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Creating Future Leaders

A model to promote moral regeneration among nurses in Limpopo province, South Africa

by

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DECLARATION

I, Nkhensani Grace Shiluvane hereby declare that thesis entitled '***A model to promote moral regeneration among nurses in Limpopo province, South Africa***' *is* my own original work. It has not been submitted before for any degree or examination at this university or any other university and all the sources that I have used or quoted are indicated and acknowledged as complete references.

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Place : University of Venda

Date : 24 February 2020

DEDICATION

This dissertation is dedicated to my late parents Thomas Huxley Mabyalane and Evelyn Maureen Mabyalane, my loving and ever-supportive husband Berry Maxangu Shiluvane and my wonderful children (Basani, Dumisani, Hlavutelo and my granddaughters Nyasha, Zazi, Andzani and grandson Hlumelo).

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ABSTRACT

Moral regeneration involves the recognition and application of universal moral values. These moral values include human dignity, equality and freedom. However, the most important value is human dignity, as agreed to by all South African. The purpose of the study was to develop a model that could promote moral regeneration among nurses in Limpopo Province, South Africa.

The study adopted multiphase methods consisting of three phases. Phase 1 which is an empirical phase includes both quantitative (stage1) and qualitative (stage 2) research approaches. The population for the quantitative approach involved different categories of nurses. A stratified sampling technique was used to sample 160 nurses. Data was collected through a self-administered questionnaire and analysed statistically. The findings of this study revealed that some nurses do practice ethical and ethical-moral behaviour and possess knowledge regarding ethical-moral behaviour. It was also clear that the majority of this knowledge was predicted by race and religion. Those who were Christians were found to be the main significant contributors to the prediction of knowledge regarding ethical and ethical-moral behaviour. The population for the qualitative approach involved patients who were purposefully sampled. Data was collected through individual face to face with 18 participants and focus group interviews with 60 participants. Data were analysed using eight steps as described by Techs. Results from patients revealed both positive and negative responses. Some participants indicated that most of the time interaction with the elderly people were observed as being poor and nurses usually spend most of their time with other younger patients rather than the elderly. Nurses were said to be harsh and rude to patients.

Patients' positive views included that some nurses displayed empathy and sympathy and caring behaviours. Some participants feared to tell the truth because they feared being victimised. Validity, reliability and trustworthiness were ensured. Ethical principles were adhered to.

Phase 2 involved concept analysis which was conducted using Walker and Avant steps to clarify and distinguish the definition of the identified concept and model development applying the framework of Dickoff, James and Wiedenbach (1968). During phase 3 the model was validated using a quantitative approach. Recommendations were made concerning the promotion of good ethical behaviour among nurses in Limpopo Province. The recommendation was also made regarding nursing practice, community, regulatory body and hospital, education, policies and future research. This study concludes that patients' views regarding nurses unacceptable ethical behaviour are a problem to them and impacts negatively on their wellbeing when hospitalized.

Keywords: ethical-moral behaviour, morals, moral regeneration, nurses, value

LIST OF ABBREVIATIONS

MMR	Mixed method research
SANC	South African Nursing Council
SPSS	Statistical Package for Social Science
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
PLWHA	People living with HIV& AIDS
ICN	International Council of Nurses
ANA	American Nurses Association
CAN	Canadian Nurse Association
PCV	Principal Component Analysis
MOHME	Ministry of Health and Medical Education
STI	Sexually transmitted infections
CHW’s	Community Health Worker
USA	United States of America
NCE	National Code of Ethics
TOP	Termination of pregnancy
PHC	Primary Health Care

PNs	Professional nurses
ENS	Enrolled Nurses
ENA	Enrolled Nursing Auxiliary

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Nursing can be described as the protection, promotion, and optimisation of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations (Stichler, 2014). Florence Nightingale believed that her work was a calling from God, and she dedicated her life to advocating important changes that would ensure the best health for many people and alleviate the suffering of the sick and disabled. Nightingale defined nursing in terms that remain acceptable today, as a noble profession and discipline that is scientifically based, influenced by caring and compassion, and advocating the implementation of changes based on solid research and evidence (Stichler, 2014).

Nightingale was concerned about the moral character of persons. Nurses who came under Nightingale's sphere of influence were expected to develop certain exemplary habits of moral behaviour. It is therefore imperative that a nurse displays a high level of moral behaviour when practising her/his profession. This will require somebody with a well-developed value system and internalised ethical behaviour. Values are personal beliefs and attitudes about what is true and worthy of any thoughts, behaviour they give direction and meaning to one's life. It indicates something very important values (Stichler,

2014). It can be managed from a personal and professional level and can be an instrument of making a decision (Stichler, 2014). It is therefore assumed that nurses as human beings have values that direct and give meaning to their lives. It is therefore important to note that these values are building blocks for the persons' morals. Values are the starting point for morality and ethics as they interact with both morals and ethics (Stichler, 2014).

Morals and ethics develop over a long time in life and originate from things valued. Morals have to do with what is right and wrong just or unjust (Arieli, Sagiv & Roccas, 2020). Morals are, therefore, influenced by the values that one holds, which means that the nurses' perception of what is right or wrong is influenced by the values that the person has towards that particular thing (Arieli et al, 2020).

Morality means "manner, character, proper behaviour") is the differentiation of intentions, decisions, and actions between those that are distinguished as proper and those that are improper. Morality can be standards or principles derived from a code of conduct from a particular philosophy, religion, or culture, or it can derive from a standard that a person believes should be universal. Morality may also be specifically synonymous with "goodness" or "rightness.", or knowledge about morals (Pitak-Arnnop, Dhanuthai, Hemprich and Pausch, 2012). "One should treat others as one would like others to treat oneself." but *ethics* is and has always been debatable. In nursing, as in life generally, nurses are presented with all sorts of issues and situations to which they should react. Many of the problems that nurses are facing have to do with things like being honest, doing good, having a choice, valuing someone's worth and being fair about what is being done to other people (Pitak-Arnnop, Dhanuthai, Hemprich and Pausch, 2012).

Nursing as a profession that deals with people have a set of acceptable ethical behaviour that guides how they care for patients. Ethics are the set of moral principles that guide a person's behaviour. Ethics reflect beliefs about what is right, what is wrong, what is just, what is unjust, what is good, and what is bad in terms of human behaviour. They serve as a compass to direct how people should behave toward each other, understand and fulfil their obligations to society, and live their lives (Pitak-Arnnop, Dhanuthai, Hemprich, and Pausch: 2012).

Moral decay means moral corruption or depravity. It refers to a process whereby morality degrades. This leads to a decline in quality of life and hence as a whole, the nation also suffers (Zajac,1996). Due to degradation in **moral**, the societies disintegrate and everyone bears the brunt thereof (Zajac,1996).

Academics are also worried about this "moral vacuum". It seems as if something important has disappeared and nothing good has replaced it. The decline in morality also experienced in the South African and African continent as a whole (Osafo, 2016).

Post-1994 South Africans received freedom and their democratically elected new government. The legacy of apartheid manifested itself in different ways; the black on black violence persisted despite the achievement of democracy. People were killing one other, woman abuse escalated, young people were exposed to drugs, teenagers falling pregnant and many more atrocities persisted. Seeing that there is moral decay in communities and the whole of South Africa, Dr Nelson Mandela introduced the concept of the Moral Regeneration Movement which he termed the Reconstruction Development

Programme (RDP) of the soul. This was an effort to resuscitate morality among the fellow citizens of South Africa. He then invited the religious leaders to come with a solution to fight the moral decay in society. This led to the formation of the Moral Regeneration Movement. It was also realised that the issue of Moral Regeneration is not the preserve of the religious people only but every citizen and sectors who love this country should join hands in the fight against moral decay (Rauch, 2005). This moral degeneration is also experienced within the different institution and the hospital is no exceptions. Nurses providing care also co-exist in such communities which do not exclude them from exhibiting such characters as seen in communities. This decay affects their relationship with colleagues and patients. It is against this background that the study sought to develop a model to promote moral regeneration amongst nurses in Limpopo province.

Different studies considered the conduct of nurses while providing care to the patients (Wang, Wang, Wang & Gu, 2013; Devenish, 2012; Pfaff, Baxter, Jack & Ploeg, 2014). From these studies, it has been observed that there are both positive and negative reports as reflected in these studies (Wang, Wang, Wang & Gu, 2013; Devenish, 2012; Pfaff, Baxter, Jack & Ploeg, 2014).

An Iranian study, conducted by Zahedi, Sanjari, Peymani, Parsapour, Bagher Maddah, Cheraghi, Mirzabeigi, Larijani and Dastgerdi (2013), showed that nurses were responsible for providing their clients/patients with high-quality care. However, nurses face various ethical challenges in their professional practice, requiring them to be familiar with the ethical codes of conduct and the essentials of ethical decision making, in order to nurse their patients in totality.

Codes of ethics have been adopted by many professions, including the nursing profession. Nursing's ethical codes have been published by nearly every recognised professional group worldwide. The first international code of ethics for nurses was adopted by the International Council of Nurses (ICN) in 1953. The two codes, prepared by the American Nurses Association (ANA) and the Canadian Nurse Association (CAN), are examples of national codes of ethics for nurses. These codes outline how the nurses should behave ethically as professional persons, and how they should act when they encounter barriers preventing them from fulfilling their professional obligations. These codes also support nurses in their practice and reduce their moral distress (Zahedi et al., 2013)

In Iran, studies have shown nurses weaknesses concerning their knowledge of ethics and its application in practice. In a qualitative study, carried out by Zahedi et al. (2013), the nurses identified a "lack of a code of ethics" as posing a barrier to patient advocacy. Zahedi et al. (2013) also reviewed nursing codes of ethics and emphasised the necessity of compiling a national code of ethics for nurses in health care settings in 2008. They suggested an adapted code of ethics considering the cultural context and the Islamic background of Iran.

Considering the growing activities in the field of medical and health care ethics in Iran, and in order to address the needs and to help actualise the goals of the health care system in that country, the National Code of Ethics for Nurses was prepared under the supervision of the Ministry of Health and Medical Education (MOHME). It was expected that the Code of Ethics for Nurses would effectively serve the interests and needs of the profession since it illustrated moral and professional obligations of nurses for preventing diseases, promoting

health in society, communicating with colleagues, managing health care systems, and performing research activities (Zahedi et al, 2013).

The study conducted in Canada by Pfaff, Baxter, Jack and Ploeg (2014) emphasised that the nursing profession has traditionally maintained a high standard of moral behaviour and ethical practice. However, nurses in clinical practice often reported experiencing moral distress when they did not believe that the treatment provided to the patient was in the best interest of the patient. A moral environment has been described as that which “encourages respectful interactions with colleagues, support of peers, and identification of issues that need to be addressed. There is some evidence that the symptoms of moral distress surface more readily when the ethical climate of an organisation is not supportive or respectful of nursing practice” (Pfaff et al., 2014). The results also indicated that the term ethical environment described a workplace environment that supported open reflection and discussion of nurses’ work. An ethical environment also supports both ethical decision-making related to patient care and respectful treatment of staff via policies, organisational philosophy and conflict resolution procedures *(*Pfaff et al., 2014).

Changes in society and the nursing profession have led to a realignment of the functions and roles of nurses and, concomitantly, brought about scrutiny of their ethical dimensions (Wang, Wang, Wang & Gu, 2013). Political, scientific, and social events of the past decade have aroused public awareness about moral discourse (Wang et al., 2013), forcing professionals to address this problem. Curricula in the health professions are beginning to emphasise humanistic studies assisting students to consider moral behaviour. Furthermore, health professionals are attempting to inculcate values in their students to enable them to

reason critically about ethical issues and to enhance their ethical decision-making processes (Wang et al., 2013).

In South Africa, moral regeneration involved the recognition and application of universal moral values, and these moral values include human dignity, equality and freedom. However, the most important one is human dignity as agreed by South Africans (Devenish, 2012). This author emphasised that the moral regeneration movement aimed to encourage people to entrust the effort of building communities, grounded on positive moral values and dedication, to building a caring society, in pursuit of creating lasting peace and prosperity in South Africa. For this reason, moral regeneration is essential in both the private and public sectors if South Africa wants to succeed as a nation (Devenish, 2012).

1.2 BACKGROUND

Nursing's origins as a profession can be traced to a school founded by Florence Nightingale in England in 1860. This position as a profession was further cemented by the "Nightingale Pledge," developed in 1893. Further, the code of conduct for nursing professionals not only promoted health and prevented illness but also ensured caring for patients experiencing varying degrees of physical, psychological and/or spiritual suffering (Mishra, 2015). Before 1960, the focus of the nursing code was on nurses' obedience to physicians, but since then patient care has remained the cornerstone of nurses' activities. Thus, the wholeness of character, which involves integrity, knowing the value of the nursing profession and one's own moral values, is central to the value system of the nursing profession (Mishra, 2015). India and many other countries face critical nursing shortages. Globally, communities are challenged by growing health care needs and diminishing numbers of professional nurses.

It has been projected that by the year 2020, the shortage of professional nurses would be 20% below the requirements (Mishra, 2015).

Hughes, Locock and Ziebland (2013) assert that the moral attitudes of nurses posed threats to their moral integrity. Thus, moral problems perceived by nurses and the emotional consequences of these problems should be considered. These authors' findings also showed that nurses might fail to recognise the moral dimensions of their experienced problems and lacked the skills required to resolve moral problems adequately. The moral problems perceived by these nurses related to end-of-life issues, communication with patients, the suffering of patients and the appropriateness of patients' medical treatments (Hughes et al., 2013).

Huffman and Rittenmeyer (2012) indicated that registered nurses had professional ethical commitments to provide nursing care based on patients' needs regardless of ethnicity, race or class and to promote social justice through developing equitable health policies (CNA, 2014). It was explained that differences in the quality of care of those nurses identified as being 'difficult' included delaying care, avoiding patients, making inaccurate assessments, withholding treatment, providing limited care (such as physical care only), providing limited information, and inappropriate behaviour such roughness when providing care. These results also showed that negative responses to patients occurred when individual behaviours were inconsistent with what the provider considered to be in the best interest of the person. Under these circumstances, some nurses continued to offer choices regardless of previous decisions or behaviours. The results described the person as "not yet ready to make a change", by emphasising that they needed to continue caring for a person perceived

to suffer from a life-threatening illness, who required care. To resist blaming individuals for failing to take personal responsibility for their health, nurses shifted their focus to the development of decision-making capacity, to enhance access to health (CNA, 2014).

In a study conducted in Kenya and Zambia, Warenius, Faxelid, Chishimba, Musandu, Ongány and Nissen (2015) emphasised that nurses moral behaviour discouraged young people from attending clinics for follow-up visits. For example, some young patients suffering from sexually transmitted infections (STIs), turned to traditional healers due to the insensitive attitudes of health professionals. Furthermore, Adolescents faced difficulties in obtaining contraceptives at public health facilities. In addition, young women who requested termination of pregnancy (TOP) services and/or post TOP care, commonly encountered negative staff attitudes (Warenius et al., 2015). The personal views and values of health professionals, including nurse midwives, might affect the quality of care as well as the accessibility of health care services. The attitudes of health providers should thus encourage adolescents to utilise sexual and reproductive health services (Warenius et al., 2015). Hence, this study was designed to explore the perceptions of patients regarding the ethical behaviour of nurses, to explore the views of patients regarding ethical-moral behaviour of nurses, and to assess the knowledge of nurses regarding their ethical moral behaviour. This information would be used to develop a model to promote moral regeneration among nurses in the Limpopo Province.

Bhengu (2016) maintained that South African nurses could not speak about the quality of nursing care, like the pioneer South African nurse educator, Sister Henrietta Stockdale did, as there was a deterioration in the quality of nursing care. This was supported by the Nursing

Strategy for South Africa, in which the then Minister of Health alluded to a perceived decline in the quality of standards of care provided by certain sections of the health professions. Members of the ministerial task team reiterated this concern about the quality in the National Strategic Plan for Nurse Education, Training and Practice (2012/13–2016/17). Studies were cited in this document, in which students admitted feeling unprepared to fulfil their nursing roles (Bhengu, 2016). Poor-quality care in various public hospitals has been published in media reports. For example, patients have turned away without receiving help, with the subsequent birth of an infant in the street (Daily Sun,

28 August 2013). Other reports pertained to the deterioration of wounds (The Times, 21 August 2013), the death of patients due to late attention by health care workers (Daily News, 27 August 2013), poor nursing care resulting in inadequate wound cleaning and, thus, nearly losing a limb (The Times, 21 August 2013), ignoring requests for a bedpan (The Times, 21 August 2013), and the death of an infant due to negligence (Daily News, 27 August 2013). Such acts of negligence were reportedly accompanied by comments indicative of nurses uncaring attitudes, such as: “If you die, it will be God’s plan and not our fault”. The Daily Sun, 28 August 2013 reported that “the level of service has sunk so low that many patients simply stay away”, defeating the purpose of primary health care (PHC), which is to encourage the utilisation of health care services. In March 2015, South Africa’s then Minister of Health convened a medico-legal summit out of concern that state funds were predominantly spent on litigations at the expense of the improvement of health services and quality of care, as espoused in the 10-point plan and PHC re-engineering programme (Bhengu, 2016).

1.3 RESEARCH RATIONALE

The researcher is a nurse educator at Limpopo College of Nursing (Giyani Campus) for the past 17 years to date, during which the researcher, as a nurse educator accompanying students in clinical areas, has also noticed that the relationships between nurses, patients and management are often strained. In this capacity and context observed and experienced that there is a problem of non-adherence to the correct code of ethics, which should govern their moral and ethical behaviour when caring for patients.

It was identified that there is a gap in the field of moral regeneration among nurses, *nurses need* to have positive attitudes towards patient care if good quality care is to be provided. Poor attitudes of nurses, resulting in poor patient care, could severely undermine the ability of the health system to provide quality care and improve outcomes for patients. Incidences of poor patient care and even willful neglect of patients' basic care, as well as on lack of management support. (Haskins, Phakathi, Grant, and Harwood, 2014). It is against this backdrop that the researcher was propelled to undertake the study and investigate, amongst others; possible reasons for such a hence the importance of the study.

1.4 PROBLEM STATEMENT

Nurses work at the frontlines of most healthcare systems, and their contributions are recognised as essential in delivering effective patient care. Providing quality nursing care is, therefore, an important consideration when discussing patient care standards. Nurses who are satisfied with their work and with the conditions under which care is provided are more likely to provide quality care that satisfies the patient. The attitude that a nurse holds towards patients and their state of ill health strongly determines the quality and extent of the

emotional, physical, and psychological help that patients receive from that nurse. Negative reports on the radio, television, and newspapers where it is indicated that there were challenges pertaining to nurses ethical-moral behaviour (Devenish, 2012) In Limpopo Province, nurses with professional misconduct 31 nurses were awaiting disciplinary hearings from 2008 to June 2012. These offences included fraud/forgery (3); maternity-related issues (5); medication-related issues (2), physical assaults of patients (1), and providing poor basic nursing care (20). Thirty persons were found guilty (Government Gazette, 09 March 2012).

Nurses with professional misconduct 26 nurses awaiting disciplinary hearing from 2013 to November 2017. These offences included fraud/forgery (3); maternity-related issues (6); medication-related issues (7), physical assaults of patients (2), and providing poor basic nursing care (6) and acting beyond scope of practice (2).

Nurses with professional misconduct, 27 nurses awaiting disciplinary hearing from 2018 to November 2020. These offences included fraud/forgery (4); maternity-related issues (5); medication-related issues (7), physical assaults of patients (4), and providing poor basic nursing care (4) and acting beyond scope of practice (3). According to the South African Nursing Council's (SANC's) professional conduct registry, poor quality care is often provided to patients. This observation is based on an increased number of complaints and professional conduct cases involving poor nursing care (46%), followed by midwifery cases comprising poor midwifery care (30%), with 74% of the perpetrators being registered nurses who are the highest trained cadre of South African nurses (SANC, 2013).

Negative behaviours observed in hospital related to rudeness: “some (nurses) do not care how they talk with the patients, they are rude to patients, they shout”. Other negative behaviours related to poor nursing care when patients were not helped to the toilet or being fed: “the nurses are not giving the patient food, the food will come and be placed next to the patient until the ‘aunties’ come and take it away, that patient who is unable to feed herself”

1.5 RESEARCH QUESTION

A research question is the specific query researchers want to answer in addressing the research problem. A research question guides the types of data to be collected in a study. Researchers, who make specific predictions about answers to research questions, pose hypotheses that are tested empirically (Polit & Beck, 2014). This study sought to address the following questions:

- What are the views of patients regarding the ethical-moral behaviour of nurses?
- What is the knowledge of nurses regarding ethical-moral behaviour?
- How can moral regeneration be promoted among nurses in Limpopo Province?

1.6 PURPOSE OF THE STUDY

The purpose of this study was to develop a model that could promote the moral regeneration of nurses in the Limpopo Province of South Africa. The model could help to improve support, resources and structures to enhance nurses moral behaviour.

1.7 OBJECTIVES

An objective denotes the concrete, measurable and attainable conception of such an end towards which the effort or ambition is directed (De Vos, 2011). These objectives were developed in line with Kohlberg's theory of moral development from view to the stage of having internalised specific behaviour.

The objectives of the study were to:

- explore the views of patients regarding the ethical-moral behaviour of nurses
- assess the knowledge of nurses regarding their ethical-moral behaviour
- develop a model to promote moral regeneration among nurses of the Limpopo Province

1.8 SIGNIFICANCE OF THE STUDY

The present study is significant for different groups that might benefit from reading and using the study's findings, creating a clear rationale for the importance of the study (Creswell, 2017).

- **Significance for patients**

The purpose of the study was to develop a model to promote nurses' moral regeneration so that the nursing care rendered to the patients would be of an acceptable standard. The study could also enable nurses, in the context of their daily work, to focus on the basics of nursing care and embark on the process of moral regeneration. Nurses could behave in accordance with the expectations of the norms and values that are cherished in society and acceptable

within nursing practice. A nurse could be a person who always observes, listens and responds, where necessary with humanity. Hence nurses' commitment towards patients should be practised in hospitals. Nurses should also seriously consider patients/clients as whole persons, practise good culture and recognise a person for what he/she is.

- **Significance for nurses**

Moral regeneration could be an awakening of the self, doing self-introspection in the institutions. Patients/clients could also benefit because morality and loyalty would be enhanced. Moral regeneration could promote good conduct and encourage nurses to steer clear of social ills and lead a life guided by moral values. Moral regeneration could assist in the development of respecting patients' dignity. The study could highlight a need for including moral development in student nurses' curriculum to empower them with knowledge about ethical behaviour and morals.

- **Policy development**

The findings of the study could assist in policy development concerning moral regeneration.

1.9 FOUNDATION OF THE STUDY

1.9.1 Theoretical Framework

A framework represents the overall conceptual underpinnings of a study. It is a group of interconnected thoughts or ideas that provides direction to the research project. It is a research instrument that enables a researcher to organise all other aspects from the research question, literature review, data collection, sampling procedures, analysis and interpretation (Saunders, Lewis & Thornhill, 2013). A theoretical framework refers to a theory

on which a study is based (Polit & Beck, 2014). Kohlberg's Theory of Moral Development directed this study. The theory was proposed by Lawrence Kohlberg in 1958, focussing on the development of morals in children. The theory believes that morals in humans are developed sequentially depending on the cognitive development of an individual. It shows the extent to which an individual had internalised the social rules and values (Bužgová & Sikorová, 2012).

In nursing, this theory has been used to explain and solve problems relating to morality in clinical and educational settings (McLeod-Sordjan, 2014). The theory is divided into three levels which are further divided into six stages, as illustrated in Figure 1.1. The following section provides a more detailed description of the six stages of Kohlberg's Theory of Moral Development.

1.9.1.1 Pre-conventional morality

This first level of Kohlberg's Theory of Moral Development comprises two initial stages and six subsequent stages. At this level, morality is based on punishment and reward. It is centred on the self, gaining more rewards than punishment. At this stage, professional nurses struggle with ethical practice and moral dilemmas. The nurse's behaviour might be influenced by the attitudes of the patients, workload, religious values and support from colleagues and other health team members. The professional nurse, at this stage, performs the task to avoid litigations and punishment. The professional nurse renders the required care to patients to avoid litigations, or any other legal actions, which could occur if documented care has not actually been rendered to a patient.

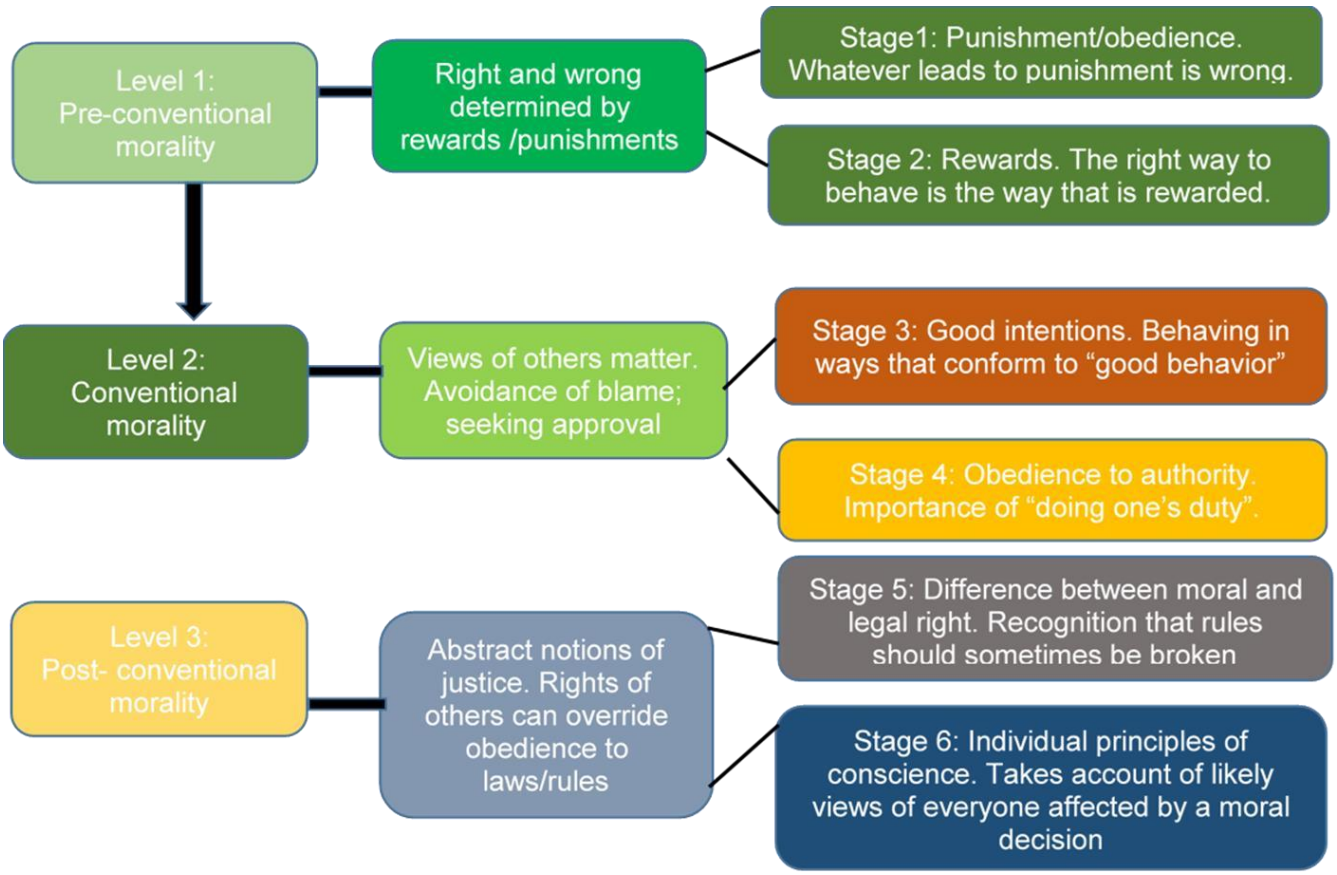

Figure 0.1.1 Kohlberg's Theory of Moral Development

1.9.1.2 Conventional morality

At the second level of Kohlberg's Theory of Moral Development, an individual's action is characterised by conformity with societal rules and regulations, irrespective of the consequences of these actions on others. The professional nurse, at this stage, in addition to avoiding legal problems, performs duty-bound actions according to the ethical codes of the profession and at the same time respects societal norms and values.

However, a professional nurse might be unable to provide optimal care because of organisational bureaucracy and/or the unavailability of resources required to provide optimal care to patients.

1.9.1.3 Post-conventional morality

At this third and highest level, the actions of an individual are informed by the respect an individual possesses for others and common values. The moral integrity of an individual at this stage is maintained. At this stage, the individual shows respect for both society and him/herself (Kim & An, 2017). The professional nurse has reached a high level of moral maturity and renders high-quality care to the patients without thinking about the self, but thinking about the patients. The nurse spends more time with the patients and might work longer than required and his/her actions are not determined by the availability of resources but by the optimal care of the patient.

1.9.2 Application of Kohlberg's Theory of Moral Development to this study

Caring, based on ethical principles, is an indispensable part of nursing practice (Ebrahimi, Nikravesh, Oslouie and Ahmadi, 2015). In clinical nursing, professional nurses make decisions concerning patients' care and well-being. These decisions are made based on the ethical principles of nursing and the morality level of an individual nurse. In this current study, Kohlberg's Theory of Moral Development was used to identify the ethical behaviour of nurses in the Limpopo Province, South Africa, based on their level of morality. The participants and respondents comprised hospitalised patients and all categories of nurses. The theory was also used during the literature review to identify gaps existing in the ethical behaviour and morality of nurses. Kohlberg's Theory of Moral Development also informed the components involved in the model of moral regeneration developed for all categories of nurses, based on this study's findings.

Pre-conventional level - the researcher explored patients' perceptions about nurses ethical and moral behaviour exhibited to patients while providing nursing care.

Conventional and post-conventional level - the researcher explored the level of knowledge the professional nurses possessed concerning nursing ethics, the morals of nurses and the identification of organisational barriers that could impede nurses decision-making processes that might affect patients and nurses.

1.10 RESEARCH DESIGN

According to Burns and Grove (2016), the design of a study is the result of a series of decisions made by the researcher concerning how the study would be conducted. Burns and Grove (2016) also defined a research design as "a blueprint for conducting the study that maximizes control over factors that could interfere with validity and findings". Research designs are plans and procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis (Creswell, 2017). The study adopted the multiphase approach consisting of three phases. Phase I: Empirical phase (Quantitative research, (Stage1) and Qualitative research, (stage 2)), Phase 2: involves concept analysis and model development and lastly phase 3 which involved model validation.

1.10.1 Phase 1 Empirical Phase

1.10.1.1 Stage 1 Quantitative Study

A cross-sectional descriptive design was used for the quantitative component. The population consisted of all categories of nurses who were selected initially using stratified

sampling techniques (according to nurses' categories) and thereafter randomly selecting respondents within each stratum. Self-administered questionnaires were distributed and computer-generated tables were used. A total of 180 questionnaires were distributed and self-administered by the author. The number of nurses per category were out of 267, 180 nurses were given questionnaires, 180 x 35% = 63 (sixty-three) enrolled nursing auxiliary, 180 x 28%= 50 (fifty) enrolled nurses and 180 x 37%= 67 (sixty-seven) professional nurses, and 18 (eighteen) were spoiled. Quantitative data were analysed using descriptive and inferential statistics using the Statistical Package for Social Sciences (SPSS) Version 25. A statistician assisted with the analysis and interpretation of the data.

1.10.1.2 Stage 2 Qualitative Study

Description involved the collection of qualitative data through semi-structured focus groups and individual interviews with patients. The study populations included patients admitted to the hospital for four days in the selected hospitals in Limpopo Province, South Africa. Participants were selected through the purposive sampling method, and data was collected through focus groups and in-depth individual interviews. Eighteen (18) participants were involved in the in-depth interviews. Sixty (60) participants were included in the focus groups. Data were analysed using Techs eight steps and trustworthiness was ensured.

1.10.2 Phase 2 Concept Analysis

The aim of phase two was to do concept analysis following eight steps:

- Selecting one or more concepts
- Determining the purpose of the analysis
- Identifying all uses of the concept(s)

- Determining defining attributes and characteristics
- Identifying model cases
- Constructing borderline, related, contrary, invented and illegitimate cases
- Identifying antecedents and consequences; and
- Defining empirical referents

Model development was done using the framework of the practice-oriented model of Dickoff, et al (1968). The practice-oriented model consists of the survey list which includes the following: agents, patience, framework, terminus, procedure and dynamics.

1.10.3 Phase 3: Model validation

A quantitative approach was used to validate the model. The population used during this phase was all nurses from the selected hospitals with two or more years' working experience in the Mopani and Vhembe districts of Limpopo Province. Simple random sampling was used to select one hospital from the two districts: namely, Mopani district (Letaba Hospital), and Vhembe district (Elim Hospital) of Limpopo Province.

Stratified random sampling was used to group nurses into different categories and simple random sampling was used to select the nurses from each stratum. Forty (40) per hospital making a total of 80 nurses. The workshop was conducted to orientate nurses on the use of the model. The questionnaires were distributed to all categories of nurses. Each respondent completed the questionnaires in his /her own time. Data were analyzed by a statistician using SPSS version 25. The researcher wanted nurses to validate a developed model to promote moral regeneration.

1.11 DEFINITIONS OF CONCEPTS

1.11.1 Promote

WHO (2019) defines promote as “the process of enabling people to increase their control over or improve their health behaviour, lecturing or about pushing people into making huge changes in their lives and partnership towards making agreed changes and taking things one small step at a time.

Moral refers to the domain of personal values and the rules of behaviour regulating social intercourse (Thompson et al, 2012). The Oxford South African School Dictionary (2014) defines promotion as helping the progress of something. In this study, promote implies the development of progress in the moral, ethical behaviour of nurses towards patients.

1.11.2 Moral

Moral means to be mindful about the choices in life that have good or evil consequences (Gert, 2005). Moral means the study of the development of the moral sense i.e. of the opacity for forming judgements about what is morally right or wrong, good or bad (Kohlberg, 2015)

The moral is concerned with the principles or rules of right conduct or distinction between right or wrong; ethical: moral attitudes (Britannica dictionary, 2010). In this study moral implies good behaviour of nurses while providing care to clients/patients.

1.11.3 Regeneration

Regeneration is to be ‘re-born, brought again into existence, formed a new and restored to better or process of regenerating or a state of being regenerated, rebirth or renewal (Burke,

2017). Regeneration is the process of regenerating- renewing or restoring something, especially after it has been damaged or lost (Medical dictionary, 2012). In this study, regeneration implies nurses' renewal of loving-kindness, compassion, sympathetic joy, responsibility, discipline, honesty, and respect for human values, dignity and rights of hospitalized patients.

1.11.4 Nurse

A nurse is a person who has completed a program of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practice nursing in his/her country. The nurse is prepared and authorized to engage in the general scope of nursing practice, including the promotion of health, prevention of illness, care of physically ill, mentally ill, and disabled people of all ages, in all health care and other community settings, to carry out health care teaching, to supervise and train nursing and health care auxiliaries (International Council of Nurses, 2017)

Nurse means a person who assists the individual, sick or well, in the performance of those activities contributing to health or its recovery that he would perform unaided if he had the necessary strength, will or knowledge (International Council of Nurses, 2017).

A person trained to care for the sick or infirm, especially in a hospital, trained to take charge of young children, give medical and other attention to a sick person, try to cure or alleviate by treating it carefully and protectively (Stichler, 2014). In this study, the term nurse will be used as defined in the International Council of Nurses, 1987.

1.11.5 Model

A model is a symbolic depiction of reality. It provides a schematic representation of a relationship among phenomena using symbols or a diagram to represent an idea. A model helps to structure the way any situation, event or group of individuals can be viewed (Chinn & Kramer, 2015).

A three-dimensional representation of a person or thing or a proposed structure, typical on a smaller scale than the original

In this study, a model was used in the form of a diagram to represent how moral regeneration could be promoted among nurses in the Limpopo Province of South Africa.

1.12 OUTLINE OF THE DISSERTATION

This dissertation comprises eight chapters.

- **CHAPTER 1:** Presented an overview of the study which included the introduction and background, research rationale to conduct the study, problem statement, purpose, research questions, objectives, significance, the foundation of the study, definition of concepts and research design.

- **CHAPTER 2:** Presented the literature review which entails the moral behaviour of nurses, ethical behaviour of nurses, unethical behaviour of nurses, the meaning of Ubuntu, Ubuntu in the health care service and professional attitudes in the health care service.

- **CHAPTER 3:** Involved research methods, research design, research setting, population, sampling, data collection methods and instrument and instrument, data analysis

- **CHAPTER 4:** Provides a detailed presentation from individual interviews, focus groups and interviews and questionnaires (nurses) Themes, Sub-themes and categories emerged. A literature control was used to contextualize the findings.

- **CHAPTER 5:** Presented the contextualization of the findings comparing the current study's findings with those reported in literature sources. The meta-inference and concept analysis as phase 3.

- **CHAPTER 6:** Discussed how the developed model will be implemented as phase 4. The following items were emphasized: overview, purpose and structure of the model. The structure of the model included assumptions on which the model was based, the definition of concepts, formulation of relation statements, the nature of the structure and description of the process.

- **CHAPTER 7:** Detailed guidelines to operationalize the model for moral regeneration are presented: The elements of the practice model discussed were: the context, agents, recipients, and dynamics as well as the procedure and outcome.

- **CHAPTER 8:** The conclusions and summary of the study, which indicates how the rationale, overall purpose and objectives of the study have been achieved. Justification in terms of the original contribution of the study to the body knowledge. Recommendations and limitations of the study were also provided.

1.14 Summary

This chapter provided an overview of the study, which included the introduction, background of the study, rationale for conducting the study, problem statement, purpose of the study, research questions, objectives of the study, significance of the study, the foundation of the study including the theoretical framework, definitions of terms, research design, and an outline of the dissertation.

The next chapter presents the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter addressed the overview of the study which includes introduction and background, problem statement, purpose, objectives, significance, the definition of concepts and methods. This chapter presents a literature review which is the study of literature available that is related to the topic under study. It entails searching, reading, finding, comprehending and reaching conclusions about published research and related theories concerning the topic. Marshall, Catherine, Gretchen and Rossman (2014) indicated that the literature review shares with readers the other studies' results that are closely related to a new study. It is a critically written summary of the state of existing knowledge on a research problem (Brink, 2006; Polit & Beck, 2012). The literature search helps the researcher to understand the research strategies, the context of the study, specific procedures and instruments needed to investigate the problem and what has already been researched and learned about the subject under study.

Burns and Grove (2009) indicate that the primary purpose of reviewing the literature is to gain a broader background to understand the information that is valuable and related to a problem. It also provides a framework for establishing the importance of the study as well as a benchmark for comparing a study's results with other studies' findings (Marshall et al., 2014).

2.2 SEARCH STRATEGY

Different search engines were used to find literature that was relevant to the topic which was: Google Scholar, Science Direct, PubMed, and other e-journal articles. The search was guided by the following search keywords: moral, ethics, values, moral behaviour, ethical behaviour, moral degeneration and moral regeneration. Data from the literature revealed the following themes: moral ethical behaviour, unethical behaviour, the meaning of Ubuntu, Ubuntu in the health care service and professional attitudes in health care.

