Factors influencing nurses' advocacy role in level two public hospitals in the North West Province of South Africa

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PREFACE

REPORT OUTLINE

This report was compiled in the article format according to the North-West University (NWU) Manual for Master's and Doctoral Studies (NWU, 2016:22). Following the guidelines, one manuscript was drafted following the instructions of the Curationis Journal. Resultantly, repetition of sections is inevitable, with some sections repeated verbatim.

The following structure will be followed:

- Chapter 1: Overview of the study
- Chapter 2: Literature review
- Chapter 3: Article manuscript: The characteristics of factors influencing nurses' advocacy role in level two Public Hospitals in the North West Province.
- Chapter 4: Evaluation of the study, limitations, and recommendations for future nursing advocacy role in practice, for education purpose and policy formulation.

The study was conducted and reported on by the researcher – Olivia Ngami, Open Researcher and Contributor Identification Number (ORCID), 0000-0002-7126-5673, under the supervision of the study leader, Professor C.S. Minnie.

The referencing style used was the NWU Harvard style, as in The North-West University Referencing Guide (NWU: 2018), except for Chapter three, where the author guidelines for Curationis were used.

DECLARATION

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I declare that this research has been conducted solely by myself. It has not been submitted elsewhere except at the NuMIQ research focus area North-West University. It has never been submitted in whole or in part in any previous application for a degree. Except where stated otherwise by reference or acknowledgement, the work presented is entirely my own.

I declare that I have followed the University policy regarding plagiarism and have complied by acknowledging all the work done from other sources. I declare that the data has been kept with confidentiality throughout the stages of data handling and that I conducted the research in my capacity as a research student.

15 August 2021

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What my eyes can't see, I still believe, everything spoken to me, there is no word, that can come back void, I will trust the report of the Lord. While I'm waiting, I'm getting stronger, my faith is rising Lord (Travis Green)

I would like to express my sincere gratitude to the following:

My Deepest gratitude goes to God. The author and the perfector of my faith. The Lion of Judah, His Name is Jehovah. He reigns supreme above all the heavens and earth, King of Glory. He said, ask, and it shall be given, knock, and the doors will be open. Heaven is his throne, and the earth is His footstool. He is the Lamp that lights my path. If it had not been for the Lord who was always by my side, I would have drowned: in the water. All the Glory and Honour belong to Him. I made it on a wing and prayer. Romans 8:28: It all works together for good to them who are called to His purpose.

My Husband, Mr Thembile Ngami. You have been nothing short of a blessing. I know we are not perfect, but the love you have shown me is perfect in my eyes. Thank you for the support, constant encouragement, and all the effort taken to assist me with our house chores; I appreciate that. In that, you have allowed me time to do my work while you took care of us. I LOVE YOU.

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The only impossible journey is the one you never began~ Anthony Robbins. It was a long journey for me - next round loading.

ABSTRACT

BACKGROUND

Nursing advocacy has been a topic of much discussion in the nursing literature for several decades. The researcher was interested in contributing to quality patient care by empowering nurses in their advocacy roles.

OBJECTIVES

The objective was to explore and describe the factors that influence nurses' advocacy roles

METHOD

A qualitative descriptive inquiry was conducted using focus group interviews with professional nurses as participants who were purposefully recruited. Interviews were conducted in all the level two public hospitals in the North West Province. The data were thematically analysed using Creswell's eight steps of data analysis to identify common themes (Creswell, 2014:209).

RESULTS

Three main themes were identified. These findings were as follows: managerial and environmental factors such as lack of management support and nurses' lack of training influence the advocacy role of nurses negatively. The second finding was personal factors such as empathy, sympathy, and assertiveness positively influenced the nurse's advocacy role. The last finding was patient-related factors such as compromised patients' rights, autonomy, religious and cultural beliefs affecting the nurses' advocacy role either negatively or positively. A unique finding of the study was that language differences could also influence the ability of nurses to advocate for their patients.

CONCLUSION

Overall, several factors can influence the nurse either positively or negatively when advocating for patients. Nurses need to be empowered in their nursing advocacy role to provide quality patient care within a public hospital setting to advocate for their patients.

Keywords: Nurse, Advocacy, Provincial hospital, North West Province

LIST OF ACRONYMS

ABP	Acting on Behalf of Patients
ANA	American Nursing Association
CEO	Chief Executive Officer
CSJ	Championing Social Justice
DoH	Department of Health
HREC	Health Research Ethics Committee
ICN	International Council of Nurses
NHREC	National Health Research Ethics Council
NMC	Nursing and Midwifery Council
NuMIQ	Research to promote quality in Nursing and Midwifery
NWP	North West Province
PI	Principal Investigator
REC	Research Ethics Committee
SANC	South African Nursing Council
SPA	Safeguarding Patients' Autonomy
SDG	Sustainable Development Goals
TIE	Time-Inconvenience-Expenses
WHO	World Health Organisation

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CHAPTER 1:
OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Patient advocacy has been a topic of much discussion in the nursing literature for some decades. Advocacy is a key nursing role, yet diverse definitions exist, confusing the purpose of a nurse's advocate role and the factors influencing nurses to advocate, making it challenging to put advocacy into practice (Negarandeh *et al*., 2008:457). Patient advocacy became a subject of interest to the researcher who aimed to explore the factors influencing nurses to advocate for patients in level two public hospitals in the North West Province. Chapter one will focus on the research background, problem statement, aim and objective of the study, as well as recruitment of participants in order to get data which will be analyzed in chapter three.

1.2 BACKGROUND TO STUDY

It remains unclear what patient advocacy entails and what values it ought to embody. Advocacy is alleged to be a means of safeguarding good patient care. Many professionals claim to be best suited for the position, many stating that the role of patient advocates is inherent to their profession. As seen in the early work of Schwartz (2002: 37), numerous role players have different interpretations of and applications for the role of an advocate. The concept of advocacy by a nurse on behalf of patients appears to have gained widespread acceptance in the western world (Breeding, 2002:110). Within an African context, patient advocacy has been identified as a core duty of the nurse (Dadzie *et al*., 2017:1). Advocacy has become an almost universal catchword among nurses, indicating that this concept has been legitimised within various nursing ethical codes (Breeding, 2002:110).

Over the past four decades, patient advocacy has become central to nursing's professional identity. Regulatory and professional nursing organisations explicitly and implicitly include advocacy activities as part of codes of conduct and ethics. The International Council of Nurses (ICN) describes advocacy as central to nurses' contribution to the development of strong and resilient healthcare systems in the United Nations Sustainable Development Goal number 3 (ICN, 2016). Nurses need to advocate for each patient who is vulnerable and at-risk; and contribute to the development of policy that supports SDG goal 3 of ensuring healthy lives and promoting the wellbeing of all patients of all ages (ICN, 2016; Water *et al*., 2016:696).

Furthermore, advocacy is usually employed by someone powerful on behalf of someone who has less or no power (Negarandeh *et al*., 2006:2). The core condition that demands advocacy action

is a patient's vulnerability because of illness and risks inherent in the institutional process to which patients are exposed. The majority of the patients exhibit various degrees of vulnerability due to their disease, culture, economic or educational background, personality, and previous experiences with healthcare. Patients ' medical conditions such as unconsciousness, cancer, or mental illness can cause vulnerability and compromise their ability to self-determine their health care and protect their best interests. Feelings of powerlessness because of limited knowledge about health care or experiences of being neglected in the health care system can increase a patient's vulnerability. In addition, the negative way that health professionals sometimes relate to patients, specifically the disregarding, dehumanising, controlling, punitive and judgemental practice of biomedicine, can increase patients' vulnerability requiring nurses to assume their role as patient advocates (Negarandeh *et al*., 2008:457).

In addition, the World Health Organisation (2014) report indicates that inaccurate diagnosis, medication errors, inappropriate or unnecessary treatment, inadequate or unsafe clinical facilities or practices, or providers who lack adequate training and expertise, prevail in all countries. These are just some highlights from the Report on Delivering Quality Health Services: A Global Imperative for Universal Health Coverage relevant to nursing advocates. The report also highlights that sickness associated with poor quality health care imposes additional expenditure on families and health systems (WHO, 2018).

To add to the report of WHO (2018), Water *et al*. (2016:698) reported an interesting case in Aotearoa, New Zealand, where a significant shift in power relations within the health care sector occurred during the 1980s. The case had important implications for patient advocacy as many patient issues regarding advocacy came to the fore during the 1987 Commission of Enquiry into allegations concerning the treatment of cervical cancer at a National Women's Hospital, also known as the Cartwright Inquiry. This inquiry led to a significant shift in public attitudes towards the medical profession by directly challenging the medical paternalism that characterised many health professionals' attitudes towards patients. Issues of inadequate patient advocacy were a key concern of the inquiry. Judge Cartwright particularly noted the failure of nurses to advocate for patients in the face of breaches of patients' rights, saying "nurses who most appropriately should be the advocates for the patient feel intimidated by the medical staff". Cartwright's comments on this case highlighted the principles that nurses should act as patients advocates. By not protecting the patients' rights, the nurses have failed in their ethical responsibility. Water *et al*. (2016:697) pointed out that patient advocacy has seen its rise to prominence within nursing as part of a series of profound changes in Western society/culture in the 1960s and 1970s. Central to these changes were the women's civil rights movements, whose critique of power relations in society that sub-judged women and minority groups were significant for health care and nursing

as a profession (Water *et al*., 2016:697). After the findings of the Cartwright Inquiry, nurses aligned themselves with patients at the rise of consumer movements to signal increased patient power within the health care system (Water *et al*., 2016:698). Nurses laid claim to this role mainly based on their patient-centred practice facilitating more insight into the needs of the patient than any other health care professional group. Hanks (2008:469) adds that at any given point, the patient exhibits characteristics that stimulate the nurse to advocate. The available literature shows that the advocacy role is more entrusted to the nursing profession than to other health care professionals, primarily because of the intimate nature of the relationships nurses have with their patients (Hanks, 2008:469; Water *et al.,* 2016:697, Negarandeh *et al.,* 2008:457).

The Nursing Act no. 33 of 2005 clearly states that it is the nurse's right to advocate for and protect patients and personnel for whom he/she has accepted responsibility (Nursing Act, 33 of 2005:7). The scope of practice of a nurse (Regulation 2598) outlines all the roles of a nurse towards a patient in any health care facility (Department of Health, 2020:3). These duties have an underlying core character of a nurse advocating for the patient by ensuring that they promote, support, and restore the health care of patients and assist health care users in maintaining the basic activities of daily living, maintaining continuity and coordination of health care, and provide a safe and conducive environment for health care. All these nursing duties, as stipulated in Regulation 2598, are achieved through nurses assuming their role as patients' advocates.

Studies in a Ghanaian and broader African context (Dadzie *et al.* 2017; 2018) show possible reasons for inadequate advocacy. The study of Dadzie *et al.* (2017:2) found that nurses are often overworked and may lack the energy and time to advocate for patients due to insufficient staff on duty and lack of resources at work, and their low level of participation in decision making in the hospital that led to frustration.

Nurses may lose compassion and find it challenging to advocate for patients who may show ingratitude. Dadzie *et al.* (2018:10) investigated patient characteristics that influence the advocacy role of nurses in Ghana. This study found that vulnerable patients show signs of neglect, regardless of their background and social status. The vulnerability of patients is a core condition that demands nursing advocacy; both for personal vulnerability due to illness, and vulnerability due to risks inherent in the institutional process to which clients are exposed (Negarandeh *et al.,* 2008:457)

Within a South African context, no studies could be found regarding factors influencing nurses advocacy role, only a newspaper article with a discussion that follows. Health care services vary from primary health care, offered for free by the public sector, to highly specialized, hi-tech health services available in both the public and private sectors. However, the public sector is stretched

and under-resourced in places Nt'sekhe, 2018:np), which means that resources are limited, leading to vulnerable patients who need advocacy. While the state contributes about 40% of all expenditure on health, the public health sector is under pressure to deliver services to about 80% of the population (Nt'sekhe, 2018:np). While access has improved, the quality of health care has deteriorated. The situation is compounded by public health challenges, including the burden of HIV and tuberculosis (TB) and a shortage of medical personnel. This situation compounds patients' vulnerability as they have to accept the treatment and care they receive without asking questions. This, in turn, affects the type of nursing offered to vulnerable patients nursed in hospitals with limited resources Nt'sekhe, 2018:np).

Patient care remains the nurse's primary responsibility, in particular the professional nurse, as primary caregivers amidst the challenges and shortcomings that the environment imposes on them, such as cost containment, minimised human resources, and the management of these resources. Within a South African context, patient advocacy has been identified as a core duty of the nurse (Dadzie *et al*., 2017:1). Patients are dependent on nurses as their primary caregivers who are expected to promote the patients' best interests in their day-to-day activities within a multidisciplinary health care team. The researcher identified a need for nurses to strengthen their role as patients' advocates by understanding what this role entails.

This study, therefore, focused on factors that influence nurses to advocate for their patients in level two public hospitals in the North West Province.

1.3 PROBLEM STATEMENT

Nurses perform a vital role as patient advocates to ensure that the treatment and care provided are appropriate and safe (Selanders & Crane, 2012; Canadian Association of Critical Care Nurses, 2013). However, the barriers that confront nurses as patient advocates are often problematic and well documented in the literature; thus, nurses do not advocate for patients (Negarandeh, 2007; Zomordodi & Foley, 2009). The literature (Selanders & Crane, 2012; Canadian Association of Critical Care Nurses, 2013, Negarandeh, 2007; Zomordodi & Foley, 2009) shows that the nurse's role as a patient advocate in healthcare settings depends on the patients' autonomy. Thus, when nurses identify patients who cannot make an autonomous decision, they realise that these patients rely on the nurses' advocacy to stand up for their views and beliefs. Vulnerability, lack of information, and neglect are key characteristics that demonstrate the need for patient advocacy (Cole *et al.*, 2014:576; Shah & Garg, 2011:4-7; Dadzie *et al.,* 2018:1).

Within a South African context, nursing advocacy is not a subject that nurses are familiar with as the researcher could not find any literature that indicates factors influencing nurses advocacy role. It is either that nurses do not know what is nursing advocacy, how to advocate, and when to advocate, which led the researcher to the following deduction. Deducing from Dadzie *et al*. (2017:20, Cole *et al.,* 2014:576; Shah & Garg, 2011:4-7; Dadzie *et al.,* 2018:1), quality patient care can be compromised by factors influencing nurses' inability to advocate for patients. In addition, nurses seek to define and clarify their role and position in practice; they search for new interpretations concerning patient advocacy. However, the factors influencing nursing advocacy in practice within a South African context in level two public hospitals are not well known yet.

1.4 PARADIGMATIC PERSPECTIVE

De Vos (2005:40) contends that the paradigmatic perspective describes the way in which the researcher views the research material. The paradigmatic perspective of this study guides the research methodology and knowledge and action of nursing (Alligood, 2010:62). The paradigmatic perspective of this study comprises the meta-theoretical, theoretical, and methodological assumptions. The following statements define the paradigmatic perspective and the parameters within which the researcher conducted the research.

1.4.1. Meta-theoretical assumptions

Meta-theoretical assumptions refer to the researcher's personal beliefs regarding man and the environment in which they live, and it is not testable. The meta-theoretical assumptions for this study are based on a Christian worldview as well as Roy's theory of adaptation in nursing practice and include beliefs regarding the following concepts: man/person, the environment, health, and illness (De Vos, 2005:40; Alligood, 2010:310). Assumptions regarding a man/person, environment, health, and illness are described as follows:

1.4.1.1. Man/person.

The researcher's view of human beings is connected to her view of God. The Almighty God is the creator of the universe, owner, and ruler of creation. He cares for His Creation and is concerned about His creations. Human beings are created as complex, unique, multidimensional beings. God has given man the task of increasing, inhabiting, ruling, cultivating and caring for creation. He has given each human being specific tasks, as well as gifts and talents, time, energy, and means to fulfil these tasks within specific societal relationships and structures (De Vos, 2005:40).

Roy's theory of adaptation views a person as an adaptive system in constant interaction with the internal and external environment (Alligood, 2010:310). In this study, the concept, man/person

refers to a nurse as a patient advocate. Roy's theory of adaptation in nursing practice considers nursing as a vital service in assisting sick or well individuals in responding to a variety of new stressors, move towards optimal well-being, and improve the quality of their lives through adaptation (Alligood, 2010:309-312). For this study, the term nursing is used to refer to the rendering of quality patient care, including acting as an advocate for patients. The patient is viewed as a person receiving care from the nurse.

1.4.1.2. Environment

Roy's theory of adaptation considers the environment as a source of a variety of stimuli that either threaten or promote a person's unique wholeness (Alligood, 2010:310). For this study, the concept environment refers to the nurses' workplace within a hospital environment.

Following Roy's theory of adaptation and the conceptual model of advocacy categories (Figure 1), the environment includes all the social, economic, and legal elements that influence patient advocacy (Dadzie *et al*., 2017:2). For this study, the researcher will focus on the social environment where the nurse-patient interaction occurs. The social environment is vital as nurses interact with other multidisciplinary team members with whom they have to advocate for patients. The patients' environment is also considered as it influences the nurses' interaction with the patient and their advocacy for patients. Environmental factors such as poverty, social status, patients' vulnerability, neglect, lack of information, intimidation, and dissatisfaction with healthcare rendered (Dadzie *et al.,* 2018:1) could influence the nurses' ability to advocate.

1.4.1.3. Health

Human beings experience health and illness in the totality of their being. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition (World Health Organization (WHO), 2014:3). The WHO defines health as the state of complete physical, mental, sexual, and social well-being and not merely the absence of disease or infirmity. Illness is seen as impairment in health, and health and illness are dynamic states (WHO, 2014:3). A person is in a healthy state when the mind, body and spirit are in a state of being integrated with the process of life (Alligood, 2010:312). For this study, health refers to a state of nurses assuming their advocacy role regardless of the factors that influence their role as advocates.

The core condition that demands advocacy action is the patients' vulnerability, in terms of both personal vulnerabilities because of illness and susceptibility to risks inherent in the institutional process to which clients are exposed in the health care system (Negarandeh *et al.*, 2008:457).

1.4.1.4. Illness

In this research, illness refers to vulnerability if a patient's nurse fails to advocate for the patient. Failure to take on an advocative role could harm the patient. This failure can be due to the nurses' state of mind, such as fear, fatigue, frustration, and burnout (Dadzie *et al.,* 2017:2).

1.4.2. Theoretical assumptions

Jackson (2015:10) argues that a pragmatic approach to nursing theory selection implies a humble and inclusive nursing practice. A nurse can critically evaluate a range of theoretical options and determine the most effective and appropriate course of action for a specific client. In the discussion below, the researcher will only introduce one model to address the research question.

1.4.2.1. Applicable theory

For this study, the researcher considers the Bu and Jezewsky advocacy model (2006:101) adapted by Dadzie *et al*. (2017:2) (see Figure 1). This model is relevant to the current study as it addresses patient advocacy and understanding of this role in general. It can be used as a basis for focusing on advocacy in nursing. The mid-range theory developed by Bu and Jezewsky (2006:101) maintains that patient advocacy consists of three core attributes: safe-guarding patients' autonomy (SPA), acting on behalf of patients (ABP), and championing social justice (CSJ) in the provision of health care.

