Nursing Dynamics

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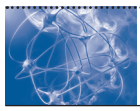


Preface

This is the fifth version of *Nursing dynamics*. Although this book is aimed at undergraduate academic programmes in Nursing Science (including advanced programmes in Nursing Science), it could also be of value to other healthcare academic programmes at undergraduate level.

The content focuses on the 'evidence-based best practice principles' of management and education in the healthcare service division or unit, also referred to as first-level management within a healthcare organisation. Discussions were held and several focus group interviews were conducted in 2014 with current clients to confirm the strengths of the fourth edition of *Nursing dynamics* (2009) and to determine the challenges that need to be addressed as experienced by nurse educators. This has resulted in a new chapter on Governance being added and the chapter on Total quality management has been integrated into the chapter on Quality improvement and clinical governance.

Because the quality and ultimate success of healthcare service division/unit management is dependent on factors beyond the control of the unit manager, selected 'critical success factors' have been added at the end of each chapter.

Head, heart and hands

The guidelines that have been supplied for the analysis of each case study are based on a *Head, Heart and Hands* model derived from the transformation learning theory developed by Virginia Henderson (1974), Jack Mezirow (1975) and other theorists and researchers. Examples of applying the model are reflected in the following publications:

- Freda Easton (initially published in 1997 and also published online in 2009): Educating the whole child, 'head, heart, and hands': Learning from the Waldorf experience. *Theory into Practice*. 36(2). Available: http://dx.doi.org/10.1080/00405849709543751.
- Yona Sipos, Bryce Battisti and Kurt Grimm. 2008. Achieving transformative sustainability learning: engaging head, hands and heart. *International Journal of Sustainability in Higher Education*. 9(1). Available: http://dx.doi.org/10.1108/14676370810842193.

- John Nicholls. 1994. The 'Heart, Head and Hands' of transforming leadership. *Leadership & Organisation Development Journal*. 15(6): 8–15. Available: http://dx.doi.org/10.1108/01437739410066072.

The visual diagram with icons has been developed by the authors of this book. It is important to note that the order of 'head, heart and hands' can be changed by the educator and/or the student subject to the nature and scope of the case study. Some examples of the educational principles to be applied by the educator are:

- transformational learning to facilitate a deep learning experience that challenges the student, not only to learn, but to change through this learning process
- achieving transformative sustainability in learning (TSL) by engaging head, hands and heart
- acknowledging that the student is a threefold human being – body, mind/soul and spirit
- to educate the thinking, feeling and willing capacities of the whole student
- enabling the students to understand their patients, themselves and the external world at deeper levels of complexity.

	Cognitive engagement → Know: *the centre of knowledge*, mind, cognition, logic, critical thinking, systems thinking, understanding, values focused critical thinking, etc.
	Enactment → *the centre of doing*: application of the knowledge and competence in practice, behaviour, professional skills, including psychomotor skills, clinical, managerial and educational interventions; experiential and applied learning.
	Feel → *the centre of life*: experiencing connection, reflecting upon values, affective state, compassion, morality, emotions, motivation, ethical, moral and emotional realities required to be equipped for efficient and competent nursing.

The Head, Heart and Hands model

Development of a professional evidence portfolio

The student is guided throughout this book to compile a professional evidence portfolio (PEP) in accordance with the formalised principle related to continuous professional development (CPD). This portfolio serves as evidence that the student completed the prescribed module and facilitation in obtaining the practical outcomes thereof. The professional portfolio is not a once-off document, but should be viewed as assisting the students on their journey of professional development, demonstrating the continuous development of their thinking and practice. The professional portfolio is dynamic and should be updated, therefore serving as a structure for collected evidence to direct a newly qualified nurse entering the professional practice environment. The professional portfolio also facilitates the student's sense of achievement, gives the student a mechanism for reflection and directs the students to think about themselves within practice. Students can have a printed portfolio in folder format or a digital portfolio. The educator is motivated to use the students' professional portfolio as an opportunity for critical reflection, enabling students to evaluate their professional growth from the beginning of the portfolio to the end.

Enjoy this journey.

I would like to thank all the educators and students for 20 years of support.

Marie Muller

Author biography

Marie Muller

After completing her nursing qualification, Marie specialised in critical care nursing practice and became well-known in this field. She joined the Rand Afrikaans University (RAU) in January 1983 as a lecturer in the Department of Nursing Science. She holds a doctoral degree in Nursing Management (1990) and was promoted to Professor of Nursing in 1992. Her research focused on quality improvement within healthcare services and she is one of the founder members of the South African Council for the Accreditation of Healthcare Services in Southern Africa (COHSASA). Marie excelled as a researcher, supervising 45 masters' and 18 doctoral students, and publishing 72 research articles in accredited research journals during her professorship at RAU. She was acknowledged as an established researcher by the NRF in 2002 when a C2 rating was awarded to her. Marie is also an author of two academic books and has written several chapters in other academic books. She also received an Excellence Award (Women in Research) from the South African Association of Women Graduates in 2001.

Marie was also very active as a professional leader in the nursing profession and was elected as the President of the South African Nursing Association in 1993, where she played a significant role in the transformation of the organised nursing profession. This transformation process resulted in the formation of the Democratic Nursing Organisation of South Africa in 1996, where she served as vice-president from 1996 to 2002. Marie received recognition for her leadership role and received two national nursing awards in 1995 – the John Tremble Award for her leadership contribution and the national gold medal for professional and academic leadership.

She was appointed as Executive Dean of the Faculty of Education and Nursing in 2001. After the merger she continued as interim Executive Dean of the Faculty of Education until she was appointed as Registrar of the University of Johannesburg (UJ) in July 2006. Significant achievements and innovations came about under her leadership as registrar, including academic administration innovations such as online applications, online registration,

significant HEMIS audit results, mobi site development for late undergraduate applications, an academic rating system for undergraduate applications and governance excellence. Marie retired at the end of December 2013 as Emeritus Professor Of Health Sciences.

Marie was awarded the UJ Council Ellen Kuzwayo medal for professional and academic leadership and significant contribution towards governance at UJ.

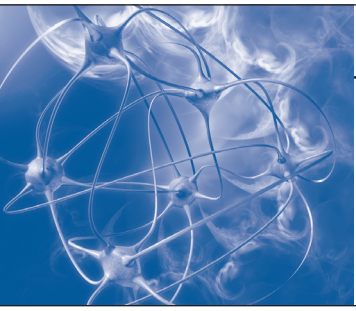
Petra Bester

Petra Bester obtained her B.Cur-degree (cum laude) in March 1997 at the former Potchefstroom University for Christian Higher Education (PU for CHE). During 1997-2000 she gained extensive practice experience as a professional nurse [General, Community, Psychiatry and Midwife] including a two-year period of lecturing Anatomy and General Nursing Science (PU for CHE). She obtained a Magister Curationis in Community Psychiatric Nursing Science under Prof Greeff in 2001 and obtained registration from the South African Nursing Council also as Nurse Educator and Nurse Administrator. From 2001 Petra left the higher education frontiers and worked within the corporate environment, gaining experience as a case manager from both the administrator's and private hospital group's perspective. In 2008 Petra Bester submitted a PhD in Nursing whereby she constructed a theory *Authentic leadership embedded in a social capital framework: A theory for Nursing Science*. Petra lectured at the School of Nursing Science on the Potchefstroom Campus of the North-West University. In her lecturing career, she presented fourteen different modules within undergraduate, post-basic and postgraduate nursing programmes.