2.2.1 MORAL BEHAVIOUR OF NURSES

Nurses face complex situations where they are expected to provide good care. Good care should enhance health integrity in physical, emotional, relational, social, moral, and spiritual dimensions. Poikkeus, Numminen, Suhonen and Leino-Kilpi (2015) indicated that nurses who participate actively in situations with moral behaviour problems invest themselves in these situations, and that passive nurses discount themselves, think about the risks of being committed to patients and tend to protect themselves and causes the state of mental and behavioural disengagement that prevent nurses from responding to moral dilemmas or even from recognising ethical issues (Poikkeus et al., 2015). Furthermore, nurses with passive attitudes experience the situation as outsiders and not their problems. This explains why the moral behaviour of nurses has sometimes been described as prohibited in their commitment to patients' experiences (Poikkeus et al., 2015). Nurses often fail to recognise the moral dimensions of the problems they experience and lack of skills they need to resolve moral problems. Lack of autonomy and authority influence their moral experience such as feelings of insecurity and powerlessness and this influence nurse's attitude to face moral problems.

Poikkeus et al. (2015) further explained that the moral attitudes of nurses are affected by factors related to their moral behaviour as well as to their levels of education, experience, their self-perceptions and include the nature of the conflict and ethical responsibilities when a nursing dilemma arises. This may result in a lack of recognition by other team members, lack of independence and power, more than often nurses may feel embarrassed by what others, especially colleagues, might think. This may lead to feelings of insecurity and not be able to nurse patients applying moral behaviour. Ebrahimi et al. (2015) studied nurses moral behaviour concerning decision-making in Iran and explained that the ethical dimension of nursing care is an essential element of nursing practice. Some nurses believe that being a nurse is a moral endeavour and almost every decision that a nurse makes has a moral dimension. However, there are ongoing concerns about the ethical practice of nurses. Performing ethical practice in the presence of daily moral dilemmas could be difficult. Nurses have a moral commitment not only to provide care for meeting the needs of a specific population, but also to develop the essential skills of critical thinking, ethical decision-making, conflict resolution, and the capability for supporting a specific population (Ebrahimi et al., 2015).

Pavlish, Brown-Saltzman, So and Wong (2016) indicated that nurse leaders and professional organisations have made it clear that nurse leaders are responsible for creating cultures that support acts of courage in nursing. These behaviours are seen in leaders who demonstrate moral courage (Pavlish et al., 2016). Similar courage in nursing was is noted in Choe, Kang and Park (2015) (a) where the courage to act in a morally distressing situation could relieve the initial moral distress felt by nurses in morally conflicting situations. It was also noted that the moral behaviour of nurses has been described as prohibiting their

commitment to relieving patients' suffering. It was reported that nurses did not experience moral problems as the most disturbing issue confronting them, as organisational issues caused more serious problems. Nurses are also experiencing other moral problems, such as communicating honestly with patients about their situations and death. It is further indicated that nurses were also afraid of destroying patients' hope and feelings of security, nurses who lacked skills cited feeling powerlessness, fearing another person's opinion, being disappointed, experiencing trauma, avoiding patients, and being uncertain. The same study further indicated that skilled nurses displayed courage and honesty, maintaining a questioning approach, reporting about patients' integrity and being confident about co-workers' capabilities (Choe et al., 2015a). Lack of autonomy and authority is beyond the control of nurses and could influence nurses moral experience. Feeling insecure and powerless might have a profound effect on nurses' perceptions and attitudes when facing moral problems (Choe et al., 2015a).

2.2.2 ETHICAL BEHAVIOUR OF NURSES

The study by Ebrahimi et al. (2015) conducted in Iran, revealed that ethical caring was essential in nursing practice and that nurses were confronted with complex situations requiring autonomous decisions to provide good care to patients. However, the results indicated that beyond nurses' legal duty to protect patients, the nurses showed dedication to their patients in nurses ethical decision-making behaviours. It was believed by some participants that being a nurse was a moral endeavour and almost every decision that a nurse made has a moral dimension. Therefore, nurses played a big role in good care to enhance total health encompassing physical, emotional, relational, social, moral and

spiritual dimensions. Ethical behaviour of nurses towards patients implies acting in ways that are consistent with one's values and commonly held values of the organisation and society as indicated by (Smith, 2015).

Smith, 2015 further indicated that ethical behaviour is the continuous effort of studying one's own moral beliefs and moral conduct and striving to ensure that he or she lives up to standards that are reasonable and solidly based. However, being professional implies ethical behaviour and knowledge of what it means to be ethical.

Furthermore, Smith (2015) explained that ethics comprises a significant component that guides nurses and the health care industry. The decisions about care and treatment are also becoming increasingly complex. Smith (2015) Another factor is that ethics distinguish right from wrong, prescribing what humans ought to do, usually in terms of rights, obligations, benefits to society, fairness, or specific virtues, and that it comes into play when they work, play, and at any time that they are interacting with patients (Smith, 2015). Nurses should practise ethically and they should adhere to ethical principles like autonomy, beneficence, justice, veracity, fidelity, confidentiality and privacy.

A study did by Numminen and Kilpi (2015) in Finland support the above authors by indicating that in modern health care environments, nurses' encounter ethical issues daily. These issues are not major dilemmas but are frequently minor issues that nurses face in their everyday contact with patients. Further, explain that newly graduated nurses' perceptions of their practice environment were mainly positive. Positive perceptions were also associated with higher levels of professional competence, more positive perceptions about the quality of care and fewer intentions to leave the job or profession (Numminen & Kilpi, 2015). Nurses

with positive perceptions and good personal views about patients usually render quality care. Hence a model to promote moral regeneration among nurses in Limpopo is necessary.

2.2.3 UNETHICAL BEHAVIOUR OF NURSES

The study by Hoyt and Price (2015) indicated that nurses have difficulty coping with the ethical dimension of care in practice. Nurses often act according to their values and norms generate internal moral distress, which has negative impacts on both nurses and patients. Nurses often accepted decisions made by others, resulting in providing less individually adapted care (Hoyt et al., 2015). Nurses were also confronted by complex care situations where they were expected to make decisions to provide good care to patients within strict timelines. Further indicated that good care promotes a patient's wellbeing, implying physical as well as psychological, relation, social, moral and spiritual well-being (Hoyt et al., 2015). Hence nurses care for patients holistically.

Choe et al. (2015b) concur with Hoyt et al. (2015) indicating that nurses make daily decisions that are ethically informed requiring nurses to deal with intimacy and privacy. Moral distress caused decreased levels of job satisfaction, increased staff turnover rates, health problems and burnout contributing to the number of nurses leaving the profession. Reportedly, the participating nurses felt that their self-image and integrity were threatened if they complied with unwritten rules and routines (Choe et al., 2015b). Further indicated that the current health care system required nurses with strong medical-technical competencies, and the ability to focus on the ethical dimensions of care, for nurses, coping with the ethical dimensions of care in practice might be difficult. Nurses act according to their values and norms. And result in negative impacts on both nurses and patients (Choe et al., 2015b).

A study was done in Sweden by Weiner (2014) support the previous authors indicating that due to the shortage of resources and the relationship between care providers' consciences, a complex health care reality, lack of time, caused ethical dilemmas and caused frustration and distress among all staff categories studied. The dilemmas were caused by the staff members' experiences of conflicting goals and interests of the organisation versus the interests of a patient. Another dilemma arose when there were more patients than beds at the clinic. The restrictions consisted either of lacking resources (beds) or a superior's orders not to break regulations (Weiner, 2014).

2.2.4 MEANING OF *UBUNTU*

The study done by Chitumba (2013) explained *Ubuntu* as "*motho ke motho ba batho bangwe / umuntu ngu muntu nga bantu*", which means that a person, can only be a person through others, a spirit of teamwork or collectivism can uplift all patients and nurses and make everyone involved. Further defined as group solidarity, philosophy of life, which in its most fundamental sense represents humanity, humaneness morality, conformity, compassion, respect, the human dignity of personhood, humanistic orientation and collective unity, as key social values. Another important principle mentioned by Chitumba
(2013) about *Ubuntu* is that of sharing of community opportunities, challenges, and responsibilities, which emphasises acknowledgement of each community member's contributions, qualities and talents. An individual does not base his/her decision on individual gains but on what can be gained for the upliftment of the community (Chitumba, 2013).

The study conducted by Downing and Hastings-Tolsma (2016) findings of the study concur with Chitumba (2013), emphasises that Ubuntu "human kindness" or "humanity towards

others" and a sharing that connects humans and plays an important role in nursing. Further explain that it incorporates values for humanity, respect, and dignity with openness and availability to others while recognising the uniqueness and differences of individuals. Mulaudzi et al. (2014) concur with the above authors by indicating that: "*Ubuntu* is a way of living that allows our best to come forth." also revealed that *Ubuntu* emphasises humanness, connectedness, cohesion, and conscience– all these characteristics are embraced by Sisulu, as well as empathy, cooperation, harmony, sharing, and warmth (Downing et al., 2016).

A similar study conducted by Ngcobo (2014) in the City of Tshwane indicated that *Ubuntu* is closely related to human dignity, which should find its substance and significance in its interconnectedness with the creative activity. *Ubuntu* is rooted in living and sharing space and being human is being with others (Ngcobo, 2014).

Eliastam (2015) cited Tutu who spoke about a 'third way'. It lies in *Ubuntu*, and it speaks of the very essence of being human. The study also revealed that people with *Ubuntu* are generous, hospitable, friendly, caring and compassionate. They also share what they have, and belong in a bundle of life, are open and available to others, affirming others' values. Further indicated they do not feel threatened that others are able and good, and their self-assurance is diminished when others are humiliated or when others are tortured or oppressed, or treated as if they were less than who they are. Results also indicate that a person cannot exist as a human being in isolation, people are interconnected and a person cannot be human all by him/herself without other people (Eliastam, 2015).

Mulaudzi and Peu (2014) concur with Eliastam (2015) that *Ubuntu* philosophy is an African idiom '*umuntu ngu muntu nga bantu'*, which translates into a person is a person because of other persons'. They emphasized interrelationships and interdependency between human beings, and that a person needs other people to be recognized as a person. A person with *Ubuntu* is always open and available to others, especially in response to the needs of others. It is therefore concluded that a person is never complete until a person is, amongst others able to fulfil the needed actions (Mulaudzi & Peu, 2014).

Kruidenier (2015) also concur with Eliastam (2015), explaining that the term '*Ubuntu*' is connected to the Nguni proverb '*umuntu ngu muntu nga batu'* (often translated as 'a person is a person through other persons') for the first time in history. This new idea indicated that *Ubuntu* means that people are interconnected (Kruidenier, 2015). *Ubuntu* people are generous, hospitable, friendly, caring, and compassionate, share what they have because they belong in a bundle of life. The study continued to indicate that a person with *Ubuntu* is open, available to others and able to affirm others. (Kruidenier, 2015).

Van Norren (2014), agreeing with Kruidenier (2015), indicated that at the centre of *Ubuntu* is the idea that *'umuntu ngu muntu nga bantu'* (*isiZulu*: an 'a person is a person through other persons'), and persons depend on persons to be persons. It is by belonging to the community that we become ourselves. The community is not opposed to the individual, nor does it simply swallow the individual; it enables everyone to become a unique centre of shared life. Human beings exist and become in relationships with other human beings. *Ubuntu* is a value-driven concept. Values are the basic foundations of each person's view of how life is supposed to be lived and values influence choices, attitudes as well as goals

in life. A person with *Ubuntu* is often defined through virtues that reflect an orientation towards other people, like kindness and hospitality (Van Norren, 2014).

According to Nzimakwe (2016), *Ubuntu* is an old African term for “humanness” – for caring and sharing, and that it is a way of life and stresses the importance of community solidarity, sharing, caring and the opposite of being selfish and self-centred, it promotes cooperation between individuals, cultures and nations. Principles of *Ubuntu*, as a leadership philosophy, emphasise collectivism and relationships over material things, including ownership of opportunities, responsibilities, and challenges. In this article, the focus was on the value of *Ubuntu* and the possible role it can play in advancing leadership and promoting good governance (Nzimakwe, 2016).

Mbhele (2015) supported the previous authors, by explaining that *Ubuntu* and the principles of leadership and good governance are compatible and complementary. Although *Ubuntu* means African humanism, it shares values with the human race in general and values such as respect, dignity, empathy, cooperation and harmony between members of society are not exclusively African but relate to the human race as a whole. However, *Ubuntu* remains an ideal, because in the global village it is not practised, but the ideal would be that the human race would care for one another. *Ubuntu* means that a person is a person through other people. Leaders should be the first to learn and practise *Ubuntu* so that they can inspire their followers. In this way, leaders could teach educators what they do not know. Consultation and transparency about service costs demonstrate *Ubuntu* dialogue and collective decision-making values. *Ubuntu* values are shown through the courteous treatment of customers and apologies where they are due. The values of caring are

demonstrated through courteous treatments while timeous addressing of problems reveals *Ubuntu* commitments to people. The *Batho Pele* principles of access to services and service information represent *Ubuntu* communalism and sharing of resources (Mbhele, 2015). These principles are in line with *Ubuntu* in that they uphold dialogue, humanity, and respect for other human beings. Furthermore, government employees should be humble and apologise when they have failed to provide timeous services. Government employees should be concerned about the needs of the people and address peoples` needs timeously (Mbhele, 2015).

2.2.5. *UBUNTU* IN THE HEALTH CARE SERVICE

Nzimakwe (2016) indicated that teamwork, is where the spirit of togetherness prevails, nurses who embrace *Ubuntu* can assist others because they understand that: “they are what they are” because of others. Nurses should be patient, collectivism and solidarity encourage sharing that inspires strong team collaboration. Further indicated that in the spirit of *Ubuntu*, nurses from different countries should be able to work better together, sharing knowledge without fear, showing mutual affection, love to one another, and should be able to promote the global vision and goals of caring for other people, which is the heart of the nursing profession (Nzimakwe, 2016).

Nzimakwe (2016) emphasised that nursing and *Ubuntu* both emphasise caring, which is the most important aspect of the nursing profession. In *Ubuntu*, an individual should have the ability to complement others belonging to the community. Nurses can be born and nurtured in an *Ubuntu* community where they can develop a sense of belonging, commitment, compassion and worthiness based on the connection between the individual and

community. Providing moral support within the group, showing honest appreciation of another person, and sharing opportunities, responsibilities, and challenges. Also indicated that the welcoming spirit that should be the foundation for the socialisation of new nurses into the profession. However, senior nurses should implement caring, by welcoming, caring for, protecting and encouraging novice nurses to join the profession and striving to help them feel part of the nursing community (Nzimakwe, 2016).

According to Poto (2016) concur with Nzimakwe (2016) that nurses who join the profession should be welcomed to the nursing community and should ensure that they begin to develop a sense of belonging that is important at the time of transition to become a nurse. Further indicated that novice nurses need one or more members of the nursing community to be with them so that they can learn the ways of the nursing community (Poto, 2016). Nurses should be mentored from being a practitioner who lacks knowledge and skills to become a self-reflective, self-confident professional nurse capable of negotiating professional and patient relationships. Mentoring of a novice nurse should enable the mentee to navigate the work environment, offer vision, encourage, develop trust, care, and provide protection. The principle of “I am because you are” makes it possible for people to be with each other, and to value each other. Young nurses, entering the nursing profession need to be supported, nurtured, and guided by mentors.

During the mentoring process, the mentor and mentee experience caring for them, realising of an ideal of *Ubuntu* philosophy (Poto, 2016).

Arko-Achemfuor (2016) concur with the above authors that *Ubuntu* leadership styles promote unity and shared vision. Respect, in *Ubuntu*, is not one-sided, because as a leader,

engagement with all levels of nurses, junior to senior, is required during decision-making and their inputs should be respected and valued. However, the relationship should be based on power and respect as junior nurses should respect senior nurses but senior nurses should also respect junior nurses (Arko-Achemfuor, 2016).

Pfaff et al. (2014) explained that the values which are transmitted from senior to junior nurses are in proportion with the ethical code of nursing and it identifies the importance of nursing care, addressing the needs of patient communities. Pfaff et al. (2014) further explained that the patient is at the centre of the relationship, the nurse using *Ubuntu* philosophy recognises the individual need of each patient, while viewing every patient as being part of a community.

2.2.6 PROFESSIONAL ATTITUDES IN THE HEALTH CARE SERVICES

A study by Dapaah (2016) reported positive attitudes from most nurses towards patients. Most nurses welcomed patients to the facilities, addressing clients with courtesy, advising clients about a wide range of issues, sometimes supporting patients financially, and comfortable interacting with them. The findings of the study seem to contradict the findings of many other studies reporting that nurses often did not communicate effectively with and/or relate to the patients. Further indicated that effective communication and interactions between nurses and patients at health centres and clinics are crucial for reducing the perceived stigma associated with the use of health services and for increasing the use of health services to address HIV-related issues (Dapaah, 2016).

Cummins (2015) supported Dapaah (2016) by indicating that the positive attitude by explaining that becoming a professional requires a person to adjust his/her attitudes to begin

to understand what it means to be a professional. Further mention that creating a personal vision of competence is essential for aligning one's values according to that image. A positive attitude in the workplace could help a person to work as an employee, or to manage others within the environment, more easily, faster and more effectively (Cummins, 2015). Being a leader requires a positive attitude in the workplace. Setting goals and asking for people's support and inputs to achieve them, and maintaining a positive attitude would enable the achievement of goals and overcoming challenges (Cummins, 2015).

Ishola, Owolabi and Filippi (2017) reported that the most frequently reported negative attitudes involved providing non-dignified care influenced by nurses' unfriendly attitudes. The least frequently reported negative experiences involved physical abuse and detention in facilities. These behaviours among nurses were influenced by low socio-economic status, lack of education and empowerment of women, poor provider training and supervision, weak health care systems, lack of accountability and legal redress mechanisms. Overall, disrespectful and abusive behaviours undermined the utilisation of health facilities and created psychological distances between women and nurses. The same Nigerian study reported that disrespect and abuse of women during childbirth occurred frequently. The most frequently reported type of abuse was non-dignified care and the least commonly reported were physical abuse and detention in facilities.

Underreporting was possible, as these behaviours might be accepted as being 'normal' and not as being 'abusive' or 'disrespectful' by some women (Ishola et al, 2017).

Another Nigerian study (Ahanonu, 2014) also reported negative attitudes by nurses towards adolescents engaging in premarital sexual activities without using contraceptives. Although

many of these adolescents knew about contraceptives, many did not use contraceptives, resulting in a high incidence of unwanted pregnancies, unsafe abortions, HIV infections and other STIs. Factors reported to be generally associated with the non-utilisation of contraceptives among adolescents included fear of stigma, shame and embarrassment, inadequate information about contraceptives, unplanned sexual activities, inability to negotiate with partners and the attitudes of nurses (Ahanonu, 2014). The same study reported similar ambivalent attitudes among nurses in Nigeria. Nearly all the interviewed nurses said they provided contraceptives to youths but mainly to those aged 18-24. A Nigerian study revealed that half of the respondents were favourably disposed to adolescent contraception. A major reason for failure to provide contraceptives to adolescents was the belief that contraceptives would promote sexual promiscuity. Thus, some respondents, by restricting access to services, thought they were protecting both the adolescents and the society (Ahanonu, 2014).

Many African studies investigated the attitudes of nurses towards providing contraceptives for unmarried adolescents. These reports revealed that many nurses had negative attitudes. For instance, a Ugandan study by Lotse (2016) reported that most nurses had negative attitudes towards providing contraceptives to young people and were not prepared, or were hesitant, to give young people contraceptives. As such, nurses imposed non-evidence-based age restrictions and consent requirements (Lotse, 2016).

A South African study conducted by (Wood & Jewkes, 2006) conducted among nurses, reported that the nurses generally stigmatised adolescent sex and felt very uncomfortable giving contraceptives to adolescent girls. These nurses often tried to influence the

adolescents who requested contraceptives not to have sex. Some nurses even requested parental permission before contraceptive services were provided to adolescents. This was not a legal requirement. A similar study was conducted among nurse-midwives providing sexual and reproductive health care services in Kenya and Zambia conducted by attitudes Warenius, Faxelid, Chishimba, Musandu, Ongány and Nissen (2015). Most of these nurses approved of contraceptive use by sexually active girls and were prepared to counsel boys about condom use. However, most nurse-midwives in both countries advised unmarried adolescent boys and girls to abstain from sex when they requested contraceptives, rather than to provide contraceptives to these adolescents. However, those nurses, who had received continuing education on adolescent sexuality and reproduction, showed more youth-friendly attitudes (Warenius, Faxelid, Chishimba, Musandu, Ongány & Nissen, 2015)

A Ghanaian study reported that health providers enforced restrictions (such as age and parity) known to impede access to services (Stan back & Twum-Baah, 2001). Some of these health providers believed that contraceptive injections could cause permanent infertility. Mold and Forbes (2013) explained that skill expected of professional consists of certain attitudes, beliefs, and behaviours known collectively as “good character.” Attitudes and behaviours are both are influenced by beliefs and we choose attitudes and behaviours ourselves (Mold & Forbes, 2013). Knowing that a person’s heart cannot be seen, it is important to be humble and guarded when judging the character of others and to understand that judging behaviour is the very thing that others will do to us (Mold & Forbes, 2013).

Smith, Cheater and Bekker (2015) explained that there are people with negative attitudes and behaviour patterns who negatively influence the people around them. Sometimes these

people spread rumours and gossip about co-workers or their supervisors (Smith et al., 2015). It might be difficult to accept a negative employee who did a good job at the expense of the productivity of others. If people ignore or tolerate problems, then the atmosphere created in this way could easily result in dissatisfaction among other employees (Smith et al., 2015).

Sabesan, Simcox and Marr (2012) explained that in conflict resolution, different attitudes might have caused problems or conflicts in one's personal and professional relationships. Conflicts arise as not everyone will have the same attitudes. However, with a positive attitude, empathy could be built to understand how other people think and feel (Sabesan et al., 2012).

Gurung and Sangchart (2014) explained that, in Lithuania, nurses' attitudes towards HIV influenced the way they felt, believed, viewed, thought and valued the lives of people living with HIV (PLWH). Negative reactions to HIV-infected patients could be due to fear of contagion, homophobia, avoidance, unwillingness to provide care, increased stress and burnout that could cause nurses to abandon the nursing profession (Gurung & Sangchart, 2014). However, Okpala, Uwak, Nwaneri, Onyiapat, Emesowum, Osuala and Adeyemo (2017) reported that nurses with higher levels of education showed less fear of HIV. In that study, fear of contracting the disease, social stigma, culture/religion, fear of losing one's job if one contract HIV and lack of knowledge were identified as potential factors that negatively influenced nurses' attitude in caring for PLWH. This confirms the findings of previous studies and represents areas where further intervention strategies should be channelled. Some respondents identified fear of losing one's job if one contracted HIV. This finding buttresses

the call to make the working environment safe and to ensure job security for the staff taking care of PLWH (Okpala et al., 2017).

A study conducted in Russia by Suominen, Laakkonen, Lioznov, Polukova, Nikolaenko, Lipiäinen, Valimaki and Kylmä (2015) explained that apart from knowledge levels, concerns were expressed about nurses' negative attitudes towards PLWH and to care for them. Student nurses' attitudes toward PLWH have been studied in different countries, and attitudes varied from positive, through average, to negative. Student nurses were apprehensive about caring for PLWH and correlations with background factors and attitudes were identified. Earlier experiences of caring for PLWH, or other contacts with PLWH, appeared to have positive influences on their attitudes. Nurses willingness to care for PLWH is also positively associated with nurses' experiences of caring for PLWH (Suominen, et al., 2015).

Homophobic attitudes vary across different countries and might be linked to attitudes concerning PLWH. Students with homophobic attitudes were less willing to care for PLWH. In the United States of America (USA), high levels of homophobia among student nurses have been reported. However, some studies suggested that student nurses might have less negative homophobic attitudes than non-nurses and/or some student nurses even showed positive attitudes towards homosexual people. In the same study, older student nurses and those with more work experience showed more negative attitudes toward homosexual patients than their counterparts. Those student nurses who had previous experience with PLWH, and who had previously cared for PLWH, showed lower degrees of homophobic attitudes. Students who were more willing to care for PLWH also showed more positive attitudes towards homosexual patients. Also, students with children showed more positive

attitudes toward homosexual patients than those who had no children. Student nurses, with limited knowledge about HIV or AIDS, tended to express more homophobic attitudes than those who had more knowledge (Suominen et al., 2015). Nursing students should also be aware of their attitudes because attitudes impact the way they are working. However, this study might be a starting point in investigating the situation, to further develop nursing education and care in a country where nursing research is emerging as a professional practice (Suominen et al., 2015).

Gamell, Glass, Luwanda, Mapesi, Samson, Mtoi, Nyamtema, Muri, Ntamatungiro, Tanner and Hatz (2016) explained that nurses did not routinely check for HIV in all children. These nurses believed that HIV testing was unnecessary and unacceptable to the mothers, and the nurses lacked the skills to conduct these tests. These nurses failed to recognise the importance of checking children for HIV and did not support the implementation of routine HIV checks. Mothers expressed fears about the nurses' lack of confidentiality, and that receiving HIV-related services could lead to unintentional disclosure of their HIV status (Gamell et al., 2016). The nurses feared adverse reactions from the mothers (Gamell et al., 2016).

Moyer, Adongo, Aborigo, Hodgson and Engmann's (2014) results indicated that many patients reported being neglected, and some suffered verbal and physical abuse from a few nurses. These patients mentioned that in many situations nurses in the public sector worked in harsh and extremely dirty conditions and there were extreme power differentials between nurses and the poor, often illiterate or semi-illiterate patients. In these situations, nurses employed tactics of humiliation, verbal coercion and even physical violence to assert their

authority and control a patient's behaviour (Moyer et al., 2014). Most pregnant women expected problems during childbirth, such as being shouted at, beaten or neglected by nurses and the twin problems of abuse and neglect were dominant features in the women's childbirth narratives. Results also indicated that the women complained that midwives were rude, inhuman, and not caring and that "nobody shows any kindness'' (Moyer et al., 2015). Several women complained about nurses scolding and shouting at them in the antenatal clinic and that some women were shouted at because they were

'talking softly', or 'moving slowly' after being called to a room, or going to a wrong room after mistakenly thinking they had been called (Moyer et al., 2015).

The findings of a South African study (Pickles, 2015) showed that patients, using obstetric services, experienced verbal abuse such as scolding, being shouted at and general rudeness, Nurses did not respect patients in general, nor their autonomy and many patients experienced acts of unkindness, physical violence or neglect. Other researchers had reported similar types of abuse in South African health care services. In particular, rudeness to patients, talking to patients as if they were children, scolding of patients (especially sexually active teenagers) were reported. Clinical neglect, for example giving adolescents contraceptives without explaining how to use them, or being told that patients were at the wrong clinic also occurred (Pickles, 2015). International reports describing abuse and neglect of patients by nurses suggest that some problems might concern structural issues including salaries, conditions of service and shortage of staff and equipment, similar to South African reports (Pickles, 2015).

2.3 SUMMARY

The literature review addressed the moral behaviour of nurses, ethical behaviour of nurses, unethical behaviour of nurses, the meaning of *Ubuntu*, *Ubuntu* in the health care service and professional attitudes in the health care service could be addressed by promoting moral regeneration. The purpose of this study was to develop a model for promoting moral regeneration among nurses in the Limpopo Province of South Africa.

Chapter 3 presents the research methodology adopted during this study to obtain information and to analyse the acquired information.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1. INTRODUCTION

The previous chapter provided a detailed review of the relevant literature to which this chapter will refer. This chapter aims to provide a detailed description of the research design and methods. According to Cohen, Manion and Morrison (2013) research is used to achieve a wide spectrum of research objectives. Scientifically, research is used to test hypotheses about a certain phenomenon that is, obtaining knowledge about a subject matter. The information obtained from the research output depends on the research design and method. This chapter discusses the research design and methodology, explains the study setting, population, sampling and sample size, data collection instrument, data collection process and analysis. This chapter is divided into three phases. Phase 1: (the empirical phase), which employed a multiphase approach using quantitative research approach (stage I) and qualitative research approach (stage 2), which addresses the main objective of the study, to develop a model to promote moral regeneration among nurses in Limpopo Province. Phase 2: addresses concept analysis and the development of the model, Phase 3: Model validation. The objectives of the study outlined in Chapter 1 followed:

Phase 1: Empirical Phase (Quantitative research [stage 1] and Qualitative research [stage 2])

- Explore the perceptions of patients regarding the ethical-moral behaviour of nurses.

- Explore the views of patients regarding the ethical-moral behaviour of nurses.
- Assess the knowledge of nurses regarding their ethical-moral behaviour.

Phase 2: Concept analysis, and model development

- conduct concept analysis
- Develop a model to promote moral regeneration among nurses in Limpopo Province.

Phase 3: Model validation

3.2. RESEARCH STRATEGY

The study followed a multiphase approach that incorporated three phases, which are empirical phase, concept analysis and model development phase, model validation. The empirical phase incorporates an exploratory triangulation concurrent mixed-method research design. The mixed-method design was used to separate quantitative and qualitative method as a mechanism to compensate for the weaknesses intrinsic in one method with the strength of the other method (Burns & Grove, 2016). Furthermore, mixed-method was used for triangulation because this strategy integrates the results of the two methods quantitative and qualitative approaches during the interpretation phase in confirm, cross-validate and corroborate findings within a single study in order to provide a more comprehensive picture of the findings (Burns & Grove, 2016). The mixed-method is a methodology for conducting research that involves collecting, analysing, and integrating quantitative data (obtained from conducting self-administered questionnaires) and

qualitative data (obtained during focus group discussions or individual interviews) as stated by (Creswell, 2013). Exploratory triangulation concurrent mixed method is characterized by an initial quantitative phase of data collection and analysis followed by a phase of qualitative data collection and analysis, with the final phase of integration or linking data from two separate strands of data (Creswell, 2013). An exploratory triangulation concurrent mixed approach was used in this study and it allows different data collection strategies from different stakeholders (patients and nurses). The design starts with the collection and analysis of quantitative data, which has the priority for addressing the study's questions (Creswell, 2013). It was also selected because it involved the integration of quantitative and qualitative approaches to develop new knowledge, but kept the qualitative and quantitative approaches separate to maintain the strength and integrity of each paradigm; for example, a qualitative design was used for the first objective (Kruger & Casey, 2009). Phase I (the empirical) consist of two stages: stage 1 involved a quantitative approach which was predictive and descriptive in nature and stage 2 involved a qualitative approach that is exploratory descriptive in nature. Thus, the two stages were implemented concurrently.

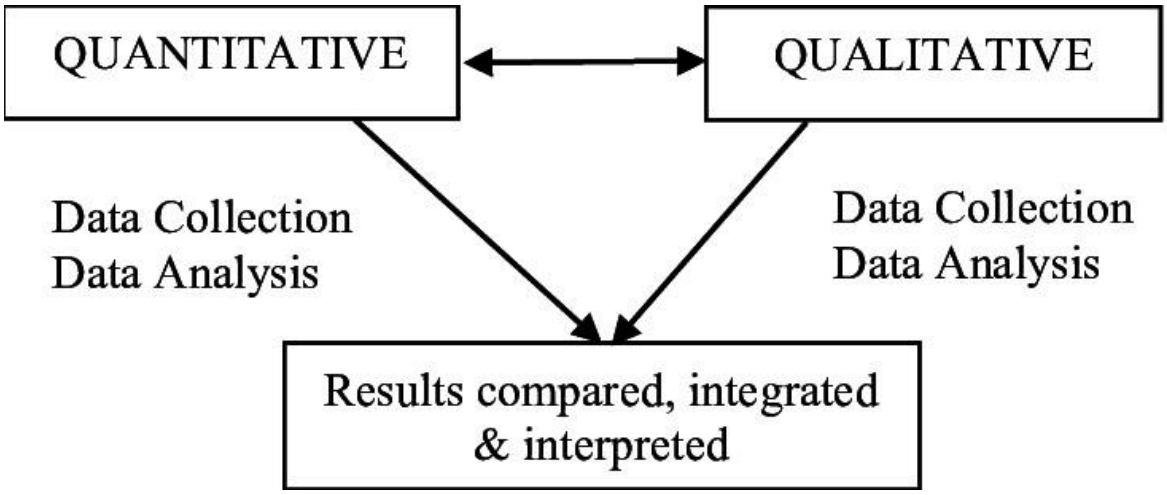

Figure 3.1: Exploratory triangulation concurrent mixed-method research design

3.3 Phase 1: Empirical Phase

The empirical phase consisted of two stages: stage 1: quantitative and stage 2: a qualitative study.

3.3.1 Stage 1: Quantitative Approach

The quantitative research approach is a formal, objective, systematic process in which numerical data can be utilised to obtain information about a phenomenon. They further indicated that quantitative research describes variables, examines relationships among variables and can determine cause-effect relationships between variables (Burns & Grove 2016). Creswell (2013) defined quantitative research as a means of testing theories objectively by examining the relationships among variables that can be measured, typically by using some instrument, so that numerical data can be analysed using statistical procedures. Creswell (2013) and Polit and Beck (2014) explained that quantitative researchers make assumptions about testing theories deductively, building in protections against bias, controlling for alternative explanations, and being able to generalise and replicate the findings. Quantitative research is an enquiry into a problem based on testing a theory composed of variables- findings measured in numbers and analysed using statistics (Burns & Grove, 2016). It is a system in the collection of numerical information where statistical procedures are being used (Burns & Grove, 2016). The quantitative approach was used in this study to achieve the third objective of assessing the nurses' knowledge about their ethical-moral behaviour and to strengthen the data that was collected through interviews of patients in qualitative research. It was created by choosing observable indicators which, in this study, occurred through questionnaires that were developed to

observe the respondent's responses (Burns & Grove, 2016). In this study, an enquiry was made on the ethical-moral behaviour of nurses in the selected hospitals at Mopani and Vhembe districts in Limpopo Province.

3.3.2 Study design (Predictive descriptive design)

The research design is the structural backbone of the research study and describes as a plan for obtaining answers to the research questions (Polit & beck, 2014). Polit and Beck (2014) further mention that the researcher selects a specific design and identifies strategies to minimise bias, it also indicates that the research design outlines what the researcher will do, how data is collected, where the study will take place (Polit & beck, 2014).

In this study predictive descriptive design was conducted to assess the knowledge of nurses regarding their ethical-moral behaviour. Predictive descriptive design is chiefly concerned with forecasting (predicting) outcomes, consequences, costs, or effects (Polit & beck, 2014). This type of research tries to extrapolate from the analysis of existing phenomena, policies, or other entities to predict something that has not been tried, tested or proposed before (Polit & beck, 2014). The goal of the study is to promote the moral behaviour of nurses in Limpopo Province. For this reason, a predictive descriptive study design was selected to conduct the research. The predictive descriptive approach enables the researcher to organise data in such a way that it becomes meaningful and induces insight (Burns & Grove, 2016).

3.3.3 Study setting

A setting is the physical location and conditions in which data collection takes place (Burns & Grove, 2016). Limpopo Province is one of the nine provinces in SA. It is situated in the

northeastern area of South Africa and shares borders with Botswana in the northeast, Zimbabwe in the north and Mozambique in the eastern part, through the Kruger National park. Limpopo Province is divided into five districts namely: Mopani to the south-north, Sekhukhune to the south-east, Capricorn to the south-west, and Waterberg to the west and Vhembe located in the north.

The study was conducted in the Mopani district which is divided into five municipalities namely: Greater Letaba, Greater Giyani, Greater Tzaneen, Ba-Phalaborwa and Maruleng and Vhembe district which is divided into four municipalities, that is, Thulamela, Makhado, Mutale and Musina. The three hospitals were selected. One regional hospital from Greater Letaba municipality in Mopani district, in the urban area and two district hospitals one from Greater Letaba municipality in Mopani and one from Collins Chabane municipality in Vhembe district in the rural area. The indigenous languages dominating this province are *Xitsonga, Venda and Sepedi*.

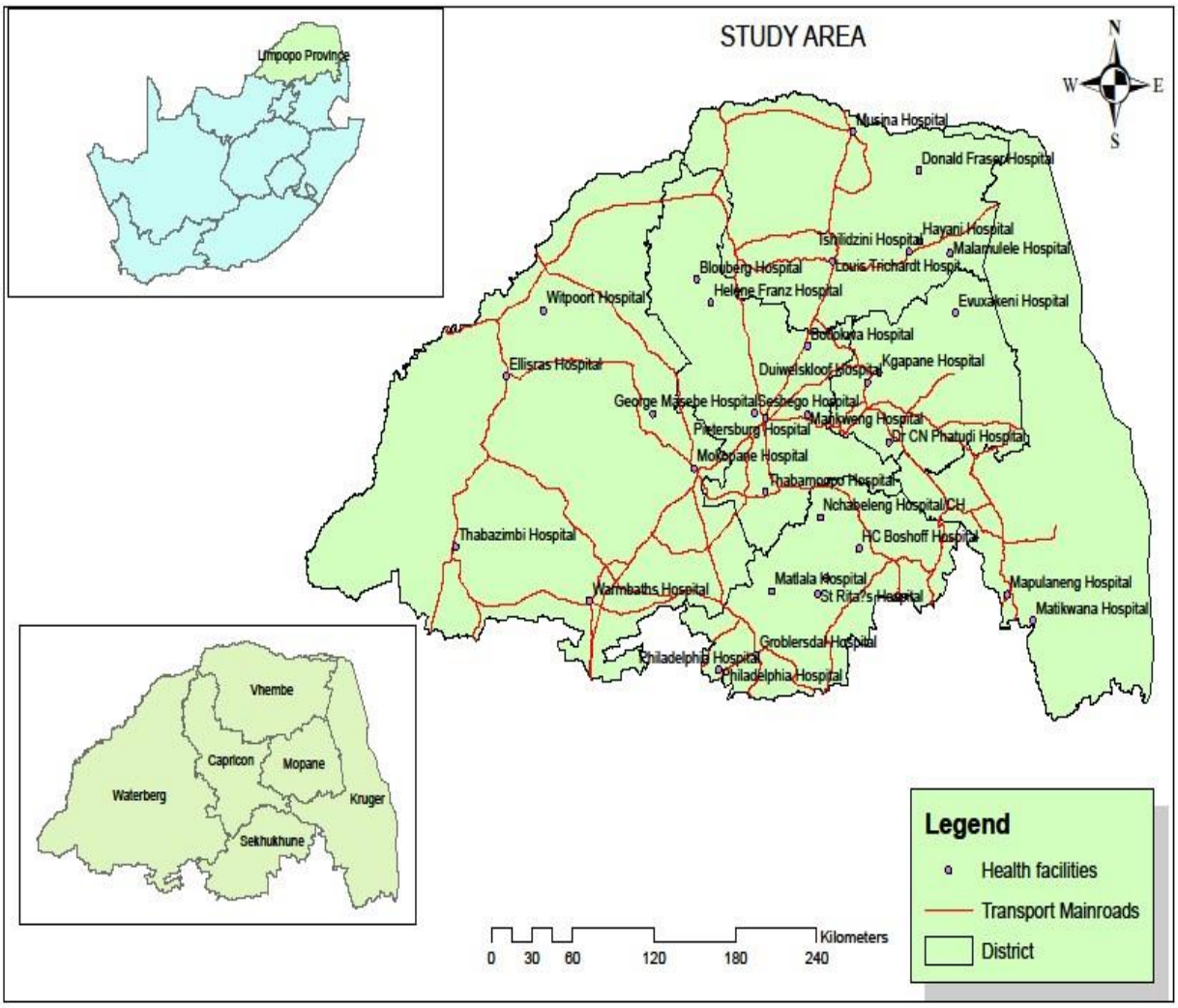

Figure: 3.2 Map showing hospitals in the Limpopo Province of South Africa

3.3.4 Study Population

The population is the set of individuals who have some common characteristics (Polit & Beck, 2014). The target population represents the aggregate about what the researcher would like to generate information and includes all members who are being studied, and who conform to a designated set of specifications (Polit & Beck, 2014). According to Burns and Grove (2016) target population is the aggregate of cases about which the researcher

would like to make generalisations. Accessible population refers to those cases that conform to the eligibility criteria and are accessible to the researcher as a pool of subjects (Polit & Beck, 2014). The population of Limpopo Province was 5.8 million in 2016, making it the fifth-largest province in South Africa. Limpopo Province is considered to be a poor part of South Africa, with approximately 87% of people living in rural areas. As many as 97.3% of the population is classified as black Africans, while whites makeup 2.4% and coloured people and Indians make up 0.2% and 0.5% respectively. The population used were all nurses in the Mopani and Vhembe districts of Limpopo Province. This study's target population for the quantitative phase comprised all categories of nurses working in the selected government hospitals in Limpopo Province who had more than two years' working experience. The accessible population comprised all nurses from the selected hospitals in Mopani and Vhembe districts with two or more years' working experience. The number of nurses per category were out of 267, 180 nurses were given questionnaires, 180 x 35% = 63 (sixty three) enrolled nursing auxiliary, 180 x 28%= 50 (fifty) enrolled nurses and 180 x 37%= 67 (sixty seven) professional nurses. The number of patients admitted to Limpopo's provincial hospitals' ranges from 130-150 per hospital per month.