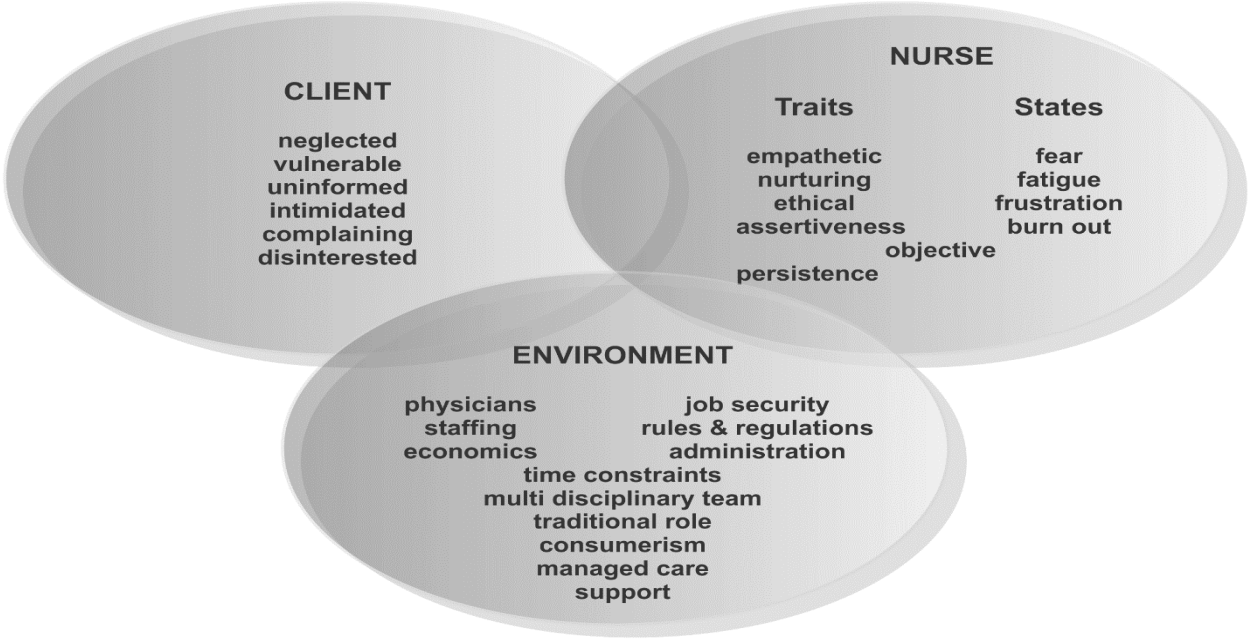

Figure 1. Conceptual model of advocacy categories and interaction

(Dadzie *et al*. 2017:2)

The model clarifies how nurses view their advocacy role and the circumstances under which they perform this role. In this model, three interdependent categories help to determine when, if and how nurses practise patient advocacy, namely, the "client", "nurse", and "environment". According to this model, the client's (or patient's) characteristics consist of neglect, vulnerability, being uninformed, intimidated, complaining and being disinterested. The nurses' characteristics are described in terms of traits and states. The relevant traits include being empathetic, nurturing, ethical, assertive, objective, and persistent. The nurse's states affecting her performance of her advocacy role are fear, fatigue, frustration, and burnout. The model then indicates the environment in which the nurse and the patient interact, comprising job security, staffing rules and regulations, administration, time constraints, multidisciplinary team traditional role, consumerism, managed care, and presence of physicians (Dadzie *et al.,* 2017:2).

The researcher chose Bu and Jezewski's (2006:101) model because it suits the research topic and appropriately matches the problem statement. This model guided the study as a lens through which the researcher viewed the study.

1.4.2.2. Conceptual definitions

With the following conceptual definitions, the researcher aimed to clarify how these concepts were applied in the current study.

Table 1: Definition of concepts and application to the study

CONCEPT	DEFINITION	APPLICATION TO THE CURRENT STUDY
Patient	A patient is a person who is physically or mentally ill or who is undergoing treatment for physical or mental illness (Freshwater & Maslin-Prothero, 2007:440).	In the current study, a patient refers to any person who meets the nurse in their professional capacity and exhibits vulnerability, neglect, lack of information, intimidation, distress, or complaining about the type of care received (Dadzie *et al.,* 2017:2).
Nurse	A nurse is a person who is registered in a category under section 31(1) to practise nursing or midwifery in South Africa.	In the current study, a nurse is a professional nurse who cares for patients and advocates for them. Professional nurses have the authority to advocate for all hospitalised patients with whom they come into contact.

CONCEPT	DEFINITION	APPLICATION TO THE CURRENT STUDY
	A professional nurse means a person registered as such in terms of section 31. (South Africa, Nursing Act 33 of 2005:6).	
Nursing	Nursing is the activity involved in providing physical care and emotional support to the sick, wounded, and helpless. Nursing includes all the activities performed by a nurse and is concerned with the restoration and maintenance of individual physical and mental health (Freshwater & Maslin-Prothero, 2007:362.) Nursing is practised by a person registered under section 31, which supports, cares for and treats a health care user to achieve or maintain health and where this is not possible, cares for a healthcare user so that he or she lives in comfort and with dignity until death the (Nursing Act 33 of 2005:6).	In the current study, nursing refers to the act of providing quality patient care and being able to identify and act as a patient advocate.
Advocacy	Advocacy means the process of providing support, referral, liaison while representing and protecting the interest of individuals and families who may or may not be aware of the need or are unable to coordinate or arrange health care for	In this study, advocacy is the ability and activity of the nurse to identify the need and act accordingly on behalf of the patient by always representing the patients' best interests. Advocacy has been described as specific actions such as helping the patient obtain the needed health care, assuring the quality of

CONCEPT	DEFINITION	APPLICATION TO THE CURRENT STUDY
	themselves (Nursing Act 33 of 2005:1).	care, defending the patient's rights, and serving as a liaison between the patient and the health care system. When a patient does not obtain the needed health care, the nurse should step in to advocate for the patient (Negarandeh *et al.,* 2006:2).
Advocate	An advocate acts for or defends the rights of another person who is unable or unwilling to act for him/herself (Freshwater & Maslin-Prothero, 2007:363).	For this study, the nurse assumes the role of an advocate as she/he represents the patients' best interests, ensuring that quality patient care for the patient. The nurse talks for the patient, and advocates on behalf of the patient due to their vulnerable position when hospitalised.
Nursing advocacy	The process of providing support, referral, liaison, representation, and protection of the interest of individuals and families who may or may not be aware of the need for, or are unable to coordinate or arrange, health care for themselves (Nursing Act 33 of 2005:4).	For this study's purpose, the researcher will apply the definition as it is relevant and applicable to nursing and the advocacy role of a nurse. In the context of typical nursing practice such as the hospital, patients need nursing care that involves nurse advocacy because they are vulnerable or debilitated by illness or injury (Kalaitzidis & Jewel, 2020:77).
Level two hospitals	Level two hospitals are defined as providing secondary level of care. This type of care is highly differentiated by function with 5 to 10 clinical specialties. These hospitals size range from 200 to 800 beds. (Jamison *et al.,* 2006:79)	For this study, level two hospitals are provincial hospitals providing secondary care within the North West Province of South Africa.

CONCEPT	DEFINITION	APPLICATION TO THE CURRENT STUDY
	In addition to that Torrey, (2020:np) explains that secondary care is when your primary care provider refers the patient to a specialist that is reachable within the same premise of care. When a patient is referred for level two or secondary care, it means the health care provider transferred the care to someone who has more specific expertise in whatever health issue.	

1.4.3. Methodological assumptions

Botma *et al.* (2015:287) define methodology, which includes the research design and methods of how researchers study whatever they believe can be made known.

For this study, the researcher followed a qualitative approach to explore the factors influencing nurses to advocate for their patients. Qualitative research is well suited for "why", "how", and "what" questions about human behaviour, motives, views, and barriers (Neergaard *et al.,* 2009:2).

1.5. RESEARCH AIMS AND OBJECTIVE

In the following section, the aim and objective of this study are discussed. The researcher was interested in contributing to quality patient care by contributing to the body of knowledge on how to perform their role as patient advocates despite the challenges currently facing the health sector in South Africa.

From the problem statement, the following question arose:

What are the factors influencing nurses' patient advocacy role in level two public hospitals in the North West Province of South Africa?

1.5.1. Research aim

This study aims to contribute towards the promotion of nursing advocacy by exploring and describing factors that influence nurses' performance of their patient advocacy roles.

1.5.2. Research objective

A research objective is a concrete, measurable end towards which effort or ambition is directed. It is defined as a clear, concise, declarative statement written in the present tense (Brink *et al*., 2016:85).

To reach the aim, the following objective was formulated:

To explore and describe factors that influence nurses' performance of their patient advocacy roles at level-two public hospitals in the North West Province.

1.6 STUDY DESIGN

The study followed a qualitative descriptive research design. Qualitative description is widely used to investigate health care and nursing-related phenomena (Kim *et al*., 2017:1). A qualitative descriptive design follows an empirical method of investigation, aiming to describe the participants' perceptions of experiences of the world. The study is also interpretative, as Sandelowski (2010:79) clearly states that all research has an interpretative component when the researcher analyses the data. For this study, the researcher followed the qualitative descriptive design to produce qualitative findings from the data, also referred to as a thematic survey (Sandelowski, 2010:78).

1.7 RESEARCH METHODOLOGY

A descriptive qualitative framework was used for this study to answer the research question and to understand the phenomenon within its specific context (Negarandeh, 2008:549; Sandelowski, 2010:7).

1.7.1. Study context

The study was carried out at all four level two public hospitals in the North West Province as they serve as secondary referral hospitals and are main referral hospitals within the province. These hospitals have a more comprehensive service provision than level one district hospitals. The participating hospitals were initially four, namely: Klerksdorp Hospital, Joe-Morolong Hospital, Job Shimankane-Tabane Hospital and Mafikeng Provincial Hospital. Klerksdorp/Tshepong hospital

has two complexes, the initial plan considered using only one complex from that hospital. However, the second complex was later included to obtain data saturation. Each hospital had a minimum of 100 nurses to a maximum of 300 nurses. The hospital had speciality services varying from neonatal wards, ante natal wards, dialysis units and oncology wards. Although the number of wards was not the same in each hospital, the researcher applied randomisation (Brink et al., 2016:123) when selecting wards for participants to be recruited from. Wards in the hospitals were randomly selected to allow all the wards an equal chance to be included in the study.

1.7.2. Population and sampling

The population is all the elements, the participants, persons, and events from which the sample is drawn. Sampling is done to obtain a picture of the phenomenon under investigation, and more practical than to include all the population elements (Brink *et al*., 2016:123).

1.7.2.1. Population

Brink *et al*. (2016:1230) define the population as the entire group of persons or objects of interest to the researcher, in other words, those that meet the criteria that the researcher is interested in studying (Brink *et al*., 2016:126). The target population (N=34) was the professional nurses who worked in the identified level two public hospitals in the North West Province. The number of professional nurses in each hospital varied from a hundred to three hundred.

1.7.2.2. Sampling

Sampling is the process of selecting the subset or portion of the population to represent the accessible population (Botma *et al*., 2015:124). Botma *et al*. (2015:200) further explain that sampling involves selecting participants or artefacts to be included in the study. Sampling is done because the target population might be too large for the researcher to include the entire population.

1.7.2.2.1. Sampling technique

A multi-level sampling technique was used in this study – for hospital wards and individual participants.

For this study, the researcher adopted both probability sampling and non-probability (purposive) sampling methods (Brink *et al*., 2016:139).

With the probability sampling method, simple random sampling was used to select wards as each unit or element of the study had an equal chance to be selected (Botma *et al*., 2015:127). The

researcher randomly selected the wards in each institution by putting ward indicators in a container and randomly drawing the required number of ward indicators.

Purposive sampling as a non-probability method was used to select the professional nurses who participated in the study. Though non-probability sampling may not accurately represent the population, it is often used in qualitative research and is suitable for this research. The quality of the data obtained from non-probability samples, such as purposively selected samples, can potentially be high when the researcher is dealing with willing and able subjects (Brink *et al.,* 2016:139).

1.7.2.2.2. Sampling size

There is no simple formula to guide the researcher to determine the sample size, which was determined by data saturation (Brink *et al*., 2016:129). Participants were recruited from the randomly selected wards for the focus groups. Each focus group consisted of six to eight participants. The researcher planned at least one focus group at each hospital. Data-saturation occurred when the researcher became very familiar with the settings, routine, or data being collected, perhaps even feeling bored and if one has heard it all (Botma *et al*., 2015:200). Five focus groups were conducted with a total of thirty-four participants. (details in Chapter three where participants demographics will be outlined).

1.7.2.2.3. Inclusion criteria

An inclusion criterion is defined as eligibility or distinguishing descriptors, which will form the basis for deciding whether an individual qualify as a member of the population in question (Brink *et al*., 2016:125). The following inclusion criteria were used:

(1). Registered as a professional nurse with the South African Nursing Council.

(2). Professional nurses with two years or more of full-time experience because such nurses have established social and work relations with other multidisciplinary health team members and have been exposed to patients who need advocacy.

(3). Professional nurses who work shifts as they interact with different professional groups and have contact with patients during weekends when most members of the management are not available. They need to take responsibility for decision-making and patients' advocacy.

1.7.2.2.4. Exclusion criteria

Exclusion criteria should be based on sound reasons. Inclusion and exclusion criteria have ethical implications (such as fairness of selection) and are not just of scientific relevance.

(1). Nurses who have just graduated and are doing community service or probation were not included because they rotate around the various units in the hospitals as part of their community service and do not have prolonged encounters with patients.

1.7.3. Data collection:

Data were collected during five focus group interviews. Focus group interviewing is a qualitative data-gathering technique used to obtain general background information and the participants' perceptions about a focused theme in a setting that is permissive and nonthreatening (Burns & Grove, 2009:513). A focus group interview is an open conversation on a specific topic in which participants make comments, ask questions, and in which there is good interaction between the researcher, co-facilitator, and the participants (Botma *et al.,* 2015:360)

1.7.3.1. Data collection tool

An interview schedule was used as a data collection tool. (See Annexure F). The interview schedule, also known as an interview protocol or topic guide, is a set of pre-determined open-ended questions that guide but does not dictate the interview. This schedule was based on the research question as it was more likely to generate valid answers in the study context. There were six questions in total, with the first question, an introductory question. Participants introduced themselves and gave biographic information with this first question. The researcher requested biographic information such as participants' age, sex, years of nursing experience, and educational qualifications as the first part of the interview schedule. The biographic question served as an introduction to relieve the potential tension between participants and researcher (Hanks, 2008:471.

The follow-up questions were based on the interview schedule (See Annexure F) and were supplemented with supporting questions. For this study, the researcher will not be discussing results found on the study conducted by Hanks as it was an old study but was more interested in how the researcher could develop the interview schedule. Hanks (2008:471) designed a pilot study for nurses' advocacy roles used as a phenomenological inquiry about a particular phenomenon. The study was found to be like the current research study as it aimed to understand the essence of factors influencing nurses to advocate for patients (Hanks, 2008:471). The researcher amended the questions to fit her study.

The researcher also collected field notes that assisted in obtaining a thick description of data (Botma *et a*l., 2015:219). The field notes formed part of the data collected and focused on aspects that participants did not verbalise, such as non-verbal cues or reactions to what other participants had said. Field notes will be saved with the collected data for storage according to the POPI Act, Act, 4 of 2013. These were very important as they assisted the researcher in obtaining an in-depth meaning of participants' feelings and behaviours accompanying what they have said during the interviews. The researcher also noted field notes such as the sitting arrangements, the order in which people speak, non-verbal behaviour such as eye contact, posture, gestures between group members, crying, fidgeting, and themes that are striking as well as specific group dynamics (Botma *et al*., 2015:219).

1.7.3.2. Data collection process

Data were collected according to a pre-established plan. Firstly, the researcher ensured that permission was obtained at different levels, such as ethics approval from the NWU (see Annexure A) and approval for the research from the North West Province Department of Health. The permission obtained from the provincial Department of Health (Annexure B), the chief executive officers of the various hospitals (Annexure C) and the unit managers of the randomly selected units granted the researcher access to recruit professional nurses for the study.

The participants were recruited as follows with information sessions and a recruitment pamphlet. The language used in the brochure was simple, written in English, and at the potential participants' level of understanding (Botma *et al*., 201514). The researcher selected a mediator such as the training officer at each hospital. They have a prior relationship with the potential participants and therefore know the appropriate people to approach and invite to participate in the study. The mediator was responsible for introducing the study to the potential participants in the relevant wards. The researcher ensured that the mediator was well trained and informed about the research study beforehand. The mediators at the various hospitals were asked to arrange information sessions where the researcher could tell the potential participants about the study. The researcher gave a brief presentation during these sessions at the wards during shift changes after report taking. Participants were able to ask the researcher questions regarding the study. After the information sessions, the recruitment pamphlets were distributed for potential participants to read during their own time to understand the study before they decided if they wanted to participate (Botma *et al*., 2015:145) (See Annexure D).

The following information was provided in the informed consent documentation (Annexure E):

- The title of the research project.

- An introduction to the research activities, extending the invitation to the nurses to participate in the study.
- The researcher's title and position to enhance the credibility of the study.
- The purpose of the project, including the long-term aim.
- The selection of the study population and sample to indicate the population to be studied as well as how and why they were selected as potential participants.
- An explanation of methods and procedures of data collection.
- A description of any risk and discomfort (be it physical, psychological, emotional, economic, or social) involved as well as the benefits.
- Confirmation of anonymity and confidentiality.
- The voluntary nature of participation. The participant must sign a non-coercive disclaimer, as a statement that his/her participation is voluntary and that refusal to participate will not involve any penalty or loss of benefits. The participants were made aware that they may withdraw at any time, without the risk of the researcher withholding some of the information deliberately.
- Participants were informed of the offers of the researcher to answer any questions they may have.
- The contact person's name if a participant needed to talk to someone regarding his/her participation.
- A delineated place for the signatures of the researcher, participant, and a witness (Brink *et al*., 2016:39).

The researcher ensured that the participants were not unduly influenced or coerced to participate, as this was unethical. All participants were allowed to voluntarily decide whether they wanted to participate. During the process of obtaining informed consent, participants were made comfortable and told that a refusal to participate would not have been prejudice to them in any way. (Brink *et al*., 2016:37).

Participants had 24 hours to decide if they wanted to participate. Participants were informed to bring back the unsigned consent form. After demonstrating their understanding of the essential information on the informed consent form, they signed it in the presence of the independent person who signed as a witness. The collected informed consent forms were stored in a sealed box to maintain the confidentiality of the participants. This box was kept in a locked cupboard for the duration of the research, with the plan to scan later and store the contents at the university for five years (see Annexure E for informed consent form).

After at least six to eight participants per hospital had signed and submitted their informed consent forms, the independent person (an administration clerk) informed the researcher. The independent person further arranged a suitable date for the focus group interviews. The time of the focus group interviews was set according to the participants' preference, and the researcher accommodated their choice, whether during day-duty, off-duty or night-duty time. A comfortable venue with enough room and privacy was selected to ensure no disturbance during the focus group interview (Brink *et al*., 2016:54, 143), for example, an office or meeting room. After the time, date and venue had been confirmed, the participants were informed of the final arrangements. They were also told that snacks and beverages would be served and that they did not need to bring food or spend from their pockets.

Focus group interviews were conducted on the days as confirmed with the participants. The researcher conducted at least one focus group interview at each hospital. More groups would be added if data saturation were not reached with the first four groups. A fifth focus group was eventually conducted with participants from the second complex of Klerksdorp/Tshepong hospital.

On the day of the focus group (all these interviews occurred before lockdown in March, thus no mention of Covid-19 lockdown), the researcher checked the room and its conduciveness to conduct a focus group interview an hour before the arranged time. The chairs were placed in a circle so that everybody in the group could see one another. Air conditioning for the room was available and set according to the participants' preferences. Snacks were available during the interviews. An audio recorder and a voice-recorder of a cell phone were used to record the data collected during the focus group interviews. Participants gave their consent to record the interviews.

The researcher asked the questions and took the field notes. She has good communication skills as she was specially trained and is a qualified educator who could facilitate interactive and meaningful group discussions. The researcher and participants met behind closed doors to prevent the interviewees from being overheard by passers-by. " Do not Disturb" notice was placed on the door.

Ground rules for the group were set before the focus group interview started, for example, allowing other participants to finish talking before someone else talked. The consent form was re-read as a reminder of what they consented to; also as a means of ensuring that participants still want to participate in the study. A critical ground rule was that participants would have to agree not to divulge the information shared during the focus group interview to ensure shared confidentiality amongst the participants and the researcher.

The focus group interviews lasted 40-60 minutes per group (Negarandeh *et al*., 2008:549).

