THE IMPACT OF THE RIGHTS AND OBLIGATIONS OF NURSES ON PATIENT CARE IN A CLINICAL SETTING IN GAUTENG PROVINCE

by

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submitted in accordance with the requirements

for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

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June 2014

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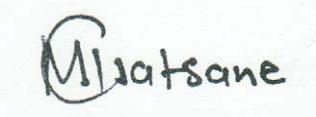
DECLARATION

I declare that **THE IMPACT OF THE RIGHTS AND OBLIGATIONS OF NURSES ON PATIENT CARE IN A CLINICAL SETTING IN GAUTENG PROVINCE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



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ABSTRACT

This study explored and described the impact of the rights and obligations of nurses on the delivery of quality patient care in a clinical setting. Quantitative research approach was utilised. Data was collected using a self-administered questionnaire. The research results revealed that respondents who participated in this study were aware of their rights and obligations, the effects and impact of factors influencing such rights and obligations on patient care. It was established that “patient abandonment” observed when nurses embark on a strike as their constitutionally enshrined right is not due to a lack of insight about their rights and obligations, but on how such rights and obligations are implemented.

The researcher recommends that further research be undertaken to explore the causes of nurses embarking on strike actions despite their high level of knowledge concerning the impact of such actions on patient care in a clinical setting.

KEY WORDS

Impact; effects; rights and obligations; patient; nurse; patient quality care; clinical setting.

ACKNOWLEDGEMENTS

I express my most sincere gratitude to Almighty God for strengthening me physically and mentally to conduct and to complete this study. The thought was daunting in the beginning, but I was inspired to continue and complete this task by His infinite grace.

While a significant number of other individuals played a crucial role in the execution of this study, I am greatly indebted to the following:

- My family, for their heartfelt encouragement, support and belief in me throughout my studies
- Professor ON Makhubela-Nkondo, for inspiring and motivating me to conduct this research
- Mrs KA Maboe, my supervisor for her insightful guidance, support, tolerance, encouragement, and compassion
- Mr BO Mmusinyane, my co-supervisor for his legal insight, continuous enlightenment and illumination on complex aspects of the investigation
- The Ethics Committee of the Department of Health Studies at the University of South Africa, for approving this study
- The Chief Executive Officer and Assistant Directors of Dr George Mukhari Hospital and its Unit Managers, for permission, collaboration and support while a crucial phase of the study was conducted on their site
- DENOSA and UNISA, for their partial funding of the research project through their respective bursary funds
- The respondents, for their willingness, time, and input during the data collection phase
- Ms S Muchengetwa, for her assistance in designing the research tool, and in the data management and the data analysis of the study
- Mrs LG Radebe, for her assistance in the initial formatting of the manuscript, and Mrs R Coetzer for the final formatting of the manuscript
- My colleagues, for their encouragement, support, and for being very considerate during my moments of anxiety
- Dr TJ Mkhonto, for the final comprehensive editing of the manuscript.

Dedication

I dedicate this dissertation to the following individuals in appreciation of their contribution to the completion of the study:

- *Those dedicated and committed nurses whose exercise of their own rights has not superseded the delivery of quality care to their patients, to whom they have pledged and ensured priority attention in spite of challenges encountered in the healthcare delivery system;*

- *My husband, Mr MA Tsatsane, for his continuous encouragement, sacrifice, support, understanding, unflinching optimism, and support for nurturing my potential.*

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANA	American Nurses Association
BCS	Basic Conditions of Service
BPP	Batho Pele Principles
CC	Constitutional Court
CCMA	Council for Conciliation, Mediation, and Arbitration
CMS	Council for Medical Schemes
DGMH	Dr George Mukhari Hospital
DoH	Department of Health
DoL	Department of Labour
EA	Equality Act
EE	Employment Equity
ESC	Essential Services Committee
GG	Government Gazette
HIV	Human Immune Virus
HPCSA	Health Professions Council of South Africa
IC	Informed Consent
ICN	International Council of Nurses
ILO	International Labour Organisation
LRA	Labour Relations Act
NHA	National Health Act
NHI	National Health Insurance
NHP	National Health Plan
NPC	National Patients' Rights Charter
RTE	Right to Equality
SA	South Africa
SAHRC	South African Human Rights Commission
SANC	South African Nursing Council
SPSS	Statistical Package for Social Sciences
SAHRC	South African Human Rights Commission
TB	Tuberculosis
TRC	Truth and Reconciliation Committee
USA	United States of America

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The health care legal and policy framework exists in order to facilitate an environment that is conducive for all the indigent people to gain access to quality public health care services within close proximity of their residential areas. In that regard, the notion of "health care for all" is espoused by the government in its initiative to actualise the five key priority areas for society's development. These five key points areas are: effective health care services delivery, crime prevention, rural development, rooting out corruption, and improving education (Bezuidenhout 2008:225).

The assertion in this research project is that patients and nurses enjoy certain rights and obligations. Furthermore, the focus will be on the impact of nurses' rights and obligations on patient care in a clinical setting. Section 27(1) (a) of the Republic of South Africa Constitution (Act 108 1996) underscores the right of patients to gain access to health care services. Section 23 of the self-same Act also endorses the right of nurses as workers to join any labour organisation of their choice, and to strike. The endorsement of workers' rights in terms of legislation, charters and policies is an attempt to remedy the previous imbalances in the labour laws of the country. In terms of the National Patients' Rights Charter (NPC), patients have among other rights, the right to access health care services at a particular health care centre for treatment services; as well as to a healthy and safe environment that will ensure their physical and mental health or well-being (Clauses 2.1, 2.3 and 2.5 of the NPC). On the other hand, patients have obligations among others, to take care of their own health and to respect the rights of other patients and health care providers (Clauses 3.1 and 3.3 of the NPC). What is not emphasised to the same extent as rights, are the responsibilities/obligations that accompany these rights.

Nurses' rights are often regarded as inferior to the rights of patients. Nurses are however, also entitled to the right to practice in a safe environment, the right not to

participate in unethical or incompetent practice against their will [The Rights of Nurses- South African Nursing Council (SANC), Chapter 2 of the National Health Act 61 of 2003], and even the right to strike subject to the provisions of Section 65 (1) (d) (i), and Section 74 of the Labour Relations Act (LRA) and Section 23 (2) (c) of the RSA Constitution. In terms of professional codes however, such rights must be exercised with due regard to patients' rights, and must not endanger the life or health of patients. The potential tension between legal rights and obligations of nurses is complicated by nurses also having to adhere to the moral and ethical norms and obligations as expected by the profession, the employer, and the community. These obligations include provision of a high standard of practice and care at all times; to be open and honest, act with integrity; and uphold the reputation of the profession (Edwards 2009:207, 221; Mellish, Oosthuizen & Paton 2010:180-183).

Moral, ethical and social obligations of all citizens are about service to humanity. In terms of Government Gazette (GG) No 18276 Vol. 387, and endorsed by Clause 3 of the Essential Services Committee (ESC) – which prescribes on essential services from 31 March 1998 - nurses were not allowed to strike or engage in lock-outs; and their labour disputes may be referred to the Council for Conciliation Mediation and Arbitration (CCMA). According to Brand (2010:2), LRA recognises the constitutional right to strike, but subjects the right to a number of limitations. One of these limitations of the LRA is that no person may take part in a strike if that person is engaged in essential services employment (Brand 2010:14-15). This limitation has specific significance for nurses. On the one hand nurses may, under specific circumstances, embark on industrial action such as a strike; while on the other hand, nurses are regarded as rendering an essential service. The foregoing statement finds common ground to this research, and seeks to explore the impact of nurses' rights and obligations on patient care in a clinical setting.

It is a common observation that nurses in public service engages in strikes almost on a regular basis for a number of reasons, and this undoubtedly has adverse repercussions on patients and their care. The research therefore explores the impact of nurses' rights and obligations on patient care in the clinical setting, mainly within the context of public health care hospitals where 60% of the nursing population in the country is employed. This sector has in the past been frequently involved in strikes by nurses and other health care workers (Breier, Wildchut & Mgqololozana 2009:2).

1.2 BACKGROUND AND CONTEXT OF THE STUDY

As-summarised by the South African Nursing Council (SANC), nurses' rights and obligations are not an end in itself, but a means to ensure improved health care delivery to patients (SANC 2004-2013:1). Nurses are also entitled to Constitutional rights as employees in the labour market. The LRA on the other hand, prohibits workers employed in an essential service environment from striking. In spite of the prescripts of the legislation, health care workers (nurses included) went on strike during 2007 and 2010.

The perspectives on the symmetry of rights and obligations – as a factor or product of both the professionalization of the labour market and the nursing professional milieu – straddle the nurses' legal, moral, and regulatory obligations, as well as their workplace imperatives and dynamics (as represented by their respective collective bargaining units or organisations). On the one hand, the dynamics of patients' rights are entailed in the relatively nascent human rights culture that is inalienably protected and guaranteed in the Constitution as the supreme law of the country.

In South Africa, as is the case in virtually all democratic societies around the world, the Constitution supersedes all other laws and any conduct or law inconsistent with it will be declared invalid (Section 2 of the Constitution). The possible inherent conflict of interests in the Constitution requires cogent jurisprudence by the relevant legal /formal state institutions such as the courts, as well as the astute statutorily regulated stewardship and intervention of bodies such as the SANC.

Legal/regulatory and policy frameworks are encapsulated in policy documents such as the National Health Plan (NHP), the National Health Act (NHA), the White Paper on the Transformation of the Health Delivery System, and the Batho-Pele Principles (BPP). The latter refers to a policy of putting the interest of the public above those of the public employee (South Africa 1997a; Mokgoro 2003:7). According to the entire spectrum of the legislative and policy frameworks, it is expected that all patients in any health care institution should benefit from the privilege of being familiarised with issues pertaining to their inalienable rights; which are not negotiable. Their rights can be claimed, and are to be observed at all times by all stakeholders and the same applies to nurses' rights (South Africa 1997a; Mokgoro, 2003:24). It is therefore expected that the nurses' rights

and those of the patients should not be contradictory, but should exist in harmony with each other.

The South African health care sector could also be regarded as contributing to the prevailing nursing distress and ethical dilemma. Mbusa and Haggstrom (2009:483) attest that there is an established workplace distress and ethical dilemmas in the Tanzanian health care system. This assertion is also reflected in the research report presented during the International Council of Nurses' 24th Quadrennial Congress on the nursing workforce and workplace (Storch, Varcoe, Pauly, MacDonald-Rencz, Rodney, Schick Makaroff & Newton 2009:20). While the nursing profession is viewed as having a catalytic potential for the general welfare and betterment of society, a rather less-inspiring perspective is also presented by other academic observers. For instance, Breier et al (2009:1) posit a stark reality on the state of the nursing profession in the country.

1.2.1 Current context

The post-1994 democratisation of South African society has ushered-in an era characterised by multi-faceted changes in the broader rubric of societal life. The changes – depending on one's developmental disposition – have been construed differently (as either progressive or necessary, or as being retrogressive and unplanned) by different individuals and groups of individuals. These changes are more prominent in the political, cultural, economic, social, and educational sphere. This has been more encapsulated by the present government's inclusion of effective health care service delivery as one of its five priority areas for developing South African society (African National Congress Abridged Elections Manifesto 2009:2).

As the backbone of society's health and developmental agenda, nursing has not been left unaffected by the post-democratic dispensation. This is supported by one of the comments after publication of the ordeals of a woman whose unborn baby died while nurses were busy singing during a strike (Pongoma 2010:2):

"I was supporting their strike. They need the money yes, but to be so heartless? The worst part is that those nurses are women too, imagine the pain of that woman. The

government should fire them. They think they are causing the government to feel their pain, but families of patients are the ones feeling the pain."

Clearly, the death or suffering of patients resulting from a strike while nurses engage on a strike is an indication that there is disequilibrium between the rights of nurses and those of patients. An appropriate approach is required to ensure the two rights coexist harmoniously.

The nursing profession in South Africa today is in need of care. The Minister of Health, Dr A Motsoaledi emphasised during the International Congress of Nurses in 2009 and during International Nurses' Day 2011 respectively, that *"nurses will remain the foundation and the backbone of health care in South Africa",* and needed to be nurtured and strengthened if the country was to overcome the health challenges facing it. Thousands of nurses have left the country, either temporarily or permanently, to seek better working conditions abroad. Those who remain face increasingly demanding workloads as Human Immune Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) and tuberculosis (TB) take their toll (Donhrn, Nzamo & Murrman 2009:28). They experience workplace stress due to shortage of staff, insufficient equipment and inadequate remuneration to deliver quality patient care. This shortfall tends to push nurses to engage in strike protest as a mechanism to compel the employer to heed their demands (Reitemeier 2000:449).

1.3 PROBLEM STATEMENT

The prominent engagement of nurses in strikes (labour action) has heralded an unprecedented era in which public health care services in the country could be randomly disrupted. Strikes by nurses have received wide media coverage and generated a sometimes emotional platform for public discourse. There seems to be a conceptual/perception and/or ideological tension between patients' and nurses' rights and obligations to provide quality patient care in the clinical setting.

Pongoma (2010:2) reports that a 28 year old woman's unborn child died as she was left unattended to while nurses were busy singing outside during the strike. This woman was assisted by her mother and friend to deliver her grand-child. Excessive or extreme conditions as in a violent strike may infringe on the rights of the patients as a community

member in a clinical setting. This tension is not desirable as it can adversely affect the patient's physical and emotional well-being (Clemen-Stone, Eigsti & McGuire 2002:427).

1.4 AIM/PURPOSE OF THE STUDY

The purpose of this study is to explore and describe the impact of nurses' rights and obligations on the delivery of quality patient care in a clinical setting, and to design supplementary guidelines for nurses to promote quality patient care in the clinical setting.

1.4.1 Objectives of the study

The objectives of the research relate to the specific intentions to be achieved (Henning 2005:1). In this regard, the objectives of this study are to:

- explore and describe the views (perceptions) of nurses about their rights and obligations in a clinical setting in a public health facility
- explore the factors that have an influence on the rights and obligations of nurses in delivering patient care in a clinical setting
- describe the effects of nurses' rights and obligations in delivering quality health care (practice) in a clinical setting
- explore the impact of nurses' rights and obligations on patient care in a clinical setting
- design guidelines for nurses regarding the implementation of their rights and obligations with the aim of promoting quality patient care in a clinical setting

1.4.2 Research questions

The following research questions are regarded as relevant in advancing the purpose of the study:

- How do nurses view (perceive) their rights and obligations in a clinical setting?

- What are the factors that have an influence on the nurses' rights and obligations in a clinical setting?
- What are the effects of nurses' rights and obligations in delivering quality health care (practice) in a clinical setting?
- What are the impact of nurses' rights and obligations on patient care in a clinical setting?

1.5 DEFINITIONS OF KEY CONCEPTS

According to Mouton (2008:175) concepts are described as cognitive units of meaning or abstract ideas, mental symbols defined as units of knowledge, word pictures, and mental ideas of a phenomenon or meanings of words. Conceptual definitions are described in books and dictionaries, while operational definition is the meaning given in the context of the study.

In this study the following concepts are defined as follows:

1.5.1 Clinical setting

An establishment of a hospital devoted to the treatment of diseases or the medical care (Oxford Concise Medical Dictionary 2002:139). In this study, it refers to the clinical areas of publicly funded health care institutions.

1.5.2 Nurse

A person registered under Section 31 (1) of the Nursing Act, 2005 in order to practice nursing or midwifery (South Africa 2005:6). In this study, it refers to all categories of nurses who are permanently employed in a clinical setting.

1.5.3 Patient

A health care recipient who is ill or hospitalized (Mosby's Medical Dictionary1997:848). In this study a patient is referred to as an individual who is sick and seek medical and nursing attention from a public health care sector.

1.5.4 Patient care

The provision of serious attention or support to any individual by a trained or qualified health care practitioner (Oxford Advanced Learner's Dictionary 2006:163 & 213) .In this study, patient care refers to care rendered to patients by nurses in a public health care facility.

1.5.5 Rights and obligations

Legally or morally enforceable and justifiable demands or claims and expectations that a person can make/claim (Muller 2009:150). In this study, rights and obligations refer to the demands nurses are entitled to make, and their expectations/responsibilities in delivering health care to patients in a public health care facility.

1.6 RESEARCH SETTING

Research setting relates to the specific place or places where the data is collected (Brink, Van der Walt & Van Rensburg 2012:59). The study was conducted at a public health care facility situated in Ga-Rankuwa Township in Gauteng Province. It is a level three hospital with bed occupancy of 1,552. Ga-Rankuwa is a highly urbanised metropolitan municipality area which straddles parts of Northern Gauteng and the North-West Province. With its proximity to the city of Tshwane and its population of approximately 92,900 people (Statistics SA 2011). The heterogeneity of the population in the area makes it an interesting research setting. It is also a referral hospital for Northwest and Limpopo Province for specialist care.

1.7 RESEARCH DESIGN AND METHOD

Research designs are plans and the procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis (Creswell 2009:3).

1.7.1 Research design

The quantitative research process refers to a formal objective, systematic study process to describe and test relationships, and intended to examine cause-and-effect interactions among variables (Burn & Grove 2009:717). In this study, a descriptive exploratory design was used. Descriptive design provides an accurate portrayal or account of characteristics of a person, event or group in real-life situations in order to discover new meaning, describing what exists, determining the frequency with which something occurs and categorise information (Burns & Grove 2009:696).

The purpose of the descriptive design is to observe, describe, classify and document aspects of a situation as it naturally occurs (Polit & Beck 2008 274). Therefore, this study gathered more insight and generated new knowledge regarding the impact of rights and obligations of nurses on delivering patient health care in a clinical setting by documenting nurses' response to their rights and obligations.

1.7.2 Research method

Research method involves the form of data collection, analysis and interpretation that the researcher proposes for the study (Creswell 2009:15).

1.7.2.1 Population

A population is defined as a group of target units in a specified area that clearly manifests the condition of concern to the programme (De Vos, Strydom, Fouche & Delport 2007:132). According to Polit and Beck (2008:337), a population is described as the entire aggregation of cases (persons or objects) in which the researcher is interested and meets the inclusion criteria. In this study, the population was all categories of nurses who are employed at Dr George Mukhari Hospital (DGMH) in Ga-Rankuwa Township (Gauteng Province). The total number of permanently employed nurses was 1,367.The inclusion criteria involved all professional, enrolled and auxillary nurses who are permanently employed at the Dr George Mukhari Hospital. The exclusion criteria involved all categories of nurses who are temporarily employed and/ or on training at the hospital.

1.7.2.2 Sample and sampling technique

Sampling refers to a process of selecting the portion of a population, or subset of a larger set to represent the entire population (Brink et al 2006:124; Polit & Beck 2008:341). Since the universal population of patients is a statistically large number that may pose quantification challenges, a portion of a representative population is sufficient to help examine the characteristics, opinions and intentions of the larger population or universe (Polit & Beck 2008:767). A stratified random sampling method was used. The strata were the categories of employed nurses at the hospital. The information from the different categories of nurses with different levels of training might be different, thus depicting a heterogeneous population. A stratified random sampling approach was thus justifiable and appropriate. From each category, 25% (reflected on the sample frame) was selected using the simple random sampling technique. A sample of 343 of three (3) categories of nurses (professional, enrolled and nursing auxillaries) was selected.

1.7.2.3 Data collection

In terms of the quantitative data collection approach, it is important to achieve efficiencies and quality of data, thus the number of respondents must be adequate for saturation of information to be accomplished (Burns & Grove 2005:352). A structured and self-administered questionnaire was used as a primary research instrument of data collection for all categories of nurses. The questionnaire was distributed to all categories of nurses by the researcher a day before and collected the following day during nurses' lunch times.

1.7.2.4 Data analysis

Data analysis entails categorising, ordering, manipulating and summarising the data and describing them in meaningful terms (Brink et al 2006:170).Data was entered and evaluated by means of the Epi-info computer program. The analysis was conducted in Statistical Package for Social Sciences (SPSS) (IBM statistics 21 version). The ANOVAS test was used to analyse variances on the levels of agreement and importance in categories (groups). In cases where there were more than two categories of variance, a post-hoc analysis was conducted using Tukey test to determine the location of the difference. The professional service of a statistician was also utilised.

Percentages, pie charts, bar chart and frequency tables were used to present the findings. Data comparison for all the respondents entailed different statistical methods as far as the quantitative research findings are concerned.

1.8 VALIDITY AND RELIABILITY

Validity refers to the ability of an instrument to measure the variable that it is intended to measure (Brink et al 2006:209; Polit & Beck 2008:768). This is the accuracy, the truth, falsity or soundness of evidence of information (Polit & Beck 2004:35). Content validity was ensured by requesting guidance from the study supervisors and statistician with regard to appropriateness, accuracy, representativity, readability and language acceptability of the study.

Reliability refers to the degree of consistency or dependability with which an instrument measures an attribute (Polit & Beck 2008:764). Reliability was ensured by conducting a pilot study prior to the actual study where the instrument was tested to identify challenges with regard to understanding of the questions. Unclear questions were modified accordingly. Ten respondents from all categories of nurses who are permanently employed in the hospital were involved in the pilot study. The respondents involved in the pilot study were not included in the actual study. Other measure included the usage of a homogenous sample, and by selecting respondents of different qualification/level of training and experience. The Cronbach alpha was used to determine the reliability of the questionnaire and it showed that it was a very reliable questionnaire.

1.9 ETHICAL CONSIDERATIONS

Polit and Beck (2008:753) illuminate that the ethical considerations of research refer to a system of moral values that adhere research to professional, legal and social obligations to the study participants. Research in health institutions is ethically and legally sensitive. It is for this reason that only volunteered participants were engaged, and strict adherence to ethical requirement was respected. Ethical considerations are a professional commitment by the researcher prior to the execution of a study (Babbie & Mouton 2002:563). The ethical considerations inherent in the research assisted in reconciling the behavioural conduct of the researcher in accordance with scientifically

accepted principles, standards, and norms with the treatment of the research respondents as primary providers and sources of information during the empirical stages of the research. In that regard, the ethical considerations could be categorised into two spheres, as discussed below.

1.9.1 Researcher-focused ethical considerations

The researcher-focused ethical considerations relate to that behavioural protocol by which the researcher commits to upholding the integrity of the study by adhering to the administrative and bureaucratic requirements as stipulated by the relevant regulatory authorities or institutions. The relevant researcher-focused ethical considerations considered in this study include the following:

- The research proposal was submitted to the University of South Africa's Health Studies Department, where the researcher is registered as a postgraduate student.
- The formal request by the researcher for an Ethical Clearance Certificate from the University of South Africa's Department of Health Studies Higher Degrees Committee. The request was approved and a clearance certificate was issued (Annexure D).
- Formal undertaking by the researcher to conduct the study in accordance with UNISA's ethical requirements of research; and upon approval by UNISA the research protocols have been obtained from the Ethics Committee and the Institutional Review Board of Dr George Mukhari Hospital (Annexure E).

