

**AN EVALUATION OF A SELECTED COMPONENT OF A
PRIMARY HEALTH CARE SERVICE:
A NURSING PERSPECTIVE**

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Assignment presented in partial fulfillment of the requirements for
the degree of Master of Nursing at the University of Stellenbosch

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DECLARATION

I, the undersigned, hereby declared that the work contained in this assignment is my own original work and has not previously in its entirety or in part been submitted at any University for a degree.

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SUMMARY

Nationally and internationally emphasis is placed on quality care in health services. The researcher identified a need to evaluate a component of primary health care service in the Northern province. A study based on the combination of qualitative and quantitative methods was conducted to formulate and evaluate structure, process and outcome standards for selected clinics in the Northern Province.

The most important results are:

- The standard relating to the structure was suboptimal. Physical and human resources are of critical importance to the rendering of quality patient care. However this did not comply with the pre-set standard norm of 80%.
- Process standards focused on physical examination of patients taking into account the age of the client and the systems involved. Sub-standard care was found in all these aspects.
- Outcome standards determined by the patient questionnaire also revealed negative findings.

Recommendations include the development of a quality improvement model for the Northern Province Health Services, formulation of standards for all disciplines of health care, annual evaluation of patient care and the institution of a formal staff development programme.

Key words: quality care, formulation of standards, structure, process, outcome

OPSOMMING

Nasionaal en internasionaal word die belang van gehaltesorg in gesondheidsdienste beklemtoon. Die navorser het 'n behoefte geïdentifiseer om 'n component van primêre gesondheidsorgdienste in die Noordelike provinsie te evalueer. 'n Kombinasie van kwalitatiewe en kwantitatiewe metodes is gebruik om struktuur-, proses en uitkomsstandaarde in geselekteerde klinieke in die Noordelike provinsie te formuleer en evalueer.

Die belangrikste resultate was:

- Die standard ten opsigte van die standard was suboptimal. Fisiese en menslike hulpbronne is van kritiese belang vir gesondheidsdienslewering. Die standaard hiervan het nie voldoen aan die voorafbepaalde norm van 80% wat gestel is nie.
- Prosesstandaarde het op fisiese ondersoek van die pasiënte gefokus met inagneming van die ouderdom van die kliënt en die simptome waarmee pasiënte presenter. Sub-standaardsorg is ten opsigte van al hierdie aspekte gevind.
- Uitkomsstandaarde is deur middel van 'n pasiëntevraelys gemeet en het negatiewe bevindinge opgelewer.

Aanbevelings sluit in die ontwikkeling van 'n gehalteversekeringsmodel vir die Noordelike Provinsie se gesondheidsdienste, die formulering van standaarde vir alle dissiplines van gesondheidsorg, jaarlikse evaluering van pasiëntesorg en die instelling van 'n formele personeelontwikkelingsprogram.

Kernwoorde: Gehaltesorg, formulering van standaarde, struktuur, proses, uitkomsstandaarde.

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CHAPTER 1

SCIENTIFIC FOUNDATION OF THE STUDY

1.1 RATIONALE

It became apparent during the 1940's and 1950's that governments had to rationalize their approach to health care in order to broaden their basis of basic health care services. This would make health services not only more accessible to individuals and communities, but also more cost-effective. This approach was endorsed by the Alma Ata Conference in 1978 and had an immediate effect on the global strategies of the World Health Organization (Dennill *et al.*, 2001).

Over the last 30 to 40 years the failures of the Western model of health care in the developing countries became very clear. This was reflected, first of all, in the health budgets. A large proportion of a relatively small budget was given to buy Western medical technology for secondary or tertiary care whilst research showed that in reality the diseases of the general population in terms of morbidity and mortality, were preventable or easily treatable at community level (MacDonald, 1993).

The Government of Zambia had the courage to admit that many people had been admitted and had died of conditions which could have been prevented or inexpensively treated closer to or even in the homes of the sufferers (MacDonald, 1993).

In South Africa, before 1994, the government spent the highest percentage of the health budget on curative services and the minority Whites benefited more than the Blacks. Statistics showed that in 1983/84 the budget for curative services

amongst whites was R127 per capita in the Cape Province and R79 in the Orange Free State. The per capita budget for all the health services in the Ciskei was R45 and in Lebowa it was R16. This resulted in an under-emphasis of preventive and primary health care and an over-emphasis of expensive secondary and tertiary health services which are inappropriate to the needs of the South African population.

According to Van Rensburg *et al.* (1993), the Department of Health, Welfare and Gender Affairs in South Africa inherited a health system from the apartheid government in 1994, which was fragmented and inaccessible. These services were mainly curative-oriented and hospital-based for the majority of South African Citizens. The hospital-based, curative health services consumed the bulk of health resources of South Africa at the expense of preventive and promotive health services and care. As a result, clients with preventable conditions overloaded the hospital services. Prominent amongst these conditions were communicable diseases and manageable complications of pregnancy. For most of these conditions, prevention, conservative or routine treatment and control measures exist in the form of the primary health care approach (Van Rensburg *et al.*, 1993). This supports the research data of Zambia as previously mentioned (MacDonald, 1993).