1.7.4. Data analysis

Qualitative data analysis involves integrating and synthesising non-numeric data that are reduced to themes and categories with the aid of a coding procedure (Brink *et al*., 2016:57). Before starting to analyse or process the data, the researcher examined the data for completeness and accuracy. The researcher followed Creswell's (2014:209) thematic data analysis method and Tesch's eight steps to identify common codes. Data were analysed manually. The researcher communicated with the co-coder via email due to the Covid-19 lockdown. There were no differences in the themes identified between the co-coder and the researcher.

Creswell refers to a generic qualitative analysis approach in which the researcher collects the qualitative data, analyses it for themes or perspectives, and reports four to five themes. The researcher interpreted data using thematic analysis by grouping information in themes as the study followed a qualitative descriptive design (Creswell, 2014:209; Sandelowski, 2010:79).

Table 2: Process of data analysis

STEPS	DESCRIPTION OF STEPS	SUB-DESCRIPTION OF STEPS
Step 1 **Organising and preparing data**	The first step was to prepare and organise the data for analysis. This involved transcribing the interview audiotapes and typing up the field notes. The researcher was aware that transcribing focus group interviews is time-consuming; accordingly, time was allocated for this process. A transcriber was hired and instructed to transcribe the audio into written form. This transcriber had to sign a confidentiality form. The transcriber used a template with enough space on both the left and the right margins to allow the researcher to make notes during the analysis. One margin was used for personal notes, and the other for identified categories. During transcription, additional data such as	

STEPS	DESCRIPTION OF STEPS	SUB-DESCRIPTION OF STEPS
	field notes were added to the transcription to enrich the depth and context of transcription (Botma *et al*., 2015:214).	
Step 2 **Developing a general sense**	The second step was to develop a general sense of the data by reading through the data (transcriptions and field notes) obtained during focus group interviews and reflecting on the overall meaning (Botma *et al*., 2015:214)	
Step 3 **Data coding**	During the third step, the data were coded, according to the eight steps of data coding (Botma *et a*l., 2015:22). Coding is the process of organising the material into chunks or segments of text before bringing meaning to the information. It involved taking text data, gathered during data gathering, segmenting (words, phrases), sentences, or paragraphs, into categories, and labelling those categories with a term based on the participants' language (Botma *et al*., 2015:225, Creswell, 2014:209). This step is important as it was used to find patterns and produce explanations using both deductive and inductive reasoning to categorise data into segments. This step is called coding; it is a process used to organise data collected during interviews or from other types of documents.	Tesch's eight steps of Coding according to Botma *et al*. (2015:224): The researcher got a sense of the whole data by reading through it. She picked one document, went through it to create meaning by writing on the margins. After completing this task of coding all five documents, the researcher identified topics and clustered them together; these topics were then put into columns. The researcher then used this list to go back to the data and abbreviate the topics into codes. This was done to determine if preliminary themes could emerge; fortunately, such themes emerged. Descriptive wording was used to turn the codes into categories.

STEPS	DESCRIPTION OF STEPS	SUB-DESCRIPTION OF STEPS
		A final decision of each category was then made regarding the abbreviations of the codes. Data was then assembled in each category to make a preliminary analysis. There was no need for re-coding. (Creswell 2014:198)
Step 4 **Describing and identifying themes**	The fourth step was to describe and identify the themes by using the coding process to generate a description of the setting or people as well as themes from the categories	
Step 5 **Representing the findings**	Step number five entailed representing the findings. This included a detailed discussion with the co-coder about the various themes identified (Creswell, 2014:209). Verbatim quotations were used when data findings were presented.	
Step 6 **Interpreting the data**	A final step in data analysis involved interpreting the meaning of the data. Support of literature was used during the data interpretation.	

Source: Botma *et al*., 2015:224.

The co-coder was an experienced qualitative researcher who signed a confidentiality agreement that all identifiable information she came across would be kept in confidence. The co-coder was instructed to follow the coding process described by Creswell, which incorporates the eight steps of data coding (Botma *et al.,* 2015:224; Creswell, 2014:209).

1.8 RIGOUR

Validity and reliability are not relevant, as qualitative research methods do not lend themselves to statistical calculations of validity. However, this does not imply that qualitative researchers are not concerned with the quality of their data collection techniques (Brink *et al.,* 2016:163). Rigour in qualitative research refers to openness, relevance, epistemological and methodological congruence, thoroughness in data collection and data analysis processes, and the researcher's self-understanding (Brink *et al.,* 2016:126).

For any missed or misunderstood information during the focus group interview, the researcher asked follow-up questions or repeated after the participants to verify what the participants had just said.

The researcher used an audio recorder and a cell phone used for backup for data collection, which ensured accuracy for data to be transcribed from the recording done (Botma *et al.,* 2015:214). The recording made it feasible for the transcriber to transcribe the data using the latest software and technology that assisted in the transcription of data and allowed the transcriber to listen to sounds that may have been missed. The transcriber also signed a confidentiality agreement. Rigour in a qualitative study deals with trustworthiness or measures put in place to ensure the quality of the research (Creswell, 2014). The authors employed measures to ensure credibility through the purposeful selection of study participants, member checking, and peer review (Creswell, 2014; Polit & Beck, 2008:509). Confirmability and transferability were also ensured.

In Table 2, the researcher presents the epistemological standards to promote rigour that was applied in this study.

Table 3: Epistemological standards for rigour as applied

EPISTEMOLOGICAL STANDARD	STRATEGY	TECHNIQUE
Truth value	Credibility: this criterion was met by using accurate descriptions and interpretations of participants' ' experiences. In addition, the participants were allowed to verify their own experiences and interpretations during the focus group sessions.	The researcher reported all the participants' perspectives as clearly as possible (Botma *et al.*, 2015:292). Credibility was ensured by using accurate descriptions and interpretations of participants' experiences (Hanks, 2008:472).
Applicability	Transferability is met if a professional nurse in another hospital who must advocate for a patient is influenced by similar factors found in this study. The reader should have enough information to decide if the findings will yield the same results within their setting. The researcher applied purposive sampling of participants, a thick description and data, and data saturation.	Polit & Beck describes thick description as a rich, thorough, and vivid description of the research context, this includes the people who participated in the study, and the experiences and processes observed during the inquiry. Thick description of this study looked into explaining the prevailing sentiment is that if findings are to be transferable by applying theme in a different province in order to yield the same results. From the study participants, also contribute to other quality criteria, including the authenticity and vividness of a qualitative study. The researcher can also share an oral report at different provinces for

		describing the findings of this study (Polit & Beck The researcher wrote her field notes as part of a thick description; these field notes added value to the description of data. The focus group interviews were conducted at all four level two public hospitals in the North West Province to get in-depth information through carefully selected questions and thorough probing. The participants were encouraged to give a detailed account of their knowledge regarding the research question (thick data), as they were telling the researcher about their personal experiences regarding the research phenomenon. Data saturation was reached when the same themes repeated themselves within the focus group interviews. The researcher gathered the data from the six to eight participants per focus group in each hospital; this was done until the researcher no longer received new information from the focus group interviews (Fusch & Ness, 2015:1413). If data saturation was not obtained after the first round of focus group interviews, more focus group interviews would have been conducted until there was saturation of data.

EPISTEMOLOGICAL STANDARD	STRATEGY	TECHNIQUE
Consistency	Dependability: this was maintained if an external reviewer was able to reach the same conclusions using the raw data and analytical documents should a similar study be conducted. For this study, the external reviewer can be an external examiner or another researcher	The researcher used peer debriefing as credibility in the research methodology class when she presented her research project during her studies. This allowed the researcher an opportunity to receive criticism and to justify the study. The researcher wrote her reflections regarding these peer reviews and debriefing to see if they could be used to build her argument. Dependability and credibility were further promoted when an external reviewer (the co-coder) reached the same conclusions using the raw data and analytical documents as the researcher. Confirmability is also supported if a reviewer of the published study reaches the same conclusions. Confirmability was supported by maintaining a verifiable audit trail of movement through the data, including field notes, the interview schedule used during the focus group interviews, and methodological notes. Applicability was promoted as a reader can apply the findings to similar samples in other public hospitals settings (Hanks, 2008:472).

Source: adapted from Burns & Grove (2009:375-376, 215-219).

1.9 ETHICAL CONSIDERATIONS

For this study, the researcher accepted the responsibility of conducting high-quality research and following the general ethical principles outlined by Brink *et al*. (2016:30-43) and the Department of Health (DoH, 2015:7). Throughout the study, these standards were followed regarding the planning, implementation, and reporting of the research. The supervisor and the scientific committee of the research entity thoroughly scrutinized the research proposal. The researcher was also committed to scientific honesty and ensured that this was maintained by highlighting the opposing and supporting viewpoints identified.

The researcher acknowledged other individuals' ideas and work by accepting the plagiarism policy of the North-West University. An extensive audit trail was kept of each step of the research process to facilitate peer review of the entire research process.

The NWU Health Research Ethics Committee executed an ethics review according to the Ethics in Research: principles, process, and structures (South Africa, 2015:7, The National Health Act (NHA), 61 of 2003 (NHA 72(1):9). The Department of Health (2015:7) requires that proposals to conduct health research must undergo an independent ethics review before the research commences. This review of proposed 'health research must be conducted by a REC (Research Ethics Committee) or AREC (Animal Research Ethics Committee) that is registered with the NHREC (73(2) of the NHA. RECs must review health research proposals and protocols to ensure that the research promotes health, contribute to the prevention of communicable or non-communicable diseases or disability, or result in cures or alleviation of suffering caused by communicable or non-communicable diseases or disability (NHA s 73(2)(a)). RECs must ensure that research proposals stand up to scientific and ethical scrutiny appropriate to the disciplines concerned. RECs must review research proposals and protocols prospectively to ensure that they meet the accepted ethical norms and standards before research commences, using these guidelines as a minimum benchmark (NHA s 73(2)(b) (DoH. 2015:7).

According to Tracy (2010:847), the researcher ensured procedural and situational ethics. As a method of procedural ethics, the researcher safeguarded participants from undue exposure by securing all personal data in a locked office or drawer (Tracy, 2010:847). Situational ethics implies that each circumstance is different and that the researcher repeatedly reflected on these differences, critiqued, and questioned her ethical decisions. In short, this ethical consideration suggested that ethical considerations should be based on the particularities of a specific scene (Tracy, 2010:847).

1.9.1. Legal authorisation

According to Section 72 of the National Health Act 61 of 2003, the National Health Research Ethics Council (NHREC), National Health Act, 61 of 2003 (NHA), the Health Research Ethics Committee (HREC) of the North-West University gave legal authorisation for the research to take place after it has approved the research protocol (see Ethics Approval Certificate, Annexure A).

The researcher received official permission to access facilities from the Department of Health of the North West Province after ethics approval. The Planning, Policy, Research, Monitoring and Evaluation Office at the Department of Health of North West Province also gave legal authorisation for the level two public hospitals in the province to be used for this research project (see Annexure B).

1.9.2. Goodwill Permission

The researcher requested goodwill permission from the gatekeepers at different levels. The CEO of the four level two hospitals in the province were requested to approve that their employees may be asked to participate in the research process. The deputy nursing director of each hospital was asked to grant goodwill permission for the hospital's nurses to be interviewed. Finally, the different unit managers were also asked to grant permission for the nurses from their units to participate in focus group interviews (See Annexure C for permission from the hospitals).

1.9.3. Probable experience of participants

Participants were informed that they were expected to participate in semi-structured focus group interviews. They will be asked to discuss their viewpoints, perceptions, opinions, and experiences on the factors that influence their role as patient advocates. They were also notified that while the discussion may be uncomfortable initially, it will likely become more comfortable during the ice-breaking and introduction session. Participants may have experienced uneasiness at the beginning of a focus group as this research aimed to understand nurses' emotions concerning factors that influence their role as patients' advocates. Some participants may have been uncomfortable due to emotions attached to past experiences with patients who needed advocacy.

1.9.4. Risk and benefits

Before beginning the study, the researcher and reviewers from the Health Research Ethics committee (HREC) examined the ratio between the benefits and risks involved. The general guideline was that the risks must not exceed the study's potential benefits. When the risk is high, the researcher must ensure every effort to reduce it and maximise the benefits as a precautionary measure (Brink *et al*., 2016:42). In this study, the benefits were more than the risks.

Risk equates to harm or injury and implies something detrimental that may occur in the future (Botma *et al*., 2016:21-22). There are six types of harm, namely physical, psychological, social, economic, legal, and dignitary harm. No legal or dignitary risks were foreseen or experienced in this study (Botma *et al*., 2016:21-22). The researcher was on the lookout for any risks that may occur because of the research, and the necessary and relevant referrals would then be made.

Table 4: Risks and precautions to limit them

RISKS	PRECAUTIONS
Physical risk: There was no physical harm or risks encountered by the participants as this study did not include any bodily contact or harm	For physical comfort, the researcher ensured that the room was not too cold or too warm and clean and well ventilated. The data were gathered before the COVID-19 pandemic with its associated risks.
Psychological risk: Participants in the study may encounter psychological risks as they may experience doubt about their ability to advocate for hospitalised patients.	If any participant becomes emotional such as being upset during a focus group interview, the researcher requests a break, offers a glass of water, and allows re-grouping. She also asked the participants if they wanted to continue or if the interview should be postponed to a better time when the participants would be able to provide information. For this study, a counsellor (an experienced psychiatric nurse) was available to counsel participants who might need counselling because of the emotions experienced during the focus group interviews.
Social risk: There is a risk of loss of confidentiality – especially in a focus group. Work can be viewed as a social environment; the participants might fear to be a social outcast at work or to be labelled as a "snitch" by other health care professionals as they were discussing factors that they have seen in	Only the participants and members of the research team know the venue where the interview took place to avoid unannounced visitors or unnecessary movements during the interview process. The venue was private to ensure that no one overhears the discussion and to limit disruptions.

RISKS	PRECAUTIONS
their working environment that influenced them and/or other nurses to advocate for their patients. This may be uncomfortable to some nurses and viewed negatively.	All the participants were requested to introduce themselves before the commencement of the focus group interview so that all those who wanted could withdraw should they feel uncomfortable. The researcher emphasised ground rules such as not divulging information gathered during the focus group interview. Complete confidentiality could not be guaranteed as it depended on the cooperation of all, only shared confidentiality. The participants were reassured that anonymity would be maintained when the research report was presented and published.
Economic risk: Participants who must travel specifically for the interviews may have travel expenses	The Time-Inconvenience-Expenses (TIE) principle must be considered for those who would have travelled; however, the focus groups were conducted during the participants' working hours or lunchtime according to their preference. Participants were not reimbursed by the researcher for time or inconvenience.

Benefits are positive values of the research, while risk refers to the possibility that the participants may be harmed during the research process. As in most aspects of daily life, all research involves a certain amount of risk (Brink *et al*.,2016:42). Direct benefits to participants are only applicable in studies where participants receive specific therapeutic interventions. There was no intervention in the current study, and therefore, participants did not receive any direct benefits.

Significant benefits included the following:

- An increase in knowledge about health care practices regarding nurses' performance of patient advocacy.

- An improvement in the participants' understanding of health care delivery and nurses' perceptions regarding their role as patients' advocates.
- The enhancement of the participants' self-esteem, as nurses learn and understand what advocacy entails and what guiding principles there are to use as they advocate for patients, thereby enhancing self-esteem.
- Improved assessment of health needs of vulnerable patients who need advocacy.

Table 5: Direct and indirect benefits of the study

DIRECT BENEFITS FOR PARTICIPANTS:	INDIRECT BENEFITS FOR SOCIETY AT LARGE OR THE RESEARCHERS/INSTITUTIONS:
There are no direct benefits as there is no therapeutic intervention.	**Patient care** It will improve because nurses will be able to understand that all patients are vulnerable when they are in hospital and that they all need advocacy (Negarandeh *et al.,* 2008:457). **Self-esteem** Participants will discuss the factors which have influenced them to advocate for patients. This will allow them to explore ways to improve this role, thereby improving their self-esteem and interpersonal relations with other health care providers; they would know how to approach issues regarding patients and assume the role of a patient advocate.
	Role clarity Nurses who understand their role as patient advocates can perform this role within the multidisciplinary health team more efficiently and effectively, not as subordinates to other health care providers.

Source: Department of Health (South Africa), 2015:16.

Tables 4 and 5 indicate that there are more benefits than risks.

1.9.5. Vulnerability of patients

There were no vulnerable participants as all were adult professional nurses with at least two years' experience at the participating hospitals.

1.9.6. Respect for participants

Section 12(2) of the Bill of Rights in the South Africa Constitution (South Africa, 1996) protects against research abuse by providing that:

"Everyone has the right to bodily and psychological integrity, which includes the right: (a) to make decisions concerning reproduction; (b) to security in and control over their body; and (c) not to be subjected to medical or scientific experiments without their informed consent, (Department of Health [South Africa], 2015:6)".

All participants were treated with respect and courtesy. Permission was asked from participants concerning participation and publication of the research findings.

1.9.6.1. Privacy and confidentiality.

Privacy is concerned with who has access to participants' personal information during data-collection, and 'confidentiality' ensures that appropriate measures are implemented to prevent disclosure of information that might identify the participant (inadvertently or not) either during the research or afterwards. The Protection of Personal Information Act, 4 of 2013 (Bangani & Moyo, 2019:3-4), has increased the need to ensure computer safety, locked record storage facilities, and careful gatekeeping about access to raw data, including completed informed consent documents.

Complete confidentiality could not be guaranteed as it depended on everybody's cooperation; only shared confidentiality is possible. Participants were urged to keep the information they became aware of during the study confidential. Instead of the actual names of the participants, pseudonyms were used during the focus groups. A voice recorder and a cell phone as backup were used for data collection. Participants were ensured that confidentiality would be maintained by deleting recordings from the device immediately after they had been transferred to a password-protected computer. After that, only the transcriber who had signed a confidentiality agreement was able to hear it. This procedure prevented any unauthorised person from having access to the recordings. During data analysis, the transcriptions were shared with the co-coder in a password-protected folder. The co-coder was instructed to delete all information after data analysis had been completed.

All paper documents (informed consent forms) were stored in a locked cupboard in the locked office of the director of NuMIQ for five years. All the printed and electronic documentation, such as consent forms and transcripts of the interviews, were kept securely (DOH, 2015:22). After the research had been finalised, the electronic documents (transcriptions and analysis documents) would first be saved on an external storage drive and then deleted from all computers. The external device was stored with the paper documents for five years.

Confidentiality agreements were entered into by the mediator, transcriber, and co-coder.

1.9.6.2. Anonymity

Anonymity means namelessness. Anonymity cannot be maintained in a focus group, as participants were known to each other. For the participant's anonymity to be maintained when data is interpreted and analysed, codes were used instead of names. The process of ensuring anonymity refers to the researcher's act of keeping the participant's identities a secret concerning their participation in the research study. Even the researcher should not link any participant and hospitals to specific findings. The researcher assured participants about safeguarding their identities when the results of the research study were published.

As focus group interviews were used, participants were made aware that absolute anonymity would not be possible as they know each other. However, the researcher processed the data anonymously (Brink *et al.*, 2016:37), and the hospitals and participants' names do not appear in the research report as only codes were used.

1.10 EXPERIENCE, SKILLS, AND COMPETENCY OF THE RESEARCHER

Researchers must be suitably qualified and technically competent to carry out the proposed research. The principal investigator (PI) or research leader has the primary responsibility to ensure participants' safety and well-being, the scientific integrity of the protocol and is responsible for the implementation of that protocol. Competence was demonstrated mainly by academic qualifications, credentials, scientific and technical competence. Competence includes research competence, which is assessed in terms of education, knowledge, certification, and experience. In addition, researchers should produce evidence of appropriate research ethics training within the previous three years.

The student researcher has undergone ethics training and has passed the required ethics assessment to be able to apply and conform to ethical considerations for the duration of the research process. The researcher has also undergone additional training to conduct focus group interviews before conducting the focus group interviews. Qualifications and relevant experience

of the supervisor/principal investigator were considered as the researcher is supervised by an experienced researcher with a doctoral qualification in nursing.

1.11 DATA MANAGEMENT

The following key areas were addressed to maintain the confidentiality of the research data:

1. Personal information and identifying essential information were captured on a datasheet. The master list of the participants' details was kept in a locked-up place away from the data. Informed consent forms were not being stapled to data collection sheets.

