and the ability of the agencies to supply professional workers to meet this demand. The most frequently cited reason for using temporary workers is the labour flexibility it provides. Thus the health care agencies have become purveyors of flexibility and human resource “brokers”, frequently undertaking functions such as recruitment, selection and training of nurses that were previously carried out by the health care organisation's human resource department (Burgess & Connell 2006: 129–140; De Ruyter 2004: 71).

In recent years considerable interest in the service provided by agencies has emerged against the backdrop of rapid growth in this form of employment, yet remarkably little is known about its implications for health care organisations and nurses. In the absence of comprehensive data, there has been much speculation and debate surrounding both the experience of agency employment for workers and employers' usage of agency nurses. It has been suggested that agency nurses are increasingly choosing to sell their services to a number of clients.

Activity 16.4: Recruitment strategies (Textbook page 185)

Direct and indirect recruitment strategies

- Direct recruiting strategies involve active efforts to find qualified people to fill jobs. Direct recruiting methods include face-to-face or media-based activities that connect a health care agency directly with potential health care personnel. In large health care organisations, direct recruiting strategies are implemented in conjunction with the Human Resource (HR) Department.
- Indirect recruiting strategies place more emphasis on creating and enhancing the external appeal of the health care agency as an employer. Indirect recruiting activities do not immediately yield employees but greatly increase the potential applicant pool. Such activities may, for example, increase the visibility of the health care agencies, health care organisations, professions and departments, and promote the appeal of working in the health care organisation.

May and Askham (2005: 426–437) have a different opinion and state that there is evidence that internal application and recruitment systems and processes, sometimes imposed by HR departments, result in unnecessary delays. They mention that bureaucracies may increase the length of the recruitment period resulting in the loss of potential nurses to

other employers. They also mention that standard HR processes may lack flexibility and the number of signatures, forms and approvals required often add to the delays.

Activity 16.5: Selection of the right candidate (Textbook page 188)

People differ in health, physical strength, intelligence, ability, personality and in their relative strengths and weaknesses, while health care jobs differ in the demands they place on nurses in terms of the physical and mental workloads. As Cooper et al. (2003: 6–7) point out, these inherent differences mean that selection decisions are often made in the face of uncertainty. These authors suggest that, to reduce the need for these uncertain decisions, a framework for systematic selection should specify the need to

- ensure that the selectors have some understanding of how people differ in different situations
- identify the unit's needs and expectations via job analyses
- set standards that meet the health care requirements
- establish evaluative standards to assess the selection method used
- set evaluative standards to assess the efficiency of the selection procedure
- identify the most appropriate selection method for the type of unit in question
- set decision-making standards (to cover the many different situations that may be experienced in a health care unit).

The benefits to be gained from this type of framework reside in the systematic assessment and matching of individually recruited nurses to specific job demands, while also providing the means to monitor and assess the efficiency of the selection system.

According to Swanepoel et al. (2003: 280–281), selection should be seen as the process of trying to determine which individuals will best match particular jobs in the health care organisation, taking into account individual differences, the requirements of the job and the health care organisation's internal and external environments. Selection is therefore the prediction of future performance in terms of individual differences. Selection requires information about the job or work in question and also about the knowledge, skills and abilities needed to do the job successfully. Selection decisions therefore require one to know how such knowledge, skills and abilities can be assessed, making the proper use of predictors in selection very important.

Activity 16.6: Selection tests (Textbook page 188)

The purpose of selection tests is mainly to predict job success among a number of applicants. These tests measure a nurse's ability, aptitude, interest and personality. There are different types of test, including tests of cognitive ability, aptitude, personality and performance.

Swanepoel et al. (2003: 286–287) and Hough and Oswald (2000: 631) highlight the different tests to be performed during selection. The measurement of intelligence has always been a popular ability test for selection. An intelligence test gives an indication of general intelligence by means of a single score. Swanepoel et al. (2003: 287) state that the following tests are used in South Africa:

- South African Wechsler Individual Intelligence Scale for Adults
- Mental Alertness Scale of the National Institute for Personnel Research
- New South African Group Test
- Aptitude tests

Aptitude measurement is used, inter alia, for the selection of job applicants. Most aptitude tests are based on primary group factors like verbal ability, word fluency, memory, deductive reasoning, inductive reasoning, numerical ability, perceptual speed, form perception, spatial aptitude and coordination.

Personality may influence a nurse's work performance. The aim of personality questionnaires is to identify personality traits. People are aware of their own behaviour and are able to make valid assessments of themselves.

The purpose of **performance tests** is to assess the nurse applicant's performance on specific tasks that are representative of the actual job. Performance tests are designed for a specific job, and appear to be good predictors of job success.

Chapter 17: Labour relations

Catarina Magdeline Erasmus

Activity 17.1: Checklist for disciplinary enquiry (Textbook page 203)

Before the enquiry commences

- Prepare thoroughly in close consultation with the accused employee.
- Decide how you will structure the case on behalf of the accused employee.
- Identify all the witnesses you will need to call.
- Establish what the witnesses will say at the enquiry.
- Decide on the order in which you will call your witnesses.
- Ensure arrangements have been made for the release of witnesses from work.
- Establish whether the accused employee is going to plead guilty or innocent.

At the outset of the enquiry

- Introduce yourself to the people present.
- If you are insufficiently prepared, request a postponement.
- Raise any objections you may have, including, for example
 - insufficient time to prepare
 - poor wording of the disciplinary charge
 - chairperson bias.
- Note responses to any of the objections you raised.

During the presentation of the employer's case

- Listen carefully to the testimony of the employer's witnesses.
- Make comprehensive notes of what is said by witnesses.
- Note topics and questions to raise during cross-examination.
- Do not be rude to the employer's witnesses.
- Ask probing questions.
- Do not cross-examine a witness on the events chronologically.
- Do not allow a witness to answer your questions with a counter question.
- Insist that a witness answers your questions.
- Ask questions which will test the credibility of company witnesses (bias, inconsistencies, conspiracy, demeanour, probabilities, corroboration, and reliability).
- Object to any leading questions asked by the company presenter of the company witness.

During the presentation of the accused employee's case

- Ask open questions. Leading questions are permissible only on background information and the events (not in dispute) that led up to those issues which are in dispute.
- Choose questions to start off with which will put the accused employee/witness at ease.
- Ask questions in a chronological order.
- Probe for evidence which corroborates the facts that you are trying to prove.
- Keep your questions focused on relevant matters.

Before the chairperson adjourns to consider guilt or innocence

- Make sure you have called all the witnesses necessary to prove your case.
- Summarise the facts that have been proven by the accused employee and his or her witnesses.
- Point out all the facts that are unfavourable to management's case.
- Point out any weaknesses in the testimony of management's witnesses (credibility).

After chairperson has found the employee guilty (if found innocent nothing further is required)

Address the chairperson on issues of mitigation (e.g. length of service, circumstances of the offence, disciplinary record).

Activity 17.2: Problems that lead to disciplinary actions (Textbook page 204)

Common disciplinary problems are the following:

- **Attendance problems**
 - Lateness
 - Unexpected absenteeism
 - Unexcused/excessive tardiness
 - Leaving workstation without permission
- **Dishonesty and related problems**
 - Theft
 - Falsifying employment application
 - Wilfully damaging organisational property
 - Punching another employee's clock card
 - Falsifying records
- **Work performance problems**
 - Failure to complete work assignments
 - Producing substandard products of service
 - Failure to meet the established production requirements

- **On-the-job behaviour problems**
 - Intoxication
 - Insubordination
 - Dangerous horseplay
 - Smoking in unauthorised places
 - Fighting
 - Gambling
 - Failure to use safety devices
 - Failure to report injuries
 - Carelessness
 - Sleeping on duty
 - Using abusive or threatening language
 - Possession of narcotics or alcohol
 - Possession of firearms or other weapons
 - Sexual harassment

General questions (Textbook page 206)

Question 3 Negotiation, mediation and arbitration

There are three methods that are commonly used by organisations to resolve a situation that has reached the stage of open conflict, namely negotiation, mediation and arbitration.

Negotiation

Negotiations mean there has to be give-and-take on various issues among the parties involved. It is a technique that is used in situations in which consensus will not be reached and the parties engage in a deliberate attempt to redefine the terms of their interrelationship. Muller et al. (2006: 381) indicate that representatives of management and employees try to resolve their differences and reach agreement on the negotiated issue. Roussel et al. (2006: 207) say negotiation includes “bargaining power, distributive bargaining, integrative bargaining and mediation”. Booyens (1993: 524), on the other hand, defines negotiation as a “set of learned and acquired skills which require conscious use of some rules coupled with an imaginative personality”. It is a deliberate process where mandated representatives of groups that are involved in the conflict meet together in order to resolve their differences and to reach agreement. The purpose of negotiation is to reconcile differences and to reach agreement by consensus. It often involves compromise. Smelter (in Booyens 1993: 525) identifies three criteria that are important in negotiation, namely:

- The issue must be negotiable.

- The negotiators must be interested in give-and-take during the process.
- There must be a trusting relationship between the negotiating parties.

Booyens (1993: 525) further identifies three prerequisites for effective negotiation:

- A knowledge of human behaviour
- An understanding of human behaviour
- That the needs of both parties are met during the process

Collective bargaining

Collective bargaining refers to the agreed-upon workplace mechanisms by which consensus is reached between management and workers. Representatives from each group come together with a mandate to find a solution collectively. It is a process where people or groups find ways of cooperating within agreed-upon rules and procedures so as to find a solution to the problem. Collective bargaining is subject to legal requirements that have to be followed by both management and labour (Booyens 1993: 650).

Conciliation

The South African labour relations legislation provides for the process of conciliation in the workplace, whereby groups that are in conflict and have failed to reach an agreement can come together once again to attempt to settle their differences. Once the dispute has been settled, the conciliation board established for that purpose is disbanded (Booyens 1993: 663).

Mediation

Mediation is part of the negotiation process but is more intense. When negotiations fail, parties often call in an independent mediator who tries to facilitate settlement of the conflict. The mediator plays an active role in the mediation process by offering advice to all groups, acting as an intermediary and suggesting possible solutions to the problem. Mediators act only in an advisory capacity; they do not have decision-making powers and cannot impose a settlement on the conflicting parties (Booyens 1993: 664).

Arbitration

Arbitration is a procedure in which an independent and impartial person is appointed to act as a judge in a dispute. The arbitrator listens and investigates the demands and counter-demands of both parties and then makes a decision that is binding upon all parties concerned. Arbitration differs from mediation and negotiation in that it does not promote the continuation of collective bargaining. Parties involved in a dispute may have a single arbitrator or a panel of arbitrators whom they will respect and whose decision they will accept as final in order to settle the conflict (Booyens 1993: 664).

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Chapter 18: Leadership and guidance in a health care unit

Hester Klopper and Petra Bester

Activity 18.1: Leadership (Textbook page 209)

Introductory discussion of the questions pertaining to Notise

The actual question to be asked here is whether a professional nurse in a surgical ward can be a leader or whether leadership is reserved for the nursing service manager. There is a risk that readers who examine the leadership literature might conclude that leadership is too difficult a task for anyone who is not a born leader.

What do you suggest would be the most effective way for Notise to introduce effective wound-care techniques to the unit?

The initial suggestion would be for Notise to combine effective leadership with sufficient wound-care knowledge as the mechanism for introducing effective wound-care techniques to the unit.

Notise wants to do what is best for her clients and wants her colleagues to participate in this as a group effort.

Do you think she can be regarded as a leader?

Yes, Notise can be regarded as a leader. One of the roles of the professional nurse is that of a leader and assuming this role should not be dependent on position or age.

Activity 18.2: Leadership theory (Textbook page 214)

Table 18.1 Literature review of all the leadership theories (Covey 2004: 352–359)

Leadership theory	Summary	Year and representative authors
Great-man theories	<ul style="list-style-type: none">History and social institutions shaped by leadership of great men and women (examples: Moses, Mohammed, Jeanne d’Arc, Gandhi, Churchill, etc.).“No such thing as leadership by masses. The individuals in every society possess different degrees of intelligence, energy and moral force, and in whatever direction the masses may be influenced to go, they are always led by the superior few.”	Dowd 1936
Trait theories	<ul style="list-style-type: none">Leader endowed with superior traits and characteristics that differentiate her or him from followers.	Barnard 1926; Bingham 1927; Kilbourne 1935;

	<ul style="list-style-type: none"> Research addresses two questions: What traits distinguish leaders from other people? What is the extent of those differences? 	Kirkpatrick & Locke 1991; Kohs & Irle 1920; Page 1935; Tead 1929
Situational theories	<ul style="list-style-type: none"> Leadership is the product of situational demands: situational factors, rather than a person's heritage determine who will emerge as a leader. Emergence of a great leader is the result of time, place and circumstance. 	Bogardus 1918; Hersey & Blanchard 1972; Hocking 1924; Person 1928; Spencer 1969
Personal-situational theories	<ul style="list-style-type: none"> Combination of great-man, trait and situational leadership. Study of leadership must include effective, intellectual and action traits, as well as the specific conditions under which the individual operates. Conditions include: personality traits, nature of the group and its members, event confronting the group. 	Barnard 1928; Bass 1960; Brown 1936; Case 1933; Gibb 1947, 1954; Jenkins 1947; Lapiere 1938; Murphy 1941; Westburgh 1931
Psychoanalysis theories	<ul style="list-style-type: none"> Leader functions as a parental figure: source of love or fear, embodiment of the superego, emotional outlet for followers' frustrations and destructive aggression. 	Erikson 1964; Frank 1939; Fromm 1941; Levison 1970; Wolman 1971
Humanistic theories	<ul style="list-style-type: none"> Humanistic theories deal with the development of the individual in effective and cohesive organisations. Human beings are by nature motivated beings, organisations are by nature structured and controlled. Leadership's task is to modify organisational constraints to provide freedom for individuals so that they can realise their full potential and contribute to the organisation. 	Argyris 1957, 1962, 1964; Blake & Mouton 1964, 1965; Hersey & Blanchard 1969, 1972; Likert 1961, 1967; Maslow 1965; McGregor 1960, 1966

Leader-role theory	<ul style="list-style-type: none"> • Characteristics of the individual and the demands of the situation interact in a way to allow one or a few individuals to emerge as leaders. • Groups are structured based upon the interactions of the members of the group; group becomes organised according to different roles and positions. • Leadership is one of the differentiated roles, and the person in that position is expected to behave in a way that is different from the behaviour of others in the group. • Leaders behave according to how they perceive their role and what others expect them to do. • Mintzberg: leadership roles are figurehead, leader, liaison, monitor, disseminator, spokesman, entrepreneur, disturbance handler, resource allocator and negotiator. 	Homans 1950; Kahn & Quinn 1970; Kerr & Jermier 1978; Mintzberg 1973; Osborn & Hunt 1975
Path-goal theory	<ul style="list-style-type: none"> • Leaders reinforce change in followers by showing followers the behaviours through which rewards may be obtained. • Leaders also clarify followers' goals and encourage them to perform well. • Situational factors will determine the way leaders will achieve these path-goal purposes. 	Evans 1970; Georgopoulos, Mahoney & Jones 1957; House 1971; House & Dessler 1974
Contingency theory	<ul style="list-style-type: none"> • Effectiveness of a task or relations-oriented leader is contingent upon the situation. Leadership training programmes modelled on this theory help a leader identify his or her orientation and adjust better to the positive features of the situation. 	Fiedler 1976; Fiedler, Chemers & Mahar 1976
Cognitive leadership: twentieth century great man	<ul style="list-style-type: none"> • Leaders are persons who by word or personal example markedly influence the behaviours, thoughts and feelings of a significant number of their fellow human beings. • Gaining an understanding of the nature of the human mind, both the leader and the followers provides insight into the nature of leadership. • Collins: difference between organisations that produce sustained great results and those that don't are that the great organisations are led by what he calls Level 5 leaders – those with a paradoxical combination of humility and 	Gardner 1995; Collins 2001

	fierce resolve.	
Theories and models of interactive processes: multiple-linkage model, multiple-screen model, vertical-dyad linkage, exchange theories, behaviour theories, communication theories	<ul style="list-style-type: none"> • Leadership is an interactive process. • Theories of leaders' initiation structure, the relationship between a leader's intelligence and his or her group's performance, relationship between the leader and each individual rather than the group, and social interaction as a form of exchange or behavioural contingency. 	Davis & Luthans 1979; Fiedler & Leister 1977; Fuld & Wendler 1982, Graen 1976; Green 1975; Yuki 1971
Power influence: participative leadership, rational-deductive	<ul style="list-style-type: none"> • Participative leadership. • Examines how much power the leader possesses and exerts. • Unidirectional causality. • Participative leadership deals with power sharing and empowerment of followers. 	Coch & French 1948; Gardner 1990; Lewin, Lippitt & White 1939; Vroom & Yettoon 1974
Attribution, information, processing and open systems	<ul style="list-style-type: none"> • Leadership is a socially constructed reality. • Individual, procedural, structural and environmental variables are mutually causal phenomena in leadership studies; delineating cause and effect among these variables is difficult. 	Bryon & Kelly 1978; Katz & Kahn 1966; Lord 1976, 1985; Lord, Binning, Rush & Thomas 1978; Mitchell, Larsen & Green 1977; Newell & Simon 1972; Weiss 1977
Integrative: transformational, values-based	<ul style="list-style-type: none"> • Leaders and followers raise one another to higher levels of morality and motivation. • Followers are assumed to transcend self-interest for the good of the group, consider long-term objectives, and develop an awareness of what is important. 	Bass & Bennis 1984, 1992, 1993; Burns 1978; Downton 1973; Fairholm 1991; O'Toole 1995; DePree 1992; Tichy, Devanna & Renesch 1986
Charismatic leadership	<ul style="list-style-type: none"> • Leaders possess exceptional qualities as perceived by followers. 	Conger & Kanungu 1987; House 1977; De

	<ul style="list-style-type: none"> • Leader's influence not based upon authority or tradition but upon the perceptions of her or his followers. • Explanations are attribution, objective observation, self-concept theory, psychoanalytical, social contagion. 	Vries 1988; Maxwell 1999; Meindl 1990; Shamir, House & Arthur, 1993; Weber 1947
Competency-based leadership	<ul style="list-style-type: none"> • One can learn and improve critical competencies that tend to predict the differences between outstanding performers (leaders) and average performers. 	Bennis 1993; Boyatzis, Cameron & Quinn 1993
Aspirational and visionary leadership	<ul style="list-style-type: none"> • Kouzes and Posner: leaders ignite followers' passions and serve as a compass by which to guide followers. • Leadership is the art of mobilising others to want to struggle for shared aspirations. • Emphasis on the followers' desire to contribute and the leader's ability to motivate others to action. • Respond to customers, create vision, energise employees, thrive in fast-paced "chaotic" environment. • Articulation of visions, embodying values, creating an environment within which things can be accomplished. 	Burns 1978 ; Kouzes & Posner 1995; Peters 2001; Richards & Engle 1986; Waterman 1990
Managerial and strategic leadership	<ul style="list-style-type: none"> • Integration between external and internal partnerships. • Drucker: three components of integration – financial, performance and personal. Leaders responsible for performance of their organisation and community as a whole. Fill roles and possess special characteristics. • Kotter: leaders communicate vision and direction, align people, and motivate, inspire and energise followers. Leaders are change agents and empower their people. • Leadership is a process of giving purpose (meaningful direction) to collective effort, causing willing effort to be expended to achieve purpose. • Effective managerial leadership spawns effective managerial work. • Leadership that is dependent upon time and place, individual and situations is favoured. 	Drucker 1999; Jacobs & Jaques 1990; Jaques & Clement 1991; Kotter 1998, 1999; Buckingham & Coffman 1999; Buckingham & Clifton 2001
Results-based leadership	<ul style="list-style-type: none"> • Ulrich et al.: leadership brand that describes distinct results leaders deliver, links results with character. 	Ulrich, Zenger & Smallwood 1999; Nohria, Joyce &

	<ul style="list-style-type: none"> • Leaders have moral character, integrity and energy in addition to technical knowledge and strategic thinking. • Demonstrate effective behaviours that further organisational success. • Leadership results are measurable, can be taught and learnt. • Practices: strategy, execution, culture and structure. 	Robertson 2003
Leader as teacher	<ul style="list-style-type: none"> • Establish a “teachable point of view”. • Motivating others by teaching stories. • Tichy: effective leadership equates to effective teaching. 	DePree 1992; Tichy 1998
Leadership as a performing art	<ul style="list-style-type: none"> • Leadership is a covert activity – leaders don’t outwardly perform leadership actions. • Leaders perform unobtrusive actions that encompass all the things a leader or manager does. • Metaphors used: orchestra conductors, jazz ensembles. 	DePree 1992; Mintzberg 1998; Vail 1989
Cultural and holistic leadership	<ul style="list-style-type: none"> • Ability to step outside the culture to start evolutionary change processes that are more adaptive. • Ability to include important stakeholders, evoke fellowship, empower others. • Wheatley’s holistic approach: leadership is contextual and systematic. • Create synergistic relationships between individuals, organisations and environment. • Promote learning organisations through adherence to the five disciplines. • Senge: leaders play three roles – designers, stewards and teachers. 	Fairholm 1994; Senge 1990; Schein 1992; Wheatley 1992
Servant leadership	<ul style="list-style-type: none"> • Leaders lead by serving others (employees, customers, community). • Characteristics: listening, empathy, healing, awareness, persuasion, conceptualisation, foresight, stewardship, commitment to other’s growth, community building. 	Greenleaf 1996; Spears & Frick 1992
Spiritual leadership	<ul style="list-style-type: none"> • Involves influencing people’s souls rather than controlling action. • Fairholm – leadership involves connecting with others. 	DePree 1989; Etzioni 1997; Greenleaf 1977; Hawley 1993; Keifer

	<ul style="list-style-type: none"> • Leaders must include spiritual care in their practice. • Leader's influence stems from his or her knowledge of the organisation's culture, customs, values and traditions. 	1992; Maxwell 1989; Vail 1989
Authentic leadership	<ul style="list-style-type: none"> • Pursuing purpose with passion. • Practising solid values. • Leading with heart. • Establishing enduring relationships. • Demonstrating self-discipline. 	George 2003; George & Sims 2007 Bester 2008; Klopper & Bester 2009

<http://www.leadership-central.com/leadership-theories.html>

Activity 18.3: Authentic leadership (Textbook page 215)

See information on authentic leadership in the table above.