1.9.2 Respondent-focused ethical considerations

The respondent-focused ethical considerations are mainly concerned with the researcher's obligation and attitude to the fair and equitable treatment of the research subjects (Polit & Beck 2008:18-19). The adherence to respondent-focused ethical considerations is in conformity with tenets of the observance of the human rights culture, which is particularly both desirable and sensitive in South Africa's embryonic democracy; according to which citizens' inalienable human rights are constitutionally guaranteed and protected. In that regard, the following respondent-specific ethical principles were complied with during the empirical execution of the study:

- The researcher formally introduced herself to the respondents during the questionnaire administration phase.
- The purpose of the research was explained to the respondents during the questionnaire administration phase, and the importance of respondents' voluntary participation in the study was emphasised.
- Consent forms were issued to all respondents after adequate information had been given to them, so as to obtain approval for their involvement in the study (Annexure A).
- The respondents who voluntarily agreed to participate in the study were asked to sign a consent form.
- The respondents were assured that they could withdraw from the study at any stage if they so wished without any penalty.
- The research respondents' right to confidentiality and anonymity was emphasised and protected. To ensure anonymity, the respondents' identity was obscured.
- To ensure confidentiality, information collected was not made accessible to others or shared with people known to the respondents and was not used for any other purpose except for this study.
- Coded numbers, instead of respondents' names, were used, and no unauthorised persons were allowed access to either the respondents' identity or the contents of their responses.

1.10 SCOPE AND LIMITATIONS

The study was conducted in one public health institution and the target population was only permanent employed nurses therefore the result may be not be applicable to generalised the findings.

1.11 STRUCTURE OF THE DISSERTATION

This dissertation is structured as follows:

Chapter 1: Orientation to the study
Chapter 2: Literature review
Chapter 3: Research design and method
Chapter 4: Analysis, presentation and description of the research findings
Chapter 5: Conclusions and recommendations

1.12 CONCLUSION

This chapter introduced and briefly highlighted the background, research problem, purpose and objectives of the study. Key concepts were defined and overview of research methodology presented. The next chapter presents the literature review on whose basis this study was conducted.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter provides the discipline-induced architecture from which the main discussion is derived. It focuses on the objective of this study and addresses the following aspects:

- The nursing profession and its applicable rights and obligations.
- The nurses' views/perceptions of their rights and obligations regarding strikes, nationally and internationally.
- Factors influencing the nurse's rights and obligations in a clinical setting.
- The impact of nurses' rights and obligations on patient care in a clinical setting.

2.2 THE NURSING PROFESSION AND APPLICABLE RIGHTS AND OBLIGATIONS

2.2.1 Human rights

There are numerous rights that co-exist even within a clinical setting. Patients have the rights as human beings and also as consumers of health care services. Human rights are a core element of professional obligations for health care workers. National and international bodies increasingly recognise the importance of incorporating rights into ethical and professional standards. Health care providers are obliged to ensure that they are not agents responsible for the violation of human rights and act positively to promote and fulfill human rights (London & Baldwin-Ragaven 2006:23-24). The Bill of Rights has far-reaching implications for nurses and midwives (South Africa 1996) who need to understand the relationship between health and human rights as they are inextricably linked (Thompson 2004:179). The Truth and Reconciliation Commission (TRC) recommendations indicate that health professionals have an ethical obligation to place the well-being of their patients at the forefront of their professional commitments. Training in human rights should be a fundamental and integral aspect of all curricula for

health professionals. The training addresses factors such as knowledge, skills, attitudes and ethical practices (TRC 2002:334-340). Knowing and understanding human rights will enhance nurses' primary function, which is to promote and deliver efficient and effective patient care in a clinical setting.

The following rights enshrined in the Constitution (South Africa 1996:6) are those that are required to co-exist within a clinical setting as some are held by patients and some by nurses:

a) the right to equality (Section 9)
b) the right to have one's dignity respected (Section 10)
c) the right to life (section 11)
d) the right to freedom and security (Section 12)
e) the right to privacy (Section 14)
f) the right to freedom of religion, belief and opinion (Section 15)
g) the right to freedom of expression (Section 16)
h) the right to assemble, demonstrate, picket and to present petitions (Section 17)
i) the right to freedom of association (Section 18)
j) the right to fair labour practices (Section 23)
k) the right to an environment that is not harmful to their health or well-being (Section 24)
(l) the right to have access to health care services (Section 27)

These human rights were not adhered to during the apartheid era as amenities were segregated and not equally available to all races. Access to health care services in SA was one of the rights that was violated since it was dispensed differently among different ethnic groups, and with limited resources, especially in rural areas (London, Holtma, Gilson, Erasmus, Khumalo, Oyedele & Ngoma 2006:11). As part of ensuring access to health services, the new democratic government, in addition to the constitutional framework, adopted laws and policies giving effect to patients' rights. The introduction of the Patients' Rights Charter was aimed at addressing the disparities of apartheid regarding access to health care services for all (London et al 2006:3).

2.2.2 Patients' rights

SA is committed to uphold, promote and protect the rights of all citizens "right to access to health care services" (South Africa 1996:13). In ensuring an intensified realisation of the "right of access to health care services", the Ministry of Health adopted the National Patients' Right Charter (NPC), whose aim is to provide common standards to achieve equal health service to all citizens. The Charter was launched by the former Minister of Health, Dr MG Tshabalala-Msimang on the 2nd November 1999 (South Africa 2002:1) to inform and guide all health care providers and consumers of health care about their obligations and rights. The Charter contains both the rights and responsibilities of the patients and among other rights contained in the Charter are:

- the right to access health care services at a particular health care provider for services or a particular health facility for treatment
- the right to a healthy and safe environment that will ensure their physical and mental health or well-being (Clauses 2.1, 2.3 and 2.5 of the NPC)

The said rights are accompanied by obligations to take care of their own health and to respect the rights of other patients and health care providers (Clauses 3.1 and 3.3 of the NPC). It is at this juncture that patients' rights of access to health care services and be treated at these facilities are deeply affected when nurses invoke their right to strike as a way of demanding better wages and working conditions.

Patients need to be fully aware as consumers of their rights and responsibilities so as to empower them to know, expect and demand high quality care. However, due to the inadequacy of both human and material resources, patients' expectations are sometimes not met, resulting in complaints or litigations. Over and above patient's rights, nurses also have their rights and obligations to be exercised, enjoyed and complied with within the prescribed parameters subject to the applicable limitations while providing and promoting quality patient care.

2.2.3 Nurses' rights

The nursing profession encompasses the values and philosophical foundation of nursing. It is essential for nurses to have a clear understanding of role obligations for

appropriate enactment of that role (Ballou 2000:172). Nurses in South Africa are governed by rules and regulations as stipulated by the SANC, which is the statutory body entrusted with regulating norms and standards in the nursing profession. Nurses are entitled to rights, among others, the right to participate in a safe environment, the right not to participate in unethical or incompetent practice against their will (SANC 2004-2013:1). Nurses also have to adhere to moral, ethical norms and obligations as are expected by the profession, the employer and the community. These obligations include the provision of a high standard of practice and care at all times, to be open and honest, and to act with integrity and uphold the reputation of her/his profession (Edwards 2009:207-221; Mellish et al 2010:180-183, 221). The SANC's standpoint is that nurses in SA can exercise their rights and obligations provided that their actions do not imperil the life and health of the patients under their care. However, such rights and obligations are not an end in itself, but a means of ensuring improved service to patients (SANC 2004-2013:1); meaning that nurses' rights are not absolute or for personal benefit, but are for promoting an efficient patient care system.

Nurses must always be accountable for their acts and omissions and will be charged with misconduct when acting irresponsibly or unprofessionally (SANC, Regulation R387 1985:C2). While patients have rights of access to health care under nurses' care, nurses do have the right to assemble, demonstrate, picket and to present petitions (Section 17 of Constitution), which normally is in accordance with their right to freedom of association, (Section18 of Constitution). According to Van Tonder (1992:30), strikes by nurses have an impact on the rights of nurses themselves. Striking nurses disregard their own privilege to care for patients and their own right to ensure nursing care for their patients. Therefore, nurse's right to strikes is in conflict with their moral rights to status, respect and courtesy. The image of nursing is also tarnished when volunteers have to take over nurses' responsibilities. As a result, patients are exposed to risks as they are turned away or sent to other hospitals; causing delays in their diagnosis and a decline in the quality of care. Delegating nurses' responsibilities to volunteers compromises the standard of nursing care; notwithstanding that some are trained nurse soldiers. This raises a concern insofar as SA's meeting the international standards of the nursing profession, whose criterion states that, "A profession is characterised by specialised preparation over a long period at a recognised educational institution" (Muller 2009:5).

Insofar as they are expected to execute the set norms and standards, nurses do have their rights to bargain for wages and better working conditions, taking into consideration their service being categorised as an essential service as indicated in the LRA. They have a protected right to strike or lockout, which is in conflict with patients' rights. This is not only a South African problem, but a universal one.

2.3 THE NURSES' VIEWS/PERCEPTIONS OF THEIR RIGHTS AND OBLIGATIONS REGARDING STRIKES IN A CLINICAL SETTING

Nurses do engage in strikes in different parts of the world as a form of pressuring their employers to listen/accede to their demands or to improve their wages and/ or living conditions within a clinical setting. The South African perception is discussed hereunder.

2.3.1 The South African perspective regarding nurses' strike

In terms of the Constitution, nurses have the same rights that are cherished by all other citizens of the country. Section 23 of the Constitution stipulates that they have the right to participate in collective bargaining activities consistent with labour law legislation. According to Brand (2010:2), the LRA recognises the constitutional right to strike, but subjects the right to several limitations, namely:

No person may take part in a strike or a lock-out if:

a) engaged in an essential service
b) engaged in maintenance service
c) bound by any arbitration award or collective agreement that regulates the issue in dispute
d) any determination made in terms of Section 44 by the Minister that regulates the issue in dispute (Section 65:C4)

As outlined in Government Gazette (GG) No.18276, 1997, s3(b), nursing is designated as an essential service by the Essential Services Committee (ESC). This means that nurses are not allowed to strike or engage in lock-outs, and therefore their employment disputes or complaints need to be directly referred to the Conciliation Commission

Mediation and Arbitration (CCMA) for conciliation and arbitration. Engaging in strikes while working in the health care services in SA has become prominent. Irrespective of the standing legislation (South Africa 1981), health workers went on strike during 2007 and 2010 respectively. Bekker's and Van der Walt's (2010:148) report indicates that as a result of nurses' strike across the country, patients were abandoned in public hospitals. Nurses and cleaners paraded through one of the state hospitals in Gauteng Province while patients were left unfed and pregnant women turned away unattended to. Clearly such negative portrayal through media may impact negatively on nurse's professional self-image and their work performance (Oosthuizen 2012:50). According to the Mail Guardian newspaper (2010:1), the Minister of Health had to request the army during the strikes to assist in the running of some health institutions to ensure continuity of patient care. During the strikes, health care workers and unions' material concerns seemed to surpass their moral obligation to the patients. This was amply demonstrated as they concentrated more on their demand for wage increase.

The penalty meted on striking workers is usually the "no work no pay principle". However, the implementation of the "no work no pay" principle seems not to have done much to deter the prominence of nurses' strikes in SA. The unions complained that the employer refused to negotiate minimum service agreements which may prevent total "patient abandonment." Roskam (2009:5) indicates that the questions of the right to strike, essential services, and minimum service agreements raise a challenge for the government in its capacity as a labour regulator. Due to these unprecedented strikes, it is clear that the employees no longer have confidence in the current model used to remedy/address their disputes and grievances. This model of referring disputes for conciliation at relevant bargaining councils or commissions and to arbitration appears to be a long and tedious process, and at times seems not taken seriously by the employer; hence failure of timeous settlement of disputes makes employees uncomfortable.

According to Loewy (2000:516-518), denying collective protest actions to workers, whether in health or other essential service, has social and political implications. If workers are denied this right, they will have to endure oppressive working conditions, and no opportunity to voice their demand for higher wages and a lack of adequate resources with which to improve those conditions. The conditions under which this right may be exercised ethically vary in regard to:

a) nature of the work
b) the prior commitment of the striking workers to persons most directly affected by the strike action
c) the particular circumstances of the strike action
d) the person the strike action is intended to benefit

In South Africa, the latter seems to be the one considered as justified by media reports. In most instances, a strike in SA usually happens during salary increment periods. Therefore, it seems as if nurses embark on strike action for their own benefits as there are other factors that impact negatively on exercising their rights and obligations like shortage of human and material resources. It is evident that in SA, nursing has been declared an essential service. Notwithstanding that, nurses have on several occasions engaged on strikes and lockouts, thus defeating the same purpose the essential service is intended to promote. As a result, an evaluation/examination of the current international practices will be critical to determine whether the position taken by SA on this matter is an effective and efficient one to deal with nurses' better wages and working conditions.

2.3.2 The International perspective regarding nurses' strike

2.3.2.1 Canada

In Canada, if an employee is given notice that he/she occupies an essential services position, that employee is prohibited from participating in a strike or in any stoppage of work (Roskam 2009:28). However, this prohibition seems to also pose some challenges to the Canadian government as in most cases they were found to have violated their employees' right to freedom of association. Historically in Canada, if the employees engage on protracted strikes in areas declared as important or essential such as nursing, "back-to-work" legislation is used to force them to return to work. This "back-to-work" legislation contains penalty/provisions for violations of the law (Roskam 2009:30).The employees are concerned about delays in achieving settlements through arbitration. However, on the other hand, the Canadian government's concern is high arbitrators' costs to reach a settlement (Roskam 2009:41).

Roskam (2009:42) asserts that there is evidence that compulsory arbitration or the 'no-strike' model "inhibits genuine collective bargaining". Rose (2008:555) posits that voluntary and peaceful settlements vary according to the essentiality of the service concerned in choosing the appropriate model for dispute resolution. There is no clear preference, but there is less resentment to outcomes under the designation model; whereby a certain percentage of the employees in the bargaining unit are deemed essential and prohibited from striking. If the latter is practiced, it will be of advantage to patients as "abandonment" of patients will be avoided and their right to access to health care assured. The advantage of this model is that not all nurses will participate in strike action. In SA, not all nurses voluntarily participate in strikes. Those who are keen to work, fear intimidation and at some stage they are forcefully dragged out from nursing units by other striking nurses. In 2010, a mass nurse strike was reported in the media that some nurse were assaulted and others stabbed for rendering services whilst others were striking (Smith 2010:1). With strict laws applied to Canada within the health environment, it is essential to look at how Italy treats its health care workers' disputes**.**

2.3.2.2 Italy

In Italy, the constitutional rights of individuals that need to be protected during strike are, to mention a few: the right to life, health, freedom of communication and safety. These constitutional rights are protected by Article 40 of the Italian Constitution of 1990. The 1990 constitution also govern the minimum service and regulates the right to strike in essential public services. The Italian Constitution was supplemented by the Act 83 of 2000), which establishes a balance between the right to strike and continuity of the public service (Roskam 2009:45). The purpose of the Act is not to deprive anyone of the right to strike, but to guarantee the operation of minimum service in the essential public service space. The results of the minimum service are positive because there are effective dispute prevention procedures (Roskam 2009:46-48).

Italy has an array of strike prevention measures, for example, a ten days' notice of strike action is required in the public service. Once this period has expired, a strike cannot exceed 4 hours and subsequently 24 hours once a further ten days' notice has been given to the employer. There must be at least ten days between two strikes in the same sector or affecting the same group of users (Crema 2005:4). The prevention measures applied in Italy are ideal as strike action is not prolonged as compared to the South

African strike model where the strike action period sometimes exceeds 3 weeks. A break between strikes allow essential services like health care to be provided to consumers/patients. Finland, on the other hand, also has its own perceptions, legislation and procedure for handling strike action specifically by nursing personnel.

2.3.2.3 Finland

According to Kangasniemi, Viitalähde and Porkka (2010:630), nurses rights are classified under human and civil, professional ethics, health care legislation and earned rights. Kangasniemi et al (2010:631) cited that the Finnish health care legislation recognises nurse's rights under the following categories:

a) the right to practice the nursing profession
b) the right relating to nurses' employment contract
c) the rights concerning the safety of working conditions

Kangasniemi et al (2010 631-633) indicate that nurses' rights need to be considered, as they are part of good care and a way to ensure the quality, safety and effectiveness of that care. To achieve this, research and education are required to increase awareness of nurse's rights. Nurses have the right to participate in industrial action, but the primary disadvantage for that action is the threat to patient care and safety. Strikes should therefore be the last alternative. Nurses should use public discussions to promote and improve their rights and social status. Regardless of any personal or other circumstances, refusing to provide care to a patient (whether in an emergency or not), is ethically, legally and professionally unacceptable.

Nurses need to continue providing care whilst their demands are still being attended to by union representatives and the employer. Nurses committed themselves under their oath that patient care will be their first consideration, and they should comply with the requirements of that oath. The Finland approach appears not to be ideal for the South African situation as the current model of addressing wage disputes has proven to pose several challenges forcing nurses to abandon their workstations and engage in no work no pay" strikes. Therefore, the Finland approach may be ideal but impractical if the model does not address the disputes on the table. It is therefore interesting to note the

approach applied in the United States of America with regard to strike and dispute resolution.

2.3.2.4 United States of America

The Bill of Rights from the American Nurses Association (ANA) was developed to support nurses in handling difficulties they encounter in the workplace. The document also serve as a source of reference for employees to help them understand what nurses need in their workplace. The Bill of Rights for registered nurses can be utilised by nurse educators in an introductory nursing course and in discussions of topics relating to clinical nursing practice (ANA 1998). Seven registered nurses rights are included in this document which are similar with the ones in SA:

a) the right to practice in a manner that fulfill their obligations to society and to those who receive nursing care
b) the right to practice in environments that allow them to act in accordance with professional standards and legally authorised scopes of practice
c) the right to a work environment that supports and facilitates ethical practice, in accordance with the Code of Ethics for nurses and its interpretive statements
d) the right to freely and openly advocate for themselves and their patients, without fear of retribution
e) the right to fair compensation for their work, consistent with their knowledge, experience and professional responsibilities
f) the right to a work environment that is safe for themselves and their patients
g) the right to negotiate the conditions of their employment, either as individuals or collectively, in all practice settings

Unlike other countries mentioned in this chapter, USA nurses' reasons for embarking on strike action include patient quality care related issues. According to Martinez and Weisfeldt (2011:1), 30% of the 2,000 nurses decided not to participate in the 1 day strike at several hospitals in USA. The nurses were protesting what they called an "erosion of care and cuts to patient protection". They were fighting for improved working conditions that will ensure the safest and highest-quality nursing care possible for patients.

Most nurses in the USA feel that they struggle with the ethical and professional implications of strikes, and that it should be an action of last resort. Before participating in a strike action, nurses should try to examine their own moral compass with some sincerity. It is incredibly difficult to deprive the patients the care they deserve by staying away because of strike action. The complications and suffering the patient has endured during a strike cannot be forgotten. If the patient dies as an outcome of a strike, death cannot be reversed. Hence it is ideal to have certain percentage of nurses to work whilst others are on strike if bargaining processes failed. It is important that all possible avenues/strategies of resolving a dispute be explored before resorting to strike action. Therefore, nurses from USA observe their ethical-professional obligations and employers try to comply with the law, like appropriate compensation of employees whilst considering other factors that influence the decision on nurses rights and obligation in the clinical setting. The American approach seems balanced as it looks at both patient and nurses interests during the negotiation period, and in the end addresses without leaving or undermining anyone rights during the process. Unlike in SA, the employer responds belatedly to employees' demands which most of the time undermine patients' rights during the process.

2.4 FACTORS INFLUENCING DECISIONS ON NURSES' AND PATIENTS RIGHTS AND OBLIGATIONS

2.4.1 Nurses' factors

Looking at the essentiality of nurses' duties and the ethical, professional and legal aspects applicable to nursing practice, patients must never be left alone or unattended to. The following factors can influence nurses' decisions on how to exercise their rights and obligations in the clinical setting during a strike action. These factors predetermine the level/degree of performance of nurses in rendering patients' care.

2.4.1.1 Competency

The health care environment requires nurses to be competent decision-makers in order to respond to client's needs. A study by Hagbaghery, Sasali and Ahmadi (2004:4) revealed that nurses' high level of knowledge, skills, experience and ability to use these skills properly, result in effective clinical decision-making. Having knowledge and skills

will assist nurses to implement decisions that will positively address the patient's identified health problems or complaints. One participant in the study cited her situation where she rescued a discopathic patient post-operatively who developed emboli on the left leg. The participant (nurse) stated that:

"When the patient was brought from theatre, one of his primary signs was leg pain. I went to his bedside and removed the blanket. I felt the left leg's temperature was lower than the right one, and his pulse was slow. I immediately called the concerned doctor and also called and arranged for the operating room. The patient was taken to the operating room and an embolectomy was done. If my knowledge had been poor, something terrible would have happened. It was that time that I felt my proper knowledge and timely decision could save the patient" (Hagbaghery et al 2004:4-5).

Knowing what to do and how to do it, will enhance the willingness of an individual nurse to involve herself/himself with others and in difficult situations. A competent nurse enjoys and has pride in executing her/his duties and knows that the task will be excellently executed. Competency enhances the nurses' moral judgement and thus influencing their decisions on how to implement their rights and obligations.

2.4.1.2 Self-confident

Self-confidence provides the nurse with the feeling of control and the ability to influence the situation and make an independent decision. Nurses' self-confidence, together with clinical competence, enables them to become initiators to assist the patients and accelerates their time in making and implementing the decisions (Hagbaghery et al 2004:5). A confident nurse is always ready to exercise her/his rights and obligations without any doubts, and keen to challenge complex nursing assignments. A confident nurse is always available and willing to take a risk and brings in change in nursing practice. Continuous self- assessment to identify weakness in performance will boost individual self-confidence.

2.4.1.3 Nursing education

According to Hagbaghery et al (2004:6), nursing education plays an important role in the development of decision-making skills of a nurse. Nursing curricula must not be

theoretical only. Students on training need to be given enough opportunity to apply theory and practice. This will enable them to adapt easily in a clinical unit after completion of training. Role modelling also plays an important part in stimulating and developing independent decision-making skills based on nurses' own judgement (Hagbaghery et al 2004:6-7). Therefore, qualified nurses need to portray a good image about the nursing profession to neophytes by behaving accordingly. Continuous education and research is to be encouraged for nurses to acquire more recent knowledge and skills that are applicable to nursing practice. The nursing curricula of different courses, for example, bridging and post basic clinical programmes are being constantly reviewed to include vital current information in nursing practice and having discussed factors impacting on nurses' role. It is vital to also discuss factors relating to patients during the strike action (Mayers 2007:53).