2. Access to confidential information was limited to those who were directly involved with the research, which was: the researcher, the supervisor, and the co-coder. No information was shared with a person who is not officially and directly involved in the research. Participants also had to agree to keep shared information from the focus group interview confidential.

3. All printed copies of data were safely and securely stored in a locked cabinet.

4. Data were anonymised and stored on a computer that was password protected (Botma *et al.*, 2015:18).

5. An audio recorder and cell phone recordings were deleted as soon as it was saved on a password-protected computer. Data captured from the participants was only shared for analysis.

1.12 DISSEMINATION OF RESEARCH RESULTS

Dissemination of research results is the communication phase or the phase of writing the research report and is done not only for publication but also for knowledge translation (Brink *et al*., 2016: 53). Dissemination will be done to academia, the institutions where the research was done, and the participants.

1.12.1. Dissemination to academia

Dissemination to academia will be done in the following way:

An article will be submitted to a peer-reviewed journal with the assistance of and under the guidance of the study's supervisor. The article will communicate each step of the study process

and will indicate the findings. The researcher will ensure compliance with the publisher's policies, and corrections will be made according to the journal's policies.

The results will also be presented at a suitable conference, addressing the improvement of quality patient care (Brink *et al*., 2016:58).

1.12.2. Dissemination to institutions

A research report will be sent to all the institutions that were involved in the research to inform them about the outcome of the study. The hospitals' chief executive officers and deputy directors of nursing who have given goodwill permission for the researcher to access the hospital will receive the reports.

1.12.3. Dissemination to participants

As some participants may not have access to platforms in which the findings will be published, a presentation of the results will be done during the provincial Department of Health research day, where nurses are usually gathered in large numbers, or at mass nursing meetings commonly held at hospitals. The researcher will request permission to do the presentation to disseminate findings to participants. The findings of the research could also be communicated to participants from the reports sent to the institutions and read out during patient hand-over in the wards when shifts change.

1.13 CONFLICT OF INTEREST

Quote "Conflict of interest represents circumstances in which professional judgements or actions regarding a primary interest, such as the responsibilities of a researcher, may be at risk of being unduly influenced by a secondary interest, such as financial gain or career advancement. The secondary interest may be financial or non-financial, and the resultant bias may be conscious or unconscious. The presence of a conflict of interest poses a problem for the professional, patient, and public trust in research and the research enterprise (Romain, 2015:122)". The researcher stands to gain no benefit, either financially or physically, from the research process; there is no funding that has been made available towards the research project itself that could influence the research process or findings. The researcher received a grant from her employer for this study, but it did not affect the research findings.

1.14 EXECUTIVE SUMMARY

In this chapter, the researcher presented the overview and introduction for the study on" Factors influencing nurses' advocacy role for patients in level two public hospitals in the North West Province of South Africa". The background and problem statement were discussed, the research question, aims, and objective were identified, the research design, method, and analysis were described, and the applicable trustworthiness and ethical considerations were highlighted. The objective was to explore and describe factors that influence nurses' performance of their patient advocacy roles at level-two public hospitals in the North West Province. The study followed a descriptive qualitative design. Participants were selected through purposive sampling, and data were collected in focus groups with professional nurses. Thematic analysis was used for data analysis.

CHAPTER 2:
LITERATURE REVIEW OF FACTORS INFLUENCING NURSING ADVOCACY

2.1 INTRODUCTION

In this chapter, the researcher will provide an overview of what is known about nursing advocacy within the South African context.

Patient advocacy is central to nursing's professional identity. It is an obligation expected to be fulfilled by nurses while discharging their professional duties. Some patients' inabilities to make suitable choices, defend their rights, and lack adequate knowledge to make informed decisions about their medical intervention, especially in developing countries, has increased the need for patient advocacy (Water *et al*., 2016:1).

Burns and Grove (2009:93) state that a literature review is an organized written presentation of what has been published on a topic by scholars. A literature review is a survey of scholarly sources on a specific topic. It provides an overview of current knowledge, allowing a researcher to identify relevant theories and gaps in the existing research.

2.2 METHOD FOR LITERATURE REVIEW

For this literature review, the researcher employed a systematic approach (Moher *et al*., 2009) to do a scoping review of relevant evidence to explore the phenomenon of the role of a nurse as an advocate for patients in a hospital setting.

The researcher performed a scoping review and not a systematic review because a scoping study tends to address broader topics where many different study designs might be applicable. Further, a systematic review aims to provide answers to questions from a relatively narrow range of quality assessed studies. In contrast, a scoping study is less likely to seek to address specific research questions or evaluate the quality of included studies (Arksey & O'Malley, 2005:20). A scoping review aims to map the key concepts underpinning the research area, the main sources, and the types of evidence available (Arksey & O'Malley, 2005:21). For this literature review, the researcher reviewed the concept of patient advocacy, with sub-headings of the ethical considerations of the nurse as a patient advocate and evidence on aspects such as attributes of a nurse as an advocate and ethics regarding nursing advocacy.

The scoping review required a search from four databases/search engines. The 'advanced search' option was used on the following search engines: EBSCO Host, Sabinet, PubMed, and Scopus. The following keywords were used: Nursing, nurse, nursing advocacy, advocate, South Africa. The search was guided by search words such as nurse*, advocacy, patient. The researcher conducted the search with the assistance of a qualified and experienced librarian. The databases were searched for 'English-language articles' only, as translating articles from a foreign language to English was not possible for a master's study with limited time and funds (Arksey & O'Malley, 2005:24).

An assessment for each of the searched records was conducted. Duplicate records found on more than one of the database searches were removed. Research records were then screened by reading the title to exclude those that did not address the research concepts (Sundqvist *et al*., 2016:423).

For the papers on which a decision regarding the relevancy could not be made based on the abstract, a full-text copy was downloaded. After reading the full-text document, a decision was made on its relevance for inclusion in the review (Arksey & O'Malley, 2005:26).

The next stage of work involved noting key items of information obtained from the primary research reports under review (Arksey & O'Malley, 2005:26)

2.3 THE CONCEPT OF NURSING ADVOCACY

The concept of nursing advocacy will be discussed as applicable in general and in nursing care to see the distinguished application of the concept.

2.3.1. Advocacy in general

The concept of patient advocacy is still poorly understood and not conceptualised (Abbasinia et al., 2020:141). In English, the word 'advocacy' has several meanings. One meaning is the act or process of supporting a cause or proposal: the act or process of advocating (Merriam-Webster Inc., 2016:np). Another meaning is to publicly support an idea, plan, or way of doing something (Oxford dictionary, 2020: np). Advocacy can also be the profession or work of a legal advocate (Abbasinah *et al*., 2020:142; Stevenson & Soanes, 2020:np)

Advocacy consists of acting on behalf of a person or supporting an individual or group to gain what they need. Advocacy can also involve influencing service delivery to enhance services for a client, group, or community (Kalaitzidis & Jewell, 2020:70). From this, the researcher deduced that this definition has an underlining understanding that advocacy means to represent a person,

to be vocal on behalf of a person who requires such representation. Sundqvist *et al*. (2016;422) support the Oxford dictionary (2020:np) that defines advocacy as the act of one person pleading or arguing on someone else's behalf. The researcher supports this definition as nurses plead on behalf of patients in their care.

2.3.2. Advocacy in nursing care

Mosby's medical, nursing and allied health dictionary (Harris & Nagy, 2014:49) defines advocacy as different from ordinary English usage. According to this dictionary, advocacy is a process whereby a nurse provides information to a patient to be able to make certain decisions (Harris & Nagy, 2006:49) rather than speaking on behalf of a patient and pleading with the patient's case (Merriam-Webster Inc., 2016:np). In nursing, the concept of patient advocacy has been defined as an advocacy role that the nurse has to assume when attending to a patient. The role of an advocate is a fundamental concept for the profession of nursing as it ensures the patients' rights and their safety (Mortell, 2018:17). Nursing advocacy is a relatively modern idea as the initial conception developed from the patient advocate movement of the 1970s. Its importance and prominence are reflected by its inclusion by various nursing bodies into their codes of ethics. Despite this, opinion is polarised regarding the nature and extent of nursing advocacy (Graham, 2012:15, Nsiah *et al.*, 2019:1125).

Several empirical studies have examined the concept of patient advocacy from patients' and nurses' perspectives about the characteristics of a nurse as a patient advocate. The attributes are empowerment of the client, informing, valuing, and respecting, protecting, continuity of care, follow-up, empathy with patients, counselling, responding, shielding, and whistleblowing (Abbasinah & Ahmadi, 2019:2). According to Abbasinia (2020:5), the concept of patient advocacy in nursing has evolved, contributing to the perception that nursing advocacy is undefined and confusing. Table 8 presents examples of definitions of studies before 2000 and those published between 2000 and 2016.

Table 6: The evolvement of the concept of nursing advocacy

EXAMPLES OF ADVOCACY PRACTICES UNTIL 2000	EXAMPLES OF ADVOCACY PRACTICES 2001-2016
Track medical errors. Protecting patients from incompetency or misconduct of co-workers and other members of the health care team.	Maintain patient privacy. Confronting inappropriate rules and policies in the health care system. Identifying and correcting inequalities in the delivery of health service.

EXAMPLES OF ADVOCACY PRACTICES UNTIL 2000	EXAMPLES OF ADVOCACY PRACTICES 2001-2016
Providing information about the patient's diagnosis, treatment, and prognosis.	
Suggesting alternatives of healthcare options. Providing information about the discharge programme. Enabling patients to make decisions freely. Maintaining individualisation and humanity. Acting in a patient's values, culture, beliefs, and preferences. Liaison between patients, families, and healthcare providers. Being the patient's voice. Communicate patient's preferences and cultural values to members of the healthcare team. Promoting self-control.	

Source: Abbasinia, 2020:5.

The researcher came to an understanding that, although the concept has evolved, it remains clear that there are several definitions and applications of this concept and that it depends on the context in which advocacy in nursing is applied. As seen in literature, several studies (Tomaschweski-Barlem *et al.*, 2016:2; Prasun, 2016:131, Kalaidtzidis & Jewell, 2020:81, Water *et al.,* 2016:697) described the concept of patient advocacy from the action of the nurses in a variety of contexts.

Holley *et al.* (2005:21) and Kalaidtzidis and Jewell (2020:81) applied patient advocacy to pain management. They argued that nurses' education provided insufficient knowledge and skills for a pain resource nurse to act as a patient advocate. Negarandeh *et al.* (2008:22), Kalaidtzidis and Jewell (2020:81) as well as Seals (2007:24,29-36) reported that a nurse's role as a patient advocate was not supported by the hospital system, by legislation, or by a code of ethics, which in turn, affected how nurses understood the concept of nursing advocacy. Josse-Eklund *et al.* (2014:21;637-683), as well as Kalaidtzidis and Jewell (2020:81), perceive advocacy as protective,

bonding, knowing, and feeling empathy for the patient, leading to the conclusion that professional competency in clinical settings is connected to the nurses understanding and experience of their relationship with patients and patient needs. Furthermore, the researcher also believes that patient advocacy can be viewed as an activity defined by Abbasinah and Ahmadi (2019:2). Prasun (2016:131), Kalaidtzidis, and Jewell (2020:81) concur with this notion by indicating that one pleads another person's cause, thereby indicating that nurses need to be competent in their clinical skills to advocate for patients.

Toda *et al.* (2015:766) conducted a review on nursing advocacy in Japan and added to the definition of the concept ‘advocacy' when involving the patient’s autonomy. Since the concept of advocacy used to be uncommon in Japan, they used keywords related to patients' rights and found 483 nursing articles published in Japan from 1983 to 2012. The major themes that evolved were the following: (a) patients' decision-making ability, (b) behavioural restrictions, (c) informed consent, (d) respect for human rights, and (e) information transfer, which indicates that advocacy is not a role only played by the nurse, but it also involves patient empowerment.

The researcher considers that this concept can be applied to nursing from different perspectives. Providing a single definition for the concept of nursing advocacy is difficult, as it encompasses a lot of active 'doing' and being responsible for the lives of the patient one cares for.

2.4 ETHICAL CONSIDERATIONS OF THE NURSE'S ROLE AS A PATIENT ADVOCATE

Nursing advocacy is the ethical practice of representing a patient and family's needs and wishes to ensure that medical decision-making is in line with the client's wishes (Dadzie *et al*., 2016:2). This was noted in 2018 when Dadzie *et al*. (2018:1) investigated patients' advocacy and found that patient advocacy is an iterative process of analysing, counselling, and responding to patients' care and self-determination preferences. Abbasinia *&* Ahmadi (2020:2) state that advocacy is a key factor in enhancing positive patient health outcomes. It is regarded as one of the fundamental concepts of nursing ethics from the 1970s when the International Council of Nursing (ICN) introduced this concept in its professional codes. Subsequently, many nursing organisations such as the American Nurses Association (ANA), Nursing and Midwifery Council (NMC) of the United Kingdom, the Japanese Nursing Association (JNA), and Australian Nursing and Midwifery Council (ANMC) have included the role of "patient advocate" in their codes of ethics (Abbasinia & Ahmadi, 2020:2).

Furthermore, the term advocacy appears in the ICN Code of Ethics for nurses. The statement "advocacy for a safe and healthy environment” appears as the 15th item out of 42. This code item attributes the responsibility of a nurse as an advocate to the practice of individual nurses. Nurses

have a responsibility to uphold the ethical standards of the International Council of Nurses (ICN, 2016, Albina, 2016:75). Advocacy is seen by the International Council of Nurses (ICN) as central to nurses' contribution to the development of strong and resilient health care systems, thereby striving to achieve the United Nations Sustainable Development Goals (SDG) (ICN, 2016). To facilitate the achievement of the SDG, nurses need to facilitate care and advocacy for those who are vulnerable and at-risk (ICN, 2016; Water *et al*., 2016:696).

The meaning of advocacy and its relative importance in nursing practise is not consistent across professional organisations' codes, as is ascertained by comparing nursing associations' professional codes. In the United States, each state has a nursing board that clearly defines and strictly enforces legal and ethical responsibilities mandated for all nurses. Nurses are further obliged by the American Nursing Association to maintain high ethical standards of practice (ANA, 2010; Albina, 2016:75). The ANA emphasizes that the nurse's primary commitment is to the patient. The nurse promotes, advocates for, and strives to protect the patient's health, safety, and rights (ANA, 2010:151-152; Albina, 2016:75). The American public repeatedly rated nurses as the most ethical and honest of all the professionals (Albina, 2016: 74), indicating that society relies on nurses to advocate for patients and speak out in the face of wrongdoing (Albina, 2016: 74).

In addition to that, the ANA's code of ethics contains nine provisions and refers to advocacy in provisions 3 and 6. It uses the term in the major heading of provision 3.3 - the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient (ANA 2010:6). This provision focuses on patient confidentiality and the right to self-determination, but subsection 3.6 is about advocating for colleagues rather than patients. Nurses in all roles should advocate for colleagues whose job performance may be impaired (ANA 2010:7). Provision 6.3 includes the term advocacy twice about the health care environment. The code attributes this responsibility to the professional associations rather than to the practice of individual nurses (ANA 2010:26).

The Nursing and Midwifery Council (NMC) regulates practices throughout England, Wales, Scotland, Northern Ireland, and the Islands. Their code refers to the term advocate once, where it requires nurses and midwives to act as an advocate. The code states that" you must act as an advocate for those in your care, helping them access relevant health and social care, information and support" (NMC, 2008:3).

The nurse's role as a patient advocate is also clear from the Code of Ethics from the South African Nursing Council (SANC, 2015:4). The following principles of ethics apply:

- (Social) Justice – Nurses are at all times expected to act fairly and equitably where there is a competition of interests among parties, groups, or individuals. Such interests may be,

amongst others, related to access to healthcare resources, issues linked to prioritising care, or any situation that may be perceived or experienced as unequal. Nurses should, therefore, pursue justice and advocate on behalf of vulnerable and disadvantaged healthcare users and should be able to justify their decisions and actions.

- Non-maleficence – This requires a nurse to consciously refrain from harming patients, individuals, groups, and communities.

- Beneficence – Nurses are required to do good and to choose the "best option" of care under given circumstances, and act with kindness always. It gives expression to compliance with the "duty to care" as a professional practice imperative.

- Veracity – This principle requires the nurse to act with truthfulness and honesty and to ensure that the information provided to and on behalf of the healthcare user is always in the best interest of the healthcare user.

- Fidelity – This entails adherence to factual and truthful accounting and balancing that with respecting, protecting, and maintaining confidential information about the delivery of healthcare, including health records of healthcare users.

- Altruism – Nurses are at all times expected to show concern for the welfare and wellbeing of healthcare users. The nurses are to be mindful that the wishes and actions of healthcare users may conflict with the values and principles of the code, e.g., where healthcare users refuse treatment to the detriment of their health and that of others.

- Autonomy – Respect for the autonomy of eligible persons (healthcare users) to make their own decisions and choices in matters affecting their health.

- Caring – Nurses are required to demonstrate the art of nurturing by applying professional competencies and positive emotions that will benefit both the nurse and the healthcare user with inner harmony.

These principles must always be upheld by all nursing practitioners in South Africa in whatever role they fulfil as direct or indirect patient care providers, including, among others, educators, administrators, researchers, policy developers, and others, in any health setting whatsoever (SANC, 2015:4; McDermott–Levy *et al*., 2018:476).

The researcher deduced that advocacy remains an essential part of nursing practice. This is reinforced by the nursing codes of conduct and ethics and embedded in the competency standards for practice. As one of the largest health professional workforces, nurses have a key

role in supporting patients, families, and communities to achieve better health outcomes. This could be enhanced by advocating for partnerships between patients and health professionals, sharing information and promoting high-quality healthcare, promoting patients' interests and rights, and advocating for the mitigation of social justice issues that impact patients and health service delivery (Water *et al.,* 2016:705).

2.5 ATTRIBUTES OF NURSES AS PATIENT ADVOCATES

To clarify and refine this concept and arrive at its defining characteristics, Bu and Jezewski (2006:101) conducted an in-depth literature review. They found three core attributes of this concept in literature:

- nurses are acting on behalf of the patient,
- nurses are safeguarding patients, and
- nurses are championing social justice in the provision of health care (Bu & Jezewski, 2006:101).

Acting on behalf of the patient implies that nurses represent patients who are unable to represent themselves, such as those who are unconscious and debilitated and all other patients who cannot speak for themselves. Safeguarding patients entails actions that promote and respect patients' determination while championing the social justice of patients in the delivery of health care. It is all about nurses trying to ensure that they address inequalities in the delivery of health services.

According to Sundqvist (2016:423), there are three essential attributes: valuing, apprising, and interceding. Abbasinia and Ahmadi, (2020:1) and Sundqvist *et al*. (2016:423) expand on the attributes. They describe safeguarding as tracking medical errors and protecting patients from incompetency or misconduct from co-workers and other members of the health care team. They describe apprising as informing patients about their diagnosis, treatment, prognosis, suggesting alternatives to healthcare, and providing information about the discharge programme. These authors further indicate the importance of allowing patients to make decisions freely, maintaining patients privacy, acting in the patients value culture, beliefs and preferences, mediating, and championing social justice in the provision of health care (confronting inappropriate policies or rules (Abbasinia & Ahmadi, 2020:1; Sundqvist *et al*., 2016:423). Other attributes mentioned in the literature are empowerment, valuing, respecting, and protecting clients, continuity of care follow up, empathy with patients, counselling, responding, shielding, and whistleblowing.