The average length of stay in medical wards is 4-5 days and in surgical wards, it is 6-8 days. One regional and two districts hospitals were selected. The regional hospital and one district hospital were selected from Mopani District and one district hospital from Vhembe District. A regional hospital was selected because it is a referral hospital and has more patients and staff members. The districts selected for this study are Mopani and Vhembe districts. District hospitals were also selected on the basis that they encounter staff shortages, under-resourced and nurses might be required to perform duties beyond their scope of practice,

and employ many enrolled nurses (ENs) and enrolled auxiliary nurses (ENAs) but few professional nurses (PNs).

3.3.5 Sampling

Sampling is a way of selecting a group of people, events, behaviours or other elements with which to conduct a research study (Burns & Groove, 2016). Polit and Beck (2014) define sampling as the process of selecting cases to represent the entire population, whereas a sample refers to a subset of the population and classified as probability sampling or nonprobability sampling (Polit & Beck, 2014). In probability sampling, the researcher can randomly select the elements and also specify the probability that the sample can include any element. However, in non-probability sampling, the researcher selects the elements deliberately, and there is no way to estimate the probability of including each element in the sample (Polit & Beck, 2014). Probability sampling refers to the units with equal chances likely to be selected when sampling whereas in non-probability sampling individuals' chances of being selected are unknown (Polit & Beck, 2014). In this study, probability simple random sampling was used to select districts and hospitals.

3.3.5.1 Sampling of districts

In Limpopo province, there are five districts. Simple random sampling was used to select districts that met the criteria for this study. Mopani and Vhembe district were randomly selected.

3.3.5.2 Sampling of hospitals

Simple random sampling was used to select hospitals from the two districts namely: Mopani and Vhembe. One regional hospital and one district hospitals were selected from Mopani District. Furthermore, one district hospital was selected from the Vhembe district. The regional hospital was selected because it is a referral hospital, serving large numbers of patients. The two district hospitals were also selected on the basis that they encounter staff shortages, under-resourced and most of these patients are very ill and require specialised care which can be exhausting for nurses.

3.3.5.3 Sampling of nurses

Stratified sampling was used to group nurses into different categories and simple random sampling was used to select the nurses from each stratum. The province has an estimated total of 9 879 nurses because 37 hospitals have an average of 267 nurses per hospital comprising professional nurses (99)/267=37% enrolled nurses (76) /267=28% and auxiliary nurses (92)/ 267=35%. The number of nurses per category were out of 267, 180 nurses were given questionnaires, 180 x 35% = 63 (sixty three) enrolled nursing auxiliary, 180 x 28%= 50 (fifty) enrolled nurses and 180 x 37%= 67 (sixty seven) professional nurses.

3.3.5.4 Sample size

The researcher used the following recommended Rao soft sample size calculator and the sample size was 162 at 80% confidence level. A 10% was added to account for incomplete, spoilt or non-return and the final sample was 178 which aggregated to 180.

The formula was obtained from their website the minimum sample size to be used in this study:

$$n = \frac{Z^2 p(1-p)}{e^2}$$ thus,

- n= 180 where n=sample size;
- Z=confidence level (80%);
- e= sampling error; and
- p = degree of variability.

The sample size was computed to be 162. However, some respondents did not return their completed questionnaires, hence the realised sample comprised 162 completed questionnaires. Different combinations of confidence levels and sampling errors could be used to determine the appropriate sample size for a particular study. According to Puszczak, Fronczyk and Urbanski (2013), a 50% degree of variability indicates the maximum variability used in calculating a more conservative sample size. All nurses who had at least two years' experience were identified from the selected three hospitals, one regional hospital and two district hospitals in the Limpopo Province.

Table 1: Research design, population, sampling, data collection and data analysis

Objectives	**Research design**	**Population**	**Sampling**	**Data collection**	**Data analysis**
Objective 3 To determine nurses knowledge about their ethical moral behaviour	Predictive Descriptive Design	All categories of nurses	Simple random sampling	Questionnaires	Statistical analysis

3.3.6 Data collection instrument (reliability and validity of the tool)

In quantitative research, the data collection method employed a measuring instrument (de Vos, 2011). A questionnaire is a data collection instrument composed of specific questions for obtaining facts and opinions about a phenomenon from people informed on the particular issue applied in different ways (de Vos, 2011). A self-administered questionnaire is a questionnaire that is given to the respondent, to complete on his/her own, in the presence of the researcher to address the problems experienced (de Vos, 2011). A questionnaire is supposed to be well-defined, neat, adequate and easy to follow with clear and precise directions and instructions (de Vos, 2011). The principles for formulating the questions of a questionnaire are the information needed, creative thinking and high level of precision by the researcher, length of the questionnaire, the format of the questionnaire, pilot testing of the questionnaire, ways to ensure completion of the questionnaire, data analysis and response system (de Vos, 2011). Questions about demographics, qualifications data of respondents, knowledge regarding ethical-moral behaviour of nurses were included in the questionnaire.

In this study, the questionnaires, in its semi-final form, was pilot- tested before it was utilized in the main data collection (de Vos, 2011). The language best understood by respondents was used and, in case they could not write, assistance was given (de Vos, 2011). Respondents were expected to respond to questions related to the demographic data, qualifications data and knowledge regarding ethical-moral behaviour of nurses. A pilot test was conducted among nurses from the hospitals that were not used in this study, to ensure that the questionnaire is readable, understandable and answerable by potential

respondents. A total of 30 nurses, 10 from each hospital, were requested to complete questionnaires. Out of the10 nurses at each hospital, 4 were Professional nurses (PNs), 4 Enrolled Nurse (ENs) and 2 were EnrolledNursing Auxiliary (ENAs).

The principles related to the instrument to be used for measuring are the measurement, reliability and validity of the measuring instrument and levels of measurement and levels of measurement. Reliability is defined as the accuracy or precision of an instrument, as the degree of consistency or agreement between two independently derived sets of scores, as the extent to which the repeated independent administrations of the same instrument yield the same results under comparable conditions (Strydom, Fouche & Delport, 2011). The average time required to complete the questionnaires was 45 to 60 minutes. Furthermore, the measurement for internal reliability of the items used in the instrument was done using Cronbach's alpha coefficients. According to George and Mallery (2003), the following criteria for Cronbach's alpha coefficients must be established: 0.9> is excellent, 0.8> is good, 0.7> is acceptable, 0.6> is questionable, 0.5> is poor and 0.5< is unacceptable. A test re-test technique was employed to confirm the result produced by SPSS to determine Cronbach's alpha coefficients. Cronbach Alpha test was performed to determine the reliability of the instrument and the test results yield was 0.769 which shows high consistency of the instrument.

Validity refers to the extent to which a data collection instrument reflects the abstract construct being examined (Burns & Grove, 2016). Instrument validity seeks to ascertain whether an instrument accurately measures what is supposed to measure (Brink, 2006). The researcher can be sure that valid instruments measure the things they are supposed to be measuring (Brink, 2006). Content validity is an assessment of how well the instrument

represents all the components (contents) of the variable to be measured. This type of validity is used mainly in the development of questionnaires, interview schedules or interview guides (Brink, 2006). To ensure content validity, the questionnaire was given to 2 experts in ethical issues, who were lecturers teaching ethics and nursing managers at different hospitals in the Limpopo Province, to examine the content in relation to this study's objectives. The questionnaire was sent to the statistician with an information sheet and the objectives of the study. Comments on items and their relevance were clarified, an experienced researcher was asked to scrutinise the questionnaire.

3.3.7 Data collection process

Data collection involves the process of gathering data from the selected respondents (Brink, 2006; Burns & Grove, 2016). Data were collected from all categories of nurses who completed questionnaires. The questionnaires were developed by examining questions that would answer the objectives of the study, as indicated by the reviewed literature. The questionnaire comprised two sections. Section one assessed the demographic data including the respondents' ages, highest qualifications, years of experience, post-basic qualifications, and hospital departments where they were working.

The age of the respondents was coded into five categories: 20-29, 30-39, 40-49 and 50+. The years of experience were coded into four categories (0-4, 5-9, 10-14 and 15+). Gender was dichotomous coded 1 for males and 2 for females. The respondents' highest qualifications, post-basic qualifications and work units were categorised into 6, 3 and 8 groups respectively.

Section two contained statements pertaining to the nurses level of knowledge about moral ethical behaviour. The nurses' knowledge about ethical-moral behaviour was assessed using a five-point Likert scale. The level of agreement on a scale from one (strongly agree) to five (strongly disagree) in response to 20 knowledge and behavioural statements, influencing moral regeneration, were measured. Responses to the 20 knowledge and behavioural statements were scored and analysed in relation to respondents' ages, gender, highest qualifications, years of nursing experience and work units, which were considered to be independent variables in this study.

Unethical moral behaviour was the outcome measured by the question: "Did you consistently demonstrate ethical-moral practice to patients during the past two years?
The responses were dichotomous and assigned "No" (assigned 0) or "Yes" (assigned 1).

The quantitative aspect of this study involved the collection of information yielding numerical data from questionnaires completed by all categories of nurses (ENs, ENAs and PNs). The questionnaires were distributed among nurses by the researcher and collected seven days after distribution, giving the respondents' time to complete.

Respondents were allowed to complete the questionnaires on their own time. The researcher made appointments for collecting the completed questionnaires seven days after distribution. A total number of 180 questionnaires were distributed, 162 questionnaires were returned to the researcher but 18 (eighteen) were spoiled implying that only 162 (N=162) questionnaires could be analysed, yielding a response rate of 80.0% (162 out of 180) of the distributed questionnaires. Quantitative researchers use several criteria to assess the quality of a study, such as the reliability and validity of data collection instruments.

3.3.8 Reliability and validity for the study

The principles related to the instrument to be used for measuring instrument are the measurements, validity and reliability of the measuring instrument and levels of measurements (de Vos et al., 2011) Validity is the degree to which an instrument measures what is intended to measure while reliability is the degree of consistency or dependability with which an instrument measures an attribute (Polit & Beck, 2014). Reliability reveal true differences (Burns & Grove, 2013)

Reliability refers to the accuracy and consistency of information obtained in a study. The concept of reliability is also important in interpreting the results of statistical analyses. Statistical reliability refers to the probability that the same results will be obtained with a completely new sample of subjects, indicating that the results are an accurate reflection of a wider group than just the particular people (sample) who participated in the study (Polit & Beck, 2014). In this case, the face validity test was employed to ascertain the validity of the measure used. However, face validity is based on an intuitive decision that involves the researcher's instinct based on his/her expertise in the field of study. In this study, the questionnaire was checked by peers, supervisor and co-supervisors for internal validity, before data collection. The statistician and linguistician checked the questionnaire for external validation before it was used.

3.3.9 Data Analysis

Data analysis is performed to reduce, summarise, organise and give meaning to data. It is the selection of appropriate statistical techniques to analyse the study's data (Burns &

Grove, 2016). The quantitative data were analysed using descriptive statistics. The analysis techniques implemented were determined primarily by the research objectives, questions, the research design, and the level of measurement achieved by the instrument (Burns & Grove, 2016). Descriptive statistics include the use of charts and frequencies.

Frequencies and percentages were used to describe the nurses' knowledge about their ethical behaviour and ethical-moral nursing practice. Bivariate analyses were used to examine the relationships between the nurses years of working experiences and sociodemographic variables. Analyses comprised of cross-tabulations and chi-square tests. A chi-square test is a technique used to identify an association between two variables under study. Statistically, chi-square tests also compare the goodness of fit of theoretical and observed frequency distributions.

Based on moral regeneration's dichotomous outcomes, two models of logistic regressions were compiled. In model 1, the effects of socio-demographic characteristics on moral regeneration were examined. In model 2, the extracted factors were examined while controlling for the socio-demographic characteristics. Results were reported as p-values, odds ratios (ORs) and confidence intervals (CIs). SPSS version 25 was used to analyse data.

3.4 Stage 2 Qualitative approach

The qualitative approach is described as a way of gaining insights through discovering meanings. A qualitative approach is the investigation of a phenomenon, in an in-depth style, through the collection of rich, narrated material using flexible design (Burns & Grove, 2013; Terblanche, Durreim & Painter, 2011). The qualitative approach was chosen, as it was

appropriate as the researcher knew very little about perceptions and views regarding the ethical-moral behaviour of nurses in Limpopo Province, the researcher was the main device in data collection. The first objective was to explore the perceptions of patients regarding the ethical behaviour of nurses and exploration of the views of patients regarding ethical-moral behaviour of nurses in Limpopo Province to develop a model to promote moral regeneration among nurses in Limpopo Province. The researcher collected detailed information from the participants at the hospital, who were patients.

Once the research was completed, the findings were used to support the existing body of theory and research (de Vos et al., 2011). The researchers interpreted the collected data this included analysing data to generate themes, sub-themes and categories, and finally, interpreting its meaning personally and theoretically, indicating the lessons learned, and subsequent questions to be asked (Creswell, 2014).

3.4.1 Study design (Exploratory descriptive design)

The explorative design is aimed at exploring the dimensions of the phenomenon, the manner in which it shows and the other factors that relate to it (Polit & Beck, 2014). The explorative study assisted in exposing a relatively unknown research section to gain insight when exploring the perception and views of patients regarding the ethical-moral behaviour of nurses. The explorative design enables the researcher to collect in-depth information (de Vos et al., 2011).

In an explorative design, the research also aims to gain insight to generate new ideas, concepts and theories regarding the problems under examination which, within the context of this research, is to explore the perceptions and views of patients regarding ethical-moral

behaviour of the nurse. In this study, detailed information was gathered through in-depth interviews and focus group interviews communicated the perceptions and views of patients on ethical-moral behaviours of nurses.

A descriptive design refers to the overall strategy that integrates the different components of the study coherently and logically, ensuring that the research problem is addressed in full (de Vos, 2011). Concepts are described and discussed through a descriptive design and their relationship are noted to give the grounds for further research studies. It provides a picture of the specific details of a circumstance, giving answers to how to explore perceptions and views regarding the ethical-moral behaviours of nurses is in that state (de Vos, 2011). Descriptive research aims at exploring and describing a phenomenon in the real-life environment, discovering a new sense and defining frequencies with which events occur (Brink, 2012).

In this study, the researcher observed and listened to participants, to ensure clear, accurate and precise descriptions related to perceptions and views regarding the ethical-moral behaviours of nurses. Description involved the collection of qualitative data through semi-structured focus groups and individual interviews with patients. The patients' understanding, views and perceptions regarding the ethical-moral behaviours of nurses were analysed and led to the development and description of the main theme, themes and categories from interview transcripts.

Table: 3.3. Objectives, Research design, Population, Sampling, Data collection and analysis

Objectives	Research design	Population	Sampling	Data collection	Data analysis
Objective 1 To explore perceptions of patients regarding the ethical-moral behaviour of nurses	Exploratory descriptive design	All patients who had spent at least more than four days in the hospital	Non-probability purposive sampling	Individual interviews	Open coding
Objective 2 To explore the views of patients regarding the ethical-moral behaviour of the nurses	Exploratory descriptive design	All patients who had spent at least more than four days in the hospital	Non-probability purposive sampling	Focus group interviews	Open coding

3.4.2 Study Population

A population is the entire group of persons or objects that are of interest to the researcher or that meet the criteria in which the researcher is interested (Brink, 2006). Burns and Grove (2016) define a population as the aggregate or totality of all objects, subjects, or members that conform to a set of specifications. In this study, the population for the qualitative research comprised all patients who had been admitted for more than four days in the selected three hospitals in Limpopo Province. The target population were all patients admitted for more than four days in the selected hospitals in the Mopani and Vhembe districts of Limpopo Province. The accessible population were all patients admitted to the selected hospitals in Mopani and Vhembe districts for at least four days.

3.4.3 Sampling

Sampling is a way of selecting a group of people, events, behaviours or other elements with which to conduct a research study (Burns & Grove, 2013), further explain that sampling plan include a probability and non-probability sampling, a non-probability sample where not every element of the population has a chance to be included in the sample (Burns & Grove, 2013). de Vos (2011) describe sampling as how people are selected or determined by their relevance to the topic researched rather than their representativeness.

3.4.3.1 Sampling of districts and hospitals

Purposive sampling was used to select hospitals from (Letaba) Mopani, (Kgapane) Mopani and (Elim) Vhembe of Limpopo Province. According to Polit and Beck (2013), purposive sampling or judgemental sampling is based on the belief that the researcher's knowledge about the population can be used to handpick sample members. Whereas Burns and Grove (2013) describe purposive sampling as where the researcher will consciously select certain participants, elements, events or incidents to include in the research. The districts selected for this study are Mopani and Vhembe districts. One regional hospital was selected because it is a referral hospital and has more patients and staff members. District hospitals were also selected on the basis that they encounter staff shortages, under-resourced and nurses might be required to perform duties beyond their scope of practice, and employ many enrolled nurses (ENs) and enrolled nursing auxiliary (ENAs) but few professional nurses (PNs)

3.4.3.2 Sampling of participants (patients)

Non-probability stratified purposive sampling was used because the researcher wanted to select elements through non-random methods, it was accessible, inexpensive and required little time the researcher used the same selected hospitals for qualitative data collection (Burns & Grove, 2013). Purposive sampling is the non-probability sampling method used when data is collected from selected patients because they exhibit certain features that are of interest to a particular study. The researcher selected patients from the selected hospitals who had been admitted at the hospital for more than four days.

3.4.3.3 Sampling criteria

Inclusion criteria refer to criteria that specify the target population (Polit & Beck, 2014). The inclusion criteria in this study were male and female patients who had been admitted to the selected hospital for more than four days.

3.4.3.4 Sample size

The sample size in qualitative research must be determined by data saturation (Brink, 2012). A total of 78 patients were determined by data saturation.

3.4.4 Data collection

According to de Vos (2011), data collection is a procedure used by researchers when collecting information from the participants. It is used to determine each participants' opinions or facts, how each participant will react to the initial and potential findings. Such a technique is useful in obtaining information related to tasks, values, preferences, attitudes, beliefs and experiences are different (de Vos, 2011). Data collection is the process of gathering information needed to address a research problem (Polit & Beck, 2014). In this

study, an individual interview and focus group interview was used to collect data from patients. The researcher used a structured interview guide to collect data during the focus group discussion and semi-structured interview during face to face individual interview.

3.4.4.1 Data collection process

The researcher obtained permission from different stakeholders, including the Department of Health, Chief Executive Officer of the hospitals (see Annexures A). Data were collected using individual interviews and focus groups that were non-restrictive and allowed participants to be free when narrating their experiences related to perception and views of patients on ethical behaviour of nurses (de Vos et al., 2011). Individual interviews and focus group interviews and were conducted: as follows:

Individual interviews

According to de Vos et al (2011), an individual interview is a method used to obtain more information from participants. Individual interviews were conducted to gather a broad range of different information from patients on the perception and views of patients on the ethical behaviour of nurses. In this study, the researcher prepared an interview guide, to be used and which had open-ended questions written in Xitsonga, Sepedi and Tshivenda. The researcher explained what data collection is all about and how it is done in this research. The interview guide was discussed. A role play on data collection using a guide was also done. On the first day of data collection, the patients were involved in the preparation for the interview as they were allowed to choose a date, time and place that suited them best for the interview. This was done to establish rapport and interaction with the patients to make the environment non-threatening. On the agreed date, the researcher arrived early, prepared the room and the tape recorder. The patient was given a chance to sit where

he/she would feel comfortable and not threatened. The places used were sideward that was not in use at the time of the interview. Data were collected in the different wards in the selected hospitals. This ensured that the natural setting would be minimally disturbed. The raw data of individual interviews were recorded verbatim (Brink, 2011).

During the individual interviews, the following questions were asked (only the Xitsonga version of questions were indicated herein).

- Can you tell me how you are treated by nurses in this hospital?
  (Mi nga hlamusela leswaku vaongori va mi khoma njhani?)
- Can you describe what you consider to be respectful behaviour?
  (Mi nga hlamusela xichavo hi ku hetiseka?)
- How do you experience the nurses' attitudes towards you as a hospitalised patient?
  (Mi nga hlamusela mavonele ya nwina ya vaongori eka vavabyi?)
- Describe your relationship with the nurses in the ward.
  (Minga hlamusela vuxaka bya vaongori na vavabyi ewadini?)
- The process of individual interviews

The process of individual interviews provided the researcher and participants flexibility. The following phases were followed during the individual interviews.

- **Preparing for the interview**

The researcher reviewed relevant literature to enable her to define the concepts and assess the data. The interviewer was also prepared emotionally because she was entering the world of the interviewees (De Vos, 2013).

- **Becoming acquainted: The initial relationship**

The interviewer projected herself in a way that evoked the least resistance from the interviewees. The basic principles of communication were adhered to, such as listening. The interviewer was frank to overcome problems of interviewees giving false answers or ending an interview at an early stage. The participants were made aware of the proposed investigation and how the results would be utilised in the development of the model. The use of an audio recorder, taking of field notes, the interview venue, time and date were also discussed. During this stage, the interviewer attempted to bridge the social distance between the participants and the interviewer (De Vos, 2013).

- **Establishing a contractual relationship**

The agreement was the outcome of a partnership that developed between the two parties, which were based on a growing mutual understanding. Interviewers and interviewees regarded each other as equals. The objectives of the interviewer and the interviewees became joint objectives and a compromise was reached between the needs of the interviewer and those interviewees (De Vos, 2013).

- **Establishing a relationship of trust**

Mutual trust ensured that the co-operation of the interviewees and also improved the quality of collected data. The interviewer responded in a manner that showed that the interviewees were worthy of their disclosure and would not condemn or oppose the interviewees about any shared information (De Vos, 2013).

- **Terminating the individual interview**

The interviewer suggested ending the interview when it became clear that the interviewee was nothing more to say. The interviewees were made aware of the expected duration of the interview and the proposed date of release of the research report (De Vos et al., 2011)

Focus Group Discussions

The purpose of the focus group was to promote self-disclosure among participants to learn what people think and feel (Krueger & Casey, 2002). Focus groups are useful when multiple viewpoints or responses are needed on a specific topic. Focus group discussions are informal sessions in which participants are requested to discuss their perceptions on a specific topic. Focus group discussions were conducted with patients who had been in the hospital for more than four days. The environment was made comfortable and conducive without disturbance. The environment was non-evaluative and non-threatening; with comfortable chairs placed in a circle to allow face-to-face interaction. Written permission was requested from each participant before beginning any focus group interview. An audio recorder was used with participants' permission (Krueger & Casey, 2002).

A research assistant was in charge of the audio recorder. Each participant was given a number to pin onto him/herself to avoid using names for anonymity. The participants set the following ground rules to facilitate the smooth running of the discussion:

- no refreshments were allowed during the discussions
- members were requested to respect each other's views
- members should allow one person to talk at a time

- cell phones were switched off

The role of the researcher

The researcher arrived early to welcome the participants when they arrived. The researcher allowed the group to introduce themselves. The researcher introduced the assistant and explained her role, which was to control the audio recorder. The researcher explained the purpose of the study in Xitsonga and Sepedi and written consent forms were handed out to be signed before commencing any focus group interview (Krueger & Casey, 2002). During the focus group interviews, the researcher took field notes. The research assistant operated the audio recorder, which was placed in the middle of the circle to capture every participant's voice. Krueger and Casey (2002) further explained that the researcher observed the group dynamics among participants such as non-verbal and verbal communication. Interviews were directed by semi-structured questions. Observations of non-verbal cues, audio recording and taking of field notes ensured that all information was captured to ensure that the voices of the participants would be heard. The researcher engaged with participants paraphrased their responses and conducted interviews where the participants were. This also allowed the researcher to observe the participants. The researcher focus group interviews were to explore patients' perceptions regarding the ethical-moral behaviour of nurses and to explore the views of patients regarding the ethical-moral behaviour of nurses. The place was quiet and there were no interruptions experienced during the interview process. The following questions were included in the interview guide were asked and deliberated on as long as the participant will narrate: Can you tell me how you are treated by nurses in this hospital, Can you describe to me what you consider to be respectful

behaviour, How do you experience the nurses' attitudes towards you as a hospitalised? Field notes were compiled during and after every interview and every interview was audio recorded to capture the information with the permission of the participants. Two focus groups were conducted at each of the three selected hospitals. During the focus group interviews, semi-structured questions (on an interview guide) were posed to all participants (patients). The patients communicated in Xitsonga, Sepedi, and Tshivenda. The researcher created a nonthreatening, comfortable environment that is free from interruptions throughout the research study. This encouraging freedom of speech. The researcher allowed the participant time to talk until he/she finished what she was saying, and kept on encouraging the participant to talk. The setting supported involvement and interaction prepared in a manner that all seats were equal. Patients who were interviewed were given an information sheet and a consent form (Annexure E1 and Annexure E2) to read and ask questions where they needed clarity and then sign. The participants were encouraged to add information or to clarify certain aspects. Patients interviews lasted up to 60 minutes.

Focus group discussions were conducted in Xitsonga and Sepedi with groups of patients selected and assembled by the researcher to discuss and comment on their personal experiences, concerning nurses ethical-moral behaviour towards patients (Benner & Ketefian, 2014). A focus group is defined by Krueger (2013) as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment, free from interruptions. According to Carey (1995), a focus group is “a semi-structured group session, moderated by a group leader held in an informal setting, to collect information on designated topics”. In this study, the participants were selected

because they had certain characteristics in common that related to the topic of the focus group, namely nurses ethical-moral behaviour towards patients.

Focus group discussions in this study were used because the questions were asked in Xitsonga and Sepedi and flexible and it was expected to be easy for participants to reveal their views. Focus group interviews are believed to generate more critical comments than individual interviews (Kitzinger, 2008) as participants share their thoughts. The shared information could be flexible, stimulating, cumulative, elaborative, assistive in information recall and capable of producing rich data (Fontana & Frey, 2000). Two focus groups discussions were conducted with patients (one for females and one for males) at each of the three participating hospitals.

Table: 3.3 Hospital, number of focus group

District	Hospital	Focus groups conducted with patients
Mopani	Letaba	Two
	Kgapane	Two
Vhembe	Elim	Two

The following methods were used to encourage the participants to talk during the interview:

The process followed when conducting focus group discussions

The following guidelines were adhered to in relation to preparations, techniques, skills and attitudes of the facilitator while conducting focus group interviews.

- **The environment**

The focus groups were conducted in a conducive environment during the evenings when the hospitals were not busy. Participants were allowed to stand or adopt any position when they wished to emphasise specific aspects (Krueger & Casey, 2002).

- **Fieldnotes**

The researcher used field notes as a piece of evidence in support of recorded experiences and as a record of context or situation. Observational notes, methodological notes and theoretical notes were compiled (De Vos, 2011).

- **Methodological notes**

These notes comprised reminders, instructions and critical comments for the researcher (DeVos, 2011).

- **Theoretical notes**

These were self-conscious, systematic attempts by the researcher to derive meaning from observational notes. The researcher thought about what she had experienced and made private declarations of meaning she felt would be meaningful. Repeatedly occurring patterns were identified and the researcher tried to explain the investigated phenomenon by contextualising it within the relevant literature (De Vos, 2011).

- **Probing**

Probing is a neutral request to clarify the ambiguous and incomplete question, finish and unfinished or complete incomplete answers. In this study, different probing questions, were asked, emanating from participant's answers, to allow the participants to give clearer

information (Annexure f1), *(For* example: *"Can you tell me more about how nurses treat patients?")* (Brink, 2006).

- **Minimal verbal responding**

According to de Vos et al. (2011), this verbal response that correlates with occasional nodding, which confirms to the participant that the researcher is still listening. In this study, the researcher nodded the head saying, "I am listening", 'hmm', 'yes' 'continue' in response to what the participant was saying. This allowed for a free flow of information and encouraged participants to say more (Annexure F2).

- **Clarifying**

According to de Vos et al. (2011), clarifying is used to get clarity on unclear statements.
In this study, the researcher asked follow-up questions, repeated the participant's statement and redesigned the questioning throughout the interview so that participants could clarify facts and consolidate some of the information or restructure some of the questions (Annexure F2).

- **Reflecting**

Reflecting happens when the researcher reflects on something that the participant has already said so that the participant can give more information on that point. In this study, the researcher took participants back to the answers already given so that they could expand more (Annexure F2)

- **Focusing**

According to de Vos et al. (2011), the researcher keeps the interview on track. In this study, full attention was given throughout in order to help the participants focus on their experiences related to perceptions and views of patients on the ethical-moral behaviour of nurses (Annexure F2).

- **Paraphrasing**

According to de Vos et al., (2011), paraphrasing is a verbal response where the researcher tries to rephrase what the participants have said but meaning the same thing, in order to seek more information. In this study, the researcher stated the participant's word in another form but with the same meaning. This made participants try to give more information needed from the question (Annexure F2).

- **Validation**

The researcher observed the participants and interpreted their non-verbal communication such as vocalization, facial expression and bodily gestures and transcribed them for analysis. The researcher asked for clarity in the observations made (de Vos et al., 2011).

In this research, all non-verbal communications collected during interviews were transcribed and analysed (Annexure F2).

- **Encouragement**

According to de Vos et al., (2011), participants have to be encouraged to pursue a line of thought. In this study, the participants were encouraged to tell more about the aspects

related to perceptions and views of patients on the ethical-moral behaviour of nurses (Annexure F2).

- **Using Silence**

Silence allows the participant to do the talking while the researcher is listening and observing (de Vos et al., 2011). In this study, the researcher had some pause or kept quiet and observed what was happening (Annexure F2). This allowed the participant to think and continue narrating at her own pace.

3.4.5 Data Analysis

According to Polit and Beck (2014), data analysis is a systematic organisation of research data and the researcher used techniques such as coding, the process of translating verbal data into categories or numeric forms. The information from the audio recorder was first transcribed verbatim before data analysis could be undertaken. The verbatim scripts were then translated into English by language experts. Each language had a translator who was an expert in English and helped to translate the language. Every translated information of all the languages was checked by other language experts who were proficient in English and the translated language (see Annexure B). In this study, the information was coded according to the themes, subthemes and descriptions which emerged from the participants' responses to the questions (Polit & Beck, 2014). The information was compared against the recorded and documented data for accuracy. Data belonging to one group were assembled in one place to assist further reading and analysis. Themes, sub-themes and categories were formulated according to the patterns that emerged from the data.

Tesch's principles of data analysis were used (Creswell, 2013).

- Getting a sense of the whole by reading through the transcriptions that were made down ideas, to get sense of the whole interview.

- Picking one document, the researcher started with the most interesting shortest and the one at the top, thought about the underlying meaning of the information while writing thoughts in the margin, thought such as perceptions and views of patients on the ethical-moral behaviour of nurses.

- Listing the topics, made a list of all topics, similar topics were clustered together and similar topics were used to form columns that will be arranged as major and unique topics/main theme, themes and categories, unique topics and uncategorized ones were displayed accordingly.

- Going back to data, abbreviated the topics as codes next to the appropriate segments of the text, which helped the researcher to see whether new categories and codes emerged. This continued through data analysis in order to refine the data.

- Describing the topics by identifying the most descriptive wording for the topics and turned them into categories. The total list of categories was reduced by making groups of topics that relate to one another. The interrelationship was indicated by drawing a line between categories.

- Abbreviating categories were made from formulated topics and arranged the codes alphabetically. Reviewed each category to check if new codes or categories emerged:

- Made a preliminary analysis by assembling data material belonging to each category in one place. This allowed the data that was not categorized to be further looked at from different angles and be categorized too. On the main theme, subthemes were generated from the data pool for analysis and discussion: lastly:

- Recorded the existing data as two main themes, sub-themes and categories which were identified by both the researcher and the independent coder. They were also compared by one external reviewer who was not part of the initial analysis, comparing the similarities and differences. All differences were discussed with the researchers, supervisors and independent coder until consensus was reached. A table of two main themes three sub-themes and seven categories were then drawn.

3.4.6 Measures to Ensure Trustworthiness

Trustworthiness is the ability of the qualitative study to represent the experience of the participants (Polit & Beck, 2014), It is described as a measure to ensure the reliability of data collection procedures and instruments to avoid bias in the interpretation of the findings The researcher applied strategies to ensure truth value (credibility), consistency (dependability), neutrality (conformability) and applicability (transferability) to confirm whether the study explored the perceptions and views of patients on the ethical-moral behaviour of nurses at Mopani and Vhembe district in Limpopo Province.

3.4.6.1 Truth value (Credibility)

Credibility is the truth of data collected and the way data was interpreted (Polit & Beck, 2014), and establishes how confident the researcher is about the truth of the findings. Credibility

means value, the belief and the degree to which the finding and methods of research applied to get research findings can be trusted. The researcher had enough time for data collection. This study achieved credibility by prolonged engagement and the time spent with participants during appointments until reaching data saturation during interviews and FGDs. The structural coherence was ensured through discussions, member checking so that no unexplained inconsistencies between the data collected and its interpretations could be noted, and field notes were taken to rationalize the relationship between the researcher and the setting (Polit & Beck, 2014).

3.4.6.2 Consistency (Dependability)

According to de Vos et al. (2011) dependability means that if an inquiry into the same phenomenon is repeated the results will be replicated. This is supported by (Polit & Beck, 2014), who indicated that dependability is sat stability over time and over conditions that is evidence which is consistent and stable. In this study, raw data from verbatim transcribed interviews and observations notes and recordings will be kept for scrutiny for verification and inquiry processes. The study's supervisors examine the auditing of the raw data, findings and interpretations against the transcripts and data analysed by an independent coder and the researcher after completion of the study to ensure internal cohesion of data, which also ensure conformability.

3.4.6.3 Neutrality (Conformability)

Conformability refers to the criteria for evaluating the quality of data, by referring to objectivity or neutrality. Conformability was ensured by playing the tape-recorded interviews to

participants, to check if what they said was what they meant (Polit & Beck, 2014). If two or more independent people are congruent about collected data relevance, meaning and accuracy, it means that there is conformability, objectivity or reliability of data collected (Polit & Beck, 2014). In this study, the research was supervised by highly qualified supervisors. In a qualitative study, the researcher follows the research design method as outlined and this leads to the collection of data that was able to develop the themes using findings in chapter 4 that is perceptions and views of patients on the ethical-moral behaviour of nurses.

Neutrality refers to the degree to which the findings are a function solely of the participants and conditions of the research and not of any bias, motivations and perspectives (Polit & Beck, 2014). In this study, the researcher achieved neutrality by prolonged engagement with participants during focus group interviews and in-depth individual interviews, reflection and verification. Multiple data sources included patients, observations and field notes to ensure that the researcher's opinions would not be reflected instead of the participants' views.

3.4.6.4 Applicability (Transferability)

Transferability refers to the degree to which the findings could be applied to another context and setting or other groups of people (Polit & Beck, 2014). The findings of research should be applied in other contexts or with other respondents. The researcher collected sufficient detailed descriptions of data context. The sample should be clearly described in terms of demographics so that the participants are clearly distinguished from the others in general (Polit & Beck, 2014). In this study, transferability was ensured by densely describing the background information of the participants. The research context and setting were also described, to allow others to assess how transferable the findings would be. The purposive

sampling technique was used to select participants, who met the inclusive criteria, has also been described in detail (Polit & Beck, 2014).

3.5 Phase 2: Concept Analysis and Model Development

This phase involved conceptualisation and model development. During conceptualisation, concepts that emerged during data analysis and literature control were identified and analysed and these concepts formed the basis of the model development procedure. Concept analysis and model development were guided by the adapted phases as explained by Rodger and Knafl (2000) and Chinn and Kramer (2014). The framework of Dickoff, James and Wiedenbach (1968) was used to classify the concepts and the model development process was guided by Chinn and Kramer's (2014) steps.

Conceptualisation

According to Mouton (2012), conceptualisation analysis refers to the clarification and analysis of the lay concepts in a study and the way one's research is integrated into the body of the existing theory and research. It also refers to the underlying theoretical framework that guided the research. Conceptualisation is the process going on in one's mind when one gathers impressions or perceptions, identifies similarities and combines these similarities to comprise a single thought, which expresses the similarities and then gives the concept a name (Mouton, 2012).

Concepts that emerged from data analysis were analysed, described, and interpreted and relationships between concepts and statements were identified. This formed the basis of the

model development process in this study (Walker & Avant, 2015). Concept analysis was conducted according to eight steps specified by Rodger and Knafl (2000), namely:

- Identification of concepts of interest ○ Identification of appropriate settings and samples for data collection
- Collecting relevant data to identify the attributes of the concept, along with surrogate terms, references, antecedents and consequences ○ Identification of concepts related to the concept of interest ○ Analysis of data regarding the above characteristics of the concept ○ Conducting interdisciplinary or temporal comparisons ○ Identification of the model case concept
- Identification of hypotheses and implications for further development.

- **Conceptual framework**

The concepts were classified using the survey list of the practice model (Dickoff et al., 1968). The survey list is discussed in this theory. The list included the agents, patients, framework, terminus, procedure and dynamics. It was used as a basis for clarification (Dickoff et al., 1968).

- **Agent**

An agent is a person or any other person/thing whose activity contributes towards the realisation of a goal (Dickoff et al., 1968). Different persons could perform different activities

while striving towards the same goal (Dickoff et al., 1968). In this study, the agents comprised all categories of nurses whose main goal was to promote moral regeneration.

- **Recipients**

These are persons or (things) who receive action from an agent and this activity contributes to a certain goal (Dickoff et al., 1968). In this study the recipients were patients.