2.4.2 Patients' factors

2.4.2.1 Conflicting interests, wishes and values

The SANC (2004-2013:1) states that nurses' rights and obligations are not an end in itself, but a means of ensuring improved service to patients. Nurses sometimes experience difficulties when exercising their rights and obligations in an endeavour to render quality patient care. The conflicting interests and wishes of an individual patient sometimes pose a problem for nurses to achieve their objectives. In instances where there are conflicting interests and wishes, nurses may have to decide the appropriate balance between them (Rowson 2007:838). This conflicting situation may happen where an individual patient who is affiliated to a certain religion like Jehovah's Witness is anaemic and blood transfusion is prohibited. The patient has the right to refuse blood transfusion while the nurse has the right and obligation to render quality patient care. In this case, nurses may be regarded as having respected a patient's right even when they do not give that right priority over all other legally required or morally permissible considerations (Rowson 2007:840). A study by Solum, Maluwa and Severinson (2012:133) confirmed that conflict between individual patient's rights may influence nurses' ideal course of action. An example of the student's awareness is expressed in the following quotation:

"It was a baby and the guardian refused a blood transfusion, I could do nothing and she died. I felt very bad".

Nurses may also encounter difficulties in situations where their abilities to do the right thing is frequently hindered by conflicting values and beliefs of other health care providers. Hence the need for all nurses in all roles across all settings, to uphold their commitment to patients by working toward creating work environments that support moral courage (Lasala & Bjarnason 2010:1). Nurses who are morally courageous are able to confidently overcome their personal fears and respond to what a given situation requires; to act in the best interests of their patients.

2.4.3 Organisation factors

2.4.3.1 Organisational structure

Hagbaghery et al (2004:5-6) indicated that organisational structure and culture influence nurses' decisions in exercising their rights and obligations. Other factors such as unbalanced nurse-patient ratios and non-nursing duties were cited as barriers in effective clinical decision making. These factors inhibit and or limit nurses' precious time of rendering quality care to patients. It is such instances that result in nurses resorting to strikes if they are not addressed within the appropriate time and prescribed dispute resolution mechanisms.

2.4.3.2 Management support

For nurses to be able to make effective clinical decisions regarding patients' care, they need management support. The support can be in the form of financial welfare, provision of care facilities and emotional support, and good working conditions. Lack of management support in health care institutions is likely to cause nurses to feel unable to meet their client's needs, lowers their morale and engenders the feeling of inability to have control over their work. This situation disturbs their obligation of rendering high standard of care to patients. Therefore, nurses need to be provided with resources and be emotionally balanced in order to execute nursing activities with diligence (Hagbaghery et al 2004:6).

2.4.3.3 Management style

The administrative areas in nursing have previously been controlled only by nurse managers. Nurses who were at functional level (bedside operators), were receiving instructions from managers. The practice of shared governance by nursing managers is of advantage towards rendering of quality patient care. It promotes collaborative decision making and shared responsibility. It also empowers nurses to act with moral courage by taking ownership of their practice. Lasala and Bjarnason (2010:5) cited that research has demonstrated several positive outcomes of shared governance, which include the following:

a) increased nurse satisfaction
b) retention of staff members
c) motivated staff members

Shared governance in the clinical setting establishes a relationship of trust between the manager and team members. There is mutual acceptance by the team members and they take ownership and accountability of the consequences of the decision taken. This management style encourages team members to do the right thing the right way. The nurses' rights and obligations are a means of providing and promoting quality patient care in the clinical setting. The implementation of their rights and obligation should not be interrupted if positive impact as discussed below has to be observed.

2.5 IMPACT OF NURSES RIGHTS AND OBLIGATIONS ON PATIENT CARE

The expectations of patients on nurses to provide health care are based on both parties to endorse mutual trust and respect. Nurses should take heed of the physical, social and psychological needs of their patients and patients should also practise reciprocity. There are a number of issues that can have a significant impact on how nurses respond to patient care and their duties in a clinical setting.

2.5.1 Advocacy

Nurses need to advocate, keep patients informed, and connect them to other multidisciplinary health team members, and protect and watch them during their health

care experiences. Honouring these expectations will ensure a positive nurse-patient relationship that results in anxiety reduction and promote healing. The outcome will impact positively on patient satisfaction (The nurse patient … [s.a.]).

If nurses guide and include patients in decisions regarding their illness and guard against mismanagement by other members of the multidisciplinary team, an element of trust will be established. The availability of nurses in clinical settings will enable them to honour their advocacy role in a secure clinical environment.

2.5.2 Safe environment

Nurses' rights to work in an environment that supports and facilitates ethical practice promotes their ability to work collaboratively with members of the multidisciplinary team, resulting in improved patient care (Hayden-Pugh 2010:3). Nurses have the right to work in a safe environment that is not harmful to their health and wellbeing (Hyden-Pugh 2010:3). This enhances patient safety by improving the effectiveness among caregivers, reducing medico-legal risks resulting in "harm-free "experiences of patients and nurses themselves. Participation of nurses in a Nursing Government Structure empowers them to make decisions about their practice. This participatory governance structure, which consists of nursing committees, also enables nurses to fulfill their rights and obligations and come up with innovative practice solutions that contribute to the provision of quality patient care (Hayden-Pugh 2010:3).

A study by Tourangeau, Doran, Mc Gillis Hall, O'Brien Pallas, Pringle, Tu and Cranley (2007:34-35) reveals that a supportive and appropriately structured nursing work environment leads to prevention of unnecessary patient deaths. The study concluded that delivery of a safe and effective patient care can be ensured by hiring and retaining baccalaureate nurses as well as providing adequate nursing staff to minimise unnecessary patient deaths (Tourangeau et al 2007:42). O'Brien-Pallas, Griffin, Shamain, Buchen, Duffield, Hughes, Spence Laschinger, North and Stones (2006:170) declare that a high turnover of nursing personnel contributes to reduced continuity of care, reduced productivity and increased risk. High rate of nurse's turnover globally is a result of factors in the practice environment that make it impossible to maximise the productivity of nurses. Nurses have the right to practice in a safe environment, equipped with adequate materials and personnel for provision of quality care; hence shortage of

nurses has an impact on patient outcome. Literature review demonstrates that patient morbidity and mortality are influenced by skill mix, patient-to-nurse ratios and years of related experience. Failure to retain nurses affects patient satisfaction negatively (O'Brien-Pallas et al 2006:171).

2.5.3 Respect and trust

Nurses are obliged to treat patients with dignity and respect so that they can disclose private details about their physical or mental conditions. Total disclosure of information will promote competent decision-making in order to respond to each patient's unique needs. The balance of trust and professional respect is the founding principle for a healthy nurse-patient relationship which will enhance patient and family satisfaction resulting in speedy recovery (The nurse patient … [s.a.]).

Trust is based on the individual's attitude. A positive, respectful, and non-judgmental attitude leads to trusting relationship and freedom of expression. Decisions taken by the nurse must correlate with patient decision reflecting understanding of the information given by the nurse as clarification of what the patient informed her/him about.

2.5.4 Operational failures

Operational failures contribute to nurses' dissatisfaction and reduce quality of patient care (Tucker 2004:154). Nurses have the right to practice in a safe environment, equipped with adequate materials and personnel to render quality patient care, as operational failures result from lack of materials, supplies and shortage of staff. When there is an operational failure, nurses' time is wasted on failure resolution activities which interrupt nurses concentration, delayed patient care, wasted hospital resources and put patients at risk (Tucker 2004:152). The effect of operational failures where a nurse have inadequate or no resources to render nursing activities can result in patient death, employee termination and expensive lawsuits. According to Tucker (2004:160), five of the 13 nurses interviewed in the study acknowledged that *"While nurses needed to take responsibility for trying to improve their work environment, many of the day-to-day failures crossed organisational boundaries".*

These operational failures are the contributory factor of low standard of care in SA resulting in litigations against Department of Health. Clearly the fact that they embark on strikes or lock outs is to a certain extent attributed to the fact that most of the mentioned factors are not adequately addressed by their employers and as a result, expose nurses vulnerable to unsafe working conditions likely to contribute immensely to the low morale of nurses to continue being principled within their working environment. If attention could be paid to their needs/challenges well in advance, it could avert disputes likely to result in a strike that compromises patient care and put the nurses under strain to uphold their obligations. Addressing nurses' needs well in advance will enhance actualisation of their rights and obligations which is delivery of efficient and effective patient care.

2.6 CONCLUSION

It is clear from this discussion that the South African nursing profession is facing problems that seems universal, yet with various solutions followed around the world. Globally, the essentiality of legislated nursing services is the same; and to promote and render quality patient care. The fact that nursing is a declared essential service requires government to rethink how it addresses nurses' demands/issues taking into account the previous accounts of compromising patient care, should nurses embark on strikes. There is a need for an ideal model for dispute resolution that will ensure avoidance of "patient abandonment" during strikes or lock outs by nurses, and guidelines for nurses on the exercise of their rights and obligations for patients' benefit during strike action. Clearly, declaration of nursing as an essential service has not done much to deter them from exercising their constitutionally protected right to strike in instances where the existing dispute resolutions mechanisms proved inadequate to address their needs. The review of literature has so far not yielded any cogent studies conducted explicitly for the purpose of exploring the solution relating to the impact of rights and obligations of nurses on patient care in a clinical setting.

The comparative approaches mentioned therefore requires South Africa to generate a hybrid solution model likely to ensure patients' rights are not compromised, and that at the same time nurses' rights are respected and their demands are addressed adequately in accordance with the set essential service standards.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

The previous chapter focused on literature review regarding the impact of the rights and obligations of nurses on patient care in a clinical setting. The review of literature has so far not yielded any cogent studies conducted explicitly for the purpose of exploring the impact of rights and obligations of nurses on patient care in a clinical setting. Chapter 3 describes the research design and methods and procedures that were used in this study. It describes the research design, research method, the population, sample selection, the data collection instrument and ethical considerations.

3.2 RESEARCH SETTING

According to Burns and Grove (2009:362), the research setting is the location or place where a study is conducted. In this study, the research setting is a public hospital situated in the north of Gauteng Province.

3.3 RESEARCH DESIGN

The descriptive and exploratory quantitative research design was used in this study. The quantitative research process refers to a formal objective, and systematic process to describe and test relationships and to examine cause-and-effect interactions among variables (Burns & Grove 2009:717). A descriptive design provides an accurate portrayal or account of characteristics of a person, event or group in real-life situations in order to discover new meaning, describe what exists, determine the frequency with which something occurs, and categorises information (Burns & Grove 2009:696).

The purpose of the descriptive research design is to observe, describe, classify and document aspects of a situation as it naturally occurs (Polit & Beck 2008:274) .The descriptive research design enabled this study to gather more insight and generated new knowledge regarding the impact of rights and obligations of nurses on the delivery of patient care in a specific clinical setting.

3.4 RESEARCH METHOD

3.4.1 Population

According to De Vos, Strydom, Fouche and Delport (2007:132), a population is described as a group of target units in a specified area that clearly manifests the condition of concern to the programme. The population comprised of nurses who are employed at Dr George Mukhari Hospital in Ga-Rankuwa Township (Gauteng Province). The target population included the following categories of nurses who are permanently employed at the above hospital:

- professional nurses
- enrolled nurses; and enrolled auxiliary nurses

The exclusion criteria were on the basis of all categories of nurses who are temporarily employed and those who are students.

3.4.1.1 Sample selection

Sampling refers to a process of selecting the portion of population, or subset of a larger set to represent the entire population (Brink et al 2006:124; Polit & Beck 2008:339). A probability sampling method was used in this study. In probability sampling, every member of the population has an equal chance of being included in the sample (Burns & Grove 2009:349; Brink et al 2006:126). This method permitted the researcher to estimate the sampling error and reduced bias in the sample and in the sampling process (Brink et al 2006:126).

Since the universal population of nurses is a statistically large number that may pose quantification challenges, a portion of the representative population is sufficient to help examine the characteristics, opinions and intentions of the larger population or universe (Polit & Beck 2008:767). A stratified random sampling method was used. The strata were the categories of nurses employed at the hospital. The information from the different categories of nurses, with different levels of training, might be different, thus depicting a heterogeneous population. Therefore, a stratified random sampling approach appeared to be justified. The sample frame consisted of 650 professional

nurses; 395 enrolled nurses; and 322 enrolled nursing auxiliaries; with a total of 1,367 permanently employed nurses.

A 25% sample from each category (as reflected on the sampling frame) was selected using a simple random sampling technique. Professional nurses, 25% of 650=163, enrolled nurses, 25% of 395=99 and enrolled nursing auxillaries, 25% of 322=81. The researcher visited the units and selected every fourth nurse on the off-duty roster, starting at the top of the list in the first unit and starting at the bottom of the list in the next unit until the sample size was obtained. This method of selecting respondents was chosen to obtain a fair representation of all categories at the various levels of seniority. If any selected respondent was unwilling to participate, the next respondent on the list was selected. A sample of 343 of three categories of nurses was selected. A determination of the size of the sample was guided by the principle that the larger the sample, the more representative of the population it is likely to be, and sampling error is reduced (Polit & Beck 2008:348).

3.4.2 Data collection

In terms of quantitative data collection approaches, it is important to acquire relevant, reliable and valid data. The number of respondents must be adequate to collect sufficient information regarding the study.

3.4.3 Data collection approach and method

In this study, the quantitative research process entailed the use of a self-administered questionnaire as a primary research instrument of data collection for all categories of nurses. The questionnaires were distributed by the researcher to all categories of nurses who consented to participate in the study a day before and collected the following day during the nurses' lunch times. The collection of the completed questionnaire by the researcher improved retention rates as this was a problem during the pilot study phase. Distribution of questionnaires was preceded by a brief explanation of the purpose of the study, voluntary participation, consent form, privacy and confidentiality aspects and how to complete the data collection instrument itself. This was done in order to have a common understanding for all categories of nurses with different levels of training. The questionnaire took approximately 25 minutes to

complete. The envelopes containing the completed questionnaires were kept locked in a cupboard. A record of distributed and received questionnaires in each unit was kept.

3.4.4 Development of the data collection instrument

The questionnaire was divided into the following four sections:

Section A: Demographic data
Section B: The views/perceptions on nurse's rights and obligations
Section C: The factors that influence decisions about a nurse's rights and obligations pertaining to patient care
Section D: The degree of impact of nurse's rights and obligations on patient care in a clinical setting (Annexure C)

The questionnaire consisted of both open- and closed-ended questions relevant to the research questions. The open-ended questions were included as they enabled the nurses to explain their perceptions in their own words. The aim was to obtain a precise reflection of the respondents' opinions and to offset some of the weaknesses of structured items allowing responses only from a selection of pre-coded answers. Questionnaires were used in this study because of the following advantages:

- they are a useful tool for collecting data from a largely widely dispersed population as it is cheap, rapid and efficient
- they offer the possibility of complete anonymity which is not possible in face to face interviews
- they have a high degree to handle sensitive personal information involving socially unacceptable behaviour
- they give the respondent time to contemplate his or her responses to specific questions. This is important when exploring sensitive aspects such as the impact of a nurse's rights and obligations on patient care
- measurement is enhanced as respondents respond to the same questions in the same sequence
- bias, introduced by the presence of researcher, which results in respondents selecting responses thought to be acceptable to the researcher, is avoided

An introductory letter was attached to the questionnaire to give a brief explanation of the research and its purpose, assure anonymity and confidentiality, and give directions for completion of the questionnaire and collection dates.

3.4.5 Pre-testing of the data collection instrument

The data collection instrument was pre-tested on 10 nurses who were from the three categories of nurses included in the study. A questionnaire was distributed to them after a brief explanation was given on how to complete it. These nurses were not included in the main study. The purpose was to further change or rephrase unclear questions and to determine the time it takes to complete the questionnaire. Any change on the instrument was done before distributing it to the respondents for the main study.

3.5 DATA ANALYSIS

Data analysis entails categorising, ordering, manipulating and summarising the data and describing them in meaningful terms (Brink et al 2006:170). Data was entered and evaluated by means of the Epi-info computer program. The analysis was conducted in Statistical Package for Social Sciences (SPSS) (IBM statistics 21 version). The ANOVAS test was used to analyse variances on the levels of agreement and importance in categories (groups). In cases where there were more than two categories of variance, a post-hoc analysis was conducted using Tukey test to determine the location of the difference. The professional service of a statistician was also utilised. Percentages, pie charts, bar charts and frequency tables were used to present the findings.

3.5.1 Validity and reliability

Validity is the ability of an instrument to measure the variable that it is intended to measure (Brink et al 2006:209; Polit & Beck 2008:768). Content validity was ensured by requesting guidance from the study supervisors and statistician with regard to appropriateness, accuracy, representativity, readability and language acceptability of the study. Content validity was validated when analysing the results of the pilot study .Even the lowest category of nurses were able to answer questions and rate items in the data collection instrument.

Reliability is the degree of consistency or dependability with which an instrument measures an attribute (Polit & Beck 2008:764). To ensure reliability, the data collection instrument was carefully designed. The items in the questionnaire were analysed and correlated to each other. The instrument was tested during the pilot study phase and was adjusted and modified accordingly. The use of heterogeneous population in the study ensures reliability as it has more participant variability than a homogeneous population (Grove, Burns & Gray 2013:389).The Cronbach alpha was used to determine the reliability of the questionnaire and it showed that it was a very reliable questionnaire

3.6 ETHICAL CONSIDERATIONS

The relevant researcher-focused ethical considerations considered in this study included the following:

- The research proposal was submitted to the Departmental Higher Degrees Committee of the Department of Health studies at the University of South Africa for ethical clearance (Annexure D).
- Formal undertaking by the researcher to conduct the study in accordance with UNISA's ethical requirements of research.
- The research protocols were obtained from the Ethics Committee and the Institutional Review Board of Dr George Mukhari Hospital (Annexure E).

3.6.1 Respondent-focused ethical considerations

The respondent-focused ethical considerations are mainly concerned with the researcher's obligation and attitude to the fair and equitable treatment of the research respondents (Polit & Beck 2008:18-19). The following respondent-specific ethical principles were complied with during data collection:

- The researcher formally introduced herself to the respondents during the questionnaire administration.
- The purpose of the research project was explained to the respondents during the questionnaire administration and the importance of respondents' voluntary participation in the study was emphasised.

- Consent forms were issued to all respondents after adequate information has been given to them, so as to obtain approval for their involvement in the study see (Annexure A).
- All the voluntary respondents were asked to sign a consent form.
- The respondents were free to withdraw from the study at any stage without any penalty.
- The research respondents' right to confidentiality and anonymity was emphasised and protected. To ensure anonymity, consent forms were collected immediately after being signed by the respondents and the completed questionnaires were placed in an envelope and collected the following day during the nurses' lunch times.
- Coded numbers, instead of respondents' names were used, and no unauthorised persons were allowed access to either the respondents' identity or the contents of their responses.
- To ensure confidentiality, information collected was not made accessible to others or shared to people known to the respondents and was not used for any other purpose except for this study.
- The completed questionnaires were kept locked up in the cupboard by the researcher, only the researcher and statistician had access to the raw data.
- The data entered onto the computer was safeguarded by secure password. After acceptance of the research report, the completed questionnaires were destroyed by the researcher and the database removed from the computer.

3.7 RETURN RATE OF QUESTIONNAIRES

Table 3.1 below illustrates the rate of return of questionnaires used in the study.

Table 3.1: Return rate of questionnaires

Questionnaire	Professional nurses	Enrolled nurses	Enrolled auxiliary nurses	Total	Percentage
No handed out	163	99	81	343	100.00
No returned	138	78	63	279	84.34

Returned and not filled = 27 (7.87%)

Not returned = 37 (10.78%)

3.8 CONCLUSION

This chapter detailed the research design and methodology used in this study. The population, the sample and sampling method, the research instrument, and the data collection and analysis methods were explained. Reliability, validity and ethical consideration issues have been discussed. Data analysis, presentation and description of research findings will be discussed in the next chapter.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION OF THE FINDINGS

4.1 INTRODUCTION

Whereas chapter 3 discussed the research design and method in detail, chapter 4 presents the findings, analysis, and interpretation of the findings. The collected data is presented in the form of tables, bars and pie diagrams, while responses to open-ended questions are summarised and categorised into appropriate classifications through the process of content analysis (Polit & Beck 2008:750).

The following research objectives were considered during the data presentation and analysis phase:

- exploring and describing the views (perceptions) of nurses regarding their rights and obligations in a clinical setting in a public health facility
- exploring the factors that exert an influence on the rights and obligations of nurses in delivering patient care in a clinical setting
- describing the effects of nurses' rights and obligations on delivering quality health care in a clinical setting
- exploring the impact of nurses' rights and obligations on patient care in a clinical setting
- designing guidelines for nurses regarding the implementation of their rights and obligations with the aim of promoting quality care in the clinical setting

4.2 DATA MANAGEMENT AND ANALYSIS

The data was obtained from 147 professional nurses, 75 enrolled nurses, and 66 enrolled auxiliary nurses who were permanently employed at Dr George Mukhari Hospital. Data coding for open-ended questions was conducted by categorising the questions into themes. Data cleaning was also conducted and responses that could not fit on any category when analysing the open-ended question responses were removed. Data were entered and evaluated by means of the Epi-info computer program. The

analysis was conducted in Statistical Package for Social Sciences (SPSS) (IBM SPSS statistics 21 version). The ANOVAs test was used to analyse variances on the levels of agreement and importance in categories (groups). In cases where there were more than two categories of variance, a *post-hoc* analysis was conducted using the Tukey test to determine the location of the difference. The Tukey test identifies any difference between two mean scores that are greater than the expected standard error. In this analysis, it was used when there were multiple comparisons in different categories of nurses. A statistician assisted with data management and analysis, for the statistician's letter (see Annexure F). The data were analysed under the following variables:

- Sample characteristics
- Knowledge score of nurses' rights and obligations
- Levels of agreement
- Variances on levels of agreement

4.3 RELIABILITY OF THE MEASUREMENT INSTRUMENTS

The Cronbach alpha was used to determine the reliability of the questionnaire and it showed that it was a very reliable questionnaire. The results of the reliability coefficient are shown in Table 4.1 below.