Chapter 19: Leadership and motivation

Karien Jooste

Activity 19.1: Different leadership and motivational theories (Textbook page 221)

Table 19.1 Leadership and motivational theories

Theory/style	Main underlying assumption of the theory	Examples for implementation in nursing practice
Trait theory	Some people are naturally better leaders.	Identifies people who have the appropriate leadership characteristics.
Great man	Best person leads followers into a successful future.	Uses intelligence and initiative of followers.
Autocratic (directive style)	Leader thus controls all information and makes all decisions for the immediate situation alone.	Leader is strict, gives orders, and uses power to ensure orderly, prompt and predictable behaviours of employees. Stays in close contact to influence actions of followers, however not influenced by followers, dictates, no delegation of tasks, followers afraid and criticised in front of others.
The laissez-faire style	Leader abdicates leadership responsibility.	Leader wants everyone to feel good. Has minimal contact with and influence over followers, nursing team left alone with tasks, lack of direction and support, inadequate communication, lack of information.
Participative style (democratic)	Employees' involvement in planning is required. Focus on human relations and teamwork.	Listens to alternatives or suggestions from the group, has frequent contact with and is influenced by followers, decisions taken after group discussions, followers feel emotionally secure and self-confidence increases.
Task versus relationship orientation	Focuses on productivity, tasks, people and relationships.	Promotes open communication and team members' participation in setting goals.
Scientific	Increases followers' efficiency by	Finds ways of making the task easier, and ways of

management	scientifically designing jobs.	getting it done in the least amount of time so that more work can be done in a day.
Human relations	Employees respond to identification with their group.	Employee viewed in totality as a whole person.
Needs theories	All human beings have needs.	If one wants to motivate another, it is important to understand what level of the hierarchy that person is currently on, and to match the individual to the job.
Two-factor	Moves human beings towards pleasurable events and away from pain or discomfort.	Acts as a motivator, focuses on achievement, recognition, responsibility and opportunity for growth.
Theories X and Y	Manager's perception of the nature of human beings is based on a certain group of assumptions.	Y: Employees view work as being natural. X: Employees are seen as lazy.
Equity theory	Employees want to be treated fairly.	Employees evaluate the perceived equity of their rewards compared to others'.
Expectancy theory	Motivation depends on individuals' expectations about their ability to perform tasks.	Rewards satisfy the employee's personal goals.
Goal-setting theory (Locke)	Behaviour is a result of conscious goals and intentions.	Develops a thorough understanding of the processes by which people set goals and then works towards reaching them.
Reinforcement theory (Skinner)	Looks at the relationship between behaviour and its consequences.	Focuses on changing or modifying the employee's on-the-job behaviour through the appropriate use of immediate rewards or punishments.
Contingency theory (Fiedler)	Effective group performance depends upon the proper match between the leader's style of interacting with followers and the demands of the situation.	Changes the leader to fit the situation or changes the situation to fit the leader.
Situational theory (Hersey and Blanchard)	Focuses on the characteristics and maturity of followers in determining appropriate leadership	Followers develop and mature, managers need to vary their leadership style with each phase. <i>Directive leadership style:</i> Where followers lack

	behaviour. Involves four leadership styles.	<p>abilities to perform a task, strategies are used to equip them to complete the task.</p> <p><i>Coaching leadership:</i> Followers are motivated, encouraged and accompanied when they are hesitant to perform a task.</p> <p><i>Supportive leadership:</i> On a daily basis, acknowledgement is given for work performance. Followers experience a relationship of trust, encouragement, participation and guidance in problem solving, and the availability of the leader.</p> <p><i>Delegating leadership:</i> The leader delegates responsibilities to competent followers, who work independently, consult, report and give feedback to the leader.</p>
Path-goal theory (House)	Responsibility to assist followers in attaining their goals and to provide the necessary direction and/or support.	Ensures that goals are compatible with the overall objectives of the group or organisation.
Elements of leader situation (Hollander)	Leadership is a dynamic, two-way process of influence.	The leader and followers are interdependent; they both have roles outside the leadership situation.
Leader-group interaction (Schreisheim, Mowby and Stogdill)	More attention should be paid to the numerous factors that affect the interrelationships between the leader and the group.	Group cohesiveness is affected by group size, stress and relationships between group members, and should be promoted.
Complex man and organisations (Schein)	People are complex and highly variable. People can develop new motives, and motives can change over time.	Uses change management strategies.
Changing leadership theories	Missing element appeared to be the ability to respond to rapid change cycles.	Uses effective change management strategies.
Transactional leadership	Leaders clarify the role and task requirements of followers.	Sets goals on what can be expected of individuals, initiates structure, and provides appropriate rewards.

Charismatic leadership	Motivates followers to transcend their expected performance.	Ability to motivate and inspire followers, instils faith, respect and trust.
Transformational leadership	Brings about significant change in both followers and organisations.	Being caring and highly ethical.

Activity 19.5: Reading matter (Textbook page 223)

Issues that make nurses dissatisfied about their workplace

Dissatisfaction among nurses in the health services may also arise for the following reasons:

- The service has lots of people in motion but not much is getting done.
- Management believes that the way the organisation has always done a job is the only way to do it.
- The service has trouble with political games and backstabbing when it comes to salary increases, promotions and perks.
- Nurse managers find it nearly impossible to make rapid changes or decisions because of a morass of policies, forms, procedures and committees.
- Management ought to be more approachable at all times.
- The service pays some of the highest salaries at a given level to the most recently hired.
- The service awards the largest budget increases and new staff positions to those who spend the most.

The above-mentioned factors are important because they lead to job dissatisfaction. Remember, however, that if they are addressed they will not necessarily result in an increase in satisfaction or motivation (Dienemann 1998: 361).

Activity 19.7: Empowering managers (Textbook page 224)

As a professional nurse one should strive to acquire the characteristics of an empowering leader. This means being a role model who demonstrates

- fairness
- expertise in the particular field of practise
- trustworthiness
- hardworking behaviour
- caring for others
- openness to criticism.

Activity 19.9: Self-concept (Textbook page 225)

Read the statements below and indicate whether or not you agree with them.

Professional nurses with a good self concept should agree that the following statements are true regarding their self-concept:

- I think I am a skilled person.
- I have a good sense of humour.
- I am someone whom people can like.
- I make a good impression on people.
- My friends find me interesting.
- I am quite a pleasant person.
- I am attractive/handsome.

A nurse should be self-motivated by feeling good about herself and making a good impression. Her sense of humour and skills should enrich her daily tasks. A good self-image implies an assertive person.

Chapter 20: Communication in a health care unit

Emmerentia du Plessis, Elizabeth Johanna Jordaan and Martha Nozizwe Jali

Activity 20.1: Communication process (Textbook page 230)

Communication is a skill as well as an art that assists us in developing collaborative partnerships, gaining cooperation, clarifying needs and problems, and working effectively in interdependent relationships with the multi-professional team, the client, his or her family, groups and the community. Effective communication is characterised by simplicity, clarity, relevance, adaptability and credibility.

Communication plays a decisive role in decision making and problem solving, both of which are important management abilities that should be required of all managers of a health care organisation (e.g. the health care unit manager), as well as of all the employees in a given unit (clinical and non-clinical). These two concepts are almost synonymous as both relate to the cognitive processes of

- purposeful selection (selecting the most appropriate alternative)
- action/intervention (implementing the selected alternative)
- facilitation (to accomplish set goals, outputs or outcomes).

Decision making focuses on proactive activities such as the development of plans, strategies, policies and standards. It also forms the basis of problem-solving strategies which can be defined as “finding a solution to a particular problem”.

Key aspects of communication in the health care unit include: the communication process, interpersonal communication, communication in a group, organisational communication, formal communication, as well as non-verbal and verbal communication skills.

The health care manager is responsible for the establishment and maintenance of appropriate communication structures and strategies to promote the health of the individual, family, group and community. Communication within the unit involves the transmission of information from one person to another.

Table 20.1 lists a number of broad actions that may be taken to limit communication barriers and improve communication.

Table 20.1 Actions to limit communication barriers

- | |
|---|
| <ul style="list-style-type: none">• Communicate clearly and directly.• Be willing to answer questions and to clarify your message.• Listen mindfully. |
|---|

- Clarify uncertainties to avoid making premature judgements or conclusions.
- Show interest.
- Choose the most appropriate channel, time and medium of communication.
- Take into consideration the influence of noise, language and culture, cognitive abilities, fields of experience, meanings attached to messages; and recognise that all perceptions are partial and subjective.
- Acknowledge the other person's viewpoint and right to express him or herself.

Activity 20.2: Self-awareness (Textbook page 231)

Exercise This is me!

Purpose: To promote individual self-awareness in relation to thoughts, feelings, beliefs and attitudes.

Procedure: Complete the worksheet by completing the sentences.

Time: Approximately 10 minutes

Name: _____ Date: _____

I like people who _____

I feel sad when _____

The best thing that could happen to me is _____

I hate _____

When I am older I _____

I wish I could _____

I feel lonely when I _____

I think I hurt others when I _____

I am afraid of _____

When I look at my life I _____

I worry about _____

I care about _____

I am happy when _____

I get upset when _____

I hope _____

I feel jealous when _____

I would like _____

I am at my best when _____

I feel bad when _____

The worst thing that could happen to me is _____

I want to be _____

I like myself because _____
I feel great when I _____
Most people think that I _____
I think _____

The idea is that the person completing this exercise should write down what immediately comes to mind, in order to avoid rationalised comments. This exercise may be adapted for use as a group exercise by following-up with sharing answers and discussing how this exercise contributed to self-awareness and to interpersonal relationships.

Source: McConnon 1990

Activity 20.3: Formal communication (Textbook page 233)

Written communication

Documents in the health care unit are often legal and confidential documents. There should thus be clear guidelines in the unit regarding access to these documents, storing them and recording their content. Guidelines for recording should give attention to aspects such as legibility, correctness of information and systematic recording.

The following are examples of guidelines for recording information in a formal document:

- The ink colour to be used should be prescribed (e.g. black ink during day shift, red ink during night shift).
- Information such as the name and title of the recorder (and of the client if applicable), the date and time of the recording should always be stated.
- Errors should be corrected by drawing a line through the error and writing the correction next to the error.
- Blank spaces should be filled by drawing a line through the blank space.
- Information should be accurate, appropriate and complete.
- Only commonly accepted abbreviations and symbols should be used.
- Recording should follow a logical, chronological sequence.

Formal interpersonal communication

The purpose of this type of communication is usually to enable the completion of tasks in the health care unit, such as managing the unit and providing health care. Broad guidelines for this type of communication include the following:

- Communicate comprehensively, but be focused, accurate, clear and exact.
- Demonstrate critical thinking (e.g. point out irregularities, changes, similarities and trends).
- State problems and consequences, suggest possible solutions and mention the impact these solutions might have.

There are particular guidelines for *meetings* as a type of formal communication (written and interpersonal) exist. For example, notice of a meeting should be given in writing and in advance, and members should be consulted on the purpose of and agenda for the meeting.

Communication via the *telephone* is another type of formal communication. The telephone should be answered clearly and audibly using a friendly tone of voice. The person answering should identify him or herself clearly and professionally and should address the caller respectfully. Confidentiality should always be upheld.

Activity 20.4: Non-verbal and verbal communication (Textbook page 234)

Okun and Kantrowitz (2007: 76–82) are experts in communication skills, and describe a range of these skills and their value. Communication skills convey empathy, active listening, understanding and interest, and include the following:

- *Minimal verbal response.* This is a verbal indication, such as “mm”, “uh-huh”, that the listener is listening and following the conversation. Be careful not to inappropriately indicate agreement by using “Yes”, “Right”, “Okay” as minimal verbal responses.
- *Paraphrasing.* A paraphrase is a verbal statement that restates the content of what the speaker has said. The words the speaker used may be replaced by synonyms. Example: “*I couldn’t manage taking the pills yesterday.*” “*You had difficulty taking the pills.*”
- *Reflecting.* This involves communicating your understanding of what the speaker has said. Reflect on stated or implied feelings, omitted or emphasised messages, and/or non-verbal cues. Example: “*You really feel angry that the doctor forgot about your appointment.*”
- *Open ended questions and statements.* These are used to elicit discussion, to assess, to explore. Be careful not to use “why” questions, as they imply that there is a “right” answer that the persons should know. Such questions may be perceived as judgemental or threatening and the other person might become defensive. Rather use a question or statement such as “*What do you think is ...?*” or “*Tell me what you think is ...*”
- *Clarifying.* This is an attempt to focus on or understand the basic nature of a statement. Example: “*I feel left out of it.*” “*Please tell me what you mean by ‘left out of it’.*”
- *Interpreting.* An advanced communication skill, interpreting is used to promote understanding and bring about therapeutic change. Point out the relation between what the person has said, her or his non-verbal communication, the circumstances and underlying feelings.
- *Confronting.* When confronting, you respectfully provide feedback about reality. Own responsibility for the confrontation by openly sharing your own genuine responses to the person, for example about his or her avoidance or resistance.
- *Informing.* This means sharing objective and factual information.
- *Summarising.* A summary is a synthesis of what has been communicated. The major affective and cognitive themes are highlighted. It serves as a type of clarification and encouragement, and also promotes the process of interaction.

- *Silence.* Be aware of the value of silence, for example that it encourages reflection and can have a calming effect. Reduce your own anxiety to break the silence and allow space for the other person to be silent for periods during interaction.

Verbal communication processes

How to get the most out of a conversation with an employee

Face-to-face communication remains the most important form of communicating, whether it occurs formally, as in a scheduled interview or disciplinary situation, or informally, as in a chance meeting in the hospital corridor. The following approaches are worth considering in a conversation:

- One initial aim must be to establish rapport by making employees feel comfortable in your presence and willing to converse freely with you. A good starting point for any conversation is to get people talking about themselves.
- Listening activity is hard work but the manager must hear what the other person is saying and convey understanding and interest.
- The key to a successful conversation involves the following:
 - Get to the point, keep the conversation factual and objective.
 - Get all the facts before reaching any conclusion.
 - Avoid using too much direct questioning and don't cross-examine.
 - Don't use verbal or facial cues that alert the listener to what is coming.
 - Confront issues, not people.
- Practise conversation skills by calling people by their name. Maintain eye contact but don't stare.
- Use clear, straightforward oral communication. Eliminate space fillers such as "um", slow down and watch for signs of uncertainty, and do not talk too much.
- Keep the conversation rolling along and use motivational phrases. Remaining silent is another way of keeping the conversation flowing.
- Organise your thoughts, know what you want to say, and say it. Jot down subjects you want to discuss and make a note of the outcome of any discussion to remind you of any necessary follow-up.

How to make best use of the grapevine

Rumours and gossip are an inevitable part of everyday work life. The grapevine may be used to the advantage of the manager by using the following principles:

- Understand why rumours begin. They may, for example, be due to lack of information, a situation loaded with anxiety or prolonged delays in decision making.
- Assess the importance of any rumour before planning corrective countermeasures.
- Combat misinformation by calling a meeting and presenting the facts.
- Adopt a positive stance and don't risk reinforcing the rumour by restating it. Try to avoid references to it when disseminating the facts.

- Encourage employees to call you immediately if they hear something which appears to be particularly injurious to the reputation of the organisation.
- Stay in constant touch with key role players and opinion leaders. Their friendship may be valuable when you need people to support your position in a time of crisis.
- Learn to use the grapevine yourself and take advantage of it. You could, for example, do the following:
 - Tune in to it and learn what people think and feel.
 - Pass the word about some planned change in organisation routine and then wait to see what reaction comes back.
 - Release good news into the system before it is officially released.

Learn to live with the grapevine because it will always exist. Devote your energy to taking appropriate action and fostering conditions in the organisation which do not fuel the fire of rumour mongering.

Non-verbal communication approaches

Effective listening skills

If a nurse manager listens attentively and with empathy, a great deal will be eliminated in terms of misunderstandings, arguments, delays and mistakes. Become a better listener by adhering to the following principles:

- Commit yourself to each individual act of listening. Focus all of your listening capacity on the speaker.
- Neutralise your biases. Do not let your personal biases turn you off, despite what you may feel about the speaker's voice, character, appearance, reputation or the subject being discussed.
- Concentrate on what is stated. Listening is not a passive activity and the more you work at concentrating while listening, the more your powers of concentration will develop.
- Encourage the speaker by showing her or him that you are listening. This can be done by nodding, facing the speaker, making eye contact, leaning forward slightly, smiling and repeating key words. Don't interrupt the speaker's train of thought.
- Ignore all distractions, particularly if the speaker or the topic is dull, because it could happen that you do not hear something worthwhile or vital.
- Test your understanding by asking for repetition, clarification, amplification and examples. Summarise from time to time.
- Delay formulating your arguments or working on a response. In doing this you do not hear what is being said.
- Suspend judgement. Listening is a separate task to interpreting and evaluating, both of which can hamper the listening process.
- Don't talk too much. If you're seeking information, you shouldn't say much – you already know what you think.
- Listening is a key to personal success. Listening earns you power and respect, and gets you the information you need to be an effective manager (Flanagan & Finger 1998: 222–223).

The use of body language to improve communication

Understanding body language can make you a better communicator

- Face the facts. Effective communication depends more on *how* we send and receive messages rather than the *what* of communication. Non-verbal messages serve to either reinforce or contradict the message we want to send, and for that reason deserve our attention.
- Be aware of posture that can indicate boredom, interest or even fear. Sit up straight and don't cross your legs and arms. The latter may be interpreted as not being open to others' ideas.
- Keep control of hand and arm movements. Folded arms may suggest defensiveness rather than being receptive. Clasp hands in the lap gives the impression that you are in control and making critical judgements. Using your hands to emphasise a point may be effective, but generally hand movements should be confined to an area about the width of the body.
- Make eye contact that suggests that you are paying attention and are at ease with the topic.
- Face the speaker directly and smile to show your enjoyment of the message.
- Keep a distance that allows you to observe the listener's body language.
- Listen to the voice volume, tone and tempo of the speaker. These may indicate emotions such as enthusiasm or anger.

Written communication

Get your message across through the printed word

- Know your audience and write from the vantage point of the reader.
- Determine what your audience want to know and give it to them.
- Avoid jargon and convert your specialised language into everyday language for the wider audience.
- Few people want to know as much about the subject as you think they should, so keep the message short, simple and lively.
- To capture the majority of readers, make your points quickly and clearly.
- Writing should reflect your own natural speech.
- Whenever you can, focus your writing about people doing things.
- You should work hard on your writing. It is a skill that has to be learnt and requires constant practice.
- Ensure that the layout of the written document emphasises the message.
- Resist trying to condense too much information into one document.
- The appearance of the written document counts and should be in the correct format, well edited, and facts could be illustrated, for example by figures.

Activity 20.6: Assessment of the problem (Textbook page 237)

The following variables, which may affect decision making or problem solving, need to be analysed:

- Internal environment (unit):
 - Are personnel physically tired?
 - What are the intellectual abilities of personnel? How could these affect decision making or problem solving?
 - What are their intellectual abilities regarding the solution to the problem?
 - What emotions, in other words desires and feelings, are involved?
 - What is the level of professional maturity of group members?
 - Are they willing or unwilling to cooperate?
 - What moral values and ethical principles does each personnel member advocate?
- External environmental (service):
 - What circumstances or events outside the individual gave rise to the problem?
 - What is the human resource capacity (number of personnel)?
 - What is the available infrastructure?
 - What other resources (e.g. technology, finance and other support systems) are available?
 - What are the general relationships between the different disciplines?
- A synthesis of the problem or issue about which a decision has to be made, or that has to be solved, is then carried out. This will involve a complete decision-making and problem-solving diagnosis.

Activity 20.8: Brainstorming and nominal group technique (Textbook page 238)

Brainstorming

Brainstorming is the informal utilisation of the ideas and contributions of a group with a view to making a decision and finding a solution to a problem. The principles of brainstorming are as follows:

- Organise a group discussion.
- State the problem clearly: nature, extent and intensity of the problem.
- Request group members to contribute ideas in respect of their expectations and wishes (the decision-making criteria will applied).
- Avoid domination by one group member and give everyone an equal opportunity to make a contribution.
- Apply the principles of effective group dynamics.
- A logical clustering of ideas is necessary to prevent an awkward and lengthy list.
- Write down the expectations – problem-solving/decision-making criteria.
- Ask for ideas in respect of possible alternative options that may be used to solve the problem.
- The clustering of these options is necessary, based on a consensus decision by the group members.
- Write down the options as indicated.
- Identify the priorities in respect of the expectations or decision making and obtain consensus on the rating which will be used – for example, 10 marks for the most important and 5 marks for the less important expectations or criteria.
- Discuss each option and allocate a rating to each one.

- Calculate the score and prioritise the possible options accordingly.
- Debate the possible actions that may be taken to implement the most suitable options.
- Delegate responsibilities – each option to a specific group member – as well as an implementation deadline.

Consensus decision making is the basis of this decision-making process, which increases group cohesion and the group's commitment towards goal achievement.

Nominal group technique

This is a more formal and democratic decision-making technique, with a more formal voting procedure. “Nominal” means “in name only”, and this technique specifically excludes group interaction during the generation of ideas. (<http://www.businessdictionary.com/definition/nominal-group-technique.html>). The contributions of the group members are made in an organised and non-threatening manner (group members are usually asked to write down their ideas in silence). Each contribution is then discussed critically to obtain clarity about its possible consequences with a view to promoting informed decision making. Formal voting takes place; each group member rates the options on an individual basis according to the problem-solving/decision-making criteria agreed upon. The total of all the votes are calculated – it thus does not involve a consensus decision, but the statistical determination of the voting results. The average of the scores is calculated for each option and the option that obtains the highest score reflects the democratic decision that has been made.

As mentioned before, the principles of group dynamics and interpersonal relationships play an important role during the processes of decision making and problem solving.

Activity 20.9: Causes of conflict (Textbook page 240)

Management actions

- Communication is poor.
- Employees experience continuing surprises; they are not informed of new decisions that are taken.
- Employees are not involved in decision making and therefore do not understand the reasons for decisions.

The amount of resources

- Nurse managers have limited human and material resources that are continually diminishing, thus adding to existing stressors.

Beliefs, values and goals

- Incompatible beliefs, values and goals may cause conflict. For example, the nurse's value system may be different from that of other health professionals and she or he may differ from them on ethical issues such as abortion and HIV/Aids.

- Personal goals may conflict with organisational goals with regard to staffing, scheduling and the climate within which health professionals work. Nurse practitioners who are obliged to violate their standards may vent their anger against the system. Violating their personal standards also causes loss of self-esteem and emotional stress.
- Different backgrounds and experience may lead to conflict.
- There may be language barriers, and certain words or expressions may offend health professionals coming from different cultural backgrounds.
- Problems may arise if leadership is, for example, inconsistent, too strong or uninformed.
- Intra-territorial conflict exists where health professionals and non-professionals are increasingly becoming involved in industrial strikes, and as consumers of health become more knowledgeable about their rights, hospital–client conflicts are also on the increase.
- Inter-territorial conflict could exist between doctors and nurses due to technological advances that lead to nurse practitioners providing advanced professional care. This kind of conflict is becoming more common in health care delivery institutions.

Stress

- Conflict leads to stress, anxiety and the disruption of professional relationships. Stress can be created by factors such as too little or too much responsibility in a unit, lack of involvement in decision making, lack of management support, increasing standards of performance and the need to cope with rapid technological advancement.

Doctors' authority

- Doctors sometimes ignore nurse practitioners' suggestions or make it clear that they do not want their feedback. This causes anger among nurse practitioners as it diminishes their self-esteem.

Role ambiguity

- Role ambiguity and role conflict lead to role confusion, which results in disagreement between managers and health professionals concerning job responsibilities.

Activity 20.10: Communication in conflict (Textbook page 241)

Roussel et al. (2006) suggest the following to promote communication and manage conflict:

- Effective communication requires that all staff members should know their role in communication.
- Everyone should be provided with factual information; be inclusive and not exclusive.
- Consider all aspects of situations, including emotions, environmental considerations, and verbal and non-verbal messages.

- The nurse manager should have basic skills that include reality orientation by being directly involved and by accepting responsibility in resolving conflict; physical and emotional composure; active listening; and giving and receiving information.
- Active listening is needed. If a health care practitioner becomes angry, the manager should paraphrase what she or he has said in order to be sure that the perceptions are correct and also to clarify the message the person is conveying.
- Do not share anger because it will add to the problem; emotions should thus be kept under control.
- Convey, by both verbal and non-verbal responses, that the problem is being given serious attention. For example, maintain eye contact, avoid interruptions such as phone calls and maintain a serious manner.
- To find the cause of the anger ask short and simple questions in a calm manner and listen to the answers.
- Separate facts from opinions. An angry person often becomes unable to separate the actual reason for stress from her or his personal opinion about it. Asking questions in a calm manner will help direct the anger away from the emotional outburst towards the objective exploration of facts.
- The nurse manager should wait until he or she understands the whole story and the personalities of those involved before making a decision.
- Encourage those involved to find a solution. Suggested solutions should be expressed from the health professional's perspective, where possible using her or his own reasoning. Using leading questions such as "What would you do?", "What ideas do you have?" may help the health professional find a solution. Do not offer paternalistic advice.

General questions (Textbook page 243)

Question 10 Read more about the following

- Communication among people and teams
- Ethical standards for communication
- Reasons for communication failure

Communication among people and teams

Communication among people

The type of channel chosen affects communication. *Channel richness* refers to the amount of information that can be transmitted during a communication episode. Selection of an appropriate channel depends on the nature of the message. Routine messages convey data that are easily understood and do not require a very rich channel. Non-routine messages, which are more likely to be misinterpreted, require richer channels. Communication is used not only to convey information, but to persuade and influence people. To persuade and influence, managers connect to others on an emotional level, for example by using symbols and stories. Non-verbal actions and behaviours have a greater effect on whether or not a desired communication takes place than do the actual words spoken. Non-verbal communication is transmitted through actions and behaviours rather than through words. Listening is the skill of receiving messages, thus accurately grasping facts and feelings in order to interpret the genuine meaning.