- **Framework/context**

The context is viewed from the aspect of the matrix of activity. To view activity is to see it in relation to other things, including persons and other activities, and to see the interrelation of these activities to other factors as a contributing organism, unity, and total context of activity (Dickoff et al., 1968). The context within which this study was conducted in the participating hospitals in the Limpopo Province provided the context/framework.

- **Terminus/purpose**

To treat an activity from the aspect of the terminus is to view an activity from the perspective of the endpoint or accomplishment of the activity (Dickoff et al., 1968). The terminus for this study was the outcome of moral regeneration.

- **Procedure**

This is to view the activity from the vantage point of the principle, rule, routine or protocol governing the activity. This is to emphasise the path, steps, patterns according to which the activity is performed (Dickoff et al., 1968). The procedure was also guided by the outcome of the concept analysis.

- **Dynamics**

These are the power sources for the activity which can be chemical, physical, biological and psychological for any person or thing functioning as an agent or patent as part of the framework for realising the goal (Dickoff et al., 1968).

3.6. PHASE 3: Model validation

3.6.1. POPULATION AND SAMPLING

The population used in this was all nurses in Mopani and Vhembe districts of Limpopo Province.

3.6.1.1 Accessible Population

The accessible population comprised all nurses from the selected hospitals in Mopani and Vhembe districts with two or more years' working experience.

3.6.1.2 Target Population

The target population comprised all categories of nurses working in the selected hospitals in Limpopo Province who had more than two years' working experience.

3.6.2 Sampling of and hospitals

Simple random sampling was used to select hospitals from the two districts; namely, Mopani and Vhembe: (Letaba) Mopani, (Kgapane) Mopani and (Elim) Vhembe of Limpopo Province. One regional hospital and one district hospitals were selected from Mopani District. One district hospital was also selected from Vhembe district. The regional hospital was selected

because it is a referral hospital serving large numbers of patients. The two district hospitals were also selected on the basis that the encounter staff shortages, under-resourced and most of these patients are very ill and require specialized care which can be exhausting for nurses.

3.6.2.1 Sampling of Participants (Nurses)

Stratified random sampling was used to group nurses into different categories and simple random sampling was used to select the nurses from each stratum. Stratified random sampling, refers to a sampling process in which population is divided into subgroups or strata according to a variable of the importance of the study so that each element of the population belongs to only one stratum (de Vos et al., 2013). The population was divided into strata or subgroups as follows: Nursing auxiliary; Enrolled nurses; professional nurses. Almost 178 nurses were drawn from 267 nursing personnel per hospital. The researcher wanted nurses to validate a developed model to promote moral regeneration.

3.6.2.2 Inclusion criteria

All nurses from the selected hospitals in Mopani and Vhembe districts had more than two years' working experience.

3.6.2.3 Sample size

In this study, the sample size was drawn from 178 all categories of nurses

3.6.2.4 Data collection

A questionnaire was designed to validate the model in quantitative data collection. The researcher presented the model and guidelines to the nurses. The questionnaires were distributed to all categories of nurses. Each respondent completed the questionnaires in his /her own time.

3.6.2.5 Data analysis

Data were analyzed by a statistician using SPSS version 25. Frequencies and percentages were used to describe the nurses' knowledge about their ethical behaviour and ethical-moral nursing practice. Bivariate analyses were used to examine the relationships between the nurses years of working experiences and socio-demographic variables.

3.6 ETHICAL CONSIDERATIONS

Ethics involves doing what is right and good during research. It is the application of all ethical principles to the research process. Ethics in research ensures that human, humane, humanistic and moral considerations pertaining to the research are maintained.

Ethics in research also enhance the credibility and trustworthiness of data (Burns & Grove 2016). The researcher ensured that the rights of participants were observed, protected and respected (Polit & Beck: 2014). In this study, everything that was agreed upon by the researcher such as respect for human rights and others was considered in that the rights of participants and other ethical considerations were observed throughout the study.

3.6.1 Permission to conduct research

In this study, a research proposal was presented to the School of Health Sciences Higher Degrees Committee and Research Ethics Committee of the University of Venda (Annexure A). The University of Venda Ethics Committee issued the ethical clearance certificate for this study (Annexure B). Applications requesting permission to conduct the study were submitted to the Limpopo Provincial Health Department (Annexure C1) and Mopani and Vhembe District Department of Health (Annexure C2). Permission was granted to access the facilities for utilization of the selected hospitals (Annexure D).

- **Informed consent**

Informed consent means that participants have adequate information regarding the research; are capable of comprehending the information, and have the power of free choice; enabling them to consent voluntarily to participate in the research or to decline participation (Polit & Beck, 2014). The researcher provided the participants with relevant and adequate information (see Annexure B) when requesting them to sign the consent form. Participants/respondents were informed about the purpose and scope of the study, and how the results would be used and how their anonymity and confidentiality would be protected (Streubert & Carpenter, 2011).

In this study, the researcher explained the purpose of the study before requesting participants/respondents to sign the consent forms. How data were collected and used helped to ensure that confidentiality, privacy and anonymity would be maintained. For this

reason, written consent was obtained from participants (see Annexure B). Participants were encouraged to keep information confidential and use code names during interactions during the focus group interviews.

- **Right to confidentiality and anonymity**

The principle of beneficence, doing good and preventing harm, applies to provide confidentiality and anonymity for research participants. Confidentiality is a pledge that any information provided by participants would not be publicly reported in a manner that could identify any individual and the data would only be accessible to the researcher, the study's supervisors and the statistician. The audio recordings, the verbatim transcripts and the completed questionnaires were kept locked-up by the researcher in a secure place. The data entered into the SPSS program were protected by a secure password on computers to which only the statistician and the researcher had access. This means that research information was not shared with strangers, nor with people are known to the participants (such as family members, physicians and nurses), unless the participant granted the researcher explicit permission to do so (Polit & Beck, 2014). Confidentiality is related to the researcher's management of private information shared by participants that should not be shared with others without authorisation by the participants (Burns & Grove, 2016).

Anonymity occurs when not even the researcher can link a participant to his or her data (Polit & Beck 2014). Anonymity relates to keeping the participants nameless in relation to their participation in the study (Brink, 2012). Anonymity means that the names of the participants were not be used. The questionnaires were completed anonymously so no completed questionnaire could be traced to any specific nurse. No names were recorded during the individual interviews conducted with patients, a unique number was assigned to

every interviewed patient. During the focus group discussions, every participant was addressed only by his/her number assigned to him/her at the commencement of every focus group. During all data collection phases, the signed consent forms were collected and placed into a container before any interview commenced. The completed questionnaires were collected in one container and the signed consent forms were collected in a different container so that no signed consent form could be linked to any specific completed questionnaire.

According to De Vos et al. (2011) confidentiality indicates handling of information in a confidential manner.

- **Right to privacy**

Privacy is the freedom an individual has to determine the time, extent, and general circumstances under which private information would be shared with or withheld from others. Private information includes one's attitudes, beliefs, behaviours, opinions and records. The research subject's privacy is protected if the subject is informed and consents to participate in a study and voluntarily shares private information with a researcher (Burns & Grove, 2016). Privacy was maintained throughout this study. The researcher ensured that participants were treated equally, regardless of their socioeconomic status, and whether they were illiterate or educated. Interviews were conducted in private rooms.

- **Right to self-determination**

The right to self-determination is based on the ethical principle of respect for persons, which states that humans are capable of self-determination or controlling their own destiny. Thus, humans should be treated as autonomous agents, who have the freedom to conduct their

lives as they choose without external controls (Burns & Grove, 2016). In this study, the participants'/respondents' right to self-determination was respected as every person had the right to participate or to refuse to do so without incurring any negative consequences.

- **Right to fair treatment**

The right to fair treatment is based on the ethical principle of justice. This principle states that each person should be treated fairly and should receive what he or she is due or owed (Burns & Grove, 2016). In this study, the selection of participants and their treatment during the course of study was fair. No patient's treatment was jeopardised in any way through his/her participation or refusal to participate. No seriously ill patient was interviewed. All interviewed patients were at least 18 years old and could legally consent to participate in the study.

- **The right to protection from discomfort**

The right to protection from discomfort and harm is based on the ethical principle of beneficence, which holds that one should do good, and above all, do no harm. The researcher ensured that participants were comfortable by selecting a suitable venue, day and time for conducting the interviews. The researcher also guarded against embarrassing the participants during interviews because questioning and probing were done cautiously and respectfully, and no patient was obliged to answer any specific question.

3.7. Summary

Chapter 3 discussed the research methodology of this study, measures to ensure trustworthiness, model development and evaluation and ethical considerations. The

methodology of the study was based on mixed methods related studies. Questionnaires were used for data collection during the quantitative phase of the study while individual interviews and focus group interviews were used to collect qualitative data. Chapter 4 focuses on data analysis.

CHAPTER 4

EMPIRICAL RESULTS AND DISCUSSION

4.1 INTRODUCTION

Chapter 3 concentrated on research methodology that was adopted in this study. In both the qualitative and quantitative research, the purpose of the study was explained to participants and verbal or written consent was obtained from participants before data collection process. Data was collected in Xitsonga, Sepedi and Tshivenda, according to the participant's language preference. Qualitative data analysis was done using Tesch's eight steps of open-coding. This chapter interprets and merges the research findings from quantitative to qualitative approaches guided by Kohlberg's Theory of Moral Development. This theory believes that morals in humans developed sequentially and depends on the cognitive development of an individual. It shows the extent to which an individual has internalised the social rules and values. In nursing, over the years, the theory has been used to explain and solve problems relating to morality in clinical and education settings (McLeod-Sordjan, 2014). In this study findings are discussed in two sections; namely the quantitative and qualitative data analysis as this study used mixed research methods. Phase one stage 1 presents the quantitative results followed by the qualitative results in Phase one stage 2. In the quantitative study (Phase I, stage 1) questionnaires were used to collect data from all categories of nurses from the selected hospitals and analysed by using descriptive and inferential statistics such as frequencies, mean and standard deviations, correlations and regressions. Data processing was carried out, with the assistance of a statistician, using the Statistical Package for Social Sciences (SPSS) version 25.

In the qualitative (Phase1, stage 2) data were collected from patients by conducting individual interviews and focus groups discussions. The first objective of stage 2 was to explore the perceptions of patients regarding the moral-ethical behaviour of nurses, the second objective was to explore the views of patients regarding the ethical ethical-moral behaviour of nurses. Qualitative research was used to meet these objectives. The third objective was to assess the knowledge of nurses regarding their ethical-moral behaviour and quantitative study was used to achieve this objective under stage 1. In the qualitative research Tech's eight steps were followed in analysing the qualitative data (Creswell, 2013). The researcher used quotes from some participants in the discussion to portray the participants' views in their own words. The qualitative study yielded two main themes, three sub-themes and seven categories during data analysis. A literature control was done to support the findings. The quantitative study *assessed the knowledge of professional nurses about their ethical-moral behaviour to ascertain whether the nurses understood nursing morals and ethics.* This chapter aims to analyse, interpret and describe the data collected.

4.2. PHASE ONE: EMPIRICAL PHASE

The empirical phase consisted of two stages; namely, stage 1 which was a quantitative study and stage 2 which was a qualitative study and are discussed hereunder.

4.2.1 Stage 1: Quantitative Study Results

In the quantitative study, data were collected through self-administered questionnaires from the three selected hospitals. These self-administered questionnaires incorporated closed-ended questions and statements. The self-administered questionnaire was subdivided into two sections: as follows that is, Section incorporated demographic

characteristics, while section B entailed knowledge about ethical behaviour, caring, empathy and sympathy, ethical-moral behaviour of nurses and respect. The questionnaires were given to all categories of nurses who had more than four years of working experience in the selected hospitals. The self-administered questionnaires were distributed among nurses in the selected hospitals by the researcher and collected seven days after distribution, giving the respondents' time to complete.

4.2.1.1 Respondents' socio-demographic profile

Table 4.1 reveals significant associations between the respondents' years of nursing experience and age, highest nursing qualification and post-basic qualifications. Of the respondents 23.6% (n=33) were aged 30-39, 5.0% (n=7) were 20-29 years old and most participants were aged 40-49 and 50-59 35.7% (n=50). Majority of participants were females 88.6% (n=124). Most of the participants' highest nursing educational level was found to be Bridging course 20.7% (n=29), 3-year diploma in nursing 22.1% (n=31) and four-year comprehensive courses (R425) 25.0% (n=35).

The demographic characteristics revealed that most participants had 15 or more years' experience in nursing 44.3% (n=62) followed by 11 to 15 years' experience in nursing 28.6% (n=40). The race of the respondents was dominated by Africans 52.1% (n=73), followed by Indians 21.4% (n=30) and coloureds 15% (n=21) The Majority of participants reported IsiZulu 24.3% (n=34), Xitsonga 16.4% (n=23), followed by Sepedi and Setswana 12.9% (n=18) respectively as their home language. About 51% (n=71) of all participants were single, followed by 27% (n=38) who were married and about 22% (n=31) that are widowed.

Table 4.1 Respondents' socio-demographic characteristics (n=140)		
		Frequency (Percent/%)
Age	20-29	7 (5.0)
	30-39	33 (23.6)
	40-49	50 (35.7)
	50-59	50 (35.7)
Gender	Male	16 (11.4)
	Female	124 (88.6)
Highest educational level	Enrolled auxiliary	3 (2.1)
	Enrolled Nurse	11 (7.9)
	Bridging Course	29 (20.7)
	3-year Diploma in nursing	31 (22.1)
	4-year comprehensive (R425)	Cours 35 (25.0)
	BA Cur	2 (1.4)
	BA Cur Hons	11 (7.9)
	Other	18 (12.9)
Years of experience in nursing	0-5 years	10 (7.1)
	5-10 year	28 (20.0)
	11-15 years	40 (28.6)
	15 years and more	62 (44.3)
Race	African	73 (52.1)
	White	4 (2.9)
	Coloured	21 (15.0)
	Indian	30 (21.4)
	Other	12 (8.6)
Home language	Xitsonga	23 (16.4)
	Sepedi	18 (12.9)
	Setswana	18 (12.9)
	Tshivenda	15 (10.7)
	IsiXhosa	19 (13.6)
	IsiZulu	34 (24.3)
	SiSwati	10 (7.1)
	Other	3 (2.1)
Marital status	Single	71 (50.7)
	Married	38 (27.1)
	Widow	31 (22.1)
Religion	Christian	73 (52.1)
	Non-Christian	15 (10.7)
	Other	52 (37.1)

4.2.1.2 Demonstrating ethical-moral behaviour

Figure 4.2 shows the nurses responses to their ethical behaviours. Of the 162 respondents, 52.1% (n=73) reported that during the two years preceding the survey, they had demonstrated ethical practice in their nursing profession.

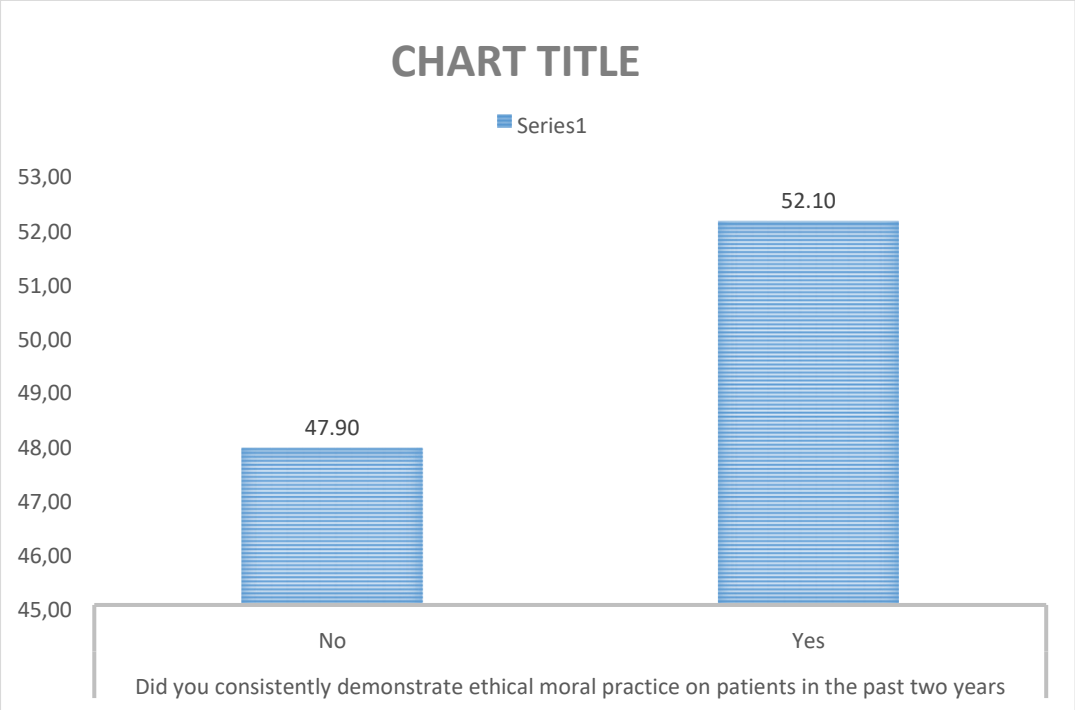

Figure 4.2: Nurses responses to ethical practice in nursing during the preceding two years

4.2.1.3 Nurses knowledge about ethical-ethical-moral behaviour

Table 4.2 presents the nurses level of knowledge about ethical-moral behaviour. For those who stated that ethical conduct was important, 63.6% (n=89) reported that it was to avoid legal action. Adherence to patients' wishes was reported by 81.4% (n=114) of the respondents. On the contrary, 72.9% (n=102) of the respondents were of the view that nurses should do what is best for the patient irrespective of the patient's opinion. As

many as 89.3% (n=125) of the respondents indicated that patients should always be told if something is wrong. In addition, 70.7% (n=99) disapproved of confidentiality of patients. Furthermore, 65.0% (n=91) disagreed that a patient who refused treatment due to his/her beliefs should be instructed to find another doctor. Treating children without the consent of their parents was endorsed by 72.2% (n=101) of the respondents, but only in cases of emergency. As many as 55.0% (n=77) disagreed with compliance with South Africa's TOP legislation. With regards to patients' wishes to die, 75.7% (n=106) of respondents disapproved of assisting patients to die.

On the other hand, 85.0% (n=119) reported that they adhered to patients' wishes. Of the responding nurses, 87.8% (n=123) informed patients if something was wrong with their illness and what was best irrespective of the patient's opinion. The proportion of respondents who stated that they informed relatives (54.3%; n=76) about the patient's condition was higher than that of those who did not do so (43.5%; n=61). Conversely, the percentage of nurses who agreed that they treated children without the consent of their parents (17.2%; n=24) was lower than that of those who disagreed that they treated children without the parents' consent (77.2%; n=108). Most nurses (83.7%; n=117) did not assist patients who wished to die. Of the nurses, 85.7% (n=120) indicated that they cared for all categories of patients and 79.2% (n=111) avoided discrimination of patients. Most respondents (94.3%; n=132) reported that they promoted equal opportunities from all persons, including disabled people and PLWH and patients suffering other diseases.

Table 4.2: Nurses knowledge about moral ethical behaviour (n=140)

	SA	A	U	DA	SD
Ethical conduct is important only to avoid legal action	53 (37,	9 36 (25,	7 2 (1,	4 29 (20,	7 20 (14,
Patient's wishes must be adhered to	59 (42,	1 55 (39,	3 2 (1,	4 19 (13,	6 5 (3,
Nurses should do what is best for the patient irrespective of patient's opinion	60 (42,	9 42 (3	0 2 (1,	4 29 (20,	7 7
A patient should always be told if something is wrong	68 (48,	6 57 (40,	7 2 (1,	4 8 (5,	7 5 (3,
Confidentiality should be abandoned	19 (13,	6 19 (13,	6 3 (2,	1 31 (22,	1 68 (48,
Patients only need to consent for operations but not for tests or medications	20 (14,	3 31 (22,	1 4 (2,	9 41 (29,	3 44 (31,
If a patient refuses treatment due to beliefs he/she should be instructed to find another doctor	16 (11,	4 26 (18,	6 7 (	5 55 (39,	3 36 (25,
Children should never be treated without the consent of their parents or guardians except in an emergency	62 (44,	3 39 (27,	9 2 (1,	4 20 (14,	3 17 (12,
The law allows abortion; therefore a nurse cannot refuse to do an abortion	23 (16,	4 31 (22,	1 9 (6,	4 44 (31,	4 33 (23,
A patient who wishes to die should be assisted in doing so	12 (8,	6 16 (11,	4 6 (4,	3 43 (30,	7 63 (45
I adhere to patients' wishes	64 (45,	7 55 (39,	3 4 (2,	9 9 (6,	4 8 (5,
I inform a patient if something is wrong with his/her illness	59 (42,	1 64 (45,	7 1 (0,	7 11 (7,	9 5 (3,
I do what is best for the patient irrespective of his/her opinion	40 (28,	6 66 (47,	1 6 (4,	3 17 (12,	1 11 (7,
I inform the relatives about the patient's condition	28 (2	0 48 (34,	3 3 (2,	1 38 (27,	1 23 (16,
I treat children without consent from their parents	5 (3,	6 19 (13,	6 8 (5,	7 46 (32,	9 62 (44,
I assist patients who wish to die	6 (4,	3 10 (7,	1 7 (	5 52 (37,	1 65 (46,
I care for all who are weak and disadvantaged: poor, the aged, the disabled and all those unable to care for themselves	89 (63,	6 31 (22,	1 3 (2,	1 7 (	5 10 (7,
I overcome discrimination on the basis of status, custom, culture ,race, gender, sexual orientation, heal status, and tradition	t 66 (47,	1 45 (32,	1 4 (2,	9 13 (9,	3 12 (8,
I promote equal opportunities from all persons including disabled people and those suffering from HIV/AIDS and other forms of diseases	95 (67,	9 37 (26,	4 0 (	0 4 (2,	9 4 (2,

If a patients refuse treatment due to beliefs, they should be instructed to find another doctor	*15 (10,*	*7*	*23 (16,*	*4*	*5 (3,*	*6*	*50 (35,*	*7*	*47*

4.2.1.4 MULTIVARIATE ANALYSIS

To examine the factors related to the inherent common structure between the 20 items concerning nurses knowledge about their ethical ethical-moral behaviour, principal component analysis (PCA) with orthogonal rotation was performed (see Table 4.3). The Kaiser-Meyer-Olkin (KMO) measure was used. The sample adequacy for the analysis was = .666 which suggested that the sample was factorable. Bartlett's test of sphericity X^2 (171) = 708, 77, p <.05, indicated that correlations between items were sufficiently large for PCA. The 20 items examined generated five components (CP) with eigenvalues greater than 1 which accounted for 56.46% of knowledge factors associated with ethical-moral behaviour among nurses. Eigenvalues of a factor represent the amount of the total variance explained by that factor (Pallant, 2010). This was necessary for this study as it explained the total variance each factor provided.

In terms of reliability, the internal consistency of the CP1, CP2, CP3, CP4 and CP5 elements had Cronbach's alpha ranging from .56 to .75. The CP5 subscale had relatively low reliability with Cronbach's alpha o.56. However, a low Cronbach's alpha score might suggest a measure of uni-dimensionality (one underlying factor or construct) (Cortina, 1993). The degree to which the factors explained the variations in the questions ranged from .420 to .732.

The principal component analysis was done and presented using factor loadings and communality values for nurse's knowledge about ethical-moral behaviour variables. Factor loadings refer to the correlation found between the original variables and the factors, and it is furthermore important for this study as it is the key to understanding the underlying nature

of a particular factor. In addition, squared factor loadings indicate the percentage of the variance in an original variable explained by a factor. With commonality being the total variance original variable shares with all other variables included in the analysis. The five items that cluster on the first component (CP1), which had an eigenvalue of 2.34, explained 12.34 per cent of the variance which reflected aspects related to knowledge and respect of a patient's autonomy. The second component (CP2), with an eigenvalue of 2.29, explained 12.06% of the variance, including six items related to knowledge of justice in ethical-moral behaviour. The third component (CP3), with two items relating to ethical dilemmas with an eigenvalue of 2.27, explained 11.99% of ethical-moral behaviour. The fourth component (CP4), with four items, correlated highly with the statements that measured compassion during ethical-moral behaviours. It had an eigenvalue of 1.96 and explained 10.35% of the total variance. The fifth component (CP5), with two items correlating with the statements that entail empathy and loyalty, had an eigenvalue of 1.85 explaining 9.73% of the variance.

4.2.1.5 Binary logistic analysis

Direct logistic regression was performed to assess the impact of several factors on the likelihood that respondents would report that they are knowledgeable about ethical-ethical-moral behaviour. The model consisted of eight independent variables (age, gender, highest qualification, and years of experience, race, home language, marital status and religion).

The full model containing all predictors was found to be statistically significant, X^2 (8, N=140) =15.919, p= 0.044, indicating that the model was successful in distinguishing between respondents who reported and did not report knowledge regarding ethical-ethical-moral behaviour among nurses.

Table 4.3: Factor loadings and communality values for nurses knowledge about ethical ethical-moral behaviour variables included in the sorted rotated factor matrix

Variables	CP1	CP2	CP3	CP4	CP5	H
Patient's wishes must be adhered to	**.634**	Na	Na	Na	Na	.420
The patient should always be told if something is wrong	**.632**	Na	Na	Na	Na	.627
I inform patients if there is something wrong with his/her illness	**.586**	Na	Na	**.471**	Na	.593
I adhere to patients wishes	**.535**	Na	Na	Na	Na	.472
Children should never be treated without the consent of their parents or guardians except in an emergency	**.502**	Na	Na	Na	Na	.462
Patients only need to consent for operations but not for tests or medications	Na	**.812**	Na	Na	Na	.678
The law allows abortion, therefore a nurse cannot refuse to do abortion	Na	**.607**	Na	Na	Na	.461
If a patient refuses treatment due to beliefs, they should be instructed to find another doctor	Na	**.503**	Na	Na	Na	.434
Confidentiality should be abandoned	Na	**.498**	Na	Na	Na	.631
Ethical conduct is important only to avoid legal action	Na	**.434**	Na	Na	Na	.601
I assist patients who wish to die	Na	Na	**.817**	Na	Na	.732
I treat children without consent from their parents	Na	Na		Na	Na	.636
A patient who wishes to die should be assisted in doing so	Na	**.412**	**.619**	Na	Na	.588
I inform the relatives about the patient's condition	Na	Na	Na	Na	Na	.530
I care for all who are weak and disadvantaged: poor, the aged, the disabled and all those unable to care for themselves	Na	Na	Na	**.784**	Na	.670
I overcome discrimination on the basis of status, custom, culture, race, gender, sexual orientation, health status, and tradition	Na	Na	Na	**.694**	Na	.566
I promote equal opportunities from all persons including disabled people and those suffering from HIV/AIDS and other forms of diseases	Na	Na	Na	**.417**	Na	.476
Nurses should do what is best for the patient irrespective of the patient's opinion	Na	Na	Na	Na	**.730**	.569
I do what is best for the patient irrespective of his/her opinion	Na	Na	Na	Na	**.705**	.583
Eigenvalues	**2.34**	**2.29**	**2.27**	**1.97**	**1.85**	
Percentage of variance explained	**12,33**	**12,05**	**11,9**	**10,35**	**9,72**	
Cronbach's alpha	**0.69**	**0.71**	**0.75**	**0.69**	**.56**	

* Loadings => 0.40, h= communality, na= not applicable

Table 4.4 Model Summary and "Hosmer and Lemeshow Test"						
				Hosmer and Lemeshow Test		
Step	*-2 Log likelihood*	*Cox & Snell R^2*	*Nagelkerke R^2*	*Chi-square*	*Df*	*Sig.*
1	*74.386a*	*.270*	*.472*	*15.919*	*8*	*.044*

The model as a whole explained between 27.0% (Cox & Snell R^2) and 47.2% (Nagelkerke R^2) of the variance in knowledge regarding ethical and ethical-moral behaviour, and correctly classified 74.3% of the cases.

As projected in Table 4.5, only 2 of the independent variables made a unique statistical significant contribution to the prediction of knowledge regarding ethical and ethical-moral behaviour in nursing (Race [African, Indian] and Religion [Non-Christian]). The strongest predictor of knowledge regarding ethical and ethical-moral behaviour was race (especially being African and Indian), recording an odds ratio of 200.12 and 9.73 respectively. This indicates that respondents who were African were 200 times more likely to report higher knowledge regarding ethical and ethical-moral behaviour and respondents who are Indian have a likelihood of 9 times to report higher knowledge regarding ethical and ethical-moral behaviour. Religion (Specifically non-Christianity) was also the most significant contributor (p=0.015) and recorded an odds ratio of 11.08 (1.601-76.66) indicating that not being Christian increases the chance of reporting higher knowledge regarding ethical and ethical-moral behaviour by 11 times.

Table 4.5: Logistic regression predicting the likelihood of nurses knowledge regarding ethicalmoral behaviour								
							95% C.I.for Odds Ratio	
	B	***S.E.***	***Wald***	***Df***	***Sig.***	***Odds Ratio***	***Lower***	***Upper***
Gender(Male)	*1.265*	*1.484*	*.726*	*1*	*.394*	*3.54*	*.193*	*64.97*
Race(African)	***5.299***	***2.562***	***4.279***	***1***	***.039***	***200.12***	***1.32***	***30327.97***
Race(White)	*.885*	*1.034*	*.732*	*1*	*.392*	*2.42*	*.32*	*18.39*
Race(Coloureds)	*1.388*	*.864*	*2.582*	*1*	*.108*	*4.00*	*.74*	*21.76*
Race(Indian)	***2.275***	***1.149***	***3.921***	***1***	***.048***	***9.73***	***1.02***	***92.45***
HL(Sepedi)	*1.652*	*1.144*	*2.084*	*1*	*.149*	*5.22*	*.55*	*49.16*
HL(Setswana)	*-.677*	*1.189*	*.325*	*1*	*.569*	*.51*	*.05*	*5.22*
HL(Venda)	*.713*	*1.195*	*.356*	*1*	*.551*	*2.04*	*.196*	*21.22*
HL(IsiXhosa)	*-.166*	*1.119*	*.022*	*1*	*.882*	*.85*	*.095*	*7.59*
HL(IsiZulu)	*.859*	*1.585*	*.293*	*1*	*.588*	*2.36*	*.106*	*52.74*
MS(Single)	*.989*	*.761*	*1.689*	*1*	*.194*	*2.69*	*.605*	*11.94*
MS(Married)	*.168*	*.873*	*.037*	*1*	*.847*	*1.18*	*.214*	*6.55*
R (Christian)	*1.650*	*1.161*	*2.022*	*1*	*.155*	*5.21*	*.536*	*50.64*
R (Non-Christian)	***2.405***	***.987***	***5.936***	***1***	***.015***	***11.08***	***1.601***	***76.66***
Constant	*-25.20*	*19796.58*	*.000*	*1*	*.999*	*.000*		

NOTE: HL-Home language; MS-Marital Status; R-Religion

The findings of this study revealed that some nurses do practice ethical and ethical-moral behaviour and also possess knowledge regarding ethical-moral behaviour. However, it was also clear that the majority of this knowledge was predicted by race and religion. Africans and Indians were regarded as the main significant contributors to the prediction of knowledge regarding ethical-moral behaviour. Regarding religion, those who were Christians were found to be the main significant contributors to the prediction of knowledge regarding ethical and ethical-moral behaviour.

4.2.2 Stage 2 Qualitative Study Results

The previous section outlined results from quantitative data. This section presents the analysis and interpretation of the qualitative data obtained from patients through individual interviews (n=18) and the focus group discussions (n=60). Tech's eight steps were followed in analysing the data (Creswell, 2013). The researcher used quotes from the data in the presentation of the results to outline participants' views in their own words. A literature control was done to support and contextualise the findings.

4.2.2.1 Patients' Demographic Information

The qualitative information obtained from patients during the individual and the focus group interviews were similar and will thus be analysed concurrently. Table 4.6 shows the patients' age groups, gender, home language, marital status, religion, and education status.

A total of 18 individual interviews were conducted with patients and 60 patients participated in six focus group interviews, totalling 78 participants. As similar results were obtained during the individual and focus group interviews, the combined data (obtained during individual and focus group interviews) are analysed and discussed for all 78 participants. In addition, the participants who participated in individual interviews were not included in the focus group interviews. The number of participants was determined by data saturation. The average time spent on each individual interview was about 45 minutes and about one hour for focus groups. These interviews were conducted for three months and the analysis was also done simultaneously.

Table 4.6: Patients' demographic characteristics (n=78)

Items	Frequency(n=78)	Percentage
Age		
20 -29	17	21.7%
30 -39	15	19.2%
40 -49	16	20.5%
50 -59	15	19.2%
60 -69	15	19.2%
Gender		
Male	44	56.4%
Female	34	43.5%
Population Group		
Tsonga	18	23.1%
Northern Sotho	30	38.5%
Southern Sotho	04	5.1%
Venda	26	33.3 %
Other	None	
Home Language		
Xitsonga	18	23.1% 38.5%
Sepedi	30	33.3%
Tshivenda	26	5.1%
Tswana	04	
Marital status		
Single	55	70.5%
Married	19	24.4%
Widow	04	5.1%
Divorced	None	
Religion		
Christian	56	71.8%
Non- Christian	07	9.0%
Other	15	19.2%
Educational status		
Primary	20	26.4% 64.1%
Secondary	50	10.3%
Tertiary	08	

As shown in Table 4.6, (19.2%; n=15) of the participants were 50-59 years old, followed by participants aged 20-29 (12.8%; n=10). More females (56.4%; n=44) than females (43.6%; n=34) were interviewed. The interviewed patients' home languages included Sepedi (38.5%; n=30), Xitsonga (23.1%; n=18), Tshivenda (33.3%; n=26) and Tswana (5.1%; n=04). Of the

interviewed patients (70.5%; n=55) were single, (24.4%; n=19) were married and (5.1%; n=04) were widowed. As many as (71.8%; n=56) of the interviewees belonged to the Christian faith and (9.0%; n=07) were non-Christians. Concerning the interviewed patients' educations levels, (64.1%; n=50) reportedly had a secondary level education, followed by (26.4%; n=20) with a primary level education, while (10.3%; n=8) had a tertiary level education.

4.2.2.2 Presentation of Findings

The qualitative study yielded two main themes, three sub-themes and seven categories during data analysis (See Table 4.7)

Table 4.7: Themes, sub-themes and categories that emerged from patients' data

THEMES	SUB- THEMES	CATEGORIES
1.Patients' perceptions of nurses ethical-moral behaviours	**Sub-theme 1:** Meaning of Ubuntu	1. Love and interact with other people
		2. Sharing with other people
		3. Respect for other human beings
2. Patients' views on ethicalmoral behaviour of nurses	**Sub-theme 2:** Patients' negative views about nurses ethical-moral behaviour	1. Nurses failure to attend to patients requiring help
		2. Nurses harshness and rude to patients
	Sub-theme 3: Patient's positive views about nurses ethical-moral behaviour	1.Nurses display caring behaviour
		2.Nurses display empathy and sympathy

- **Theme 1: Patient's perceptions about nurses ethical-moral behaviour**

The interviewed participants described their perceptions about nurses ethical-moral behaviour as the ability to behave well, love and live harmoniously with other people. The

interviewed patients added that Ubuntu is a positive attitude or negative attitude depending on how one has been raised. Positive attitudes are expressed through having good manners and maintaining good interpersonal relationships with people. It was also indicated that ethical-moral behaviour involved the ability to make morally right decisions and/or choices. Patients also mentioned that nurses often fail to recognise the moral dimensions of the problems they experience and also lack the skills they need to resolve moral problems adequately. Nurses also lack autonomy and authority influence their moral experience, intrinsic factors such as feelings of insecurity and powerlessness have a profound effect on nurses perceptions and attitude in the face of a moral problem. Three sub-themes emerged from this theme:

Sub-theme 1: The meaning of Ubuntu

The meaning of Ubuntu comprised of three categories; thus, live and interact with other people; sharing with other people, and respect for other human beings.

Category 1: Live and interact with other people

In this study, the interviewed patients explained that from an Ubuntu perspective a human being should be kind, generous and live in harmony with himself, the environment, other people, and the Creator. They described Ubuntu as the ability to live and interact with one another *be positive, treat each patient as an individual, and provide them with the care that you want for yourself or your family members.* They also mentioned that the most important thing you can do for a patient is just to be positive, actually listen to them when they have a complaint and they just need to know that someone cares. They really appreciate it when

you remember their preferences, little things, like bringing them milk because you remember they enjoyed it yesterday. They really notice that you are paying attention to their needs. Through their early interactions, people develop relationships, feel secure, communicate, and enjoy being with people, express love and affection, learn, and have their needs met through contact with others. Patients indicated that communication with hospital staff is good; for example, communicating about meals and nutrition, arranging to have a nutrition plan that will help, as poor communication between hospital staff and patients may affect quality care, recovery and length of stay as illustrated by the following patients' quotes:

> *"Is to live good, peaceful with other people, to feel for other people (pause)…. you…… you must be concerned about the welfare for other people, see someone else as one of my own or our own, after all, a person is a person because of others and when others are behaving in an inappropriate way correct them, loving and caring for others being good to others and not being a thief, being human so that your neighbour can assist you when required" (P*. 1)

The participants said people have to be good to others, be polite and not harass others, people should be united, be respectful and treat people the way they would like to be treated. This is illustrated by the following quotes:

> "*Is to be united with other people, to be able to help others, Aaaah! Obeying rules wherever you are, not having tribalism, kind and behaving in a good manner (pause)….. "Hey!!!!! is to interact good with other people, speak well with other people, not undermining others" (pause)..... being good to others and do good things with*

other people, be polite, not harassing or curse others, treat others the way you would also like to be treated, feeling for other people, and be generous" (P.2)

In living with one another, the patients said one has to have self-respect and love for others. In the spirit of Ubuntu, one must not be arrogant and cruel to other people. One must be able to listen, learn appropriate social behaviours, such as sharing, cooperating, and respecting the property of others. This is illustrated by the following quotes:

"Umuntu n ngu muntu nga bantu" *A person is a person by others", being good and listening to others and take care of others or having a good heart, treating people equally, to live in a good way and do good things, respect themselves well as others, Eish…..not falling in love with another woman's husband and be proud about that, and be friendly to one another and being a good person and having a good heart, be kind to other people, and not fighting with people, in general, Aaaah!!! when you borrow something from your neighbour, you should take it back" (P.3).*

The participants indicated that Ubuntu among nurses requires the display of good interactions with patients, treating patients with kindness and patients the required assistance. This is supported by the following quotes:

"To interact with others in a good manner and always lend a helping hand as well as sympathise and help others, peacefully and doing well to others, take care of one another, even if we are not from the same country and being good to others not being rude" "I thoroughly enjoy the interactions I have with my nurses and the friendships that are made, they are to listen to each patient and have compassion, always greet

us with a smile and have a positive attitude. They try their best to help without us having to ask, offer us what we may need."(P.4).