Table 7: Attributes of nurses as patient advocates

Resources	**Attributes** Attributes are a feature or quality of a person or a thing; for this study, attributes are qualities of a nurse (van Rensburg *et al.,* 2019:41).
Bu and Jezewski (2006:101-110) identified three broad attributes of a nurse as an advocate.	1. Safeguarding patients' autonomy. 2. Acting on behalf of patients. 3. Championing social justice in the provision of health care. These three broad attributes occur explicitly or implicitly in advocacy literature.
Sundqvist *et al*. (2016:423) acknowledge that work that had been done by Bu and Jezewski when they identified the three core attributes of patient advocacy in their concept analysis.	These attributes are: 1. Safeguarding patients' autonomy. 2. Acting on behalf of patients. 3. Championing social justice in the provision of health care. Furthermore, Sundqvist *et al*. (2016:423) maintained the same argument from the early work of Baldwin (2003: 17) about nursing advocacy that it is positively influenced by nurses' attributes. Three attributes were identified by Baldwin (2003: 17): 2. Valuing 3. Appraising 4. Interceding Successful patient advocacy generates positive outcomes for nurses as it increases satisfaction, self-confidence, and self-esteem yielded by the implementation of their attributes.
Abbasinia et al. (2020:1) looked at the different definitions that were available in literature during the time of this research and found that there were many definitions,	These attributes are: 1. Empowerment of the client. 2. Informing. 3. Valuing and respecting. 4. Protecting. 5. Continuity of care.

but from those definitions, they were able to deduce and come to identify 11 attributes of a nurse.	6. 7. 8. 9. 10. 11.	Follow up. Empathy with patients. Counselling. Responding. Shielding. Whistleblowing.

2.6 NURSE TRAITS THAT INITIATE NURSES' ADVOCACY ROLE FOR PATIENT ADVOCACY

An attribute is defining as a quality, character, or characteristic ascribed to someone or something (Merriam-Webster Inc., 2021:np). It differs from a trait as it is defined as a distinguishing quality, an inherited characteristic (Merriam-Webster Inc., 2021:np). Koolen (2019:np) agrees with the latter statement that a personality trait is often ingrained. When thinking of traits, it could be outgoing, shy, gregarious, or introverted. An attribute is generally discussed in the context of specific behaviours learned as part of external experiences, e.g., a person is loyal, committed, or has strong integrity.

Patients have shown the following traits when in need of advocacy: powerlessness, helplessness, dependency, vulnerability, inability to speak, and loss of self-control (Hebert *et al*., 2011:325). Patients and their families trust that the nurse, who is caring, knowledgeable and skilled, will help them safely navigate the health care system to achieve better outcomes (Galuska, 2016:410).

Dadzie *et al*. (2017:1) found that the following traits can enhance nurses' advocacy role: being empathetic, nurturing, and compassionate, having the determination to help patients, and having good communication skills.

Empathy is the ability to put oneself in the place of other people to visualise and feel the experiences of others from the same perspective (Davoodvand *et al.,* 2016:4). A study conducted by Abbaszadeh *et al.* (2019:40) revealed that nurses in a hospital environment perceived empathy as understanding patients' conditions and have a psychological relationship with the individual patient. Furthermore, nurses view empathy as a process to gain knowledge to act as an advocate in the care they provide to individual patients. It is done for the physical, psychological, and emotional well-being of the patients and their condition. Nurses can be more empathetic if they better understand their patients' needs, improving the nurse-patient relationship (Davoodvand *et al.,* 2016:4).

Nurturing is another trait of a nurse advocate. In their nurturing role, nurses spend more time with patients and provide personal care, fostering closeness, which helps to identify patients' problems (Dadzie *et al*., 2017: 1). The role of a nurse advocate as a nurturer can occur in the context of connected relationships between the nurse and the patient (Dadzie *et al.*, 2017:1; Water *et al*. 2016:704).

Dadzie *et al*. (2017:1) established that helping patients navigate the health system was another nurses' advocacy trait that requires being assertive and persistent. The researcher concludes that the role of nurses as an advocate is capacitated by their traits and attributes. The researcher comes to an understanding that the traits of nurses as advocates serve as a basis for their nurturing and caring roles for all patients, and this ensures that, through advocacy, patients receive holistic care.

2.7 POSITIVE CONSEQUENCES OF PATIENT ADVOCACY.

Consequences are the outcomes or the results of a concept. Patient advocacy affects both nurses and patients, and the absence of advocacy has negative effects (Nsiah *et al.,* 2019:1124).

For patients, the positive consequences are improved patient safety and quality of care, development of a sense of self-determination and empowerment, improved collaboration among patients, families, and the healthcare team, improved access to health and social services, and an improved public health system (Nsiah *et al.,* 2019:1124). When nurses fulfil the role of an advocate at the individual, clinical, system, and societal levels, there are many benefits. At the individual level, as the nurse-patient relationship develops, trust is established. With trust comes the patient's expectation of competence, belief in the nurse's goodwill, and an acceptance of vulnerability along with some element of risk (Galuska, 2016:411, Bell & Duffy, 2009:46-41).

For nurses, the consequences of patient advocacy could be positive and negative. The positive effects for nurses are when they experience a sense of being worthwhile, having improved self-concept, job motivation, job satisfaction, and enhancement of the public image of nursing. However, the negative consequences are conflicts with other health team members, being labelled as a troublemaker, whistle-blower, and bad co-worker. Moreover, experiencing feelings of isolation and frustration, moral distress or dilemmas, quarrel with the organisation's authorities, receiving oral/written admonitions, and loss of one's job, reputation, and professional status may be the result (Abbasinia & Ahmadi, 2020:6). In addition, Nsiah *et al. (*2019) agree with Abbaszadeh *et al.* (2013) and Black (2011) when describing nursing advocacy as being the patient's voice as well as acting on behalf of a patient to ensure that their needs are met. This

illustrated that many nurses advocate for patients as it is advantageous for patient wellbeing and has a high possibility of increasing patients recovery rate

Furthermore, Tomaszewski-Barlem *et al.* (2016:3) elaborated on the possible harmful consequences for nurses advocating for their patients. Their study concluded that nurses advocate mainly through open and genuine dialogue, even with the risk of possible breakups in their professional relationships. They also found that nurses are often reported on their dialogue with patients to inform them about their rights to ensure their autonomy in decision-making. Patients are sometimes not sufficiently informed due to restrictive practices and policies of the institution. By opting for the truth and honesty in their relationships with patients, ensuring patient autonomy and minimising the possibility of moral distress, the advocacy action can negatively affect the relationship between management and nurses (Tomaschewski-Barlem *et al*., 2015:807.

2.8 CONCLUSION OF THE LITERATURE REVIEW

After this literature review, the researcher came to an understanding that there is evidence of factors that influence the nurse to advocate, but limited research has been done in South Africa. Nurses, as patient advocates, have the opportunity to make a significant difference in the lives of patients and their families (Prasun, 2016:1). Regardless of their work context, nurses should follow their codes of ethics, which direct them to respect human rights, ensure that each patient receives accurate and sufficient information, and demonstrate respectfulness, responsiveness, compassion, trustworthiness, and integrity (Sundqvist *et al*., 2016:432). From the literature search and review, the researcher concluded that there is still room for further research about nurses' patient advocacy role within a South African context.

The following chapter is presented as an article manuscript based on the study that will be submitted for publication.

CHAPTER 3: ARTICLE MANUSCRIPT: FACTORS INFLUENCING NURSES' ADVOCACY ROLE IN LEVEL-TWO PUBLIC HOSPITALS IN THE NORTH WEST PROVINCE

CHAPTER THREE OUTLINE

This chapter was written in accordance with the article format as stated in the NWU Manual for Masters and Doctoral studies concerning submitting a dissertation. The manuscript was written following the instructions for authors of Curationis (see ANNEXURE H).

A cover letter to accompany the manuscript at submission was prepared (ANNEXURE G), but the manuscript will only be submitted after examination of the dissertation.

As the article manuscript must be understood as a stand-alone document when published, there is some repetition – in some instances, verbatim of what was written in chapters one and two. The style of the references differs from the rest of the document as it was done according to the authors' guidelines for Curationis (ANNEXURE H).

COVER PAGE

Title: Factors influencing nurses' advocacy role in level-two public hospitals in the North West Province

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ABSTRACT

Background

Nursing advocacy has been a topic of much discussion in the nursing literature for several decades. This study seeks to explore and describe factors that influence the nurses' advocacy role within a South African context.

Objective

The researcher was interested in contributing to quality patient care by empowering nurses in their advocacy roles by objectively exploring and describing factors influencing nurses' advocacy roles.

Method

A qualitative descriptive inquiry was conducted using focus group interviews with professional nurses as participants who were purposefully recruited. Interviews were conducted in all the level-two hospitals in the North West Province. The data were thematically analysed using Creswell's eight steps of data analysis to identify common themes.

Results

Three main themes were identified, namely: managerial and environmental factors such as lack of management support and nurses' lack of training negatively influence the advocacy role of nurses, personal factors such as empathy, sympathy, and assertiveness positively influenced the nurse's advocacy role and lastly patient-related factors such as compromised patients' rights, autonomy, religious and cultural beliefs affecting the nurses' advocacy role either negatively or positively. A unique finding of the study was that language differences could influence nurses to advocate for patients.

Conclusion

Overall, several factors can influence the nurse either positively or negatively when advocating for patients. Nurses need to be empowered in their nursing advocacy role to provide quality patient care within a public hospital setting to advocate for their patients.

KEYWORDS:

Advocate

Advocacy

Nursing advocacy

Patient advocate

Nursing

Nurse

South Africa.

MANUSCRIPT: FACTORS INFLUENCING NURSES' ADVOCACY ROLE IN LEVEL-TWO PUBLIC HOSPITALS IN THE NORTH WEST PROVINCE

INTRODUCTION

Patient advocacy has been a topic of much discussion in the nursing literature for several decades. Advocacy is a key nursing role, yet diverse definitions exist (Negarandeh, Oskouie, Ahmadi & Nikravesh, 2008:45). Nursing advocacy has become a subject of interest to the researcher, who aimed to explore the factors influencing nurses to advocate for patients in level-two public hospitals in the North West Province.

Schwartz (2002:37) wrote about nursing advocacy and indicated that it remains unclear what patient advocacy entails and what values it ought to embody. The concept of advocacy by a nurse on behalf of patients appears to have gained widespread acceptance in the western world (Breeding, 2002:110). Within an African context, patient advocacy has been identified as a core duty of the nurse (Dadzie, Aziato & Aikins, 2017:1). Advocacy has become an almost universal catchword among nurses indicating that this concept has been legitimised within various nursing ethical codes (Breeding, 2002:110). Over the past four decades, patient advocacy has become central to nursing's professional identity (International Council of Nurses [ICN] 2016:np). An interesting contention is maintained by Water, Ford, Spence, and Rasmussen (2016:697) that patient advocacy has situated its rise to prominence within nursing as part of a series of profound changes that occurred in Western society/culture.

Advocacy is usually employed by someone powerful on behalf of someone who has less or no power (Negarandeh *et al.,* 2006:2). The core condition that demands advocacy action is the clients' vulnerability, in terms of personal vulnerability because of illness and vulnerability to risks inherent in the institutional process to which clients are exposed in the health care system. Feelings of powerlessness because of limited knowledge about health care or experiences of being neglected in the health care system can increase a patient's vulnerability (Negarandeh *et al.,* 2008:457). Hanks (2008:469) adds that the client, who is the patient, exhibits characteristics that stimulate the nurse to advocate at any given point.

Studies in an African context show possible reasons for inadequate advocacy. The study of Dadzie *et al.* (2017:2) from Ghana indicated that nurses are overworked and may lack the energy and time to advocate for patients due to the staff shortage. Other factors such as poor remuneration and lack of resources at work and their low level of participation in decision-making could also lead to frustration. Nurses may also lose compassion and find it challenging to advocate for patients who may show ingratitude. It was necessary to do a study in the South

African context, which will illustrate factors influencing nurses' advocacy role for patients for this study; the focus was on factors that influence nurses to advocate for their patients in level two public hospitals in the North West Province.

For this study, the researcher considered the Bu and Jezewsky (2006:101) advocacy model adapted by Dadzie *et al*. (2017:2) (see Figure 1). This model is relevant to the current study as it addresses patient advocacy and understanding this role in general. The mid-range theory developed by Bu and Jezewsky (2006:101) maintains that patient advocacy consists of three core attributes: safeguarding patient's autonomy (SPA), acting on behalf of patients (ABP), and championing social justice (CSJ) in the provision of health care.

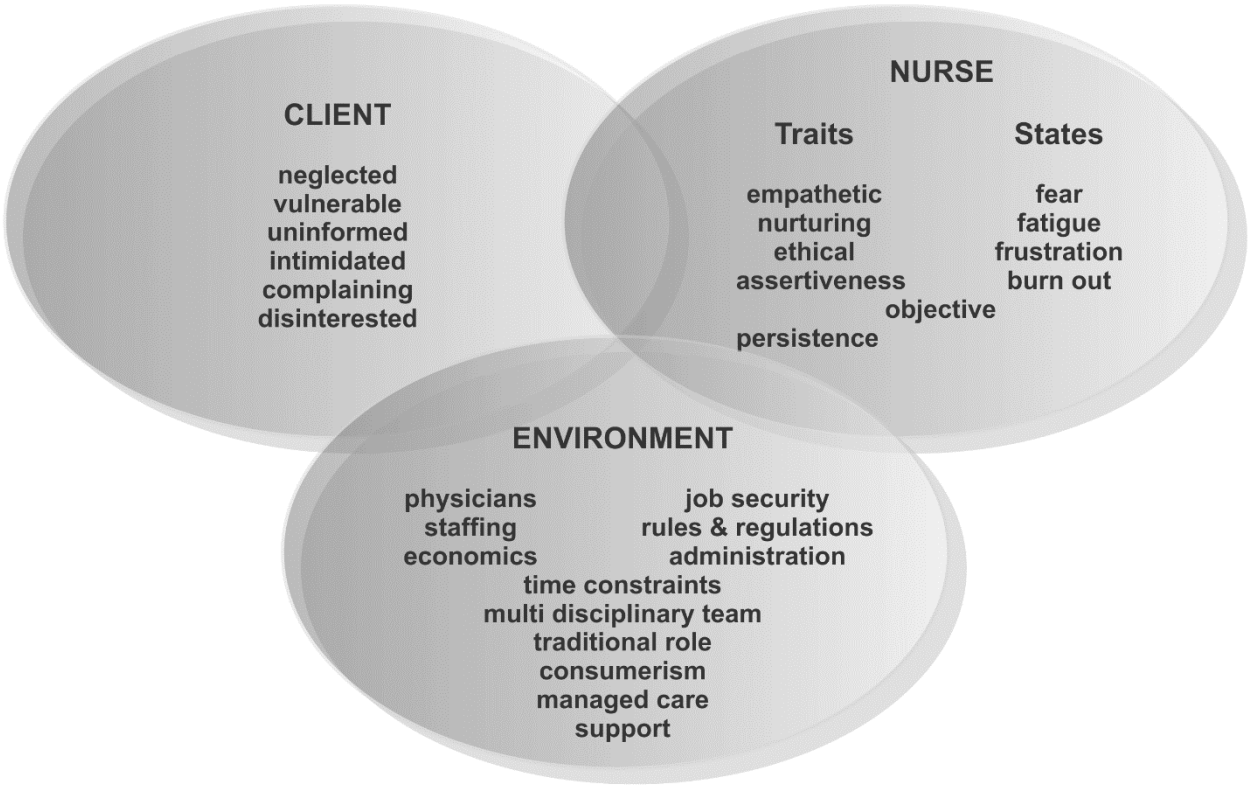

Fig: 1. Conceptual model of advocacy categories and interaction.

Source: Dadzie *et al.*, (2017:2)

AIM AND OBJECTIVE OF THE STUDY.

This study aims to contribute towards the promotion of nursing advocacy by exploring and describing factors that influence nurses' performance of their patient advocacy roles.

To reach the aim, the following objective was formulated:

To explore and describe factors that influence nurses' performance of their patient advocacy roles at level-two public hospitals in the North West Province.

RESEARCH METHOD AND DESIGN

A descriptive qualitative research design was used to answer the research question and understand the phenomenon within its specific context (Negarandeh *et al*., 2008:549; Sandelowski, 2010:79). A descriptive design is used when little is known about the topic (Botma, Greef, Molaudzi & Wright, 2015:110).

The setting of the study/ study context

The study was carried out at the four level-two public hospitals in the North West Province. The participating hospitals were Klerksdorp/Tshepong Hospital complex, Joe-Morolong Hospital, Job Shimankane-Tabane Hospital, and Mafikeng Provincial Hospital. Klerksdorp/Tshepong hospital had two complexes, the initial plan considered using only one complex from that hospital. However, the second complex was later included to obtain data saturation.

Study population and sampling

The target population was the professional nurses who worked in level-two public hospitals in the North West Province.

A multi-level sampling technique was used in this study – for hospital wards and individual participants. Hospital wards were randomly selected. For this study, the researcher adopted both probability and non-probability sampling methods (Brink, Van der Walt & Van Rensburg, 2016:139).

The participants for the focus groups were purposively sampled from the selected wards according to specific inclusion criteria (Botma *et al*., 2015:127; Brink *et al.,* 2016:126). The final sample size (N:34) was five focus groups with a total of thirty-four participants.

The following inclusion and exclusion criteria were applied

Inclusion criteria

(1). Registered as a professional nurse with the South African Nursing Council.

(2). Professional nurses with two years or more of full-time experience because such nurses have established social and work relations with other multidisciplinary health team members and have been exposed to patients who need advocacy.

(3). Professional nurses who work on shifts as these are the nurses who interact with different workgroups and have contact with patients during weekends where most members of the management are not available, and they need to take responsibility for decision making and patients' advocacy.

Exclusion criteria

(1). Nurses who have just graduated and are doing community service or on probation were not included because they rotate around the various units in the hospitals as part of their community service and do not have prolonged encounters with patients.

Each focus group consisted of six to eight participants varying from one hospital to the other. Initially, four focus groups were conducted, and a fifth one was used to ensure data saturation. Data saturation means that no new or relevant data emerged (Botma *et al*., 2015:200).

Data collection

Participants for the focus groups were recruited from the randomly selected wards. At least one semi-structured focus group was planned at each hospital. Data-saturation occurred when the researcher became very familiar with the settings, routine, or data being collected, perhaps even feeling bored and if one has heard it all (Botma *et al*., 2015:200). A leaflet was used to recruit participants who fit the criteria. The language used in the brochure was simple, written in English, and at the level of potential participants' level of understanding (Botma *et al*., 201514).

An interview schedule was used as a data collection instrument. There were six questions in total, with the first question an introductory question. Participants gave their biographical information data with this first question. Open-ended questions based on the interview schedule by Hanks (2008:471) were used. The first question was to obtain biographic information such as the participants' age, sex, years of nursing experience, and educational qualifications. From the second question, the researcher asked five main questions with supporting questions. Data were collected using a voice recorder and a cell phone with a voice recording application during the focus group interview.

Data analysis

The researcher followed Creswell's (2014:209) thematic method of data analysis and Tesch's eight steps to identify common codes to arrive at themes. The researcher interpreted data using thematic surveys by grouping information into themes as the study followed a qualitative descriptive design (Creswell, 2014:198, Sandelowski, 2010:79).

The 1st step was to prepare and organise the data for analysis which involved transcribing the interview. The process began by organising and preparing the data for analysis. Organising the data involved transcribing the interview voice recorder and cell phone recorded data, then transferred to a password-protected computer (Botma *et al*., 2015:214, Polit & Beck, 2008:509). The 2nd step was to develop a general sense of the data by reading through the data. The 3rd step was to code the data. Coding is organising the material into chunks or segments of text before bringing meaning to the information (Botma *et al*., 2015:225, Creswell, 2014:198). The 4th step was to describe and identify the themes by using the coding process to generate a description of the setting or people as well as themes from the categories. The researcher checked the reliability of the coding by having a co-coder encode the data and check for agreement (Botma *et al.,* 2015:193-194, 225). Instructions were given to the co-coder to follow the coding process described by Creswell, which incorporates the eight steps of data coding (Botma *et al.,* 2015:224). The 5th step entailed representing the findings which included a detailed discussion with the co-coder about the several themes identified and reaching consensus (Creswell, 2014:198). The 6th step was data interpretation of the meaning of the data (Creswell, 2014: 186).

RIGOUR

Rigour in a qualitative study deals with trustworthiness or measures put in place to ensure the quality of the research (Creswell, 2014). The authors employed measures to ensure credibility through the purposeful selection of study participants, member checking, and peer review (Creswell, 2014; Polit & Beck, 2008:509). Confirmability and transferability were also ensured.