Communication in teams

A *centralised* network means that team members communicate through a single person to solve problems or make decisions. In a *decentralised* network team members communicate freely with each other and arrive at decisions together. The *centralised network* is faster and is more appropriate for less complex tasks. The decentralised network is better for more complex tasks. A recent trend for empowering employees is *open communication*, which means sharing all types of information through the organisation, across functions and hierarchical levels. *Dialogue* offers a means of creating team spirit. It is a group communication process in which employees together create a stream of shared meaning that enables them to understand each other and share a view of the world.

Small and large group communication

People join small groups because they offer security, strength in numbers, moral support and ready access to advice.

The advantages of a small group are the depth of information available, the great number of solutions to problems it can generate and members' increased commitment to the group. The disadvantages of the small group are that it produces conformity among members; group thinking, which occurs when members start thinking alike, reduces creativity; one person may dominate, which reduces the effectiveness of the others; and group work is slower than individual action.

Large group communication may take place through meetings and conferences. For these activities to be effective, the following are important:

- Set a date, time and place.
- Plan the agenda, allow for variety on the agenda and allocate ample time.
- Arrange supplementary material.
- Arrange for the dissemination of post-meeting communication.

Ethical standards for communication

Examples of ethical standards for communication are as follows:

- Honesty and truthfulness in communicating facts
- Openness in distributing information to others
- Being informative about a specific situation and in making the correct decision
- Maintaining a positive attitude and friendliness in a climate of communication
- Using verbal and non-verbal communication to convey information that is accurate, complete, timely and correct
- Equal and fair treatment of clients in the delivering of health services

Reasons for communication failure

Communication fails for a variety of reasons. Understanding the reasons for communication failure will help you manage the situations that frequently result in communication failure.

Communication sometimes fails because of a *distortion in the facts*. Distortion results from deliberate lies as well as from being misinformed about the facts. Depending on the situation, distortion of facts may result in serious harm to an individual as well as to the organisation.

Communication also fails because of an *overload situation*. Overload frequently occurs when an individual is exposed to too much information in too short a time. An effective way to combat an overload situation is to transmit the message in writing rather than orally.

Communication may be hampered from a *lack of concentration* on the message. This may be the result of several factors, including disinterest, daydreaming, physical activity or noise occurring in the area, and fatigue.

Semantics problems may occur when an individual uses words in a way not commonly understood by the recipient, either because the word is misused or because the recipient is not familiar with that use of the word.

An important factor is *load*, which is the amount of information that can be sent through the channel during a given period of time. The sender needs to guard against creating an overload situation.

Another important factor is *immediacy*. The more quickly the message needs to be received, the more likely it is that the sender will have to depend either on one of the electronic mediums, including telecommunications, or transmission by courier.

Some channels result in one-way communication while others permit two-way communication. If *feedback* is necessary, a two-way communication process will be required. As a rule, one-way communication is faster than two-way communication, but two-way communication tends to be more accurate.

The *suitability of the channel* for the message is important. Some channels are more suited for some messages than are others; and some channels are simply not appropriate for certain types of messages.

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Chapter 22: Control and safety measures in a health care unit

Patricia Williams, Louwna Joubert Pretorius and Karien Jooste

Activity 22.1: Characteristics of control (Textbook page 255)

The following are the characteristics of control:

- *Control is a continuous process.* This means that the process is never complete but that it is ongoing. As new objectives are set or problems are identified new performance standards are established.
- *Control is a management process.* Controlling is an important management function, because it highlights and identifies errors and allows corrective action to be taken so that deviations from standards are minimised and the stated goals of the organisation are achieved in the desired manner. Controlling builds on the other management functions, namely planning, organising, staffing and directing
- *Control is embedded in each level of organisational hierarchy.* Control takes place at all levels of the organisation's hierarchy. Each of these levels has established objectives, and these are measured according to prescribed performance standards.
- *Control is both forward looking (anticipatory) and retrospective.* The control process anticipates problems and takes preventive action. With corrective action, the process follows up on problems. Ideally each person in an organisation should view control as his or her responsibility. The organisational culture should be such as to encourage people not to walk away from small, easily solvable problems because of the attitude that "it is not my responsibility".
- *Control is linked with planning.* Controlling requires the existence of plans, since planning provides the necessary performance standards or objectives. Planning and control bridge the gap between formulating and attaining objectives and ensure that all activities are performed as they should be.
- *Controlling is a tool for achieving organisational activities.*

Activity 22.4: Monitoring (Textbook page 261)

Please refer to [Appendix A: A policy on quality in health care for South Africa](#), for more information on monitoring.

Activity 22.5: Scenario (Textbook page 263)

Ward G is a medical unit; it is being managed by a newly appointed unit manager. She faces a great many challenges as the previous unit manager left without giving her any orientation on the functioning of the unit. The ward does not have a vision, mission statement or a philosophy. There are a few policies and procedures but these need updating. Personnel

have been carrying out their daily functions in a nonchalant manner, which has drawn complaints from the doctors. Client dissatisfaction is high even though there is no evidence from client evaluation forms to prove this. It is, however, apparent from the way some of the clients interact with the personnel. The personnel have a high absenteeism profile and are not committed to their work. Quality client care seems to be a foreign concept to them. The unit manager from the next ward tells her: “The big issue in Ward G was that the unit manager was a poor planner and did not know how to exercise control. People need to be controlled otherwise they will walk all over you.”

- Critically evaluate the above scenario.
- Identify the challenges faced by the manager.
- Design strategies that she can implement to deal with the challenges she faces.

Activity 22.6: Reading matter on occupation and safety (Textbook page 263)

Occupational health and safety legislation

South Africa’s legal framework comprises the Constitution, common law and lawmaking.

Read the following information and complete the activities provided.

Common law

Fundamentally there are two areas in South African law concerning the health and safety of persons. These are common law and statutes – written law consisting of acts and regulations. The Constitution is a statute. This is illustrated in Figure 22.1.

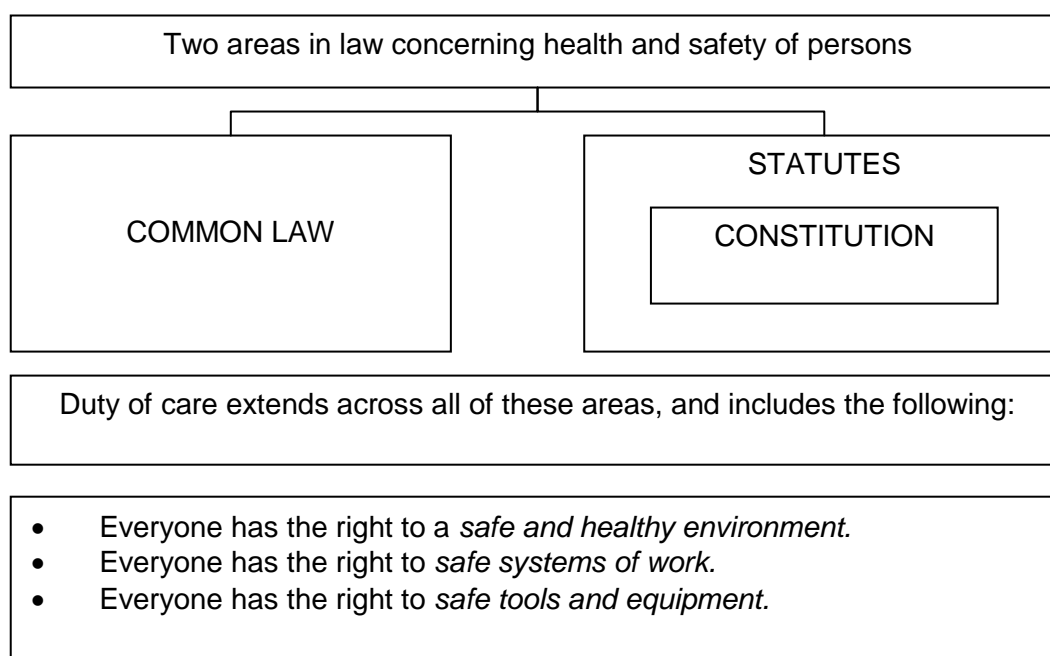


Figure 22.1 Overview of the health and safety legislation in South Africa

Common law is that part of South African law that is not contained in legislation. It includes Roman Dutch law, English law influences, tribal legal systems, old writings and reported court cases.

The Constitution

The Constitution of the Republic of South Africa, Act No. 108 of 1996, was approved by the Constitutional Court (CC) on 4 December 1996 and took effect on 4 February 1997. The Constitution is the supreme law of the land. This means that any legal provision, whether contained in common law or legislation, is subservient to the provisions of the Constitution. Furthermore, any such legal provision that is in conflict with a provision of the Constitution can be challenged in the Constitutional Court and may be declared invalid by the Constitutional Court.

Thus, no other law or government action can supersede the provisions of the Constitution. South Africa's Constitution is one of the most progressive in the world, and enjoys high acclaim internationally. The crux of the right to a healthy environment is found in section 24 of the Act. Everyone has the right to

- an environment that is not harmful to their health or well-being; and
- have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures that:
 - prevent pollution and ecological degradation;
 - promote conservation; and
 - secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development.

Law making: the South African legislative process

When a change in policy is made, the government often first puts forward its proposals in a *Green Paper*, which is a discussion document on policy options. It originates in the department of the ministry concerned and is then published for comment and ideas. A submission date is usually given for input from civil society. This document forms the basis for a *White Paper*, which is a broad statement of government policy. Comment may again be invited from interested parties.

Once these inputs have been taken into account (if they are sought at all), the minister and officials within the state department concerned may draft legislative proposals. At this stage, the cabinet also considers the proposals. Occasionally the proposed new law may be gazetted as a Draft Bill, for comment by a defined date, or given to certain organisations for comment. Once all comments have been considered the document is taken to the State Law Advisers, who check the proposals in detail and their consistency with existing legislation. These proposals are then printed by parliament, given a number and go to be tabled (i.e. introduced) in either the National Assembly or the National Council of Provinces. The document is now no longer a Draft Bill. It is a Bill and the introduction or tabling is called the first reading. After the reading it is put on the Order Paper and it goes to a committee for consideration.

The committee consists of members of the different parties represented in parliament who discuss the Bill. They sometimes call expert witnesses or invite submissions to help refine it, after which they may amend it. When the committee has approved the Bill, it goes for debate in the house in which it was tabled. Once that house has agreed to the Bill, it is transmitted to the other house and the same procedure is followed. When both houses have passed the

Bill, it is allocated an *Act* number and goes to the state president to be signed. It is then published in the Government Gazette as an Act and it becomes a law of the land. Sometimes there is no Green and/or White Paper and the process begins with the legislative proposals originating in the ministry or department. Figure 23.2 gives an overview of the process of how South African law develops.

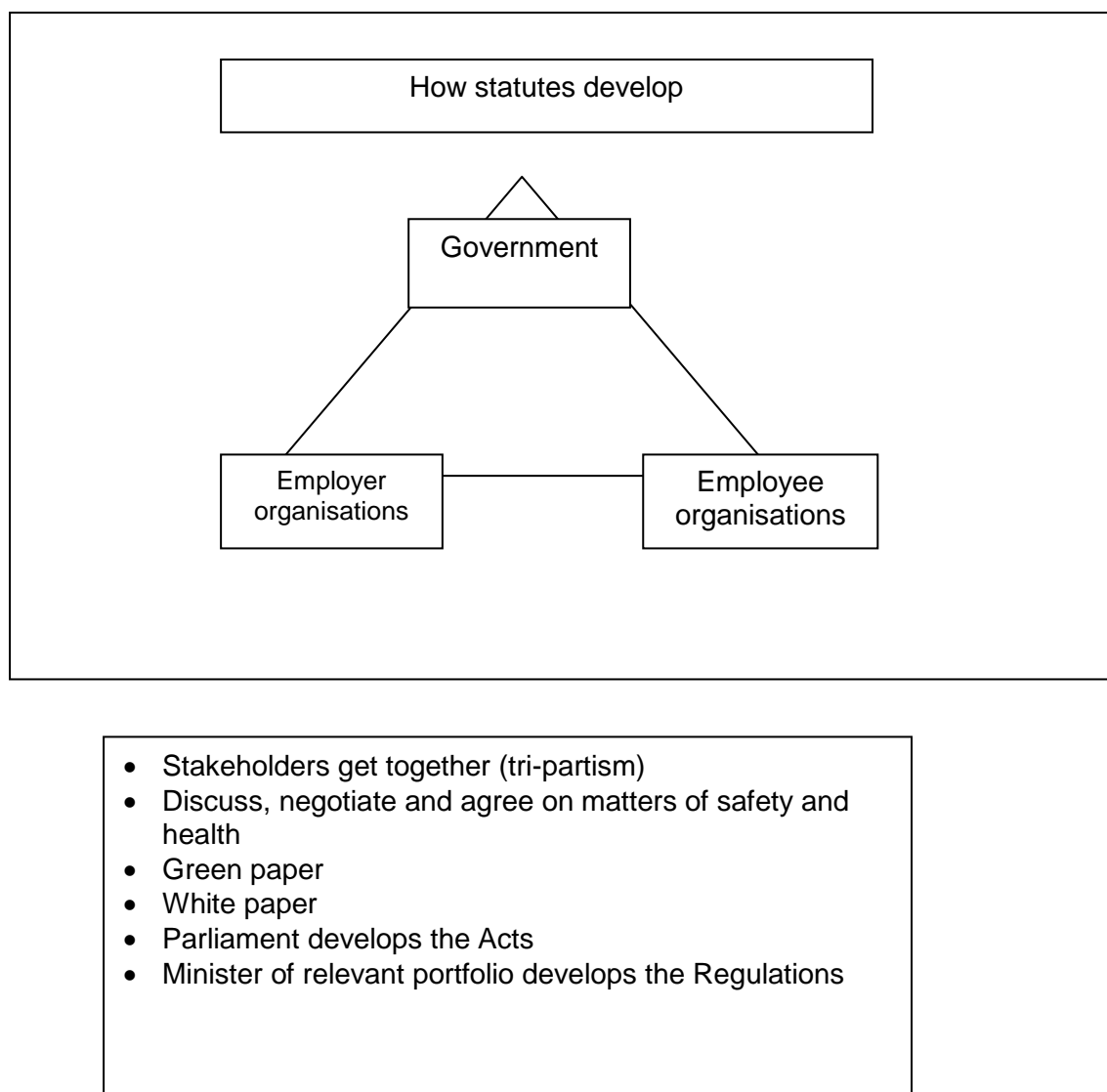


Figure 22.2 Process of law development

Table 22.1 explains the difference between an Act and a Regulation.

Table 22.1 Difference between an Act and a Regulation

<i>ACT</i>	<i>REGULATION</i>
Called an Act of parliament	Called a Regulation
Parts referred to as a section	Parts referred to as a Regulation
Sanctioned by parliament	Sanctioned by the minister of a particular portfolio in terms of the powers vested in the minister by parliament

Signed by the president	Signed by the minister of the particular portfolio
Only parliament can make or alter an Act or a part thereof, after consultation with relevant stakeholders	The minister can make or alter a Regulation or part thereof, after consultation with relevant stakeholders
Acts are more generalist	Regulations are more specific to help address the intent of the Act
An Act is like a policy	A Regulation is like a procedure on how to implement the Act/policy

Figure 22.3 explains the development of the Mine Health and Safety Act and Regulations.

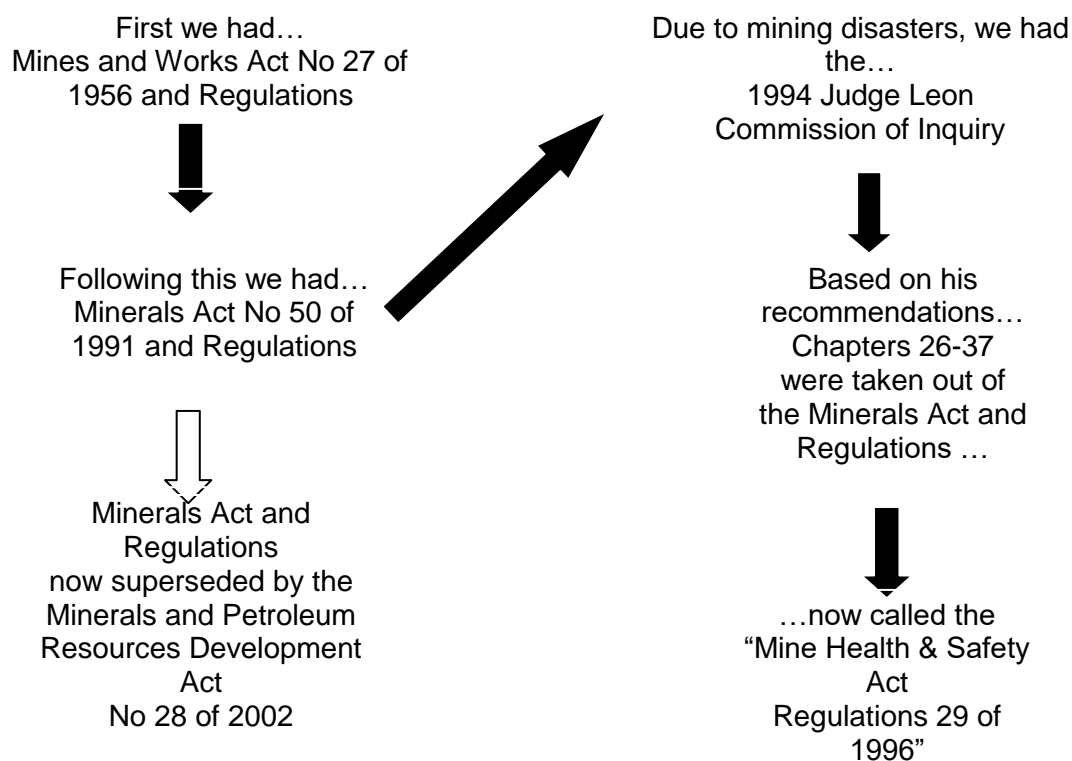


Figure 22.3 Development of the Mine Health and Safety Act and Regulations

Now study the sections of the Occupational Health and Safety Act No. 85 of 1993 (as amended) as instructed below.

Occupational Health and Safety Act (OHSA) No. 85 of 1993 (as amended)
Important sections and regulations
<p>Some important <i>sections</i> of the <i>Act</i>:</p> <ul style="list-style-type: none"> Read the headings of the sections to get an overview of what each section is all about. (Start with numerical numbering 1, 2, 3... .)

- Read the “long title” of the Act.
- Preview the definitions (section 1 – always in alphabetical order).
- Read “Penalties” (section 38).
- Read “Certain Acts not applicable”, section 1(3).
- Preview “Regulations” (General/Health/Mechanical/Electrical).
- Preview the annexures, tables, appendix and schedules to get an overview of how they apply to your current work environment.
- Preview “General duties of employers to their employees” (section 8).
- Preview “Duty to inform” (section 13).
- Preview “General duties of employees” (section 14).
- Preview “CEO charged with certain duties (section 16.1, 16.2).
- Preview “Functions of health and safety representatives” (section 18).
- Preview “Functions of the Health and Safety committee (sections 19, 20).
- Preview “Report to Inspector regarding certain incidents, occupational injuries and diseases” (sections 24, 25).
- Preview “Functions of an Inspector” (section 29).

Some important **Regulations**:

- Read the headings to get an overview of what each of the regulations is all about.
- Preview the definitions (Regulation 1 of each set of regulations).
- Preview the general Administrative Regulations, General Safety Regulations, Environmental Regulations for Workplaces, Hazardous Biological Agent regulations, Hazardous Chemical regulations, Vessel under Pressure regulations, Driven Machinery regulations and Electrical regulations in relation to the legal requirements for a health care unit.

Liability

In law we can identify two main types of liability, namely criminal liability (public law) and civil liability (private law).

Criminal liability falls within the ambit of the public law. The state charges a subject (which may be a natural person or a legal person such as a company) with a crime. For example, a person may be found guilty of the crime of culpable homicide if he or she wrongfully and negligently caused the death of another person.

Civil liability falls within the ambit of the private law. Civil liability arises between two or more subjects, when they litigate against each other. If, for example, a person sues the Department of Safety and Security for wrongful arrest, it is still civil liability although one of the parties is the state (see Figure 22.4).

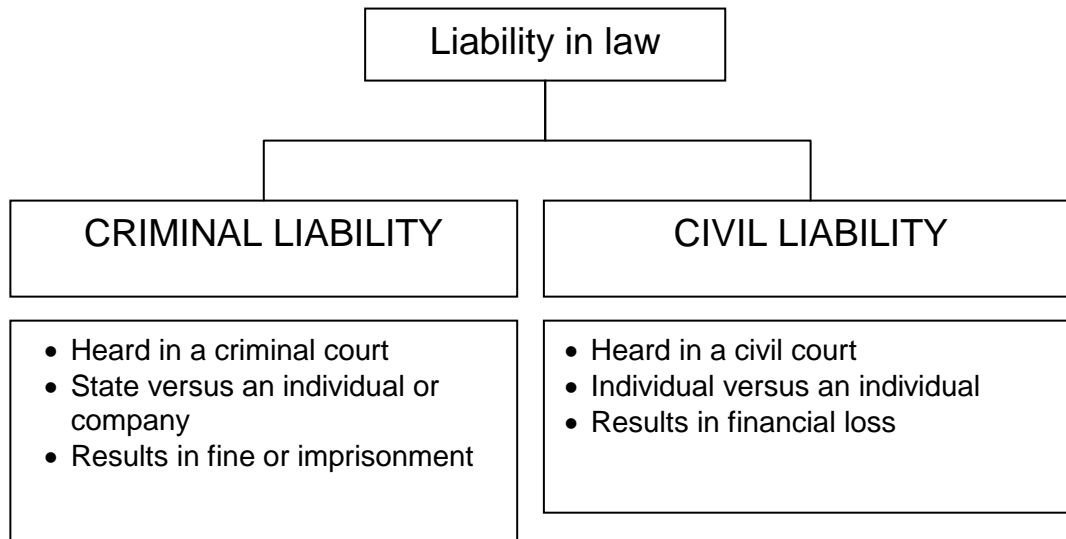


Figure 22.4 Liability in law

Personal liability. Various legislative provisions make individuals personally liable for contraventions.

The following sections of the Occupational Health and Safety (OHS) Act are relevant.

- Section 16 (1): Duties of CEO
Every chief executive officer shall as far as is reasonably practicable ensure that the duties of his employer as contemplated in this Act are properly discharged.
- Section 14c: General duties of employees at work
Every employee shall at work -
carry out any lawful order given to him, and obey the health and safety rules and procedures laid down by his employer or by anyone authorized thereto by his employer, in the interest of health or safety.
- Section 37 (3): Acts or omissions by employees or mandatories
Whenever any employee or mandatory of any employer or user does or omits to do an act which it would be an offence in terms of this Act for the employer or any such user to do or omit to do, he shall be liable to be convicted and sentenced in respect thereof as if he were the employer or user.

The following section of the Compensation for Occupational Injuries and Diseases (COID) Act No 130 of 1993 is relevant.

- Section 87 (c)
An employer who refuses or fails to pay any assessment, instalment or fine referred to in this section or any other money payable in terms of this Act, shall be guilty of an offence. This section should be read with section 89(1) (b) reading: If a contractor fails so to register or pay any assessment, the said employees of the contractor shall be deemed to be the employees of the mandator, and the mandator shall pay the assessments in respect of those employees.

Liability in respect of the environment can be established in terms of the National Environmental Management Act (NEMA), the following section of which is relevant.

- Section 34 (6)

Whenever any manager, agent or employee does or omits to do an act which it had been his or her task to do or to refrain from doing on behalf of the employer and which would be an offence under any provision listed in Schedule 3 for the employer to do or omit to do, he or she shall be liable to be convicted and sentenced in respect thereof as if he or she were the employer.