Table 4.1 Cronbach's overall reliability tests

Aspect	**Cronbach's alpha reliability coefficient**
Section C:(13 items) – The factors that influence decision on nurses' rights and obligation on patient care in a clinical setting	0.867
Section D: (12 items) – Impact of nurses' rights and obligation on patient care in a clinical setting	0.824
Section E: (7 items) – Statements regarding general behaviour of nurses on patient care (nurses' obligations)	0.865
Section F: (8 items) – Factors which may impact on the quality of patient care when nurses are on strike	0.880
Overall reliability (40 items)	0.910

The overall reliability of the measurement instruments consisting of all 40 items had an excellent reliability coefficient of 0.910. A test with a Cronbach alpha of 0.910 indicates

that the test will be 91.0% reliable in practice, so that the higher the Cronbach alpha, the more reliable the test results will be. In this case, our test has a reliability rate of 91%. All sections had reliabilities greater than 7, which is an acceptable basis to determine the Cronbach alpha for this questionnaire as an indication that it was a reliable research instrument.

4.4 RESEARCH RESULTS

The results of this study will be presented using the following headings:

- Sample characteristics
- Knowledge score of nurses' rights and obligations
- Levels of agreement or importance
- Variances on levels of agreement or importance

4.4.1 Sample characteristics

A total of 288 nurses participated in the survey from an intended target of 343, thus giving a response rate of about 83.96%. Stratified sampling was conducted and this is a representative sample since it is more than 20% of the target population. The findings can thus be generalised to the whole population at the hospital (Leedy & Ormond 2010:213-214).

4.4.1.1 Gender

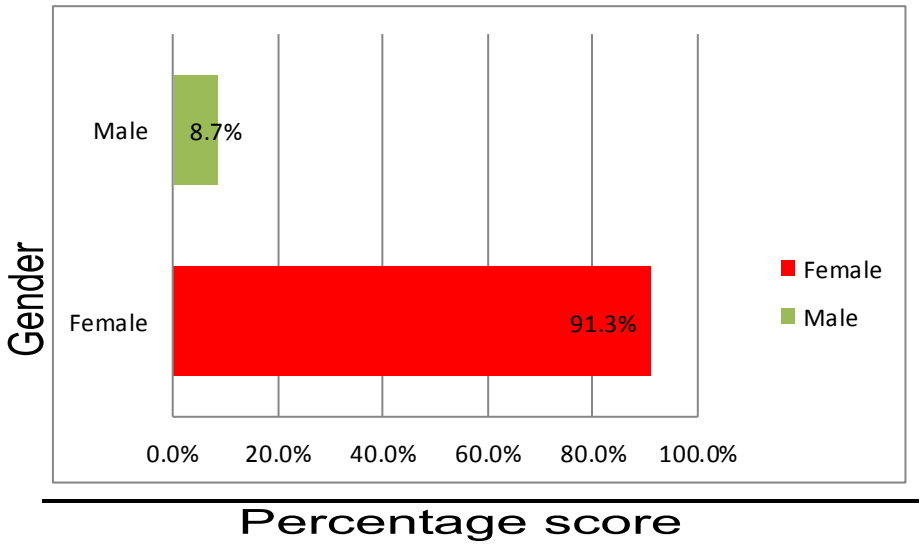

Figure 4.1 Gender distribution of the respondents (N=288)

From the 288 respondents, 8.7% (n=25) were males, whilst 91.3% (n=263) were females. There were more females than males since the nursing profession is mainly dominated by females. Notwithstanding the above, the latest South African Nursing Council (SANC) statistics indicate a sharp increase of male nurses over the past ten years. In spite of the increase in the number of male nurses, the gap in the number of males compared to female nurses is far from being reduced (Mngoma 2013:1).

4.4.1.2 Age

About 286 respondents indicated their age as shown in figure 4.2.

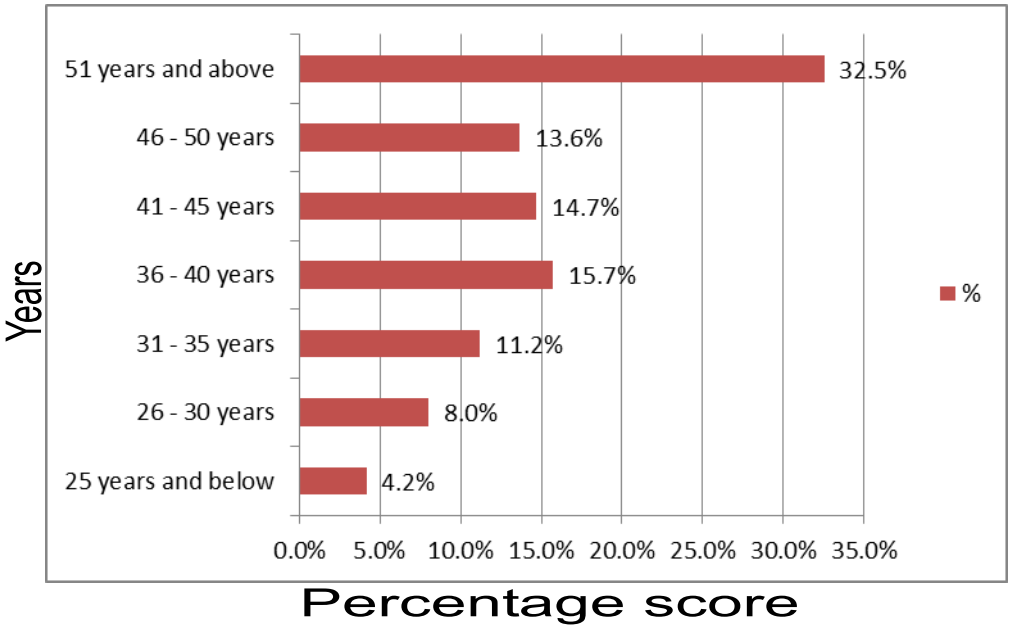

Figure 4.2 Age (N=286)

The findings show that 32.5% (n=93) of respondents were 51 years and older whilst 60.8% (n=124) are above 40 years of age. Thus, the majority of the employees were mature.

4.4.1.3 Nursing category

In terms of the nursing category, all the respondents managed to indicate their responses. The information is indicated in figure 4.3.

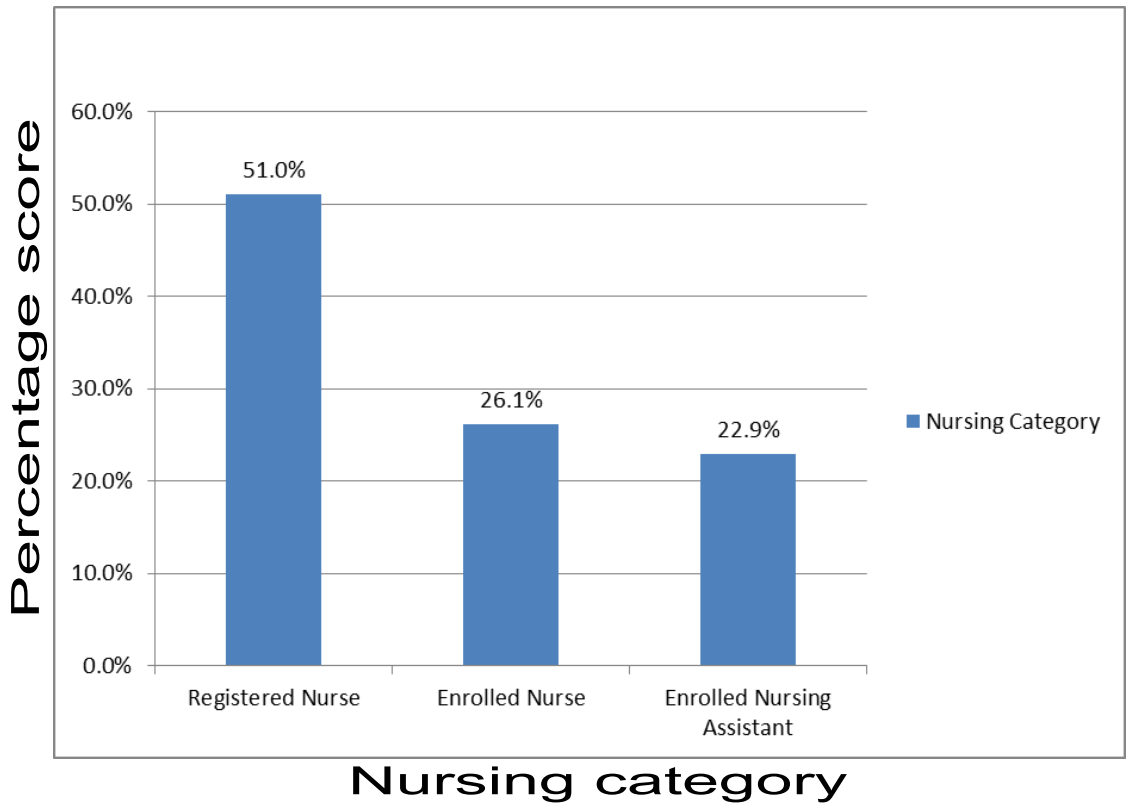

Figure 4.3 Nursing category (N=288)

Registered nurses comprised 51.0% (n=147) of the sample. This is in concord with the hospital employment profile as registered nurses are the largest nursing category, and the sample depicted the pattern of the population.

4.4.1.4 Monthly income

In terms of income, about 276 respondents indicated their income.

Figure 4.4 illustrates the respondents' incomes per category.

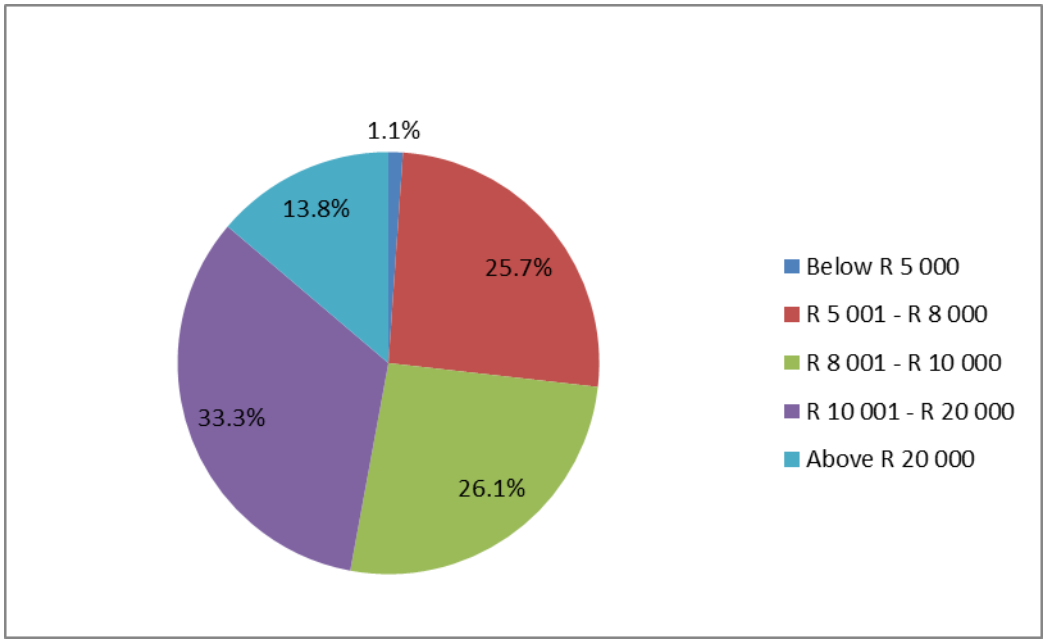

Figure 4.4 Monthly income (N=276)

The findings indicated that 33.3% (n=95) of respondents earned an income above R10,000.00 per month. This may be attributed to the fact that the majority were professional nurses who are higher earners than the other categories. It shows that 1.1% (n=3) of respondents still earned an income below R5,000.00 in spite of rendering an essential service.

4.4.1.5 Years actively practicing as a nurse

A total of 287 respondents indicated the number of years of their active employment as nursing practitioners, as reflected in figure 4.5.

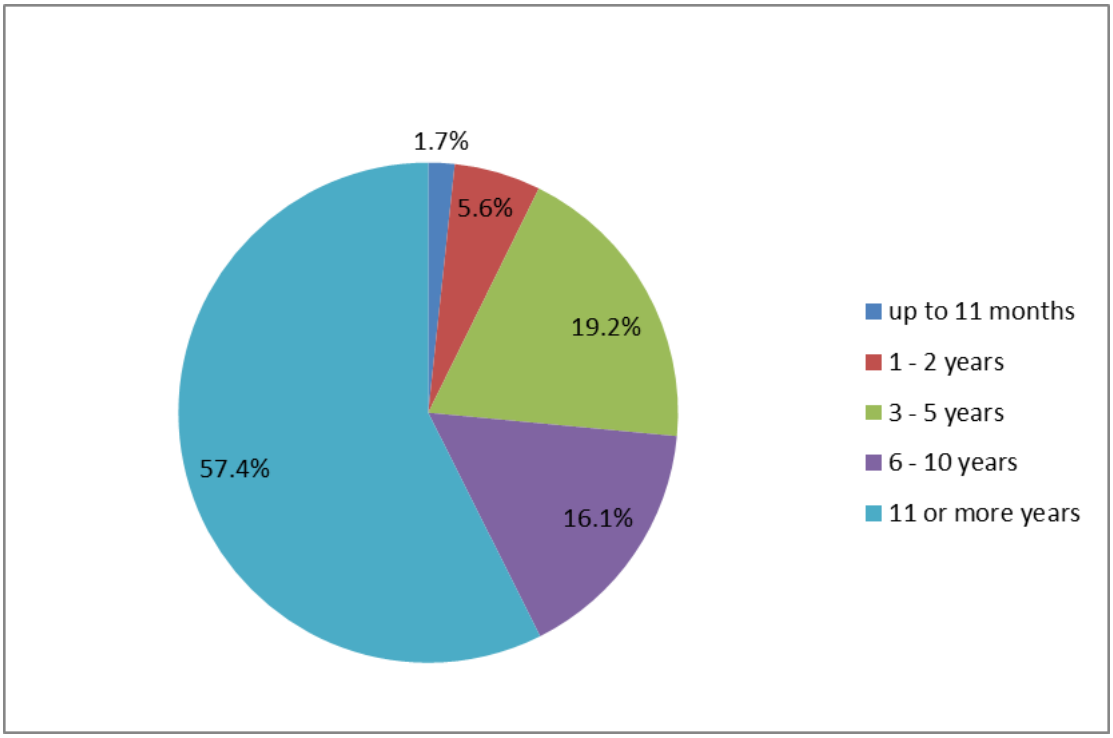

Figure 4.5 Years actively practising as a nurse (N=287)

The findings indicated that, 57.4% (n=165) of nurses had at least 11 years' experience, while only 1.7% (n=5) had less than one year's experience. This group (n=165) has much experience and could thus give valuable information. The study conducted undertaken by Hagbaghery, Sasali and Ahmadi (2004:6) confirmed that nurses' knowledge, skills, experience and abilities, result in effective clinical decision-making which promoted quality patient care. The latter is in agreement with the South African Nursing Council (SANC) purpose of stipulating nurses' rights.

4.4.2 The views of nurses' rights and obligations

In terms of knowing their rights and obligations as nurses, there were 281 valid responses recorded.

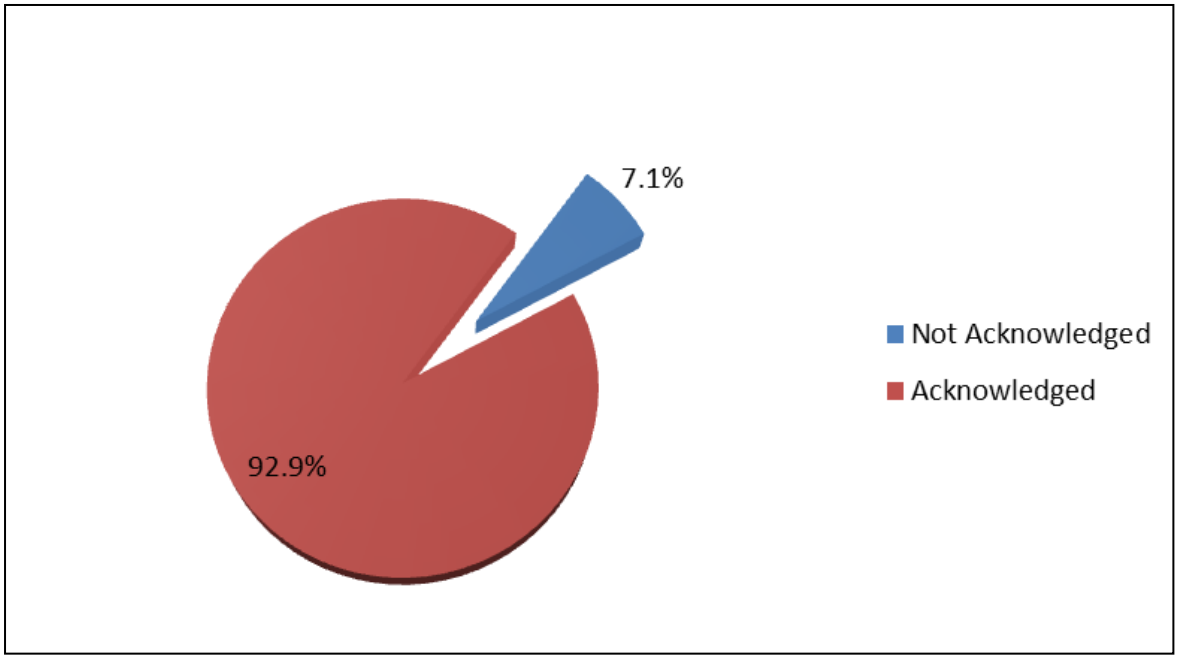

Figure 4.6 Views of nurses' rights and obligations (N=281)

The majority of 92.9% (n=261) acknowledged that they knew their rights and obligations, whilst 7.1% (n=20) indicated that they did not have full knowledge of their rights and obligations. The latter response might have negative effects on the quality of care rendered to patients as nurses' rights are to improve and promote quality patient care.

4.4.2.1 Source of information regarding rights and obligations

In terms of source of information regarding rights and obligation, there were 271 nurses who responded to the question. This was a multiple response question which the respondents provided multiple reasons as indicated in Table 4.2.

Table 4.2 Source of information on rights and obligations (N=271)

Reason	Frequency	% of Cases	Rank
South African Nursing Council (SANC)	126	46.5	1
Union representative	67	24.7	2
Literature review	52	19.2	3
In-service training	51	18.8	4
Nursing manager	22	8.1	5
Workshops	20	7.4	6
Colleagues	1	0.4	7
Labour Relations Act	1	0.4	7
Internet	1	0.4	7
Pamphlets	1	0.4	7

Some respondents 46.5% (n=126) obtained information about their rights and obligations from the SANC. The information regarding their rights is stipulated by the SANC as part of their expectations/obligations. The SANC is the statutory body entrusted with regulating norms and standards in the nursing profession (SANC 2004-2013:1). The information obtained from the union representative is 24.7% (n=67) as the trade unions also plays a significant role in educating and as the source of information communicating/championing nurses' rights and obligations regularly with the nurses as well as the employer; and 19.2 % (n=52) obtained the information from literature sources.

4.4.2.2 Knowledge of nurses' rights in a clinical setting

The respondents were asked to determine their level of knowledge regarding nurses' rights in a clinical setting. An overall knowledge score was created by assigning one point for each correct designation of a knowledge statement as true or false. No points were given for an incorrect answer, considering (as indicated above) that the "do not know" responses were recorded as incorrect. The highest possible score was 11 points. Table 4.3 presents the findings of the knowledge proportions.

Table 4.3 Knowledge of nurses' rights in a clinical setting

Statement	% Correctly judged as true or false	% Incorrectly judged as true or false
I have the right to practice in a safe environment, equipped with adequate materials and personnel (t)	97.6	2.4
I must under all circumstance practice according to rules and regulations of the nursing profession (t)	95.5	4.5
I have the right to expect medical support or an effective referral system to handle emergency situations responsibly (t)	92.0	8.0
I must under all circumstances adhere to the policies of the institutions to be able to provide quality patient care(t)	91.3	8.7
I have the right to question any practice that I find unethical (t)	88.2	11.8
I am obliged to negotiate with the employer to go for continuing education that is related to my responsibilities (t)	87.5	12.5
I have the right to refuse to practice if I was not properly orientated and received the appropriate in-service education in my area of work(t)	85.8	14.2
I have the right to refuse to participate in any activities that according to my own professional judgement are not in the interest of the patient(t)	84.0	16.0
I do not have the right to question practices of other member of multidisciplinary team in the provision of health care service to patients if I regard it as inappropriate or unprofessional (f)	79.2	20.8
If responsibilities for patient care are allocated to me by my superiors and they fall within my scope of professional practice, I do not have the right to object (t)	73.6	26.4
I have the right to participate in industrial actions for bargaining purpose, regardless of who will take the responsibility of care for patients(f)	65.3	34.7

(t), statement is true; (f), statement is false

The respondents gave the right answers to a mean of 9.4 statements out of 11 statements. One could thus conclude that most of the respondents correctly judged the statement as true or false.

The findings indicated that 65.3% (n=177) correctly responded to the statement "*I have the right to participate in industrial actions for bargaining purpose, regardless of who will take the responsibility of care for patient*".. Only 34.7% (n=94) responded incorrectly to the statement. The latter judgement implies that some nurses still need to be reminded that their rights are not an end itself, but a means of ensuring improved service to

patients (SANC 2004-2013:1); they are therefore not supposed to leave patients unattended to by participating in industrial actions.

4.4.2.3 Knowledge of nurses' obligations in a clinical setting

In terms of knowledge regarding nurses' obligations in a clinical setting, an overall knowledge score was also created by assigning one point for each correct designation of a knowledge statement as true or false. The highest possible score was 7 points. Table 4.4 below presents the knowledge proportions.

Table 4.4 Knowledge of nurses' obligations in a clinical setting

Statement	% Correctly judged as true or false	% incorrectly judged as true or false
I have to protect and promote the health and wellbeing of those under my care (t)	97.9	2.1
The care of patients is my first concern(t)	97.9	2.1
My nursing practice is based on professional and legal requirements (t)	96.2	3.8
I provide individualised care to patients under my care (t)	86.8	13.2
I depend on the employer to keep my skills and knowledge up to date(f)	68.4	31.6
During nurses' strike, I follow my union representative's instructions (f)	39.6	60.4
It is my choice to render high standard of care to patients(f)	33.7	66.3

(t), statement is true; (f), statement is false

The respondents gave the correct answer to a mean of 5.2 statements out of 7 statements. Thus, one could conclude that most of the respondents correctly judged the statement as true or false. Five statements were correctly judged to be true or false by a majority of the respondents. The statements not judged correctly were: "*During nurses' strikes, I follow my union representative's instructions"* (60.4%); and *"It is my choice to render high standard of care to patients"* (66.3%).One could conclude that the majority of the respondents think that it is their choice to render high standard of care to patients, and that during strikes they can follow their union representative's instructions. This judgment is justified by the incident cited by Bekker and Van der Walt (2010:148) that "patients were left unfed and pregnant women turned away unattended to" during the 2010 health workers' strike. This judgement is in contrast with the practiced in the

United States of America (USA). According to Martinez and Weisfeldt (2011:1), 30% of 2000 nurses decided not to participate in the-one day strike at several hospitals in the USA. They felt that the complications and suffering the patient has endured during the strike cannot be forgotten or reversed.