In April 2011 Petra accepted the appointment as programme chair for the postgraduate office at the School of Nursing Science. Having the office under control, Petra Bester entered the post-basic nursing programmes based on distance education as programme chair. In January 2013 Petra Bester embarked on new management territory, taking the lead as academic manager to integrate the delivery of nursing programmes into the Unit for Open Distance Learning (UODL), a new strategic direction of the North-West University. During Petra's collaboration within the UODL, she pursued the continuous quality improvement of distance programmes coupled with a progressive direction towards technology-enhanced learning and empowerment of nurses within Higher Education.

From May 2015 Petra accepted the position as senior lecturer at the Africa Unit for Transdisciplinary Health Research (AUTHeR), a research unit within the Faculty of Health Sciences. In this position Petra focuses on strengthening

of healthcare systems with a strong focus on health service management. To date (2015) Petra participated in the completion of 19 Master's degrees. She participated in the development team of the research focus area INSINQ, within the School of Nursing Science. Her research and publication profile presents a strong focus on health service management, health systems and health informatics. In addition, Petra has a lifelong interest in thanatology and assisting people to find meaning and purpose in death and dying. Where possible she participates in terminal guidance to patients and families. Petra is married to Tertius Bester, resides in Potchefstroom and enjoys what little free time is available with her two sons, Ebert and Reuben.



Chapter 1

Foundations of professional practice

Learning Outcomes

The learner should demonstrate insight and critical/analytical reasoning abilities related to the framework for a healthcare service division by:

- outlining a framework for the foundations of a professional practice
- analysing selected global trends and perspectives related to professional practice and applied to nursing and midwifery
- analysing the criteria of a profession and assessing the South African nursing profession's compliance with these criteria
- analysing the philosophical framework of healthcare service delivery, with specific application to nursing and midwifery
- interpreting the constitutional framework related to fundamental human rights
- analysing the rights of patients
- analysing the rights of the healthcare service provider
- analysing the principles of professionalism as applied to nursing and midwifery
- designing a strategy to enable a 'caring nursing/midwifery ethos' in the unit.

Introduction

The healthcare service division/unit is located in a healthcare service institution that is governed in accordance with the national constitutional and legal/regulatory framework for healthcare service delivery in South Africa, as contained in the National Health Act 61 of 2003. It is therefore

important to be acquainted with the Constitution (South Africa, 1996) and related fundamental human rights, including the corporate governance (refer to Chapter 2) and strategic management framework as applied to healthcare service delivery (refer to Chapter 6). It is also important to be acquainted with the global trends and perspectives applicable to healthcare service delivery impacting on the healthcare service division/unit at the clinical operational level.

The National Development Plan: Vision 2030 for South Africa serves as the visionary framework for service delivery in the country (refer to Chapter 6). The 2030 vision for health is contained in Chapter 10 of the National Development Plan (National Planning Commission 2011) and in the subsequent National Development Plan Vision 2030: Outcome 2 Health vision and trajectory to enable 'a long and healthy life for all South Africans'. This outcome has been converted into the national strategic framework for healthcare service delivery in South Africa and the development of *National Core Standards for Health Establishments in South Africa* (refer to Chapter 6).

There are many national and international constitutional, legal and professional–ethical principles impacting on the foundations of professional practice, resulting in a challenge to balance the principles of public and professional accountability and the fundamental constitutional rights of every South African citizen, including the healthcare practitioner. However, the professional healthcare practitioner remains personally and professionally accountable for her or his own decisions and actions irrespective of external and internal variables impacting on the decisions and actions.

This chapter focuses on the foundations of professional practice as applied to nursing/midwifery in South Africa:

- selected global perspectives, trends and challenges
- the criteria of a profession
- the philosophical framework for professional practice related to the Credo and the Nurses' Pledge of Service
- world/life views and the development of a philosophy for the healthcare service division/unit
- professionalism
- protection of the patient with reference to the fundamental human rights as applied to healthcare service delivery (patients and healthcare service providers), including the *Batho Pele* principles
- protection of the healthcare service provider related to their rights
- a caring nursing ethos
- critical success factors related to the framework for professional practice.

Framework for the foundations of a professional practice

The theoretical and legal framework for foundations of professional practice in this chapter is based on at least the following:

- Castell, F. 2008. *Professionalism in nursing practice*
- The Constitution of the Republic of South Africa, 1996
- Companies Act 71 of 2008, as amended 2011
- Democratic Nursing Organisation of South Africa
- Frenk, J. 2010. *The global health system: strengthening national health systems as the next step for global progress*
- Institute of Directors in Southern Africa. 2009: *King Report on Governance for South Africa*
- International Council of Nurses
- legislation and related regulations, directives policies, etc. for healthcare service providers in South Africa as amended (e.g. Allied Health Professions Act 63 of 1982, Health Professions Act 56 of 1974, Nursing Act 33 of 2005, Pharmacy Act 53 of 1974)
- legislation and related regulations, directives and policies for health workers
- legislation and related regulations, directives and policies with reference to the management of information (access, protection of personal information, information technology, etc.)
- legislative framework for enabling (support) services within the healthcare organisation concerned, for example human resources, information technology and communication management services, occupational health and safety, operations (security and protection services, properties/buildings, environmental management, municipal/metropolitan by-laws, etc.), marketing/public relations
- legislation and principles related to 'common and criminal' law
- Muller, ME. 2002. *Nursing dynamics*
- Muller, ME. 2009. *Nursing dynamics*
- National Health Act 61 of 2003 and related regulations, directives, policies, and other legal/constitutional documents applicable at all levels: national, provincial, district and health establishments
- other legislation and related regulations, directives and policies in accordance with the specialised healthcare service delivery (core business) of the healthcare organisation concerned
- Searle, C. 1969. *A South African nurses' credo*
- Searle C. 1987. *Ethos of nursing and midwifery: a general perspective*
- South African Nursing Council. 2008. *The rights of nurses*

- the legal/constitutional framework of the healthcare organisation/establishment concerned (public, private, combined public/private partnership, etc.)
- World Health Organization: global trends and perspectives.

Constitutional and legal framework

The background related to the Constitution, the National Health Act 61 of 2003, additional legislation, regulations, directives and strategies, including the professional, legal and ethical framework, are briefly highlighted.

The Constitution

The Constitution of the Republic of South Africa, 1996 places obligations on the state to progressively realise socio-economic rights, including access to healthcare. Section 4 of the Constitution reflects health as a concurrent national and provincial legislative competence. Section 9 of the Constitution states that everyone has the right to equality, including access to healthcare services as reflected in Section 4 of the Constitution. The Constitution therefore forms the basis of healthcare service delivery, especially regarding the fundamental human rights of South Africans. The Bill of Human Rights is the cornerstone of democracy and is reflected in Chapter 2 of the Constitution and therefore impacts on the foundations of professional practice in a healthcare service division/unit.

The National Health Act 61 of 2003

The National Health Act (South Africa, 2003) provides a framework for a structured healthcare system within the country. It takes into account and makes provision for the obligations imposed by the Constitution (South Africa, 1996) and by other laws relating to healthcare services at national, provincial and local levels. The level and context of healthcare service delivery therefore determines the context of the healthcare organisation. It is also important to note that the National Department of Health has developed and published various national strategies, policies and charters that are applicable to both public and private healthcare organisations/establishments, therefore also impacting on the service delivery by the healthcare practitioner (refer to Chapter 6).

Additional legislation, regulations, directives and strategies

Other legislation, regulations, directives and strategies also impact on the foundations of professional practice within a healthcare service division. The healthcare practitioner must be acquainted with these with due regard to partners from the enabling support services such as financial management, human resource management, occupational health and safety, environmental and disaster management, as well as access to information and many more. The healthcare practitioner must therefore be acquainted with the relevant legislation, regulations, directives and strategies impacting on the foundations of professional practice.