"The *behaviour is good and they are well coming and treat me well, I have learned and discovered new things, they are caring and consistently come check on me and work quite well quick to assist, even if we make a mess they clean up after us and give us food in time, clearly they do the work they love" "Seeing a nurse smile, I appreciate that, when they offer us coffee or water for each patient that is allowed to have it and see this small service as something that makes this hospital stand above others."(FGD 1. P1).*

"Hmm…… nurses are good to us; they give us food, treatment and clothes. They are taking care of me like my mother looked after us while growing up, can't lie they are very good and patient to us and they are not biased" Eeeeeh! They are like brothers and sisters to me" (FGD.2 P52).

"*They just smile and use a calm and welcoming voice, Everyone else is rushing in and out and most times they don't even know who is in their room, but they take the time to introduce themselves and tell us how they are going to take care of us". "They open the blinds, prop us up to be more comfortable, ask how we are doing"* (FGD 4. P29)

The participants also indicated that nurses were concerned about the well-being of patients as illustrated by the following patient's statement:

"*They do communicate well with us since I have arrived in the hospital honestly speaking nurses have been behaving very well, they are always speaking to me, the*

behaviour is different it differs with people". They developed personal relationships with us so we can customize our care to make us as happy and comfortable as possible. Mealtime is the best part for us, and it feels great to get to have them as part of that."(FGD 1. P.36)

Smiling, making jokes and caring about the well-being of patients, were also said to be indications of Ubuntu, as expressed by the following statement of a patient:

"Nurses interact with us in a good manner, they crack jokes very much, when you call for help they respond very well, and they come and ask if you are in need help, sometimes they come when they are not busy and ask if I had my tablets, they pay more attention to those who are helpless" (FGD 5. P.49).

According to some patients, participating in this study, the behaviour of the nurses depended on their shifts, as explained by the following patients' statements:

"Some are good and some are not good depending on the shifts, at night yesterday I fought with one of them because she wanted me to do things on my own which I was unable, when it comes to treatment there is no consistency as to the time we receive medications, they don't serve us and don't have time, sometimes morning shifts are better than evening shifts". (FGD 5 P.41).

"They don't spend time with elderly patients, except for one nurse working night duty who stays with us and teach us about health issues. During the day shifts they are nice but some during the night shift aren't nice and only respond if they feel like, the training nurses are good and treat us well". (P.5).

The findings on living and interacting with one another in this study are supported by the findings by Gade (2011) who also explained the term 'Ubuntu' - the Nguni proverb 'umuntu ngu muntu nga bantu' (often translated as "a person is a person through other persons") for the first time in history. It further explains that ubuntu means that people are interconnected and that a person with Ubuntu is open and available to others and able to affirm others. The person does not feel threatened if others are able and good. Most authors refer to the proverb when describing *Ubuntu*, irrespective of whether they consider *Ubuntu* to be a human quality, African humanism, a philosophy, an ethic, or a worldview (Gade, 2011).

Tutu (2008) concurs with what this study's participants said, that a person is a person through other persons. This author (Tutu, 2008) maintained that no person comes into the world fully formed and people would not know how to think, or walk, or speak, or behave as human beings unless a person earned it from other human beings. Ubuntu speaks about the fact that a person cannot exist as a human being in isolation. Interconnectedness is an essential aspect of Ubuntu as a person cannot be human all by her/himself, and when you have the quality of Ubuntu, you will be known as being generous. Tutu (2008) describes a person with Ubuntu as being open and available to others, affirming others as one who has proper self-assurance.

Mulaudzi et al. (2014) contend that maintaining virtue ethics emphasises personal traits, such as respect, caring, compassion, kindness, warmth, understanding, sharing, humanness, reaching out, wisdom and neighbourliness. The philosophy of Ubuntu upholds similar core defining values such as caring, compassion, unity, tolerance, respect, closeness, generosity, genuineness, empathy, hospitality, conscience, conformity, and

sharing. While the fundamental values of Ubuntu form the basis or cornerstone of African ethics, they are also the foundation of values found in many nations and cultures and professions (Mulaudzi et al., 2014).

Mulaudzi et al. (2014) assert that Ubuntu optimises the African philosophy of respect and human dignity that is fundamental to being able to transcend ethnic divisions by working together and respecting each other. People who truly practise Ubuntu are always open and make themselves available to others, affirming others without feeling threatened and accepting that others are able and good. With Ubuntu, one has a proper assurance that comes with the fundamental recognition that each individual belongs to a greater community (Mulaudzi et al., 2014).

Mulaudzi et al. (2014) further explain that the Ubuntu philosophy represents an African conception of human beings and their relationship with the community that embodies the ethics defining Africans and their social behaviours. Africans are social beings that are in constant communion with one another in an environment where a human being is regarded as a human being only through his or her relationships with other human beings. Therefore, the survival of a human being depends on other people – the community and society. The African Ubuntu philosophy represents humanness, a pervasive spirit of caring within the community in which the individuals in the community love one another. This Ubuntu approach plays a pivotal role in determining the success of any African organisation. Ubuntu transcends the narrow confines of the nuclear family to include the extended kinship network that is omnipresent in many African communities. As a philosophy, Ubuntu is an orientation to life that contrasts with rampant individualism, insensitive competitiveness, and unilateral

decision-making. The Ubuntu teachings are pervasive of all ages, in families, organisations and communities in Africa (Mulaudzi et al., 2014).

Taylor (2014) indicated that Ubuntu is both a world view and a moral philosophy that historically unites African communities. The concept of Ubuntu is found in diverse forms in many societies throughout Africa. Several different definitions, some of which are contradictory, making it difficult to extract one central definition of Ubuntu that would be universally acceptable. Irrespective of any definition, Taylor (2014) suggested that there are two basic aspects to Ubuntu: relationships between people and how those relationships are maintained. Considering the preceding Ubuntu-related information, nurses should have positive attitudes towards patients. Nurses should greet patients in the morning, and ask how they slept during the night, give them water to bath but first ask permission from the patient before performing any procedure (Taylor, 2014).

Category 2: Sharing with other people

During interviews, participants defined Ubuntu as living and interacting with other people, and sharing with other people. Sharing was described by patients as a means of expressing one's humanness and finding joy within oneself because one would have awakened one's heart. During this study's interviews patients explained that Ubuntu also involved people sharing their skills and knowledge. Nurses shared the information that they had, what they were supposed to do in life and new happenings, through health education provided at health facilities, as illustrated by the following statements:

"Hmmm….. (Pause) sharing is to open one's heart and to share generously with others, Hey!!!!!! a person is a person because of others, some nurses share information with us, they usually give health education about illnesses and about how we are supposed to do in life, and about new things that are happening in life"(P.6)

"In the morning, before they start working, they share the word of God with us, sometimes as patients, we share information with them, sometimes when they are not busy they come to sit with us and we share different things in life. Hey!!!!! Sharing is good, nurses teach us about diseases and how to prevent them" (FGD. 7P.10)

"We usually share things with neighbours, for example, wheelbarrow…. (Pause) my neighbour is generous, he is so good and caring, and sometimes he gives us vegetables from his garden, here at the hospital nurses give us food and medication" (FGD.5 P.20).

This study's findings correlate with Downing and Tolsma (2016), who explained that Albertina Sisulu appreciated education and this value was reflected in the sacrifices she made to further the education of those she loved. Being there for the individual and sharing the moment of enlightenment and movement to a deeper connection with the self, takes place during the caring moment. The nurse and the person sharing the caring moment are of the utmost importance. The nurse's focus is on health, healing, and caring as part of the patient's experience. Sisulu's focus provides a foundation for nurses to create caring for professional practice with patients, sharing human experiences, happenings, and encounters in a conscious interaction of now. In the world of caring and nursing, it would be Sisulu who provided the connectedness to the persons in need of care and hope. She

instilled hope, trust and provided the most excellent and competent care possible during those critical moments of engagement with her family and extended community. Caring involves a compassionate sharing of love, heartfelt empathy and dignity (Downing et al., 2016).

Blankenship and Ruona (2009) motivated members to share their knowledge with colleagues. Being accessible to one another, whether it be physical, virtual or during a common planning time increases the likelihood that knowledge sharing will occur. In the study conducted by Blankenship and Ruona (2009), nurses also revealed that they had opportunities to share knowledge during their formal meetings, both during their team meetings as well as during their whole-academy meetings, while working together or supporting each other. Teachers shared detailed examples of how, through both formal and informal channels, they shared knowledge, strategized and developed innovative solutions to work-related issues. Blankenship and Ruona's (2009) study identified opportunities to share as being a factor influencing knowledge sharing, work specifically focused on the relational learning channels available to individuals. Factors such as proximity - physically, virtually and temporally - also facilitate knowledge sharing through increasing opportunities to share. Once those participants had been housed together and were given common planning times, their opportunities for sharing increased (Blankenship & Ruona, 2009). Furthermore, they indicated that it was important to share knowledge among core employees, but that it was also vital for non-core employees to share their knowledge with core employees. For example, valuable information could be gained from production workers or sales representatives with special insights into the production processes or clients' specific needs (Blankenship & Ruona, 2009).

Nurses who embrace Ubuntu are obliged to assist others, but sharing remains important in everyday life. Nurses should share information and skills. The spirit of sharing is embodied in the philosophy of Ubuntu. It embraces hospitality as shown by nurses when caring about their patients, being able to go the extra mile for the sake of others. This study's participants (patients) believed that nurses humanity was caught up, bound up, inextricably with those of others. Nurses shared information by giving health education about illnesses and sharing the word of God with patients in the mornings. Knowledge sharing is more than simply putting people together. It is about creating an environment in which people are knowledgeable and willing to extend their knowledge for the benefit of others.

Category.3: Respect for other human beings

During this study's interviews, the participants explained that respect covers many things. Respect should be shown for elders, children and all members of one's community, respect for ancestors, traditions, the ancient teachings and practices. They indicated that nurses showed respect in how they related information to the patients, as illustrated by the following statements:

> *"Nurses are very good, they respect, they show that by greeting and asking me how I feel before they render nursing care, they attend to me where ever I need help, there is a rainbow nation amongst us and we are to communicate even if our languages differ, they make sure that we end up understanding and communicating with each other" (P.8).*

According to the participants in this study, nurses always listened to them, when they asked for treatment because of pain. Nurses asked permission when they wanted to do procedures. Nurses always kept patients' information confidential.

> *"They give us medication, when you report to be in pain, during treatment time they even tell you what time they will be bringing them again, they also give us food, water and change my bedding, they respect us the same way, they greet us in the morning and they pray with us, always ask for permission when they want to do something to us, at 05h00 they give us warm water to bath, I am the one who refuses to bath telling them that I am not going to work, and before they knock off they ask if I am still fine, they are loving and also helping to get things I cannot reach, they remain confidential with regard to my illness, they spend time talking to me about things" (P.10).*

Some participants, interviewed during this study, explained that some nurses did not respect patients because they shouted at them and did not respect elderly people, but the nurse's respected patients' social status and those who had been educated, as stated:

> *"Hey!!!!! (frowning) some nurses shout at patients and they don't respect old patients, the middle-aged people are treated well, but those who are educated are treated in a good manner, they ignore us when we call them, when calling a nurse for a chamber they ignore us that is my main worry (pause)…… because we are here to be helped, some nurses say they will come back but never return*, Eeeh! *some nurses become good when they realize that you know your rights when you are old and not educated they don't show respect, nurses are not the same as they treat us according to class and status" (FGD.4 P.8)*

"*Nurses bath me in the morning and give me food (pause)…. Yes they are not selective, they give us medication, Eeeee…… some respect us very much, they come quickly when we need assistance, some scold at us as if they are talking to a young child, They are disrespectful as if they don't have families" (FGD.3 P.13)*

Results from this study are supported by Bauman and Smyt (2007), emphasising that respect has great importance in everyday life. During childhood, we should have been taught to respect our parents, teachers, elders, school rules, traffic laws, family and cultural traditions, other people's feelings and rights, our country's flag and leaders, the truth and people's differing opinions. Respect was valued for things such as shaking of heads (or fists) at people who seem not to have learned to respect them. Respect was developed for people we consider exemplary and we lose respect for those we discover to be non-exemplary, trying to respect only those who are truly worthy of our respect. At some level, all people are worthy of respect. We may learn that jobs and relationships become unbearable if we receive no respect in those jobs and relationships (Bauman, 2007).

Findings are supported by Shahriari, Mohammadi, Abbaszadeh and Bahrami (2013) who agreed that respect for human values, dignity and rights is an important nursing value. The same authors indicated that some nurses do not respect elderly people; they respect patients who are educated and rich. Violators of human rights should be brought to justice. Maintaining the security of all individuals and their living environments is paramount for creating a feeling of inclusion and an atmosphere of participation in society (Shahriari et al., 2013)

Nursing care without respect tends to dehumanise patients supporting, what this study's participants indicated. Advocacy or protecting patients' rights was one method that nurses used to resolve or cope with ethical dilemmas. Findings, from this study, indicated that the minority of nurses lacked respect but most nurses respected patients. This was shown by many participants reporting good things about nurses, for example, asking how they felt and giving patients food and treatment. Some participants indicated nurses respected patients according to their social status. If the patient was an illiterate person the nurses did not respect him/her. It was indicated by a minority of participants that some nurses shouted at elderly people, nurses only respected middle-aged patients. Disrespect was also shown by nurses when ignoring patients' requests for help, especially during the night. Participants also explained that some nurses looked down on patients, sometimes having 'disgusted faces'. Nurses also displayed tribalism, using a language that some patients did not understand. All this indicated that some nurses lacked respect, hence a model should be developed for the moral regeneration of nurses in the Limpopo Province.

- **Theme 2: Patients' views about nurses ethical-moral behaviour**

This is the second theme that emerged from the data which reflects the patients' perceptions and views about nurses ethical-moral behaviour. The theme generated two sub-themes with two categories each. The first sub-theme which emerged was patients' negative perceptions and views about nurses ethical-moral behaviour.

Sub-theme 1: Patient's negative views about nurses ethical-moral behaviour

Many participants (patients) expressed negative perceptions and views about ethical-moral behaviour. One of the categories which emerged from the negative ethical-moral behaviour of nurses indicated that nurses failed to meet patients' needs.

Category 1: Nurses failure to attend to patients requiring help

Some participants in this study considered nursing care to be poor because nurses did not care about the patients as they did not assist the patients, who could not do anything for themselves when these patients needed help. Nurses failed to explain to the patients about their conditions as illustrated by the following statements:

> *"When I arrived I was not able to hold anything using my hands but they did not assist me on bathing and feeding, when calling a nurse for chamber they ignored us when I asked questions about my condition, they told us to wait for the doctor to come and explain to us, sometimes they responded with anger and never returned when help was needed.... (Pause) they become good when they realise that you are educated and know your rights" Eish!! they did not check on my drip since it got finished" (P.11)*

Some participants reported that assistance from nurses was not up to standard; they also indicated that nurses complained about too much work due to shortages of staff and nurses were always angry, often ignoring patients as illustrated by the following statements:

> *"There are times when I' am unable to wake up, they did not come and assist me when I have called them, some promised to come back, but they never returned, they had not explained after the operation, they lost patience with us, Eeeh! They didn't give us*

help when we asked them, they ignored us when we called them that is my main worry, and they did tell us about the shortage of nurses, Aaaah! (pause) they did not usually smile at me and did not care about my wellbeing, and sometimes they did not give us clothes after bathing, sometimes when we asked for bedpans they ignored us, sometimes they took time to get things done…..(pause) like yesterday where they told me that they would be back but they never returned"(P.7).

Some participants indicated that nurses interpersonal relationships were poor and fellow patients were not treated well in their presence. Sometimes, no communication occurred between the nurses and the patients.

"Aaah! When you call them, they take their time to get here, they don't check on us, they just do their job e.g. give medication and leave without talking to us, Eish….. (pause) some of my roommates are not treated well, the problem is that they sometimes tell us that it's not their job to help us when we can't, especially during the night" (P.4).

Similar results were reported by Allen, Rieck and Salisbury (2016), who indicated that patients' experiences of their hospitalization were unpleasant. The patients' bad experiences included allegations that some nurses failed to listen to their concerns and/or meet the patients' needs. In particular, participants mentioned that some nurses seemed to be too busy, were rushing around or did not like to be bothered. Furthermore, the participants pointed out that being hospitalized was scary, and that nurses emotional support were needed to make hospitalization a positive experience. One patient, who had been nursed in isolation, described a sense of loneliness as nurses communication was limited as they did

not want to go through the ordeal of putting on personal protective clothing before entering the isolation room (Allen et al., 2016).

The study by Twayana and Adhikari (2015) also indicated that nurses attitudes towards patients influenced patients' perceptions of nursing care. For example, patients might expect much from nurses and patients might desire adequate information about their conditions, procedures, treatment options and expectations from nurses during hospitalization. The study by Twayana and Adhikari (2015) intended to assess some areas that had not previously been addressed, such as patients' perceptions and experiences regarding nursing care. Patients' perceptions of nursing care could determine the quality of nursing care. Patients' satisfaction levels might be affected by patients' characteristics, nurses behaviour as well as nurses professional knowledge and skills. Therefore, a patient might be more satisfied with nursing care if nurses had met his/her needs, expectations and provided adequate information about the patient's condition and treatment. This study on patients' perceptions of the overall aspects of nursing care was negative. Patients' perceptions about support service facilities, such as safe drinking water, bed linen and visitors' chairs were negative (Twayana & Adhikari, 2015).

According to Ammouri, Raddaha, Dsouza, Geethakrishnan, Noronha, Obeidat, and Shakman (2014) concerning patients' safety findings indicated that 57.9% (n=14) of the participating patients experienced low levels of patient safety. This could be related to nurses who reported negative perceptions of the work environment (hospital). A positive work environment, managerial commitment, nurses education levels and addressing reported mistakes could have a positive impact on patient safety outcomes. In addition, Ammouri et

al. (2014) reported that nurses who perceived more supervisor/manager expectations, received more feedback and communication about errors, were involved in more teamwork across hospital units, had better perceptions about patient safety. On the other hand, a strong relationship was identified between nurses levels of job satisfaction, patient safety and perceived quality of care (Ammouri et al., 2014). This study revealed that (11.4%; n=16) of nurses were dissatisfied with nursing as a job. This supports the finding related to nurses perception and view of low patient safety.

A study conducted by Atefi, Abdullah, Wong and Mazlom (2014) correlated with the findings of Twayana et al. (2015), by identifying three main themes that influenced nurses levels of job satisfaction/dissatisfaction: spiritual feelings, work environment factors, and motivation. Nurse managers should ensure a flexible practice environment with adequate numbers of staff and resources in order to improve the quality of patients' care and safety (Twayana et al., 2015). However, the attitudes displayed by some nurses in various hospitals caused patients to have bad perceptions about the nurses. Nurses should do something about those perceptions by living up to patients' expectations and by doing what nurses had been taught in the classrooms (Twayana et al., 2015).

Jewkes and Kekana (2015) concur with these claims about patients' negative perceptions and views concerning nurses attitudes towards them. Although that study focused on nurses behaviour towards women receiving obstetric care, the findings showed similar negative attitudes displayed by the nurses towards patients. The obstetric patients experienced verbal abuse in the form of scolding, being shouted at and general rudeness. Nurses did not

respect patients and those patients reportedly experienced arbitrary acts of unkindness, physical violence or neglect (Jewkes & Kekana, 2015)

Ebrahimi, Nikravesh, Oskouie and Ahmadi (2015) studied nurses ethical behaviour and decision-making. Some nurses believed that being a nurse was a moral endeavour and almost every decision that a nurse could make would have a moral dimension. Nurses faced complex situations when they were expected to provide good care that could enhance patients' health in the physical, emotional, relational, social, moral, and spiritual dimensions. However, there were ongoing concerns about the ethical practice of nurses. Performing ethical practice in the presence of daily moral dilemmas was difficult. Nurses had a moral commitment not only to provide care to meet the needs of a specific population, but also to develop the essential skills of critical thinking, ethical decision-making, conflict resolution, and the capability to support a specific population (Ebrahimi et al., 2015).

Based on this study's data, nurses failed to attend to patients requiring help to meet their needs, failed to assist patients who could care for themselves and those who could not do so. Nurses promised patients that they would come back for help, but they never returned and some nurses were impatient when asked for help, indicating poor ethical-moral behaviour of nurses.

Another category associated with the perceived negative attitudes towards patients was that some nurses were harsh and rude to patients.

Category 2: Nurses harshness and rudeness to patients

Participants reported that some nurses were harsh and rude, ill-mannered or uncivilised or bad-mannered towards patients who could not do anything for themselves, and they ignored patients' calls for help. Some nurses told patients that they were too demanding and did not attend to emergencies as demonstrated by the following statement:

> *"They don't respect, (sad look) they were rude to a patient and wanted her to do things for herself, even though she was in pain, Hey!!!! Pause….. sometimes they come when they are called, they tell us we are too demanding, it is like they don't want their job, it is not the same to everyone, and sometimes we have to call home for help. Eeeee!!!!!! (looking shocked) they are disrespectful in the sense that when you arrive in pain, they do not attend to you immediately, they are quick to lose patience, but they are not the same, some ignore us when we call them and when they decide to come they make an excuse of not hearing us" (FGD.2 P.5)*

Another participant said nurses ignored patients when they called for help, though the nurses were in the nursing station. Nurses treated patients according to the status of the patient, nurses spoke in languages that some patients could not understand. Some nurses scolded elderly people, but middle-aged patients and patients who had been educated were treated better, as illustrated by the following statements:

> *"Hey!!!!! (Frowning) during the night, when you call them they don't respond or come Eish…… (pause) but you can hear them talking from the station, You…….you know they tend to have disgusted look on their faces at times, to look down on patients, there*

is tribalism, the middle-aged people are treated well, they scold the elderly but those who are educated are treated in a good manner, they greet us in the morning and give us water to bath and give us food to eat, some do some don't, they are not the same. They treat us according to status" (P.14)

Jewkes et al. (2016) concurred that many pregnant women expected problems giving birth in specific health care centres. These women expected to be shouted at, beaten or neglected by nurses. Abuse and neglect were dominant features of the narrative accounts of many of the women whose babies were born at Kwazola. These patients also complained that midwives were rude, inhuman, and not caring and that "nobody showed any kindness'' (Jewkes et al., 2016). Several women complained that nurses scolded them and shouted at them in the antenatal clinic. Some were shouted at when they irritated the staff by 'talking softly', or 'moving slowly' when called to go to a room or going to a room after mistakenly thinking they had been called (Jewkes et al., 2016).

Singh, Kaur and Rochwani (2013) also reported that patients' satisfaction levels regarding the quality of service, rendered by nurses and paramedics were high as most patients were satisfied with the availability, communication/behaviours of nurses and paramedics in the wards during admission. Most of the patients came from underserved sections of the community. Time-lapse between admission and initiation of treatment was more than 30 minutes in 13% of cases. However, 18% of those patients described the nurses and paramedics' behaviour as being harsh, rude and/or avoiding patients. The cause for such behaviours might be due to overburdened nurses as a result of staff shortages, but such behaviours should be addressed during education sessions (Singh et al., 2013).

Ojwang, Ogutu and Matu (2010) concurred that Kenyan patients' and nurses perspectives, indicated that the attitudes of both nurses and patients posed challenges for the realisation of the charter of patients 'rights. Nurses posed the most challenges for the implementation of rights as specified in the patients' charter. Nurses perceived their role as being that of the all-knowing benefactor and were not receptive to patients' inputs. Public perceptions had not changed, because nurses in public hospitals were still regarded as being aloof and unresponsive to patients' needs. Patients expected to experience interactions with nurses promoting patients' dignity and reducing the nurse-patient communication gap, while nurses expected patients to maintain a degree of formality. The aim of the study of Ojwang et al. (2010) study was to change the longstanding public perception that nurses in public hospitals routinely ignored patients' right to respectful treatment, and also focused on linguistic indicators of violation or promotion of patients' rights in the health care context. Ojwang et al. (2010) examining the extent to which patients' rights to dignity, respect, and humaneness had been observed or denied, and argued that impolite utterances impeded rather than promoted the realisation of other fundamental human rights. Nurses impoliteness not merely constituted rudeness but encoded a violation of dignity which, in turn, hampered the chances of enjoyment of broader human rights such as the right to autonomy, free expression, self-determination, information, personalised attention, and nondiscrimination. Ojwang et al. (2010) argued that, for patients to enjoy their rights in the hospital setting, a clear definition of roles and relationships and public education on strategies of asserting these rights without intimidation, was necessary. It emerged that when patients' rights had been denied, patients resorted to retaliation by violating the dignity of the nurses. This

jeopardised the envisaged mutual support in the nurse-patient relationship and compromised patient satisfaction (Ojwang et al., 2010).

The study by Dapaah and Senah (2016), conducted in Ghana, found that the mere presence of a person at the HIV counselling centre or clinic was sufficient for the person to be labelled as or suspected to be HIV-infected. It demonstrated that stigmatisation might occur not only in the community but also in the health facility itself. Consequently, for many HIV and AIDS patients, access to antiretroviral therapy and treatment of related nosocomial infections could be problematic. Furthermore, the study found that many clients and potential users of services were uncomfortable with the quality of care provided by some nurses, especially as they breached confidentiality about their clients' health status. This compelled many patients and potential users of the services to adopt a modus vivendi that provides access to some care services while protecting the patients' identity (Dapaah et al., 2016).

Dapaah et al. (2016) in Ghana, also reported that people generally felt that nurses in hospitals were often unfriendly and rude. However, it was not uncommon in Ghananian hospitals to find a few nurses who behaved positively towards patients.

Based on this study's findings, some nurses were reportedly harsh and rude to patients, ignored patients in need of help, showed disgust and scolded elderly people. However, some patients also expressed positive perceptions and views about nurses behaviour, leading to the second sub-theme of patients' positive perceptions and views about nurses ethical-moral behaviour.

Sub-theme 2: Patients' positive views about nurses ethical-moral behaviour

Different positive perceptions and views about nurses ethical-moral behaviour were portrayed by patients who participated in this study. Patients explained that some nurses talked to them in a 'good manner', always laughing, never shouting at patients.

Category 1: Nurses display caring behaviours

The participants reported that nurses cared for and embraced them, their needs became the nurses' needs, their joys and sorrows became the nurses' joys and sorrows. In Ubuntu, people are human through interactions with others and without others, people are not human. Nurses welcomed interactions with patients regardless of whether they were pleasant or not, expressing their humanness. Some participants in this study reported that nurses cared for their needs and showed their humanness in the way in which the patients were treated and addressed as expressed by the following statement:

> *"Most nurses are providing great patient care are patience, understanding, compassion, and sympathy, they pay attention to detail and make the short time they are with us there memorable can make a big difference in their day. When one of us is celebrating a birthday in the hospital, they make a special dessert in accordance with their diet, which always brings a smile to our faces."*

> *"When they walk into a patient's room, look them in the eye, greet them by name, and say "Good Morning". When they enter a room they make us feel like the only person who matters at that moment."*

"Before they start treating me they first ask how I' am doing, and how I am feeling and if I am feeling the pain they give me medication, they always ask if they should address me using my title or my name, and they address me as grandpa and I am happy about that, Eeeeh!! (pause)… since I am on bed rest I am able to call the nurses to assist me when I need the toilet and they do so, they usually tell us jokes and laugh with us, they come and spend time with those that have been here for a long time, Oooh!! they are always around and they care for everyone" (P.16).

Some participants in this study said that whenever they needed help the nurses attended to them. They also explained that the nurses paid special attention to very ill patients. Nurses addressed patients using their surnames or called them grandma or grandpa, as illustrated by the following statements:

"They address me as Vhamusanda, they have a positive attitude towards us, Aaaah!! when they come in the morning they ask if we have bathed and also fix our beds, but they find it difficult when it comes to clothes, but when it is cold they give us blankets when you complain they forward complaints to the relevant people, they are always happy with us as patients…yes they come and help where necessary, Eish!!! (pause) when it comes to rating, there are some weaknesses, so I can't give them 10 out of 10, some are patient, I can give them 6, Eish!!..... Some they look at your status and what you have, when I first came here was admitted at high care, nurses there, I can give them 10 out of 10 '(P.12).

The participants in this study also explained that nurses greeted and asked permission when they wanted to do something, treated patients equally and responding appropriately, as illustrated by the following statement:

> *"They first greet me and then from there they use my surname, they ask for permission first before doing anything to you, they are very nice, the way they treat me, it's of a high standard, they are loving and also help me get things that I cannot reach., When I tell them I am in pain they give me pills because we get what we need. I feel at home, they have a good attitude" "Heeee!!!!! nurses are good and check on us, and they don't have tribalism"(FGD.6 P.39)*

Most participants in this study indicated that many nurses were neither harsh nor rude to them. Participants also indicated that, out of all the healthcare workers, nurses spend the most time with the patients, they interacted with patients more often than any other health care personnel in the hospital, and also translated information imparted by doctors professionally with a humane touch, as stated:

> "*Nurses call me mom, they are always happy, cheerful and gentle and friendly, yes……yes… they are nice to all of us, they care for everyone, they help those that find it difficult to do things for themselves when they have the time they spend most of their time and interact often with us unlike doctors….pause… doctors only come once during the day, Hey!!!! (pause) they translate information to the doctor during ward rounds they explain conditions to us* (P.14).

Participants in this study mentioned that nurses treated them as human beings, addressed them properly, and before going off duty, the nurses asked whether the patients needed something. The nurses gave patients' food and medication on time. Nurses maintained confidentiality as expressed by the following statement:

> *"Nurses do treat us as people, they give us water and medication when necessary, they call me sister and before they knock-off, they ask if I am still fine, they also give me food and bath me', they keep secrets, they spend time with me and my baby (P.8).*

The participants in this study indicated that honesty, trust and responsibility were communication values that were shared by patients and nurses. They also indicated that nurses focused primarily on patient care, and unacceptable behaviours of nurses were seen as jeopardising patients' well-being, as expressed in the following statement:

Category 2: Nurses display of empathy and sympathy

According to the information from participants (patients) interviewed during this study, empathy is a person's ability to recognise and share the emotions of another person, Empathy is often confused with pity, sympathy, and compassion, which are all reactions to the plight of others. During this study's interviews, participants explained that empathy was the ability to successfully enter into the emotional situation of another person, to listen and feel genuine sympathy because you hear and feel what others share with you. Most of the participants indicated that nurses showed sympathy to their patients. Nurses communicated with patients informing patients that they would get better. Nurses displayed empathy by

being friendly and loving. Participants mentioned that some nurses showed interest and provided comfort and support when they stated:

> *"They show sympathy, interest, comfort, friendliness and support by asking how we feel about our illnesses, and since I am unable to move they assist me, Some are not, they are always angry, Eeeeeh!! …..some they just come and do what they ought to do and leave, some communicate in a good manner and just tell us we will get better, except one nurse Yooo!!...who even told me that she cannot smile at me, (pause)…… some come and inject us and they leave afterwards, they don't show concern as to whether I'm in pain or not" (P.18).*

> *"Hmmm... They are sympathetic and understand, support and comfort, yes…. they ask me how I'm doing in the morning and evening, sometimes they ask if you are getting better, yes…. it shows they want us to get better. ….., when I'm in pain they try by all means to help me, they even try to speak my language, they are friendly and they do not scold at us, they also tell me that I will get better, except the cleaners," (P.48).*

Patients, interviewed during this study, indicated that nurses asked how the patients felt about their illness. Some nurses asked whether a patient was in pain and also indicated that they would get better. However, some patients indicated that nursing care during the day differed from nursing care during the night, as illustrated by the following statements:

> *"Even now that I'm here and when I'm in pain they try by all means to help me, they tell us that we will get better, they are friendly to a point where you can ask anything, they communicate quite well with me, they ask me how I'm doing in the morning and*

evening, they show interest, but a few during the night do care, some are not even concerned" (P .4).

However some participants reported that some nurses did not care when patients were talking to them, the nurses started other conversations. They also reported that nurses attended to them when they needed help, by stating:

Jeffrey (2016) explained that empathy, sympathy and compassion are also elements with other forms of social behaviour such as generosity, kindness and patient-centeredness. Empathy, sympathy and compassion are often confused with each other and with a number of other processes involving sharing another person's feelings, especially of feelings of distress or suffering. Compassion and empathy are often used interchangeably and the close link between them is reflected in the term 'compassionate empathy' which represents his attempt to clarify the confusion by adopting the broadest term. Also defining empathy, some authors contrast the concept with sympathy, which has been defined as experiencing another's emotions. It has also been described as a concern for the welfare of others. Some authors felt sympathy is a wholly distinct concept from empathy, while others maintained that sympathy overlaps with the emotional component of empathy. Sympathy might slide into a feeling of pity or feeling sorry for the other person. Sympathy takes a 'self-orientated' perspective which may arise from motivation to help the other person in order to relieve one's own distress. In taking such a self-orientated perspective, the person risks being distressed or overwhelmed (Jeffrey, 2016).

According to Sinclair, Beamer, Hack, McClement, Bouchal, Chochinov and Hagen (2017), sympathy has been described as an unwanted, pity-based response to a distressing

situation, characterized by a lack of understanding and self-preservation of the observer. Hence, empathy was described as an experienced effective response that acknowledges and attempts to understand an individual's suffering through emotional resonance. Compassion enhances the key facets of empathy while adding distinct features of being motivated by love, the altruistic role of the responder, action, and small superego acts of kindness. Patients reported that, unlike sympathy, empathy and compassion were beneficial, with compassion being the most preferred and impactful. Although sympathy, empathy, and compassion are used interchangeably and frequently conflated in healthcare literature, patients distinguish and experience them uniquely. Understanding the patients' perspectives is important and can guide practice, policy reform, and future research (Sinclair et al., 2017).

4.3. SUMMARY

The main themes of this study were patients' perceptions about nurses ethical-moral behaviours, which explained the meaning of Ubuntu and patient's views on ethical-moral behaviour of nurses, which included patients' negative views about nurses ethical-moral behaviour, as well as patient's positive views about nurses ethical-moral behaviour.

CHAPTER 5

CONCEPT ANALYSIS

5.1. INTRODUCTION

Chapter 4 presented and discussed the data analysis of this study's findings which indicated the need to develop a model to promote moral regeneration among nurses in the Limpopo Province. This chapter discusses the concept analysis phase II utilized in this study. In this chapter, the researcher clarifies and distinguishes the definition of the concept "Moral regeneration", in order to share the meaning of this concept with the readers as well as with participants. Data were analysed separately for qualitative and quantitative methods then findings are compared and discussed. The findings of qualitative data were grouped into two themes, and three subthemes and seven subcategories. The main theme of patients' perceptions about nurses 'ethical-moral behaviours revealed that nurses are behaving well and living harmoniously with other people and showing love. They added to say that it is a positive attitude or a negative attitude influenced by how one has been raised. Positive attitudes are expressed through good manners enhancing good interpersonal relationships. It was also indicated that ethical-moral behaviour involves the ability to make morally right decisions and/or choices. Patients indicated nurses respected patients according to their social status. If the patient was an illiterate person, the nurses did not respect him/her. It was also indicated revealed that some nurses shouted at elderly people, nurses only respected the middle-aged patients. Disrespect was also shown by nurses when ignoring patients' requests for help, especially during the night.

The quantitative results revealed that the strongest predictor of knowledge regarding ethical-moral behaviour was race (especially being African and Indian), recording an odds ratio of 200.12 and 9.73, respectively. This indicates that respondents who were African were 200 times more likely to report higher knowledge regarding ethical-moral behaviour and respondents who are Indian, have a likelihood of 9 times to report higher knowledge regarding ethical-moral behaviour. Religion (Specifically non-Christianity) was also the most significant contributor (p=0.015) and recorded an odds ratio of 11.08 (1.601-76.66) indicating that not being Christian increases the chance of reporting higher knowledge regarding ethical-moral behaviour by 11 times.

These findings were contextualised by comparing and contrasting this study's findings with those reported in relevant literature sources. The purpose of chapter 5 is to analyse the concept that would enable the researcher, and the readers, to understand the meaning of the concept of moral regeneration. The objectives of this chapter are to:

- Conduct meta-inference of quantitative and qualitative findings
- analyse the selected concept "moral regeneration "
- describe the meaning of "moral regeneration"
- Develop a graphic presentation of the moral regeneration process.

5.2 META-INFERENCE OF QUANTITATIVE AND QUALITATIVE FINDINGS

The section provides the meta-inference of quantitative and qualitative results. Metainference is defined as the“overall conclusion, explanation of understanding developed through an integration of the inferences obtained from the quantitative and qualitative strands of a mixed-method study” (Tashakkori & Teddlie, 2008). Demonstration of ethical-moral behaviour, Nurses knowledge regarding ethical-moral behaviour and the impact of the race towards knowledge of ethical-moral behaviour are discussed in this section.

5.2.1 Demonstration of ethical-moral behaviour

It was evident from the results of this study that most nurses have demonstrated ethical-moral behaviour in their nursing care process. This was projected through the display in Fig 4.1 (Chapter 4) indicating that 52.1% (n=73) of nurses had demonstrated ethical-moral behaviour with an astonishing number indicating that 49% of nurses had never demonstrated ethical-moral behaviour in their nursing care provision. Ammouri et al (2014)relate that nurses report negative perceptions concerning the work environment (hospital setting). A positive work environment, managerial commitment, nurses education levels and addressing reported mistakes could have a positive impact on patient safety outcomes. Still, in line with this study, Ammouri et al. (2014) reported that nurses who perceived more supervisor/manager expectations, received more feedback and communication about errors, were involved in more teamwork across hospital units, had better perceptions about patient safety. On the other hand, a strong relationship was

identified between nurses levels of job satisfaction, patient safety and perceived quality of care. This study revealed that (11.4%;n=16) of nurses were dissatisfied with nursing as a job. This supports the finding related to nurses perception of low patient safety.

There were similar results, indicating that beyond nurses legal duty to protect patients, nurses showed generally dedication to their patients in nurses ethical decision-making behaviours (Ebrahimi et al., 2015; Smith, 2015; Numminen & Kilpi, 2015). Furthermore, the nurses are dedicated to their job and are available to the clients, spend time on their patients, have a delayed exit from their workplace, a practice that helps to protect, preserve, promote, and improve the health of patients. These behaviours, provide the comfort of conscience, sense of competence, and self-satisfaction in nurses and satisfaction in the clients. Nurses showed their ethical dimension of nursing care to be an essential element of nursing practice and that nurses awareness of their moral responsibilities in nursing care is increasing. Given the importance of ethical-moral behaviour in the provision of nursing care, it is always important for all nurses to practice their nursing care in a way that demonstrates their ethical-moral behaviour.

However, the study also revealed that some nurses lack moral behaviour. Allen et al, (2016) revealed that some patients' experiences regarding their hospitalization were unpleasant, they reported bad experiences, this includes the fact that some nurses failed to listen to their concerns and/or to meet their needs. The same study found that patients continue mentioning that some nurses seemed to be too busy, were rushing around or did not like to be bothered (Allen et al, 2016). Patients also indicated that being hospitalised was scary and that nurses' emotional support was needed to make hospitalisation a positive experience. One patient, who had been nursed in isolation, described a sense of loneliness

as nurses communication was limited as they did not want to go through the ordeal of putting on personal protective clothing before entering the isolation room, by doing harmful behaviour to the patients and being illegally or morally unacceptable to patients which lead the researcher to develop a model to promote moral regeneration among nurses.