4.4.3 Factors that influence decisions on nurses' rights and obligations on patient care in a clinical setting

The respondents were asked to indicate their agreement level on factors that influence nurses' rights and obligations on patient care in a clinical setting. There were 13 items. Table 4.5 presents the responses.

Table 4.5 Factors influencing nurses' rights and obligations

Statement	Level of agreement			Sample size	Rank
	Strongly agree and agree	Undecided	Strongly disagree and Disagree		
Ethical principles	93.9% (262)	2.9% (8)	3.3% (9)	279	1
Professional rules and regulations	93.2% (261)	4.3% (12)	2.5% (7)	280	2
Level of commitment	90.7% (252)	4.3% (12)	5% (14)	278	3
Level of training	88.5% (245)	4.7% (13)	6.9% (19)	277	4
The working environment	86.3% (239)	8.7% (24)	5% (14)	277	5
Individual competence	85.8% (236)	5.5% (15)	8.7% (24)	275	6
The labour laws	82.6% (229)	12.3% (34)	5.1% (14)	277	7
Organisation management style	78.6% (217)	14.1% (39)	7.2% (20)	276	8
Organisation leadership style	78.3% (213)	14.3% (39)	7.3% (20)	272	9
Constitution of the country	74.1% (203)	15.0% (41)	10.9% (30)	274	10
Community/consumer's expectation about nursing	73.8% (200)	14.0% (38)	12.2% (33)	271	11
Conflict of interest, wishes and values	72.2% (200)	14.8% (41)	13% (36)	277	12
The infrastructure	69.8% (189)	19.2% (52)	11.1% (30)	271	13

The following depict factors whose responses/level of agreeing (strongly agree or agree) was above the 80% response rate:

- Ethical principles (93.9%)
- Professional rules and regulations (93.2%)
- Level of commitment (90.7%)
- Level of training (88.5 %)
- The working environment (86.3%)
- Individual competence (85.8%)
- The labour laws (82.6 %)

The findings show that most factors that scored more than 50% in Table 4.5 (where respondents strongly agreed and agreed) are vital to nursing practice. They ensure that nurses make and implement effective clinical decisions and judgment to positively address the patients' identified health needs as indicated by (Hagbaghery et al 2004:4-5) study. The respondents who strongly disagreed and disagreed were in the minority, which implies that most nurses would be able to render quality patient care.

4.4.4 Impact of nurses' rights and obligations on a patient care in a clinical setting

The respondents were asked to indicate their agreement level on indicators which impact on nurses' rights and obligations concerning patient care in a clinical setting. There were 12 items as illustrated in Table 4.6.

Table 4.6 Impact of nurses' rights

Statement	Level of agreement			Sample size	Rank
	Strongly agree and agree	Un-decided	Strongly Disagree and disagree		
Nurses' ability to abide by rules and regulations of the nursing profession which enable them to act within the set standards.	93.3% (263)	3.2% (9)	3.6% (10)	282	1
Promotion of in-service training and orientation which is functioning efficiently, enhance the effective and productive work performance of a nurse	92.5% (260)	4.6% (13)	2.8% (8)	281	2
Nurses protect and care for patients under their care holistically, thus assuring them quality care	91.8% (259)	5.3% (15)	2.8% (8)	282	3
Availability of adequate resources and conducive environments assists nurses in providing quality health care	90.4% (255)	3.5% (10)	6.1% (17)	282	4
Nurses uphold the ethical principle of beneficence, namely, to do good and to do no harm to any patient	89.2% (249)	7.9% (22)	2.9% (8)	279	5
Nurses' ability to manage emergencies appropriately and promptly, provided they have medical support or referral systems	87.9% (247)	7.8% (22)	4.2% (12)	281	6
Nurses are prepared to negotiate with the employer for continuing education in order to be able to respond competently in her/his area of work	84.3% (236)	6.8% (19)	8.9% (25)	280	7
Nurses adhere to the ideals and moral norms of the profession and embrace them as part of what it means to be a nurse	83.5% (237)	10.2% (29)	6.4% (18)	284	8
Nurses engage in policy determination relevant to the scope of their work in order for them to manage patients' conditions appropriately	81.2% (229)	10.3% (29)	8.5% (24)	282	9
Nurses refrain from any activities that they feel are not in the best interest of their patients	76.9% (216)	12.8% (36)	10.3% (29)	281	10

Statement	Level of agreement			Sample size	Rank
	Strongly agree and agree	Un-decided	Strongly Disagree and disagree		
Nurses are allowed to refuse to participate in activities where they feel they do not possess adequate knowledge and skills	69.2% (195)	16.3% (46)	14.6% (41)	282	11
Nurses are allowed to strike for bargaining purposes regarding conditions of service to ensure improved patient care	55.5% (157)	20.1% (57)	24.4% (69)	283	12

The following are the top-most indicators regarding the impact of nurses' rights and obligations on patient care in a clinical setting with a level of agreement of more than 80%, and indicate whether or not the respondents strongly agree and agree:

- Nurses' ability to abide to rules and regulations of the nursing profession, which enables them to act within the set standards (93.3%)
- Promotion of in-service training and orientation which is efficiently functioning, enhance the effective and productive work performance of a nurse (92.5%)
- Nurses protect and care for patients under their care holistically, thus assuring them quality care (91.8%)
- Availability of adequate resources and conducive environment assists nurses in providing quality health care (90.4%)
- Nurses uphold the ethical principle of beneficence, namely to do good and to do no harm to any patient (89.2%)
- Nurses' ability to manage emergencies appropriately and promptly provided they have medical support or referral systems (87.9%)
- Nurses are prepared to negotiate with the employer for continuing education to be able to respond competently in her/his area of work (84.3%)
- Nurses adhere to the ideals and moral norms of the profession and embrace them as part of what it means to be a nurse (83.5%)
- Nurses engage in policy determination relevant to the scope of their work in order for them to manage patients' conditions appropriately (81.2%)

The respondents 90.4% (n=255) strongly agreed and agreed that the availability of adequate resources and conducive environment assist nurses in providing quality care. Tucker's (2004:152) study revealed that operational failures result from lack of

materials, supplies and shortage of staff and this can lead to patient death, employee termination and expensive lawsuits. Nurses need to practice in a supportive and appropriate structured nursing work environment to enhance the effective work performance of a nurse on patient care as confirmed in (Tourangeau, Doran, Mc Gillis Hall, Obrien-Pallas, Pringle, Tu & Cranley's (2007:34-35) study.

4.4.4.1 Impact on nurses' obligations

The respondents indicated their level of agreement regarding the general behaviour of nurses on patient care (nurses' obligations) as Table 4.7 illustrates.

Table 4.7 The level of agreement on the impact of nurses' general behaviour (nurses' obligations)

Statement	Level of agreement			Sample size	Rank
	Strongly agree and agree	Un-decided	Strongly Disagree and disagree		
Nurses are knowledgeable and provide a high standard of health care	89.7% (254)	7.4% (21)	2.8% (8)	283	1
Nurses provide patient care in accordance with their professional and legal legislations governing their profession	89.6% (251)	5.4% (15)	5% (14)	280	2
Nurses take the responsibility of updating their knowledge and skills to improve their knowledge and competency to provide patient care	88.3% (249)	8.9% (25)	2.8% (8)	282	3
Nurses treat patients as individuals, deliver nursing services with respect for human needs and value, without any prejudice	82.9% (232)	9.6% (27)	7.5% (21)	280	4
Nurses are available at all times caring for patients and their relatives	82.6% (233)	11.7% (33)	5.7% (16)	282	5
Nurses are always open and honest when executing their duties	74.5% (210)	16.0% (45)	9.6% (27)	282	6
Nurses never leave patients under their care unattended	70.8% (194)	18.2% (50)	10.9% (30)	274	7

Depicted below are the levels of agreement of more than 80%where the respondents strongly agree and agree:

- Nurses are knowledgeable and provide a high standard of health care (89.7%)
- Nurses provide patient care in accordance with their professional and legal legislations governing their profession (89.6%)
- Nurses take the responsibility of updating their knowledge and skills to improve their knowledge and competency to provide patient care (88.3%)
- Nurses treat patient as individuals, deliver nursing services with respect for human needs and value and without prejudice (82.9%)
- Nurses are available at all times caring for patients and their relatives (82.6%)

The findings show that 82.6 % (n=233) of the nurses strongly agreed and agreed that they needed to be available at all times to care for patients and their relatives, meaning that the presence of nurses in the clinical setting would enhance and promote quality care. This means that nurses are not supposed to strike or engage in lock-outs; which could prevent “patient abandonment” that results in compromised patient care. If strike action is the last option, the Italian model will be ideal where there is a break in between strikes that allows essential services like health care provision to patients (Crema 2005:4).

4.4.5 The degree of the importance of factors which may impact on the quality of patient care

The respondents indicated the degree of importance of factors which may impact on the quality of patient care as indicated in Table 4.8:

Table 4.8 Factors that impact on the quality of patient care

Statement	Level of agreement			Sample size	Rank
	Strongly agree and agree	Neutral	Strongly Disagree and disagree		
Provision of health services	89.8 % (245)	7.0% (19)	3.3% (9)	273	1
Inadequate number of nurses	89.4% (244)	3.7% (10)	7% (19)	273	2
Inadequate material resources	86.3% (239)	4.3% (12)	9.4% (26)	277	3
Absence of nurses	83.8% (233)	3.6% (10)	12.6% (35)	278	4
Lack of orientation regarding nursing activities	83.8% (216)	7.0% (18)	9.3% (24)	258	5
No provision of a safe and healthy environment	83.3% (229)	6.5% (18)	10.1% (28)	275	6
Lack of accountability or responsibility of patient under nurses' care	81.6% (223)	7.0% (19)	11.4% (31)	273	7
Inadequate number of other members of the multidisciplinary team	79% (218)	12.3% (34)	8.7% (24)	276	8

Shown below are the top most indicators of factors that impact on the quality of patient care with a level of agreement of more than 90% where the respondents strongly agree and agree:

- Provision of health services (89.8 %)
- Inadequate number of nurses (89.4%)
- Inadequate material resources (86.3%)
- Absence of nurses (83.8%)
- Lack of orientation regarding nursing activities (83.8 %)
- No provision of a safe and healthy environment (83.3%)
- Lack of accountability or responsibility of patient under nurses' care (81.6 %)

The findings show that 83.8 % (n=233) of respondents strongly agreed and agreed that the absence of nurses, the provision of health services 89.8% (n=245), and inadequate numbers of nurses 89.4% (n=244) would impact on the quality of patient care as reflected in Table 4.8. The provision of quality health services will be achieved by the presence of adequate numbers of nurses. According to Tourangeau et al (2007:42), the

provision of safe and effective patient care can be ensured by hiring and retaining nurses as well as providing adequate personnel to minimise unnecessary patient deaths. The study by Kangasniemi, Viitalähde and Porkka (2010:631-633) indicates that nurses have the right to participate in strike action, but the primary disadvantage for that action is the threat to patient care and safety.

4.4.6 The effects of nurses' rights and obligations on patient care in the clinical setting

The respondents were asked to specify the effects of nurses' rights and obligations on patient care in the clinical setting. The following effects in Table 4.9 represent their responses:

Table 4.9 The effects on nurses' rights and obligations on patient care (N=246)

Effects	Frequency (n)	% of Cases	Rank
Category1: Patient related effects			
To ensure quality care	126	51.2	1
Patients are nursed in an environment that is safe and promotes healing	36	14.6	2
Nurses have the right to work in a safe environment	34	13.8	3
Patients are discharged in a satisfactory condition	22	8.9	4
It promotes quality service when nurses practice under prescribed rules and regulations	20	8.1	5
Patients will have trust and believe in nurses	16	6.5	6
Patient advocacy	12	4.9	7
Medico-legal actions will be avoided	7	2.8	8
Short stay in hospital	6	2.4	9
Holistic care	4	1.6	10
Physically well-being	3	1.2	11
Cooperation amongst staff members	1	0.4	12

Table 4.9 shows that 51.2% (n=126) of the nurses indicated that ensuring quality care has an effect on nurses' rights and obligations on patient care in the clinical setting, followed by the statement that: "*Patients are nursed in an environment that is safe and promotes healing*" [14.6% (n=36)], and "*Nurses have the right to work in a safe environment" [*13.8% (n=34)]. These findings are supported by the study conducted by Kangasniemi et al (2010:631-633) which indicate that nurses' rights need to be

considered, as they are part of good care and a mechanism to ensure the quality, safety and effectiveness of that care.

The responses are in tandem with the statement cited by (SANC 2004-2013:1) that nurses rights are not absolute, but are for promoting efficient patient care and in terms of the nurses' pledge of service.

4.4.7 The opinions on the impact of the failure to exercise rights and obligations during nurses' strikes

The respondents were asked to give their opinions on the impact of the failure to exercise their rights and obligations on the quality of nursing care rendered to patients during times of nurses' strikes. In this regard, the following responses in Table 4.10 were obtained:

Table 4.10 Opinions on the impact of the failure to exercise rights and obligations (N=246)

View	Frequency (n)	% of Cases	Rank
Category 1: Patient care related impact			
Poor patient care due to skeleton staff	96	39.0	1
High death rate	88	35.8	2
High infections and more complications	38	15.4	3
Compromised care	28	11.4	4
Increased mortality rate	28	11.4	4
Violation of patients' rights	15	6.1	7
Long stay by patients in hospital	15	6.1	7
Medico-legal hazard will increase	13	5.3	9
No advocates for patient	8	3.3	12
Category 2 :Nurse related impact			
Victimisation of nurses during strike by others multidisciplinary team	20	8.1	6
Absenteeism	9	3.7	11
Even the community insults striking nurses claiming that their relatives are dying	8	3.3	12
Does not promote team building	6	2.4	14
Feel abused and stressed	6	2.4	14
Overworked	1	0.4	15
Category 3: Legal/professional			
Litigation from the patient and relatives	13	5.3	9

Table 4.10 demonstrates that 39.0% (n=96) indicated *"poor patient care due to skeleton staff"* whilst 35.8% (n=88) indicated "*high death rate"*. Meaning that nurses are fully aware that their failure to exercise their rights and obligations taking into cognisance patients under their care during nurses' strikes will have adverse consequences on the quality of patient care.

4.4.8 Knowledge score

4.4.8.1 Knowledge of nurses' rights in a clinical setting

The respondents were asked to determine their level of knowledge regarding nurses' rights in a clinical setting. An overall knowledge score was created by assigning one point for each correct designation of a knowledge statement as true or false. No points were given for an incorrect answer. The response of respondents who did not know the answer, or who left it blank, was recorded as incorrect. The highest possible score was 11 points. Table 4.11 reflects the knowledge scores.

Table 4.11 Knowledge of nurses' rights in a clinical setting

Statement	**% Correctly judged as true or false**
I have the right to practice in a safe environment, equipped with adequate materials and personnel (t)	97.6
I must under all circumstance practice according to the rules and regulations of the nursing profession (t)	95.5
I have the right to expect medical support or an effective referral system to handle emergency situations responsibly (t)	92.0
I must under all circumstances adhere to the policies of the institutions to be able to provide quality patient care (t)	91.3
I have the right to question any practice that I find unethical (t)	88.2
I am obliged to negotiate with the employer to go for continuing education that is related to my responsibilities (t)	87.5
I have the right to refuse to practice if I was not properly orientated and received the appropriate in-service education in my area of work (t)	85.8
I have the right to refuse to participate in any activities that according to my own professional judgement are not in the interest of the patient (t)	84.0
I do not have the right to question practices of other member of multidisciplinary team in the provision of health care service to patients if I regard it as inappropriate or unprofessional (f)	79.2
If responsibilities for patient care are allocated to me by my superiors and they fall within my scope of professional practice, I do not have the right to object (t)	73.6
I have the right to participate in industrial actions for bargaining purpose, regardless of who will take the responsibility of care for patient (f)	65.3

(t), statement is true; (f), statement is false

The respondents provided the correct answer to a mean of 9.4 statements out of 11 statements. Thus, one can conclude that most of the respondents correctly judged the statement as true or false. Only 34.7% respondent incorrectly to the statement, *"I have the right to participate in industrial actions for bargaining purpose regardless of who will take the responsibility of care for patient"*. The majority of nurses knew that they are not supposed to participate in industrial action when nobody was taking responsibility of patient care. However, these findings are in contrast with what has been observed in SA in 2007 and 2010 respectively during the health care workers' strikes. According to the Mail & Guardian newspaper (2010:1), South African soldiers were requested to take over the responsibility of patient care during these strikes.

4.4.8.1.1 Gender

An independent t-test was conducted to determine whether the knowledge score of nurses' rights differed by gender. The following results shown in Table 4.12 were obtained.

Table 4.12 Gender independent t-tests for difference in knowledge score of nurses' rights in a clinical setting

Group	Mean	T-value	P-value	Decision
Male	9.28	-0.406	0.685	There are not significantly different
Female	9.41			

*Note: The statistical significance of the t-values is ** for p<0.01 and * for p<0.05*

The following results in Table 4.12 were obtained. Females tend to have a higher mean knowledge score of 9.41 than that of males registering9.28. The null hypothesis of equal means was not rejected since the p-value was greater than 0.05 (p-value=0.685). Thus, one can conclude that males and females' knowledge on nurses' rights is the same.

4.4.8.1.2 Age

A test was conducted to determine whether the knowledge scores on nurses' rights differed by age. Since age group had more than two groups, an analysis of variance was used to determine whether the knowledge mean score of nurses' rights was the same for the age groups. This resulted in ***f-value=1.152*** and ***p-value=0.332***. Based on the latter, the null hypothesis of equal means was not rejected.

4.4.8.1.3 Nursing category

The null hypothesis of equal mean knowledge score among nursing category was rejected. The ***f-value=17.528*** and ***p-value=0.000***. The results are shown in Table 4.13.

Table 4.13 Post-hoc analysis of knowledge of nurses' rights by nursing category

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05		
		1	2	3
Enrolled nursing assistant	66	8.62		
Enrolled nurse	75		9.19	
Registered nurse	147			9.86

Knowledge of nurses' rights differed by nursing category. Three homogeneous nursing groups were constructed. The lowest mean knowledge score was 8.62 from the enrolled nursing assistants, whilst the highest mean knowledge score was 9.86 from the registered nurses' group. From this information, one can conclude that registered nurses were more knowledgeable about nurses' rights in a clinical setting, followed by enrolled nurses.

4.4.8.1.4 Length of service

In terms of a nurse's actual period of service, the null hypothesis of equal mean knowledge score among the categories was rejected. The ***f-value=4.112*** and ***p-value=0.003.*** The *post-hoc* analysis of homogeneous groups is shown in Table 4.14.

Table 4.14 Post-hoc analysis of knowledge of nurses' rights by length of service practicing as a nurse

TukeyB[a,b]

Years actively practicing as a nurse	n	Subset for alpha=0.05	
		1	2
Up to 11 months	5	7.20	
6–10 years	46		9.15
3–5 years	55		9.22
1–2 years	16		9.38
11 or more years	165		9.62

The lowest mean knowledge score was 7.2 from those who have practiced for less than a year, whilst the highest mean of 9.62 was for those who practiced for more than 10 years. Two homogeneous groups were obtained. Looking at Table 4.14, one can conclude that nurses who have just started practicing do not fully know nurses' rights, compared to the more experienced nurses.

4.4.8.2 Knowledge of nurses' obligations in a clinical setting

In terms of knowledge of nurses' obligations in a clinical setting, the highest possible score was 7 points. Table 4.15 presents the knowledge scores.

Table 4.15 Knowledge of nurses' obligations in a clinical setting

Statement	% Correctly judged as true or false
I have to protect and promote the health and wellbeing of those under my care (t)	97.9
The care of patients is my first concern (t)	97.9
My nursing practice is based on professional and legal requirements (t)	96.2
I provide individualised care to patients under my care (t)	86.8
I depend on the employer to keep my skills and knowledge up to date (f)	68.4
During nurses' strike, I follow my union representative's instructions (f)	39.6
It is my choice to render high standard of care to patients (f)	33.7

(t), statement is true; (f), statement is false

The respondents gave the correct answer to a mean of 5.2 statements out of 7 statements. Thus, most of the respondents correctly judged the statements as being

true or false. Five statements were correctly judged to be true or false by a majority of the respondents. The statements not judged correctly were "*During nurses' strike, I follow my union representative's instructions* "and *"It is my choice to render high standard of care to patients"*. One can conclude that the majority of the respondents think that it is their right to render high standard of care to patients and during strikes, they can follow their union representative's instructions.

4.4.8.2.1 Gender

An independent t-test was conducted to determine whether knowledge score of nurses' obligations differed by gender. Table 4.16 presents the results.

Table 4.16 Gender independent t-tests for difference in knowledge score of nurses' obligations in a clinical setting

Group	Mean	T-value	P-value	Decision
Male	5.28	0.353	0.724	There are not significantly different
Female	5.20			

*Note: The statistical significance of the t-values is ** for p<0.01 and * for p<0.05*

Table 4.16 indicates that males tended to have a higher mean knowledge score of 5.28 than females with 5.20. A p-value of 0.724 was obtained. Since 0.724 is greater than 0.05, the null hypothesis of equal means was not rejected. Thus, one can conclude that males and females' knowledge on nurses' obligations is similar.

4.4.8.2.2 Age

A test was conducted to determine whether the knowledge scores on nurses' obligations and rights differed by age. Since age group had more than two groups, an analysis of variance was used to determine whether the knowledge mean score of nurses' obligations was the same for the age groups. This resulted in ***f-value=1.058*** and ***p-value=0.388***. Thus, the null hypothesis of equal means was not rejected.

4.4.8.2.3 Nursing category

The null hypothesis of equal mean knowledge score among nursing category was rejected. The ***f-value=12.206*** and ***p-value=0.000***. Table 4.17 presents the results.

Table 4.17 Post-hoc analysis of knowledge of nurses' obligations by nursing category

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05	
		1	2
Enrolled nurse	75	4.88	
Enrolled nursing assistant	66	4.89	
Registered nurse	147		5.51

There were two homogeneous groups. The knowledge of nurses' obligations differed by nursing category. The lowest mean knowledge score was 4.88 from the enrolled nurse whilst the highest mean knowledge score was 5.51 from the registered nurse. The mean knowledge score for enrolled nurses and enrolled nursing assistants were not significantly different from each other. However, registered nurses had knowledge mean score higher that the other groups. Registered nurses were more knowledgeable about nurses' obligations in a clinical setting than the other nursing categories.