ETHICAL CONSIDERATIONS

The researcher accepted the responsibility of high-quality, ethical research by complying with ethical principles laid down by Brink *et al*. (2016:30-43) and DoH (2015:12). Ethical rules of Section 72 of the National Health Act, 61 of 2003 (NHA), the National Health Research Ethics Council (NHREC). Ethical rules of Section 72 of the National Health Act, 61 of 2003 (NHA), the National Health Research Ethics Council (NHREC), were also followed. The Health Research Ethics Committee (HREC) of the North-West University gave legal authorisation for the research to be conducted (Ethics approval: NWU-00432-19-S1) (see ANNEXURE A). After ethics approval from the HREC, the researcher received official permission to gain access to hospital facilities from the Department of Health of the North West Province.

The Protection of Personal Information Act, 4 of 2013 (Bangani & Moyo, 2019:3-4) has increased the need to ensure computer safety, locked record storage facilities, and careful gatekeeping of access to raw data, including completed informed consent documents. Pseudo names were used instead of the actual names of the participants.

After the research was finalised, the electronic documents (transcriptions and analysed documents) and the scanned completed informed consent forms were first saved on an external storage drive. The external drive will be stored in a locked cupboard in the locked office of the director of NuMIQ for five years, after which it will be destroyed.

RESULTS

The interview schedule consisted of six questions.

The first question was an introductory question to gather biographic data, with the core questions (no. 2-6) asked as broad questions based on the interview schedule of Hanks (2008:471).

See Table 1 for the demographic data of the participants.

Table 1: Participants demographical information

DEMOGRAPHIC ASPECT	FOCUS GROUP 1	FOCUS GROUP 2	FOCUS GROUP 3	FOCUS GROUP 4	FOCUS GROUP 5
Number of participants	**7**	**7**	**7**	**6**	**7**
Age					
20-29 years	-	-	-	1	-
30-39 years	1	2	-7	-	1
40-49 years	4	2	-	4	2
50-59 years	2	3	-	1	4
Gender					
Male:	-	1	1	1	-
Female	7	6	6	5	7
Qualifications					
Diploma	7	7	7	4	7
Degree	-	1	-	2	-
ICU Speciality	1	1	1	-	-
Nephrology trained.	4	-	-	1	2
Advanced Midwifery	-	-	-	-	-
Occupational health and safety	-	-	-	-	-
training.	-	-	-	-	-
Trauma trained	-	-	1	-	-
Nursing degree in Education and management	-	2	-	1	-
Population group:					
White:	-	-	-	-	-
African:	4	7	7	6	7
Coloured:	3	-	-	-	-
Years of experience:					
2-5 years	1	4	5	1	-
6-10 years	2	2	2	2	3
11-15 years	3	-	-	2	3

DEMOGRAPHIC ASPECT	FOCUS GROUP 1	FOCUS GROUP 2	FOCUS GROUP 3	FOCUS GROUP 4	FOCUS GROUP 5
16 years and above	1	1	-	1	1

From this demographics information about the five focus groups with 34 participants in total, three participants were specialised in Intensive Care Unit (ICU) patient care, seven had Nephrology nursing as a speciality, one participant was specialised in Trauma Critical Care Nursing while three had a post-basic degree in Nursing Education and Management. Focus groups 1, 4 and 5 had participants with more years of experience than focus groups 2 and 3.

The findings were synthesised into three main themes, each with subthemes.

Table 2: Themes and subthemes

Themes	Subthemes
Theme 1: Managerial and environmental factors can negatively influence the advocacy role of nurses.	*Subtheme 1:* Lack of management support negatively influences nurses' advocacy role. *Subtheme 2:* The power imbalance between nurses and doctors negatively influences their advocacy role for patients. *Subtheme 3:* Lack of development opportunities and training negatively impacts nurses' ability to advocate for patients. *Subtheme 4*: Staff shortage and being overworked impact negatively on the nurses' role as an advocate.

Themes	Subthemes
Theme 2: Personal factors can have a positive influence on the advocacy role of nurses.	*Subtheme 1:* Nurses feel a sense of responsibility towards their patients and their health care, which positively influenced their nursing role as advocates. *Subtheme 2:* Assertiveness influences the nurses' ability to assume their advocacy role. *Subtheme 3:* Applicable knowledge and empowerment have a positive influence on nurses' advocacy role. *Subtheme 4:* Personal Traits of nurses influence nurses to advocate for their patients.
Theme 3: Patient-related factors influence the nurses' role as an advocate.	*Subtheme1*: Patients' vulnerability stimulates the nurses' advocacy role. *Subtheme 2*: Patients' characteristics can negatively influence the nurses' advocacy role.

Quotations are marked according to the focus group in which the contribution was made as well as the number of the participant that said it; for example, in Focus group 1, participant number 5 will be 1:5

Theme 1: Managerial and environmental factors can negatively influence the advocacy role of nurses

Nurses face a range of managerial and environmental barriers when practising patient advocacy. The factors included lack of support from management and other health care providers that may negatively affect nurses' advocacy role.

Subtheme 1*:* Lack of management support negatively influences nurses' advocacy role.

Below is a participant's response about the lack of management support for professional nurses when assuming their role as patients' advocates:

> 1:3 "*and then you see the Managers coming down to you, but when we complain about the doctors, as nurses, it's not taken seriously. So, the same attitude of the doctors together with their clinical Managers and the nursing management, they are more on the side of the doctors than the side of the nurses, so we end up not wanting to push serious matters because we know that we're going to be victimised and stigmatised and say…"*

You see that sister, she's always the problem in the unit" because you always stand up for the patients."

Studies conducted by Nsiah, Siakwa, and Ninnoni (2019:651) and early studies of Vaartio *et al*. (2006:22-292) revealed the absence of guidelines, fear of making mistakes, and its unknown consequences prohibited some nurses from advocating for patients. Furthermore, nurses were wrongfully labelled and vindicated by an employer, coupled with the possibility of losing one's job, which served as a barrier during patient advocacy. This finding was supported by Water, Ford, Spence, and Rasmussen (2016:702) when articulating that nurses find it challenging to act as patient advocates if the employing institution does not support patients' rights to participate in health decisions or recognise nurses' ethical responsibilities to speak up when witnessing infringements. The finding of this study about the lack of support for nurses by management to advocate for their patients effectively is supported by the literature.

Subtheme 2: The power imbalance between nurses and doctors negatively influences their advocacy role for patients.

Two participants indicated that their antagonistic relationship with doctors when assuming their role as patient advocates.

1:3: *There's the attitude of the doctors, like she said. Other doctors will tell you that…" I run the show".*

4:7: "…*and sometimes you become unpopular in the hospital. You become unpopular when they come in, when they introduce you, they say…" you know, this one is a sister, she'll fight you "…even with the Interns, they know that no, this one will fight the whole year. You, see*?"

Participants revealed that being a nurse and a patient advocate cause problems because the doctors do not like having their authority challenged and may not accept a nurse's perspective (Mortell, 2018:965).

Subtheme 3*:* Lack of development opportunities and training negatively impact their ability to advocate for patients.

This theme is about the nurses' limited knowledge of patients' conditions and approaching the advocacy process. Below are direct quotes from participants:

1:6:" lack of knowledge or incompetency or lack of teamwork between the colleagues. For example, let us say maybe I'm doing day duty, I make a mistake, you're coming night duty. Instead of correcting my mistake to protect the patient, you want to expose me."

3:5:" it's lack of competency because the organisations they're working like…err… they're taking us as work-forcers. Yeah…most of the time, they can…you can end up with five years without any training that is trying to uplift your experience."

The study of Davoodvand *et al*. (2016:5) indicated a lack of adequate knowledge as one of the reasons nurses are reluctant to take on an advocacy role, and this has also been evident in this study. Nurses will be better positioned to provide patient advocacy if they have specialised training and attend in-service training based on the latest research.

Subtheme 4: Staff shortage and being overworked impact negatively on the nurses' role as an advocate

Limited time was reported as a significant barrier to patient advocacy. Nurses expressed extreme frustration due to time constraints. This barrier prevents nurses from getting to know their patients well and decreasing their ability to speak on behalf of their specific interests and needs effectively. Participants from different focus groups mentioned limited time as a factor.

1:1:" I think it depends on the number of…it can be the number of staff in a unit. Number of staff…ratio-staff-patient…ratio of patient-staff. Uhm…if a unit is having 40 patients and there are only 3 or 4 nurses, it's difficult to advocate or to…yeah to advocate for each and every patient. Sometimes you miss some important information of the patient and not being able to advocate".

2:5:" I was also about to say that shortage… it's a huge problem that sometimes led us to not advocating for our patients."

Oliviera and Tariman (2017:10) conducted an integrative literature study and concluded that higher workloads limit nurses' time with their patients. In Davoodvand *et al*. (2016:5) study, participants committed themselves to advocate and protect their patients' rights regardless of factors such as staff shortage that negatively influenced their role as patient advocates. These nurses showed commitment to their work as nurse advocates and did not focus on factors influencing their role as advocates.

Theme 2: Personal factors can have a positive influence on the advocacy role of nurses.

The need for justice is one of the basic human needs (Johnstone, 2011:34-44). Nurses are in contact with patients and their problems; therefore, they can provide justice for the patients better than anyone else. Nurses are the first advocates for patients and link the patient and the health care system. Patient advocacy is one of the critical roles of the nurse (Davoodvand *et al*., 2016:2).

Subtheme 1: Nurses feel a sense of responsibility towards their patients and the patient's health care.

Nursing regulatory and professional organisations explicitly and implicitly include advocacy activities as part of their codes of conduct and ethics (Water *et al*., 2016:696), for example, the South African Nursing Council [SANC], 2015:2-7). The Code of Ethics for Nurses of the South African Nursing Council (South African Nursing Council [SANC], 2015:2-7) describes that nurses should respect human rights, ensure that an individual receives accurate, sufficient, and timely information. They should also meet the health and social needs and champion equity and social justice in access to healthcare resources. "Safe-guarding" and "apprising" are integral parts of patient advocacy. Obtaining health-related information and decision-making can be difficult for patients, and they need someone to advocate for them. Due to the long periods spent with the patients and the chance to build a relationship, nurses are in the best position to advocate for patients (Abbasinah & Ahmadi, 2019:142-147).

> *2:5:" I believe that everyone must be treated fairly and equally. Just imagine…or imagine yourself in that bed and you being treated in that kind of way? So…"*
>
> *5:1 from surgical ward in hospital number 5 expressed the following: "I've discovered that, especially in our specialty field, most of our patients are uninformed about their diagnosis, so that made me to be this advocate for them. And the other thing is that…uhh…when adding to Number 6's point of view…uhh…the language barrier makes patients to be afraid. They have this fear of the unknown, they have this fear of the doctors, where they simply shut down and keep quiet, and sometimes they way…how the doctors treat the patients, or how they treat the patients bring out that advocacy in me.*

Subtheme 2: Assertiveness influence the nurses' ability to assume their advocacy role

This subtheme describes assertiveness as a nursing trait which was also found in the study by Dadzie *et al.* (2017:4). A study conducted by Hanks (2008:469) found that the level of education attained by practising nurses influenced their perceived assertiveness, an attribute believed to be

linked to nursing advocacy competencies. These findings are relevant to the current study as it yields that nurses are more assertive to assume their role as advocates when trained and skilled in their day-to-day activities.

> 5:*1: "There are times where a nurse is supposed to be…should I say…assertive, stand to your point even though you might be labelled as arrogant if you are not submissive but if you know your guidelines, if you know your policies, then they can label you as being arrogant, but there are times where we're supposed…really supposed to be just assertive and say…" this is this"…and this is supposed to happen."*
>
> *4:7 "I'm very confident and assertive, so when something is not right, I confront…confront but in…not in a way that it will make someone to feel small, you see? I will come and say…" Doctor, you know, I see that you have ordered this treatment, but I have the guideline. See…maybe you have got your reasons of giving this treatment but check with the guideline, can't you check with this guideline?"…you know?"*

***Subtheme 3**:* Applicable knowledge and empowerment have a positive influence on nurses' advocacy role

Considering nurses' lack of knowledge about patient advocacy in nursing and its irreparable consequences, several authors recommend the necessity to train nurses on patient advocacy (Davoodvand *et al*., 2016:2; Barlem *et al*., 2015: 255-267; Josse-Eklund *et al*., 2014:673-683). The patient advocacy provided by nurses is based on their values and professional skills (Davoodvand *et al*., 2016:6).

> *2:3:" So it's a challenge for us, on us also as healthcare providers to advocate if you don't have enough information so we need to make sure that we gather more information so that we can be able to advocate, so when we advocate, we know what you're talking about. So, we need to have information at hand, that will help us a lot.*"

***Subtheme 4**:* Traits influence nurses to advocate for their patients.

Empathy is the ability to define the unique situation of others and is an inseparable part of the nurse-patient relationship (Davoodvand *et al*., 2016:5).

> *5:5:" Sympathy is one, where you feel like if I was in the same situation, I would like this to be done for me, so you would like to advocate for that…for the patient to be…for those things to be done for the patient".*

5:7." They trust us more than the doctors, and they've also realized that doctors just come for a few minutes, and then they leave, we are the people who spend most of the time with them".

Davoodvand *et al.* (2016:6) state that patient advocacy in nursing includes empathy as a nurse advocate. The researcher understood that traits such as trustworthiness, sympathy and empathy, to mention a few, play an important role in assuming the role of an advocate as a nurse.

Theme 3: Patient-related factors influence the nurses' role as an advocate.

From the study findings, participants indicated that there are patient-related factors that stimulate their role as nurse advocates.

Subtheme1: Patients' vulnerability stimulates the nurses' advocacy role.

Regarding patients with a lack of autonomy, participants stated that they have to stand up and represent patients.

P3:" I believe that as a nurse, I should be standing up for the patient who cannot stand up and say…" This is my right".

Concerning patients' vulnerability due to a language barrier, fear for interaction with other health care providers, and low social standing, this is what one participant had to say:

1:1: In our unit, I see most of our patients, they are intubated and ventilated, so they are not able to speak out for themselves or to talk, and mostly they are semi-conscious or unconscious. So being a nurse, nursing the patient, obviously, you should be the eyes of the patient…the mouth of the patient, the ears of the patient, you're doing everything for the patient. And being a nurse, spending most of the time with that patient, you have to do everything…to explain more to the doctors.

According to a statement by Water *et al.* (2016: 697), an increasing emphasis upon the primacy of individual autonomy and self-determination in Western cultures resulted in a greater focus upon the elucidation of individual rights in various domains, including health. This rights-based focus is fundamental to the need for patient advocacy as patient rights, particularly the right to self-determination, were seen to require active protection.

***Subtheme 2*:** Patients' characteristics can negatively influence the nurses' advocacy role.

With regards to religious beliefs of patients that hinder nursing advocacy, this is what participants had to say:

5:3: Religion. The religion also is hindering us to help the patient, for example, those who…especially when we come to transfusion, there are those who are religious and they don't want to be transfused, according to how they do they might not do it, I don't understand, but you know that if maybe that patient was not…after giving blood he'll be fine, but the patient and the family will resist. Religion also a big factor in the hospital."

A finding from a study conducted by Nsiah (2016:652) indicated that the respondents noted individual patients as hindrances to the advocacy process due to limited understanding of their conditions, superstitions, and ideologies. Some patients opted to pray rather than be referred for proper care in another health facility, which corresponds to this study findings.

DISCUSSION

This study described factors that influence nurses' advocacy role in level-two public hospitals in North West Province. The findings were grouped as three main themes with subthemes: managerial and environmental factors can negatively influence the advocacy role of nurses; personal factors can have a positive influence on the advocacy role of nurses, and patient-related factors influence the nurses' role as an advocate.

In the case of organisational-related factors, the first theme addressed managerial and environmental factors, including policies and authorities to support nurses in their role as patient advocates (Abbasinah *et al*., 2019:146). After Martell's (2018:967) study conducted in Iran and Singapore, the author declared that healthcare organisations must support nurses as patient advocates and condemned organisations that failed to endorse patient advocacy as patient safety may be compromised. They found that, for a patient advocate to function effectively, there must be an administrative policy and procedure that provide guidelines for the advocacy role. The researcher also believes that better working conditions will ensure nursing advocacy.

The second theme looked at nurses' related factors. Nurses care for vulnerable individuals who cannot defend their rights or may not know their rights and need help in this regard. Every human being has a right to treatment, access to health care, confidentiality, and privacy (Davoodvand *et al*., 2016:5; DoH, 2020:np). Davoodvand *et al.* (2016:5) argue that nurses should defend patients' rights. The right to be informed and participate in decision-making through nursing advocacy is a part of protecting patients from any harm.

The research sample used in this study represented various strata of nurses, including nurses from all age groups with a minimum of two years' experience, both genders, and different nursing specialities, allowing multiple viewpoints to be analysed. The research study yielded that nurses generally need specific individual characteristics for nursing advocacy. Abbasinah *et al*.

(2019:146) articulate that the required personal features are work motivation, professional commitment, independence, and self-confidence. According to Bu and Jezewski's (2006:101) midrange theory, patient advocacy is an essential component of the registered nurse's professional role. The philosophy of the nursing profession, nurses' educational background, and the unique position of nurses in the healthcare system mean that they should be able to advocate effectively for patients. The required professional features of this role include legal knowledge, professional knowledge and skills, adequate knowledge of the patients' needs, wishes and values, having the ability to interact appropriately with patients and other healthcare team members, and having the ability to participate in the healthcare policy decision-making (Abbasinah *et al*., 2019:146). The researcher supports the view of Hanks (2008:469) that the main aim of advocating is an integral component of nursing ethics whereby the nurse's actions support the autonomy (and other rights) of the patient. The researcher also agrees with Bu and Jezewski's (2006:101) midrange theory, which indicated that patient advocacy is an essential component of the registered nurse's professional role. As such, nurses should be continuously empowered through training to provide quality patient care by advocating for patients.

According to Abbasinah *et al.* (2019:146), nurses–related factors indicate that nurses should have individual and professional features to advocate for their patients. One of the professional features a nurse should have is to be competent in the role of advocacy; this competency can be obtained through education. Competency in patient advocacy can assist in gaining a patient's trust and impact the long-term nurse-patient therapeutic relationship. Further, Agom *et al.* (2015:3) suggest that nursing education would promote the role of advocacy, and this could be achieved by assigning nursing students during their clinical experience to take responsibility for becoming patient advocates. Hanks (2008: 468) found that the education attained by practising nurses influenced their perceived assertiveness, which can be linked to nursing advocacy competency. Training could be attained through in-service training or advancement in their careers to be clinically specialised to be better advocates without feeling inferior due to lack of knowledge.

The last theme addressed patient-related factors as some patients may not express their needs, wishes, and values due to impairments in consciousness or speech. Others have lost their independence or cannot make the decisions regarding their own lives due to illiteracy, socio-cultural weakness, or the lack of knowledge of health issues (Abbasinah *et al*., 2019:146; Oliviera & Tariman, 2017:8). Hospitalisation further separates patients from their family and friends and impairs their support network.

Some of the study's findings linked directly to the advocacy model by Bu and Jezewsky that maintains that patient advocacy consists of three core attributes: safeguarding patients' autonomy (SPA), acting on behalf of patients (ABP), and championing social justice (CSJ). All three of these

were present in the current study. Safeguarding patients' autonomy (SPA) was mostly seen as part of the third theme, where participants revealed that patients' vulnerability, such as lack of autonomy, language barriers, fear for interaction with other health care providers and low social standing, stimulated the nurses' advocacy role. The second attribute of Bu and Jezewsky (2006:101) theory was to act on behalf of patients (ABP). It was reflected in this study that this attribute, when linked to nurses' traits, serves as a strong motivation to act on behalf of patients. Nurses' traits, such as assertiveness, influence the nurses' ability to assume their advocacy role. In the third attribute, championing social justice (CSJ), traits such as empathy, honesty, trustworthiness, kindness, and humility influence nurses to advocate for their patients. Nurses in the study indicated that they champion social justice by identifying the social needs of patients and referring patients for further assistance in that regard.