Many environmental acts contain similar provisions to those of section 37 of the OHS Act, namely that principals can be held liable for offences committed by mandatories and/or agents.

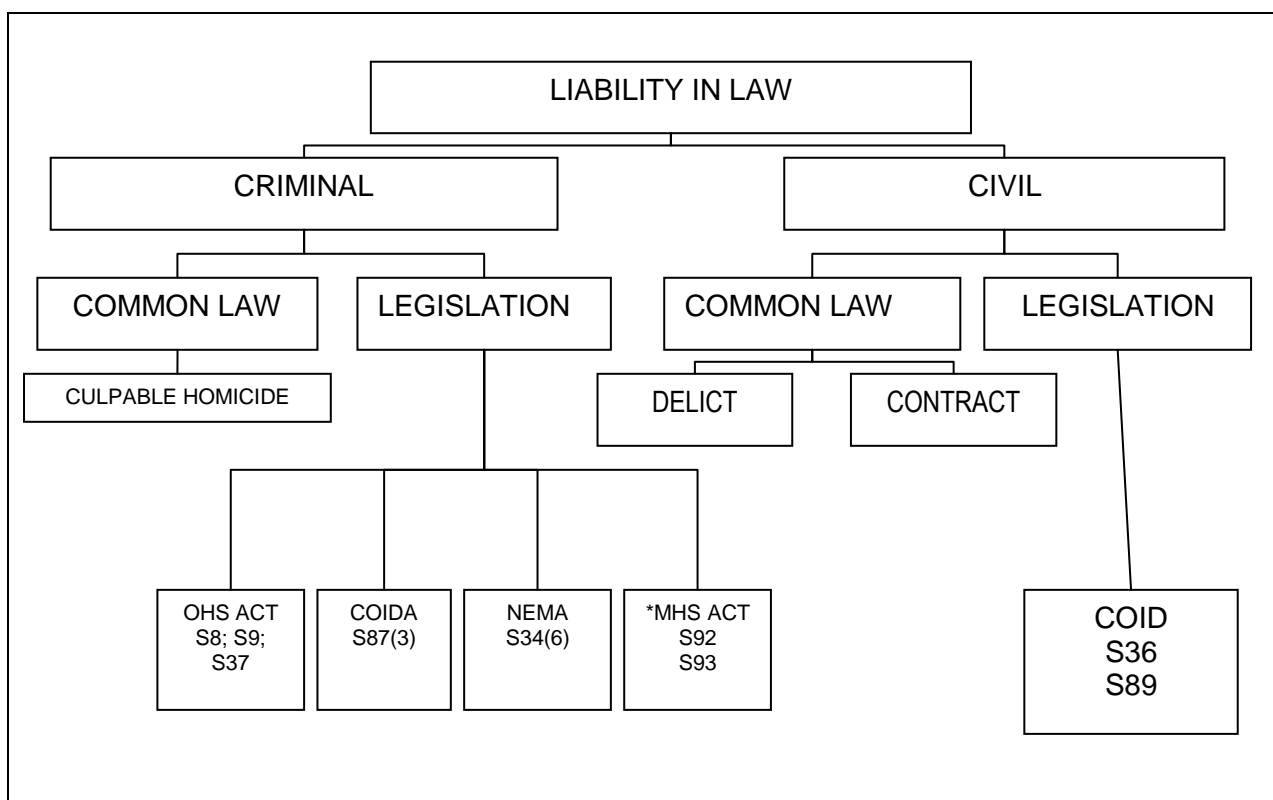


Figure 23.5 Liability in law – an overview

* MHS = Mine and Health Safety Act

Activity

Answer the following questions. Work in groups, if possible.

1. Give an example of a requirement in the OHS Act that is referred to in a regulation
2. Find an example in the OHS Act where reference is made to the use of an SABS/SANS code.
3. Find an example in the OHS Act where reference is made to the use of a Code of Practice.
4. Explain the numbering of the Compensation for Occupational Injuries and Diseases Act No 130 1993.
5. Can a Health and Safety Representative incur civil liability when he or she fails to do anything required by the OHS or MHS Acts? Find the answer in your Act.

6. Give an example of criminal liability. State who has to prove the liability, and whether there is a prescribed punishment for criminal liability.
7. Give an example of civil liability. State who has to prove civil liability and private law
8. In terms of the OHS and MHS Acts, does a CEO/employer have personal liability regarding the safety of his employees? Where in these Acts can the answer be found?
9. In terms of the OHS and MHS Acts, does an employee have personal liability regarding his or her own safety? Where in these Acts can the answer be found?
10. Have you ever had a civil liability case? Or do you know someone who has? Write an account of the case and its outcome.

Answers to above activity questions

1. For example: section 24 indicates that injuries must be reported; and in general administrative regulations (GAR) 8 it is explained how and when
2. Example: DMR - after DMR 23 - Incorporation of Safety Standards. SABS 0147, SABS 0148
3. Example: DMR – after DMR 23 – Incorporation of Safety Standards. National Code of Practice – For the evaluation of training providers for lifting machine operators.
4. It means that it was the 130th Act that was promulgated (signed by the state president) in 1993
5. No – OHS Act – section 18(4); MHS Act sections 25/26
7. For example: attorneys.
8. Yes – OHS Act section 16(1) ; MHS Act section 2(A)
9. Yes – OHS Act section 14(c); MHS Act section 22

Activity 22.7: Types of risk assessment (Textbook page 265)

Baseline risk assessment

The purpose of a baseline risk assessment is to determine the current risk profile of the place of work in order to identify the main focus areas of the risk assessment programme. The output of a baseline risk assessment is a set of risk profiles, which are used to prioritise both issue-based risk assessments and action programmes.

The first step in conducting a baseline risk assessment is to decide on the set of risk profiles that should be developed, that are most appropriate for the particular place of work. In developing a set of risk profiles, care should be taken to ensure that all significant risks are identified. It is possible to overlook significant risks if the risk profile selection is done incorrectly.

Typically, risk profiles may be developed for geographical areas. When this approach is used to develop a set of risk profiles, care should be taken that all activities, occupations and tasks, within each geographical area, that pose a significant risk, are included in the assessment.

During this type of risk assessment the following should at least be considered:

- Legal requirements
- Processes in any given area
- Activities in the geographical areas
- Tasks making up the processes or activities

Issue-based risk assessment

The purpose of an issue-based risk assessment is to conduct a detailed assessment study of the activities, occupations and tasks identified during the baseline risk assessment as posing a significant risk.

The output of an issue-based risk assessment is clear recommendations to management for

- input into continuous risk assessment
- action plans for the treatment of significant risk in terms of the statutory hierarchy of control and
- input into training programmes, standards, procedures, codes of practice and management systems.

The activities arising from the issue-based risk assessment programme may need to be modified due to, for example, the following occurrences:

- Accidents, incidents or “dangerous occurrences”
- New, and/or changes to, designs, layouts, equipment, or processes, etc.
- Findings that come to the fore during continuous risk assessment
- Requests from employees, regulators or members of affected stakeholder parties
- A change in the baseline risk profile
- New knowledge and information becoming available on the level of risk to employees
- A change in the perception of what a tolerable risk is

There are various techniques such as HAZOP, SWIFT, Fault Tree Analysis, SCAT analysis etc., that can be used to conduct an issue-based risk assessment.

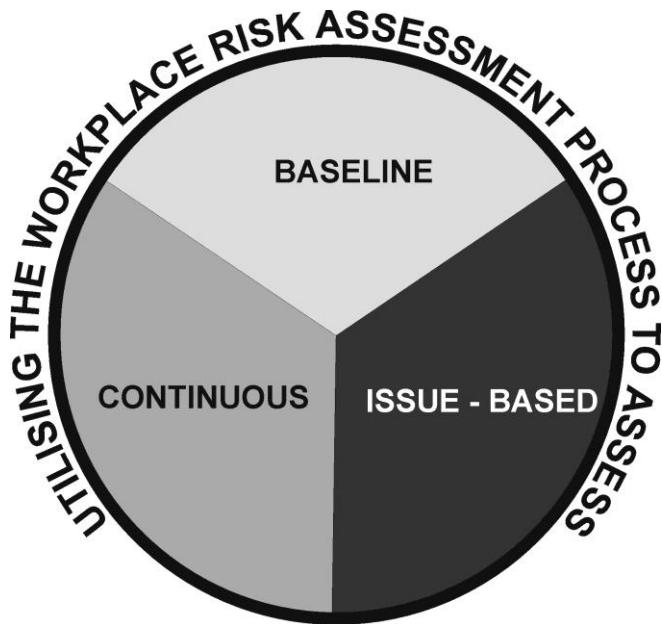


Figure 22.6 Types of risk assessment

Continuous risk assessment

This form of risk assessment is possibly the most powerful and important of all the types available, despite the fact that the level of sophistication is much lower than that of the baseline or issue-based risk assessments.

The purpose of a continuous risk assessment is to operationally identify occupational health, safety and environmental hazards for the purpose of treating significant risks.

Outputs of continuous risk assessment are as follows:

- Immediate treatment of risks, in order of significance and in a manner determined during the issue-based risk assessment
- Information that feeds back into issue-based risk assessment

The term “continuous risk assessment” is the main culprit in confusing most of the uninformed. From the name it is interpreted that the risk assessment will take place constantly, in other words without any breaks, irrespective of the location of the individual, and that all employees should identify any and all risks.

It is a fact that every employee – irrespective of the location, position or job category – should identify dangerous situations and take actions that will prevent incidents, but this has nothing to do with continuous risk assessment. These are merely activities that will occur at any place of work where the culture allows them to take place.

Continuous risk assessment should take place regularly, as an integral part of the day-to-day tasks of managers, supervisors and workers alike. This does not imply that the continuous risk assessment takes place continuously, but rather at predetermined intervals or times as identified during the issue-based risk assessment. The following activities could form the basis of continuous risk assessment provided they were developed from issue-based risk assessments:

- Planned inspections
- Planned maintenance systems
- Pre-work assessments
- Audits
- Planned task observations.
- Checklists
- Registers for fire extinguishers, ladders, various gas cylinders, medical equipment and supplies

In continuous risk assessment, the emphasis is on routine hazard identification, through risk assessment, and immediate risk treatment in a manner determined during the issue-based risk assessment part of the programme.

Activity 22.8 (Textbook page 268)

Examples of standards on infection control

Administrative measures of infection control in the unit

- A designated infection control practitioner is available.
- Vision, mission and core values on infection control are made available to all health care practitioners.
- Monthly statistics on nosocomial infections are kept.
- Reports on investigations of infections are kept.
- Reports of all notifiable diseases are available.
- Minutes of infection control committee meetings are available.
- The infection control quality improvement plan of the service is available.
- Reports are written on environmental hygiene and written recommendations to management are made.

Education and training

- Staff members attend the infection control in-service training programme.
- There is a programme for orientation of new staff members on infection control principles and practices.
- Policies and procedures are in place.
- There is a manual with infection control guidelines available in the unit.
- The institutional policies and procedures on infection control are available.
- Policies are available on
 - protective clothing
 - care of wounds
 - infections in burns
 - notification of diseases
 - clinical waste and sharps
 - linen management

- procedure of urinary catheterisation
- specimen collection
- isolation of clients
- preparedness for highly contagious diseases.

Statistics

Monthly statistics are available on all notifiable diseases and monthly wound infections.

Clinical areas and ward round

The unit manager should ensure that the following infection control areas are monitored during a ward round:

Clinical areas

- The walls and floors clean
- The ceilings, light fittings and ceiling fans clean
- Drains maintained in a good working order
- The toilets maintained clean and odour-free
- Dressing room/treatment room clean
- Trolleys clean
- Hand washing facilities available
- The temperature of the fridge monitored and kept at 0 to 5 CC
- The refrigerator cleaned and defrosted once weekly or when necessary
- Cupboards scrubbed at least once weekly
- The sluice room well ventilated, clean and neat
- Bed pans and urinals washed daily and decontaminated
- Windows clean and dust free
- The linen room well ventilated, clean, neat and well labelled
- The mattresses protected with washable waterproof covers

Equipment and supplies

- All supplies in the treatment room stored above floor level
- The shelf life for sterile packs and items followed
- Medicine kept and given according to established principles
- Medicine cupboard kept under lock and key
- The stock room kept clean and neat with shelves well labelled
- Stock room kept well controlled and locked at all times
- Stock levels indicated to prevent overstocking and to facilitate replenishment of stock
- Faulty equipment sent out timeously for repairs or condemning
- Vacolitrés checked for cracks and expiry dates

- Terminal disinfection done after each discharge or death
- Blankets sent for laundering after discharge or death of clients
- All containers for sharps disposable, rigid and puncture, water and tamper proof
- The waste management done according to protocol
- The colour coding of waste done according to protocol
- Well-operated water tap, sinks and soap available at strategic points in all clinical areas

Client safety

- Clients given continued health education on the importance of frequent hand washing and hygiene
- Hands washed before attending to the intravenous line
- Cannulae changed every 48 to 72 hours
- Infusion sites inspected at least twice daily
- Catheterisation done under aseptic technique
- Hands washed before and after client contact
- Aseptic technique followed for all dressings
- Septic wounds done at the end of the round
- Protective clothing readily available in all clinical areas
- Use of protective clothing closely controlled

Records

- There is a pest control contract
- There is a pre-planned nursing care plan available to enhance effective implementation of infection control practices
- All records kept and completed according to protocol and legal requirements

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Appendix A

A POLICY ON QUALITY IN HEALTH CARE FOR SOUTH AFRICA

National Department of Health, Pretoria

April 2007

<i>Abbreviated version</i>

Foreword

This abbreviated version of the *Policy on Quality in Health Care for South Africa* follows on the original that became national policy in 2001. It comes at a time when the public health care system is in dire need of again refocusing its collective efforts towards improving the quality of care provided in public health facilities and communities. Knowing that quality is never an accident, always the result of high intention, sincere effort, intelligent direction and skilfull execution, and that it represents the wise choice of many alternatives, this abbreviated version attempts to provide to all public health officials in a nutshell and in a more reader friendly language, the strategic direction health facilities and officials need to follow to assure quality in health care and continuous improvement in the care that is being provided. Health care personnel are encouraged to use this copy of the Policy to focus their intentions and guide their efforts.

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A. Background to the policy

1. A quality assurance policy for the whole health system - public and private

Each year 8% or more of the gross national product (GNP is an indicator of the wealth produced by the country) is spent on the national health system, including both the public and private health sectors. On average 60% of this is spent in the private sector, which provides care to 20% of the population. 80% of the population relies on the public health system for health care. This sector receives 40% of total expenditure on health. Any national policy must therefore include both private and public sector issues, and by so doing contribute towards strengthening the partnership between the public and private sector.

2. The key aims of the policy

The National Policy on Quality in Health Care provides a way to improve the quality of care in both the public and private sectors.

The policy sets out the main objectives of Government to assure quality in health care and to continuously improve the care that is being provided.

Achieving the goal of a quality health care system requires a national commitment to measure, improve and maintain high-quality health care for all its citizens. This involves measuring the gap between standards and actual practice, and working out ways to close the gap.

National aims for improvement include, but are not limited to:

Addressing access to health care;

Increasing patients' participation and the dignity afforded to them;

Reducing underlying causes of illness, injury, and disability through preventive and health promotion activities;

Expanding research on evidence of effectiveness;

Ensuring the appropriate use of health care services; and

Reducing health care errors (adverse events).

The national aims also reflect the needs of specific vulnerable populations and geographical areas.

Within each of these broad aims, health care providers should establish specific measurable objectives so that they can track progress in achieving these aims.

Priority is given in the policy to:

- **Conditions where most improvement can occur**, and which have the greatest impact on reducing the burden of disease, mortality and improving patients' quality of life and their ability to function;
- **Conditions where there is wide variation in service**, indicating that many health care practices may be inappropriate and not in line with current knowledge about effective health care; and
- **Conditions that is common and/or costly**, where improvements will most broadly result in better health of the population and more appropriate use of health resources.

3. The problems with quality in health care

Many quality problems in health care have been identified, in both the public and the private sectors. These include:

- Under-use and overuse of services;
- Avoidable errors;
- Variation in services;
- Lack of resources;
- Inadequate diagnosis and treatment;
- Inefficient use of resources;
- Poor information;
- An inadequate referral system;
- Disregard for human dignity;
- Drug shortages;
- Records not well kept; and
- Poor delivery systems.

These shortcomings endanger the health and lives of all patients, add costs to the health care system, and reduce productivity.

To achieve necessary improvements, a national policy on quality in health care is needed, together with commitment from all stakeholders, beginning with leadership from the highest levels of government, the national health system, labour, and the health care professions.

4. Issues addressed in developing the policy

4.1 Improve access to quality health care

Reduce excess capacity, plan packages of care at each level of care and allocate resources equitably to improve access to appropriate health care.

Health care capacity should be matched to the health needs of the population -

There is a need to reduce excess capacity, avoid waste and reduce costs, as well as increase capacity in other areas to ensure access for under-served populations, and ensure that the care provided across the health care system is appropriate.

Improved co-ordination of capacity - Access to knowledgeable and experienced health professionals is essential to improve access to quality health care. Also, research shows that facilities and practitioners that perform a higher volume of specific procedures can achieve better results than those that perform relatively few of the same procedures. Improved planning for which services are to be provided at which levels can help to maximize the benefits of volume and expertise.

An increase in health care capacity increases health care use - With more services and resources available, more people will want to use these services. This can help to extend the delivery of health care services to previously under-served populations.

Inadequate health care capacity, particularly in rural areas - In these areas, there needs to be targeted development efforts and new methods of delivering quality health care. For example, good quality care cannot be provided without high-quality doctors, but in many remote rural areas there are too few doctors. One approach is to limit new private medical practices in areas where there is already an oversupply of doctors, using the “certificates of need” procedure contained in the National Health Act, i.e. Act 61 of 2003.

4.2 Increase patients' participation and the dignity afforded to them

Community participation and the adoption of the *Batho Pele* principles are key to empowering users of services to take control of their own health care and that of their families.

Informing patients and involving them in decision-making - The active participation of patients in their care can improve the effectiveness of care as well as their satisfaction with their care. Patients who are treated with dignity and are well informed and able to participate in treatment decisions are more likely to comply with their treatment plans.

Enabling patients to care for themselves - Empowering individuals with the skills and tools to care for themselves is especially important for individuals with chronic illness or disability. Enabling users to assess their health, practise preventive health care, and self-care, will improve their health and reduce unnecessary health care services and costs.

Community participation - Not only individuals need to be encouraged to participate in health care, but also whole communities. The importance of community action has already been clearly demonstrated in the fight against AIDS.

4.3 Reduce underlying causes of illness, injury, and disability

Prevention is a good way to reduce the burden of disease and improve the quality of life.

Ensuring that correct clinical preventive services are available and used is an important way to reduce the underlying causes of illness, injury, and disability.

The shift from treatment to prevention has perhaps been most complete in the public sector. In the private sector many preventive services are either not sufficiently offered to appropriate patients or are widely provided despite a lack of evidence of their effectiveness.

While health care is important, many other factors contribute to the health status of the population. For example, injuries are the single greatest cause of disability and death, so injury prevention is essential to preventing avoidable disability and death.

Also, major gaps in health status among racial, socio-economic, and underserved populations need to be targeted to reduce the underlying causes of illness, injury, and disability. For example, individuals living in poverty are more likely to experience delays in receiving appropriate treatment, or to lack access to water and sanitation within their dwelling. Lack of transport is also a problem.

4.4 Expand research on treatments specific to South African needs and on evidence of effectiveness

Research and its application will help us to understand what treatments work best in South Africa.

Improving health care treatments through innovation and applying practices based on evidence of effectiveness is a major aim for improving the health status of South Africans. Additional efforts are needed to improve the ability to prevent, diagnose, and treat conditions that are common, costly, or significantly reduce health or functional capacity.

Until recently many health care practices lacked scientific evidence to demonstrate their effectiveness. More and better research is beginning to provide a sound base on which to develop evidence-based clinical practice. The commitment to evidence based health care requires a long-term effort to evaluate new and existing health care practices.

4.5 Ensure appropriate use of services

The appropriate selection of treatments and use of services require the practice of evidence-based health care.

A major aim for improving the quality of health care in South African should be to seek more appropriate use of health services through the practice of evidence-based health care, which is where scientific research has demonstrated the effectiveness or ineffectiveness of care.

The inappropriate use of many health care services has negative effects on the quality of care. Inappropriate care can result from either under-use (the failure to provide a service whose benefit is greater than its risk) or overuse (when a health service is provided even though its risk outweighs its benefit).

4.6 Reduce errors in health care

Health care can be improved by increasing patient safety.

Significant levels of error occur with health care, which often result in injury to patients. Health care and health status can be improved by way of improving patient safety and reducing the level of error in health care delivery. Systems can be designed and health professionals trained in methods to improve patient safety by reducing hazards in health care, and to make the consequences of errors less serious when they do occur.

5. Targeting quality assurance interventions

There are four main targets of intervention, namely:

- Health professionals;
- Patients;
- The community; and
- The health service delivery system.

Many interventions are directed at a combination of these targets.

5.1 Interventions aimed at health professionals

There is a need to develop expertise to help clinicians modernise their practice.

One of the greatest challenges facing health professionals is the rate of change and technical innovation in the health sector. Every year brings advances in the interventions available to screen for diseases, prevent diseases from developing, make diagnoses, treat conditions, and monitor the progress of disease. Keeping up with these changes is a daunting task. Also, the sheer volume of information available to the health professional is enormous and dealing with this information overload is a serious challenge. One cause of quality of care problems is that the health professional has erroneous, outdated, or no information or skills.

The traditional approach to keeping health professionals up-to-date is continuing professional development, using the continuing medical education (CME) conference.

Research has shown that the conference is not, by itself, an effective mechanism of change. More individualised outreach educational efforts involving leaders, often referred to as academic detailing, are more effective than traditional educational interventions. The outreach approach uses a combination of methods such as a departmental lecture by an expert, printed guidelines, and one-on-one visits with each practitioner.

Another method for improving care is structured encounter forms. Prenatal care forms are one example. Trials have shown that practitioners using a structured form had greater adherence to standards than those without the form. Patient satisfaction was also higher.

Feedback to health professionals about their performance has also proved to be a useful way of improving quality.

The policy recommends a range of interventions - rather one or two single measures - to assist health professionals to keep abreast of changes in health care knowledge and practice.

5.2 Interventions aimed at patients

Understanding patient's perceptions and concerns is key to improving quality.

There is a growing emphasis in health care on partnerships between the patient and the provider. It is clear that improved communication between the health professional and the patient, and providing patients with understandable information about their condition and treatment options, has a positive effect on health outcomes.

A common problem is patient refusal to participate in recommended interventions, such as in the treatment of TB. Strategies that focus on the needs and attitudes of patients - most commonly to enhance the use of preventive services and improve management of chronic conditions - have been found to be one of the successful approaches to this problem.

As with changing the behaviour of practitioners to improve quality, single approaches, such as user education strategies, are often not effective on their own.

Rather, multiple approaches are required.

5.3 Interventions aimed at the community

The active involvement of communities improves the overall health status of the population.

Not only is individual patient participation important in improving quality, but also the active involvement of whole communities. This has been amply demonstrated in the key role played by communities in the fight against HIV and AIDS.

Partnerships with community structures such as non-governmental organizations (NGOs) and community-based organisations (CBOs) are important for mobilizing community action and advocacy around health issues. These could include environmental awareness (for example, avoiding pollution of rivers and ground water, waste management, sanitation), domestic violence, road safety, and awareness raising campaigns around prevalent diseases and conditions like HIV and AIDS, diabetes, hypertension and obesity. NGOs and CBOs also play a vital role in the delivery of services like home-based care and community health workers. Representative structures like clinic committees and hospital boards help to facilitate community participation in local decision-making on health issues of concern to the local community.

5.4 Interventions aimed at systems

Managers can help to improve quality through modernising health care delivery systems.

Perhaps the most important innovation in quality improvement has been the increased focus on problems with systems.