Professional, legal and ethical framework

Clinical practice by healthcare service providers and services rendered by health workers and other employees in the enabling support services is governed by the respective professional, ethical and legal frameworks (refer to Chapter 3). The healthcare practitioner must not only be acquainted with the specialised regulatory and professional-ethical framework, but must also be familiar with the scope of practice and competencies of the other healthcare professionals or service providers working in the division/unit.

Global trends and perspectives

Global trends and perspectives related to healthcare service delivery have changed significantly over the past decade and are continuously changing in the interest of global health as reflected in the Millennium Development Goals (MDGs). Figure 1.1 organises the trends and foundations applied to nursing and midwifery practice from a South African and global perspective.

The specialised clinical practice (such as nursing and midwifery) foundations and service delivery should be viewed within the context of global trends. This chapter challenges you to view nursing/midwifery from a global perspective where it is central to the health outcomes of the global population. The World Health Organization publication *Strategic Direction for Strengthening Nurses and Midwifery Services* – 2011-2015, (WHO, 2011) describes the role of nurses in policy and collaboration in global health services.

Internationalisation and globalisation are two trends that are currently influencing healthcare service delivery at large, and in particular the practice of nursing and midwifery. Internationalisation, on the one hand, refers to a deliberate awareness and linkage *between countries*, especially referring to

collaboration, contracts, business and economics. Globalisation, on the other hand, is the process that occurs when *organisations and systems* are linked between countries because connectivity is available.

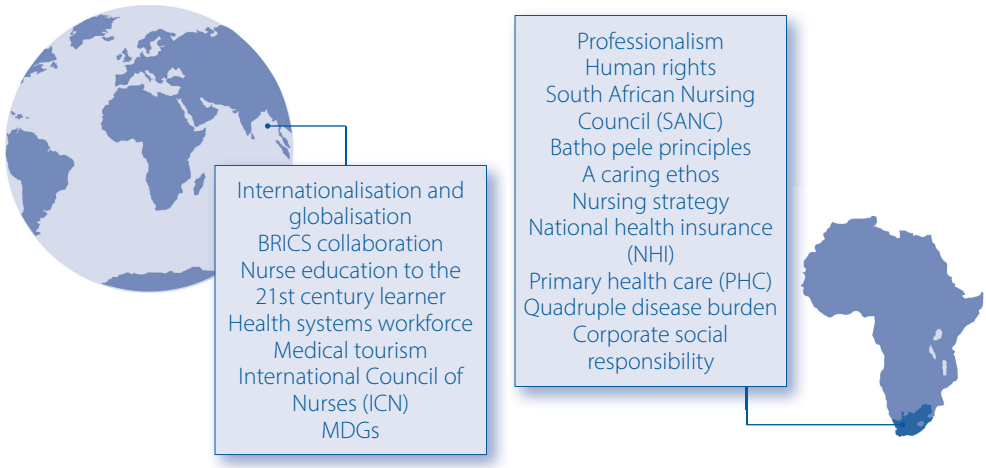


Figure 1.1 Graphic illustration of global trends and foundations applied to nursing and midwifery practice from a South African perspective

Internationalisation

Internationalisation in healthcare services is to link with other healthcare services from other countries and exchange, for example, best practices. South African trained nurses/midwives employed by a United Kingdom owned hospital in Abu-Dhabi serve as a good example in this regard. In 2010, South Africa became part of the BRICS countries (Brazil, Russia, India, China and South Africa), referring to the five emerging national economies. These five countries have similar challenges in education and healthcare and can now combine efforts to research health.

The healthcare industry is a dynamic environment requiring healthcare professionals trained and equipped to work anywhere in the world. This requires that the education of professional healthcare service providers is reviewed internationally as the role of the specialised clinical practitioner (such as nurses and midwives) is reconsidered. Internationally, the training of nursing/midwifery is changing and education is becoming directed more towards lifelong learning for the 21st century student. Lifelong learning entails that as a nurse/midwife, you will not view your basic nursing education as the end of your training, but that you will continue to learn and expand your knowledge. Specialised clinical education for the 21st century learner – for example nursing/midwifery education – relates to the use of technology

to enhance learning. It also implies advancing from a generalist to a specialist during the course of your career.

The international arena in which nurses/midwives function is also characterised by medical (also known as health) tourism. Medical tourism involves a patient leaving his or her country of origin and traveling to another country to access healthcare. Medical tourism also refers to patients from high income countries traveling to lower-income countries where healthcare is more affordable (Medical Tourism Association of South Africa). Medical tourism has gained significant momentum over the past decade, to such an extent that the Medical Tourism Association of South Africa has been established (www.medicaltourismassociation.org.sa). It is registered as a non-profit organisation in accordance with the Companies Act 71 of 2008 as amended 2011).

Healthcare systems

From an international perspective, healthcare professionals work within healthcare systems. A healthcare system is a collective word explaining the complex links between the people, the organisations and the actions that work to restore, maintain and promote health. A health service delivery site, such as a clinic, cannot function in isolation but needs an infrastructure, staff, medicines, and equipment, together with a source of funds to pay salaries and maintain all services.

When a healthcare system functions optimally, the patients being served will manifest improved health. A healthcare system is complex and a healthcare facility is one component in a complex cumulative system (WHO, 2007).

Frenk (2010) discusses dimensions of a healthcare system, which are reflected in Figure 1.2 below. The first dimension of a healthcare system is to not only have the points of service delivery (such as clinics, hospitals, pharmacy and consultation rooms) but to also experience the important relationships between the different components. Secondly, there are providers of healthcare systems as well as recipients (patients) of the service. Thirdly, healthcare systems don't just render healthcare services but are also responsible and accountable for managerial and governance excellence – a healthcare system has the additional responsibility of ensuring financial fairness, legal and responsive rendering of services, and the equitable and dignified treatment of people. The final dimension related to a healthcare system is to enable positive outcomes with specific reference to all the services and duties associated with the system concerned. For example, healthcare systems (refer to Figure 1.2) also relate to the health of the nurses practitioners as a workforce and good financial management (being a steward, managing funds wisely and using resources responsibly).

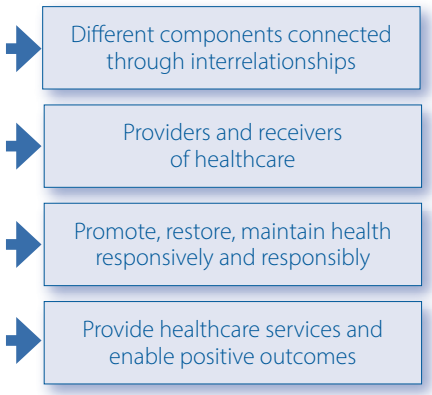


Figure 1.2 Dimensions of a healthcare system

The World Health Organization (2007), Western Pacific Region, has developed a framework for a well-functioning healthcare system. The six building blocks of a healthcare system are reflected in Figure 1.3.

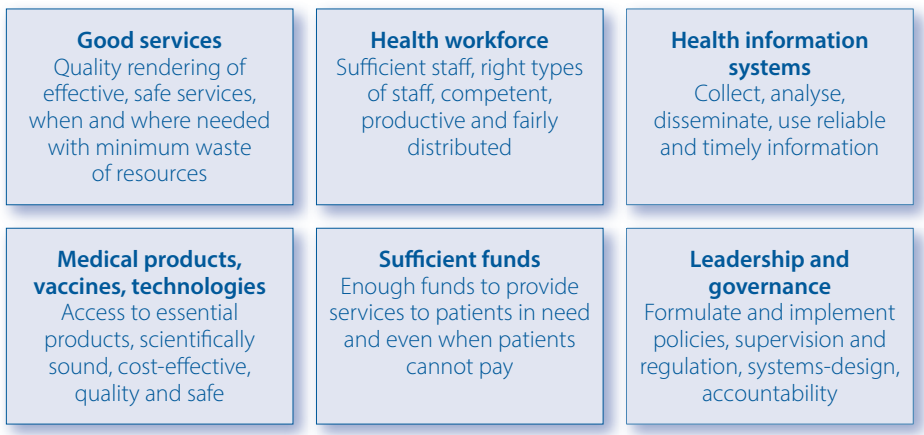


Figure 1.3 The six building blocks of a healthcare system (WHO, 2007)

All six building blocks are necessary to achieve the desired outcomes. This implies that if one building block is absent, goals cannot be achieved. The ideal outcome of a healthcare system is to enable and to ensure improved health, responsiveness, social and financial risk management and improved efficiency.