A unique finding from this study was the language barrier between patients and health care providers. Language differences negatively impacted communication between patients and other multidisciplinary health team members, leading to patients' fear of asking questions can become barriers to the advocacy role of nurses as indicated by data findings of theme three and its subthemes.

LIMITATIONS

1. The study was planned and conducted only in the North West Province of South Africa. Data were collected in the four level-two public hospitals of the province. The findings from these public hospitals might not reflect what takes place in private hospitals, which are managed differently than public hospitals.
2. The appointments of the focus group interviews were set according to the shifts that nurses were working, which limited the participation of nurses that were off duty as some nurses could have made a valuable contribution to the study but were missed due to shift work.
3. Other categories of nurses such as Enrolled Nurses and Enrolled Auxillary Nurses may also have contributed to the study, but advocacy is mainly a responsibility of a professional nurse. The study used a qualitative research design, which limited the researcher to generalise the findings. The staff mix may have yielded different data.

CONCLUSION

This study aimed to explore factors that influence nurses' advocacy role within a public hospital setting. Three main themes were identified, and they were as follows: 1. Managerial and environmental factors can negatively influence the advocacy role of nurses, 2. Personal factors can have a positive influence on the advocacy role of nurses, and 3. Patient-related factors

influence the nurses' role as an advocate. These three themes addressed the main question of the study concerning what factors influenced nurses’ advocacy role in level-two public hospitals in the North West Province of South Africa.

Participants provided data regarding their negative and positive factors, which influenced their role as patients’ advocates. Factors such as nurses’ traits, namely empathy, trustworthiness, humility, and assertiveness, positively influenced the nurses to advocate for patients. Other factors such as patient vulnerability, lack of knowledge, and lack of autonomy also positively influenced nurses to advocate for patients. Factors that negatively influenced nurses' role as patient advocates were lack of management support and lack of training and interference from patients bound by their cultural and religious beliefs, which hindered the nurses' advocacy role.

This study will add value to the knowledge of the role of nurses as advocates as it can provide insight to the top management regarding factors that either positively or negatively influence nurses as advocates.

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Competing interest

The authors declare no financial or any otherwise competing interests.

Authors' contribution

Olivia Ngami conducted the study, collected the data, thematically analysed the data, and wrote the preliminary findings of the study.

C.S. Minnie planned and designed the study, made valuable contributions regarding the background of the study, and managed the scientific and ethical approval.

Both authors contributed to the writing of the manuscript.

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Data availability

Data sharing is not applicable to this study.

Disclaimer

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CHAPTER 4:

EVALUATION, LIMITATIONS, AND RECOMMENDATIONS

4.1 INTRODUCTION

This chapter evaluates the study on the factors that influence nurses' advocacy role in level two public hospitals in the North West Province of South Africa. After the evaluation, the following are discussed: the study's limitations, recommendations for nursing practice, nursing research, nursing education, and policy.

4.2 EVALUATION OF THE STUDY

The study aimed to contribute to promoting nursing advocacy by exploring and describing factors that influence nurses' performance of their patient advocacy roles. The objective of this study was to explore and describe the factors that influence the nurse's advocacy role in level two public hospitals in the North West Province of South Africa and formulate recommendations to promote nurse advocacy. The objective was accomplished through the identification of three themes and sub-themes. The three identified themes were: (1) managerial and environmental factors that can negatively influence the advocacy role of nurses, (2) Personal factors can have a positive influence on the advocacy role of nurses, and (3) Patient-related factors influence the nurses' role as an advocate.

The researcher applied the advocacy model of Bu and Jezewsky (2006:101) as adopted by Dadzie *et al*. (2007:2) (see Figure 1). This model was relevant to the current study as it addressed patient advocacy and the understanding of the role of a nurse as an advocate. The mid-range theory developed by Bu and Jezewsky (2006:101) maintains that patient advocacy consists of three core attributes: safeguarding patient's autonomy (SPA), act on behalf of patients (ABP), and championing social justice (CSJ). All three of these were found in the current study. Safeguarding the patient's autonomy (SPA) was seen in the third theme where participants revealed that patients' vulnerability, such as lack of autonomy, language barrier, fear for interaction with other health care providers, and low social standing, stimulates the nurses' advocacy role. The second attribute of the Bu and Jezewsky (2006:101) theory was for nurses to act on behalf of patients (ABP). It was reflected that when linked to their traits, a strong motivation to act on behalf of patients exists. Nurses' traits, such as assertiveness, influence the nurses' ability to assume their advocacy role. The third attribute was the championing of social justice (CSJ). This attribute was reflected when participants indicated that patients have equal rights and those who have social problems that prevented them from receiving care need to be advocated for.

A qualitative descriptive research design as described by Sandelowski *et al.* (2010:79) was used in the study. This design was the most suitable because it can enable the researcher to answer the research question and contribute to understanding the phenomenon within its specific context (Negarandeh *et al*., 2008:549; Sandelowski, 2010:79).

After the literature review presented in chapter two, the researcher understood the available evidence of factors that influence a nurse to advocate for his/her patients. Still, limited research has been done in South Africa. Nurses, as patient advocates, can make a significant difference in the lives of patients and their families (Prasun, 2016:1). Regardless of their work context, nurses should follow their codes of ethics, which directs them to respect human rights and ensures that each patient receives accurate and sufficient information that demonstrates respectfulness, responsiveness, compassion, trustworthiness, and integrity (Sundqvist *et al*., 2016:432). From the review of literature, the researcher concluded that there is a need for further research in nurses' patient advocacy within a South African context.

In chapter three, the researcher analysed data from four hospitals, with one hospital having two complexes. The participating hospitals were Klerksdorp/Tshepong Hospital complex, Joe-Morolong Hospital, Job Shimankane-Tabane Hospital and Mafikeng Provincial Hospital. Klerksdorp/Tshepong hospital had two complexes, the initial plan considered using only one complex from that hospital. However, the second complex was later included to obtain data saturation. These two hospital complexes both have gatekeepers. Wards in the hospitals were randomly selected to allow all the wards an equal chance to be included in the study. Data were collected with an audio recorder during focus group interviews, where all participants were purposively selected (Burns & Grove, 2009:513). The focus group interviews' responses were transcribed in preparation for the subsequent analysis (Botma *et al*., 2015:219).

Three main themes with subthemes were found from the data collected, and they were as follows:

***Theme 1*:** Managerial and environmental factors can negatively influence the advocacy role of nurses.

***Theme 2*:** Personal factors can have a positive influence on the advocacy role of nurses.

***Theme 3*:** Patient-related factors influence the nurses' role as an advocate.

The findings indicate managerial and environmental factors which negatively influenced the advocacy role of nurses. Several factors can positively influence the advocacy role of nurses, such as nurses' feeling of responsibility towards their patients and the patient's health care and characteristics like assertiveness and empowerment through specialised training.

A unique finding from this study was the language barrier between patients and health care providers. Language differences negatively impacted the communication between patients and other multidisciplinary health team members, leading to patients' fear of asking questions and a barrier to the advocacy role of nurses, as indicated by Theme three and its subthemes.

As planned in chapter one, the researcher ensured rigour during the focus group interviews by asking follow-up questions or repeat responses to verify what the participants had just said. Similar strategies were implemented to maintain trustworthiness throughout the research process.

4.3 LIMITATIONS OF THE STUDY

1. The study was planned and conducted only in the North West Province of South Africa. Data were collected in the level two public hospitals of the province. Findings may not reflect what takes place in private hospitals as they are managed differently.

2. The appointments of the focus group interviews were set according to the shifts that nurses were working, which limited the participation of nurses that were off duty as some of these nurses could have made valuable contributions but were missed due to shift work.

4.4 RECOMMENDATIONS

The researcher will focus on making recommendations for nursing practice, nursing research, nursing education, nursing policy, and nursing management. The recommendations are as follows:

4.4.1. Recommendations for nursing practice

The following recommendations were formulated for nursing practice.

- Nursing professionals must be good practitioners of advocacy in nursing through the implementation of nursing advocacy in-service training programmes based on literature and the outcomes of the study.

- Establishment of advocacy offices and officers in hospitals as a basis for nurses to be active patient advocates. Such offices can be similar to Quality Assurance offices and officers currently found in the hospitals. The Advocacy office can provide a service to patients referred to this office if they need to lay a complaint about any injustice during their

hospitalisation. Nurses can also refer cases to this office as an intermediate platform to express their concerns and to receive support in their roles as advocates.

- No mention was made of an advocacy office or officers in the current study as the focus was on factors influencing advocacy and not the promotion of patient advocacy. Based on the literature (Water *et al*. 2016:698), such an office will facilitate patient advocacy.

- A monthly meeting can be held where nurses can discuss their challenges regarding factors influencing nursing advocacy in general and find ways to improve nursing advocacy to provide quality patient care.

- Each ward can have an advocacy champion who will ensure an emphasis on the nursing advocacy role and that nurses are not intimidated or undermined in exercising their role as advocates.

- An annual recognition award can also be given to the most effective and hardworking nurse advocate who implements nursing policies, applies patents rights, and has a good working relationship with other members of the multidisciplinary health team. This award can be decided by the patients through a monthly voting system by answering simple short questionnaires.

4.4.2. Recommendations for nursing research

- More research can be conducted into patient-related factors influencing advocacy within a South African context to empower nurses to advocate for patients.

- Additional studies are needed concerning how other multidisciplinary health team members view the role of a nurse as a patient advocate. Therefore, medical health care professionals' understanding of nurses' advocacy role is recommended for research.

- A final recommendation should be a study of nurses' resilience as patients' advocates because if nurses are resilient to challenges they face in practice, whether the factors are negative or positive, they will advocate regardless.

- The managerial factors that influence the nurses' role as advocates should be researched further due to their negative impact. The researcher recommends more research into the positive impact of the managerial role as a factor that influences advocacy role.

- The researcher also recommends a study to be conducted on factors influencing all levels of nursing advocacy in both public and private facilities.

4.4.3. Recommendations for education

- There is a need to widen the scope of nursing education about the nursing advocacy role within the curriculum. Therefore, it is recommended that more emphasis be placed on nursing education in the undergraduate programme.

- It is recommended that advocacy must be emphasised in nursing ethics theory classes. The curriculum will not have to be developed from the start as the nursing ethos is already part of most of the institutional curricula.

- For nurses currently in practice, short courses can be developed with updates being done following current evidence-based nursing practices.

- Concerning continuous quality patient care, ongoing in-service training should be presented to all nursing categories.

4.4.4. Recommendations for policy

There must be more attention paid to nursing policies regarding nursing advocacy. Except for the Nursing Act, 33 of 2020, nurses' advocacy role is not emphasised in other policies. The patients' rights charter (DOH, 2020) also encourages patients to be vocal by being involved in decision making. However, a unique finding of this study showed that language could be a barrier for nurses to advocate policy activity within the South African context. Therefore, the following is recommended:

- Language interpretation policies in hospitals with the intention of facilitating patients' involvement, where necessary, should be strictly adhered to facilitate such activities.

- A strategic policy can be developed within a hospital setting supported by the nursing profession in their role as advocates.

- Quality improvement policies that will guide nurses to practice as advocates on their daily activities and routines when in contact with patients should be implemented.

- The quality department in the hospitals can be approached to formulate key indicators for nurses as advocates and assist in drafting policies that include advocacy as one of the activities to promote quality patient care.

- The Department of Health can also be approached to ensure that policies regarding quality patient care are implemented across the nursing fraternity.

4.4.5. Recommendations for nursing management

- Management of hospitals should create awareness concerning nursing advocacy during nursing staff meetings such as quality assurance meetings.
- Daily to weekly in-service programmes can also be implemented, focusing on the role of a nurse as an advocate.
- A monthly feedback system can be implemented by the management when collecting data for patients' statistics and administrative statistics to evaluate the improvement of quality patient care, which can be used as an indicator for the evaluation of nursing advocacy.
- A patient satisfaction tool specifically focusing on nursing advocacy can be developed to measure this indicator. This will, in turn, encourage nurses to assume their role as patients' advocates, thereby improving the provision of quality patient care.

4.5 CONCLUSION

In this chapter, the study was evaluated, limitations in the study were identified, and recommendations for future nursing practice, nursing research, nursing education, policy, and management were made. Nursing traits such as assertiveness, kindness, empathy, honesty, trustworthiness, kindness, and humility influence nurses to advocate for their patients. Even though nurses played their advocacy role when in contact with vulnerable patients, several factors such as lack of management support, lack of development opportunities, and training and power imbalances between nurses and doctors negatively influence their advocacy role for patients.

In view of the entire study, minimum literature exists regarding factors that influence nurses' advocacy role within the South African perspective. The researcher took note of research work published in the Sub-Saharan region, with the research done by Dadzie *et a*l. (2017, 2018) in Ghana, which was recognised and considered in the early stages of the study. As the investigation progressed, nursing advocacy was more prominent in other countries than South Africa, which led to the researcher's view that there is a gap in the literature regarding advocacy within South African nursing. This called for more research work to be done within the African continent.

The study was based on the work of Bu and Jezewski's (2006:101) conceptual model of advocacy, which was also used as the conceptual framework of the study in chapter three. The conceptual model explains that a patient and a nurse will always have interaction within an environment which is the hospital. The model then indicates that as the nurse is in contact with the patient for nursing interventions and provision of care, there are factors within the environment

that influence the nurse to advocate. These factors were found from the data that was analysed in chapter three, where three themes emerged with subthemes that were discussed.

The study concludes that factors influencing nurses' advocacy role within a South Africa context are similar to factors found in other studies. A unique finding was that language differences between patients and health care providers can influence nurses' advocacy as they need to intervene by advocating for patients who have little or no understanding of care rendered to them by other health care providers. The researcher believes that nurses always have a voice and a right to step up and advocate for patients

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APPENDIX A: ETHICS APPROVAL

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Web: http://www.nwu.ac.za

Health Sciences Ethics Office for Research, Training and Support

North-West University Health Research Ethics Committee (NWU-HREC)
Tel: 018-285 2291
Email: Wayne.Towers@nwu.ac.za

05 August 2019

To whom it may concern

APPROVAL OF THE RESEARCH STUDY FROM THE NORTH-WEST UNIVERSITY HEALTH RESEARCH ETHICS COMMITTEE (NWU-HREC) OF THE FACULTY OF HEALTH SCIENCES

Ethics number: NWU-00432-19-S1

Kindly use the ethics reference number provided above in all future correspondence or documents submitted to the administrative assistant of the North-West University Health Research Ethics Committee (NWU-HREC).

Study title: Factors influencing nurses' advocacy role in level two provincial hospitals in the North West Province of South Africa

Study leader/supervisor: Prof CS Minnie

Student: O Ngami-23795875

Application type: Single study

Risk level: Minimal

You are kindly informed that this application was reviewed at the meeting of the North-West University Health Research Ethics Committee (NWU-HREC), Faculty of Health Sciences, North-West University, held on 13/06/2019. Following review of the application, it has been decided that the study is approved. Approval in this letter means that **final ethics approval** was indeed granted for the **research methodology and the ethical aspects** of this study and that the NWU-HREC has **no further ethical concerns** relating to the research ethics process, except for the outstanding documentation indicated below, which must be provided to the NWU-HREC by the researcher. It is important to mention that this letter indicates that there are no further ethical concerns that exist, regarding the execution of the research. A final ethics letter will be issued upon the receipt of the following documentation:

a. A copy of the permission letter from you as the North West Department of Health, indicating that the study can proceed

The mentioned document, as indicated above, should be submitted to Ethics-HRECProcess@nwu.ac.za by the researcher, for review before the ethics approval certificate can be provided. This approval is provided *for a year*, after which continuation of the study is dependent on receipt of an annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation for another year.

If you have any questions or need further assistance, please contact the Faculty of Health Sciences Ethics Office for Research, Training and Support at Ethics-HRECApply@nwu.ac.za.

Yours sincerely

Digitally signed by Wayne Towers
Date: 2019.08.05 10:46:19 +02'00'

Prof Wayne Towers
Chairperson: NWU-HREC

Digitally signed by Prof Minrie Greeff
Date: 2019.08.05 23:07:18 +02'00'

Prof Minrie Greeff
Head of Health Sciences Ethics Office for Research, Training and Support

Current details: (23239522) G:\My Drive\9. Research and Postgraduate Education\9.1.5.3 Letters Templates\9.1.5.3.6_Gatekeepers_Letter_HREC.docm
30 April 2018

File reference: 9.1.5.3.6

APPENDIX B: APPROVAL FROM NWP DEPARTMENT OF HEALTH

health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

3801 First Street
New Office Park
MAHIKENG, 2735

Enq: Nthabiseng Mapogo
Tel: 018 391 4504
NMapogo@nwpg.gov.za
www.nwhealth.gov.za

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Ms. O. Ngami
North West University

Physical Address (Work/ Institution) 11 Hoffman Street, North West University
Potchefstroom Campus
Potchefstroom, 2531

Subject : Research Approval Letter- Factors influencing nurses nurses' advocacy role in level two provincial hospitals in the North West Province of South Africa.

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the Department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards

DEPARTMENT OF HEALTH
OFFICE OF THE SUPERINTENDENT GENERAL
21-11-2019
PRIVATE BAG X 2068 MMABATHO, 2735

Ms. N. Mangonyane
Acting Director: PPRM&E

20/11/2019
Date

O. Ngami
Researcher

21/11/2019.
Date

Healthy Living for All

APPENDIX C: PERMISSION FROM HOSPITALS

REQUEST LETTER

LETTER SEEKING CONSENT TO CONDUCT RESEARCH AT LEVEL TWO PROVINCIAL HOSPITALS

IN THE NORTH WEST PROVINCE.

THE MATRON

Job Shimankane Provincial Hospital

Cnr Bosch & Heystek Street

Rustenburg

0299

Re: Application to conduct a research study

I am currently studying for the Master's Degree in Nursing (MCuR) with the North West University, Potchefstroom Campus Under NuMIQ. I am expected to conduct a research study as a requirement for the degree currently under way. May I therefore request your permission to perform data collection in this hospital

The topic for my research is: Factors influencing nurse's advocacy role in level two provincial hospitals in the North West Province of South Africa

The target population is all the professional nurses who meets the criteria outlined in the study and are allocated in different clinical setting.

Kindly receive the questionnaire which will be used to collect data enclosed

Thanking you in anticipation

Yours Sincerely.

Olivia Ngami

Clinical Preceptor (RN, BCur Edu et Admin, Neph RN)

Cell: 074 883 4227/ Office: 018 299 2759

EXAMPLE OF AN APPROVAL LETTER

KLERKSDORP/TSHEPONG HOSPITAL COMPLEX – CLINICAL MANAGER'S OFFICE

17th February 2020

To : Mrs. Olivia Ngami

Dear Sir/ Madam

RE : Factors influencing nurse's advocacy role in the level two Provincial hospitals in the North West Province

Presenter: Mrs. Olivia Ngami
Date of presentation: 13th February 2020

This letter serves to confirm that permission has been granted by K/T Hospital Complex Patient Safety Group (PSG) for study approval letter for study title: Factors influencing nurse's advocacy role in the level two Provincial hospitals in the North West Province. The researcher is requested to submit regular study progress reports and final study report upon completion of the project. The permission is subject of approval of the Ethics Committee.

Kind Regards,

.....
Dr. R.I. Mahume
Clinical Manager Support
KT Hospital Complex

1

Healthy Living for All

APPENDIX D: RECRUITMENT MATERIAL

INVITATION TO PARTICIPATE IN RESEARCH

Do you believe in improving quality patient care?

Do you see yourself as a voice to the voiceless?

Then you are what we are looking for...

Factors influencing nurses' advocacy role in level two public hospitals in the North West Province of South Africa

INCLUSION & EXCLUSION CRITERIA

You are invited to participate in the research if you

- Are registered as professional nurses at the South African Nursing Council
- Have at least two years of full-time experience
- Are working shifts in one of the selected wards of your hospital.

You will unfortunately not be able to take part in this research if you are:

- Newly graduated and are doing community service or are on probation
- not fluent in English as it will be the main language used during the interviews.

WHAT WILL BE EXPECTED FROM PARTICIPANTS?