However, it was evident that some nurses did not manage to demonstrate ethical-moral behaviour. This means that nurses are also not performing their required or necessary care to patients amid an ethical-moral context. It also shows that nurses lost their integrity and inability to provide patients with good care, there is a poor nurse-patient relationship. The standard of nursing care is not improving, and this will result in a negative impact on nurses job satisfaction. But the smaller number of nurses that did not demonstrate ethical-moral behaviour can have an impact on the daily nursing care of patients, which can lead to disciplinary hearing and loss of a job. The nurse will experience a poor nurse manager-nurse relationship which will lead to poor nursing care and burnout which will result in litigation and punishment. Poor nursing care, not following the scope of practice will lead to poor nurse-patient. Lack of professional responsibility. Disciplinary hearing by the mother body (SANC) will lead to lawsuits. Hence the development of a model to promote moral regeneration among nurses in Limpopo Province is important to improve the standard of nursing care.

5.2.2 Nurses' knowledge regarding ethical-moral behaviour

This study revealed that most of the nurses possessed adequate knowledge regarding ethical-moral behaviour. This is true, given that all items of knowledge were answered correctly by most of the nurses with scores ranging from 54.3% to 94.3% (See Table

4.2 in Chapter 4). According to Osingada et al. (2015), only 15% of the respondents scored ≥50% in the ethics knowledge test. It differs by country, the results on knowledge of ethics are slightly lower than the reports from Germany, where colleagues showed that only 25% of nurse respondents knew about their codes (Osingada et al, 2015). Similar reports among advanced practice nurses show that nurses exhibited low levels of knowledge in ethics despite high levels of confidence during their practice in the USA (Osingada et al, 2015). Huffman and Rittenmeyer (2012) also support by indicating that ethical conflict is natural for health professionals, due to inevitable staff relationships and the ethical responsibilities in patient caring. Studies about nurses ethical conflicts began in the two last decades. However, there is little known about nurses ethical conflicts and the typically resulting unfavourable consequences. Nurses need to understand what ethical conflict is and what the sources of conflict are, which is necessary to reduce and prevent exposition because ethical conflict represents a barrier against providing a high quality of nursing care to patients and their families (Huffman & Rittenmeyer, 2012). These results mean that there is a need to increase nurses knowledge of ethics, more so because adequate working knowledge in ethics is postulated to transform nurses attitudes and approaches towards the provision of quality nursing care.

Abrahimi (2015) also indicated that there is little knowledge about nurses ability to follow the decision and the consequences of their decisions as well as the impact of practice settings on their decisions. Studies show a consistent pattern in ethical practices of nurses over time in different countries, with respect to the nursing scholars, emphasizing the importance of promotion in nurses moral competence and considering the differences.

The same study continues to show that the ethical behaviour of nurses is a strong relational and contextual process in which individual and contextual aspects play an important role. Individual factors such as values, faith, experience, knowledge, skills and contextual factors such as moral awareness, observation, analysis and judgment may affect nurses ethical behaviour and decisions. Furthermore, nurses rely on education, religious values, their intuition and feelings, guidelines, standards, colleagues' support, and the potential consequences of their choices to justify their decisions. Furthermore, the patients' characteristics affect nurses ethical decision-making process (Abrahimi, 2015).

The above discussions show that there is a need for nurses to think about patients' value and belief while providing nursing care to them, to prevent dilemmas. For example, the client's right to refuse treatment may conflict and carry out the treatment. The nurse can think in advance to make a better moral decision about their beliefs and moral value and about patients problems they may encounter while caring for the patient. This is because every nurse-patient contact can result in a legal or ethical situation.

Nurses must respect the client's wishes, even if they do not agree with them. Finally, justice requires that all clients be treated equally and fairly. Nurses face issues of justice daily when organizing care for their clients and deciding how much time they will spend with each based on client needs and a fair distribution of resources. Hence the researcher developing a model which will promote moral regeneration among nurses in Limpopo Province.

5.2.3 Impact of a race on knowledge of ethical-moral behaviour

This study further highlighted that knowledge regarding ethical-moral behaviour is predicted by race, more especially being African and Indian. The strongest predictor of knowledge regarding ethical-moral behaviour was race.

The findings of this study revealed that some nurses do practice ethical-moral behaviour and also possess knowledge regarding ethical-moral behaviour. However, it was also clear that race and religion were the main predictors of their knowledge regarding ethical-moral behaviour. Being from African and Indian domination was found to be the main significant contributors to the prediction of knowledge regarding ethical-moral behaviour. This means that Africans and Indian culture possesses cultural practices that promote ethical-moral behaviours that are embedded within their traditions and these have the potential to improve the ethical-moral behaviour of nurses in the provision of care. This was also emphasised in qualitative by the report on Ubuntu which is an African cultural and moral stand. Mulaudzi et al. (2014) said that Ubuntu optimises the African philosophy of respect and human dignity that is fundamental to being able to transcend ethnic divisions by working together and respecting each other.

People who truly practise Ubuntu are always open and make themselves available to others, affirming others without feeling threatened and accepting that others are able and good (Mulaudzi et al, 2014) With Ubuntu, one has a proper assurance that comes with the fundamental recognition that each individual belongs to a greater community.

In this study, Ubuntu was also further explained as love and interact with other people and sharing with other people, respect the uniqueness and dignity of each person, Protect patient privacy, being honest, and commitments open, do the right thing, have integrity and personal morality.

5.3. THE CONCEPT ANALYSIS PROCESS

Concept analysis is defined as a strategy that allows researchers to examine the attributes or characteristics of a concept (Walker & Avant, 2014). According to Walker and Avant (2014) concept analysis is a formal, linguistic exercise to determine those defining attributes. The purpose and use of concept analysis are to distinguish the defining attributes of a concept from its irrelevant attributes (Walker & Avant, 2014).

The theoretical meaning of the concept was analysed following the eight steps of the Walker and Avant method, to clarify and distinguish the definition of the main concepts because it seems to be the most influential model in nursing science (Nuopponen, 2010). In addition, the researcher adopted the Walker and Avant method to render precise theoretical and operational definitions in the study. This helped the researcher to clarify nursing terms that are popular phrases. Furthermore, concept analysis also assists the researcher to develop an instrument and nursing diagnosis (Walker and Avant, 2014). Concept analysis has been useful in model development and nursing language development (Walker & Avant, 2014). The reasons for choosing concept analysis, during model development, were that it rendered very precise theoretical as well as operational definitions for use in model development and research (Walker & Avant., 2014). It also enabled the researcher to clarify similar concepts (model case) to the concept of moral regeneration. The theoretical

perspective of the meaning of the concept was described following the process of concept analysis by Walker & Avant (2014). Eight steps will be used:

- Selecting one or more concepts
- Determining the purpose of the analysis
- Identifying all uses of the concept(s)
- Determining defining attributes and characteristics
- Identifying model cases
- Constructing borderline, related, contrary, invented and illegitimate cases
- Identifying antecedents and consequences; and
- Defining empirical referents.

5.3.1. Selecting the concept

According to Walker and Avant (2014), concept selection is the most difficult step that should be done carefully, to avoid primitive terms that can be defined by giving examples only. It also helps to simplify, clarify, refine, and determine the concept's internal structure. Some authors have indicated that concept selection should reflect the topic or area of greatest interest to the researcher (Nuopponen, 2010; Walker & Avant, 2014). In this study, the researcher selected the concept of "*moral regeneration among nurses"* as the key to this study. This concept was identified because empirical data indicated that most of the nurses did not respect the patients *'you know nurses do not respect us they usually come and scold us in front of other patients ….using rude language when talking to us hence their ethical - moral behaviour is not acceptable'.*

The concept that was central in correcting bad ethical-moral behaviour of nurses was identified as *"moral regeneration among nurses*" as the understanding of the concept had

assisted the researcher in identifying its characteristics that can help shape the ethical-moral behaviour of nurses. The concept of bad ethical-moral behaviour of nurses was mentioned several times where both nurse's knowledge of the expected behaviour and practising good ethical-moral behaviour during the provision of nursing care was identified as wanting. Most of the time the participants responded as follows: '*it's very difficult to practice nursing according to the code of conduct, the environment is depressing, there is a high shortage of staff and poor in-service training that makes it difficult to care for patients correctly'.* This shows the need to promote ethical-moral behaviour so that nurses internalise good ethical-moral behaviour and apply it in their everyday nursing care processes.

"*Moral regeneration*" was said to be the best remedy for the bad moral behaviour of nurses '*a lot of nurses are reported to the South African Nursing Council, because of their bad behaviour, we often hear stories of mothers giving birth in the streets, at the clinic gate or alone because nurses sent that women back or did not examine her, it's* shameful'.

It is from all these quotes and data that "moral regeneration" was identified as a central concept that can be used as a remedy for the ethical-moral bad behaviour of nurses in Limpopo Province.

Therefore "regeneration" was selected as part of the concept "*Moral regeneration among nurses*" In this study, the word *"regeneration"* as giving life or strength to something

5.3.2 Determining the purpose of the concept analysis

Determining the purpose of concept analysis is the second step of the eight steps of concept analysis (Walker & Avant, 2014; Chinn & Kramer 2015). The purpose of concept analysis is

to set boundaries to limit becoming hopelessly lost in the process. In this study, the researcher determined the purpose of concept analysis as follows:

- To distinguish between ordinary and scientific usage of the same concept.
- To clarify the meaning of the existing concept.
- To develop an operational definition, or something similar (Walker & Avant, 2014)
- To define the meaning of a concept “Moral regeneration among nurses” its attributes and the meaning of the related terms with different meanings, to clarify the concept (Chinn & Kramer’s, 1999 cited in Barker, 2013)

5.3.3 Identifying all uses of the concept “moral regeneration”

According to Walker and Avant (2014), it is important to identify all uses of a concept when collecting empirical data for the analysis. In this study, the researcher clarified concepts using dictionaries, theses, colleagues and literature control, to promote further understanding among other disciplines. In this study, the researcher operationalized concepts of “*moral regeneration among nurses”* to guide the discipline so as not to lose useful information (Chinn & Kramer’s, 1999 cited in Barker, 2013). The concept ‘moral regeneration’ has been identified as being central to this study, as it was identified from the patients’ data about the ethical-moral behaviour of nurses (as discussed in chapter 4 of this thesis). It was shown that some nurses lacked ethical-moral behaviour according to the participants. It was concluded that moral regeneration should be the central concept as it will allow nurses to change their behaviour towards patients. The researcher utilised relevant available sources of information and colleagues in academia, to identify as many practical

uses of the concept ‘moral regeneration’ as possible, without limiting the search of the terms to the nursing and medical contexts (Walker & Avant, 2014). The review of the relevant literature helped to support and validate the ultimate choices of the defining attributes (Walker & Avant, 2014). The researcher proceeded with the process of defining conceptual meaning, by using multiple resources from the literature review “moral regeneration”. The concept ‘moral regeneration’ has two components ‘moral’ and ‘regeneration’.

The uses of the components will be described separately. Table 5.1 indicates the approach used during the literature review (Walker & Avant, 2014).

Table 5.1. The approach used during the literature review

Source	Year	Field	Uses of the Concept
Oxford Advanced Dictionary	2005	Moral (General)	The connection of what is right or wrong, good or virtuous
Cook	2004	Moral (General)	According to ethics, a moral refers to an individual’s own principles regarding right or wrong, sometimes they are interchangeable, ethics refers to rules provided by an external source for example codes of conduct in the workplace or principles of religion
Flanagan	2009	Psychology	A moral refers to the development of the moral sense i.e. of the capacity for forming a judgement about what is right or wrong, good or bad
Loland	2013	Sport	A moral is a way of giving moral support to a person or cause, or one side in a conflict, without making any contribution beyond the emotional or the psychological value of encouragement
Durkheim	2018	Sociology	The system by which we determine right or wrong, or to be mindful about the choices in life that have good or evil consequences, for example, some people may decide that the highest good is to help

			people and harm as little as possible. They would make decisions to spend their time and resources helping those who can't help themselves
Kleinknecht-Dolf., Frei, Spichiger, Müller, Martin, and Spirig	2015	Nursing	A moral refers to a judgement about behaviour. Nursing requires courage to be moral, taking tough stands for what is right, and living by one's moral values, along with a new interest in virtue and a valued element of human morality has increased
Mariaye	2006	Education	A moral education refers to the process by which the relevant knowledge, attitudes, values and skills are transmitted and developed in children
Merriam Webster Dictionary	2007	Regeneration(General)	Defines "regeneration" as an act or the process of regenerating, state of being regenerated, spiritual renewal or revival, renewal or restoration of a body,
Smith	2019	Nursing	The replacement of tissues e.g. growth of nails or hair or repair of tissues or organs lost through damage, further explains that is the process of coming back, growing a new or spiritual rebirth.
Blakeley & Evans	2015	Sociology	The process of neural regeneration leads to the regrowth and development of entirely new neurons or neurons being repaired
Lucarelli & Hallin	2014	Psychology	Regeneration means the attempt to reverse that decline by both improving the physical structure, and, more importantly, and elusively, the economy of those areas
Ephesians 2:4		Spiritually	Regeneration means that God brings Christians to a new life or "born again" from a previous state of separation from God and subjection to the decay of death.

5.3.3.1 Moral

A moral is a connection of what is right or wrong, good or virtuous (Oxford Advanced Dictionary, 2005). According to ethics moral refers to an individual's own principles regarding right or wrong, sometimes they are interchangeable, ethics refers to rules provided by an external source for example codes of conduct in the workplace or principles of religion (Cook, 2004).

Whereas in psychology moral refers to the development of the moral sense that is of the capacity for forming a judgement about what is right or wrong, good or bad (Flanagan, 2009). In sport, moral is a way of giving moral support to a person or cause, or one side in a conflict, without making any contribution beyond the emotional or psychological value of encouragement (Loland, 2013).

A Moral is further described in sociology as the system by which we determine right or wrong, or to be mindful about the choices in life that have good or evil consequences, for example, some people may decide that the highest good is to help people and harm as little as possible. They would make decisions to spend their time and resources helping those who can't help themselves (Durkheim, 2018).

In nursing, a moral refers to a judgement about behaviour. Nursing requires courage to be moral, taking tough stands for what is right, and living by one's moral values, along with a new interest in virtue and a valued element of human morality has increased. Moral courage involves standing up for your values, ethics, and beliefs, even the risk of your reputation, emotional anxiety, social isolation, it further explains that it is the ability to endure distress

inherent in difficult situations when a nurse needs to do what is right (Kleinknecht-Dolf., Frei, Spichiger, Müller, Martin & Spirig, 2015).

A moral education refers, according to Mariaye (2006) to the process by which the relevant knowledge, attitudes, values and skills are transmitted and developed in children.

A moral education thus focuses on the development of the cognitive, social and emotional skills which are necessary for moral thinking, feeling and behaviour. Moral education is an important aspect of developing a moral posture. Moral teaching might happen organically as children are socialised into good habits and choices by witnessing what right choices adults around them make, or this might happen when children are formally taught what is right and wrong (Peters, 2015). Moral teaching pertains then to the teaching of the right knowledge, attitudes, values, and skills.

Moral education is an important aspect of moral development. The teaching of morality has been studied through the ages from diverse angles such as the Christianity Values Education approach, and Education. Moral teachings have been closely monitored throughout history in traditional societies through ritual practices which contain moral lessons that are imparted by elders who are custodians of knowledge contained in institutions like initiation schools (Katide, 2017).

Uses of the concept of moral

When morality is used simply refer to a code of conduct put forward by ban actual group, including a society, even if it is distinguished from etiquette, law, religion, it is being used in

a descriptive sense, it is also being used in the descriptive sense when it refers to important attitudes of individuals (Gert, 2002).

The concept ‘moral’ in nursing is related to the following synonyms:

- Ethical
- Good
- Right
- Honest
- Decent
- Proper
- Honourable
- Just

A moral in this study means that nurses should understand the difference between right and wrong, and should be taught good behaviour, receive and provide moral support when nursing patients, and maintain good conduct towards their patients. Out of the 162 respondents who completed the questionnaires 52.1% (n=73) reported that during the two years preceding the survey, they had demonstrated ethical practice as nurses. Participants revealed that nurses were harsh and rude, ill-mannered or uncivilized or bad-mannered towards patients who could not do anything for themselves, and they ignored patients’ calls for help. Some nurses told patients that they were too demanding and did not attend to emergencies. Nurses ignored patients when they called for help, Patients were treated according to the status of the patient, nurses uses language that some patients could not understand. Some nurses scolded elderly people, the middle-aged patients and patients

who had been educated were treated better, but scolding to elderly patients.*"They don't respect, (sad look) they were rude to a patient and wanted her to do things for herself, even though she was in pain, Hey!!!! Pause….. sometimes they come when they are called, they tell us we are too demanding, it is like they don't want their job, it is not the same to everyone, and sometimes we have to call home for help*."

"Nurses interact with us in a good manner, they crack jokes very much, when you call for help they respond very well, and they come and ask if you are in need help, sometimes they come when they are not busy and ask if I had my tablets, they pay more attention to those who are helpless"

"Some are good and some are not good depending on the shifts, at night yesterday I fought with one of them because she wanted me to do things on my own which I was unable, when it comes to treatment there is no consistency as to the time we receive medications, they don't serve us and don't have time, sometimes morning shifts are better than evening shifts".

5.3.3.2 Regeneration

The Merriam Webster Dictionary (2007) defines "regeneration" as an act or the process of regenerating, state of being regenerated, spiritual renewal or revival, renewal or restoration of a body, further explain that the term 'regeneration' refers to a confirmed commitment of faith especially after an intense religious experience having returned to or newly adopted an activity, a conviction, or a persona especially with a proselytising zeal a born-again conservative (The Merrian Webster Dictionary, 2007).

Regeneration in nursing means the replacement of tissues, for example, growth of nails or hair, or repair of tissues or organs lost through damage, further explain that is the process of coming back, growing a new or a spiritual rebirth (Smith, 2019).

In sociology, regeneration is the process of neural regeneration that leads to the regrowth and development of entirely new neurons or neurons being repaired (Blakeley & Evans, 2015).

In psychology, regeneration means the attempt to reverse that decline by both improving the physical structure, and, more importantly, and elusively, the economy of those areas (Lucarelli & Hallin, 2014).

Spiritually, Regeneration means that God brings Christians to a new life or "born again" from a previous state of separation from God and subjection to the decay of death (Ephesians 2:4). Thus, in Lutheran and Roman Catholic theology, it generally means that which takes place during baptism.

Uses of regeneration

To remove the years of wasted lives; wasted opportunities and wasted output that occurs if we just let events take their natural course: it shortens the period between decline and rise.

Regeneration in nursing is related to the following Synonyms:

- Renewal
- Rebirth
- Revival

- Renaissance
- Restoration
- Redevelopment
- Reinforcement

In this study regeneration refers to the restoration of lost nurses qualities, enhancing the morality of nurses and giving them renewed strength to change their behaviour.

Regeneration also refers to revival from a previous stage of behaviour to a new level where patients are respected, their culture, religious confidence and self-determination is taken care of patients and other people, nurturing the morals, values, respect and humanness of nurses towards patients in the hospital. In this study, as shown in chapter 4, (63.6%; n=89) of the respondents (nurses) stated that ethical conduct was important to avoid legal action. Adherence to patients' wishes was reported by (81.4%; n=114) of the nurses indicating that nurses respected the culture of their patients. (72.9%; n=102) of the nurses maintained that nurses should do what is best for the patient irrespective of the patient's opinion, portraying nurses humanness. Whereas some participants indicated nurses respected patients considering their social status if the patient was illiterate the nurses did not respect him/her. The minority of participants reported that some nurses shouted at elderly people, and only respected middle-aged patients. Participants also indicated nurses were ignoring patients' requests for help, especially during the night. Participants also reported that nurses also displayed tribalism, using a language that some patients did not understand

Lusenga (2011) stated that regeneration implies that there was once something, which presently no longer exists or is being shelved aside or probably deleted. That something is

no longer visible. The word “re” means again or bringing something back. We need to go back to the basics. The lives of people need to be recaptured, rekindled, revisited, reclaimed and renewed.

Packer (2012) defined regeneration as the spiritual change wrought in the heart of a man by the Holy Spirit in which his/her inherently sinful nature is changed so that he/she can respond to God in Faith, and live by His Will (Matthew 19:28; John 3:3,5,7; Titus 3:5). It extends to the whole nature of man, altering his governing disposition, illuminating his mind, freeing his will, and renewing his nature.

Based on Packer’s (2012) explanation of regeneration**,** as the spiritual transformation of a person, brought about by the Holy Spirit that changes the individual from being spiritually dead to becoming a spiritually alive human being. Regeneration is another way of speaking about the new birth *or the* second birth *or being* born again. Packer’s (2012) definition of regeneration as the spiritual change could be regarded as being the basis of this study as regeneration requires the involvement of nurses to change spiritually implying renewal, restoration, and growth

5.3.3.3 Moral regeneration

The Merrian Webster Dictionary (2007) defines moral regeneration as the revival of moral values that have decayed, a process of bringing back all acceptable traditional and cultural behavioural patterns and laws followed when one was growing up.

Moral regeneration is the revival of moral values that have decayed. This is a process of bringing back all acceptable traditional and cultural behavioural patterns and laws followed

when one was growing up. In other words, moral regeneration is the promotion of good conduct and the encouragement of the youth to keep away from social ills and lead a life that is guided by moral values. Today there is a dire need to revive morals amongst our communities (Ladzani, 2014).

According to Motshekga (2014), moral regeneration in nursing is a civil society led by the movement to raise awareness and arm the communities with strategies to fight moral decay in our country. Motshekga (2014) observed that the levels of moral degeneration in South African communities require a serious national intervention that goes beyond advocacy for healthy living. In other words, moral regeneration is the promotion of good conduct and the encouragement of the youth to keep away from social ills and lead lives that are guided by moral values (Motshekga, 2014).

Motshekga (2014) argues that there is an urgent need to occupy children and youth after school and over the weekends at cultural centres in townships and informal centres through which school children and out-of-school youth could be engaged in spiritual growth and development through practical programmes. These could include spiritual music, indigenous games, cultural and other creative activities.

In this study moral regeneration refers to being honest in whatever a nurse is doing for patients, respect, sharing, Ubuntu, change. In this study (as portrayed in chapter 4 of this thesis), fewer respondents (17.2%; n=24) agreed that they treated children without their parents' consent than those respondents (nurses) who disagreed (77.2%; n=108) that they treated children without their parents' consent. This finding implies that human dignity and honesty were practised by nurses. Participants (patients) expressed Ubuntu as correct

behaviour, by having relations with other people and behaving well towards others or acting in ways that benefit the community. Living and interacting with one another and through their early interactions, people develop relationships, feel secure, communicate, and enjoy being with people, express love and affection, learn, and have their needs met through contact with others.

5.3.4 Characteristics and Attributes

Respect and human dignity - respect, care and concern - are among the values of South African people, recognising that there can be no peace or security without respect and care. Nurses should respect all patients, irrespective of race, gender, age, status and class and care for all patients whether weak, disabled, young (Charter of Positive Values, 2015). In this study (chapter 4 of this thesis) (79.2%; n=111) of the nurses (respondents) avoided discrimination of patients and (85.7%; n=120) indicated that they cared for all patients irrespective of race or age and (94.3%; n=132) indicated that they promoted equal opportunities for all patients, including disabled people. Participants indicated nurses failed to attend to patients requiring help to meet their needs, failed to assist patients who could not care for themselves and those who could not do so. Nurses promised patients that they would come back for help but they never returned and some nurses were impatient when asked for help, indicating poor moral behaviour of nurses.

Upholding honesty, integrity and loyalty requires nurses to interact openly and honestly with patients. Nurses should promote and encourage good relations when interacting with patients (Charter of Positive Values, 2015).

The purpose of developing a model of moral regeneration among nurses in the Limpopo Province was to:

- promote good ethics and behaviour in the nursing profession
- promote the implementation of *Batho Pele* principles (as discussed in chapter 7 under guidelines regarding the dynamics of moral regeneration of this thesis)
- raise awareness and enable communities to address moral decay in hospitals
- develop theoretical definition (s) of the concept “moral regeneration” that helped in the development and description of the model
- discuss the theory of moral regeneration: the Theory of Model Development (as discussed in chapter 8 of this thesis under guidelines regarding the process of moral regeneration)
- discuss and interpret the results of concept analysis that will assist to create/construct a model of moral regeneration.

The researcher selected the phrase, “moral emotions” as it appears first on the list of related concepts to verify whether it would provide any different view of “moral” According to The Merrian Webster Dictionary (2007), the explanation or uses of ‘moral emotions’ are related to the uses of ‘moral’. The word ‘moral emotions’ also comes from The Merrian Webster Dictionary (2007), which means a systematic statement of a body law, a system of rules or principles, a system of signals for communication.

Tangney, Stuewig and Mashek (2011) supported this standpoint by describing moral emotions as representing a key element of our human moral apparatus, influencing the link between moral standards and moral behaviour. It reviews current theory and research on

moral emotions, focusing on a triad of negatively valued self-conscious emotions - shame, guilt, and embarrassment. As in previous decades, much research remains focused on shame and guilt. Current thinking was reviewed on the distinction between shame and guilt, and the relative advantages and disadvantages of these two moral emotions. Several new areas of research are highlighted: research on the domain-specific phenomenon of body shame, styles of coping with shame, psychobiological aspects of shame, the link between childhood abuse and later proneness to shame, and the phenomenon of vicarious or 'collective' experiences of shame and guilt. In recent years, the concept of moral emotions has been expanded to include several positive emotions - elevation, gratitude, and sometimes morally relevant experiences of pride.

Jacob (2010) concurred with Tangney et al. (2011), indicating that moral emotions could be classified according to their target. Emotions, evaluating one's own actions or characteristics, such as guilt, pride, regret or shame, have been referred to as self-directed emotions or actor emotions. In contrast, emotions that are directed at other persons' actions or characteristics, such as admiration, anger, or sympathy, contempt, indignation, pride, and respect have been labelled as other-directed emotions or observer emotions. Moreover, all moral emotions contain an evaluative function. This implies that positive moral emotions are elicited following one's own (actor emotions) or another person's (observer emotions) morally positive behaviour, such as actions meeting or exceeding positive moral standards like helping someone in need or investing effort to attain a morally positive goal. In contrast, negative moral emotions occur after one's own (actor emotions) or others' (observer emotions) morally negative behaviour, such as transgressing moral standards like lying or cheating or not investing effort to attain a positive goal. Cook and Brunton (2017) also

concurred that moral emotions play an important role in communication between members of culturally diverse nursing teams.

These emotions determine ethically responsive patient care and team relationships. Scott (2000) concurred that emotion plays a crucial part in moral judgment and shapes clinical actions. The account of moral emotions was developed by Haidt (2003), where he distinguishes between emotions that have a moral value attached to their intentional object (moral emotions) and those that do not (non-moral emotions). Moral emotions are defined as "…those emotions that are linked to the interests or welfare either of society as a whole or at least of persons other than the judge or agent" (Haidt, 2003). Moral emotions are evoked when employees determine that a communicative event or action either benefits or undermines another's well-being (Cook& Brunton, 2017). Moral emotions are self-conscious emotions that reinforce the behaviour.

In this study moral emotions refer to nurses who can respect patients and people around them, have interpersonal relationships, be able to interact with patients and multidisciplinary health care team members. It also refers to the abilities to share with other people, to have empathy and to sympathise. Most of the participants in this study indicated that nurses showed sympathy to their patients. Communication with patients informing patients that they would get better. Nurses are being friendly and loving to patients. Participants mentioned that some nurses showed interest and provided comfort and support.

5.3.5 Determination of defining attributes and characteristics

According to Walker and Avant (2014) defining characteristics of a concept make up the core of concept analysis. Once the chief concepts had been identified and defined, defining attributes were listed, analysed and synthesised to form a definition of the main concept, namely ‘moral regeneration’. The defining attributes of the concept are the collection of attributes that are frequently associated with the concept and allow the researcher to gain insight into this concept. The Cambridge English Dictionary (2017) defines the attribute as a quality or characteristic that someone or something has, whereas The Merrian Webster Dictionary (2007) defines the attribute as a quality or characteristic given to a person, group, or some other thing. A quality, character, or characteristic ascribed to someone or something has leadership attributes, an object closely associated with or belonging to a specific person, thing, or office, like a sceptre which is the attribute of power; an object used for identification in painting or sculpture. Defining attributes might change the understanding of the concept, as it is improved and developed (Chinn et al., 2015). Respect for human values includes dignity and rights, peace, care, kindness, compassion, sympathetic and empathetic joy, responsibility, discipline and honesty.

The characteristics of both components of the concept ‘moral regeneration’ which appeared more than ones for ‘moral’ were moral code: a written, formal and consistent set of rules prescribing righteous behaviour, accepted by a person or by a group of people, moral integrity; being honest and having strong moral principles, moral uprightness, whole and complete, morality; principle concerning the distinction between right and wrong or good behaviour (Collins English Dictionary, 2017). For ‘regeneration’ the following characteristics

were identified: about-face, alteration, born again, change of heart, changeover, exchange, growth, modification, progress, and reorganisation.

For 'moral regeneration' the derived attributes included honesty, respect, integrity, fairness, culture, beliefs, equality, conscience, peace, empathy, sympathy, loyalty.

5.3.5.1 MORAL

Moral emotions imply a written, formal, and consistent set of rules prescribing righteous behaviour, accepted by a person or by a group of people (The Merrian Webster Dictionary, 2007).

'About-face' implies a turn made to face the opposite direction (The Merrian Webster Dictionary, 2007).

'Alteration' refers to a change, modification or adjustment (The Oxford Dictionary, 2016).

'Born again' usually relates to being a Christian person who has made a renewed commitment to moral integrity: The qualifications require a person, to be honest, and have strong moral principles, moral uprightness. Generally, personal choice concerns holding oneself to consistent moral and ethical standards (The Oxford Dictionary, 2016).

'Morality' involves the principles concerning the distinction between right and wrong or good or bad behaviour (The Oxford Dictionary, 2016).

'Morals' relate to or are concerned with the principles or rules of right conduct or the distinction between right or wrong (The Oxford Dictionary, 2016).

'Moral support' implies encouraging a person and showing him or her that you approve of what they are doing, rather than giving practical help (The Cambridge Dictionary, 2017).

'Good morals' relate to, or are concerned with the principles or rules of right conduct; the distinction between right and wrong (The Oxford Dictionary, 2016).

5.3.5.2 Regeneration

The term 'regeneration' refers to a confirmed commitment of faith, especially after an intense religious experience having returned to or newly adopted an activity, a conviction, or a persona, especially with a proselytising zeal of a born-again conservative (The Merrian Webster Dictionary, 2007).

'Change of heart' implies changing one's opinion or the way one feels about something (The Oxford Dictionary, 2014).

'Changeover' refers to a conversion or complete change from one thing, condition, or system to another, as in equipment, personnel, methods of production (The Oxford Dictionary, 2016).

'Exchange' refers to an act of giving one thing and receiving another (especially of the same kind) in return (The Merrian Webster Dictionary, 2007).

'Growth' is a stage in the process of growing, the process of growing progressive development (The Merrian Webster Dictionary, 2007).

'Modification' refers to making a limited change to something (The Merrian Webster Dictionary, 2007).

'Progress' refers to the movement to an improved or more developed state, or to a forward position (The Merrian Webster Dictionary, 2007).

'Reorganisation' implies a change in the way that something (such as a company) is organised, in order to improve it (The Oxford Dictionary, 2014).

5.3.5.3 Moral Regeneration

'Honesty' implies the quality or fact of being honest, upright and fair, truthfulness, sincerity, or frankness, freedom from deceit or fraud (The Merrian Webster Dictionary, 2007).

'Respect' pertains to a feeling of deep admiration for someone or something elicited by their abilities, qualities, or achievements. The state of being admired or respected (The Merrian Webster Dictionary, 2007).

'Integrity' refers to a firm adherence to a code of especially moral or artistic values, unimpaired condition, the quality or state of being complete or undivided (The Merrian Webster Dictionary, 2007).

'Fairness' implies a state, condition, or quality of being fair, or free from bias or injustice; evenhandedness (The Merrian Webster Dictionary, 2007).

'Culture' refers to the act of developing the intellectual and moral faculties especially through education (The Merrian Webster Dictionary, 2007).

‘Beliefs’ imply a state or habit of mind in which trust or confidence is placed in some person or thing or belief in God, a belief in democracy. For example, I bought the table in the belief that it was an antique, contrary to popular belief (The Merrian Webster Dictionary, 2007).

‘Equality’ refers to the state of being equal, especially in status, rights, or opportunities (The Merrian Webster Dictionary, 2007)

‘Conscience’ describes a person's moral sense of right and wrong, viewed as acting as a guide to one's behaviour (The Merrian Webster Dictionary, 2007).

‘Peaceful’ means free from disturbance; tranquil, not involving war or violence (The Merrian Webster Dictionary, 2007).

‘Empathy’ means ‘the ability to understand and share the feelings of another’ (as in both authors have the skill to make you feel empathy with their heroines) (English Oxford Dictionary, 2014)

‘Sympathy’ means ‘feelings of pity and sorrow for someone else's misfortune’ (as in they had great sympathy for the flood victims) (English Oxford Dictionary, 2014)

‘Loyalty’ is the quality of staying firm in your friendship or support for someone or something (English Oxford Dictionary, 2014).

5.3.6 Identification or construction of a model case

Walker and Avant (2014) described a “model case” as an example of the use of the concept that demonstrates all the defining characteristics or attributes of a concept. The researcher had to develop model cases representing and describing a true example of the uses of the

concept, including all critical attributes of that concept (Nuopponen, 2010), based on the identified uses and the defining attributes of the concept. Model cases can be drawn from literature, art or films or any other context in which the concept is symbolised. The model case was developed to reflect the real-life situation where moral regeneration takes place.

"Nandipa, a 30-year old professional nurse, raised in a Christian family and also a Christian, working in a female surgical ward. She admitted a female patient, Sophy, a 58year-old female diabetic patient with gangrene of the left foot. On admission, the Nandipa displayed kindness, warmth and sensitivity. She informed her that the doctor would come to see her. The nurse further told the patient that she was going to receive treatment which would help her to get better. The nurse called the doctor to see the patient. The nurse showed the patient photos of patients with gangrene. Family members, who brought the patient to the hospital, were also counselled and showing empathy and sympathy explaining that the disease is incurable but that the doctor will prescribe some tablets for pain."

The above case indicates that the nurse showed respect and demonstrated empathy and sympathy. The nurse had a moral duty to promote Sophy's well-being. To do so, professionally, nurses are expected to balance their expert professional knowledge and understanding with the preferences of their patients. In terms of their professional expectations, nurses ought to work collaboratively with patients, thus informing, guiding, and helping them to make responsible choices about their health. Influences impacting a person's health status, such as beliefs, cultural background and social circumstances, must be taken into consideration. The nurse has to consider how the patient makes decisions on the one hand, and ensure that he/she complies with the legal ethical framework of his/her

practice and own convictions on the other hand. Nurses are professionally bound to do good by promoting the health of their patients, and not to discriminate based on race, colour, conviction or religion. Nurses have committed themselves to act virtuously. In Sophy's situation, nurses are required to demonstrate honesty, caring, trustworthiness, respect, empathy and sympathy.

Related cases are related to the concept under study but do not contain critical attributes, though they might resemble or be connected to the concept. They help to add insight into reasons why the concept being studied fits into the network of concepts surrounding it (Walker & Avant, 2014).

5.3.7 Construction of borderline, related and contrary cases.

Borderline cases are those that reflect some, but not all attributes of the concept. They are somewhat inconsistent. They help clarify thoughts about the defining attributes of the concept under study (Walker & Avant, 2014). For this study, borderline and contrary cases reflect attributes that are not an instance of the concept under investigation. A contrary case ultimately leads to the identification of critical attributes through explication of the contrary ones (Walker & Avant, 2014). The researcher had to develop a model case that represents and clearly described the true uses and attributes of the concept of "moral regeneration".

The theoretical definition of "moral regeneration" includes good, right, revival, renewal, restoration, decent, redevelopment, honourable, which include elements as recommended by section 1 of the constitution of South Africa. The researcher identified an example of a model case of the concept "moral regeneration" based on the uses, attributes and

characteristics of the concept (Walker & Avant, 2014). The model case was constructed in such a way that contained all defining characteristics of the concept “moral regeneration”.

Ellen, a student nurse aged 21-years, was allocated to the medical ward as a requirement by the SANC. The nurse does not greet patients when he arrives in the ward every morning. The nurse does not show respect to the poor patients for example when he changes the patient’s position, does not screen the bed for privacy. Patients reported that she always scold them whenever they ask for a bedpan or urinal. She always tells the patients that she is tired. During visiting hours she does not give clear information to the relatives.

Good communication between the nurse and patients influence satisfaction, medication adherence.

Nurses can directly impact the care of patients and their families through the use of therapeutic communication (Wilkinson, Gambles & Roberts, 2002). Communication skills between a healthcare provider and a patient can be defined as the specific behaviours and responses used in a therapeutic relationship (Sheldon, 2005). Communication influences factors such as patient satisfaction, anxiety, medication adherence, and clinical outcomes (Eid, Petty, Hutchins, & Thompson, 2009; Tobin & Begley, 2008). Patients and families want clear information regarding the disease was not satisfactory. In addition, patients and families prefer the style of communication to include empathy and honesty, balanced with sensitivity and hope (Parker et al., 2007). The report challenges healthcare providers to strive for a partnership with patients that incorporates respect, solidarity, and empathy. Nurses need to be taught how to respond to these difficult questions and how to communicate effectively with patients with cancer and their families about treatment options

and how they relate to goals of care. A goals-of-care conversation has all the qualities described in patient-centred care.

5.3.8 Identify antecedents and consequences

Identifying antecedents and consequences are the next steps in concept analysis (Walker & Avant, 2014). The identification of consequences and antecedents is an important outcome of concept analysis. This serves to identify the assumptions of the concept and enrich the understanding of the context in which the concept is being used (Strauss & Corbin, 2009). The antecedents and consequences were identified from the relevant literature about moral regeneration.

5.3.8.1 Antecedents of 'moral regeneration'

Antecedents are aspects that normally precede the word, in this study's case they are aspects preceding 'moral regeneration' especially in relation to the moral behaviour of nurses. "Antecedents are defined as the events or attributes that must arise before a concept's occurrence" (Walker & Avant, 2014). Antecedents are experiences identified before other concepts (Chinn & Kramer, 2015). Antecedents can be classified as those factors that facilitate the occurrence of moral regeneration. Moral regeneration can only occur if the following antecedents are fulfilled: a respectful nurse practitioner maintains good interpersonal relationships, has a positive attitude towards patients, respects patient's values, beliefs, and culture. Respect is related to treating people in a positive manner that acknowledges them for who they are and/or what they are doing. Being treated or treating an individual in a dignified manner, with equality for all human beings, respecting the worth

of all individuals, irrespective of social origin, race, gender, age, status and class. Respect is earned and is never just given. But respect must be given for it to be received. Nurses need to care for all who are weak and disadvantaged: the poor, the aged, the disabled, and all those unable to care for themselves such as patients. Nurses need to avoid discrimination based on status, custom, culture, race, gender, sexual orientation, health status, and tradition while working for the physical security and protection of all people in their care.

Good interpersonal relationships imply interactions with individuals by treating them with dignity and in a respectful manner as this shows one's character as a person. Promoting and encouraging good relations, mutual trust and respect will be reciprocated. A nurse must always behave respectfully as this reflects his/her character, integrity and values.