Within the international perspectives of nursing and midwifery, the International Council of Nurses (ICN) is a prominent role-player. More than 130 national nurses associations (including the Democratic Nursing Organisation of South Africa, DENOSA) throughout the world, representing

over 16 million nurses, are linked into one federation, the ICN. The ICN is an international voice for nurses and midwives, linking with international organisations such as the World Health Organization (WHO) and the World Bank.

Millennium Development Goals

Internationally, nurses and midwives are central to the MDGs. In 2000, the United Nations signed the United Nations Millennium Declaration. This declaration served as a commitment by world leaders to combat illiteracy, disease, poverty, hunger, discrimination against women and the degradation of the environment. Eight MDGs were formulated and were intended to be achieved by 2015. However, progress reports of health-related MDGs show that these have not been achieved and have been held back by conflict, high prevalence of HIV/AIDS and economic hardships.

The member states of the United Nations (UN) adopted the Millennium Declaration, which resolves to strengthen peace, development, and human rights and to strengthen the UN's ability to act on behalf of human rights and human priorities. The declaration calls for global policies and measures corresponding to the needs of developing countries and economies in particular. The MDGs seek to free men, women and children from the dehumanising conditions of extreme poverty. They commit the international community to an expanded vision of development, one that vigorously promotes human development as the key to sustaining social and economic progress in all countries and which recognises the importance of creating a global partnership for development. The eight MDGs focus on the following (UN, 2013):

- eradicating extreme poverty and hunger
- achieving universal primary education
- promoting gender equality and empowering women
- reducing child mortality
- improving maternal health
- combatting HIV/AIDS, malaria and other health challenges
- ensuring environmental sustainability
- developing a global partnership for development.

The progress in general is positive as reflected in *The Millennium Development Goals Report 2013* (UN, 2013) written in the format of a fact sheet and published by the United Nations to reflect the progress on each of the above millennium goals focusing on the current stance of achieving the targets, what is working and patterning for success.

e-Health strategy in South Africa

Effective monitoring of healthcare service delivery and overall performance of the healthcare system requires a reliable, functional and trustworthy information system capable of producing real-time information for decision making (National Department of Health, 2012: 5). The e-Health Strategy for the public health sector provides the roadmap for achieving a well-functioning national health information system with the patient located at the centre. The e-Health Strategy for 2012–2016 focuses on the following priorities (National Department of Health, 2012: 5–7):

- strategy and leadership
- stakeholder engagement
- standards and interoperability
- governance and regulation
- investment, affordability and sustainability
- benefits realisation
- capacity and workforce
- e-health foundations
- applications and tools to support healthcare delivery
- monitoring and evaluation of the e-health strategy.

Nursing/midwifery as a profession

Each profession has unique characteristics and traditions determined by its practitioners. A profession refers to a specific career where work of an intellectual nature is performed. This career makes a public statement in respect of its uniqueness, the career-specific training, education required, as well as the career-specific values and norms that are pursued. The attributes of a profession are summarised as follows (Muller, 2009:5–6):

- There is a special body of knowledge that is continually improved and expanded through research.
- The services provided involve intellectual activities underpinned by accountability.
- The practitioners are educated in regulated, accredited institutions of higher education.
- The practitioners are motivated by service and work-based ethics.
- There is a code of ethics to guide the decisions and conduct of practitioners.
- Nursing/midwifery, like any other profession, must comply with the international criteria related to a profession. These criteria are reflected in Table 1.1.

Table 1.1 The criteria of a profession (adapted from Searle, 1978)

Criteria	Description
1	A profession is characterised by an extensive, specialised theory-content with well-developed technical skills based on such a theory.
2	A profession is characterised by the utilisation of the theory of physical science, as well as other disciplines related to their practice.
3	A profession is characterised by specialised preparation over a long period at a recognised educational institution.
4	A profession is characterised by the testing of professional competence prior to admission to the ranks of the profession.
5	A profession is characterised by some form of registration and licensure to practice.
6	A profession is characterised by self-organisation, which leads to the establishment of a professional association and a self-governing body to exercise control over professional standards.
7	A profession is characterised by ethical control of professional conduct by the members of such a profession.
8	A profession is characterised by a service motive based on the needs of the client who requires professional assistance, regardless of her or his ability to pay for services, because the well-being of the client is the primary consideration.
9	A profession is characterised by a high degree of accountability for professional acts towards the public, the client, the employer and other members of the profession.
10	A profession is characterised by a feeling of exclusiveness.
11	A profession is characterised by an acknowledged status in terms of legislation.
12	A profession is characterised by a high social status and considerable power in society.
13	A profession is characterised by the performance of activities that are based on an understanding of what these activities involve, so that the consequences of acts or omissions can be predicted.
14	A profession is characterised by sustained critical analysis of activities, which leads to a change in practice on the basis of such analysis, with the result that a profession is always subjected to change and development and is never static.

continued

Criteria	Description
15	A profession is characterised by the ability of its members to select, in a responsible manner, the activities that are of material importance to that particular practice, and where the mastering of the profession falls within the realistic reach of members.
16	A profession is characterised by the individual members being allowed the maximum discretion and initiative in their practice of their profession, but independent functions and accountability for their performance are inherent.
17	A profession is characterised by the obligation of its members to use their best endeavours in meeting the needs of the patient.
18	A profession is characterised by a sustained striving towards excellence because competence alone is not enough.

The philosophical framework of healthcare service delivery

A philosophical framework refers to the combination of beliefs and convictions that direct a practice. For nursing/midwifery, it reflects a dominant or majority view of nurses and midwives in South Africa regarding what nursing is and how it should be practised.

This philosophical framework is described with reference to the following: the Credo and the Nurses Pledge of Service, world/life views and a philosophy for the nursing unit (Muller, 2009:2).

The South African Nurses' Credo

The Credo (Searle, 1969) is a summary of South African nurses' beliefs and convictions about nursing. It was compiled by Professor Charlotte Searle in 1969 and describes the philosophical light beacons that guide South African nursing. Some of these beacons are clearly rooted in Christian philosophy. The philosophical light beacons are as follows:

- **Nursing is a belief** in the essential worth of every human life and in the divine reason for the existence of this life. It is a belief in the uniqueness and irreplaceability of every human being and a belief that the Creator charged humankind with the serious responsibility for her or his own personal well-being and for the well-being of the rest of humankind. For nurses, this belief has a deep significance. This is something from which we

derive support when our burdens becomes almost unbearable and which makes our work and existence meaningful.