Participants will be required to sign an informed consent form BENEFITS OF THE STUDY

You will be more knowledgeable about factors that influence nurses' patient advocacy role.

You will be in a better position to apply the knowledge gathered during the research process to be a better advocate for patients.

Quality patient care will be improved as you will be more knowledgeable about factors that influence your role as a patient advocate.

DECLINE TO PARTICIPATE/PRIVACY

There is no coercion to participate. Should you agree to take part in the study and later decide that you want to withdraw, you will not be penalized or coerced to continue with the study. Participation is voluntary without any prejudice or litigations.

Should you voluntarily take part in the study, privacy and confidentiality will be maintained throughout the research process. This will be clarified at the stage of obtaining informed consent, where you will be expected to sign the consent form as a participant.

COSTS

You will not be reimbursed for this study as data collection is likely to take place while participants are on duty. A light snack will be served during the focus group interview session.

THE RESEARCHER

Mrs Olivia Ngami is a Registered Professional Nurse, Registered Nurse Educator, Registered Nephrology Trained Nurse. Currently employed as Clinical Preceptor at the North-West University, Potchefstroom Campus. Passionate about patients' advocacy and Nephrology nursing.

CONTACT DETAILS

Email: 23795875@nwu.ac.za

Tel: 018 299 1887

APPENDIX E: INFORMED CONSENT

Private Bag X1290, Potchefstroom
South Africa 2520

Tel: +2718 299-1111/2222
Fax: +2718 299-4910
Web: http://www.nwu.ac.za

HREC Stamp

INFORMED CONSENT DOCUMENTATION FOR Professional nurses working in the two public hospitals in the North West Province

TITLE OF THE RESEARCH STUDY: Factors influencing nurses' advocacy role in level two public hospitals in the North West Province of South Africa.

ETHICS REFERENCE NUMBERS:

PRINCIPAL INVESTIGATOR: C.S Minnie

POST GRADUATE STUDENT: Olivia Ngami

ADDRESS: 11 Malherbe La Hoff Street, Klerksdorp, 2571

CONTACT NUMBER: 074 883 4227

You are being invited to take part in a research study that forms part of a Masters in Nursing Science degree. I have indicated the names of both the research leader (principal investigator) and the researcher (postgraduate student). Please take some time to read the information presented in this document, which will explain the details of this study. Please ask the researcher, or person explaining the research to you (independent person who will be collecting the informed consent forms) any questions about any part of this study that you do not fully understand. It is

very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is entirely voluntary, and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now. Partial confidentiality will be maintained as this is a semi-structured focus group interview, not a one-on-one interview session where full confidentiality can be maintained between the interviewer (researcher) and interviewee (participant), participants will be expected to engage and discuss factors influencing their role as nurses to advocate for patients. This means that names will not be used during data collection, analysis, and interpretation. No names will be mentioned during data dissemination. All the participants will be expected to maintain confidentiality during the study. No information discussed during the focus group interview will be divulged to non-participants until the study is concluded and data is disseminated accordingly by the researcher.

This study will be approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University, which will give the North-West University ethics number. (NWU-00432-19S) and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (Department of Health, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

1. What is this research study all about?

   - *We plan to conduct a study on nurses' patient advocacy role. The study will involve professional nurses who will meet the set inclusion criteria for the research study at hand.*
   - *This study will be. conducted in level two public hospitals in the North West Province during 2020 after scientific and ethics committee approval has been granted by the NWU. The study will involve professional nurses in level two public hospitals in the North West Province of South Africa after the DoH has granted permission. The interviewer will be Olivia Ngami, a student from the NWU.*
   - *The research will be done by experienced health researchers trained in group interviewing who attended the ethics training session. About 6 to 8 participants from each hospital will be selected through purposive sampling.*

2. Why have you been invited to participate?

   - *You have been invited to be part of this research because you are a professional nurse who fits the inclusion criteria.*

(1). Two years or more of full-time experience because the nurses at this point have formed some social and work relations with other multidisciplinary health team members and are exposed to the type of patient needs that will yield information relevant to nurses' patient advocacy role.

(2) Professional nurses who work on shifts as these are the nurses who interact with different work groups and have contact with patients during weekends where most of the management is not available, and they need to take the responsibility for decision making and for patients' advocacy.

- *You will unfortunately not be able to take part in this research if the following aspects apply to you:*

  (1). Newly employed nurses who have just graduated and are on community service or probation will not form part of the research since they rotate around the different units in the hospitals as part of their community service and do not have prolonged encounters with patients as most of them do not work shifts.

  (2) Nurses who are not fluent in English as it will be the main language used during the interviews.

  (3) Nurses who have not consented to be part of the study will also be excluded as this is an ethical consideration.

3. What will be expected of you?

   - *You will be expected to participate in a semi-structured focus group interview, where semi-structured questions will be asked to the group, and all participants will be expected to answer the questions. All discussions will be audio recorded. The interview session will take 45-60 minutes. About 6 questions, each with one or two supporting or follow-up questions, will be asked. There will be no other activities except the interview session. The interviewer will start by introducing herself. All the participants involved will also introduce themselves. Refreshments will be available for the day.an attendance register will circulate to ensure that all the participants who gave consent are attending the interview session.*

4. Will you gain anything from taking part in this research?

   - *The gains for you, if you take part in this study, will be knowledge of what nurses' advocacy role implies, how one can practise the advocacy role without fear of intimidation from other multidisciplinary team members or from the environment itself.*
   - *The other gains of the study relate to the improved quality of patient care.*
   - *There will be no direct gains for you by participating in this study.*

- *The other gain of the study is that patients could gain indirectly as their quality of care will be improved.*

5. Are there risks involved in you taking part in this research, and what will be done to prevent them?

- *Work can be viewed as a social environment; the participants might fear to be a social outcast at work or to be labelled as a "snitch" by other health care professionals, which may lead to social intimidation as they will be discussing factors that they have seen in their working environment that influenced them and/or other nurses to advocate for their patients. This may be uncomfortable to other nurses and viewed in a negative way.*
- *A precautionary measure that will be in place regarding this risk is that participants will be reassured that anonymity will be maintained when the research report is published. Participants will also be requested to keep the discussed data confidential during the study until data is disseminated accordingly.*
- *Participants will also be given privacy during the interview process to ensure that there is no one who overhears the discussion, group members must be able to hear each other when talking. For any missed or misunderstood information during the focus group interview, the researcher will ask to follow up questions or repeat after the participants to*
- *The participant will gain more knowledge on how to advocate for the patients, when to advocate for the patients, what to identify as a need for patients to actively advocate and improve quality patient care. The participant will also be more assertive in practising the role as an advocate as one will be more knowledgeable about factors that influence a nurse to advocate for the patient, but this will be limited by the willingness of the nurse to perform the role of a patient advocate.*
- *There are more gains in joining this study than there are risks.*

6. How will we protect your confidentiality, and who will see your findings?

- *Anonymity of your findings will be protected by ensuring that all the participants' names are not stored where the collected data will be stored. Since this is a group interview session, all the participants will be required not to divulge what has been discussed in the group outside the interview room. Your privacy will be respected by all who take part, names will not be published should the research findings be made public. All the information gathered during interviews data by using audio recorders will be transferred to a password-protected computer or desktop used by the*

researcher for the purpose of the study. The audio-recorder will then be deleted to ensure that the data is kept confidential. The saved audio will then be handed over to a qualified transcriber who will transcribe the data as recorded. The transcribed will be kept under a password-protected computer. A final draft of the data will be archived at the NWU for safety. Your results will be kept confidential by the researcher. Only the researcher, study supervisor, transcribers and data analyst and will be able to look the findings. Findings will be kept safe by storing hard copies in locked cupboards in the researcher's office, and for electronic data, it will be password protected.

- *Your privacy will be respected by all who take part in the research process, what will be discussed during the interview session will be kept partially confidential as there is a transcriber who will have to listen to the audio recording and transcribe it. The co-coder will also be part of the individuals who will gain access to the data for the data capturing process. All the information that is personal and is captured during the informed consent process will be kept safe at the university under lock, and key access will be limited to the researcher. Your results will be kept confidential by ensuring that all the informed consent forms are scanned and converted into a PDF file that will be kept on a password-protected computer. During dissemination of data, no participant's name or details will be mentioned in the research finding to ensure privacy and confidentiality. Only the researcher, the co-coder and the principal researcher will have access to the data collected and will be able to look at the findings. Data will be stored for 5 years.*

1. What will happen with the findings or samples?

   - *The findings of this study will NOT be used in future. The data and the samples of this study will not be used in any other studies except for this one for which the researcher has obtained permission from the participants. Any further studies that will be a continuation from this study will have to be granted permission by the research committee at the university. The data from this research will be analysed and disseminated in the North West University in the Potchefstroom campus in South Africa. Storage will also be at the North-West University, Potchefstroom Campus. Outcomes of this study will be used to empower nurses across the country as the aim of this research is to improve the role of nurses as patient advocates.*

2. How will you know about the results of this research?
   - *We will share the results of this research with you when the research has been completed, and data have been interpreted prior to being published.*

- *You will be informed of any new relevant findings by the researcher who will communicate the findings to you.*
- *We will give you the results of this research when the NWU has approved that the results can be published. The researcher will give participants a copy of the article that is published as some may not have the access to platforms where the article has been published. This hard copy will be sent to the gatekeeper of the institution/hospital to be aware of the study's findings.*
- *You will be informed of any new relevant findings by email or telephone contact should the researcher deem it to be necessary.*

3. Will you be paid to take part in this study, and are there any costs for you?

   This study is self-funded by the postgraduate student. There are no funders or sponsorships.

   Yes, you will not be reimbursed for participating in this study as the focus group will be undertaken during work time with the permission of the ward manager. There might be some work inconvenience for the participants to take part in the study as some might have had patients they nursed and needed to attend to during that time they would have attended the focus group interview.

   Refreshments will be served prior to the interview session to allow all the participants to be at ease, this can be used as a time to get acquainted.

4. Is there anything else that you should know or do?
   - You can contact Olivia Ngami at 074 883 4227 if you have any further questions or have any problems.
   - You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
   - You will receive a copy of this information and consent form for your own purposes.

Declaration by participant involved in the study.

By signing below, I (name and surname of participant) ……. agree to take part in the research study titled: Factors influencing nurses' advocacy role in the two public hospitals in the North West Province.

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is voluntary, and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished if the researcher feels it is in the best interest or if I do not follow the procedure as agreed.

Signed at (*place*) .....…..……. on (*date*) ……...……. 20....

....

Signature of participant Signature of witness

Declaration by the person obtaining consent

I *(name)* ……..…… declare that:

- I clearly and in detail explained the information contained in this document to

…….

- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (*place*) .....…..……... on (*date*) ……...……... 20....

.....

Signature of person obtaining consent

Declaration by researcher

I, Olivia Ngami, declare that:

- I explained the information in this document to ……. or I had it explained by …… who I trained for this purpose.
- I did/did not use an interpreter
- I will be available to answer any questions prior to the commencement of the focus group interview session.
- The informed consent will be obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) .....…..…… on (*date*) ……...……... 20....

.....

Signature of researcher O Ngami

Title of the study: Factors influencing nurses´ advocacy role in level two public hospitals in the North West Province of South Africa

Introduction/ biographic questions

The first question numbered 1, is an introductory question to collect biographic data, with the core questions numbered 2-6 asked as broad questions.

1. Can you introduce yourself and tell us where you work, how long have you worked there and how old are you? And tell us how long have you worked in the hospital and what other qualifications you have except for general nursing?

Core questions

These are the main questions of the research interview schedule:

2. Can you explain in your own understanding what nursing advocacy is?
   - What do we mean when we speak of a nurse as an advocate for patients?
3. In your view, what are the environmental factors that influence you as a nurse to advocate or not to advocate?
   - These could be job security, staffing rules and regulations, administration, or time constraints.
4. What nursing traits influence nurses to advocate or not to advocate?
   - These are empathy, persistence, and assertiveness.
5. What is the current nursing state in terms of nurse-patient advocacy?
   - What could be the reason for nurses' inactive role for patient advocacy in the environment of patient care?
   - Why are nurses not actively advocating for patients during their hospital stay?
   - Are nurses so frustrated by their working environment that advocacy for the patient is regarded as being less important than taking daily observations?
6. What factors influenced you as a nurse to advocate for the patient in your workplace setting?

- Talk about what needs you have identified from patients who exhibited a need for advocacy.

APPENDIX G: COVER LETTER TO THE EDITOR OF CURATIONIS

Private bag X1290
Potchefstroom
South Africa
2520
Tel: 018 299-2759
Fax: 018 299-4910
Web: http://www.nwu.ac.za

Editor-in-Chief
Curationis Journal

Re: Article for submission

The article titled: “Factors influencing nurses' advocacy role in level two public hospitals in the North West Province of South Africa”: a qualitative descriptive inquiry” is hereby submitted.

The manuscript was not submitted to any other journal. Ethical approval was obtained from the North-West University (NWU) (certificate number: NWU-00432-19-s1) to conduct the empirical study.

The study was funded by the principal investigator, UCDP grant, North-West University Post Graduate Bursary, North-West University staff discount, and HWSETA Bursary. The researcher declares an NWU post-graduate bursary for part-time students as the researcher is employed on a fixed-term contract for the School of Nursing Science as a clinical preceptor. No conflict of interest is declared.

Thank you for considering this manuscript for publication.

Kind Regards,

APPENDIX H: GUIDELINES FOR AUTHORS - CURATIONIS

Overview

The author guidelines include information about the types of articles received for publication and preparing a manuscript for submission. Other relevant information about the journal's policies and the reviewing process can be found under the about section. The **compulsory cover letter** forms part of a submission and must be submitted together with all the required **forms.** All forms need to be completed in English.

Original Research Article

An original article provides an overview of innovative research in a particular field within or related to the focus and scope of the journal, presented according to a clear and well-structured format.

Word limit	7000 words (excluding the structured abstract and references)
Structured abstract	250 words to cover a Background, Objectives, Method, Results and Conclusion
References	60 or less
Tables/Figures	no more than 7 Tables/Figure
Ethical statement	should be included in the manuscript
Compulsory supplementary file	ethical clearance letter/certificate

Corrections

A correction provides the platform to communicate important, scientifically relevant errors or missing information in a published article. Any changes after publication that affect the scientific interpretation (e.g., changes to a misleading portion of an otherwise reliable publication, an error in a figure, error in data that does not affect conclusions or addition of missing details about a method) are announced using a Correction. Read our submission procedure for **corrections** and **publishing policies**.

Compulsory title	The title of the submission should have the following format: 'Corrigendum: Title of original article'.
Submission File	completed **Correction Submission Form** (required)
Compulsory supplementary file	any supporting documents or emails, **Author Change Request Form** (if applicable), **Corresponding Author Change Request Form** (if applicable)

Cover Letter

The authorship, disclosure statements, copyright, and license agreement form is our compulsory cover letter which needs to form part of your submission. Kindly download and complete, in English, the provided **form**.

Anyone that has made a significant contribution to the research and the paper must be listed as an author in your cover letter. Contributions that fall short of meeting the criteria as stipulated in our policy should rather be mentioned in the 'Acknowledgements' section of the manuscript. Read our **authorship** guidelines and **author contribution** statement policies.

Original Research Article full structure

Title: The article's full title should contain a maximum of 95 characters (including spaces).

Abstract: The abstract, written in English, should be no longer than 250 words and must be written in the past tense. The abstract should give a succinct account of the objectives, methods, results and significance of the matter. The structured abstract for an Original Research article should consist of five paragraphs labelled Background, Objectives, Method, Results and Conclusion.

- Background: *Why do we care about the problem?* State the context and purpose of the study. (What practical, scientific or theoretical gap is your research filling?)
- Objectives: *What problem are you trying to solve*? What is the scope of your work (e.g. is it a generalised approach or for a specific situation)? Be careful not to use too much jargon.
- Method: *How did you go about solving or making progress on the problem*? State how the study was performed and which statistical tests were used. (What did you actually do to get the results?) Clearly express the basic design of the study; name or briefly describe the basic methodology used without going into excessive detail. Be sure to indicate the key techniques used.
- Results: *What is the answer*? Present the main findings (that is, as a result of completing the procedure or study, state what you have learnt, invented or created). Identify trends, relative change or differences on answers to questions.
- Conclusion: *What are the implications of your answer*? Briefly summarise any potential implications. (What are the larger implications of your findings, especially for the problem or gap identified in your motivation?)

Do not cite references and do not use abbreviations excessively in the abstract.

Introduction: The introduction must contain your argument for the social and scientific value of the study, as well as the aim and objectives:

- Social value: The first part of the introduction should make a clear and logical argument for the importance or relevance of the study. Your argument should be supported by use of evidence from the literature.
- Scientific value: The second part of the introduction should make a clear and logical argument for the originality of the study. This should include a summary of what is already known about the research question or specific topic, and should clarify the knowledge gap that this study will address. Your argument should be supported by use of evidence from the literature.
- Conceptual framework: In some research articles it will also be important to describe the underlying theoretical basis for the research and how these theories are linked together in a conceptual framework. The theoretical evidence used to construct the conceptual framework should be referenced from the literature.
- Aim and objectives: The introduction should conclude with a clear summary of the aim and objectives of this study.

Research methods and design: This must address the following:

- Study design: An outline of the type of study design.
- Setting: A description of the setting for the study; for example, the type of community from which the participants came or the nature of the health system and services in which the study is conducted.
- Study population and sampling strategy: Describe the study population and any inclusion or exclusion criteria. Describe the intended sample size and your sample size calculation or justification. Describe the sampling strategy used. Describe in practical terms how this was implemented.
- Intervention (if appropriate): If there were intervention and comparison groups, describe the intervention in detail and what happened to the comparison groups.
- Data collection: Define the data collection tools that were used and their validity. Describe in practical terms how data were collected and any key issues involved, e.g. language barriers.

- Data analysis: Describe how data were captured, checked and cleaned. Describe the analysis process, for example, the statistical tests used or steps followed in qualitative data analysis.
- Ethical considerations: Approval must have been obtained for all studies from the author's institution or other relevant ethics committee and the institution's name and permit numbers should be stated here.

Results: Present the results of your study in a logical sequence that addresses the aim and objectives of your study. Use tables and figures as required to present your findings. Use quotations as required to establish your interpretation of qualitative data. All units should conform to the **SI convention** and be abbreviated accordingly. Metric units and their international symbols are used throughout, as is the decimal point (not the decimal comma).

Discussion: The discussion section should address the following four elements:

- Key findings: Summarise the key findings without reiterating details of the results.
- Discussion of key findings: Explain how the key findings relate to previous research or to existing knowledge, practice or policy.
- Strengths and limitations: Describe the strengths and limitations of your methods and what the reader should take into account when interpreting your results.
- Implications or recommendations: State the implications of your study or recommendations for future research (questions that remain unanswered), policy or practice. Make sure that the recommendations flow directly from your findings.

Conclusion: Provide a brief conclusion that summarises the results and their meaning or significance in relation to each objective of the study.

Acknowledgements: Those who contributed to the work but do not meet our authorship criteria should be listed in the Acknowledgments with a description of the contribution. Authors are responsible for ensuring that anyone named in the Acknowledgments agrees to be named. Refer to the acknowledgement structure guide on our *Formatting Requirements* page.

Also provide the following, each under their own heading:

- Competing interests: This section should list specific competing interests associated with any of the authors. If authors declare that no competing interests exist, the article will include a statement to this effect: *The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.* Read our **policy on competing interests**.
- Author contributions: All authors must meet the criteria for authorship as outlined in the **authorship** policy and **author contribution** statement policies.
- Funding: Provide information on funding if relevant
- Data availability: All research articles are encouraged to have a data availability statement.
- Disclaimer: A statement that the views expressed in the submitted article are his or her own and not an official position of the institution or funder.

References: Authors should provide direct references to original research sources whenever possible. References should not be used by authors, editors, or peer reviewers to promote self-interests. Refer to the journal referencing style downloadable on our *Formatting Requirements* page.

APPENDIX I: TURNITIN REPORT

10387323:Olivia_Ngami_10_August_2021_Final_draft.docx

ORIGINALITY REPORT

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