Maintaining a positive attitude towards patients is a concern that relates to the peace, comfort, and harmony of another person, and of being kind and considerate, respectful, knowledgeable, and treating the patient as an individual are all characteristics of caring.

Respecting a patient's values, beliefs, and culture relates to a nurse inquiring about a patient's culture, dietary practice, beliefs and religious practices that would help in the care of the patient. It is essential to understand that each person is an individual who might or might not adhere to certain cultural beliefs or practices common in the nurse's culture. Asking patients about their beliefs and way of life is the best way to be sure a nurse knows how patients' values might impact their care.

For moral regeneration to take place, nurses should have respect, empathy and sympathy, have good interpersonal relationships with patients, have positive caring attitudes, and respect patients' values, beliefs and culture.

5.3.8.2 Consequences of "moral regeneration"

Consequences are those events or incidents that can occur as a result of the occurrence of a concept and that can often stimulate new ideas or avenues for research pertaining to certain concepts, generally called 'outcomes of the concept' or the end result (Walker& Avant, 2014). Both antecedents and consequences help to enrich an understanding of the context in which the concept is generally used, thus helping to refine critical attributes (Walker & Avant, 2014). When linked to practice, one should consider the consequences/outcomes of 'moral regeneration'. In this study, the consequence of moral regeneration among nurses would be that nurses would understanding 'moral regeneration' and act accordingly. Such information will assist them to adopt moral behaviour; greeting people, being empathetic and sympathetic, and behaving in ways that demonstrate sharing, caring, compassion, generosity and hospitality. Good interpersonal relationships, culture awareness sensitivity, respect for other cultures are also attributes of moral regeneration. In this study, nurses working in operating theatres were less likely to demonstrate moral behaviour than those working in medical units. This might be attributable to the possibility that in operating theatres generosity might generally not be practised. Compared to enrolled nurse auxiliaries, nurses who had completed the four-year comprehensive programme (R425), were less likely to practise moral behaviour. Participants (patients) in this study indicated that nurses always greeted, introduced themselves, explained the procedures to

be done, before they started with their work and they asked how the patients were feeling. Participants also indicated that some nurses asked whether a patient was in pain and also indicated that they would get better.

However, some patients indicated that nursing care during the day differed from nursing care during the night.

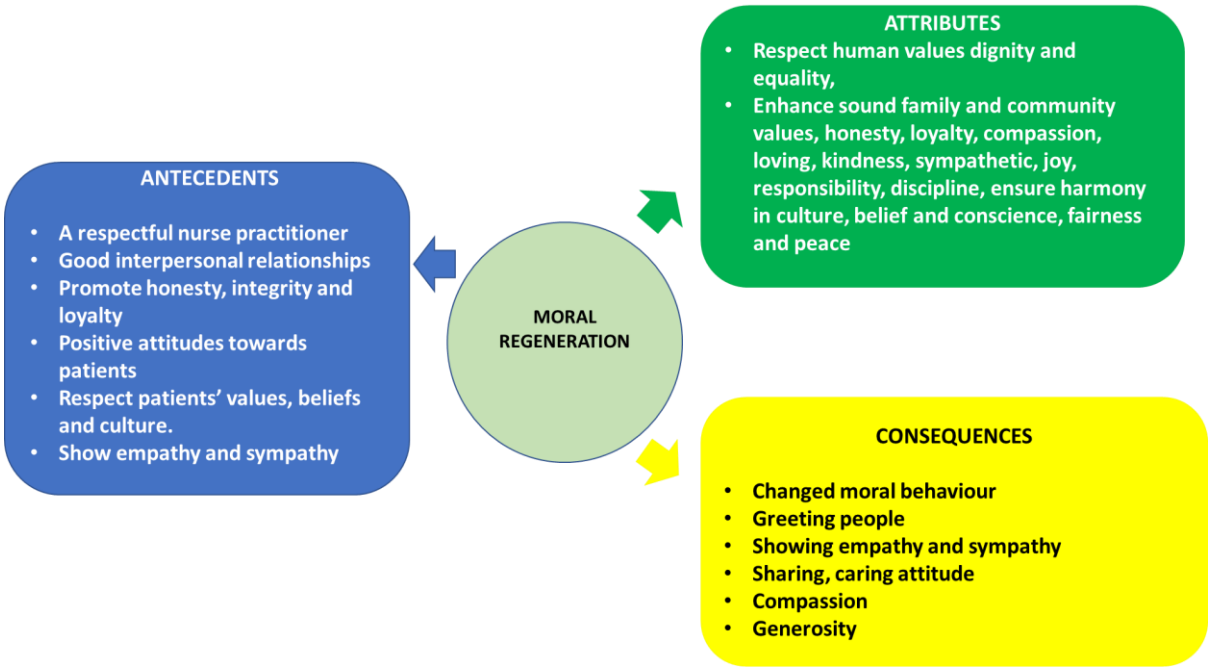

Figure 5.1 Relationship amongst antecedents, attributes or characteristics, and consequences of "Moral Regeneration"

5.3.9 Definition of empirical referents

For 'moral regeneration' the derived attributes included honesty, respect, integrity, fairness, culture, beliefs, equality, conscience, peace, empathy, sympathy, loyalty.

The final step of Walker and Avant's (2014) method of concept analysis is providing empirical references. Empirical references indicate how the concept should be measured. It is the

event that demonstrates the existence of the concept. Empirical referents are classes or categories of actual variables that, by their existence, demonstrate the presence of the concept. The concept “moral regeneration” has been used throughout the study focus on the promotion of moral regeneration among nurses in Limpopo Province. Empirical referents are significant in clarifying abstract concepts and their critical attributes. Empirical referents are linked to the theoretical base of the concept and contribute to both content and construct validity. These empirical referents could also be categories that emerged from the literature (Walker & Avant, 2014). In this study, empirical referents refer to the outcomes of critical thinking, which should be specifically contextualized. The following laws and policies guide the development of “moral regeneration”:

- **Ethos of nursing**

Ethos is the character or fundamental values of a person, people, culture, or movement. Ethos is strongly related to health professions and especially the nursing profession (Dlugan: 2018). To promote and maintain health, to care for people when their health is compromised, to assist recovery, to facilitate independence, to meet needs, to improve/maintain well-being and quality of health, to promote healing, growth, and development. Furthermore, to prevent disease illness or injury, minimize distress and suffering, educate people to understand, and cope with their illness and treatments. Additionally, to give the best quality of life until death. A particular mode of intervention – empowering people, helping them to achieve, maintain and recover independence. Also assisting on the identification of nursing need, advocacy and includes management teaching policy and knowledge development.

A particular domain – people's unique responses to illness, health, disability, frailty within their context. Responses may be psycho-social, biological, cultural or spiritual. A particular focus – the whole person and the whole human response.A particular value base – ethical values respecting autonomy, dignity, individuality, personal accountability, the unique nurse-patient relationship. Expressed in written codes of ethics and supported by professional regulation. A commitment to partnership – patients, relatives, carers, other health professionals.Co-ordinator, leader, team player. Always accountable for one's own actions and decisions.

- **Scope of practice**

The purpose of the Scope of practice in nursing is to provide nurses and midwives with professional guidance and support on matters relating to the scope of their clinical practice. It helps nurse and midwives to define and make decisions about their own scope of practice. The scope of practice describes the procedures, activities, and processes that a healthcare practitioner is permitted to undertake in keeping with the terms of their professional license. The scope of practice is limited to that which the law allows for specific education and experience and specific demonstrated competency.

- **Code of Conduct**

Code of conduct help to the maintenance of good relationships with co-workers, and promote human rights of patients, meet the health and social needs of the public, and maintain the standards of personal conduct required by the nursing profession, and 'getting upset' when lacking necessary equipment to provide good patient care.

Nurses create a code of conduct (or code of professionalism) that serves as a model of interdisciplinary collegial relationships (different but equal) and collaboration (mutual trust and respect that produces willing cooperation). Clearly articulate the standard of behaviour desired as well as unacceptable behaviours—don't assume staff know this, so be clear. Further address disrespectful behaviour must start with an absolute belief by all staff that no one deserves to be treated with disrespect. Furthermore, the code of conduct should not allow any exemptions. As long as those who generate the most revenue are excused from responsibility for their actions, the code of conduct will have little impact on anyone else's behaviour (Leape, Shore, Dienstag, Mayer, Edgman-Levitan, Meyer & Healy, 2012).

- **Nurses' pledge of service**

High levels of agreement on caring for sick patients with the necessary skill and understanding, reciting the Nurses Pledge with pride; valuing the health and well-being of patients or persons, respecting and promoting the autonomy of patients or clients and helping them to select their choice of health services, valuing and advocating the dignity and self-respect of human beings, maintaining the confidentiality and safeguarding the trust of clients or patients, applying and promoting the principles of equity and fairness to ensure unbiased treatment, being accountable and consistent in maintaining professional responsibilities and standards of practice and advocating practice environments that promote organizational and human support, to provide safe, competent and ethical nursing care (Burkhardt & Nathaniel, 2002).

- **Human Rights**

The purpose of human rights refers to the application of human rights principles to the context of patient care. It provides a principled alternative to the growing discourse of "patient's rights" that has evolved in response to widespread and severe human rights violations in health settings (Cohen & Ezer, 2013). The concept of human rights derived from inherent human dignity and neutrally applies universal, legally recognised human rights principles, protecting both patients and providers and admitting limitations that can be justified by human rights norms. I recognize the interrelation between patient and provider rights, particularly in the context where providers face simultaneous obligations to patients and the state and may be pressured to abet human rights (Cohen & Ezer, 2013).

- **Bible**

First Corinthians chapter 15 verse 33" Do not be deceived" Bad company ruins good morals" in this verse we see that morality is not much what others see on the outside but what comes from within and if others are living sinful lives and we associate either them, it should come as no surprise then that we too might become like them. It is not what goes into the mouth that defiles a person but what comes out of the mouth for it reveals what's in our hearts for what is drawn out of the well reveals what's in water.

- **Section 1 of The Constitution**

The Republic of South Africa is one, sovereign, democratic state founded on the following values: (a) Human dignity, the achievement of equality and the advancement of human rights and freedoms. (b) Non-racialism and non-sexism. (c) The supremacy of the

constitution and the rule of law. (d) Universal adult suffrage, a national common voter's roll, regular elections and a multi-party system of democratic government, to ensure accountability, responsiveness and openness (The Constitution of the Republic of South Africa, 1996)

5.4 SUMMARY

Chapter 5 discussed concept analysis according to steps outlined by Chinn et al., (2015) and Walker and Avant (2014). The concept 'moral regeneration' was defined according to The Oxford Dictionary. The uses, attributes, antecedents and consequences of the concept were determined and described. The practical perspective was based on the model to promote moral regeneration among nurses in the Limpopo Province of South Africa. The next chapter focuses on model development, using the framework of Dickoff et al. (1968).

CHAPTER 6

MODEL DEVELOPMENT AND VALIDATION

6.1 INTRODUCTION

The previous chapter discussed concept analysis using the eight steps in the Walker and Avante (2014), to clarify and distinguish the definition of the identified concept. This chapter focuses on model development and validation. This chapter outlines how the concept analysis results were integrated and form the building blocks of the model using the framework of Dickoff, James and Wiedenbach (1968). In this study, the researcher classified concepts derived from empirical data and concept analysis. A model to promote moral regeneration was conceptualised using the six-survey list as described by Dickoff et al. (1968). The survey list includes the following aspects which are: Context, agents, patiency, dynamics, procedure and terminus. The survey list will be used as a basis for classification (Dickoff et al., 1968).

6.2 OBJECTIVES OF THIS CHAPTER

The objectives of this chapter were to:

- Classify activities according to the six elements of the survey list of Dickoff et al. (1968), and
- Develop the model to promote moral regeneration among nurses in Limpopo Province

6.3 SIX ELEMENTS OF THE PRACTICE MODEL

The identified elements used to survey the practical activity correspond to the following survey list:

6.3.1 CONTEXT

In what context is the activity performed? The context is viewed from the aspect of the matrix of the activity. The context specifies the environment within which moral regeneration should take place because it enables the activity to be viewed in relation to other things. Therefore, the contexts within which moral regeneration should take place are the following: Community, regulatory bodies and government policies and hospital environment.

- **Community/society context**

This is the basic or first level context within which all activities takes place that has a bearing on how government and the regulatory bodies are shaped. The regulations that are formed are shaped by the values and norms of the communities. It is out of these cultural beliefs and practices that regulation are formed or promulgated. It is therefore important to note that for the activity to succeed, it is dependent on its congruency with the cultural beliefs and practices of the communities/society that it is intended to serve.

This context also gives a prescription on how the communities wish to be served, while the service provider needs to observe their values and norms in their provision of services. This context is important because the socio-cultural beliefs that are shared by the patients influence nurses moral regeneration. The patients' socio-cultural beliefs (in this study as discussed in chapter 4 of this thesis) imposed certain rules on the nurses allocated to the hospital units/departments. The role of patients, with regard to their

discussions about nurses moral behaviour of nurses, is also culturally determined. The context might interfere with how moral regeneration can be initiated at the hospitals. The patients believed that talking about nurses behaviour was not an allowed cultural practice therefore some patients might only have said positive things about nurses. The patients also believed that moral regeneration among nurses should mainly start at home during socialisation. It was also believed that individual nurses behaved differently, some had positive attitudes while some had a negative attitude towards patients. In this study (81.4%; n=114) of the nurses (respondents) reported that they adhered to patients' wishes which showed positive attitudes towards patients. Participants also indicated that, out of all the multidisciplinary health team, nurses spend the most time with the patients, interact with patients more often than any other health care personnel in the hospital, and also translated information imparted by doctors professionally with a humane touch.

- **Regulatory Body and Government Policies**

Society/community forms the platform where professional regulatory bodies and government develop regulations, policies and guidelines. The following are bodies that provide a second level context where the activity (moral regeneration) is expected to occur which are the South African nursing council, scope of practice, rights and responsibilities, Pledge of Service and Department of Health guidelines.

South African Nursing Council

The SANC is the regulatory body and authorised by the Nursing (Act no 33 2005), to develop and maintain the Scope of Practice, as specified in R2598, professional standards and competencies through section 3(e) to maintain professional conduct at the required practice standards and to uphold and maintain professional and ethical

standards in nursing. The SANC's standards depend on three concepts, namely, the scope of practice, standards and competencies. These concepts are sometimes used interchangeably or different concepts or variations might be used. It will, therefore, be binding for the model that is developed to take note of all these regulations, to ensure that all the different categories of nurses function within the prescript of their scope and at the acceptable ethical-moral level. It is also important to note that within this context all nurses should abide by the oath that was taken before starting to practice which is the 'Pledge of service'.

Department of Health guidelines and policies

The quality of health services is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. The quality of health care services should be effective, efficient, equitable, patient-centred, safe and timely, representing one context within which moral regeneration should take place. Quality of care is ensured and guided by the different policies and guidelines that are provided at the departmental level in relation to the different ways that nurses are required to provide care. National and Provincial guidelines and policies also dictate how the interaction should take place at the service delivery level and ensures that activities are not implemented haphazardly. These guidelines and policies are embedded within the moral and ethical prescripts which need to be observed. Hence the developed model should take into consideration these prescripts to ensure that all the activity that is moral regeneration should occur within the prescribed guidelines and policies.

- **Hospital Context**

This is the third level context, where the activity takes place which is at the hospital level. Within this context also consist of policies, protocols including ethical standards which nurses are expected to uphold. The context is characterised by the different ways of caring for patients. It is very important to understand this context so that the model could address the dynamics involved in engaging nurses in good moral behaviour. The nurses' context is also characterised by inequality between patients and nurses. The two parties should engage with each other in a morally acceptable way. The nurses comprise professional nurses, enrolled nurses and enrolled nursing auxiliaries, who could be sources exerting both negative and positive influences on patients. This is also the context where nurses receive formal and informal clinical and in-service education. The hospital context was found not to be conducive to teach nurses moral behaviour, per patients interviewed during this study. These findings indicated that nurses did not always care properly for their patients. Some nurses were harsh to patients, especially to elderly people. These issues could be addressed by proper hospital guidelines, protocol and ethical standards that nurses are expected to uphold. All these factors provide an environment that is conducive for the successful implementation of the moral regeneration model by nurses. The hospital context also functions within the cultural context and cultural beliefs and has an impact on the moral regeneration of nurses. Nurses were also influenced by their families' values and norms which influenced how they cared for patients.

FIGURE 6.1 CONTEXT OF MORAL REGENERATION

6.3.2 Agent

Who or what performs the activity? An agent is a person or any other person/thing whose activity contributes towards the realisation of a goal (Dickoff et al., 1968).

Different persons can perform different activities while striving towards the same goal (Dickoff et al., 1986). In this study agents, contributing to the realisation of moral regeneration were identified as nurse educators, nurse managers and colleagues.

- ***Nurse Educators***

Nurse educators have the responsibility of delivering the nursing curriculum within colleges and nursing schools. There need to impart knowledge of SANC regulations, Government guidelines and policies and most importantly shaping the moral behaviour of nurses through the teaching of ethos and being good role modelling. The activity provided by nurse educators contributes immensely towards the realisation of the goal

of moral regeneration of nurse in the Limpopo Province. Nurse educators deliver the nursing curriculum and provide the fundamentals of the Nursing Profession including the Pledge of service, and therefore plays an important role as agents in the development and formation of nurses.

- ***Nurse Managers***

Nurse managers also play an important role as agents in the strive towards building the moral behaviour of nurses during the application of the moral regeneration model at the practice level. This category of nurses helps the neophyte to integrate theory and practice within the acceptable moral and ethical principles. This is achieved while performing their supervisory and management role. Nurse managers provide that conducive environment to allow the activity within the unit to be done within the prescripts of the law. The nurse managers also monitor activities and teach nurses through role modelling and the use of teachable moments. Nursing care is also observed and reinforced through punishment and appraisal. Changes in the health care landscape are daily, if not hourly, realities. The nurse manager must have strong leadership skills to navigate through change with a focus on the patient and the provision of safe and reliable care. The nurse manager should guide, facilitate support, inspire and influence others to implement changes.

- ***Colleagues***

A professional nurse, enrolled nurse and enrolled nurse auxiliary working in the unit, provide a support system to each other whilst delivering patient. They provide a pool of reference for each other and can provide the role of agents as they encourage, correct or caution each other while caring for patients. The experienced nurses could also provide as agents by role modelling the best moral behaviour and newly qualified nurses

can learn by copying from them. This context provides nurses means to takes pride in their profession and makes them to strives towards the maintenance of a positive professional image. This means that the professional nurse's traditional values and norms influence the professional and personal image and is conveyed positively by her or his professional appearance and conduct. Hence, the service directedness implies the love of one's neighbour and that the nurse is prepared to make personal sacrifices to relieve the pain and suffering of other people. Nurses have relationships with their patients without sacrificing nurses own rights. The professional responsibilities should be carried out by every nurse during his/her nursing practice.

This needs to be passed on to the recipients who have not yet developed this attitude.

6.3.3 Patiency/recipients

Patiency/recipients in this study are all categories of nurses; namely, professional nurses, enrolled nurses, and enrolled nursing auxiliaries who received action from agents who are nurse educators, nurse managers and colleagues (Dickoff et al., 1968). The activity that is happening between the agent and recipient is to engage the recipient in moral regeneration working in a hospital setting within the regulatory statutes. The goal to be achieved in this activity is that patients should get proper nursing care provided with respect, honesty and cultural sensitivity. Nurses, as recipients, should acknowledge that moral regeneration is of importance when nursing patients and should strive to provide morally acceptable care.

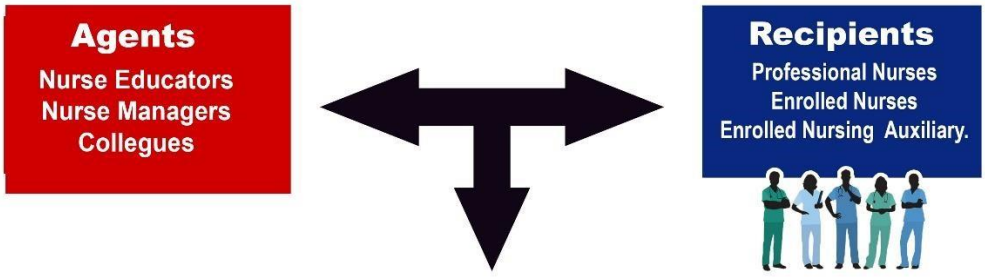

Figure: 6.2 Agents and recipients

6.3.4 Dynamics

What is the energy source of the activity (underlying dynamics?) These are the power sources for the activity which can be chemical, physical, biological and psychological for any person or thing functioning as an agent, forming part of the framework to realise the goal (Dickoff et al., 1986). The following were the dynamics for moral regeneration: storylines shared/elicited or extracted from the story shared by the participants (patients) in this study as presented in chapter 4 of this thesis) which included nurses lack of respect, rudeness and harshness, lack of morals, integrity, loyalty, belief and conscience. What the participating patients shared during this study's individual in-depth interviews and focus group discussions implied legal mandates. The following dynamics are identified as critical in the pursuit to regenerate the morals of nurses as they provide care to the patients: power inequality, respect, honesty and integrity.

- ***Power inequality***

This should do with unequal power that exists between the agent and the recipient. More than often the recipient adopts an inferior position and might always feel that the agent is exercising undue authority on him/her. This view by the recipients will determine whether he/she accepts the supervision, monitoring and coaching the comes from the agent. Insubordination can exhibit itself by not taking instructions from the agent and

might interfere with internalising required or acceptable moral behaviour. This can also be attributed to low self-esteem, low confidence or an authoritative approach from both parties and can affect how moral regeneration progresses.

- ***Mutual Respect***

Respect for other human beings dictates how the interaction between agents and recipients is going to unfold. It is important for all participants to mutually respect one another during moral regeneration. Lack of respect can affect the level of interaction especially if the participants do not respect each other's cultural, religious beliefs and practices. This also includes respecting the rights and dignity of individuals involved which are agents and nurses.

- ***Honesty and Integrity***

Fair and honest engagement between agents and recipients should be upheld at all times during interaction to produce the required outcome which to regenerate the morals of nurses. Upholding the pledge of service as a nursing professional ensure that the nursing practice activities are delivered with the highest quality (see figure 6.3).

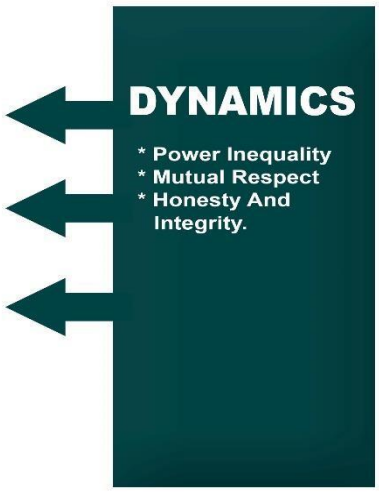

Figure: 6.3 Dynamics of moral regeneration

6.3.5 Procedure

What is the guiding procedure? This is to view the activity from the vantage point of the principle, rule, routine or protocol governing the activity. This is to emphasise the path, steps, pattern according to which the activity is performed (Dickoff et al., 1986). The procedure was also guided by the outcome of the concept analysis. The procedure for moral regeneration initiation involves the application of the stages as described in Kohlberg's Theory of Moral Development which are the following: pre-conventional morality, conventional morality and post Conventional morality. The movement of this activity will be spiral as moral development might move backwards and forwards as individual strive to internalise the accepted moral behaviour.

6.3.5.1 Stage one- pre-conventional morality

This is the first level, comprising the first two out of six stages, of Kohlberg's Theory of Moral Development. At this stage, nurses struggle with ethical practice and moral dilemmas. The nurse's behaviour might be influenced by the attitudes of patients, workload, religious values and support from colleagues and health team members. The nurse at this stage performs the task to avoid litigations and punishment. The nurse renders the required care to patients to avoid litigations or other legal actions that might occur if documented care had not been rendered to the patient. Any nurse at this stage might encounter frequent legal actions.

- **Punishment and rewards**

It is centred on self, gaining more rewards than punishments. The nurse, at this stage, performs the task to avoid litigations and punishment. The nurse struggles with ethical practice and moral dilemmas. The nurse not only renders the required care to patients

but, to avoid litigations or any other legal actions, ensures that documented care has been rendered to the patient. Any nurse, at this stage, could face legal actions.

- **Protocols**

Protocols in health care comprise a set of instructions describing a process to be followed to investigate a set of findings pertaining to a patient or to a method that should be followed to control a certain disease/condition. Protocols are implemented to manage a patient's clinical status. A protocol allows the application of specific interventions to be decided upon by the nurse based on certain criteria to be met by the patient. This is designed to help nurses to react to clinical situations appropriately with little or no guidance from colleagues. Protocols represent the framework for managing a specific disorder or clinical situation, while the procedures that complement a specific protocol, represent the detailed steps for implementing that protocol.

- **Patient' rights**

Patient's rights include the right to make decisions regarding medical care, the right to accept or refuse treatment, and the right to formulate written instructions. Patients' rights are those basic rules of conduct between patients and medical caregivers as well as institutions and people that support them. A person is anyone who has requested to be evaluated by or who is being evaluated by any health care professional.

6.3.5.2 Stage two- Conventional morality

The nurse at this stage, in addition to avoiding legal problems, performs her duty per the ethical codes of the profession and at the same time respects the societal norms and values. However, he/she might be prevented from performing care to the optimal level because of organisational bureaucracy and the non-availability of needed resources to

provide optimal level care to the patients. During this stage, the following is experienced or displayed by the recipients: acceptance of blame, seeking approval, good intentions, good behaviour and obedience to authority

6.3.5.3 Stage three- post-conventional morality

At this stage, the individual shows respect for both society and oneself (Kim & An, 2017). The nurse has reached a high level of moral maturity. The nurse renders high-quality care to the patients not thinking about the self but the patients. The nurse spends more time with the patients and might work past closing time and actions are not determined by the availability of resources but rather by the optimal care of the patient. At this stage, nurses show respect to their patients, society, and themselves. Caring for patients is characterised by honesty and cultural sensitivity where the rights of others (patients) could override obedience to laws/rules. Figure 6.4 display the procedure for moral regeneration.

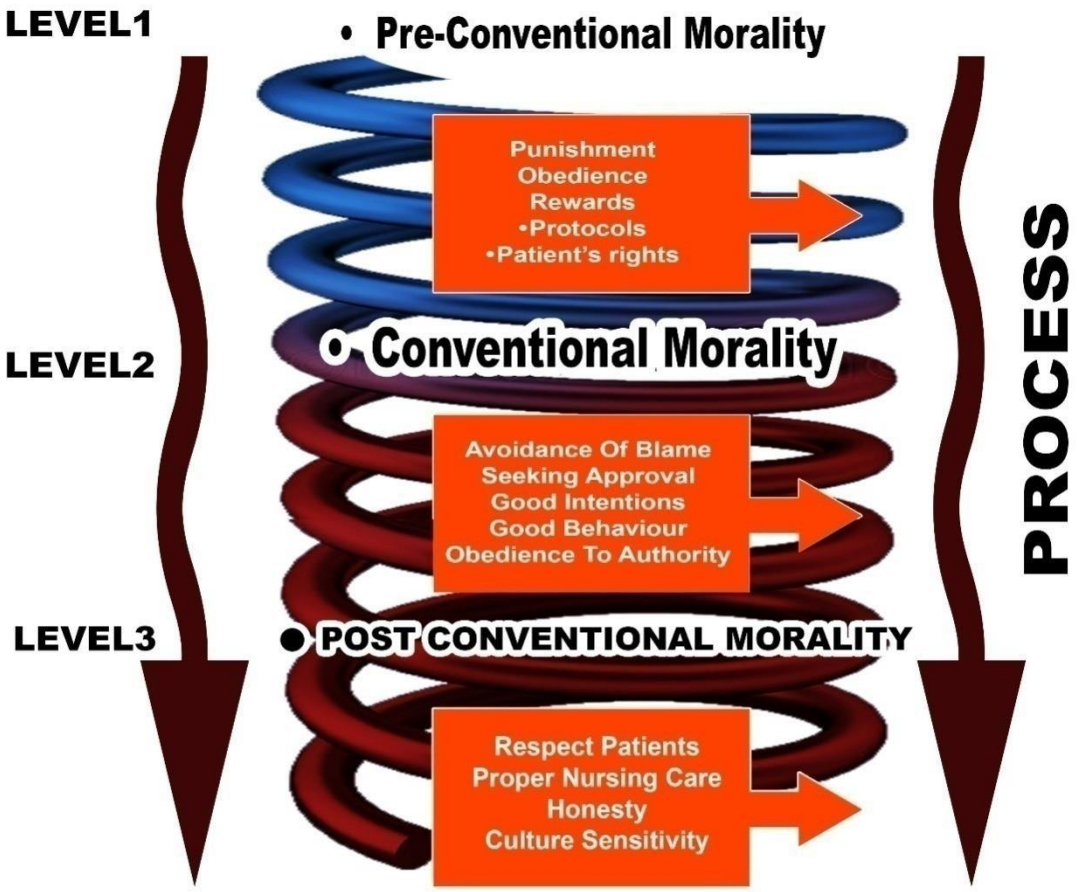

Figure 6.4: Process of moral regeneration (stages as described in Kohlberg's Theory of Moral Development)

6.3.6 Terminus/purpose

Terminus is viewing activity from the perspective of the endpoint or accomplishment of an activity (Dickoff et al., 1968).

What is the endpoint of the activity? To treat activity from the aspect of the terminus is to view activity from the perspective of the endpoint or accomplishment of the activity

(Dickoff, et al., 1968). The terminus for this study was the outcome of moral regeneration, nurses who are morally characterised by respecting patients, providing proper nursing care, being honest, respecting the rights of others, obeying laws/rules and being culturally sensitive. In this study (see Section A in Chapter 4 on knowledge on ethical behaviour of this thesis) the most nurses (respondents) (70.7%; n=99) disapproved of confidentiality of patients' information indicating that the rights of patients were not respected.

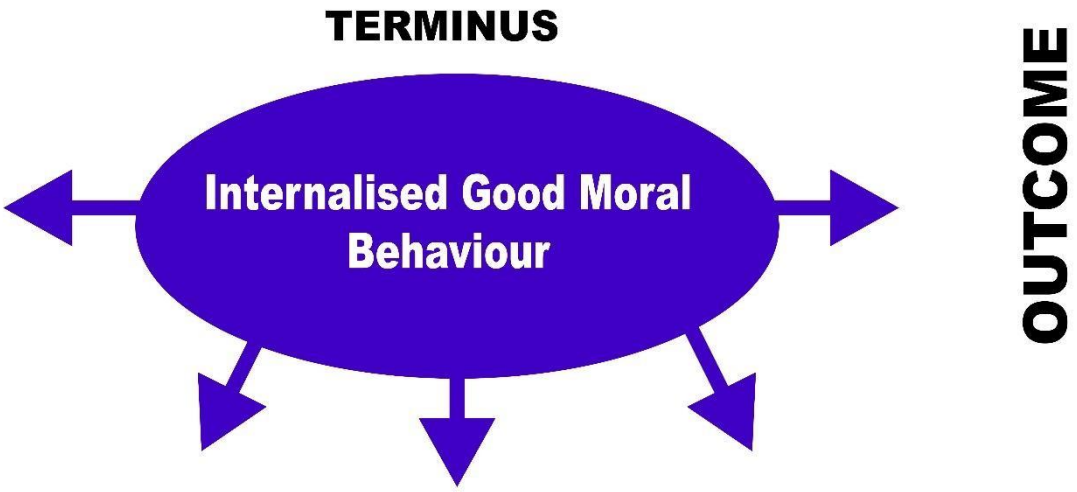

Figure 6.5: Outcome of moral regeneration

6.4 Model Description

Based on the explanation given in the classification of main concepts per Dickoff et al. (1986), the model for the promotion of moral regeneration among nurses is discussed under the following headings as described by Chinn et al. (2015) which are:

- an overview of the model
- the purpose of the model

- the structure of the model comprising the following subcategories: assumptions of the model, concept definition, relation statement and nature of the structure description of the model process and validation.

6.4.1 Overview of the model

A model is a schematic presentation that indicates how moral regeneration will be promoted among nurses. The model will be explained at three different levels, within which the six stages of Kohlberg's Theory of Moral Development are embedded see Figure 6.6.

- **LEVEL 1- pre-conventional morality- Stages 1 and 2**
- **LEVEL 2- Conventional morality- Stages 3 and 4**
- **LEVEL3- Post conventional theory- Stages 5 and 6**

6.4.2 The purpose of the model

The purpose of the model is to promote moral regeneration among nurses in hospitals of Limpopo Province in South Africa.

6.4.3 Structure of the model

The researcher described the assumptions on which the model was based, the main concepts and sub-concepts, the rational statements deduced and the nature of the structure. The description of nature made it possible to follow the reasoning of the model in its entire graphic presentation, to demonstrate the nature, and how colours were selected, assisting in emphasising certain aspects (Chinn et al., 2015). The model was based on the following elements: assumptions of the model, concept definition, relation statements and the nature of the structure.

6.4.3.1 Assumptions of the model

The following were the assumptions upon which this model was based:

- The agents (nurse managers, nursing colleagues, nurse educators) and recipients (all categories of nurses) had their beliefs and meanings about the promotion of moral regeneration among nurses.
- These attitudes influenced the promotion of moral regeneration among nurses.

  Each participant had internal moral regeneration within him/herself.
- The moral regeneration process produced new meaning and understanding among participants.

6.4.3.2 Concept definition

The following contexts were central to this model: the SANC, provincial nursing services, local hospitals and clinics, nurse managers, colleagues, nurse educators and the nursing curriculum. The agents were all categories of nurses who were recipients as discussed in Section 6.4 of this thesis.

CONTEXT

The SANC context impacts how moral regeneration can be initiated at hospitals. Some patients, who were interviewed during this study (as reported in Chapter 4 of this thesis), believed it was not culturally permissible to talk about nurses behaviour and might thus have said only positive things. Some patients also believed that moral regeneration among nurses should start at home during socialisation. It is also stated that individual nurses behaved differently, some had positive attitudes while some had negative attitudes towards patients. Provincial nursing services are characterised by different

ways of caring for patients. It is very important to understand this context so that the model should address the dynamics involved in engaging nurses in good moral behaviour. The nurse's context is also characterised by inequality between patients and nurses. The two parties should engage with each other in moral regeneration and should function at the same level which could be difficult for patients. Local hospitals and clinics function within the cultural context and cultural beliefs could also impact the moral regeneration among nurses working in hospitals in the Limpopo Province. Nurses family values and norms could influence how they care for patients (refer to Chapter 6, 6.3.1 in this thesis).

Interactive process– The processes of moral regeneration in this model were interactive in that both the agents and recipients should participate in moral regeneration to achieve an understanding of moral behaviour. Participants needed to examine their own beliefs and meanings and to be aware of them to promote moral regeneration that would allow them to achieve a deeper level of understanding.

The outcome of a meaningful dialogue was the ultimate outcome of moral regeneration where agents and recipients could engage with each other to achieve meaningful moral regeneration.

Dynamics were discussed in Section 6.3.4 of this thesis and Figure 6.5 shows the diagrammatic presentation of the model.

6.4.3.3 Relation statement of the model

This is the description, explanation, or prediction of the nature of the interaction between the concepts of the theory (Chinn et al., 2015). The following relation statements were formulated for this model of promotion of moral regeneration among nurses.

- Moral regeneration among nurses was influenced by the context within which it existed, the context being the community, regulatory bodies and Department of Health guidelines and policies and the hospitals.

- Fruitful moral regeneration could be promoted if the participants examined their moral values and meanings about moral behaviour before engaging in moral regeneration.

- Moral regeneration involved mutual interaction between nurse managers, colleagues, nurse educators and all categories of nurses.

- Dynamics that drove the process of moral regeneration between all categories of nurses and patients were power inequality, mutual respect, honesty and integrity

- Successful interaction during moral regeneration would produce a new understanding and meanings of moral behaviour among nurses.

6.5 THE NATURE OF THE STRUCTURE

The schematic presentation of the model in Figure 6.6 explains the relationship between the identified concepts.

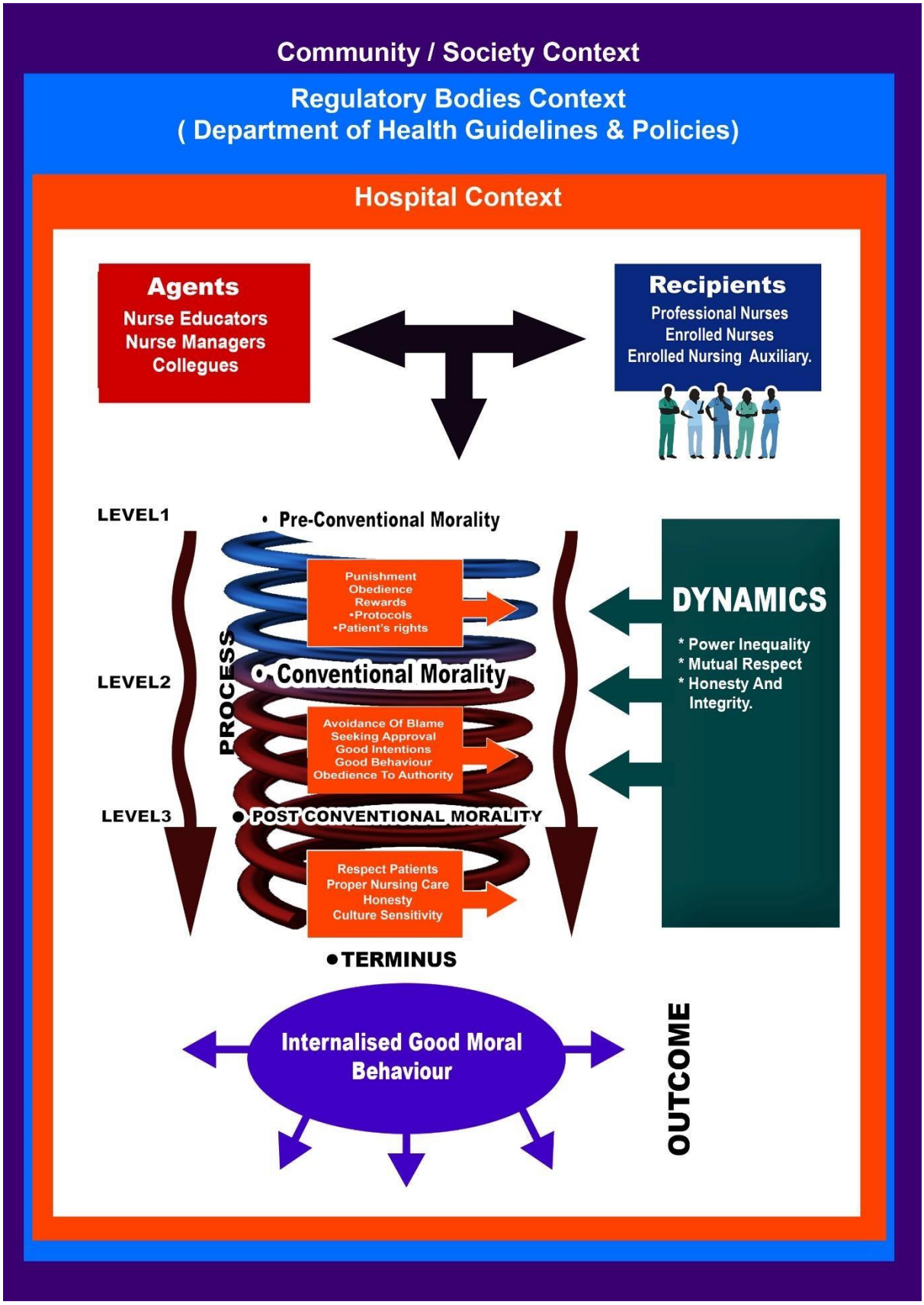

Figure 6.6: Schematic presentation of the Model for Moral Regeneration

6.6 VALIDATION OF THE MODEL

6.6.1 Methodology

A qualitative approach was used to explore the views of participants regarding the importance, usability, clarity, understandability and accessibility of the developed model. Focused Group Discussions were used to expose the model and collect data for validation. The FGD was conducted in a workshop format for two days where the use of the model was explained, and participants had to interact with the content and structure of the model. This provided them with an orientation to the model before questions could be raised. One FGD was held in each hospital and included 6-8 participants. The FGD consisted of 6 males and 15 females, making a total of 21 participants

6.6.2 Participant Recruitment and sample

Participants were recruited from the hospitals through the nursing service manager, in each group all categories of nurses were represented. Purposive sampling was used to select participants who had more than two years of working experience. Participants gave informed consent and participated voluntarily. Confidentiality was ensured by using code names. A total of 21 participants was determined by saturation.