- **Nursing is faith** in a continual source of inner strength that will assist us in doing what is expected of us, and that will guide our behaviour. Nursing is a yearning – to be a worthy servant of humanity and an effective instrument of medical science. Nursing is acceptance – of the fact that every human being is unique and of the need to employ all health aids to provide for the health needs of each unique being. It is acceptance of the fact that there really are no patients and that disease viewed as a separate entity does not really exist, but that there are only sick people or people with health needs. It is acceptance of the fact that nursing consists not only of a series of tasks that have to be performed or a set of procedures that have to be followed, but that it is a professional service to humankind that includes instrumental and expressive functions. Nursing is about transforming the so-called nurse–patient relationship into a human being to human being relationship. Nursing is conservation and change – the conservation of a precious human life through change, for nursing seeks to prevent, to promote, to reverse or to balance in order to conserve.
- **Nursing is assistance and support**, not only to those who are dependent on the health staff, but also to those who render the service. In its application of scientific skills during the treatment and care of the human being, nursing is a technology.
- **Nursing is the therapeutic use of the self**; it is love that is made visible.

The Nurses' Pledge of service

The Nurses' Pledge provides the ethical foundation of the nursing profession in South Africa. The Pledge is derived from the Nightingale Pledge and has been in use since the introduction of nurse training in South Africa. When taking the Pledge, the nurse/midwife enters into a verbal agreement with the community. The question which arises, however, is whether this Pledge reflects the dominant views of nurse practitioners in South Africa (Muller, 2009:3).

The South African Nurses' Pledge of service is as follows:

> *I solemnly pledge myself to the service of humanity and will endeavour to practise my profession with conscience and with dignity. I will maintain by all the means in my power the honour and the noble traditions of my profession. The total health of my patients will be my first consideration. I will hold in confidence all personal matters coming to my knowledge. I will not permit considerations of religion, nationality, race or social standing to intervene*

between my duty and my patient. I will maintain the utmost respect for human life. I make these promises solemnly, freely and upon my honour.

This pledge reflects the nurse's service-directed mission. This service-directedness further implies that the nurse/midwife will always put the patient first – in other words, the nurse/midwife's own interests will always come second. 'Nobility' refers to excellence, or the best service that the nurse can give. The nurse/midwife also promises professional confidentiality, and all patients are considered to be equal, regardless of social status or parentage.

World/life views

A world/life view (also referred to as a philosophical view) is the way we see and perceive our world. It is the way in which a person thinks about life and the world, informed by the values and beliefs of that person. The foundations of a worldview are developed during childhood as part of the process of personal socialisation and are further developed during professional socialisation within the world of training, education and work. A person's culture and all the accompanying influences (for example, educational, political and religious, customs, traditions) especially during the process of becoming an adult could influence a person's initial worldview. Every culture presents a coherent and meaningful pattern which is rooted in the dominant world view of that community. These convictions or views indicate what people think and believe about the world, as well as their attitudes towards life itself. Cultural practices are directed by the world view of a cultural group. Through a process of socialisation, the world view influences a person's personal view of life which is reflected in her or his beliefs, choices, convictions and stance taken on certain matters. This personal life view becomes a person's 'way of life' and prompts the search for answers to such questions as: How do I view the world/universe? How do I view mankind? What is wrong with the world and how can we fix it? (Muller, 2009:10).

There are different types of world/life views from which certain models and theories are derived. Examples are a Western world view, a humanistic world view (for example, behaviourism, existentialism, rationalism, pragmatism, postmodernism), a Christian world view, an African humanistic world view (ubuntu), etc. It is therefore important to be acquainted with the different world/life views and cultural groups in the unit and the world/life views of people who will impact on professional practice. The African, Western and Eastern world/life views are reflected in Figure 1.4.

Figure 1.4 Depiction of world/life views

Development of a philosophy for the healthcare division/unit

The philosophy of the unit reflects the essential value convictions – what the employees believe in – and it is therefore necessary that all group members accept ownership for the philosophy. Philosophy refers to a system of thought and reflects the collective views on the values and convictions of employees in the healthcare division/unit. The philosophy of the unit is the summary of the group members' collective views and convictions (philosophical views) on humankind, people and other applied healthcare concepts based on consensus decision making. These philosophical views explain why certain things are done. The employees in a specific unit use the philosophy as a basis for justifying certain acts. The philosophy of the unit offers the framework for motivation, principles, values and convictions within which the practitioner functions and includes belief statements on the patient, nursing/midwifery care, the nursing/midwifery practitioner and health/illness. Concepts such as continuing professional development and research could be added in accordance with the nature and scope of the healthcare division/unit (Muller, 2009:11–13).

Factors influencing the formulation of a philosophy

The following factors influence the formulation of the nursing unit's philosophy (Muller, 2009:11):

- the employee profile and life view of each team member
- the employees' internalised professional values and personal virtues as they are influenced by the training/educational institution and other internal and external environmental variables

- the value preferences of the employees, such as economic, political, aesthetic, social and theoretical values
- the patient profile and the type of healthcare service delivery (such as nursing care) that is practised in the unit
- the different phases of life in which the employees find themselves (the newly qualified nursing practitioner has possibly not yet clarified a personal life view or philosophy, while the more senior person probably has and will defend these convictions in an assertive manner).

Formulating the philosophy

The following guidelines are suggested for the formulation of the philosophy of the healthcare unit (Muller, 2009:11–12):

- Organise a group discussion session with the employees to formulate a philosophy.
- Obtain the life views of every member of the group regarding humankind/people and debate the different views, based on the questions such as: Who am I? What are my beliefs? How do I view life? How do I view the patient? How do I view nursing?
- Obtain consensus and formulate a view about humankind: 'We believe a person is ...'
- Apply this view to the patient, healthcare practitioner and the nature of the clinical practice (e.g. paediatric nursing).
- Debate the views of the group members.
- Once consensus has been obtained, finalise the philosophy.

The principles of professionalism applied to nursing and midwifery

Professionalism refers to the extent to which an individual identifies with his or her profession and complies with the subsequent standards. Professionalism therefore relates to the professional attributes and key behaviours displayed by the healthcare service practitioner resulting from professional socialisation. It refers to the conduct expected from that practitioner in accordance with the legal and professional-ethical principles. The practitioner's practice and conduct is related to the following: accountability, abilities/competencies (knowledge, skills, values and attitudes), leadership, self-regulation, commitment to excellence, social values, service-directedness and duty, honour and integrity, respect for others as well as compassion and empathy, including a caring ethos (Castell, 2008:13–17, Muller, 2009:7). The definitions of nursing and midwifery, as reflected below, describe the essence of professionalism for these disciplines.

Nursing defined

The Nurses' Pledge raises the question: what does nursing mean? The International Council of Nurses (ICN, 2014:27) defines nursing as follows:

> *Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.*

Nursing is defined in the Nursing Act 33 of 2005: Clause 1 as follows:

> *Nursing is a caring profession practised by a person registered under section 31, which supports, cares for and treats a healthcare user to achieve or maintain health and where this is not possible, cares for a healthcare user so that he or she lives in comfort and with dignity until death.*

The South African Nursing Charter (South African Nursing Council, 2004/2008) defines nursing as representing continuity of care, a unique feature amongst healthcare professions.

Midwifery defined

Midwifery is defined in the Nursing Act 33 of 2005: Clause 1 as 'a caring profession practised by persons registered under this Act, which supports and assists the healthcare use and in particular the mother and baby, to achieve and maintain optimum health during pregnancy, all stages of labour and the puerperium'.

Protecting the patient

The patient is protected by the Constitution with reference to the fundamental human rights, the *Batho Pele* principles, resulting in the formalised Charter for Patient Rights.

The constitutional framework related to fundamental human rights

The Constitution forms the basis of governance and management, especially regarding the fundamental human rights of South Africans. The Bill of Human Rights is the cornerstone of democracy and is reflected in Chapter 2 of the Constitution (South Africa, 1996). In addition to the fundamental human rights, the following rights are also crucial: access to information (South Africa, 2000), promotion of administrative justice (South Africa, 2000) and the promotion of equality and prevention of unfair discrimination (South Africa, 2000). The healthcare organisation should therefore have policies and processes in place to facilitate compliance with these enacted rights, devolved to the level of healthcare service division management. The fundamental human rights and selected documents derived from these rights are briefly highlighted.