By identifying weaknesses in systems that cause errors in processes or outcomes, the systems can be redesigned to avoid these errors and improve the quality of health care delivery. The results of changes to systems can be monitored and evaluated and further adjustments made where necessary. This is an ongoing process of assessment, redesign and monitoring and evaluation that ensures that systems are constantly evaluated and, where necessary, modernised to improve quality.

B. The Policy

This policy is based on a two-pronged approach to quality improvement:

- Creating the environment in which quality health care will flourish; and
- Building capacity to improve quality.

1. Creating the environment in which quality health care will flourish

Creating the environment will be done by:

- Strengthening the hand of the user;
- Focusing on equity of health care and vulnerable populations;
- Promoting public/private partnerships and the accountability of both sectors for quality improvement; and
- Reducing errors and increasing safety in health care.

1.1 Strengthening the hand of the user

Strengthening the hand of users requires information that they can use to make informed choices.

The needs of the users of health care services are of utmost importance. Empowered users have the ability to influence the quality of the care that they receive. This policy therefore includes several steps to strengthen the hand of users. These steps include:

- Ongoing user education;
- Providing users with reliable and relevant information on quality;
- Developing effective ways of communicating information;
- Providing assistance to users who need help in making informed health care decisions;
- Promoting user involvement on promoting the effective use of information by users.

Users need understandable, reliable information about quality to effectively participate in efforts to improve health care quality and fully exercise their rights and responsibilities.

Even when data on health care quality is available; it can often only be understood by researchers and clinicians - not by the general public. Therefore, there is no need to:

- Translate accurate, reliable quality data into user-friendly information that the public can understand;
- Use plain language and languages with which users are most familiar;
- Use a variety of communication approaches - not just the written word; and
- Ensure that information is available at the right time, when people need it.

1.2 Focusing on equity of health care and vulnerable populations

Equity can be used as the driving force to improve quality care to underserved populations.

Equity means ensuring that the whole population has access to quality health care. This means addressing the uneven distribution of health care resources across the country, as well as the wide variation in the quality of care throughout the health care system. In particular, there is a need to focus on the needs of historically disadvantaged individuals and communities and the most vulnerable sectors of society, i.e. women, children, older people and people with disabilities.

Equity requires:

- Redistributing health expenditure to achieve equity - those with equal need
- should receive the same level of funding;
- Redistributing health resources, in particular doctors and nurses;
- Setting national norms and standards to judge that all people receive an
- acceptable quality of care; and
- Monitoring progress.

Setting norms and standards is one important way of addressing the issue of equity as they help to ensure a basic minimum standard of care for all users of the health system, and their implementation can be monitored and evaluated.

Primary health care is the vehicle for achieving the long-term ambition of bringing the quality of health care for all people up to an acceptable standard. Norms and standards for primary health care spell out the standards of quality that are expected of the primary health care services in the public health sector.

Packages of care and associated norms and standards need also to be developed for other levels of care. These packages of care and associated norms and standards for the public sector will also be useful in the private sector to help address the problems of oversupply and overuse of services.

1.3 Promoting public/private partnerships and the accountability of both sectors for quality improvement

All participants in the health care system must be accountable for improving the quality of health care in South Africa.

A national initiative to provide leadership and direction to quality improvement in the National Health System requires collaboration between the public and private sectors. Through co-ordinated effort, the two sectors can complement each other.

Build on existing resources, experience, and expertise

A successful national effort to improve health care quality will need to build on existing resources, experience, and expertise. All efforts should promote and strengthen existing innovative work that is being done. Competing with, stifling, or slowing down these actions will not advance the national agenda for quality improvement.

Incorporate the views and expertise of all stakeholders

The commitment and active participation of all relevant parties is required to advance a co-ordinated national effort to improve health care quality. The various departments of health at each level of government, group purchasers, users of health services, public health officials, and health care organisations need information on quality to inform their purchasing or policy decisions.

Individual health professionals and health care organisations need to produce data and information on quality for both external and internal purposes. In order to provide stakeholders with the useful information they require, and to build their commitment and participation, their views on quality improvement will be actively sought. Not all stakeholders will be able to directly participate in policy-making processes.

Therefore, these processes must be as open, accessible, and accountable to the public as possible. They must also make available information that is easily accessible to all parties with an interest in health care quality.

Ensuring accountability for quality improvement in both the public and private sectors

To ensure that the public and private health sectors are collectively accountable for improving quality of health care throughout the country, strong public/private partnerships need to be developed through structures such as the National Consultative Health Forum, the Provincial Health Councils, Provincial Consultative Bodies and District Health Councils. These structures are ideally placed to ensure all stakeholders are incorporated or involved, the required technical expertise is accessed, and a nationwide agenda to improve health care quality is promoted and followed.

It is proposed that the governance structures mentioned above:

- Advise the National Health Council and/or Office of Standards Compliance on any matter relating to the quality of health care;
- Promote the development of national, provincial and local capacity to provide the technical requirements to further the quality care agenda;
- Suggest new additional quality systems; and
- Support the nationally located Office of Standards Compliance and the provincially based Inspectorates for Health Establishments in their respective tasks of ensuring compliance with the National Health Act, No 61 of 2003.

All participants in the health care system are accountable for improving the quality of health care in South Africa. To ensure that the national, provincial and local level structures mentioned above serve their full purpose of assuring and improving quality in health care, private sector organisations and national professional organisations will need to make a commitment to participate in these legal entities and in the national quality improvement processes they

follow. Also, medical schemes will need to continue to strengthen their accreditation, certification, quality measurement, and other quality-related activities in support of the national quality improvement strategy.

Private sector organisations and national professional organisations could demonstrate their commitment by:

- Participating in developing a comprehensive quality measurement strategy to address the national aims for quality improvement;
- Providing the said structures with information on compliance with the Patients' Rights Charter;
- Providing the Inspectorates for Health Establishments and/or the Office of Standards Compliance with information on the extent to which medical schemes, facilities, and other entities are reporting core sets of quality measures;
- Producing, for the public, comparative quality reports on the institutions they oversee;
- Recommending strategies for achieving greater improvements in health care quality;
- Identifying issues pertaining to quality improvement as required by the structures mentioned;
- Participating in the development of a research and development agenda for quality improvement;
- Implementing public education and communication initiatives in line with a national strategy; and
- Helping to agree on the measurement and reporting of quality for public accountability, and ensure implementation of standardised core measurement sets, and widespread compliance with an agreed national measurement and

1.4 Reducing errors and increasing safety in health care

An “adverse events” reporting system will help to reduce errors and increase safety.

Identifying and reducing errors and focusing on systems changes, can substantially reduce injuries and adverse events. Therefore an adverse events (incidents) reporting system will be developed for the National Health System to identify errors and prevent their recurrence.

2. Building the capacity to improve quality

This will be done by:

- Fostering evidence-based practice and innovation;
- Adapting organisations for change;
- Engaging the health care workforce;
- Providing appropriate training; and
- Investing in information systems that measure quality improvements

2.1 Fostering evidence-based practice and innovation

Fostering evidence-based practice requires building-up expertise in research on effectiveness issues, technology assessments and dissemination processes.

Improving the quality of health care requires a commitment to delivering health care based on sound scientific evidence and continuously introducing innovative, effective health care practices and preventive approaches. The lack of evidence supporting effective health care practices contributes to inappropriate care. Encouraging evidence-based practice, and promoting appropriate, effective health care requires a robust health care research enterprise, careful assessments of the effectiveness of health care technologies and practices, and approaches to encourage the widespread dissemination of effective health care.

Both public and private sector funding needs to focus on:

- Basic, clinical, prevention, and health services research specific to the needs of South Africa;
- Strengthening the scientific evidence base for health care practices through collaborating in technology assessment and research targeted at gaps in existing knowledge, in the South African context; and
- Encouraging widespread adoption of innovations that have been demonstrated to be effective, through awareness raising, information, and technical and other support for implementation programmes.

Dissemination of information on effective health care practice

To overcome the information overload described earlier, and promote evidence-based health care practices, it is essential to make existing clinical literature more accessible to practitioners and to develop practice guidelines.

Practice guidelines will be developed by respected institutions, and allow for local adaptation. Guidelines will actively involve local clinical leaders, and enable health professionals to use clinical judgement to determine whether they are applicable to particular patients.

Technical assistance and implementation programmes will be developed to encourage the widespread implementation of effective evidence-based health care practices.

Health care technology assessments

Any technology, device, new technique or therapy that has not been positively assessed elsewhere, should not be introduced in South Africa. Should the latter not be the case such technology, device, new technique or therapy should undergo an assessment procedure in South Africa. Where necessary, local expertise will be used to adapt assessments undertaken internationally for the South African health environment and culture.

2.2 Adapting organisations for change

Being able to adapt organizations for change requires skilled managers with a commitment to creating learning organizations seeking excellence, focused on users and working with clinicians.

Health care organisations (health sciences faculties, medical schemes, hospitals, nursing homes, other health establishments, and health professionals) need to keep up with the rapid pace of change in the science of health care.

Quality health care depends heavily on building strong relationships between patients and those who care for them. However, the systems of care that surround those relationships are becoming increasingly complex and difficult to manage. Health care organisations must be willing to learn from other industries that have demonstrated success in making complex systems function better in order to improve quality. While numerous health care organisations already have begun to tackle this task and provide good role models for others, much remains to be done.

The three key areas that need to be considered when looking at the organizational development required to improve quality in the National Health System, are as follows:

- **Quality improvement requires leadership** - Only strong leadership can build an organisational culture that supports change, establishes aims for improvement, and mobilises resources to meet those aims.
- **Quality improvement requires learning** - A health care organisation dedicated to continuous improvement must become a learning organisation.
- **Quality improvement requires organisational change** - Not all change is improvement, but all improvement requires change.

2.3 Engaging the health care workforce

Health professionals need to be closely involved in working out ways to improve the way they work

The changes taking place in health care systems and the efforts to improve quality mean that many health professionals are taking on new roles and responsibilities. Some health professionals are excited about these changes and the new opportunities they create. Others are unsure about whether their training has adequately prepared them for such dramatic changes. Also, while they understand the need for change, many of these health professionals want a greater voice in the process of change.

Health professionals who are strongly dedicated to caring for patients, knowledgeable, well trained, committed to continuous quality improvement and secure in their employment, need to be further developed to improve the quality of care.

The impact of restructuring on the workforce

Understanding the impact of industry change on workers is an important part of assessing the industry's overall quality improvement efforts. While policymakers, consultants, and managers can design quality improvement strategies, it is health professionals, ancillary personnel, technicians, and other health care workers who ultimately have to implement those strategies. Their willingness to strive for continuous improvement in their work depends on that work remaining intellectually and emotionally rewarding and on the extent to which health care workers are treated as stakeholders in all respects.

Evaluation of work systems

As is the case in many other industries, health care organisations are looking to reengineer internal operations to increase efficiency and effectiveness and improve quality and patient satisfaction. Changes are being made not only in how work is organised, but also in workplace culture. Traditional hierarchies are being challenged and workers are being asked to take on new roles and responsibilities.

The reorganisation of work often involves:

- Breaking down departmental barriers and professional alliances;
- Challenging commonly accepted assumptions about the need for centralized clinical support functions (e.g. lab, radiology); and
- Re-examining and reconfiguring job requirements and skills.

There are many different terms used to describe these processes, including patientcentred care, work redesign, operational re-engineering, or simply restructuring.

2.4 Training and professional development

Providing quality care to patients requires training skilled health workers and establishing a culture that values lifelong learning and recognizes its important role in improving quality.

Training

The philosophy and approaches of this policy need to be reflected in under-graduate training curricula of all categories of health care workers and in the post-graduate training curricula of all categories of health professionals.

Continuous Quality Improvement (CQI) skills and techniques need to become an integral part of the management training of health workers. A learning framework for quality assurance will be developed and the National Health Council will use this framework to ensure that a critical mass of expertise is established at each level of care. Every training programme will provide a strategy for on-going support and mentorship.

Continuing Professional Development (CPD)

Continuous advances in health technology and patient care require that the skills of health professionals be continually developed. Professional competencies directly impact on the quality of care being provided and on the amount of trust patients and their families place in health professionals.

Continuing Professional Development will be expanded to include all categories of health professionals registered in terms of applicable legislation.

Health professionals and professional bodies, in collaboration with their colleagues will develop Continuing Professional Development programmes. The programmes will meet the National Health System's service development needs and the learning needs of individual health professionals, including specific professional development needs, or different learning preferences such as peer group or individual learning, and learning on-site.

Outcome review programmes will be developed to continually measure the competence of health professionals.

Adjusting education to changes in health care provision

Changes in the National Health System are bringing changes in the skills health professionals within that system need to do their jobs. The institutions that educate health professionals, such as academic institutions, employer-based programmes, and other entities, need to embrace change if they are to succeed in preparing the next generation of physicians, nurses, allied health professionals, and other health care workers.

2.5 Investing in information systems that measure quality improvements

National standards for private and public information systems are required to measure quality improvements across the National Health System

Health care information systems must be able to:

- Guide internal quality improvement efforts;
- Generate data on the individual and institutions' comparative performance;
- Help improve the co-ordination of care;
- Advance evidence-based health care; and
- Support continued research and innovation.

Existing information systems generally are not adequate for these purposes. National standards for the structure, content, definition, and coding of health information will be established to support improvements in information systems. Whenever possible, this effort will encourage the widespread adoption of existing standards and build on the work of existing public and private entities rather than creating additional layers of oversight.

3. Delivering quality care - in the public sector

While it is sensible to have a national policy and develop national standards for both public and private health care, it is the task of staff in each sector to deliver the quality improvements. This requires a Quality Assurance culture and approach to the delivery of health care. For the public sector this requires action at all levels. This part of the policy document describes proposed methods to be used that follow the approaches outlined above.

Consistent local action is needed to ensure that national standards and guidelines are reflected in the delivery of services. The District Health System is ideally positioned to facilitate this local action, because it is close enough to the community to be responsive to their needs, and is a powerful vehicle for improving the quality of care.

However, Level II (Regional), Level III (Tertiary) and Specialised Hospitals that are not viewed as part of the health district will also require very special attention. The need for action at the local and hospital level demands that competent health professionals are available to assure quality in health care and to continuously improve the care that is being provided. Competent and skilled health professionals can only be obtained by continual training and professional development.

3.1 The District Health System

The District Health Team

Each District Health Team will, among other things, be required to:

- Nominate at least one person to take responsibility for quality assurance (QA) and continuous quality improvement (CQI) activities within the district. This person(s) will be accountable to the District Health Manager;
- Ensure that proper processes are in place for assuring and improving the quality of the clinical services they provide within communities, clinics, community health centres, district hospitals and other district-based health facilities. This will include, among other measures, processes to ensure an effective referral system;
- Ensure that local communities are empowered to actively participate in the development of local health policies and in decision-making on matters affecting their health. This will be done through establishing functional facility-based committees/boards in all health facilities and through the training of committee/board members.

- Ensure the catchment areas of all facilities are mapped and a clear picture is provided of the population to be served, the needs of the community and the role of the health facility in providing appropriate services.
- Demonstrate to governing authorities such as the District Health Council, the metropolitan or district municipal council, or to the local municipality within the relevant health district, that actions have been taken to address issues highlighted by regular Patient Satisfaction Surveys.

The responsible person(s) within a health district will collaborate with the Inspectorate for Health Establishment to ensure that quality standards are being met. The responsible person(s) will also ensure that quality improvement teams are established within and/or amongst health establishments in the district and that all health professionals participate in the programmes of these teams. Guidance will be provided to health facilities to establish these Facility Based Quality Teams (Service Improvement Teams) and programmes will be designed to empower employees.

Hospitals at all levels and Specialised Hospitals will also be required to nominate one or more persons to take responsibility for quality assurance (QA) and continuous quality improvement (CQI) activities within their hospital or hospital complex. These activities will also be undertaken through Service Improvement Teams.

The Facility or District Based Quality Teams responsible for ensuring and improving quality and for resolving quality problems, will apply the following five main principles:

- **A focus on user needs:** User needs and desires will be central in the planning and performance of any activity. The term “user” refers, in this case, to both, (a) external user, i.e. the beneficiaries of health services, and (b) internal user, i.e. those within the organisation who rely on fellow workers for products and services that help them to fulfill their part in providing quality care to the external user. Internal users include front-line health professionals, supervisors, and other health team members;
- **A focus on systems and processes:** A system is a set of processes that function together, e.g. a vaccination system includes processes for the delivery of vaccines, their storage and distribution, vaccine administration, and programme evaluation;
- **A focus on data-based decisions:** Improving processes requires information about how they function. Decisions about problem areas and improvements shall therefore be based on accurate and timely data, not assumptions;
- **A focus on participation and teamwork:** All health workers need to participate in making changes in their organisation’s systems and processes; and
- **A focus on leadership:** Leadership will be developed and nourished to ensure that each district and each hospital has a critical mass of leaders and managers.

Public health facilities and private health practitioners have a close relationship, especially where the private health practitioner depends on the public health facility for accessing technology such as aseptic operating theatre suites with anaesthetic machines, intensive care units and radiological services. This relationship demands that the district ensures private health practitioners contribute towards:

- Planning the facility’s clinical services;
- The functioning of the facility’s multidisciplinary team(s);
- The facility’s patient record;
- Ensuring a safe clinical environment;
- Ensuring safe delegation of responsibility to other staff members; and
- Monitoring the quality of care in the facility environment.

Health Districts, as health care providers, will enter into contracts or agreements with the funders of services. These agreements will also focus on matters that relate to quality of care.

Provincial Departments of Health

Provincial health departments will control and improve the quality of all health services and facilities in their respective provinces. This will be achieved by utilizing their respective Inspectorates for Health Establishments, Provincial Health Councils, Provincial Consultative Bodies, and District Health Councils.

A dedicated unit to manage all provincial initiatives regarding quality assurance and continuous quality improvement, needs to be established in each Provincial Health Department. This unit shall closely collaborate with the provincial Inspectorate for Health Establishments, and establish strong links with the Provincial Health Council, the Provincial

Consultative Body, and the various District Health Councils within the province to support quality improvement in health services.

3.2 Monitoring Standards

There will be an ongoing Quality Monitoring (monitoring compliance with standards) process within the National Health System to determine whether health services really are delivering the quality care patients have a right to expect.

Quality monitoring by the user of services

A National Complaints Procedure

The user of services within the National Health System is entitled, personally or by representative, to obtain a full explanation and a speedy and effective remedy for a professional or other fault from a public, private or non-governmental health establishment, its governing body, its directors, or employees or a health care provider.

Therefore:

- A National Complaints Procedure needs to be established and should be upheld by all health establishments.
- The National Complaints Procedure allows for:
 - (a) Resolving complaints at the point of service delivery; and/or
 - (b) Referral of unresolved complaints.
 - (c) Providing feedback on the outcome of the procedure.
- Mechanisms will be established to inform communities of these procedures.

A Patient Satisfaction Survey

The views and experiences of users of the National Health System are an important element in assessing performance of the health services. The surveys will enable health establishments to assess their own progress and compare their performance with services elsewhere.

Therefore:

- Regular national patient satisfaction surveys will be held to collect information on patient and user experiences and views;
- The results of the surveys will be published in national reports that will be made available to the public; and
- The surveys will include, among other measures, an assessment of compliance with standards that relate to the National Patients' Rights Charter.

Quality monitoring through structures of governance

The Office of Standards Compliance

The Office of Standards Compliance will select a standard national set of a limited number of indicators for each level of care to monitor, so that it can provide the Minister of Health and/or the National Health Council with an annual General Assessment Report on quality.

The Office of Standards Compliance will conduct specific ad hoc surveys to obtain baseline information, to determine progress after a defined period of time, and to set national benchmarks.

The provincial Inspectorate for Health Establishments will measure standards compliance in private and public health establishments in accordance with standards agreed by the Office of Standards Compliance. Compliance will be rewarded through a system of accreditation, licensure and certification.

The provincial Inspectorate for Health Establishments

The provincial Inspectorate for Health Establishments will develop and monitor a standard provincial set of indicators that will include the national set of indicators, so that it can, (a) compare establishments within a specific province, and (b) report to the relevant member of the Executive Council and the Office of Standards Compliance every quarter.

The Inspectorate for Health Establishments will monitor aspects of quality contained in the contracts or agreements between providers and funders of health care services. The Inspectorate for Health Establishments will also monitor how health establishments comply with conditions imposed on them relating to the certificate-of-need process.

Hospital Boards and Clinic Committees

Every hospital and every clinic will establish a board or committee with members from the community and from management. The board or committee shall, among other matters, deal with matters relating to the quality of care provided to the community. Such matters include:

- Whether patients' health rights are being upheld;
- Whether *Batho-Pele* principles are adhered to in service delivery; and
- Collective complaints

Quality monitoring by the provider of services

A Staff Satisfaction Survey

A national Staff (Provider) Satisfaction Survey will run together with the national patient satisfaction surveys. Information on the experiences and views of health care providers will be collected and used to identify what aspects are negatively impacting on the quality of care that is being provided.

Clinical audit

Clinical audit is essential in patient care as it brings together professionals from all divisions of health care to:

- Consider clinical evidence (evidence-based health care);
- Promote education and research;
- Develop and implement clinical guidelines;
- Enhance information management skills; and
- Contribute towards better management of resources.

All health professionals at all levels of care will participate in clinical audit. Self-assessment needs to take place to accurately assess performance in relation to established standards. Clinical audit teams will be established to perform the following tasks:

- Determine what aspects of current work are to be considered for auditing;
- Describe and measure present performance and trends;
- Develop standards, if these are not available;
- Decide what needs to be changed;
- Negotiate change;
- Mobilise resources to effect change; and
- Review and renew processes

A standardised managerial model will be developed to prevent the clinical audit and peer review process developing into a search for error only, which could lead to the denigration and condemnation of others.

To enjoy public confidence, the process of peer review will be:

- Open to public scrutiny;
- Responsive to changing clinical practice and service needs;
- Publicly accountable for nationally set professional standards; and
- Publicly accountable for the action taken to maintain these standards.

Professional bodies will have procedures in place to ensure prompt action when problems occur.

Supervisory visits

Supervisors will agree with staff on the number and format of formal supervisory visits to take place each year. These formal supervisory visits shall ensure all aspects of service delivery are addressed and health workers' needs are met. Supervision will, include:

- Providing support in solving problems;
- Training to help improve performance;
- Reviewing individual performance;
- Monitoring clinic services; and
- Inspecting mandatory or statutory functions.

Facility Based Quality Teams

Facility Based Quality Teams (Service Improvement Teams) will monitor the quality of the services they provide through analyzing the core data they collect on, for example, health resources, management information, maternal, child & women's health (mortality and morbidity data), and infectious diseases.

Quality monitoring by professional bodies

Professional bodies will continue to monitor standards of professional conduct in accordance with relevant legislation.

* Please note that this document has been modified for purposes of this book.

Chapter 23: Staff development

Zerish Zethu Nkosi, Ansie Minnaar and Karien Jooste

Activity 23.1: Demonstration (Textbook page 275)

Performing an accurate procedure on the client is a priority in the health care environment. As a health care professional you need to be competent before practising your skills on a real client. The process outlined below may be followed in a clinical skills laboratory under the supervision of a facilitator or preceptor.

- A skill in which the students are incompetent is chosen.
- The procedure should be done in pairs.
- The skill is practised on a mannequin.
- Instructions on a checklist should be followed carefully.
- Peers should observe each other critically.
- Roles should then be exchanged and the procedure repeated.
- The learners should then comment about their experiences after their peers have judged their performance.

Activity 23.2: Discussion (Textbook page 276)

Jarvis and Gibson's (1997) three discussion methods are described below.

Teacher-controlled discussion

The teachers are in charge of the interaction and they present the topic for discussion, expecting some verbal participation on the part of the students. The teacher directs the discussion, controls its pace and also selects the topic under discussion.