4.4.8.2.4 Length of service

In terms of the actual period of service, the null hypothesis of equal mean knowledge score among the categories was rejected. The ***f-value=2.761*** and ***p-value=0.028.***The *post-hoc* analysis of homogeneous groups are reflected in Table 4.18.

Table 4.18 Post-hoc analysis of knowledge of nurses' obligations by length of service practicing as a nurse

TukeyB[a,b]

Years actively practicing as a nurse	n	Subset for alpha=0.05	
		1	2
1–2 years	16	4.75	
6 –10 years	46	5.04	
11 or more years	165	5.20	
3–5 years	55	5.38	
Up to 11 months	5		6.40

The lowest mean knowledge score was 4.75 from those who have practiced for 1–2 years whilst the highest mean of 6.40 was for those who have practiced for a year. Two homogeneous groups were obtained. New nurses tend to be more knowledgeable on nurses' obligations than the other groups. Looking at Table 4.18, one can conclude that nurses who have just started practicing know nursing obligations than the more experienced ones amongst all categories

4.4.9 The levels of agreement or importance

An independent t-test was conducted to determine whether factors that influence decisions on nurses' rights and obligations on patient care in a clinical setting differed by gender. All factors show that the means were not significantly different on factors that influence decisions on nurses' rights and obligations.

All p-values were greater than 0.05, the null hypothesis of equal means was thus not rejected in all aspects. It can be concluded that there is no difference in levels of agreement by gender on factors that influence decisions on nurses' rights and obligations on patient care in a clinical setting.

4.4.9.1 The impact of nurses' rights and obligations

The gender independent t-test was conducted on all aspects regarding the impact of nurses' rights and obligations on patient care in a clinical setting. The null hypothesis of equal means was not rejected in all aspects since p-values were greater than 0.05. Thus, one can conclude that there is no difference in levels of agreement by gender on factors regarding impact of nurses' rights and obligations on patient care in a clinical setting.

4.4.9.2 General behaviour of nurses on patient care

In terms of the general behaviour of nurses on patient care (nurse' obligations), all aspects resulted in the null hypothesis of equal means not being rejected. All p-values were greater than 0.05, and the null hypothesis of equal means was therefore not rejected in all aspects. Based on the latter, it could be concluded that there is no

difference in levels of agreement by gender on the general behaviour of nurses (nurses' obligations).

4.4.9.3 Factors which may impact on the quality of patient care

In terms of whether levels of agreement differed by gender on factors which may impact on the quality of patient care, there was only in factor that showed a difference.

Table 4.19 Gender independent t-tests for difference on factors which may impact on the quality of patient care

Statement	Group	Mean	T-value	P-value	Decision
Absence of nurses	Male	1.20	-3.877**	0.000	The means are significantly different
	Female	1.71			

*Note: The statistical significance of the f-values is ** for p<0.01 and * for p<0.05*

The null hypothesis of equal *means* was rejected in all aspects except on the aspect of the "*absence of nurses".* The mean for males was 1.20, whilst that for females was 1.71. It could therefore be concluded that males tend to regard the aspect of nurses' absence as the most important, whilst females regard it as just equally important.

4.4.10 The ANOVAs on the levels of agreement and importance

4.4.10.1 Analysis of variances on factors influencing decisions on nursing rights and obligations

The ANOVAs test was conducted in order to determine whether or not factors that influence decisions on rights and obligations on patient care in a clinical settings differed by age, nursing category and years practicing as a nurse.

4.4.10.1.1 Age

ANOVAs were conducted to determine whether the levels of agreement of factors that influence nurses' rights and obligations on patient care differed by age. There was a difference in only one factor as showed in Table 4.20.

Table 4.20 ANOVAs for difference 0n factors that influence decisions on nurses' rights and obligations by age

Statement	F-value	P-value	Decision
Ethical principles	3.240**	0.004	The means are significantly different

*Note: The statistical significance of the f-values is ** for p<0.01 and * for p<0.05*

All aspects showed that there was no difference by age except for the statement "*ethical principles*". It resulted in **f-value=3.240** and a **p-value=0.000**. The level of agreement on the factor *"ethical principles"* influencing nurses' rights and obligations therefore differs significantly by age. This variable showed that the age group of 46–50 years strongly agreed than the age group of 36–40 years.

Table 4.21 Age homogeneous subsets for mean scores for the factor that influence decisions on nurses' right and obligations on patient care in a clinical setting − ethical principles

TukeyB[a,b]

Age	n	Subset for alpha=0.05	
		1	2
46–50 years	38	1.26	
25 years and below	11	1.36	1.36
51 years and older	93	1.38	1.38
41–45 years	39	1.44	1.44
31–35 years	31	1.45	1.45
26–30 years	23	1.74	1.74
36 –40 years	42		1.86

There are two homogeneous age groups in this category. The lowest mean of 1.26 was recorded by the age group 46–50 years and the highest mean of 1.86 by the age group 36–40 years. One could then conclude that the 46–50 years age groups tend to agree more strongly on the statement "ethical principles" as an influencing factor than the age group 36–40 years age group.

4.4.10.1.2 Nursing category

Table 4.22 ANOVAs for difference 0n factors that influence decisions on nurses' rights and obligations by nursing category

Statement	F-value	P-value	Decision
Individual competence	3.667*	0.027	The means are significantly different
Level of commitment	3.462*	0.033	The means are significantly different
Organisational leadership style	4.627*	0.011	The means are significantly different
Organisational management style	9.800**	0.000	The means are significantly different
The infrastructure	3.833*	0.023	The means are significantly different
Ethical principles	3.242*	0.041	The means are significantly different

*Note: The statistical significance of the f-values is ** for p<0.01 and * for p<0.05*

In terms of nursing category, the null hypothesis of equal means was not rejected in all statements at the 5% level of significance except the statements *"individual competence", "level of commitment", "organisational leadership style", "organisational management style", "the infrastructure", and "ethical principles"* as indicated in Table 4.22.

Table 4.23 Nursing category homogenous subsets on the factor that influence decisions on nurses' right and obligations on patient care in a clinical setting − individual competence

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05	
		1	2
Registered nurse	138	1.56	
Enrolled nurse	73	1.82	1.82
Enrolled nursing assistant	63		1.95

In terms of the "individual competence" factor, there were two homogeneous groups. The enrolled nursing assistants had the highest level of agreement with a mean of 1.95. Most of them were in agreement. The registered nurse group had the lowest mean of 1.56.

It could then be concluded that the significant difference was between registered nurses and enrolled nursing assistant. The registered nurses were more in agreement.

For the influencing factor *"level of commitment"*, the same pattern was obtained and thus two homogeneous groups were constructed as shown in Table 4.24.

Table 4.24 Nursing category homogenous subsets on the factor that influence decisions on nurses' right and obligations on patient care in a clinical setting − level of commitment

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05	
		1	2
Registered nurse	142	1.42	
Enrolled nurse	71	1.55	1.55
Enrolled nursing assistant	64		1.78

The lowest mean score was 1.42 from the registered nurses' group while the highest mean score was 1.78 from the enrolled nursing assistants. Enrolled nurses belonged to both groups. It is therefore noted that registered nurses were in total agreement.

In terms of the influencing factor, *"organisational leadership style*" there were two homogenous groups as indicated in Table 4.25.

Table 4.25 Nursing category homogenous subsets on the factor that influence decisions on nurses' right and obligations on patient care in a clinical setting − organisational leadership style

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05	
		1	2
Registered nurse	140	1.79	
Enrolled nurse	70	2.07	2.07
Enrolled nursing assistant	61		2.20

The group registered nurse has the lowest mean of 1.79 which was significantly different from that of the enrolled nursing assistants' mean of 2.20. The enrolled nursing

assistants were more in agreement for the aspect "*organisation leadership* style" as an influencing factor.

In terms of the influencing factor *"organisation management style"*, the *post-hoc* analysis yielded two homogeneous groups as indicated in Table 4.26.

Table 4.26 Nursing category homogenous subsets on the factor that influence decisions on nurses' right and obligations on patient care in a clinical setting − organisation management style

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05	
		1	2
Registered nurse	140	1.72	
Enrolled nurse	71	1.99	
Enrolled nursing assistant	64		2.34

The lowest mean score was 1.72 from registered nurses, while the highest mean score was 2.34 from the enrolled nursing assistant. One can conclude that the registered nurses and enrolled nurses were more in agreement than enrolled nursing assistant on the factor *"organisational management style"* as influencing factor.

Table 4.27 gives the two homogeneous groups of the influencing factor *"the infrastructure".*

Table 4.27 Nursing category homogenous subsets on the factor that influence decisions on nurses' right and obligations on patient care in a clinical setting − the infrastructure

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05	
		1	2
Registered nurse	71	2.03	
Enrolled nurse	137	2.03	
Enrolled nursing assistant	62		2.44

The enrolled nurses and registered nurses had the lowest mean of 2.03 thus they were not significantly different. The enrolled nursing assistant had the highest mean of 2.44. All the groups had means close to two signifying agreement with enrolled nurses and registered nurses more in agreement that *"the infrastructure"* is an influencing factor on

decisions on nurses' right and obligations.

4.4.10.1.3 Years practicing as a nurse

ANOVAs were conducted to determine whether or not the levels of agreement for factors that influence nurses' rights and obligations on patient care differed by years practicing as a nurse.

All p-values were greater than 0.05, and all factors showed that there was no difference in mean score by the number of years practicing as a nurse.

4.4.10.2 Analysis of variances on the impact of nursing rights and obligations

An analysis of variance was conducted to determine whether impact of nurses' rights and obligations on patient care in a clinical settings differed by age, nursing category and years practicing as a nurse.

4.4.10.2.1 Age

Table 4.28 Age ANOVAs on the impact of nurses' rights and obligations

Statement	F-value	P-value	Decision
Nurses adhere to the ideals and moral norms of the profession and embrace them as part of it what means to be a nurse	2.560*	0.020	The means are significantly different

*Note: The statistical significance of the f-values is ** for p<0.01 and * for p<0.05*

For the differences by age of all aspects regarding the impact of nurses' rights and obligations on patient care, the null hypothesis of equal means was not rejected in all aspects except on the aspect of *"Nurses adhering to the ideals and moral norms of the profession and embrace them as part of it what means to be a nurse"* in a clinical setting, as shown in Table 4.28, with ***f-value =2.560*** and ***p-value =0.02***. Since p-value was less than 0.05, one can conclude that the age groups view the impact of the factor that *"nurses adhere to the ideals and moral norms of the profession and embrace them as part of it what means to be a nurse"* on patient care in a clinical setting as valid. A

post-hoc analysis was conducted to determine where the difference exists. This resulted in two homogeneous groups, as shown in Table 4.28.

Table 4.29 Age homogenous subsets on the impact of nurses' rights and obligations on patient care in a clinical setting -nurses adhere to the ideals and moral norms of the profession

TukeyB[a,b]

Age	n	Subset for alpha=0.05	
		1	2
46–50 years	39	1.56	
51 years and older	92	1.60	1.60
25 years and below	12	1.67	1.67
36–40 years	45	1.69	1.69
31–35 years	32	1.91	1.91
41–45 years	40	1.95	1.95
26–30 years	22		2.27

The respondents aged 46–50 years had the lowest mean of 1.56, and the highest mean was 2.27 from those aged 26–30 years. There was significant difference between those aged 46–50 years and those aged 26–30 years since the other age groups belong to both subsets. The 26–30 years agreed more than any other age cohort in the sample. .

4.4.10.2.2 Nursing category

An analysis of variance on aspects regarding impact of nurses' rights and obligations on patient care in a clinical setting by nursing category resulted in four aspects having p-values less than 0.05. For that reason, the null hypothesis of equal means was rejected in these aspects as shown in Table 4.30.

Table 4.30 ANOVAs for difference in aspects regarding impact of nurses' rights and obligations by nursing category

Statement	F-value	P-value	Decision
Availability of adequate resources and conducive environments assist nurses in providing quality health care	3.187*	0.043	The means are significantly different
Nurses uphold the ethical principle of beneficence, namely: to do good and to do no harm to any patient	3.923*	0.021	The means are significantly different
Nurses adhere to the ideals and moral norms of the profession and embrace them as part of it what means to be a nurse	3.352*	0.036	The means are significantly different
Nurses refrain from any activities that they feel are not in the best interest of their patients	5.324**	0.005	The means are significantly different

*Note: The statistical significance of the f-values is ** for p<0.01 and * for p<0.05*

The null hypothesis of equal means was rejected in the aspects *"availability of adequate resources and conducive environments assists nurses in providing quality health care"; "nurses uphold the ethical principle of beneficence, namely to do good and to do no harm to any patient"*: *"nurses adhere to the ideals and moral norms of the profession and embrace them as part of it what means to be a nurse";* and *"nurses refrain from any activities that they feel are not in the best interest of their patients".*

In terms of the aspect *"availability of adequate resources and conducive environments assists nurses in providing quality health care",* there were two homogeneous groups as indicated in Table 4.31.

Table 4.31 Nursing category homogenous subsets on the impact of nurses' rights and obligations on patient care in a clinical setting − availability of adequate resources and conducive environments.

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05	
		1	2
Registered nurse	145	1.37	
Enrolled nurse	74	1.50	1.50
Enrolled nursing assistant	62		1.71

The registered nurses had the lowest mean of 1.37, whilst the enrolled nursing assistants had the highest mean of 1.71. The registered nurses strongly agreed to the aspect of *"availability of adequate resources and conducive environments assists nurses in providing quality health care".* There was a significant difference between registered nurses and enrolled nursing assistants.

Two homogeneous groups were obtained on the aspect *"nurses uphold the ethical principle of beneficence, namely, to do good and to do no harm to any patient"* as indicated in Table 4.32.

Table 4.32 Nursing category homogenous subsets on the impact of nurses' rights and obligations on patient care in a clinical setting − nurses uphold the ethical principle of beneficence

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05	
		1	2
Registered nurse	72	1.42	
Enrolled nurse	145	1.45	
Enrolled nursing assistant	61		1.75

One homogeneous group consisted of enrolled nurses and registered nurses. Enrolled nursing assistants were in a group of their own and had the highest mean of 1.75. The enrolled nursing assistants were in agreement with the aspect of *"nurses uphold the ethical principle of beneficence, namely to do good and to do no harm to any patient",* whilst the other groups strongly agreed with the aspect.

In terms of the aspect *"nurses adhere to the ideals and moral norms of the profession and embrace them as part of it what means to be a nurse",* there was a homogeneous group as shown in Table 4.33.

Table 4.33 Nursing category homogenous subsets on the impact of nurses' right and obligations on patient care in a clinical setting − moral norms of the profession.

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05
		1
Registered nurse	144	1.63
Enrolled nurse	64	1.86
Enrolled nursing assistant	75	1.93

The registered nurses tended to agree more than the enrolled nurses on the aspect of "*nurses adhere to the ideals and moral norms of the profession and embrace them as part of it what means to be a nurse"*.

In terms of the aspect, *"nurses refrain from any activities that they feel are not in the best interest of their patients",* there were two *post-hoc* homogeneous groups as shown in Table 4.34.

Table 4.34 Nursing category homogenous subsets on the impact of nurses' right and obligations on patient care in a clinical setting − nurses refrain from any activities that they feel are not in the best interest of their patients

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05	
		1	2
Registered nurse	144	1.76	
Enrolled nurse	73	2.05	2.05
Enrolled nursing assistant	63		2.27

The lowest mean score was 1.76 for the registered nurses, while the highest mean score was 2.27 from enrolled nursing assistants. This shows that nursing categories in levels of agreement on the aspect "*nurses refrain from any activities that they feel are not in the best interest of their patients".* Registered nurses tended to agree more than the other groups.

4.4.10.2.3 Years practicing as a nurse

The differences by years of practicing as a nurse in all aspects regarding the impact of nurses' rights and obligations on patient care in a clinical setting are shown in Table 4.35.

Table 4.35 ANOVAs for difference in impact of nurses' rights and obligations by years practicing as a nurse

Statement	F-value	P-value	Decision
Nurses' ability to abide to rules and regulations of the nursing profession which enable them to act within the set standards	4.772**	0.001	The means are significantly different
Availability of adequate resources and conducive environments assists nurses in providing quality health care	3.680**	0.006	The means are significantly different

*Note: The statistical significance of the f-values is ** for p<0.01 and * for p<0.05*

The null hypothesis of equal means was not rejected in all aspects, except*"nurses' ability to abide to rules and regulations of the nursing profession which enable them to act within the set standards",* and *"availability of adequate resources and conducive environments assists nurses in providing quality health care"* where the p-values were **0.001** and **0.006** respectively.

In terms of the aspect *"nurses' ability to abide to rules and regulations of the nursing profession which enable them to act within the set standards",* there were two homogeneous groups as shown in Table 4.36.

Table 4.36 Years practicing as a nurse homogenous subsets on the impact of nurses' right and obligations on patient care in a clinical setting − nurses' ability to abide to rules and regulations of the nursing profession

TukeyB[a,b]

Years actively practicing as a nurse	n	Subset for alpha=0.05	
		1	2
1–2 years	16	1.25	
11 or more years	164	1.42	
3–5 years	53	1.64	
6–10 years	43	1.70	
Up to 11 months	5		2.60

The least experienced respondents (up to 11 months) were in their own homogeneous group with a mean score of 2.60. Therefore, the group neither agreed nor disagreed. However, the other groups were in agreement with those with 1–2 years and 11 or more years' experience agreeing strongly to the aspect having more impact on nurses' rights and obligation on patient care in a clinical setting. Table 4.37 below indicates the homogeneous group for the aspect on the *"availability of adequate resources and conducive environments assists nurses in providing quality health care"*.

Table 4.37 Years practicing as a nurse homogenous subsets on the impact of nurses' right and obligations on patient care in a clinical setting − availability of adequate resources and conducive environments

TukeyB[a,b]

Years actively practicing as a nurse	n	Subset for alpha=0.05	
		1	2
1–2 years	16	1.25	
11 or more years	163	1.40	
3–5 years	44	1.55	
6–10 years	53	1.58	
Up to 11 months	5		2.80

The same pattern was observed as in Table 4.36. The least experienced (up to 11 months) were in their own homogeneous group with a mean score of 2.80. Thus, the group had mixed opinions. However, the other groups were in agreement with those with 1–2 years and 11 or more years' experience agreeing strongly with the aspect *"availability of adequate resources and conducive environments assists nurses in providing quality health care"*.

4.4.10.3 Analysis of variances on aspects regarding general behaviour of nurses on patient care (nurses' obligations)

The ANOVAs were conducted in order to determine whether aspects regarding the general behaviour of nurses on patient care (nursing obligations) by age, nursing category and years practicing as a nurse.

4.4.10.3.1 Age

In terms of general behaviour of nurses on patient care (nurse' obligations), all aspects resulted in the null hypothesis of equal means not being rejected except the aspect

"nurses provide patient care in accordance with their professional and legal legislations governing their profession". The information is given in table 4.38.

Table 4.38 ANOVAs for difference in general behaviour of nurses' on patient care by age

Statement	F-value	P-value	Decision
Nurses provide patient care in accordance with their professional and legal legislations governing their profession	2.392*	0.029	The means are significantly differently

*Note: The statistical significance of the f-values is ** for p<0.01 and * for p<0.05*

All p-values were greater than 0.05 except on the factor *"nurses provide patient care in accordance with their professional and legal legislations governing their profession"* where the ***f-value=2.392*** with a ***p-value=0.029***. The *post-hoc* analysis yielded one homogeneous group as shown in Table 4.39.

Table 4.39 Age homogenous subsets on aspects regarding general behaviour of nurses on patient care (nurses' obligations) − nurses provide patient care in accordance with their professional and legal legislations governing their profession

TukeyB[a,b]

Age	n	Subset for alpha=0.05
		1
31–35 years	32	1.44
51 years and older	93	1.47
36–40 years	43	1.53
46–50 years	36	1.61
25 years and below	12	1.83
41–45 years	39	1.90
26–30 years	23	2.00

The lowest mean score was 1.44 for those aged 31–35 years, while the highest mean score was 2.00 for those aged 26–30 years. Thus, those aged 31–35 years were strongly agreeing to the aspect as compared to those aged 26–30 years.

4.4.10.3.2 Nursing category

The differences by nursing category on all aspects regarding the impact of nurses' rights and obligations on patient care in a clinical setting resulted in only three aspects being rejected, as shown in Table 4.40.

Table 4.40 Nursing category ANOVAs for difference in general behaviour of nurses' on patient care

Statement	F-value	P-value	Decision
Nurses are knowledgeable and provide a high standard of health care	3.959*	0.020	The means are significantly different
Nurses are always open and honest when executing their duties	3.838*	0.023	The means are significantly different
Nurses never leave patients under their care unattended	3.285*	0.039	The means are significantly different

*Note: The statistical significance of the f-values is ** for p<0.01 and * for p<0.05*

All aspects had p-values greater than 0.05, except the aspects *"nurses are knowledgeable and provide a high standard of health care"* with ***p-value = 0.020,*** and a ***f-value=3.959***; *"nurses are always open and honest when executing their duties"* with ***p-value=0.023;*** and ***f-value=3.838*** and *"nurses never leave patients under their care unattended"* with ***p-value=0.039*** and ***f-value=3.285***. The null hypothesis of equal means was thus rejected on these three aspects.

The *post-hoc* analysis for the aspect *"nurses are knowledgeable and provide a high standard of health care"* resulted in two homogeneous groups, as shown in Table 4.41.

Table 4.41 Nursing category homogenous subsets on aspects regarding general behaviour of nurses on patient care (nurses' obligations) − nurses are knowledgeable and provide a high standard of health care

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05	
		1	2
Registered nurse	73	1.42	
Enrolled nurse	63	1.52	1.52
Enrolled nursing assistant	146		1.72

The first homogeneous groups consisted of registered nurses and enrolled nurses with means scores of 1.42 and 1.52 respectively. The second homogeneous group consisted of enrolled nurses and enrolled nursing assistants, with a mean of 1.72. Enrolled nursing assistants thus strongly agreed with the aspect that *"nurses are knowledgeable and provide a high standard of health care"*. Table 4.42 indicates the homogeneous group for the aspect *"nurses are always open and honest when executing their duties".*

Table 4.42 Nursing category homogenous subsets on aspects regarding general behaviour of nurses on patient care (nurses' obligations) − nurses are always open and honest when executing their duties

TukeyBa,b

Nursing category	n	Subset for alpha=0.05	
		1	2
Registered nurse	62	1.71	
Enrolled nurse	73	1.82	1.82
Enrolled nursing assistant	146		2.09

Registered nurses and enrolled nurses belonged to the same group with a means of 1.71 and 1.82 respectively. Enrolled nurses and enrolled nursing assistants were in the other group with mean scores of 1.82 and 2.09 respectively. Thus, enrolled nurses belonged to both groups, which meant that the significant difference was between enrolled nursing assistants and registered nurses. The enrolled nursing assistants were more in agreement with the aspect *"nurses are always open and honest when executing their duties".*

In terms of the aspect *"nurses never leave patients under their care unattended",* there was one homogeneous group as shown in Table 4.43.