Fundamental human rights

Human rights have been an important theme of discussion for many years, especially after the Universal Declaration of Human Rights in 1948 by the United Nations. The Constitution of South Africa, 1996: Chapter 2 contains the Bill of Rights, which focuses on the following:

- equality on the part of every person before the law, as well as fundamental equity
- accessibility and treatment – therefore no discrimination
- respect for and protection of human dignity: beneficence and prevention of or protection against harm
- life
- personal freedom and security
- privacy and confidentiality
- freedom of conscience, religion, thoughts/reason
- conviction and opinion
- freedom of choice, speech and expression
- political rights
- freedom of association, meetings, protest and petitions
- freedom of movement, to stay or leave
- information and informed decision making/consent
- administrative and natural justice
- property and the protection thereof
- participation in economic activities
- fair labour practices and industrial relations

- a clean and healthy environment
- language and culture
- child care
- education and training, as well as equal accessibility.

Application of the fundamental human rights

In addition to the fundamental human rights reflected in the Constitution, other rights and principles such as the *Batho Pele* principles for public services and the rights of patients and healthcare service providers have also been developed. These have been derived from the Bill of Rights and subsequent national professional regulatory requirements, including international statements in this regard (refer also to Chapter 3).

The South African *Batho Pele* principles

The *Batho Pele* principles, meaning 'people first', focus on the following six principles (DPSA, 2010):

- consultation
- service standards
- access
- courtesy
- information
- openness and transparency.

These principles have been divided into ten divisions (DPSA, 2010) to enable South Africans to understand their rights and responsibilities in this regard. The content areas in the Health section are also highlighted:

- Citizenship
- Human Settlements
- Basic Needs
- Health: health education, promotion of adequate nutrition, adequate supply of clean water and sanitation, immunisation against major infectious diseases, effective treatment of common diseases and injuries, provision of essential drugs, prevention and control of locally endemic diseases
- Education
- Fair Labour Relations
- Rights and Law
- Services and Programmes
- Redress and Recourse
- Social Development.

Protecting the rights of patients

In addition to their constitutional rights, patients are also protected by the National Department of Health's Patients' Rights Charter. The Charter was introduced in 1999 and was published in the *National Core Standards for Health Establishments in South Africa* (National Department of Health, 2011:17–20). It focuses on the following principles related to the 'right to dignity':

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

Patient rights are classified in the *National Core Standards for Health Establishments in South Africa* in the following eight sub-domains with subsequent measurable standards (National Department of Health, 2011: 18–20):

- Respect and dignity
- Access to information for patients
- Physical access
- Continuity of care
- Reducing delays in care
- Emergency care
- Access to a package of services
- Complaints management.

In addition to the above, the Charter of Nursing Practice (SANC, 2004:12–14) also contains the rights of a healthcare user with reference to nursing care, focusing on the following:

- the rights of the unborn child
- the high-risk newborn infant
- the unusually vulnerable healthcare user

- a person that is HIV positive and a person with AIDS
- the right to independent decision making.

Protecting the rights of professional healthcare service providers

In addition to the fundamental rights reflected in the Constitution, the rights of healthcare service providers are also determined by their respective professional regulatory organisations or their professional organised or labour bodies. The healthcare division manager should therefore be acquainted with the rights of the professional service providers in accordance with the most recent publications in this regard. The rights of the nursing/midwifery practitioner as determined by the ICN and the rights of the nursing/midwifery practitioner in South Africa are briefly highlighted.

The rights of the nursing/midwifery practitioner in South Africa

The rights of nursing/midwifery practitioners are reflected in several position papers, strategies and directives, most particularly, the ICN (www.icn.ch), DENOSA and the SANC (2008). The Rights of Nurses as stated by the SANC (SANC, 'Nurses rights') are summarised as follows:

- practice in accordance with the legal scope of practice
- safe and adequately equipped working environment
- orientation and goal-directed in-service education
- negotiated continuing professional education
- participative planning and decision making related to the treatment of the patient
- advocacy for and protection of patients
- refusal to carry out a task reasonably regarded as outside the scope of practice and abilities
- lodging of a conscientious objection, subject to governance requirements
- not to participate in unethical or incompetent practice
- written policies guidelines/prescriptions related to the management of the working environment
- refusal to participate in activities that are not in the interest of the healthcare user
- disclosure of the diagnosis of patients for whom he/she accepts responsibility
- working environment that is free of threats, intimidation and/or interference

In addition to the above, the rights of the nurse are also contained in the Charter of Nursing Practice (SANC, 2004:15–16) focusing on the following:

- practising in accordance with the scope of practice
- a safe working environment
- proper orientation and goal-directed in-service education
- negotiation with the employer for continuing professional education
- equal and full participation in such policy determination, planning and decision making
- advocacy for and protection of the healthcare users and personnel
- lodging of a conscientious objection subject to certain provisions
- refusing to carry out a task reasonably regarded as outside the scope of practice
- withholding participation in unethical or incompetent practice
- written policy guidelines and prescriptions related to the management of the working environment
- refusing to implement a prescription or to participate in activities which, according to her/his professional judgement, are not in the interest of the healthcare user
- disclosure to her/him the diagnoses of a healthcare user for whom she/he accepts responsibility
- a working environment free of threats, intimidation and/or interference
- a medical support or referral system to manage emergency situations responsibly.

Although the different sets of rights can be confusing, the healthcare service unit manager must ensure that the rights of the healthcare practitioners, health workers and other employees in the unit are protected with due regard to the institutional delegation of authority and related processes in this regard.

Enabling a caring nursing/midwifery ethos

Reflecting or exhibiting a 'caring ethos' is a fundamental requirement for professional practice in the unit. The word 'ethos' refers to a person or group's character, moral nature or guiding beliefs. A caring ethos focuses on at least the following: compassion, competence, commitment and empathy, and including a nurturing inclination (Muller, 2009:10). According to Landman (2002), nurse practitioners care by:

- defending the patient's human rights: nurse practitioners do not defend human rights dispassionately, but they do so from having feelings that identify with those in need

- promoting the good or best interests of others: preventing disease, relieving pain, comforting, rehabilitating and advocacy
- living the good or moral life: embodying the virtues of compassion, sympathy or empathy
- 'entering' into the patient's personal experience of illness, injustice, etc. with confidence and professionalism
- fostering trust, especially related to confidentiality
- not exploiting the vulnerability of the patient
- being present and engaged with the person in need with an attitude of 'Can I help you?'
- exhibiting the knowledge and skills claimed and expected to have.

It is therefore necessary to develop a strategy to facilitate a caring ethos in the healthcare service division/unit. The principles of strategy development are applicable (refer to Figure 1.5 and to Chapter 6): strategy analysis and assessment, strategy development, strategy execution and strategy review.

Critical success factors related to foundations for a healthcare service division/unit

The following critical success factors are applicable:

- The healthcare service division/unit manager is acquainted with at least the following:
  - selected global trends and perspectives impacting on the healthcare service delivery in the unit and foundations of professional practice
  - the constitutional provisions impacting on the fundamental human rights and related rights of healthcare service providers.
- The professional healthcare practitioner is acquainted with at least the following and its relevance to the foundations of professional practice:
  - Credo
  - Pledge of service
  - world/life views
  - development of a philosophy for the unit
  - the constitutional framework with reference to the fundamental rights
  - the rights of patients and healthcare professionals
  - the principles of professionalism, including a caring ethos in the unit.
- There is a strategy in the unit to enable/facilitate a caring ethos in the unit.