Guided instruction

This approach utilises the student's experiences more than is the case in a teacher-controlled discussion. Teachers seek to elicit information, knowledge and ideas from the students by means of a carefully prepared process of questioning. Teachers lead the students from what they already know into new realms of thought by building one question upon another, taking the students through a logical sequence of stages until they are able to draw conclusions. The guided discussion technique is useful to help students reflect upon their learning experiences, capitalise on their learning and pursue more thoroughly the ideas that the experiences set in motion.

Student-controlled discussion

In this situation the students ask all the questions. The degree to which the students feel free to ask significant questions will depend upon the rapport between the teacher and the students. Students should always be encouraged to raise significant questions about professional practice. The answers they receive should always be honest. Thus if the

facilitator does not know the answer to a question, she or he should admit to it and suggest that they endeavour to discover the answer, together.

Activity 23.3: Crossword puzzle (Textbook page 276)

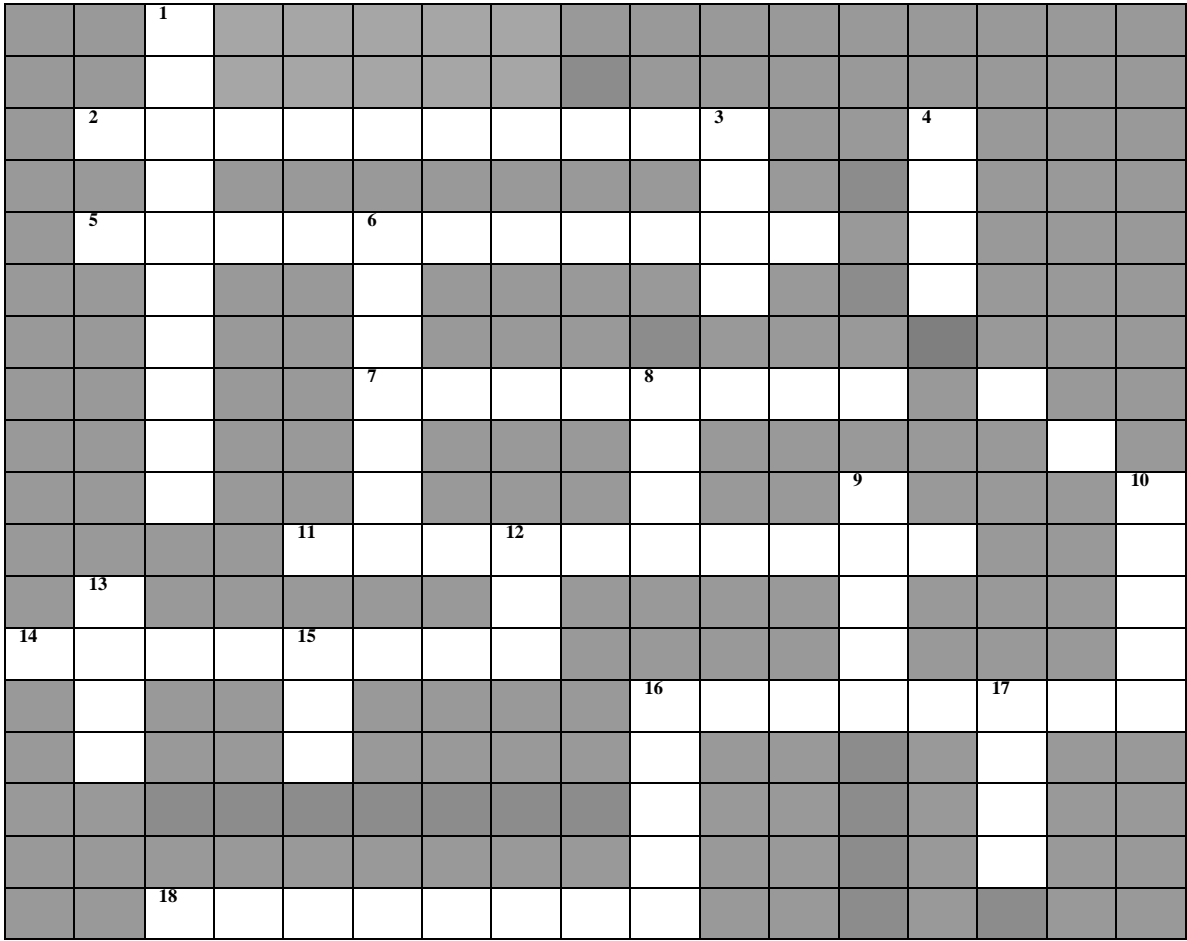
The number in brackets indicates the number of letters.

Across

2. ----- promotes critical thinking (10)
5. A guide and a leader for students (11)
7. A teaching method that dramatises real life events (4, 4)
11. Supplying spontaneous suggestions or solutions to the problem (10)
14. ----- pays (4, 4)
16. Each and every learner should be ----- literate (8)
18. The results of performance in terms of success or failure (8)

Downwards/Upwards

1. A novice should perform a----- first before dealing with a real client (10) (upwards)
3. The level of concentration drops at this time (4)
4. Either you win or you ----- (5) (upwards)
6. Nowadays, one aspires to be a self -directed ----- (7)
8. Writing instruments (4)
9. Working in a ----- improves your problem solving skills (5)
10. It is wise to plan realistic ----- goals (5) 12. The ----- runs dry (3)
13. An exam result is pass or a ----- (4)
15. Students who work hard ----- in the end (3)
16. These are examples of real problems (5)
17. Due to shortages of staff ----- scheduling is the best solution (4)



Which team finished the puzzle first? Announce the winners!

Mentoring

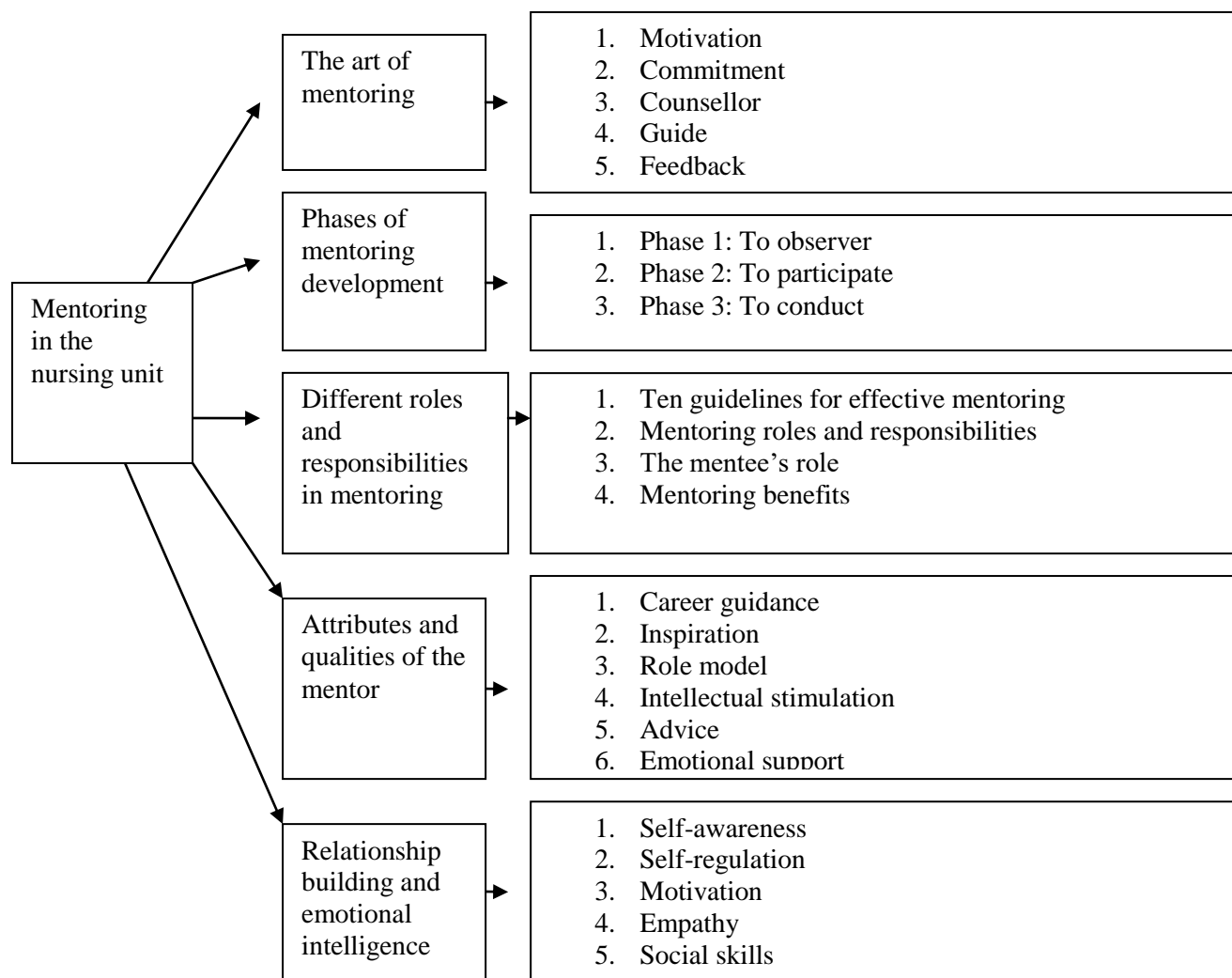


Figure 23.1 Mentoring

Activity 23.4: Scenario (Textbook page 277)

Most new mentors do not know where to start the mentoring process. The problem is that most health care professionals were not mentored or, if they did receive any mentoring, they were not mentored in the correct way and therefore do not know how to approach the process. Read the scenario below, and answer the questions that follow.

Scenario

You are a qualified health care professional and are appointed as unit manager in a surgical unit for twenty clients. There are ten health care professionals in the following categories:

- Two health care professionals. One, S/r Twary, is newly qualified and seems a little lost in the ward. The second health care professional, S/r Zwani, is studying for a degree in health care management and education through a tertiary educational institution.

- Four staff health care professionals. Two of them have been in the same position for ten years and are very experienced in the unit. The other two are newly qualified and one of them has applied to bridge to a professional health care category.
- Two second-year student health care professionals. They have no experience in surgical health care and are doing their clinical practice in general health care.
- Two auxiliary health care professionals. They have worked in the unit for twenty years and are nearing retirement age. One has serious back problems and is constantly on sick leave. When on duty she can hardly move.

Now answer the following questions: Identify the health care professional/s that you will want to mentor and explain why you have made that choice.

1. Develop a plan to mentor the health care professional/s. Keep in mind that mentoring is an extremely time consuming activity and you will need to devote large chunks of your time to it. Remember that you will still need to carry out the management functions of a unit manager at the same time.

Answers

Question 1

The individual who should be mentored is the professional health care professional who is studying health care management and education. She is showing an interest in her own development and the fact that she is studying for a tertiary qualification in health care suggests that she is committed to staying in the profession. She has experience with and knowledge of the surgical unit and the type of clients cared for in the unit. The reason for choosing S/r Zwani is that she has potential and mentoring her would open up succession planning possibilities.

Question 2

Mentoring plan

Name of mentee	Tasks with time frames	Mentor's role	Indicator of success
S/r Zwani	1. Demonstration of compiling a duty roster for a week Time frame: 15 February; between 14:00 and 15:00, in the unit	Demonstration of the task to the mentee and answering her questions, such as: <ul style="list-style-type: none"> • Why is this job important? • What are the key components of the job? • What are the cautions? • What timing issues are important? • Why should I learn to do it? 	A duty roster which is completed for one week, done by the mentor and understood by the mentee
S/r Zwani	2. Participation in compiling a duty roster for a week	After demonstrating the task, the next phase is to let the mentee do the duty roster with the mentor. The mentor needs to ask the following	A week's duty roster compiled and correct

	Time frame: 17–18 February; between 14:00 and 15:00 in the unit	<p>three questions:</p> <ul style="list-style-type: none"> • How can the task be shared? Mentor and mentee will both do part of it. The mentee could assist in the task while the mentor performs the essentials. • Does the mentee understand the principles? Ask her. • Is there time to learn? The mentor should not make the mentee feel time pressure to complete the task. 	
S/r Zwani	<p>3. The mentee compiles the duty roster for one week on her own</p> <p>Time frame: 19–21 February; in her own time (at home or in the unit)</p>	<p>The mentor could ask the following questions:</p> <ul style="list-style-type: none"> • How can the mentee demonstrate competency? • What level of competency will be adequate? • How much inaccuracy will be allowed? • When will the mentee be able to work unsupervised? 	An error-free duty roster compiled by the mentee on her own

Activity 23.5: Guidelines for a mentor (Textbook page 278)

1. The mentor must know her or his work and professional practice well.
2. The effective mentor must know the organisation well.
3. The mentor must build a relationship with the mentee.
4. Learn to be a good and excellent teacher. Know the methods of teaching adults and read up about high impact presentations and powerful training methods. Also, develop yourself as a mentor.
5. Learn to learn and to constantly take information in, not only about teaching and mentoring, but also about the latest techniques in health care and medical sciences.
6. Be patient and work on understanding human nature. Develop compassion and awareness of the different levels at which people operate and the different ways in which they function.
7. Be tactful, kind, courteous and gentle, but firm. The mentee must always know that the mentor expects only the very best performance.
8. Take risks and give the mentee challenging tasks. The mentee must know that she or he will not always be a hundred per cent successful, but the only way to learn is to take on the difficult tasks and then learn from the mistakes made. However, in health care we can never take risks if the client's wellbeing is at stake.
9. Celebrate success with the mentee and give feedback to her or him regarding her or his progress. Try to have a bit of fun as well and celebrate achievements.

10. Encourage your mentee to become a mentor as well: this is how the circle of development will be sustained (Holliday 2001: 132).

Activity 23.6: Roles of the mentor (Textbook page 279)

Mentor roles	Personal	Functional	Relational
	<i>Promoting</i> Self-development Confidence building Creativity Fulfilment of potential Risk taking	<i>Providing</i> Teaching Coaching Role modelling Counselling Support Advice Sponsorship Guidance resources	<i>Facilitating</i> Interpersonal relations Social relations Networking Sharing trust

Activity 23.7: Emotional intelligence (Textbook page 280)

The significance of emotional intelligence in mentoring health care professionals

Emotional intelligence is a powerful relationship builder and empowers leaders and followers. Those who lead with caring and understanding, focusing on individuals' capabilities, will be better able to interact with others. Emotional intelligence is the ability to recognise one's own feelings and the feelings of others (Kotze 2008: 208).

Health care managers and health care professional managers need to form good relationships within the organisation to stay better informed and to bring a depth and richness to health services. Personal and interpersonal skills need to be developed to allow the individual to comfortably create these relationships. Many of the daily tasks of a unit manager can be classified under the five emotional intelligence skills (see Table 23.1 below). It is important to note *how* the unit manager completes those tasks and how she or he will be shaped by her or his emotional intelligence abilities (Freshman & Rubino 2004: 4–5).

Table 23.1 The five emotional intelligence skill categories, definitions and examples of unit management application

Emotional intelligence skill	Definition	Examples of unit management application
Self-awareness	A deep understanding of one's	<ul style="list-style-type: none"> Decisiveness

	emotions and drives	<ul style="list-style-type: none"> • Control issues • Self-assessment • Burnout/workaholic • Self-worth
Self-regulation	Adaptability to change and control over impulses	<ul style="list-style-type: none"> • Ethical behaviour • Temper/patience • Favouritism/nepotism • Multi -asking/ time management • Objectivity
Motivation	Ability to enjoy challenges and to be passionate about work	<ul style="list-style-type: none"> • Being positive • Concern about organisational culture • Cost control • Meetings
Empathy	Social awareness skill: the ability to put oneself in another's shoes	<ul style="list-style-type: none"> • Bioethical issues • Client centeredness • Client/family interventions • Employee problems • Employee assistant programmes
Social skills	Supportive Communication skills The ability to influence and inspire	<ul style="list-style-type: none"> • Negotiation skills • Being attentive • Personal evaluation • Figurehead role (role model) • Committee relations

Providing support for health care students in the clinical setting

Health care is a clinical-based profession and health care students need to be exposed to the work of other professional health care practitioners and assisted to adopt positive behaviours. Clinical teaching is, therefore, an important function of the professional practitioner because it is in the clinical setting, during clinical placement, that health care students come into direct contact with clients as they integrate theory and practice. The quality of health care education therefore depends on the quality of the clinical experiences that students receive in the clinical setting.

The health care unit becomes the clinical learning environment and provides health care students with many learning opportunities. It is in the clinical setting that they get opportunities to observe professional practitioners as they provide client care, to develop and practise their health care and problem-solving skills and to begin reflecting on what they have seen, heard and done. The clinical environment also enables professional health care practitioners to

socialise health care students with respect to the core values of the profession: empathy, compassion, conscientiousness, commitment, confidence and competence (Searle & Pera 1995: 133).

The clinical environment is very threatening for the health care students. It creates feelings of helplessness, anxiety and vulnerability because learning occurs in an unstructured, overwhelming and unpredictable environment. Health care students feel vulnerable as they are not familiar with clients and staff members. The professional health care practitioner in the clinical setting has a major influence on health care students. She or he has to create a positive learning environment in which students feel welcomed, appreciated, regarded as not-so-experienced colleagues and treated as such, and incorporated as members of the multidisciplinary team. The professional health care practitioner's behaviour and body language are always observed by the health care students and others. It is therefore essential that she or he should become a positive role model by exhibiting behaviours that present a positive attitude and by establishing a supportive work culture and a learning environment for the health care students. If health care students are treated with hostility and disrespect, or even ignored, they will be unable to learn while in the clinical setting. They will then use the health care professional's role modelling to create their own negative understanding of the client's world and the role that they have to play in the health care delivery system.

The professional health care practitioner should be competent in clinical practice and should be able to direct students' learning in a positive manner. The amount of interest she or he shows in the learning needs of health care students and the role that she or he plays in exposing them to appropriate clinical learning experiences and helping them to meet their learning needs play an important role in their development. A good clinical teacher is described as supportive, approachable, friendly, resourceful, helpful, understanding, welcoming and having the interest of the health care students at heart.

The primary responsibility of the professional health care practitioner is to provide quality service to clients within the legal and social parameters. The complex nature of the health care delivery system makes it difficult for health care students to observe the professional practitioner carrying out her or his responsibilities. Members of the multidisciplinary team also violate the rights of clients (intentionally or unintentionally). The professional practitioner has to demonstrate leadership and be a client advocate to protect the client's right when they are violated. She or he has to be a change agent who demonstrates an understanding of her accountability to the client in the fast changing health care delivery system (Searle & Pera 1995: 133; Chaska 1990: 77–83).

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Solution to crossword puzzle (Activity 23.3)

Across

2. Discussion; 5. Facilitator; 7. Role play; 11. Brainstorm; 14. Hard work; 16. Computer; 18. Outcomes.

Downwards/Upwards

1. Simulation; 3. Noon; 4. Lose; (upwards); 6. Learner; 8. Pens; 9. Group; 10. Real; 12. Ink; 13. Fail; 15. Win; 16. Cases; 17. Team.

Chapter 25: Foundations of research

Ebin Jacobus Arries

Activity 25.1: Conceptual and theoretical frameworks (Textbook page 295)

A conceptual model, in addition to the classifying function of typologies, also has a describing function. A theory may be defined as a highly refined conceptual structure consisting of an integrated set of defined concepts, existence statements and relational statements (e.g. hypotheses) that provide an explanation of phenomena by postulating an underlying causal mechanism, with which one can explain, predict or control phenomena. Thus, in addition to classifying and describing, a theoretical framework also has an explanatory (explaining) function.

A theoretical framework may be defined as a framework that is based on propositional statements from a theory or theories (Crookes & Davies 1998: 106). In other words, it is based on studies in which the concepts or variables involved have been truly substantiated by previous research, and where the intention now is to test perceived relationships between them. While there are similarities between the two types of frameworks in that they both perform certain functions, there are also fundamental differences. Using the terms interchangeably, as most researchers often do, is not only confusing, particularly to novice researchers, but also incorrect and imprecise. The essential differences between conceptual and theoretical frameworks relates to the following:

- The level of knowledge regarding the concepts examined within the study in question
- The direction and strength of the relationships thought to exist between those concepts
- The validity of the empirical testing of the concepts and the relationships between them

Activity 25.4: Research and nursing research (Textbook page 296)

Depoy and Gitlin (1994, in Hek et al 2002: 8) favour a broad approach in their conception of research in health and human services. They define research as

Multiple, systematic strategies to generate knowledge about human behaviour, human experience, and human environments in which the thought and action process of the researcher are clearly specified so that they are logical, understandable, confirmable and useful.

An interesting dimension of this definition is its emphasis on the important role of the researcher, which many definitions of this concept do not consider explicitly. Polit, Beck and Hangler (2001) describe research as a systematic examination that uses scientific methods to answer questions or solve problems. Hence Burns and Grove's (2002) definition of research as "a systematic investigation to find answers to a problem". Both these definitions add a practical dimension to a conception of research in terms of which it is seen as answering questions or solving problems. Brink (2000: 3) rightly points out common characteristics or commonalities shared by most conceptions of research: an increase in knowledge as the end result of research; research as a method of discovery or inquiry; the

systematic and scientific nature of research as a process. However, a sometimes forgotten theme in defining research is the concept of “truth”.

Activity 25.5: Role of nursing research in health service research (Textbook page 297)

Nursing research has an important role in health service research. It may be undertaken to determine ways by which nurses and nursing care can contribute more effectively to the entire spectrum of health service delivery. There are numerous examples of health service research that involve nursing and/or nurses. Researchers with a background in nursing also have much to offer across a wide variety of health service research topics. This is partly due to the very nature of nursing. In particular, nurses can contribute knowledge and experience of the actual delivery of care in different settings. Unfortunately few nurses have the appropriate skills to participate in health service research.

Mouton and Marais (1990: 121) distinguish between research on first level phenomena and research on second level phenomena. Research on first level phenomena focuses on nursing practice whereas research on second level phenomena focuses on the constructs of research, namely concepts, statement and conceptual frameworks. Examples of research on second level phenomena include model development and theory development. If we consider nursing science to be both a human-related science and a clinical health science, which may be regarded as a communal social activity (sociological dimension) whereby certain phenomena in nursing reality (ontological dimension) may be studied based on a scientific method (methodological dimension) with the aim of grasping the phenomena (teleological dimension), then based on this we can identify different dimensions of social science research (Mouton & Marais 1990:7).

Activity 25.6: Empirics: the science of nursing (Textbook page 300)

Creating conceptual meaning “produces a tentative definition of a concept and set of tentative criteria for determining if the concept exists in a particular situation” (Chinn & Kramer 1995: 57). For example, if you want to study the concept of caring in your area of practice, you would first have to define what you mean by caring. In the process of doing so, you would develop some criteria or indicators in order that you can ultimately judge whether the concept exists in an area of study. This activity is not arbitrary but systematic, and commonly used methods for creating conceptual meaning include concept clarification, concept analysis and concept development.

Structuring and contextualising theory is concerned with forming systematic links between and among concepts, resulting in a formal theoretical structure (Chinn & Kramer 1995) or, put more simply, it is about constructing theory. All theories comprise concepts, and theory construction is concerned with establishing the relationships between these concepts. Theory construction is a highly complex activity and approaches vary depending on whether you are constructing a new theory or whether you are developing somebody else’s previously constructed ideas. The replication and validation of empiric phenomena are achieved through the relationship between theory and research. Research provides the vehicle for validating or testing theory. What is important in terms of nursing is that a variety of

research methods other than the traditional scientific method can be employed, depending on the nature of the question and the stage of conceptual and theoretical development.

Activity 25.7: Personal knowing (Textbook page 301)

Personal knowing is the most difficult pattern to master and teach. It cannot be expressed in language and can only be described as the self that *was* through reflection, stories and autobiographies. Without personal knowledge, therapeutic use of the self is not possible in the interpersonal encounter. Personal knowing is about the self and self-awareness, and the process of coming to know the self. Personal knowing involves creating congruence between the authentic self and the self as disclosed to others. It is only through knowing the self that we can hope to know others and, through that, knowing can accept ambiguity, difference and vagueness (Chinn & Kramer 1995). The importance of personal knowing is that it is about the development of an authentic personal relationship between people.