Table 4.43 Nursing category homogenous subsets on aspects regarding general behaviour of nurses on patient care (nurses' obligations) − nurses never leave patients under their care unattended

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05
		1
Registered nurse	67	1.76
Enrolled nurse	62	1.84
Enrolled nursing assistant	144	2.12

The lowest mean score was 1.76 from registered nurses and the highest mean was 2.12 from enrolled nursing assistants. Enrolled nursing assistants are more in agreement than any other group.

4.4.10.3.3 Years practicing as a nurse

The differences by nursing category on all aspects regarding the impact of nurses' rights and obligations on patient care in a clinical setting resulted in one aspect being rejected.

Table 4.44 Nursing category ANOVAs for difference in general behaviour of nurses' on patient care

Statement	F-value	P-value	Decision
Nurses are available at all times caring for patients and their relatives	2.775*	0.027	The means are significantly different

*Note: The statistical significance of the f-values is ** for p<0.01 and * for p<0.05*

All aspects had p-values greater than 0.05, except the aspect on *"nurses are available at all times caring for patients and their relatives",* which had a ***p-value=0.027*** and a ***f-value=2.775***. The null hypothesis of equal means was rejected on this aspect. The *post-hoc* analysis resulted in two homogeneous groups as shown in Table 4.45.

Table 4.45 Years practicing as a nurse homogenous subsets on aspects regarding general behaviour of nurses on patient care (nurses' obligations) - nurses are available at all times caring for patients and their relatives

TukeyB[a,b]

Years actively practicing as a nurse	n	Subset for alpha=0.05	
		1	2
1–2 years	16	1.44	
11 or more years	163	1.57	
3–5 years	54	1.69	
6–10 years	44	1.91	1.91
Up to 11 months	5		2.60

The respondents with 1–2 years' experience had the lowest mean of 1.44, and those with up to 11months' experience had the highest mean of 2.60.

It is therefore axiomatic that those with 1–2 years' experience strongly agreed, and those with up to 11 months' work experience were neutral.

4.4.10.4 Analysis of variances on factors that may impact on the quality of patient care

The ANOVAs were conducted to determine whether or not the degree of importance of factors that impact on the quality of patient care differed by age, nursing category and years of practice as a nurse when nurses are on strike.

4.4.10.4.1 Age

Table 4.46 depicts the two aspects that resulted in significant difference regarding levels of agreement by age on factors which may impact on the quality of patient care when nurses are on strike.

Table 4.46 Age ANOVAs for difference on factors which may impact on the quality of patient care when nurses are on strike

Statement	F-value	P-value	Decision
Absence of nurses	2.431*	0.026	The means are significantly different
Inadequate number of nurses	2.323*	0.033	The means are significantly different

*Note: The statistical significance of the f-values is ** for p<0.01 and * for p<0.05*

The null hypothesis of equal *means* was rejected in all aspects except on the aspects, "*absence of nurses"* and *"inadequate number of nurses"*. For the aspect "*absence of nurses"* there are two homogeneous groups as indicated in Table 4.47.

Table 4.47 Age homogenous subsets on aspects regarding general behaviour of nurses on patient care (nurses' obligations) − absence of nurses

TukeyB[a,b]

Age	n	Subset for alpha=0.05	
		1	2
25 years and below	12	1.08	
31–35 years	32	1.47	1.47
41–45 years	39	1.54	1.54
51 years and older	89	1.57	1.57
36–40 years	42	1.60	1.60
26–30 years	23	1.70	1.70
46 –50 years	39		2.33

Those respondents who were 25 years and below had the lowest mean score of 1.08, and those with 46–50 years had the highest mean score of 2.33. The respondents who were 25 years and below regarded the aspect on absence of nurses as one of the most important aspects impacting on the quality of patient care.

In terms of the aspect, *"inadequate number of nurses"*, there was one homogeneous group as shown in Table 4.48.

Table 4.48 Age homogenous subsets on aspects regarding general behaviour of nurses on patient care (nurses' obligations) − inadequate number of nurses

TukeyB[a,b]

Age	n	Subset for alpha=0.05
		1
31–35 years	31	1.32
25 years and below	12	1.33
36–40 years	41	1.37
41–45 years	39	1.51
51 years and older	89	1.55
26–30 years	23	1.78
46–50 years	36	2.06

The 31–35 years age group had the lowest mean of 1.32, whilst the 46–50 years had the highest mean of 2.06. All groups were in agreement that the aspect on *"inadequate number of nurses"* was important as a factor that impacted on the quality of patient care. The age groups 31–35 years, 25 years and below, and 36–40 years had mean scores close to one indicating that the group held the view that *"inadequate number of nurses"* is a very important factor that impacted on the quality of patient care.

4.4.10.4.2 Nursing category

An analysis of variance to determine whether differences exist on the factors that impact on the quality of patient care when nurses are on strike by nursing category, resulted is two aspects that showed a significant difference, as illustrated in Table 4.49.

Table 4.49 Nursing category ANOVAs for difference on factors which may impact on the quality of patient care when nurses are on strike

Statement	F-value	P-value	Decision
Absence of nurses	8.003**	0.000	The means are significantly different
No provision of a safe and healthy environment	4.150*	0.017	The means are significantly different

*Note: The statistical significance of the f-values is ** for p<0.01 and * for p<0.05*

The null hypothesis of equal *means* was rejected in all aspects, except on the aspect "*absence of nurses"* and *"no provision of a safe and healthy environment"*. The p-values were 0.000 and 0.017, thus leading to the rejection of the null hypothesis.

In terms of the aspect factor "*absence of nurses",* there were two homogeneous groups as shown in Table 4.50.

Table 4.50 Nursing category homogenous subsets on aspects regarding general behaviour of nurses on patient care (nurses' obligations) − absence of nurses

Nursing category	n	Subset for alpha=0.05	
		1	2
Registered nurse	140	1.37	
Enrolled nurse	74		1.86
Enrolled nursing assistant	63		2.10

The registered nurses were in their own homogeneous group with a mean of 1.37. Thus, one can conclude that registered nurses view the *"absence of nurses"* as a very important factor that impacts on the quality of patient care during nurses' strikes. The other homogeneous groups consisted of enrolled nurses and enrolled nursing assistants, with mean scores of 1.86 and 2.10 respectively; which demonstrates that they view the factor (absence of nurses) as important. The emphasis of its importance was made by the registered nurses.

In terms of the aspect, *"no provision of a safe and healthy environment",* there was one homogeneous group as indicated in Table 4.51.

Table 4.51 Nursing category homogenous subsets on aspects regarding general behaviour of nurses on patient care (nurses' obligations) – no provision of a safe and healthy environment

TukeyB[a,b]

Nursing category	n	Subset for alpha=0.05
		1
Registered nurse	141	1.57
Enrolled nursing assistant	63	1.94
Enrolled nurse	70	1.99

Registered nurses had the lowest mean of 1.57, whilst enrolled nurses had the highest mean of 1.99. The degree of importance was thus emphasised by the professional nurses on the aspect, *"no provision of a safe and healthy environment"* as a factor that impacted on the quality of patient care when nurses are on strike.

4.4.10.4.3 Years practicing as a nurse

ANOVA tests were conducted to determine whether or not factors which may impact on the quality of patient care during nurses' strike were impacted on by years practicing as a nurse.

All p-values were greater than 0.05, thus, the null hypothesis of equal *means* was not rejected in all aspects. One can conclude that years of experience were not a factor in determining whether or not any particular factor had an impact on nurses going on strike.

4.5 CONCLUSION

In this chapter, data collected from the permanently employed nursing personnel has been analysed. The collected data revealed that the majority of respondents are experienced and mature; as such, had the potential to give valuable information.

The professional nurses were found to be more knowledgeable about their rights than other categories. Data analysis has also revealed that ethics, professional rules and regulations, as well as the availability of resources influence and determine the quality of care to be rendered to patients.

The views and opinions of respondents indicated that nurses need to exercise their rights and obligations primarily for the purposes of ensuring and promoting efficient and effective quality patient care even during strikes. Therefore, their presence at patients' bed side at all times is crucial. The analysis reveals that the failure of nurses to exercise their rights and obligations while taking cognisance
of the patients' rights during strikes, cost human life and intense suffering to them. Some respondents feel that patients' rights are considered more than their rights and

they are exploited. They are of opinion that for effective resolution of their problems to be considered, they need to “blow the whistle” by engaging in strike action.

In the next chapter, conclusions drawn from these findings, limitations and guidelines will be presented.

CHAPTER 5

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS GUIDELINES

5.1 INTRODUCTION

The previous chapter presented an analysis and interpretation of the findings of the research. This study was conducted to explore and describe the impact of the rights and obligations of nurses on patients' care in a clinical setting. In this chapter, a description of the findings, the limitations of the study, and guidelines for nurses on the exercise of their rights and obligations was discussed.

5.2 RESEARCH DESIGN AND METHOD

A quantitative, exploratory descriptive research design was employed in the study. The data was collected from one public hospital in the Gauteng Province. Data was collected using self-administered structured questionnaires. Of the 343 questionnaires distributed, 288 were responded to and returned. The respondents were permanently employed nurses from the following three categories:

- Professional nurses
- Enrolled nurses
- Enrolled auxiliary nurses

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

The findings from this study are discussed according to the objectives of the study. The stated objectives of the study are:

- to explore and describe the views (perceptions) of nurses about their rights and obligations in a clinical setting in a public health facility
- to explore factors that exert an influence on the rights and obligations of nurses in delivering patient care in a clinical setting

- to describe the effects of nurses' rights and obligations on delivering quality health care in a clinical setting
- to explore the impact of nurses' rights and obligations on patient care in a clinical setting
- to design guidelines for nurses regarding the implementations of their rights and obligations with the aim to promote quality care in the clinical setting

5.3.1 The views (perceptions) of nurses about their rights and obligations in a clinical setting

The findings on the views of nurses concerning their rights and obligations in a clinical setting show that from a total of 281 nurses who responded to this question, 92.9% (n=261) acknowledged that they knew their rights and obligations; whilst 7.1% (n=20) did not have such knowledge about their rights and obligations. The latter response might have negative effects on the quality of care rendered to patients as nurses' knowledge concerning their rights and obligations, which if implemented correctly, would improve and promote the quality of patient care in the clinical setting.

Of the 288 respondents, 46.5% (n=126) indicated that they obtained information concerning their rights and obligations from the SANC, and 24.7% (n=67) from the union representatives, while 19.2 % (n=52) obtained such information from literature on the subject. Assessing the level of knowledge regarding nurses' rights, the respondents scored an average of 9.4 out of 11(pertaining to 11 different statements) which indicated a good level of knowledge. Only 34.7% replied incorrectly to the statement *"I have the right to participate in industrial actions for bargaining purpose, regardless of who will take the responsibility of care for patient".*

An independent t-test was conducted to determine whether knowledge score of nurses' rights differed by gender, age, nursing category and duration of service. The null hypothesis of equal means was not rejected with regard to nursing category. These findings showed that registered nurses were more knowledgeable about nurses' rights with a mean score knowledge score of 9.86, followed by enrolled nurses with a mean knowledge score of 9.19.The findings revealed that nurses who had just started practicing lacked knowledge about their rights compared to the more experienced nurses who had at least 11 years' experience (n=165) with a mean score of 9.62.

Concerning the level of knowledge about nurses' obligations, the majority of the respondents correctly judged the statements. The mean score was 5.2 out of 7 statements.

The statements not judged correctly included:

- *"during nurses' strike, I follow my union representative instructions"* (60.4%)
- *"it is my choice to render high standard of care to patients"* (63.3%)

This judgment is justified by the incident cited in (Bekker & Van der Walt 2010:148) that *"patients were left unfed and pregnant women turned away unattended to"* during the 2010 health care workers' strike. Regarding the knowledge score of nurses' obligations, the statements that were correctly judged and earn above 90% were:

- I have to protect and promote the health and wellbeing of those under my care (97.9)
- The care of patients is my first concern (97.9%)
- My nursing practice is based on professional and legal requirements (96.2) respectively

An independent t-test was conducted to determine whether the knowledge score of the nurses' obligations differed in respect of gender, age, nursing category, and duration of practice. The findings revealed that for gender and age, the null hypothesis of equal means was not rejected, meaning that there was no significant difference in knowledge scores in relation to the nurses' duration of experience.

In terms of nursing category, the findings revealed that registered nurses were more knowledgeable about their obligations than the other nursing categories. In terms of the duration of service, it was found that nurses who had just started practicing (up to 11 months) are more knowledgeable about nurses' obligations than the more experienced ones in all nursing categories.

5.3.1.1 Conclusion

The knowledge level of respondents who participated in this study regarding their rights and obligations was high; the registered nurses were outstanding in all categories.

5.3.2 The factors that influence the rights and obligations of nurses on the delivery of patient care

The findings on factors that exert an influence on the rights and obligations of nurses in the delivery of patient care revealed that 90.4 % (n=255) strongly agreed and agreed that the availability of adequate resources and a conducive environment assist nurses to provide good quality patient care. This finding is in concord with Tucker's study (2004:152) who revealed that operational failures result from lack of materials, suppliers and staff; all of which directly and/or indirectly have the potential to cause patient deaths, employee termination, and expensive lawsuits. The findings also revealed that 82, 6% (n=233) of the respondents strongly agreed and agreed that they needed to be available at all times to care for patients and their relatives. This means that nurses are not supposed to abandon patients, in order to prevent compromising the quality of patient care.

5.3.2.1 The ANOVAs' on the levels of agreement on factors that exert an influence on the rights and obligations of nurses

ANOVAs test was conducted to analyse variances on the levels of agreement or importance on factors that exert an influence on the rights and obligations of nurses. The findings revealed that in terms of age there was no difference except "ethical principles". The matured group of 46-50 years strongly agreed that "ethical principles" influence decisions on nurses' rights and obligations.

In terms of nursing category, there were only differences pertaining to: individual competence, level of commitment, leadership style, management style, infrastructure and ethical principles.

The enrolled nursing assistants strongly disagreed on the factor" individual competence" with a mean score of 1.95 whilst registered nurses strongly agreed. In terms of the other mentioned factors, the enrolled nurses and registered nurses strongly agreed more than the enrolled nursing assistants.

In terms of whether availability of adequate resources and a conducive work environment assist nurses in providing health care, the findings revealed that the registered nurses with a mean score of 1.37 strongly agreed more than the nursing assistants with a mean score of 1.71.

5.3.2.2 Conclusion

The respondents strongly agreed that availability of material and adequate human resources and a conducive work environment will influence provision of good quality patient care. There were differences on levels of agreement or importance on factors that exert influence on the rights and obligations of nurses in terms of age and nursing category.

5.3.3 The effects of nurses' rights and obligations on patients care in the clinical setting

On the aspect of the effects of nurses' rights and obligations on patients' care, the findings revealed that quality care was only ensured for 51, 2% (n=126) of the patients who were nursed in a safe environment that promoted healing 14,6% (n=34). According to Kangasniemi, Viitalähde and Porkka (2010:631-633), nurses' rights need to be considered as they are part of good care and a way to ensure the quality, safety and effectiveness of that care.

5.3.3.1 Conclusion

More than half of the respondents agreed that the effects of their rights and obligations ensure good quality care to patients, with the desired outcome of promoting healing.

5.3.4 The impact of nurses' rights and obligations on a patient care in a clinical setting

The findings showed that 83,8% (n=233) of respondents strongly agreed and agreed that the absence of nurses, the provision of health services 89,8%(n=245), and inadequate number of nurses 89,4 % (n=244) would impact adversely on the quality of patients' care. These findings are supported by the study of Tourangeau, Doran, McGillis Hall, Obrien-Pallas, Pringle, Tu and Cranley (2007:33), which indicated that the provision of safe and effective patient care could be ensured by hiring and retaining nurses as well as providing adequate personnel to minimize unnecessary patient deaths.

5.3.4.1 The level of agreement or importance on the impact of the rights and obligations of nurses on patient care

On the levels of agreement or importance on factors that might impact on nurses' rights and obligations on patient care in a clinical setting, the findings revealed that in terms of gender, there was no difference in all aspects except "absence of nurses". The mean for males was 1.20 whilst that for females was 1.71, meaning that males tended to regard the "absence of nurses" as the more important aspect that might impact on the quality of nursing care in the clinical setting. In terms of age, the 25 year old cohort of nurses strongly agreed on the same aspect with a mean score of 1.08.

5.3.4.2 Analysis of variance on factors that may impact on the quality of patient care

In terms of the variance on factors that may impact on the quality of patient care, the findings revealed that concerning the aspect "inadequate number of nurses", the 31-35 year age cohort strongly agreed with a mean score of 1.32. In terms of nursing category on the aspect "no provision of a safe and healthy environment", the registered nurses strongly agreed with a mean score of 1.57. The differences in the level of agreement and importance might be attributed to the nurses' understanding of their rights and obligations, taking into cognizance their level of training and maturity.

5.3.4.3 Conclusion

The majority of respondents strongly agreed that the absence and/or inadequate number of nurses and provision of services might impact on the quality of patient care in the clinical setting.

5.3.5 The opinions on the impact of the failure to exercise rights and obligations during nurses' strikes

The findings indicated that 39.0% (n=96) of the respondents are of the opinion that failure to exercise their rights as nurses would result in poor patient care due to the inadequate number of nurses. Some respondents 35, 8% (n=88) also indicated that there would be a high death rate due to high infection rates and more complications 15,4% (n=38) resulting from compromised nursing care. Of the total number of respondents (n=288), respondents, 3.3% (n=8) indicated that the community insulted the striking nurses due to the loss of life incurred when their next of kin die.

5.3.5.1 Conclusion

The inadequate number of nurses due to strike action by nurses would cause more complications to patients and resulting in high death rate.

5.4 CONCLUSIONS

The results of this study revealed that the respondents (nurses) who participated in this study knew their rights and obligations, as well as the effects and impact they have on quality patient care. This implies that "patient abandonment" usually observed when nurses embark on strike for bargaining purpose as their constitutional right is not due to lack of insight and understanding of their rights and obligations, but on the implementation of these rights and obligations.

The findings indicated the need for guidelines on the implementation/exercise of these rights by nurses, and the extent to which the government/employer addresses the challenges encountered by nurses during implementation of their rights and obligations.

5.5 GUIDELINES

Guidelines were designed for nurses regarding the implementation of their rights and obligations with the aim of promoting quality care in the clinical setting .The guidelines were based on the findings of this study. The proposed guidelines are:

Guideline 1: Knowledge and understanding of nurses' rights and obligations

- Nurses' rights and obligations to be made a fundamental and integral aspect of all curricula for nursing programmes. The knowledge concerning their rights and obligations should be translated into action. Opportunities should be provided during in-service and continuing education sessions using strategies such as role play and case studies.
- Emphasis should be made on the assurance that nurses' rights are not an end in itself (absolute) (SANC 2004-2013: 1) but of ensuring improved service to patients, and all categories of nurses should have the same understanding.
- Nurses' rights and obligations to be conspicuously displayed at all sectors of health to remind nurses, conscientise the employer and community members that nurses also have rights that must be considered if quality patient care is to be delivered. According to Kangasniemi et al (2010:631-633), nurses' rights need to be considered as they are part of good care and a way to ensure the quality, safety and effectiveness of that care. The shortcomings in the clinical setting should be identified by the employer in order to create a safe environment that is conducive to the provision of good quality patient care.
- Nurses' trade unions to specifically assist in cultivating the information as they will have insight and better understanding of both constitutional and professional rights and obligations of nurses.
- Nurses should own the responsibility of knowing and understanding their rights and obligations and the influence, impact and effects they have on patient care.

Guideline 2: Implementing/exercises rights and obligations without compromising patients' care in the clinical area

- Nurses to weigh objectively their challenges/demands against the advantages and disadvantages on quality patient care.
- Nurses to consider ethical-professional framework and moral issues with some sincerity when implementing their rights and obligations.
- When encountering any challenges with regard to implementation of their rights, nurses to negotiate in good faith. If unsuccessful, nurses to urge the nurses' union to attend to those challenges well in advance in order to prevent full blown strikes by following and exhausting all the dispute resolution mechanisms established for that purpose.
- If negotiations fail, nurses to consider other options, such as picketing during lunch time in turns; this is a practice yet to be fully explored within the South African nursing environment.
- Nurses not to be selective when implementing rights and obligations as had been the practice in SA when nurses engage on strike action, mainly during salary increment periods. All nurses' rights and obligations aim at improving and promoting quality patient care. The reasons for embarking on strike action, if it is the last resort, should also be to improve patient care and their working environment.
- If a strike is unavoidable, nurses should have a certain percentage of nurses to work without intimidation, in order to prevent patient abandonment at all costs, poor quality care, complications, deaths and dented professional image as revealed in the findings of this study. This is supported by the study conducted by Martinez and Weisfeldt (2011:1) where 30% of the 2,000 nurses decided not to participate in strikes at several hospitals in USA. They verbalized that complications and suffering the patient has endured during strike action cannot be forgotten and if they die, death cannot be reversed.

Guideline 3: Legal aspect

- The government should rethink the mechanisms deployed to address nurses' constitutional demands/issues as essential service, taking into account the

previous accounts of compromising patient care when nurses embarked on a strike.

- Develop/design an ideal model for dispute resolution that will ensure avoidance of "patient abandonment" due to absence of nurses during strikes or locks out by nurses. According to Roskam (2009:5) the employees, including nurses no longer have confidence in the current model used to address their disputes and grievances. They need a model that would ensure that patients' rights are not compromised, and at the same time ensure that nurses' rights are respected; and that their demands are timeously addressed in accordance with the set essential service standards.

5.6 CONTRIBUTIONS OF THE STUDY

This study will contribute towards educating all nursing categories in clinical setting regarding the importance of exercising their rights and obligations, taking into considerations the moral, legal and ethical- professional framework. The findings of this study will be used to contribute towards government policy on current dispute resolution strategies. The strategies need to be reviewed in accordance with essential service standards as these strategies have not done much to deter nurses from exercising their constitutionally protected right to strike and causing "patient abandonment". The patients in return will be assured of improved and holistic quality health care in the clinical setting.

5.7 LIMITATIONS OF THE STUDY

This study was conducted only in one public health facility in Gauteng Province, and the target population comprised of only permanently employed nurses. Consequently, these findings cannot be generalized to the Gauteng Province without conducting similar studies in randomly selected parts of this province. The random sampling technique posed a challenge when selected respondents changed shifts or placement/allocation. The time for returning the questionnaire was therefore extended.