Concluding remarks

It is important to understand and interpret the foundations of professional practice for application in the healthcare division/unit. There are global trends and perspectives impacting on the healthcare service delivery at clinical operational level. Nursing is a profession as confirmed by the criteria of a profession and we need to nurture our professional status in this regard. The philosophical framework consists of the Nursing Credo, the Nursing Pledge of Service, world/life views of the practitioners in the unit and the development of a philosophy for the healthcare unit. The fundamental human rights are contained in the Constitution of the Republic of South Africa, 1996 and refined by the National Department of Health and the South African Nursing Council. The principles of professionalism must be exhibited by the professional healthcare practitioner to ensure continuation of our professional status. Finally, the healthcare practitioners must comply with the principles related to a caring ethos as the essence of the nursing/midwifery profession.

Reflection and application

Self-evaluation and reflection

Develop a strategy for the unit on a caring ethos. Use Figure 1.5 below and apply the principles of strategy development described in Chapter 6.

Figure 1.5 Development of a strategy to facilitate a caring ethos in the unit

Assessment criteria

The learner demonstrates critical analytical and reflective abilities (knowledge, skills, values and attitudes) in designing a strategy to facilitate a caring nursing ethos in the healthcare division/unit by applying the principles of strategy development.

Strategy analysis and assessment

Strategy analysis and assessment entails the conducting of an internal (and an external if necessary) analysis and assessment. This entails at least the following:

- Conduct an analysis to determine the status of a caring ethos in the unit, including the strengths, weaknesses, opportunities and threats related to

a caring ethos and focusing on compassion, competence, commitment, empathy and any others, such as trust relationships and the art of nurturing.
- Analyse and assess the practitioners' profile: abilities (knowledge, skills and attitudes) related to a caring ethos.
- Analyse and assess other contributing factors that may impact on the strategy, for example value conflict or any signs of 'moral turpitude'. Moral turpitude refers to conduct that involves one or more of the following (ICN, 2005:24):
  - intentional or 'reckless' conduct
  - conduct done knowingly contrary to justice and honesty
  - conduct that is contrary to the accepted and customary rule of right and duty that a person owes to fellow human beings and society in general.
- Debate the historical principles and purpose of the annual 'Nurses Day' with specific reference to the historical 'compassionate character' that was the impetus for care and gave the nursing profession its ethos.
- Debate the principles contained in the Pledge of Service and applied to a caring ethos.
- Formulate the final statement/conclusion related to the analysis and assessment: the existence/status of a caring ethos in the unit.

Strategy development

Strategy development relates to the objectives/goals, implementation plans and performance indicators to facilitate a caring ethos in the unit. Strategy development should be based on thorough consultation with all the internal stakeholders and when appropriate, discussions with the departmental and/or organisation managers as well as discussions with other healthcare unit managers to identify best practices in this regard. To apply the principles of strategy development, the healthcare service division/unit manager and other internal stakeholders should (Muller, 2009:115–116):

- Analyse the results of assessment and analysis with due regard to challenges and risks identified.
- Describe and compile the content/criteria related to a caring ethos to be included in the strategy, with due regard to the results of the assessment and analysis.
- Identify the changes/transformation actions required to meet the challenges: what needs to be changed or transformed in the unit to enable a caring ethos and how these changes can be brought about.
- Draft/develop the intent/objectives.
- Develop the action plan: how the objectives can be achieved, who is responsible for each action (allocation of duties/tasks/responsibilities) and

when this has to be completed (due/target dates). The strategy should also make provision for the necessary empowerment of personnel (including leadership development) to cope with the new challenge, the management of resistance to change, optimal utilisation of the strengths within the unit, and how to counteract the threats and weaknesses that could possibly impact on the strategy.
- Identify the key priority areas and convert them into key performance indicators (KPIs): the measurable outcome to be achieved.

Strategy execution

The successful and timely execution of the strategy is crucial and is in accordance with the principles of corporate governance, cooperative governance and participative management (refer to Chapter 2 and Figure 2.7). The following principles for successful strategy execution are highlighted (Muller, 2009:116, Mankins and Steel, (2011:209–228):

- Keep it simple: clearly describe the actions related to what the unit staff will do and won't do as opposed to lengthy and complicated descriptions.
- Challenge assumptions: the underlying reasons for the strategy or revised strategy are clearly stated and incorrect assumptions are debated accordingly.
- Speak the same language: unit managers and the strategy team members agree on a common understanding of the strategy framework for execution and assessing performance.
- Discuss resource deployments: determine the resource implications in a trustworthy manner, and negotiate and execute the resource deployments accordingly.
- Continuously monitor performance by tracking real-time results against the relevant performance indicators.
- Develop execution ability by relevant empowerment and continuous motivation of the stakeholders concerned and the selection and development of the right project leaders.
- Implement the strategy with the necessary support, empowerment and continuous motivation by the healthcare service division manager.
- Communicate the strategy to all the stakeholders in the division/unit.
- The healthcare service division/unit manager exercises strategic and operational leadership in the implementation of the strategy.
- The strategy is aligned with the performance management system of the healthcare service division/unit. The individual practitioner's contributions towards attainment of the goals and KPIs are continuously reviewed and communicated.

Strategy review

Strategy review is the final process and is in accordance with the principles of corporate and cooperative governance (refer to Chapter 2 and Figure 2.7) to critically analyse the outcome focusing on at least the following (Muller, 2009:116):

- Formal evaluation of the outcomes and achievement of objectives is conducted to determine the success of the strategy.
- The strategy review and progress is a standing item on the agenda of the healthcare service division meetings.
- If necessary, quarterly formal review sessions are conducted where the KPIs are assessed and reasons for success or non-achievement are identified and analysed.
- This should form part of the performance management process of the healthcare service division manager.

Final review and evaluation are concluded based on the attainment of goals and performance indicators at the end of the period.

Application

Apply what you have learnt in this chapter by working through the following tasks.

Case study

This case study is based on a real court case (note: the names in the case study are fictitious).

The Plaintiff is Mrs Cathy Sibongi in her personal and representative capacity as the mother of Abigale Sibongi, who instituted action against the Defendant for payment of an amount of R27 290 000. The Plaintiff alleges the following:

1. In August 2009, the Plaintiff attended the Kingston Hospital to ascertain whether she was pregnant and if so, to receive advice, care and assessment on the progress of her pregnancy. Included in this was the expectation of knowing the due date of her baby, receiving advice and treatment in the event of the foetus not progressing appropriately, and being assessed for intrauterine growth retardation.
2. She was informed by the attending medical staff at the hospital that the foetus had progressed appropriately.

3. During the early morning of February 2010, the Plaintiff experienced symptoms associated with labour and attended the hospital at approximately 06:30 where she was admitted for confinement.
4. The Plaintiff gave birth approximately 15 hours later at 21:00.
5. Upon arrival, the Plaintiff informed the attending medical staff that she was experiencing labour pains, but was ignored and left unattended for a long time.
6. A vaginal examination was performed later and the Plaintiff was advised that she was not yet ready to deliver her baby.
7. A cardiotachograph was not used to monitor the foetal heart rate and contractions.
8. During the course of the day, a doctor examined the Plaintiff and advised her that she was still not ready to deliver her baby.
9. The plaintiff alleged that she was left unattended and unmonitored for lengthy periods.
10. At approximately 18:00 a doctor perused the hospital file pertaining to the Plaintiff and advised the attending nurse to make immediate arrangements to transfer the Plaintiff to another hospital for a caesarean section to deliver the baby.
11. At this stage, the Plaintiff was experiencing severe labour pains, disproportionate to what is normally expected during labour.
12. The Plaintiff endured several hours of labour in circumstances where a caesarean section was indicated.
13. The Plaintiff gave birth by normal vaginal delivery.
14. After birth, baby girl Abigale did not cry and was blue in colour.
15. The Plaintiff further alleges that as a result of the prolonged labour and the defendant's failure to perform a caesarean section timeously, the baby suffered an hypoxic-ischaemic incident or birth asphyxia, including perinatal asphyxia, causing her to sustain severe brain damage. As a result she now suffers from cerebral palsy, mental retardation and epilepsy.