Activity 25.8: Ethical knowing (Textbook page 301)

This kind of knowledge is more than just knowing the ethical codes of a discipline and includes all actions that are subject to a judgement about whether they are right or wrong. This is also referred to as “knowledge why”. It is not enough to possess “knowledge that” and “knowledge how”: each act should be undertaken on the basis of whether it ought to be done. For example, a nurse may know how to use a skill and may possess the attendant knowledge, for example, of anatomy and physiology, but the decision about whether a particular task ought to be done with the ultimate aim of benefiting the client is a moral question. Moral reasoning must be based on a rational foundation, and requires the ability to articulate one’s moral position in a coherent and logical way. This is achieved through enquiry into moral perceptions, moral reasoning and moral judgement, and essentially constitutes an examination of the self. Moral knowing and personal knowing are also closely linked. Benner (1984) proposes that such learning can take place effectively through an exploration of practice using reflection, critical analysis, storytelling and discussion. Although Carper’s (1978) work had enormous significance for the development of nursing knowledge, nurses are cautioned against an uncritical acceptance of her views.

Activity 25.10: The world of philosophy of science (Textbook page 304)

The philosophy of science, according to Mouton (1990: 125) **may** be defined as the philosophical reflection on the nature, structure and dynamics of science as a human activity. Although in the philosophy of science the focus is primarily on the nature and structure of science, it cannot exclude a reflection on human beings and the society. Studies in the philosophy of science generally aim to bring about greater conceptual clarity to some of the key concepts in science, including truth, objectivity, validity and progress. In this vein, if the nurse scientist experiences problems and/or discrepancies or a lack of clarity related to phenomena on the first and second level, he or she directs

the attention to the third level to achieve greater clarity about the nature, structure and dynamics of nursing as a science.

The aim of the philosophy of science is to construct an interpretive framework to answer questions about, for example, the relationship between science and non-science, the scientific nature of the research process and the growth of science. Lastly it may also include questions regarding the criteria for the acceptability of scientific theories as well as the purpose of scientific theories. The history of science is also about the development of models of the philosophy science, namely positivism, logical empiricism, phenomenology, hermeneutics, critical rationalism, critical theory and so on.

When nurses engage in science, it is clear that they are seeking knowledge to better nursing practice and to advance nursing as a discipline. In speaking of the aim of their endeavours, they inevitably refer to the development of nursing's body of knowledge. However, amid all this talk about nursing knowledge and nursing science, mention of the word "truth" is conspicuously absent, despite its importance in nursing science as a process of inquiry.

It is important for us to realise that when nurse researchers ask such questions as: "What is truth in research?" they are not just asking for a definition of the word "truth". If that were all they wanted, they could look it up in the dictionary. The question goes far beyond that. They are seeking an altogether deeper understanding of the concept, and how it actually functions in our thoughts and our lives, and of other ways in which it might also be used, and of the possible challenges or dangers of its use, and of how it does or could relate to other key concepts in research such as theory and knowledge. Questions of such a nature belong to the third level.

Activity 25.11: The nature and types of truth (Textbook page 304)

Kikuchi (1996: 5) states the following nurse researchers:

[N]urses, in their undertakings as inquirers, are invested not in pursuing falsity but rather in pursuing its opposite, truth. In addition, they do claim cognitive status for their theories – that is, they aspire to be developing nursing knowledge and so, knowingly or not, subject their products to the criteria of truth and falsity. In so doing, they are bound by the logic of truth, in which the irrefragable unity of truth or the whole truth is presupposed.

The whole truth, according to Kikuchi (1996), is the ideal goal of the pursuit of truth – that is, the commitment to a never-ending endeavour of getting to "know" all that is "knowable". The pursuit of truth (of which the whole truth is the goal) is therefore really the pursuit of knowledge. Thus when we say we "know" something, we mean we have grasped the truth about it. To speak of "true knowledge" is to be redundant; to speak of "false knowledge" is to be contradictory (Adler 1990: 49). Two preconditions about "whole" (in "the whole truth") that ought to be accommodated if we hope to develop a body of nursing knowledge adequate to guide nursing practice, are: (1) the sense in which whole means all – all the different kinds of truth that exist – and (2) the sense in which whole refers to

the quality of “unity” or “oneness” of truth. The unity of truth is due to the logic of truth, which is the same across all formal branches of knowledge and applies to all propositions that are subject to contradiction (Kikuchi 1996).

Nursing, wrote Kikuchi (1996), as a discipline (as one of the sciences) is simply one component in the whole truth, and it, like every other part, is bound by the logic of truth and, as Adler (1990: 27) puts it, “must have coherence and be compatible with all the other parts of the whole ... [*that much*] is what is required by the logic of truth in terms of the unity of truth”. Thus, bound by the logic of truth, nursing as a discipline is obligated to evaluate and monitor whether its propositions are coherent and compatible with propositions known to be true inside and outside the discipline. Disciplines (or at least all formal disciplines) claiming logical truth hold, as universally applicable, the notion that (following sufficient investigation and weighing of the evidence and/or reasons) whatever is inconsistent or incompatible with agreed-upon truths at a given time must be regarded as false. Thus the disproof of either a descriptive or a prescriptive proposition or theory or model may be accomplished by the proof of its contrary or of its contradictory. According to the logic of truth, two contradictory propositions cannot both be true – one must be true, and the other false. And of two contrary propositions, both cannot be true, but both may be false. The implication for nursing research is, that with every nursing proposition we put forward, we must first decide whether we are making a cognitive claim and, if so, whether, as far as we know, it is coherent and compatible with the rest of the whole of truth. If we do less, Kikuchi (1996) is of the opinion that we fail to meet our moral obligation to our own and other disciplines in the pursuit of truth.

Subjective and objective truth

According to Adler (1990: 42), the subjective and objective aspects of truth may be distinguished from one another in that the subjective aspect

lies in the claim that the individual makes for the veracity of his judgement [whereas] the objective aspect lies in the agreement or correspondence between what an individual believes or opines and the reality about which he is making a judgement when he holds a certain belief or opinion (Kikuchi 1996: 12).

In nursing, in some strands in research, such as phenomenology, there appears to be a reluctance to admit the objective aspect of truth and a tendency to focus solely on the subjective aspect (or inter-subjective aspect as it may also be called). The implication for developing a body of knowledge to guide nursing practice focusing only on the subjective aspect of truth is significant. In this vein, Kikuchi (1996) is of the opinion that we are left with no legitimate basis for resolving differences of opinion and with no means by which to replace errors and falsities with truths. Nursing’s body of knowledge can therefore expand to infinity with ever-changing non-exclusionary propositions, some (or all) of which may be contrary to each other or to what has been established as true in other parts of the whole of truth. Hence, he asks a question for us to contemplate: can the discipline of nursing survive such uncorrected and unrestrained subjectivism?

Probable and absolute truth

Probable truth may be described as referring to those propositions of which some are true beyond a reasonable doubt or supported by a preponderance of evidence and reason. Absolute truth, on the other hand, refers to those propositions that are true beyond a shadow of doubt.

Logical and poetical truth

According to Kikuchi (1996), the line that divides the actual from the possible also divides logical truth from poetical truth. Logical truth is attributable to propositions that are about the actual and are therefore subject to contradiction. The products to which poetical truth applies are about the possible and are therefore not subject to contradiction – they are in no way incompatible with each other and are not subject to the logic of truth (Adler 1990: 10–11). For example, personal stories or narratives of clients as a source of nursing truths appear to fall into the realm of poetical truth in that all the stories are apparently viewed as possible and true.

Descriptive and prescriptive truth

In explaining the difference between descriptive and prescriptive truth, Kikuchi (1996) regards descriptive truth as referring to truth about “what is” whereas prescriptive truth refers to truth about “what ought to be done”.

Bibliography

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Chapter 26: Ethics in research

Karien Jooste

Activity 26.1: Informed consent form (Textbook page 312)

Table 26.1 Informed consent form

I have read the foregoing information and have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study titled and understand that I have the right to withdraw from the study at any time without discrimination.

Print name of participant.....

Signature of participant.....

Date.....

Name of person taking consent.....

Signature.....

(if different from researcher)

Date.....

Activity 26.2: Ethical principles and clinical records (Textbook page 313)

Evaluate any permission letter and indicate whether it complies with the ethical principles set out in Table 26.2.

Table 26.2 Checklist for letter of permission and informed consent

	C*	PC*	NC*
Letter has addresses			
Title of proposal			
Invitation to participate			
Purpose of the research			
Type of research intervention			

Participant selection			
Voluntary participation			
Procedures to be followed			
Time frame of participation			
Risks and discomforts			
Benefits			
Confidentiality and anonymity			
Privacy			
Sharing the results			
Right to refuse or withdraw			
Whom to contact			

* C = comply PC = partly comply NC= do not comply

Study the guidelines for the use of clinical records in research.

Guidelines for the use of clinical records in research

Consent

- Obtain the consent of the health departments (proof of client consent document should be attached) and/or
- Seek consent of the clinician currently or most recently responsible for the care of the client (client consent document should be attached) or
- Obtain consent of the client

Permission letter

The permission letter of the relevant authority or clinician should be addressed to the participant. Health departments and/or clinicians should be asked for permission from participants such as clients to use records and the permission letter should state that coded or named information will be used for research purposes

- confidentiality procedures will be followed.

An informed consent letter to the relevant authority or clinician or client should include the following:

- Title and purpose of the study
- Request to participate
- Proof of standardised client consent form (only authority or clinician)

- Investigator's agreement to confidentiality of data
 - Undertaking not to allow unauthorised persons access to the information (privacy)
 - Undertaking that no names of participants will be mentioned (anonymous)
- Results to be made available
- Right of the participant to withdraw information at any stage
- Contact details of researcher(s)
- Informed consent form (if needed from client)

Storage of tissue is not allowed without the consent of the client.

It is the responsibility of the researcher to ensure that the above criteria are met.

Chapter 27: Initial steps of planning in research

Charlene Downing

Activity 27.1: Significance of the contribution of the study (Textbook page 317)

The following questions may assist the novice researcher in identifying the significance of the contribution of the study:

- Of what importance is the problem to the field of nursing?
- Of what value is this research to the field of nursing?
- Who would benefit from the research and how would they benefit; for example, the clients, other health care professionals and the greater community?
- What contribution would be made to the knowledge and practice base of nursing?
- What effect or impact will this research have on current nursing practices and applied nursing policies?
- How can the findings of the study be implemented and what would the result of the implementation be?

(Adapted from Brink 2006: 61.)

Activity 27.2: Feasibility of a study (Textbook page 317)

The question that needs to be asked is: Is the study feasible?

Time. As a novice researcher, take the steps of the research process as the framework of your research process. It is essential to work out a project plan for each step, with specific reference to a timeline. Make use of other researchers as references to assist you in this regard. Careful planning of your time will contribute to your own interest and your motivation to maintain the impetus for the research project.

Resources. As suggested above, use a project outline to list all the resources that you will need to progress in the research project and to complete the project within your timeline.

Subject and participant availability and willingness. The researcher needs to establish if enough participants will be available and willing to participate in the research project. The interest and motivation of the participants and subjects are key factors in seeking the truth value within the research question or hypothesis.

Expertise of the researcher. As a novice researcher you need to establish your own knowledge and skills within the field of choice for the research project.

Researcher motivation and interest. As a novice researcher you need to understand that to take on a research project is a commitment that is made for an extended time period. It is suggested that you should take on something that you can

live with for several months. Ask yourself, “Can I sleep, eat and drink this for the next year?” Your own interest and motivation are without doubt the most important factors that will carry you through this journey.

The research problem exists within a context. The identified research problem will be viewed by the researcher within a certain perspective or paradigm of thinking, believing and doing. The following questions need to be asked by the researcher: “Where do I stand on this problem? How do I look at this problem?” It is important to be clear about one’s perspectives on the world, nursing and one’s own philosophical beliefs (Brink 2006: 62–64).

Activity 27.3: Example of a problem statement (Textbook page 318)

The researcher has been involved in teaching and clinical practice supervision of under and postgraduate psychiatric nurses in a variety of psychiatric clinical situations in hospitals and communities in South Africa.

During this time, it has become increasingly evident that psychiatric nurse–client interactions often appear to be non-therapeutic, characterised by emotional disengagement and an uncaring, aloof attitude on the part of nurse (Barry 1984: 142). Instrumental tasks such as ward administration and intellectualised client care rounds appear to enjoy priority, and certainly receive the most devoted attention from nurses (Burgess 1990: 17; Menzies, 1970: 11). Some of the ways in which these attitudes are manifested have been observed by the researcher: labelling, reference to clients ... The researcher has observed some of the following dysfunctional nursing behaviours and expressions which serve to maintain and enhance this system ...

In conclusion, it may be said that psychiatric nurses face the particularly difficult task of confronting the challenges involved in the nature of the interpersonal care they are required to render, and their own psychic make-up and defence systems. When the discrepancy between these is too great, some breakdown in the nurse–client relationship is inevitable. It is possible that if nurses were to be more knowledgeable (intellectually and emotionally) about the internal world experiences of their clients, they would render more adequate therapeutic interventions within the context of the nurse–client relationship, and so meaningfully facilitate the mental health of their clients (Müller 1993: 6).

In the first paragraph of this example the researcher sketches the background of his or her own experience within the identified field of the research, namely psychiatric nursing. This may be seen as evidence of the researcher’s experience of the identified problem and concern within the field of psychiatric nursing.

The second paragraph indicates the significance and the background of the area of concern, namely the nurse–client interaction. The researcher uses various key studies focused on the nurse–client interaction to enhance the various problems identified.

The last paragraph in this example gives a clear statement of the problem. The researcher identifies the gap in the knowledge and the practice within the interaction between the psychiatric nurse and the client.

Activity 27.4: Types of hypothesis (Textbook page 320)

According to Burns and Grove (2005: 163), a *simple hypothesis* states the relationship between two variables. A simple hypothesis is stated in the relationship between one independent and one dependent variable. This relationship may be a correlation or a difference (Brink 2006: 84; Burns & Grove 2005: 164). A *complex hypothesis* states the relationship between three or more variables. An associative relationship within the hypothesis statement indicates that when one variable changes the other variable changes. Hypotheses with a causal relationship identify the cause and effect interaction between two or more variables. The independent variable is manipulated to provide evidence of change within the dependent variable. The dependent variable is measured to establish the effect that is created by the independent variable (Burns & Grove 2005: 162).

A *non-directional hypothesis* states the existing relationship between two or more variables but does not provide an indication of the direction. A *directional hypothesis* states the direction between two or more variables. A researcher will find words like “more”, “less”, “negatively”, “positively” and “greater” or “less” within the hypothesis (Brink 2006: 83; Burns & Grove 2005: 164). A *null hypothesis* is also referred to as the statistical hypothesis. The researcher uses a null hypothesis for statistical testing and interpretation of statistical outcomes. Therefore the researcher states that there is no difference or no correlation between the variables (Brink 2006: 84; Burns & Grove 2005: 164).

Chapter 28: Conceptualisation in research

Susan Catharina Wright

Activity 28.1: National and international databases (Textbook page 325)

Search for the databases given below, for more information on how to obtain literature sources.

CINAHL

<http://www.cochrane.org/reviews/index.htm>

<http://arjournals.annualreviews.org>

<http://www.sarpn.org.za>

<http://www.sciencedirect.com>

<http://www.globalhealthfacts.org>

<http://www.medscape.com/home>

<http://medicine.plosjournals.org>

<http://www.sciencedirect.com>

<http://www.lib.gla.ac.uk/Resources/Databases/pubmed.shtm>

<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>

<http://www.sahealthinfo.org/cancer/oncologyresearch.pdf>

<http://www.jstor.org/about/desc.html>

<http://www.sabinet.co.za/journals/onlinejournals.html>

<http://www.who.int/en/>

<http://www.cdc.gov>

<http://www.scirus.com>

<http://arc.cs.odu.edu>

Activity 28.2: Common mistakes in writing a literature review (Textbook page 326)

Students and novice writers underestimate the time required to write a comprehensive and well-grounded literature review. Because they tend not to read enough, they do not gather enough literature to provide a comprehensive review. Frequently, authors do not write an introductory paragraph, but start immediately with facts in the introductory paragraph. The result is that there is no introduction to the structure of the review and the reader is left uninformed.

Other mistakes are writing about just the main concept, repeating the same points over and over, and writing the review from just one perspective, not giving a balanced view of all the literature available. To prevent the literature review from reading as a series of loose paragraphs not related to each, use linking sentences to link the paragraphs. If you do not write linking sentences, paragraphs are just loose elements of the text with no logical flow. The author

should write from the perspective of the research problem. Explain why a concept is important or how it relates to the research problem.

Finally, students often do not write a concluding paragraph to indicate how the literature review links with the research problem. They simply stop and there is no logical connection between the literature review and the research problem or question.

Activity 28.3: Avoiding plagiarism (Textbook page 326)

You can avoid plagiarism by following these guidelines:

- Do not deliberately commit plagiarism. It may be the end of your academic career.
- Always rewrite information from another source in your own words and acknowledge the source. This does not mean that you just change a word or two but that you take the essential points, evidence or meaning and use those points in the review.
- Do not cut and paste information directly from electronic sources (the Internet).
- Use your university's citation and referencing guide when doing your citations and references.
- You must include a citation and reference to the original source whenever you
 - quote the exact words of another author
 - refer to someone else's ideas, theories or research directly or in your own words
 - present another author's opinion or understanding about a topic directly in your own words
 - report factual information, for example statistics, tables, interviews or diaries, that you have obtained from someone else
 - present a table or figure taken or adapted from another source or when you construct a table or figure from data or information taken from another source.

Activity 28.4: Improving your scientific writing (Textbook page 326)

The following are some suggestions to improve the writing of a literature review:

- Write the literature review in the past tense, but use the present tense when presenting the work of a published author.
- Do not use imprecise words such as “a lot of” or “much” or “they” as exact, concise writing is required in a scientific document.
- Use linking words to create a logical whole when writing a section or paragraph. Some of these linking words are “however”, “moreover”, “in addition” and “notwithstanding”. Using these (and other) linking words assists with connecting the work of different writers and maintains the logic in their arguments. For example, if two authors support the argument being made, the first author's perspective could be described, and then, using the linking words “in addition”, the second author's views could be linked to the argument of

the first. “However” should be used when an opposing view is presented.

- Brink (2006) states that the review should consist of a critique of the existing work. A critique is an assessment of the strengths and weaknesses of a study. The intention is therefore not just to write that the study was done, but to write about how the study was done and why the results may or may not be applicable to your own intended study.
- A good structure to follow is to begin with the literature regarding the independent variable and thereafter describe the literature related to the independent variables (Brink 2006).

Activity 28.5: Evaluating your review (Textbook page 326)

Some suggestions to evaluate the review are as follows:

- Count how many referenced sources you have used and evaluate how recent the sources are. Evaluate the number of sources in the light of the type of document you are writing. If you are writing a literature review for a thesis, twenty literature sources will not be enough; but if you are writing an article, this may be adequate. Also take into consideration your topic as some topics have been researched extensively whereas others have not.
- Is the review balanced, or, when you read what you have written, is there a skewed presentation to either support or contradict a specific position?
- Did you include the work of well-known scientists in the study field? Are the sources you have used also been used in other articles that you have read?
- What is the balance in terms of primary and secondary sources? While some secondary sources may be acceptable, their number should be limited. The literature review should be based mainly on primary sources.
- Evaluate whether the review provides a comprehensive review of the evidence available on the research problem or question and therefore gives a solid basis for the intended study.

Activity 28.6: Research activity (Textbook page 327)

Choose a topic of interest to you and complete the following activities:

- Write down the key words.
- Use these key words to do a literature search of both electronic and non-electronic sources. Make sure you include a variety of sources such as journal articles, recent academic books, research reports and articles from newspapers or magazines.
- Make a table. In the left column, list the concepts or variables starting with the most appropriate one. In the right column, list the references you obtained for each concept or variable.
- Evaluate your literature sources. Add more literature where required.

- Use this structure to write a literature review and indicate possible research problems based on the gaps found in the current knowledge base.

Chapter 29: Research design, population and sampling

Charlene Downing

Activity 29.1: Solomon 4-group design (Textbook page 331)

A development from and combination of the pre-test post-test design is known as the Solomon 4-group design. Subjects are randomly selected for participation in the research project and then randomly assigned to experimental and control groups. Two groups receive the pre-test and two groups receive no pre-test. The combination of the pre-test-post-test control group design with the post-test only design is the Solomon 4-group design (as illustrated in Figures 29.1 and 29.2).

Although this may seem to be a rather cumbersome design, it effectively measures the influence of pre-testing on post-test scores. The Solomon 4-group design is seen as a stronger tool than the pre-test-post-test design; as a result the researcher obtains a more complicated statistical analysis of data (Brink 2006: 95-96; *Ways of approaching research: quantitative designs* n.d.).

Activity 29.2: Appreciative inquiry (Textbook page 334)

Sue Annis Hammond's (1996) *The Thin book of Appreciative Enquiry* identifies the following eight assumptions of appreciative inquiry:

- In every society or organisation, something works.
- What we focus on becomes our reality.
- Reality is created in the moment, and there are multiple realities.
- The act of asking questions of an organisation or group influences the group in the same way. People have more confidence and comfort to journey to the future (the unknown) when they carry forward parts of the past (the known).
- What we carry forward should be the best of the past.
- It is important to value differences.
- The language we use creates our reality.

The overall process used is known as the Appreciative Inquiry “4-D” cycle:

- You start by exploring what is working and an appreciation for the best of the experience. This discovery is made through story-telling and interviews.
- This is where you envision your ideal possibilities and create bold statements.
- You co-determine the dream in reality and establish principles and priorities.
- You take a sustained action to innovation of the newness; then create and decide in which way the possibilities can develop and shape the dream (Priest 2005).

Bibliography

Hammond, S.A. 1996. *The Thin book of Appreciative Enquiry*. Plano TX: Thin Book Publishing.

Chapter 30: Data gathering and analysis

Ansie Minnaar

General questions (Textbook page 348)

Question 3: Information on qualitative data analysis and data obtained from focus groups

Analysing data from qualitative studies

- Non-numerical
- Written words, videotapes, audiotapes, photographs
- Analysis of words, not numbers
- Massive amounts of data, therefore very time consuming
- Reflection on possible meanings and relationships in data
- Often done concurrently with data collection
- A series of common steps among different methods
- Methods commonly used are those of Tesch, Giorgi, Kerlinger, Field and Morse, Strauss and Corbin
- Different qualitative approaches have different forms of analysis

Some qualitative analysis concepts

- **Coding**
 - Is used to organise data collected in an interview and other types of documents; for example, a naïve sketch.
 - Dependability of the coding is checked by having another person encode the same data and then checking for agreement between the two sets.
 - Data may also be validated by checking back with respondents and/or forms of evidence.
 - Coding involves inventing and applying a categorisation system.
- **Categories**
 - Development is facilitated through the use of manual or computer activities.
 - Manual analysis involves a thorough review of all recorded information.
 - Computer programs can sort, code and rearrange data in many different ways.

Common steps across methods

- Coding for themes and categories
- Memos about text and variations
- Verifying selected themes
- Refining the categories
- Recording of supporting data for categories

- Identification of propositions

Qualitative data analysis: Tesch and other authors

- **Step one**
Get a sense of the whole. Read through all of the transcriptions carefully. Perhaps jot down some ideas as they come to mind.
- **Step two**
Pick one document (one interview) – the most interesting, the shortest, the one at the top of the pile. Go through it, asking yourself “What is this about?” Do not think about substance, but rather about the underlying meaning. Write your thoughts in the margin.
- **Step three**
When you have done this for several documents, make a list of all topics. Cluster together similar topics. Organise them into columns that might be labelled major topics, unique topics and leftovers.
- **Step four**
Now take this list and go back to your data. Abbreviate the topics as codes, and write the codes next to the appropriate segments of text. Try out this preliminary organising scheme to see whether new topics and codes emerge.
- **Step five**
Find the most descriptive wording for your topics and turn them into categories. Try to reduce your total list of categories by grouping topics that relate to each other. Perhaps draw lines between categories to show interrelationships.
- **Step six**
Make a final decision on abbreviations for each category and alphabetise these codes.
- **Step seven**
Assemble the data material belonging to each category in one place and perform a preliminary analysis.
- **Step eight**
If necessary, recode your existing data.