5.7.1 Recommendations for further research

It is recommended that similar studies in the other regions of Gauteng Province and other provinces be conducted, as nurses' rights and obligations are the same countrywide in order to generalise the findings.

Further research needs to be conducted to explore reasons for nurses implementing or exercising their constitutional right by embarking on strike action or lock outs despite their high level of knowledge about the effects and impact of their rights and obligations on patient care in the clinical setting.

5.8 CONCLUDING REMARKS

Data presented in this study provided adequate information in relation to the research question and objectives. The findings of this study revealed that correct implementation of nurses' rights and obligations in the clinical setting, emphasising the availability of nurses; adequate resources; and a safe environment to mention a few, will optimise influence and impact positively on patient care in the clinical setting. It is envisaged that the challenges encountered by nurses during the implementation of their constitutional and professional rights and obligations would be timeously addressed to ensure that patient's rights are not compromised and that nurses' rights are respected at the same time.

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ANNEXURE: A

INFORMED CONSENT FORM

My name is Merriam Tsatsane, based at the Ga-Rankuwa Nursing College. I am conducting a research project to determine how nurses' rights and obligations impact on patient care in a clinical setting. I would appreciate it very much if you could consider being a participant in the research project. If you consent, I give you the assurance that the study will be conducted with integrity. Your privacy and anonymity are guaranteed. The information you divulge will be kept confidential. Your name will not appear on the questionnaire. Neither will your responses be linked to identifiers. This study is neither an invasive nor intrusive procedure that will cause any harm to you. As a respondent, you are entitled to your full rights.

i) The right to be informed – you must know the risks (if they exist) and benefit of the research project.

ii) The right to refuse – if you are reluctant or feel uncomfortable, you may decline to participate.

iii) Conditional participation – I f you agree to participate, give honest answers.

iv) Withdrawal – if at any stage you feel uneasy, you can still withdraw even if you have signed this consent form.

My contact details are: 073 818 4912

If you agree to participate please sign the form in the space provided.

Signature:_____

Date:_____

Place:_____

ANNEXURE: B

LETTER OF REQUEST TO CONDUCT RESEARCH

Name of Hospital

Dear Sir/Madam

REQUEST TO CONDUCT RESEARCH PROJECT: THE IMPACT OF RIGHTS AND OBLIGATIONS OF NURSES ON PATIENTS' CARE IN A CLINICAL SETTING

I hereby request a permission to conduct a study on the above cited topic in fulfilment of my MACur [Health Studies] at UNISA. The purpose of the study is to explore the relationship between and impact of nurses' rights and obligations in the clinical setting.

I am a lecturer at Garankuwa Nursing College. I promise to adhere to all scientifically, legally and morally acceptable ethical conduct when conducting the study. Ethical approval from the University of South Africa will be sent with research proposal prior to the collection of data from the institution.

Hoping that my application will be favourably considered.

Yours faithfully

Mrs Meriam Tsatsane

TITLE OF THE STUDY:

THE IMPACT OF RIGHTS AND OBLIGATIONS OF NURSES ON PATIENT CARE IN CLINICAL SETTING

RESEARCHER: MRS M S TSATSANE

CONTACT NUMBER: 0738184912

Dear respondents

You are invited to participate in the above-mentioned study. Participation is voluntary. If you agree to participate, read and sign the consent form provided. Read the instructions carefully and complete the questionnaire. The questionnaire will take approximately 25 (twenty five) minutes to complete it. The researcher will collect the completed questionnaire the following day.

If you encounter any problems during the process, please feel free to contact the researcher on the above contact number.

Your participation will be highly appreciated.

MRS MS TSATSANE

ANNEXURE: C

QUESTIONNAIRE SURVEY: NURSES

RESEARCH PROJECT: THE IMPACT OF RIGHTS AND OBLIGATIONS OF NURSES ON PATIENT CARE IN A CLINICAL SETTING.

Instructions:

Please answer all the questions as honestly as possible. The information collected for this study will be analysed in order to form an accurate picture about the impact of nurses' rights and obligations on patient care in one public clinical setting in Gauteng, South Africa, during strike actions. Based on the possible findings of this study, recommendations can be suggested to curb potential imbalances to ensure effective and efficient health service delivery at all times. You do not need to identify yourself and, similarly, the researcher will uphold anonymity in that there will be no possibility of any respondent being identified or linked in any way to the research findings in the final research report. Where required please indicate your answer with a cross (X) in the appropriate box or write a response in the space provided. For the open-ended questions, please write your responses clearly and legibly in the space provided. If there is insufficient space for your response please number a blank sheet of paper with the question number and continue writing your response on the extra piece of paper. You can also write your responses (with the relevant question numbers) on any blank space anywhere on this questionnaire.

There are no right or wrong answers. Your honest opinions are required.

If you are willing to complete a questionnaire, please sign the consent form and hand that to me. This will ensure that no signed consent form can be linked to any completed questionnaire.

Thank you for completing this questionnaire. The completed questionnaire will be collected during tomorrow's lunch times.

SECTION A: DEMOGRAPHIC DETAILS

Indicate your choice by marking the appropriate selected blank block with an "X".

The following questions are **for statistical purposes only**.

Q1. Gender:

Male	1	
Female	2	

Q2. Age

25 years and below	1	
26–30 years	2	
31–35 years	3	
36–40 years	4	
41–45 years	5	
46–50 years	6	
51 years and older	7	

Q3. What is your nursing category?

Registered nurse	1	
Enrolled nurse	2	
Enrolled nursing assistant	3	

Q4. What is your monthly income?

Below R5 000	1	
R5 001 – R8 000	2	
R8 001 - R10 000	3	
R10 001 – R20 000	4	
Above R20 000	5	

Q5. How many years have you been actively practicing as a nurse?

up to 11 months	1	
1 – 2 years	2	
3 – 5 years	3	
6 – 10 years	4	
11 or more years	5	

SECTION B: THE VIEWS (PERCEPTION) ON NURSES' RIGHTS AND OBLIGATIONS

Indicate your choice by marking the appropriate selected blank block with an "X".

Q6.Do you know your rights and obligations as a nurse?

Yes	1	
No	2	

Q7. What was the source of information regarding your rights and obligations?

Nursing manager	1	
Union representative	2	
In-service training	3	
Workshops	4	
South African Nursing Council (SANC)	5	
Literature	6	
Other (Specify)		

Q8. Indicate your view regarding nurses' rights in a clinical setting based on the following statements. Please indicate by marking with an X, whether you regard the following statements as true or false.

		True	False
Q8a) I must under all circumstances practice according to rules and regulations of nursing profession	1		
Q8b) I have the right to practise in a safe environment, equipped with adequate materials and personnel	2		
Q8c) I have the right to refuse to practice if I was not properly orientated and received the appropriate in-service education in my area of work	3		
Q8d) I must under all circumstances adhere to the policies of the institutions to be able to provide quality patient care.	4		
Q8e) I do not have the right to question practices of other member of multidisciplinary team in the provision of health care service to patients if I regard it as inappropriate or unprofessional.	5		
Q8f) If responsibilities for patient care are allocated to me by my superiors and they fall within my scope of professional practice, I do not have the right to object.	6		

Q8g) I am obliged to negotiate with the employer to go for continuing education that is related to my responsibilities	7		
Q8h) I have the right to question any practice that I find unethical	8		
Q8i) I have the right to refuse to participate in any activities that according to my own professional judgement are not in the interest of the patient	9		
Q8j) I have the right to expect medical support or an effective referral system to handle emergency situations responsibly	10		
Q8k) I have the right to participate in industrial actions for bargaining purpose, regardless of who will take the responsibility of care for patients	11		

Q9. Indicate your view regarding nurses' obligations in a clinical setting based on the following statements. Please indicate by marking with an X, whether you regard the following statements as true or false.

		True	False
Q9a) I have to protect and promote the health and wellbeing of those under my care,	1		
Q9b) It is my choice to render high standard of care to patients.	2		
Q9c) During nurses' strike, I follow my union representative' instructions.	3		
Q9d) The care of patients is my first concern.	4		
Q9e) I provide individualised care to patients under my care.	5		
Q9f) I depend on the employer to keep my skills and knowledge up to date	6		
Q9g)My nursing practice is based on professional and legal requirements	7		

SECTION C: THE FACTORS THAT INFLUENCE DECISIONS ON NURSES' RIGHTS AND OBLIGATIONS ON PATIENT CARE IN A CLINICAL SETTING

Q10. Indicate your level of agreement on the following factors that influence nurses' rights and obligations on patient care in a clinical setting.

Please indicate by marking with an X, on the appropriate column for your response.

	Strongly Agree (1)	Agree(2)	Neither agree or disagree (3)	Disagree (4)	Strongly Disagree (5)
Q10a)Individual competence	○	○	○	○	○
Q10b) Level of commitment	○	○	○	○	○
Q10c)Level of training	○	○	○	○	○
Q10d)Organisation leadership style	○	○	○	○	○
Q10e) Organisation management style	○	○	○	○	○
Q10f) The infrastructure	○	○	○	○	○
Q10g) Professional rules and regulations	○	○	○	○	○
Q10h) Ethical principles	○	○	○	○	○
Q10i) Conflict of interest, wishes and values	○	○	○	○	○
Q10j) Constitution of the country	○	○	○	○	○
Q10k) Community/consumer's expectation about nursing	○	○	○	○	○
Q10l) The working environment.	○	○	○	○	○
Q10m)The Labour laws	○	○	○	○	○

SECTION D: IMPACT OF NURSES RIGHTS AND OBLIGATIONS ON PATIENT CARE IN A CLINICAL SETTING

Q11. Indicate your level of agreement on the following statements regarding the impact of nurses' rights and obligations on patient care in a clinical setting.

Please indicate by marking with an X, on the appropriate column for your response.

	Strongly Agree (1)	Agree(2)	Neither agree or disagree (3)	Disagree (4)	Strongly Disagree (5)
Q11a) Nurses' ability to abide to rules and regulations of the nursing profession which enable them to act within the set standards.	○	○	○	○	○
Q11b) Availability of adequate resources and conducive environments assists nurses in providing quality health care.	○	○	○	○	○
Q11c) Promotion of in-service training and orientation which is efficiently functioning, enhance the effective and productive work performance of a nurse.	○	○	○	○	○
Q11d) Nurses are prepared to negotiate with the employer for continuing education to be able to respond competently in her/his area of work.	○	○	○	○	○
Q11e) Nurses engage in policy determination relevant to the scope of their work in order for them to manage patients' conditions appropriately.	○	○	○	○	○
Q11f)Nurses protect and care for patients under their care holistically thus assuring them quality care	○	○	○	○	○
Q11g) Nurses uphold the ethical principle of beneficence, namely to do good and to do no harm to any patient.	○	○	○	○	○
Q11h) Nurses are allowed to refuse to participate in activities where they feel	○	○	○	○	○

they do not possess adequate knowledge and skills.					
Q11i) Nurses adhere to the ideals and moral norms of the profession and embrace them as part of it what means to be a nurse.	○	○	○	○	○
Q11j) Nurses refrain from any activities that they feel are not in the best interest of their patients.	○	○	○	○	○
Q11l) Nurses' ability to manage emergencies appropriately and promptly provided they have medical support or referral systems.	○	○	○	○	○
Q11m) Nurses are allowed to strike for bargaining purposes regarding conditions of service to ensure improved patient care.	○	○	○	○	○

Q12. Indicate your level of agreement on the following statement regarding general behaviour of nurses on patient care (nurses' obligations).

Please indicate by marking with an X, on the appropriate column for your response

	Strongly Agree (1)	Agree (2)	Neither agree or disagree (3)	Disagree (4)	Strongly Disagree (5)
Q12a) Nurses are available at all times caring for patients and their relatives.	○	○	○	○	○
Q12b)Nurses are knowledgeable and provide a high standard of health care	○	○	○	○	○
Q12c) Nurses are always open and honest when executing their duties.	○	○	○	○	○
Q12d)Nurses never leave patients under their care unattended	○	○	○	○	○
Q12e) Nurses treat patients as individuals, deliver nursing services with respect for human needs and values and without prejudice.	○	○	○	○	○
Q12f) Nurses take the responsibility of up-dating their knowledge and skills to improve	○	○	○	○	○

their knowledge and competency to provide patient care.					
Q12g) Nurses provide patient care in accordance with their professional and legal legislations governing their profession.	○	○	○	○	○

Q13. If nurses are on strike, please indicate the degree of importance of the following factors which may impact on the quality of patient care.

	Most important1)	Important (2)	Neither important or not important (3)	Least important(4)	Not important at all (5)
Q13a) Absence of nurses	○	○	○	○	○
Q13b) Inadequate material resources.	○	○	○	○	○
Q13c) Inadequate number of nurses.	○	○	○	○	○
Q13d) Inadequate number of other members of the multidisciplinary team	○	○	○	○	○
Q13e) Provision of health services	○	○	○	○	○
Q13f) Lack of accountability or responsibility of patients under nurses' care	○	○	○	○	○
Q13g) No provision of a safe and healthy environment	○	○	○	○	○
Q13h) Lack of orientation regarding nursing activities					

Q14. Specify the effects of nurses' rights and obligations on patient care in the clinical setting.

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Q15. In your opinion, what is the impact of the failure to exercise your rights and obligations on quality of nursing care rendered to patients under your care during times of nurses' strikes?

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Thank you for answering the questions.

health and
social development
Department: Health and Social Development
GAUTENG PROVINCE

Enquiries: Dr. P. Shembe
Tel no: 012 529 3880
Fax no: 012 5600099

To : Mrs Meriam Tsatsane
167 Unit U
MABOPANE
0190

Date : 12 MARCH 2013

PERMISSION TO CONDUCT RESEARCH

The Dr. George Mukhari Hospital hereby grants you permission to conduct research on "The impact of the rights and obligations of nurses on patients' care in a Clinical setting".

We note that you have already obtained ethical clearance from UNISA Department of Health Studies Higher Degrees Committee.

This permission is granted subject to the following conditions:

☐ That you obtain Ethical Clearance from the Human Research Ethics Committee of the relevant University

☐ That the Hospital incurs no cost in the course of your research

☐ That access to the staff and patients at the Dr George Mukhari Hospital will not interrupt the daily provision of services.

☐ That prior to conducting the research you will liaise with the supervisors of the relevant sections to introduce yourself (with this letter) and to make arrangements with them in a manner that is convenient to the sections.

Yours sincerely

DR. P SHEMBE
DIRECTOR: CLINICAL SERVICES

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/72/2012

Date of meeting: 30 July 2012 Student No: 527-570-9

Project Title: The impact of the rights and obligations of nurses on patient care in a clinical setting.

Researcher: Meriam Semanki Tsatsane

Degree: MA in Health Studies Code: DIS702M

Supervisor: Mrs KA Maboe
Qualification: MA in Health Studies
Joint Supervisor: BO Mmusinyane

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof D van der Wal
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

For **Dr MM Moleki**
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE: F

STATISTICIAN CERTIFICATE

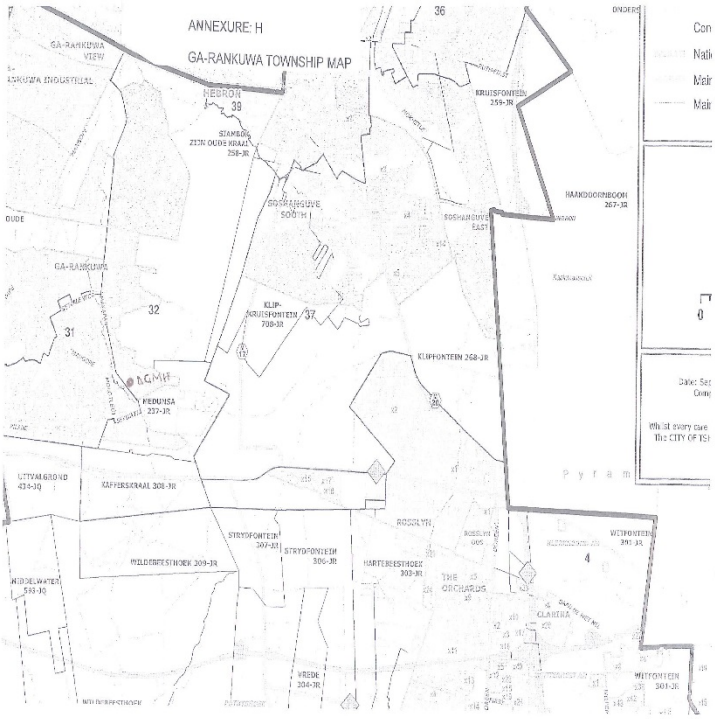
This is to confirm that, I, Suwisa Muchengetwa assisted Meriam Semanki Tsatsane with data analysis of the dissertation title: " **Impact of rights and obligations of nurses on patient care in a clinical setting.**"

Contact number:

e-mail: muches@unisa.ac.za.

Signature ..... **Date** 13-05-2014

ANNEXURE H


ANNEXURE: H
GA-RANKUWA TOWNSHIP MAP
GA-RANKUWA VIEW
HEBRON 39
SIAMBOS 222K OUDE KRAAL 256-JR
KRUISFONTEIN 259-JR
HAANDDORINBOOM 267-JR
GA-RANKUWA
KLIP-KRUISFONTEIN 709-JR
KLIPFONTEIN 268-JR
PEDUNSA 237-JR
KAFFERSKRAAL 308-JR
STRYDFONTEIN 307-JR
STRYDFONTEIN 306-JR
WILDEBEESTHOEK 309-JR
HARTEBEESTHOEK 303-JR
ROSSLYN
WITPOORTJIE 305-JR
THE ORCHARDS
CLARA
WREDE 304-JR
WITFONTEIN 301-JR

ANNEXURE: I

SowetanLIVE

'The nurses were busy singing while my unborn baby was dying'

Aug 23, 2010 | Luzuko Pongoma | 79 comments

ON Saturday the Thwala family buried their baby who died because of alleged negligence by striking nurses.

SAD: Busi Thwala and her mother mourn the death of Busi's unborn baby after nurses allegedly refused to help her

When they pulled the baby out they used force and the head was separated into two parts

RELATED ARTICLES

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Busi Thwala, 28, said she went to Germiston Hospital to give birth but left traumatised after her baby died because nurses refused to help her.

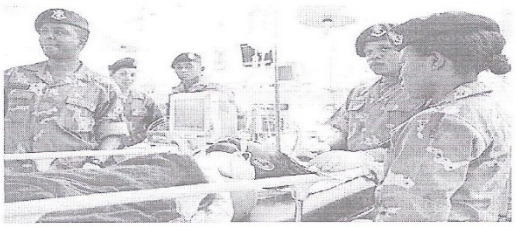
"I arrived at 5.30pm on Tuesday and I told them that my baby was due, but the nurse told me that I could do whatever I liked because other people were also waiting.

"They were busy singing while my baby was dying," she said.

South African public sector strike 'endangering lives'

Army deployed to hospitals as striking workers are accused of blocking entrances, assaulting colleagues and disrupting surgery

David Smith in Johannesburg
The Guardian, Monday 23 August 2010 18.02 BST



Soldiers attend to a patient at the Chris Hani Baragwanath hospital in Soweto. Photograph: Jon Hrusa/EPA

A public sector strike has bitterly divided South Africa as protesting workers are accused of deliberately endangering the lives of hospital patients.

The crippling stoppage, now in its sixth day, has seen the army deployed to hospitals and the government health minister forced to return to his previous job as a doctor.

Demonstrating workers have been condemned for allegedly blocking hospital entrances, assaulting colleagues who want to work and even disrupting surgery in operating theatres.

Violence erupted again today when police fired teargas, rubber bullets and water cannons and arrested 67 public servants in Gauteng and Northern Cape provinces. There were several injuries.

The stoppage is led by a coalition of more than a dozen unions who represent 1.3 million state employees including teachers, police, nurses, customs officials and office workers. Many continue to defy a court order issued at the weekend for those employed in essential services to return to work.

The health minister, Aaron Motsoaledi, who last worked as a doctor 16 years ago, stitched up the wounds of at least a dozen stab victims during a night shift at Chris Hani Baragwanath hospital in Soweto on Friday.

He spoke out angrily against strikers for invading a sterilised area of the hospital to toyi-toyi (an apartheid-era protest dance) and, at another hospital, for interfering with an operation on an anaesthetised patient.

"In other words, they were saying: 'Leave this one to die'," Motsoaledi told South Africa's Sunday Times. "You can't have a health worker who is also a killer. A health worker, by

South African nurses beaten during state worker strikes

Government hopes unions will accept latest pay offer as schools and hospitals remain paralysed by industrial action

David Smith in Johannesburg
theguardian.com, Monday 6 September 2010 11.22 BST

Union members protest in Johannesburg during a strike of South African public sector employees. Photograph: Themba Hadebe/AP

Pressure for an end to South Africa's public sector strike is intensifying after reports of nurses being beaten, stabbed and kidnapped for crossing the picket line.

Union leaders are expected to make an announcement today on whether to accept the government's latest wage offer and end the stoppage that has crippled the country's hospitals and schools.

South African media have published accounts of numerous acts of violence and intimidation against health and education staff who insist on going to work.

A nurse needed treatment on Friday for serious head and neck injuries. Lynette Dube had reportedly been beaten by striking workers at Chris Hani Baragwanath hospital, in Soweto.

A day earlier, another nurse was stabbed at a hospital in Pietermaritzburg. There were also reports of a nurse being abducted and held for several hours before being released unharmed.

Nomvula Mokonyane, the premier of Gauteng province, condemned the behaviour of some workers. "Our differences should not degenerate into senseless killing of fellow human beings," she said.

The strike is now in its fourth week and has seen 1.3 million workers down tools and demand an 8.6% pay rise – double the rate of inflation – and a 1,000 rand (£90) monthly housing allowance.

"The strike must end, we want workers to return to their posts but consultations to continue," one union official told Reuters. "We will need to convince other unions."

Another official said: "Members are still divided on whether to accept the offer but we don't see any reason why they can't go to work while we continue our deliberations."

EDITOR'S LETTER

This letter serves to confirm that I, Themba J Mkhonto rendered editorial services in respect of comprehensive language control/academic compatibility, proof-reading, technical compliance, and research methodology adherence for the Master's dissertation of:

MRS MERIAM SEMANKI TSATSANE

UNISA Student Number: 527-570-9, whose title is:

THE IMPACT OF THE RIGHTS AND OBLIGATIONS OF NURSES ON PATIENT CARE IN A CLINICAL SETTING

Field of Study: Health Studies

Level of Study: Master of Arts

SIGNED: ..... **Date:** 10/06/2014

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