Head, Heart and Hands

After reading this case study, apply what you have learnt in this chapter and describe how you will manage this case. Use the Head, Heart and Hands model that follows as a guide.

Caring ethos

1. Analyse and describe the rights of the mother and the rights of the unborn baby.
2. Identify and debate the transgression of these rights, and by whom, as contained in the case study.
3. Analyse and determine: what went wrong – where and how?
4. Analyse and debate: is this an example of 'reckless conduct'?
5. What has happened to our caring ethos in the unit as they were certainly not applied?

Professional scope of practice and acts and omissions

6. Analyse and describe the professional responsibilities of the midwives involved in this case.
7. Analyse and debate the 'acts and omissions' of the midwives involved in this case.
8. Analyse and describe the multi-professional responsibilities of the healthcare practitioners involved in this case.
9. Debate the amount of money claimed by the Plaintiff based on the principle of reasonableness? Do you think this is reasonable? Can this amount of money be viewed as a 'reasonable reward for the cerebral damage' of this baby?
10. Analyse and imagine the lifelong grief and costs involved in this case.

1. Compile the caring ethos strategy for the unit, based on the guidelines presented above – see the heading *Self-evaluation and reflection*.
2. Give a presentation of the caring ethos strategy at the next professional development session.
3. Present the findings to the 'clinical governance' (adverse events) committee and debate the lessons learned.
4. Analyse the existing clinical care standards/policies in the unit and revise if applicable to include the lessons learned from this case.
5. Arrange a multi-professional debate with all the team members involved in this case from admission to the birth of the baby.

1. Debate the ethical values related to effective leadership as applied to this case:
   - responsibility
   - competence
   - commitment.

continued

	2. Debate the principles related to the moral duties as applied to this case: • conscience • competence • commitment • professional communication between the members of the healthcare team. 3. Debate the personal, cultural and professional-ethical values of the professional multi-disciplinary team members involved in this case. 4. Express your emotional feelings during the debate and relate them to the principles of a caring ethos in the unit. 5. Confirm the commitment by all concerned in the unit to comply with the principles and strategy of a caring ethos.

Personal portfolio development

Access the following:

1. Chapter two of the Constitution: Bill of Rights.
2. The *Batho Pele* principles (DPSA, 2010).
3. The UN Millennium Development Goals Report: www.un.org/millenniumgoals/reports.shtml.
4. The rights of healthcare service providers applicable to your profession (e.g. the rights of nurses/midwives).
5. The ICN Strategic Plan 2014–2018 (www.icn.ch).
6. Access *The Nursing Ethos* used as the basis for celebrating Nurses Day on the 12th of May each year (www.careuk.com/sites/default/files/CareUK_Nursing_Ethos.pdf).
7. Compile a table reflecting the rights of the patient as contained in international and national sources.

References

Castell, F. 2008. Professionalism in nursing practice. *Nursing Journal.* 12:13–17.

Democratic Nursing Organisation of South Africa (DENOSA): www.denosa.org.za.

Department of Public Services (DPSA). 2010. *Batho pele – People First. Know your service rights and responsibilities. YOU, Integrated Social Protection, Human Development and Human Settlements.* 2nd edition. Available: www.dpsa.gov.za/batho-pele/docs/Know%20your%20Service%20rights/English.pdf [2015, July 1].

Frenk, J. 2010. *The global health system: strengthening national health systems as the next step for global progress.* Available: www.ncbi.nlm.nih.gov/pmc/articles/PMC2797599 [2015, July 1].

International Council of Nurses (ICN). 1973. *ICN on health and human rights.* ICN: Geneva.

International Council of Nurses (ICN). 2005. *Regulation terminology: International Council of Nurses*, November 2005, version1. Available: www.area-c54.it/public/regulation%20terminology.pdf [2015, July 1].
International Council of Nurses (ICN). 2014. *The ICN definition of nursing.* Available: www.icn.ch/who-we-are/icn-definition-of-nursing [2015, 1 July].
Institute of Directors in Southern Africa (IoDSA). 2009: *King Report on Governance for South Africa.* Institute of Directors in Southern Africa: Johannesburg.
Landman, WA. 2002. Nursing: The Profession of Caring. *Nursing Update.* 26(1):21–22. DENOSA: Pretoria.
Mankins, C. & Steele, R. 2011. Turning great strategy into great performance. In *HRB's 10 Must Reads: On Strategy.* Harvard Business Review Press. Boston.
Medical Tourism Association of South Africa: www.medicaltourismassociation.org.za.
Muller, ME. 2002. *Nursing dynamics.* 3rd ed. Heinemann: Sandton.
Muller, ME. 2009. *Nursing dynamics.* 4th ed. Heinemann: Sandton.
National Department of Health. 1999. *A Patients' Rights Charter.* Pretoria: Department of Health.
National Department of Health. 2011. *National Core Standards for Health Establishments in South Africa.* National Department of Health: Pretoria.
National Department of Health. 2012. *eHealth Strategy South Africa 2012–2016.* National Department of Health: Pretoria.
National Planning Commission. 2011. *National Development Plan Vision 2030. Our Future – Make it Work.* The Presidency. Sirino Printers: Pretoria.
Searle C. 1969. *A South African nurses' credo.* South African Nursing Association: Pretoria.
Searle C. 1987. *Ethos of nursing and midwifery: a general perspective.* Butterworth: Durban.
South Africa (Republic). 1996. *Constitution of the Republic of South Africa.* 1996. Government Printer: Pretoria.
South Africa (Republic). 1997. *White Paper on Transforming Public Service Delivery. Batho Pele White Paper.* No. 18340 of 1997. Government Printer: Pretoria.
South Africa (Republic). 2000. *Promotion of Access to Information Act.* No. 2 of 2000. Government Printer: Pretoria.
South Africa (Republic). 2000. *Promotion of Administrative Justice Act.* No. 3 of 2000. Government Printer. Pretoria.
South Africa (Republic). 2000. *Promotion of Equality and Prevention of Unfair Discrimination Act.* No. 4 of 2000. Government Printer. Pretoria.
South Africa (Republic). 2003. *National Health Act.* No. 61 of 2003. Government Printer: Pretoria.
South Africa (Republic). 2005. *Nursing Act.* No. 33 of 2005. Government Printer: Pretoria.
South Africa (Republic). 2008. *Companies Act.* No. 71 of 2008, as amended 2011. Government Printer: Pretoria.
South African Nursing Council (SANC). 2004. *Charter of nursing practice.* Available: www.sanc.co.za/pdf/charter%20draft.pdf [2015, July 1].
South African Nursing Council (SANC). n.d. *Nurses rights.* Available: www.sanc.org.za/policyrights.htm [2015, July 1].
United Nations (UN). 2010. *The Millennium Development Goals Report 2010.* United Nations: New York.
United Nations (UN). 2013. *The Millennium Development Goals Report 2013.* United Nations: New York. Available: www.un.org/millenniumgoals/pdf/report-2013/mdg-report-2013-english.pdf [2015, July 1].

World Health Organization (WHO). 2007. Health systems framework. Available: www.wpro.who.int/health_services/health_systems_framework/en [2015, July 1].
World Health Organization (WHO). 2011. *Strategic directions for strengthening nursing and midwifery services – 2011–2015.* Available: www.who.int/hrh/resources/nmsd/en [2015, July 1].