Chapter 31: Validity, reliability and trustworthiness

Hester Klopper and Siedine Knobloch

Activity 31.1: Scenario: pre-scientific versus scientific knowledge (Textbook page 349)

A good example of pre-scientific versus scientific knowledge is found in midwifery practice. It was once believed that there were micro-organisms present in the pubic hair of women, which caused infection post-delivery. This belief was held for many years, and led to the routine practice of shaving all women's pubic and perineal hair pre-delivery. Only in the 1970s was research carried out to explore the evidence for routinely conducting such a procedure. The findings of the study showed that there was no increase of infection when pubic hair was not removed, which has caused this practice to be discontinued in midwifery today (Brink 2006: 4–7).

Activity 31.2: Theoretical definition (Textbook page 351)

Mouton and Marais (1996: 63) describe a theoretical definition as classifying or systematising the most essential dimensions of the meaning of a concept. According to Rossouw (2005: 19–20), there are some basic guidelines one must adhere to when defining a concept. These are as follows:

- The definition must indicate the unique identifying characteristics of the concept.
- The definition must not be circular.
- The definition must contain all the characteristics normally associated with the word and should not be too broad, or include too many characteristics, nor be too narrow, or include too few characteristics.
- The definition should not employ figurative language.
- The definition should not be formulated negatively.
- The definition should be free of emotive words.

Activity 31.3: Audit trial (Textbook page 355)

An audit trial is conducted by reviewing at least six classes of data (Babbie et al. 2005: 278):

1. Raw data: recorder audiotapes and/or videotapes, field notes, documents
2. Data reduction and analysis: write-ups of field notes, theoretical notes, reduction of data, concepts
3. Data reconstruction and synthesis: themes, findings, conclusions and a final report
4. Process notes: methodological notes, trustworthiness notes and audit trial notes
5. Material relating to intentions and dispositions: inquiry proposal, personal notes and expectations
6. Instrument development information: pilots, forms, preliminary schedules, observation formats and surveys

Activity 31.4: Standards with which statements must comply (Textbook page 355)

Statements should comply with the following standards:

- *Statements must be acceptable.* Statements must be based on rational grounds or reasons, such as empirical observations or coherence with existing theoretical frameworks.
- *Statements must be relevant to the conclusion.* Statements grounded on empirical observations and existing theoretical frameworks should stipulate the relevance of the statements to the conclusion.
- *Statements should adequately support and qualify the conclusion.* The loophole and underlining method may be used in deductive arguments, while the support in inductive arguments is described as good, average or weak (Botes 2003: 184).

General questions (Textbook page 357)

Question 6: Strategies to increase trustworthiness in a focus group

For qualitative data to be trustworthy, the following principles must be adhered to:

- Credibility or truth value
- Transferability or applicability
- Dependability or consistency
- Confirmability and neutrality

Table 31.4 Principles of trustworthiness

Credibility	Transferability	Dependability	Confirmability
<ol style="list-style-type: none"> 1. Prolonged involvement <ul style="list-style-type: none"> • trust • values and context • scope 2. Continuous observation <ul style="list-style-type: none"> • depth • essentials 3. Triangulation <ul style="list-style-type: none"> • data sources • research methods • researches • theory, model or processes 4. Target group consensus 5. Adequate referencing <ul style="list-style-type: none"> • raw data • referential adequacy • saturation of data 6. Consensus with people involved 	<ul style="list-style-type: none"> • Time-frame context influence • Thick description • Transferability to similar context 	<ul style="list-style-type: none"> • Indirectly through steps to ensure credibility • More directly through triangulation • Product and process audits 	<ol style="list-style-type: none"> 1. Audit route and process <ul style="list-style-type: none"> • completeness • usefulness • clarity • logic 2. Are findings based on raw data? <ul style="list-style-type: none"> • inferences • analytical thought • applicable categories • methodological logic • sampling method • methods of triangulation • unbiased finding • critical reflection • premature judgement • Hawthorne effect 3. Sophistication of researcher

Chapter 32: Reporting the research findings

Mashudu Davhana-Maselesele

Activity 32.1: Read an abstract (Textbook page 361)

Psycho-social effects of caring for people living with HIV/AIDS among nurses in Limpopo Province of South Africa

Abstract

The rate of HIV infection in the country poses several challenges, especially with the provision of a caring environment for those who are already sick. Nurses bear the brunt of having to provide care for those who are dying and for their grieving families. This study examines the psycho-social effects of caring for people living with HIV and AIDS (PLWA) among 174 nurses in the Limpopo Province of South Africa. A structured interview guide was used for data collection. The interview guide incorporated the AIDS Impact Scale (AIS), Maslach Burnout Inventory (MBI), Beck Depression Inventory (BDI) and the participants' demographic and professional characteristics. Participants were conveniently selected from five randomly selected hospitals in Limpopo Province. The study showed that personal accomplishments among the nurses remained high amid low levels of emotional exhaustion and depersonalisation. About three out of four nurses were experiencing mood disturbances ranging from mild to extreme depression. Higher average scores were noted for items on the depression scale like sadness, dissatisfaction, fatigue and low level of energy. Emotional exhaustion was positively associated with age and years of experience; personal accomplishment was noted to be higher with higher training qualification. The AIS items contributed more to the prediction of emotional exhaustion when compared to their contribution to the prediction of depersonalisation and personal accomplishment. The stigma-related AIS items were the major contributors to the variations in depersonalisation. The findings of this study highlight the need to address social stigma; develop psychological support programmes for nurses caring for AIDS clients; promote the provision of social incentives and develop creative ways of recognising the role of nurses in AIDS care.

Keywords: AIDS Impact Scale (AIS), burnout, depression, HIV and AIDS, nurses

Activity 32.2: Evaluation criteria (Textbook page 363)

Examples of criteria evaluating an article

Comply = 1	Non-compl	Partial	Comply
Partially comply = 2			
Compliance = 3			

CRITERIA	1	2	3
<i>Introduction and background</i>			
The researcher formulates the research problem/question/issue clearly and concisely.			
The topic of inquiry is relevant to the scholarship and practice of the country, and the researcher discusses the motivation for the investigation sufficiently.			
The researcher contextualises the inquiry in scholarship and in practice.			
<i>Purpose statement, goal and objective</i>			
The aims, objectives and/or research purposes of the study are clearly formulated.			
<i>Conceptualisation, conceptual framework, literature study</i>			
The study reflects the researcher's critical understanding of the theories related to the research.			
The literature review reflects relevant studies and how they illuminate and contextualise the research topic.			
<i>Research design</i>			
There is sufficient evidence of design logic (coherence of research problem/question[s], methodological assumptions and methods) in the research plan.			
The inquiry reflects an understanding of the sound application of the selected research methods.			
The researcher authoritatively discusses the validity and reliability or trustworthiness of the inquiry.			
The researcher indicates clearly/explicitly how she or he implemented measures to ensure ethical research.			
<i>Research findings</i>			
The researcher draws inferentially valid conclusions in discussing the findings.			
The researcher uses theoretical evidence from the literature competently as integrated evidence in arguments.			
The researcher writes argumentatively and logically.			

<i>Conclusions, recommendations, guidelines, limitations</i>			
The conclusions relate logically to the research question/issue/problem.			
Relevant recommendations or guidelines address the research question.			
Limitations of the study are mentioned.			
<i>Scientific presentation</i>			
The different sections of the study are coherent.			
<i>Technical presentation</i>			
Reference details are presented accurately and in a consistent reference style.			
The reference list reflects the in-text citations and references accurately.			
Tables, figures and other visual materials are used effectively and presented correctly.			
Appendices (if applicable) complement the main text.			
The text is presented logically and has been edited scrupulously.			

Chapter 33: Health systems

Kaarina Meintjes

Activity 33.2: The health care system in the UK (Textbook page 373)

Leadership and governance

The UK health care system is a publicly funded system. It is known as the National Health Service (NHS). The health policies, priorities and directions are communicated through the different levels of the NHS in all four countries – England, Scotland, Wales and Northern Ireland (Winchester & Storey 2008: 2). Each country of the UK manages its own health service separately (Dougherty 2008: 1). The NHS Improvement plan has been launched and set out in detail in the "five year forward view" document (NHS, 2014).

NHS England

The NHS is divided into Strategic Health Authorities (SHAs) and primary care groups (PCGs) with assigned boundaries. This is a top-down model with geographical splits to enhance control and management. The SHAs oversee the financial aspects and the development of all the health care services in their geographical areas. The PCGs form the direct link to the SHAs (Winchester & Storey 2008: 2). The PCG provides primary care and contracts with other NHS providers for specialist care and hospitalisation. Each PCG is responsible for the quality of the services rendered, as well as for the promotion of the overall health of the community (Bindman et al. 2001: 134).

NHS Scotland

The Scottish parliament and health department are positioned at the top of Scotland's health system. Fourteen NHS Health Boards and Special Health Boards are responsible for providing primary and acute health services in their geographical areas. Community health partnerships and Managed Clinical Networks – formal groups of specialists – are also linked to the NHS Boards (Winchester & Storey 2008: 11). The Scottish NHS has a centralised approach to the management of health services.

NHS Wales

NHS Wales looks very similar to NHS England. At the top are the National Assembly and the Department of Health and Social Services, with their regional offices. This is followed by the Trusts, delivering acute health care services, and local Health Boards, similar to the PCG, rendering primary health care services. The Wales system differs from that of England in that strong emphasis is placed on local community services and public health (Winchester & Storey 2008: 13).

NHS Northern Ireland

The NHS of Northern Ireland is still in the process of reorganisation due to political stumbling blocks. The Assembly, together with the Department of Health, Social Services and Public Safety (DHSSPS), is at the summit of this health system. Northern Ireland is divided into four Area Boards, similar to England's SHAs. Within each Board there are

Trusts responsible for a wide range of health care and social services – including primary and acute health services. The responsibility for health care services is centralised (Winchester & Storey 2008: 17).

All four nations in the UK render free health care services, but their structures are different.

Service delivery

The health system of the UK is known as the National Health Service (NHS). It provides the majority of health care for England, Scotland, Wales and Northern Ireland. The NHS served more than 5 million people per week (NHS, 2014: 12). The services rendered are equitable, comprehensive and based on clinical need (Dougherty 2008: 1). The NHS has a new 10-point plan to improve health and service delivery by 2020. Some of the elements included in the plan are to improve the quality of care for cancer, mental health, learning disabilities and diabetes mellitus type 2; reduce the risk of developing diabetes mellitus type 2; increase access to emergency services through a single call centre; use of technology to improve access to primary care; and controlling of costs to bridge the gap between existing funds and the efficient use thereof (NHS, 2016: 46-47). New care models for the 10-point plan will be implemented. Continuous analysis of the health system helps to ensure a non-static system that can adjust to the changing needs of its customers.

Funding the health system

The NHS is completely funded by means of a general tax. It is the world's largest publicly funded health care system. The contribution of each British citizen in 2007 amounted to approximately \$2950. Health makes up 9,4 per cent of the GDP; 82 per cent comes from general tax and the rest from private insurance and user fees. Citizens who wish to purchase private health insurance are free to do so, but they still have to contribute towards the NHS via their general tax – thus in effect paying the system twice (Dougherty 2008: 1). The NHS is also one of the largest employers in the world. All the hospital doctors and nurses are employed by the NHS, while general practitioners, dentists and other self-employed health care providers contract their services with the NHS (Dougherty 2008: 1). Costs must be controlled and therefore treatment guidelines and recommendations are available for health care providers (Dougherty 2008: 2). Due to the aging population, the health needs of, and demands on, the NHS have changed, therefore constant research and addressing different ways of efficient health service delivery are important (NHS, 2016: 48-53).

Workforce

Every health care provider is either employed by the NHS or their services are contracted with the NHS. The UK meets the WHO required minimum health work force. However, the NHS has a vision of a highly skilled and looked-after health care workforce and is working on increasing the numbers and the work satisfaction of their workforce (NHS, 2014: 29-31).

Pharmaceuticals

The NHS has a National Electronic Library for Medicines (NeLM). This service was started in 1998 and is updated daily. The main objective is to promote safe, effective and efficient use of medicines. It is a free service. The content is mainly provided by the NHS pharmacy medicine information service and it is updated daily (National Electronic

Library for Medicines 2016: About the NeLM). Different services are offered through this library, for example clinical guidelines, clinical governance, epidemiology/health statistics, prescription and supply of medicine, national service framework, provision of information, drug reviews, travel health and unlicensed medicines (National Electronic Library for Medicines 2016: Medicines information, National Health Service).

Health information systems

The NHS used different models of health information systems, but with varying success. The new way forward is to have key elements nationally dealt with, but the local NHS can make decisions for their areas provided that they are in line with the nationally prescribed key areas. These key areas will include:

- NHS care record service to be fully electronic to create a paperless patient record system that can be accessed everywhere
- Electronic booking service that is available everywhere
- Electronic transmission of prescriptions and repeat prescriptions to be available everywhere
- Comprehensive transparency of performance data
- Use of NHS-accredited health apps

Aligning hospital, family doctor, administrative and audit data to make decisions on quality care and priority health care for patients (NHS, 2014: 33).

Chapter 34: Health care indicators and profiles

Wanda Jacobs

Activity 34.1: “Indicator” (Textbook page 382)

The concept of an “indicator”

The WHO defines “indicators” as “variables which help to measure changes”. An indicator, as the word suggests, “indicates” or gives an indication of either a change or a situation. It may be used as a marker of how well a health system is performing. When an indicator is used to measure a change or situation over time it may indicate both the direction and the speed of the change.

Indicators are yardsticks that can be used in the monitoring process, whereby countries can compare their own progress with other countries. They can also be used to compare data and health situations between countries as well as between different areas within a country. An example would be the percentage of population in the different regions within a country that have access to water and sanitation.

Indicators should reflect progress. This is a fundamental principle when selecting indicators: they should be meaningful! Indicators are not objectives or targets but are used as markers of progress towards objectives and targets set by countries to attain health for all their people. Indicators can indicate the extent to which these objectives and targets are being achieved.

The suggested indicators, as pointed out by the WHO (www.who.int), are not comprehensive and countries are not compelled to use them. The intention is to assist countries in selecting the indicators they will need to assess progress towards health for all. They are grouped into four categories: health policy indicators; social and economic indicators related to health; indicators of the provision of health care; and health status indicators.

Activity 34.2: Other goals, targets and indicators (Textbook page 383)

Goal 2: Achieve universal primary education

Target 3: Ensure that by 2015 children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

The biggest factor in determining whether or not children go to school is poverty. Achieving universal primary education means more than full enrolment. It means that all children attending school regularly learn basic literacy and numeracy skills and complete their primary schooling on time (UN 2008: 11).

Goal 3: Promote gender equality and empower women

Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and at all levels of education no later than 2015

The enrolment of girls and boys in developing countries is nearly equal in the richest households and in urban areas. However girls in rural areas and from poorer households rarely enrol for or finish primary education.

Goal 4: Reduce child mortality

Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Indicator 13: Under-five mortality rate per 1000 live births

Indicator 14: Infant mortality rate

Indicator 15: Proportion of one-year-old children immunized against measles

The mortality data indicate that there is a dip in the deaths of under-five children to below ten million. Deaths of children from preventable causes are unacceptable. Sub-Saharan Africa accounts for about half of these deaths in the developing world.

The leading causes of childhood deaths are pneumonia, diarrhoea, malaria and measles. These deaths could easily be prevented by improving basic health services and through interventions like oral rehydration, vaccination and the use of insecticides and nets.

Improved neonatal and maternal care could save potential deaths, as 37 per cent of under-five deaths occur within the first month of life and under-nutrition is estimated to be the underlying cause of death in more than a third of the deaths (UN 2008: 21).

Measles, which is a major cause of child mortality, can effectively be prevented by vaccination of the two doses. It is, however, important to know that one dose is not sufficient; the child needs the second booster dose to provide life-long protection.

Goal 5: Improve maternal health

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Indicator 16: Maternal mortality ratio

Indicator 17: Proportion of births attended by skilled health personnel

In 2005, 500 000 women died in pregnancy, childbirth or in the six weeks after birth. Of these, 99 per cent were in the developing countries. This is clearly unacceptably high.

Skilled health workers with proper equipment and referral options during the antenatal, delivery and post-natal period are crucial in creating a safety net for healthy motherhood and childbirth where the mother as well as her offspring can be monitored, reducing maternal deaths and delivery of such services should be standard practice (UN 2008: 24/25).

Birth to women 15 to 19 years old is also an indicator that can assist in attaining the target to achieve, by 2015, universal access to reproductive health by assessing the adolescent fertility rate.

Adolescent pregnancy contributes to maternal and childhood mortality. Early motherhood more often results in the mother dying during childbirth. A pregnant adolescent misses out on education opportunities resulting in an uneducated mother who deprives her child of the benefit of knowledge that is passed on by educated mothers to their children.

Proportion of married women aged 15 to 49 years with unmet needs for family planning is a useful indicator. If family planning needs are not met, the ability of the woman to plan her family and decide when she wants to fall pregnant and how many times is undermined. High fertility rates result in increased maternal and child mortality. The more children a family has the more unlikely it is that the family will have the means to afford education and health care for all the children.

Goals 6: Combat HIV/Aids, malaria and other diseases

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/Aids

Indicator 18: HIV prevalence among pregnant women aged 15-24 years

Indicator 19: Condom use rate of the contraceptive prevalence rate

Indicator 20: Ratio of school attendance of non-orphans aged 10 – 14 years

The lack of HIV prevention and treatment results in a staggering number of people becoming infected with HIV (7500 per day) and dying of Aids (5500 per day). Even though these numbers are staggering, some progress has been made in that the number of newly infected people declined from 3 million in 2001 to 2,7million in 2007. In addition, because of antiretroviral treatment the number of people living with HIV rose to 33 million in 2007 (UN 2008: 28).

HIV prevalence in South Africa has increased. So too has the proportion of women with TB, from 34,9 per cent in 1995 to 43,5 per cent in 2004.

The rate of condom use among men aged 15 to 24 has increased. In South Africa, in 2006/07, on average 11,1 condoms were distributed per male aged 15 years and older.

Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Indicator 21: Prevalence and death rates associated with malaria

Indicator 22: Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures

Indicator 23: Prevalence and death rates associated with tuberculosis

Indicator 24: Proportion of tuberculosis cases detected and cured under DOTS

The prevention of malaria by using insecticide-treated mosquito nets has resulted in an increased production of nets. The most important way of combating malaria is by prevention. Once a person has malaria, treatment is important. The proportion of children with fever who received anti-malaria medicines dropped from 41 per cent in 2000 to 34 per cent in 2005 (UN 2008: 31)

Malaria cases and deaths may be substantially reduced by prevention programmes and improving access to effective anti-malaria drugs.

The success of eradicating tuberculosis depends on early detection of new cases and early effective treatment. DOTS (Directly Observed Treatment Short-course) involves the appropriate diagnosis and registration of each tuberculosis client and treatment with a standardised multi-drug regime. There is some evidence that the DOTS programme is meeting with success.

The *number of new tuberculosis cases per 100 000 population, excluding people who are HIV positive*, is also an indicator used to measure progress towards the tuberculosis target of halving the tuberculosis prevalence rate by 2015.

Some indicators related to health millennium development goals are as follows:

- Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation, measured by the *proportion of the population using an improved drinking water source, and the proportion of the population using an improved sanitation facility*
- By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers, reflected by the *percentage of urban households living in slum conditions and with one shelter deprivation*. People living in slums lack improved sanitation and water facilities, durable housing and sufficient living areas. This has a direct impact on their health.
- In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries, reflected by the *proportion of the population with access to affordable essential drugs on a sustainable basis*. Most countries have a list of drugs approved by the government for use in the public health services at a very low cost or free of charge. It is, however important, to ensure the availability of these drugs.

Activity 34.3: Other indicators (Textbook page 393)

Adult literacy

Education is a social factor which is not directly related to the health sector but which has a significant influence on the health of a population. The literacy rate is defined by the percentage of the population aged 15 and older that can read and write in any language.

The literacy rate, more specifically health literacy, is of importance to health, especially among women, as they are most likely to be responsible for looking after the family and providing primary health care in the home. Health literacy is of importance for the understanding of nutrition, health needs as well as the prevention and control of common health problems. The health status of the children, family and ultimately the community are influenced by whether or not the women in the community have an elementary understanding and comprehension of the importance of primary health care at home. Literacy rate indicators differentiating gender are available as women's literacy rate is of greater importance to health than that of men.

Additional indicators that may be used are the number of pupils enrolled in educational institutions expressed as a percentage of the estimated population aged 5 to 19. The percentage of this population divided into primary, secondary and tertiary level may also be of significant importance and value, as well as actual attendance at an educational institution. Attendance could in itself be an indication of healthy or sick children, although absenteeism may also be an indication of children being used in the labour force, child-headed families or girls working in the home.

Housing

Progress towards health for all is not directly linked to indicators relating to housing but they do reflect the indirect influence of inadequate or adequate housing on the health of a community. Housing is related to health in the sense that inadequate housing may lead to exposure to extreme weather conditions, like cold and heat, which influence the health of the inhabitants. Poorly structured housing without ventilation, water and sanitation influences health in that the inhabitants are exposed to disease-carrying insects and rodents as well as to communicable diseases like tuberculosis as a result of limited ventilation.

The most common indicator regarding adequate housing is the number of persons per room, keeping in mind the size of the room. The standard for the number of people per room in each country will set the target.

The housing indicator is also of importance in reflecting changes over a period of time.

Working conditions

Indicators that might be relevant are the employment and unemployment rates, the economic dependency rate, availability of work, and the percentage of women in the labour force. These indicators will give a reflection of the economic circumstances and development of a country and regions as well as of gender equality. Unemployment, in particular, influences the economic circumstances and quality of life of the individual.

Health problems occur as a result of a lack of economic development that might lead to poverty which then results in insufficient food, overcrowding and lack of sanitation.

Demographic factors such as the age structure of the population may influence the socio-economic development of a country or region and relates to working conditions. The proportion of the population that does not have wage-earning capacity may be deduced from the dependency ratio, indicating the number of persons between the ages of 15 and 64 per 100 persons. People under the age of 15 and over the age of 65 are generally not viewed as part of the workforce and are therefore regarded as the dependant population.

The structure of the workforce, working conditions and the age structure of a population may all influence the progress towards health for all.

Availability of food

Food is important to health. One of the indicators to use is the *per capita energy availability*. This is calculated from food balance sheets, taking into account local food production, imports, exports, wastage and diversion for non-human use. Additional to this, the national accounts record, which records private expenditure on food at constant prices, may be used.

Activity 34.4: Health status indicators (Textbook page 397)

Disease-specific mortality and morbidity

Of significance are those mortalities that result from communicable diseases that children get immunised for and that are therefore preventable deaths. This indicator is calculated for specific causes of death. Morbidity is the incidence and/or prevalence of certain diseases or disabilities. Morbidity usually reflects the six diseases most prevalent in a specific country, community or age. Destructive lifestyles associated with first world living, like smoking, relate to diseases like lung cancer. Obesity, alcohol, violence and homicide may also be associated with developed countries. An additional indicator indicating the degree of dental diseases and the provision of dental care is the average number of decayed, missing or filled teeth. This has been developed as an indicator of oral health. The WHO (1981: 37) proposed an acceptable level as an average of no more than three decayed, missing or filled teeth at the age of 12 years.

Social and mental wellbeing

Indicators that can be used in determining the social and mental wellbeing of a community or population include the rate of suicides, homicides, drug and alcohol abuse, smoking, obesity and violent acts like attacks, reported to the police or by victims seeking medical treatment, in general and specifically those against women, children and the elderly.

These indicators may be stated as the proportion of suicides and suicide attempts reported to the relevant authorities for a specific age group or the number of violent acts reported to the police or by victims who seek medical treatment at a health facility as the result of, for example, an attack.