6.6.3 Analysis of the model

Validation of the model was conducted in accordance with the guidelines provided by Chinn et al (2015) which asks the following questions which participants responded to:

- How clear is the model?
- How simple is the model?

- How general is the model?
- How accessible is the model?
- How important is the model?

How clear is the model?

Participants expressed their satisfaction in relation to the clarity of the model. They explained that the model did not have a lot of drawings and words which makes it simple to follow. This is what they said ‘you know this structure is not busy and makes it simple to understand’.

How simple is the model?

The model was said to be simple especially for professional nurses who are conversant with Kohlberg’s Theory of Moral Development. It was suggested a narrative of this theory be made available so that whenever these workshops are held in the unit one could use them to explain the different levels. One enrolled nurse said the model is simple but to enhance understanding please have notes of Kohlberg’s Theory of Moral Development so that we can always refer to it when we don’t understand.

How general is the model?

The model was said to be applicable to all categories of nurses it was also said it can be adapted and applied to any type of professions.

How accessible is the model?

Accessibility was viewed as a challenge as they alluded to the fact that there was no internet in the unit and that they rarely attended conferences. Participants were advised

to read journal articles. It was suggested that the model be made available to the in-service education department, colleges and nursing schools. Nurse in training should be exposed to this model during ethics learning. This suggestion was taken.

How important is the model?

This model was said to be of great importance as it is going to promote good moral behaviour of nurses and eventually improve the quality of care given to patients.

6.7 SUMMARY

This chapter focused on the description of the model to promote moral regeneration among nurses in the Limpopo Province, South Africa. The following items were emphasised: overview, purpose and structure of the model. The structure of the model included assumptions on which the model was based, the definition of concepts, formulation of relation statements, the nature of the structure and description of the process. The model was in accordance with the criteria set out by Chinn and Kramer (2015). Chapter 7 focuses on the description of guidelines to operationalise the model and on its evaluation. Limitations, the justification for the study, recommendations and the final summary of the study will be provided in Chapter 8.

CHAPTER 7

GUIDELINES TO OPERATIONALISE THE MODEL

7.1 INTRODUCTION

Chapter 6 focused on the development and validation of the model to promote moral regeneration among nurses in the Limpopo Province of South Africa. The purpose of this chapter is to operationalise the model.

7.2 GUIDELINES TO OPERATIONALISE THE MODEL

The final step in model development is the application of the model (Chinn & Kramer, 2015). Application of the model involves a description of a guideline as to how the model should be operationalised. The guidelines for the model to promote moral regeneration among nurses is described according to the practice model as presented in Chapter 6 of this thesis.

The six elements of the practice model are:

- Guidelines pertaining to the context
- The agents
- The recipients
- The procedure
- The dynamics
- The outcome or purpose of moral regeneration

7.2.1. Guidelines for the context

- **Community**

The community serves as the context where the activity will and is going to take place. Thus, the practice of ethical-moral behaviour is mainly taking place in the community and affect most stakeholders.

- **Regulatory bodies and Government**

The regulatory body and government include the South African Nursing Council and the governmental policies

Regulatory Body: South African Nursing Council The SANC will:

- assist nurses to identify ethical values that form the foundation of professional conduct
- provide the framework for reflection on the influence of ethical values on the behaviour and interaction between nurses and the public, stakeholders and health care users
- provide the framework for ethical decision-making practice
- indicating to the public, stakeholders and health care users the standards and values they can expect from nurses
- guide professional conduct or ethical committees regarding decisions relating to unethical behaviour

- require nurses to demonstrate the art of nurturing by both applying professional competence and positive emotions that will benefit the nurse and the healthcare user with inner harmony.

Government (DOH)

The provincial nursing services should require nurse always to:

- regard the interest or well-being of their patients as their primary professional duty
- regard the interest of all their patients as their primary professional duty
- honour the trust of their patients
- be mindful that nurses are in a position of power over their patients and avoid abusing their position
- be accessible to patients when they are on duty, and make arrangements for access when they are not on duty, where this might be necessary
- ensure that their personal beliefs do not prejudice their patients' healthcare (Beliefs that might prejudice care relate to patient's race, culture, ethnicity, social status, lifestyle, age, gender, spiritual beliefs).
- respond appropriately to protect patients from any risk or harm
- respond to criticism and complaints promptly and constructively
- ensure that treatment is not refused because nurses believe that the patient's actions have contributed to his/her condition or because the health care practitioners might be putting their own health at risk.

- inform the patients if they are in the employ of, in association with, linked to, or have an interest in any organisation or facility that could be interpreted by an average person as potentially creating a conflict of interest or dual loyalty in respect of their patients

- provide health care within limits of their practice and according to their education and training, experience and competency under proper conditions and inappropriate surroundings

Hospitals

Hospitals should ensure that the nurses:

- respect the privacy, confidentiality and dignity of patients treat patients politely and with consideration.

- listen to patients and respect their opinions

- avoid improper relationships with patients and those who are accompanying the patient, such as sexual relationships or explorative financial arrangements

- guard against human rights violations of patients, and not allow, participate in or condone any actions that lead to violations of the rights of patients

- inform the patient of the choice of having a chaperone in the room during an intimate examination

- provide information patients might request and/or require about their condition, its treatment and prognosis

- provide information to patients in a way that patients can comprehend it, in a language understood by the patient and considering the patient's literacy level, values and beliefs.

7.2.2 Guidelines for the agents and recipients

- **Agents**

The agents could be nurse managers, nurse educators, the nursing curriculum, colleagues, and SANC.

Nurse Managers

The nurse managers' responsibilities include that they should:

- develop leadership programmes should stimulate quality activities in the hospital departments and encourage nurses career development.
- have 24-hour accountability and continuing employee development and should direct, plan and coordinate activities in the unit
- maintain effective communication, interpersonal and leadership skills and must be good motivators to encourage employees to contribute to its successful implementation
- be responsible for ensuring patient safety and a healthy environment that supports the healthcare practitioners and prevents patients from harmful incidents in the units
- Should advocate for patient safety and access to quality care.

Nursing Colleagues

Nursing colleagues should refer patients to other practitioners, students, members of an interdisciplinary health team, support staff and employers in the working environment as well as all other individuals who are considered colleagues, to act in their best interest and to respect their dignity, to abstain from attaining personal gain at the patient's expense.

Nurse educators

Clinical educators should facilitate the professional development of practising nurses. They promote best practice by mentoring others and acting as an information source and assisting in the development of policies and procedures. The nursing education institution must set clinical learning outcomes for each learning area of the programme. Clinical education and training should be provided in clinical facilities that are approved by SANC in terms of accreditation of the programme. The nursing education institution must specify clinical learning outcomes for each learning area of the programme in accordance with the guidelines and should keep records of all
clinical training.

The nursing education institution is accountable for the clinical accompaniment and clinical supervision of student nurses. Clinical nursing educators play a crucial role in assisting student nurses to integrate the theory and practice of nursing. The nursing curriculum should emphasise ethical codes for students and continuous education for staff and recognise failures of the health care system, optimising nursing care, informing patients about nursing ethics, promoting patient's rights and achieving patient satisfaction to minimise differences between nursing theory and nursing practice.

- **Recipients**

Health care providers should be aware of developing and deteriorating nurse-patient relationships and support the value of the therapeutic relationship as an instrument to restore and promote patients'/clients' health.

7.2.3 Guidelines regarding the dynamics of moral regeneration

The dynamics that drive moral regeneration among nurses are based on R2598 regulating the scope of practice for nurses, the code of conduct, and the *Bathopele* principles. The guidelines to operationalise the dynamics of moral regeneration are described as follows:

- **Scope of practice**

During moral regeneration nurses should ensure that the practice of nursing is a dynamic process that provides and maintains the care of individuals, groups and communities facing actual or potential health problems, promotes, supports and restores health status. Moral regeneration should assist a healthcare user to maintain the basic activities of daily living, provide continuous support and care to health care users, irrespective of their state of health and throughout all stages of life. It describes the procedures, actions and processes that a nurse is permitted to undertake in adhering to the terms of his/her professional licence (Veazie, Galloway, MatsonKoffman, Labarthe, Brownstein, Bolton, Freund, Fulwood, Guyton-Krishnan, J. and Hong, 2005).

- **Code of conduct**

It serves as a declaration by nurses that they will always provide due care to the public and healthcare consumers to the best of their ability while supporting each other in the

process. It is based on the belief that the nursing profession embraces respect for life, human dignity and the rights of other persons. In this study, more than 52% of nurses chose to respect a patient's wish including informing the patient about their progress. The issues of confidentiality were strongly disagreed upon by almost 43% of the participating nurses. Hence study focussed on model development to promote moral regeneration among nurses in the Limpopo Province.

- ***Bathopele* principles**

The eight *Bathopele* principles and belief sets can easily be applied within patient nursing care by professional nurses working in hospitals. See chapter 6 under Dynamics 6.3.4.

7.2.4 Guidelines regarding the procedures/processes of moral regeneration

The process of moral regeneration involves describing the procedure that will be followed to promote moral regeneration. The process is described at three levels.

- **Level 1** involves pre-conventional morality,
- **Level 2** involves conventional morality and level 3 involves post-conventional morality: See chapter 6 on 6.5.3.
- **Level 3** introduces the outcome or terminus

The purpose of the model describes the outcomes that the model will achieve after its implementation. Its purpose is to promote moral regeneration among nurses. The participants will develop the skills of engaging each other in moral regeneration. The evaluation of having achieved a level of meaningful moral regeneration will be determined by the following:

- All stakeholders, including the SANC, provincial nursing services, hospitals and clinics are able to work together to achieve moral regeneration among nurses in Limpopo Province of South Africa.

- Nurses demonstrate positive attitudes of questioning and challenging different views about the promotion of moral regeneration.

- Nurses develop better communication skills and interpersonal skills with patients/clients which lead to the achievement of moral regeneration.

- Nurses put patients first and their own interests second.

- Nurses demonstrate professional confidentiality, and all patients/clients will be considered to be equal regardless of social status.

- Nurses preserve and promote patients' dignity, rights and interests.
- Nurses are familiar with the professional ethical and legal framework within which their practice is based.

- There is a visible movement towards change in the nurses' moral behaviour and value system in relation to moral regeneration.

- Nurses demonstrate a high level of openness and honesty

7.3 SUMMARY

Chapter 7 discussed the operationalisation of the model. The guidelines to operationalise the model were described in accordance with the elements of the practice model as described by Dickoff et al. (1968). The elements of the practice model discussed were: the context, agents, recipients, and dynamics as well as the procedure and outcome

(Dickoff et al., 1968). Chapter 8 focuses on evaluation, justification, limitations, conclusions and recommendations of the current stud

CHAPTER 8

EVALUATION, JUSTIFICATION, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

Chapter 7 described how the model should be operationalised. This final chapter focuses on the evaluation of the study in terms of its ability to meet the objectives specified in chapter one. Justification of the study regarding its original contribution to the body of knowledge will be addressed. The limitations, conclusions and recommendations in relation to the promotion of nurses moral regeneration will be described.

8.2 EVALUATION OF THE STUDY

The study is evaluated against its rationale, purpose and objectives as set out in Chapter 1.

8.2.1 THE RATIONALE OF THE STUDY

A research rationale is a set of convincing reasons provided by a researcher for conducting a specific. It involves delimiting the scope of the research, the participants in the research and the intended method to be used to collect data (Sage, 2007). This study was developed to address the perceived moral deterioration in the nursing sector in Limpopo province by developing a model of moral regeneration for nurses. The study was carried out in the Limpopo province among all categories of nurses and the patients who had been hospitalised for at least four days.

8.2.2 PURPOSE OF THE STUDY

The purpose of the study was to develop a model that would help to promote the moral regeneration of nurses in the Limpopo Province of South Africa. The model could facilitate better support of resources and structures to enhance nurses moral behaviour.

8.2.3 RESEARCH OBJECTIVES

The study's objectives that were set in chapter 1 will be evaluated separately as follows:

- Objectives 1, 2 and 3 explored the perceptions of patients regarding the ethical behaviour of nurses, exploring the views of patients regarding ethical-moral behaviour of nurses, and assessing the knowledge of nurses regarding their ethical moral behaviour.

The first three objectives were met during phase one of the study.

The study adopted mixed methods, both quantitative and qualitative research approaches. focus groups discussions. Data were analysed using Tech's eight steps and trustworthiness was ensured. A cross-sectional descriptive design was used for the quantitative data collected from all categories of nurses selected through purposive sampling techniques. Self-administered questionnaires were distributed, and computer-generated tables were used. A total of 178 questionnaires were distributed and162 were returned and could be analysed. Quantitative data were analysed using descriptive and inferential statistics through the use of the Statistical Package for Social Science (SPSS) Version 25.

The aim of phase two was to address objective 4, namely to develop a model to promote moral regeneration among nurses in the Limpopo province. This phase involved conceptualisation, model development, model description and evaluation.

The results indicated that Ubuntu emphasises personal traits such as respect, caring, compassion, kindness, warmth, understanding, sharing, humanness, reaching out, wisdom and neighbourliness. Some nurses demonstrated poor interaction with elderly people as nurses usually spent time with other patients. Patients' negative views included complaints that some nurses did not pay attention to patients who needed help, some nurses were harsh and rude to patients. Patients' positive views included comments that some nurses displayed empathy and sympathy and caring behaviours. Most participants (patients) indicated that many nurses were not harsh or rude to them, but, if a patient was poor, the nurses did not care much. However, if the patient was rich, nurses would do anything for the patient. Some participants were happy with the nurses' treatment, while some were unhappy. Some participants feared telling the truth because they feared being labelled. Nurses have cared much for their patients, about 51% of the nurses indicated that they adhered to patients' wishes as a way of caring. Nurses (about 56%) also prefered to give information to their patients about the illness even if it got worse. Nurses stated that they will care for all patients despite their background or status. The data drawn from these participants formed the basis for concept analysis and model development as discussed in chapter 5.

Conceptualisation

Central to the study was the concept of "moral regeneration", which was analysed according to the steps of Chinn and Kramer (2015) and Walker and Avant (2014). The appropriate setting where moral regeneration was supposed to take place, included the

SANC, provincial nursing services and hospitals and clinics. The sample of data about moral regeneration was selected from dictionaries and books as well as from national and international journals. A theoretical definition was derived from these definitions which directed the development of the model.

The attributes of the concept assisted in identifying the occurrence of a specific phenomenon. Other uses of the concept were identified and these enhance the understanding of the concept. Antecedents and consequences of the term were described and improved by clarifying the concept. Related concepts, used interchangeably with the concept “moral regeneration”, were also described. Data related to moral regeneration were analysed and themes and subthemes were developed. Conceptualisation, therefore, led to model development and description.

Model development and description

The results derived from objectives 1 to 4 formed a basis for describing the model to promote moral regeneration among nurses. The survey practice list of Dickoff et al. (1968) was used as a framework for model development. Chinn and Kramer’s (2015) guidelines were used to describe and evaluate the model. Guidelines derived from both phases of this study were also described.

8.3 JUSTIFICATION OF THE ORIGINAL CONTRIBUTION OF THE RESEARCH TO THE BODY OF NURSING KNOWLEDGE

This study is an original contribution to the body of nursing knowledge, with particular emphasis on the moral behaviour of nurses in the context of the SANC, provincial nursing services, hospitals and clinics. The following are the reasons given for this original contribution:

Patients' perceptions regarding the ethical behaviour of nurses and patients' views regarding the ethical-moral behaviour of nurses, were explored. The patients' perceptions and views were analysed using Tech's eight steps (Creswell, 2013). Relevant literature and results were used in the shaping of the model that was developed. The concept "moral regeneration" was analysed systematically during concept analysis using the steps of Rodger and Knafl (2000). The results derived from the concept analysis revealed that "moral regeneration" is the revival of moral values that have decayed, a process of bringing back all acceptable traditional and cultural behavioural patterns and laws followed when one was growing up (The Merrian Webster Dictionary, 2007). Moral regeneration is the promotion of good conduct and the encouragement of youth to keep away from social ills and lead a life that is guided by moral values. Motshekga (2011) observed that the levels of moral degeneration in South African communities require a serious national intervention that goes beyond advocacy for a healthy life.

Moral regeneration, according to Motshekga (2011), requires a serious national intervention that goes beyond the mere advocacy of healthy lifestyles. This author maintains that there is an urgent and great need to occupy children and youth after school and over the weekends through the establishment of cultural centres in townships and informal centres through which school children and out-of-school youth could be engaged for spiritual growth and development through practical programmes. These could include spiritual music, indigenous games, cultural and other creative activities. This belief awakens children and the youth to the need for ethical conduct and the respect for equal rights and freedom of others. Above all, it leads to self-knowledge, self-worth and self-esteem, and a sense of progress.

The results for the recent study were be presented in research forums and seminars by the researcher to professional enrolled and enrolled nursing auxiliary and were refined. The results of the concept analysis gave direction to the model's development and description. The theoretical definition of moral regeneration among nurses is unique to the context of the SANC, provincial nursing services and hospitals and clinics. The survey list of the practice model of Dickoff et al. (1968) was used to describe and evaluate the model. The guidelines for the original practice model to promote moral regeneration among nurses were described in order to operationalise the model.

8.4 LIMITATIONS OF THE RESEARCH

The researcher received much support from the nurse managers of hospitals and Primary Health Care, Chief Executive Officers of the hospitals from which participants and respondents were drawn. It was also easy to get the samples for the study. Furthermore, the participants were willing to be interviewed. However the following was the limitations of the study: Firstly the researcher was disappointed with the targeted participants who decided not to take part in the individual and focus groups at the last minutes, after making appointments. Furthermore, some participants decided not to continue with the interview in the middle of the interviews because they felt that the topic was intrusive. Some indicated that they were uncomfortable with the research question and did not feel comfortable discussing the topic.

In addition, data were collected in two districts of Limpopo Province: namely, Mopani and Vhembe. Therefore the findings will only be transferable within these two districts. The pilot for the model will be done as part of the post-doctoral study. However, the model has not yet tested.

8.5. RECOMMENDATIONS

Recommendations emanating from the study and from the guidelines that have been described from operationalizing the model were formulated. The recommendations made will promote moral regeneration among nurses in Limpopo Province.

8.5.1 Recommendations regarding Nursing Practice

Community

- The researcher recommends that the community should teach people a lesson to shape a society in which a bright future for all under the sun, embrace the good, the positive and inculcate it in our children and their offsprings, in order to have society/nurses with good moral behaviour.
- Community need to help people to fight against bad morals, values and make the right decisions to distinguish between good and bad, wrong and right.

Regulatory body

- The researcher recommends the Department of Health implement policies to protect the public's health and welfare by assuring that safe and competent nursing care is provided by licensed nurses with good ethical-moral behaviour.
- The researcher recommends the SANC inform the nursing practice about the legal framework and the code of conduct to minimize unacceptable behaviour.
- Monitor and control on the basis of principles, guidelines and regulations deemed important by the profession to improve ethical-moral behaviour
- Monitor the public's rights to equality health care services to prevent discrimination against patients

- ❖ Monitor proper standards of nursing practice to allow good morals.

Hospital

- ❖ The researcher recommends that all nursing practitioners should revisit the Batho Pele principles to minimize bad moral behaviour
- ❖ Nurses are expected to comply with policies and legislation governing their profession so that they can identify complications and intervene accordingly.
- ❖ Assist in driving its campaign to safeguard public assists from being vandalized.

8.5.2 Moral regeneration as a process

The process of implementing a model to promote moral regeneration among nurses in Limpopo Province, South Africa should involve offering workshops about using the model. Roleplay could also be used to assist participants to understand how moral regeneration could be promoted. The SANC, provincial nursing services, and hospitals should be encouraged to engage themselves in moral regeneration to identify problems as this could help to refine the model.

Workshops are conducted by experts, including the researcher and support groups should also be formed. Funding could also be sought to support such promotion.

Education

Leaders at all levels in all sectors should be role models and be persons of integrity and be good examples setting the standard for morality.

- ❖ Capacity Building for both agents and recipients,

- Revised curriculum to address the current needs and changing health system landscape.

- The researcher recommends that the Moral regeneration movement should support nurses towards the moral renewal of nurses.

- To assist in driving its campaign should aim to make a moral formation in the education system in both theory and practice
- Ensure that the media carry positive stories of moral courage and renewal theory and in practice.
- Aims at strengthening the family unit

Policies

- The researcher recommends the assessment of clear and reasonable policies and guidelines in the promotion of moral regeneration
- Monitoring of implementation of policies and guidelines and training to evaluate progress on moral behaviour.
- Update policies, guidelines and protocols based on the recent needs and processes.

8.5.3 Recommendation for Future Research

The purpose of this study was to develop a model to promote moral regeneration among nurses in Limpopo Province. The focus was to promote moral behaviour of nurses in all angles, thereby respecting patients, proper nursing care, honesty and cultural sensitivity.

- The researcher recommends further research may include study involving clinics and other hospitals in Limpopo.

- The researcher recommends the piloting of the model, to check if the model is reliable and valid to promote moral regeneration.

  Evaluation of the developed model, to assess the impact/effect studies regarding the model implementation, and determine the changes in perceptions among nurses and or patients regarding their moral behaviour,

- Describe the nurse-patient relationship post model implementation to promote moral regeneration.

8.6 Summary

This chapter is the conclusion of this study, it indicates how the rational, overall purpose and objectives of the study have been achieved. Justification in terms of the original contribution of the study to the body knowledge. Recommendations and limitations of the study were also provided. Nurses were challenged to take responsibility for moral behaviour and as they implemented the model, and to come up with more ways of moral regeneration and disseminate information to the world of nursing.

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ANNEXURE A: APPROVAL OF RESEARCH PROPOSAL BY UNIVERSITY OF VENDAHIGHER DEGREES COMMITTEE

UNIVERSITY OF VENDA

OFFICE OF THE DEPUTY VICE-CHANCELLOR: ACADEMIC

TO : MR/MS N.G SHILUVANE

SCHOOL OF HEALTH SCIENCE

FROM: PROF J.E. CRAFFORD

DEPUTY VICE-CHANCELLOR: ACADEMI C

DATE : 06 AUGUST 2014

DECISIONS TAKEN BY UHDC OF 07 APRIL 2014

Application for approval of Thesis research proposal in Health Science:
Shiluvane N.G 11551419S

Topic: "A model to promote moral regeneration among nurses in Limpopo Province: South Africa".

Promoter:	UNIVEN	Dr. R.T Lebese
Co-promoter:	UNIVEN	Dr. H.N Shibulane

UHDC approved PhD proposal

Prof J.E. CRAFFORD
DEPUTY VICE-CHANCELLOR: ACADEMIC

ANNEXURE B: ETHICAL CLEARANCE- UNIVERSITY OF VENDA

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Mrs NG Shiluvane

Student No:
11514198

PROJECT TITLE: **A model to promote moral regeneration among nurse in Limpopo Province: South Africa**

PROJECT NO: SHS/14/PDC/05/1809

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr RT Lebese	University of Venda	Promoter
Dr HN Shilubane	University of Venda	Co-promoter
Mrs NG Shiluvane	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: September 2014
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Prof. G.E. Ekosse

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950λ LIMPOPO PROVINCEλ SOUTH AFRICA
TELEPHONE (015) 962 8816/8313 **FAX** (015) 962 9060
"A quality driven financially sustainable, rural-based Comprehensive University"

ANNEXURE C1: APPLICATION TO LIMPOPO PROVINCE DEPARTMENT OF HEALTH

Enquiries: Shiluvane NG **P.O. Box 582**

Cell: 0837728779 **Giyani**

Work contact: 0158120330 **0826**

To: Limpopo Province Department of Health Ethical Committee

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH

I Shiluvane Nkhensani Grace a PhD student at the University of Venda request permission to conduct research at the district and regional hospitals in Limpopo Province.

The title of the study is **the model to promote moral regeneration among nurses in Limpopo Province.**

The purpose of the study is to develop a model that will promote moral regeneration among nurses in Limpopo Province.

The significance of the study

The findings of the study may help nurses to develop strategies to improve their ethical behaviour. The study might influence changes in the practice of nurses in relation to the proper management of patients and reduce the long stay of patients in the hospital hence costs will be reduced. The relationship between the employees and the employer may improve and there might be a reduction of industrial actions. Patient/clients will benefit because the nurse may respect their dignity and boost their morale. The study may assist in the development of a curriculum for nurse training to empower them with knowledge of ethics and morals during training. The findings of the study may assist policymakers in

formulating new policies on moral regeneration. The study may also assist researchers on suggested areas of research on moral regeneration and ethical behaviour of nurses.

If you have any queries on any matter which is not reflected in this correspondence, the contact details are as follows:

Researcher: NG Shiluvane	**Cell: 0837728779**
Promoter: Prof RT Lebese	**Cell: 0715618263**
Co-promoter: Dr L Makhado	**Cell: 0611472002**
Co-promoter: Dr NH Shilubane	**Cell: 0825367441**

ANNEXURE C2: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH IN LIMPOPO HOSPITALS

Enquiries: Shiluvane NG **P.O. Box 582**

Giyani

0826

Cell: 0837728779

To: Chief executive Officer (Hospitals of Limpopo)

RE: Request for permission to conduct a research Limpopo Province

I Shiluvane Nkhensani Grace a PhD student at the University of Venda request permission to conduct research at the hospitals in Limpopo Province.

The title of the study is **the model to promote moral regeneration among nurses in Limpopo Province.**

The purpose of the study is to develop a model that will promote moral regeneration among nurses In Limpopo Province.

The significance of the study

The findings of the study may help nurses to develop strategies to improve their ethical behaviour. The study might influence changes in the practice of nurses in relation to the proper management of patients and reduce the long stay of patients in the hospital hence costs will be reduced. The relationship between the employees and the employer may improve and there might be a reduction of industrial actions. Patient/clients will benefit because the nurse may respect their dignity and boost their morale. The study may assist in the development of curriculum for nurse training to empower them with knowledge of ethics and morals during training. The findings of the study may assist policymakers in

formulating new policies on moral regeneration. The study may also assist researchers on suggested areas of research on moral regeneration and ethical behaviour of nurses.

If you have any queries on any matter which is not reflected in this correspondence, the contact details are as follows:

Researcher: NG Shiluvane	**Cell: 0837728779**
Promoter: Prof RT Lebese	**Cell: 0715618263**
Co-promoter: Dr L Makhado	**Cell: 0611472002**
Co-promoter: Dr NH Shilubane	**Cell: 0825367441**

Thank you in anticipation

ANNEXURE D: PERMISSION FROM LIMPOPO PROVINCE DEPARTMENT OF HEALTH TO CONDUCT STUDY

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila Ref:4/2/2

Shiluvane NG
University of Venda
Private Bag X5050
Thohoyando
0950

Greetings,

RE : A model to promote moral regeneration among nurse in Limpopo Province : South Africa

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, a copy should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.

Your cooperation will be highly appreciated.

Head of Department

25/02/2015
Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOKWANE, 0700

ANNEXURE E1: PARTICIPANT INFORMATION SHEET

Title: A model to promote moral regeneration among nurses in Limpopo Province South Africa.

Purpose: To develop a model that will promote the moral regeneration of nurses in Limpopo Province.

Objectives:

- To explore the perceptions of nurses on their ethical behaviour.
- To explore the views of patients regarding the ethical behaviour of nurses.
- To identify and assess the knowledge of nurses regarding ethical-moral regeneration.
- To develop a model to promote moral regeneration among nurses of Limpopo Province

Significance of the study

The findings of the study may help nurses to develop strategies to improve with moral regeneration in Limpopo Province. There will be changes in the practice of nurses and avoid a long stay of patients in the hospital and costs will be reduced. The relationship between the employees and the employer may be improved and be strengthened and the morals, values, and behaviours will be taken into consideration. Patient/clients will benefit because the nurse may respect their dignity. The study may assist in the development of curriculum for nurse training to empower them with knowledge of ethics during training. The findings of the study may assist policymakers in formulating new policies on moral regeneration. It may assist researchers to do more research on moral regeneration.

What are the risks?

There are no risks anticipated except for some tiredness during interviews. You may experience some temporary discomfort from sharing your experience**.**

What are the benefits?

Participation is voluntary and you may end participation at any time without any penalties or loss of benefits which you are entitled. Patients will also benefit from your participation.

Whom you should contact

Your participation in this project is appreciated, if you have queries, please contact the researchers at the numbers listed below:

Researcher: NG Shiluvane	**Cell: 0837728779**
Promoter: Prof RT Lebese	**Cell: 0715618263**
Co-promoter: Dr L Makhado	**Cell: 0611472002**
Co-promoter: Dr NH Shilubane	**Cell: 0825367441**

ANNEXURE E2: INFORMED CONSENT

I_____ on the _____ of _____ 2016 hereby consent to:

1 be interviewed by Shiluvane Nkhensani Grace on the topic “Model to promote moral regeneration of nurses in Limpopo Province”

2 The interviews will be audiotaped

I also understand that:

1. I am free to end my involvement or to recall my consent to participate in this research at any time.
2. Information given up to the point of my termination of participation could however still be used by the researcher
3. No reimbursement will be made by the researcher for information given for my participation in this project
4. I may refrain from answering questions should I feel these are an invasion of my privacy
5. By signing this agreement, I undertake to give honest answers to reasonable questions and not to mislead the researcher

I hereby acknowledge that the researcher/interviewer has:

1. discussed the aims and objectives of this research project with me
2. informed me about the content of this agreement
3. informed the implications of signing this agreement

In co-signing this agreement, the researcher undertakes to:

1 maintain confidentiality and privacy regarding the interviewee’s identity and information given by the interviewee

2 arrange in advance a suitable time and place for an interview to take place 3 safeguard the duplicate of this agreement

(Interviewee) _____ DATE: _____

(Interviewer) _____ DATE: _____

ANNEXURE F1: INTERVIEW GUIDE FOR PATIENTS

TITLE: A MODEL TO PROMOTE MORAL REGENERATION AMONG NURSES IN LIMPOPO PROVINCE: SOUTH AFRICA

1. Please fill the information in the appropriate spaces with an X
2. The questionnaire consists of two sections
3. Complete all sections

SECTION I: DEMOGRAPHIC DETAILS

1.1. Age

1.1.1	15-19	
1.1.2	20-29	
1.1.3	30-39	
1.1.4	40-49	
1.1.5	50-59	
1.1.6	60+	

1.2. Gender

1.2.1.	Male	
1.2.2	Female	

1.3. Population group

1.3.1	Tsonga	
1.3.2	Northern Sotho	
13.3.	Southern Sotho	
1.3.4	Venda	
1.3.5	Xhosa	
1.3.6.	Zulu	
1.3.7.	Swazi	
1.3.8	Ndebele	
1.3.9.	OTHER (please specify)	

1.4. Race

1.4.1	Black South African	

1.4.2	White South African	
1.4.3.	Coloured	
1.4.4.	Indian	
1.4.5.	Other (please specify)	

1.5. Home language (Choose only one language)

1.5.1	Xitsonga	
15.2	Sepedi	
15.3	Setswana	
1.5.4	Tshivenda	
1.5.5	IsiXhosa	
1.5.6	IsiZulu	
1.5.7	I siSwati	
1.5.8.	IsiNdebele	
1.5.9.	Other (please specify)	

1.6. Marital status

1.6.1	Single	
1.6.2	Married	
1.6.3	Widow	
1.6.4	Divorced	

1.7. Religion

1.7.1.	Christian	
1.7.2.	Non-Christian	
17.3.	Other (please specify	

1.8. Highest educational level

1.8.1.	Primary	
1.8.2.	Secondary	
1.8.3.	Tertiary	

SECTION B

2.1. KNOWLEDGE ABOUT MORAL REGENERATION

2.1.1. What is your understanding of moral regeneration?

2.1.2. What do you understand by the meaning of UBUNTU?

2.1.3. What knowledge do you have regarding moral behaviour among nurses? **2.2.**

RESPECT

2.2.1. Can you give me some examples of things that you think would be respectful?

- Can you describe what do you think respectful behaviour is? Can you tell me about some examples of ways in which you have been treated with respect?

2.2.2. Can you give me some examples of things that you think would be disrespectful?

- Can you tell me about some examples of ways in which you have been treated disrespectfully?

2.2.3. Do nurses treat you as a human being?

2.2.4. Do nurses show respect to all individuals, irrespective of social origin, race, gender, age, status and class.?

2.2.5. Do nurses allow you to ask questions about your illness and respond appropriately?

2.3. CARING

2.3.1. How do nurses communicate with you? e.g. Address you politely or call you by title or name.

2.3.2. Do nurses provide excellent patient care?

2.3.2. Do nurses spend time with you?

2.3.3. Do nurses give you treatment on time?

2.3.4. Do nurses allow you to have choices on your care?

2.2.5. How is the attitude of nurses towards you?

2.2.6. Do nurses care for all who are weak and disadvantaged: the poor, the aged, the disabled and all those unable to care for themselves?

2.3. EMPATHY AND SYMPATHY

2.3.1. Do nurses show interest, sympathy and understanding about your illness?

2.3.2. Do nurses show friendliness during conversations with you?

2.3.3. How do nurses communicate with you?

ANNEXURE F2: QUESTIONNAIRE FOR NURSES

TITLE: A MODEL TO PROMOTE MORAL REGENERATION AMONG NURSES IN LIMPOPO PROVINCE: SOUTH AFRICA

General background information indicates the characteristics of the different categories of nurses.

Please answer questions by marking with "X" for the appropriate answer.

SECTION A: DEMOGRAPHIC DETAIL

1. Age

1.1	***15-19***	
1.2	***20-29***	
1.3	***30-39***	
1.4	***40-49***	
1.5	***50-59***	
1.6	***60+***	

2. **Gender**

2.1.	Male	
2.2.	Female	

4. INDICATE YOUR HIGHEST QUALIFICATIONS

4.1.	Enrolled Auxiliary	
4.2	Enrolled nurse	
4.3	Bridging course	
4.4	3 Year Diploma in Nursing	
4.5	4year comprehensive Course (R425)	
4.6	BA CUR	
4.7	BA CUR HONS	
4.8	MA CUR	

4.9	Other (please specify	

5. How many years of nursing experience do you have?

5.1.	**0 to 5 years**	
5.2	**5 to 10 years**	
5.3	**11 to 15 years**	
5.4	**15 years and more**	

6. Indicate your post-basic qualifications

5.1.	Diploma in midwifery	
5.2	Diploma in nursing education	
5.3	Diploma in Community Nursing science	
5.4	Diploma in Nursing Management	
5.5	Diploma in Paediatric nursing	
5.6	Diploma in Intensive Care Nursing	
5.7	Other (please specify)	

5. Indicate the section in which you are currently working

5.1	Medical unit	
5.2	Surgical unit	
5.3	Paediatric unit	
5.4	Maternity unit	
5.5	Theatre	
5.6.	Outpatient department/ trauma	

SECTION B

In this section, you will do self-assessment to assess the knowledge regarding ethical-moral behaviour. Respond by marking with an "X'' as in section A in the appropriate block.

KEY:

1. SA= Strongly agree
2. DA = Disagree
3. A = Agree
4. U = Undecided
5. SDA = Strongly Disagree

1.KNOWLEDGE ABOUT ETHICAL BEHAVIOUR	SA	DA	A	U	SDA
Ethical conduct is important only to avoid legal action					
Patients' wishes must always be adhered to					
Nurses should do what is best for the patient irrespective of the patient's opinion					
Patients should always be told if something is wrong					
Confidentiality should be abandoned					
Close relatives must always be told about a patient's condition					
Patients only need to consent for operations but not for tests or medications					
Children should never be treated without the consent of their parents or guardians except in an emergency					
If patients refuse treatment due to beliefs, they should be instructed to find another doctor					

The law allows abortion to be performed, therefore a nurse cannot refuse to do an abortion					
The patient who wishes to die should be assisted in doing so					
2.CARING	SA	DA	U	A	SDA
I adhere to patients' wishes					

I inform a patient if there is something wrong with his/her illness					
I do what is best for the patient irrespective of his/her opinions					
I inform the relatives about the patient's condition					
I treat children without consent from their parents					
I assist patients who wish to die					
I care for all who are weak and disadvantaged: poor, the aged, the disabled and all those unable to care for themselves.					
I overcome discrimination based on status, custom, culture, race, gender, sexual orientation, health status, and tradition.					
3.EMPATHY AND SYMPATHY	SA	DA	A	U	SDA
I promote equal opportunities for all persons including disabled people and those suffering from HIV and AIDS and other forms of the disease					
If patients refuse treatment due to beliefs, they should be instructed to find another doctor.					
4.MORAL BEHAVIOUR OF NURSES	SA	DA	A	U	SDA
The moral behaviour of nurses is affected by the level of education and experience					

Other moral problems experienced by nurses are in relation to communicating honestly with patients about their situation and death					
I practise ethically when I adhere to ethical principles like autonomy, beneficence, justice, veracity, fidelity, confidentiality and privacy.					
Moral distress leads to decreased job satisfaction, increased staff turnover, health problems and burnout					
I follow ethical conduct when nursing patients to avoid legal action					

Shortage of resources leads to dilemmas					
I have a passive attitude when confronting moral issues					
I counter aggression and rudeness with respect and understanding					
RESPECT					
The law allows abortion to be performed; therefore a nurse cannot refuse to do an abortion.					
I promote the right of every patient to give expression to his/her views without fear of intimidation or harassment.					
I interact with patients openly and honestly					
I respect the beliefs and value systems of patients					
I respect the worth of individuals, irrespective of social origin, race, gender, age, status and class					
A sense of social responsibility by respecting the rule of law, honesty, hard work and standards of ethical decency					

I promote respect for beliefs and value systems of patients.					
I promote friendship, peace, tolerance among cultural and religious beliefs of the patients.					

ANNEXURE G: CONFIRMATION BY LANGUAGE EDITOR