Presently the goal of both the national and the provincial Department of Health is to change the manner in which health services are delivered in South Africa by:

- designing a health service delivery system which can reach the majority of people;
- employing measures to prevent and treat preventable diseases and conditions;
- redirecting the thrust of health care in the broader context of development; and
- providing a caring, compassionate service

(Reconstruction and Development Programme, 1994).

The Department of Health is in the process of implementing a new strategy that

will change the fragmented health system into a comprehensive and integrated health system based on primary health care principles. This strategy is derived from the National Health Bill, the Reconstruction and Development Programme, the official policy of the National Department of Health. Central to this strategy is commitment to a system of health care that is accessible and affordable, and addresses the socio-economic issues which impact on health, through community participation and inter-sectoral collaboration (National Health Plan, 1994).

Financial resources in South Africa, as anywhere in the world, are the determining factor in the supply of quality and quantity of care as well as in the policy making and prioritizing processes of health care delivery. The aim is always to have a balanced and comprehensive approach in order to render an optimal service to the entire population.

Three important considerations that should always be kept in mind are:

- cost-effectiveness (optimal allocation and expenditure of resources);
- internal effectiveness (optimized internal system functioning); and
- justice (appropriate, available, affordable and acceptable health care).

The percentage of a country's Gross National Product (GNP) spent on health care is usually a good indication of the standard of their care.

The WHO determined a minimum of 5% of a country's GNP as acceptable. Developing countries' percentage varied from 2-4% of their GNP while developed countries' GNP varied from 5-10% of their GNP. In South Africa it varied from 4,9% in 1975/76 to 6,4% in 1989/90.

Public expenditure has, however, not kept pace with the rate of population growth and rising inflation rate since 1985. Financial resources for health care thus diminished steadily and were not distributed evenly between services and consumers.

In view of the latest declared policy of the government, primary health care services must be made available to the different communities with quality and cost-effectiveness as the keywords.

Development of a primary health care service brings health services to the people in remote areas. For example, an increased number of mobile services and an increased number of clinics were instituted in villages which did not have services before. In the Northern Province where the researcher works, one clinic serves six villages with a population of 9 000 00 for the six villages. The services are rendered by four professional nurses and three staff nurses (Hospital Statistics, WF Knobel Hospital, 2000). It became clear that services had to be extended and the Department of Health of the Northern Province instituted mobile services to serve the under-serviced villages.

Nurses in South Africa constitute 67,9% of all health workers and are considered as being the backbone of the health services, especially in the rural areas. However, the maldistribution of nursing staff between urban and rural areas is evident, with some rural areas having virtually no health workers at all (Dennill, 1997).

The primary role of the nurse in the services is to assess, diagnose, prescribe treatment to clients and attend to emergencies. This entails rendering a comprehensive service and fulfils an advocacy role with regard to the client.

The clinics or primary health care centres in the Northern Province where the researcher is also working, operate from 07:00-16:00, seven days a week. In general two professional nurses and two enrolled nurses run the clinic. According to the WHO (1993) the nurse-client ratio, in a health service of this nature, should be 1:16 per day. This ratio would allow the nurse to fulfil the roles as mentioned above completely and thus render a high standard of care to the client.

However, the researcher has observed that this is not what is happening in the

clinics where she practised. The nursing staff see between 100 and 200 clients daily. It was further observed that the staff could not maintain the pace. This has led to staff members complaining of burnout, a high absenteeism rate, increase in staff turnover and demotivated staff.

The researcher was further alarmed by the fact that, according to her observation as an experienced nurse, the clients/clients did not receive the nursing care to which they were entitled. Furthermore, the management in general appeared to deteriorate. In total the researcher observed a slow but continuous decline in the standard of care measured against the standards she had informally set herself. The researcher is of the opinion that, with the emphasis today on quality of care as well as cost containment, the nurse should assume greater responsibility to systematically evaluate such changes on an ongoing basis. This will enable the nurses and other health care providers to make informed decisions regarding the quality of client care by correcting the problems that affect client care.

To do these evaluations it is necessary to formally develop standards according to the relevant criteria against which the care could be measured.

In all her years of practical experience the researcher could not find any formal or informal methods of evaluating the nursing care rendered in the clinics.

In light of the above-mentioned scenario it became clear that it was of critical importance to evaluate the client care in selected clinics in the Northern Province.

1.2 PROBLEM STATEMENT

In the light of the discussions in 1.1 the following questions arose as indication for the research.:

- Which component of the primary health care services should be evaluated urgently?

- Are there existing standards that could be used in this evaluation?
- If standards exist, could they be used or do they need modification?
- If standards need to be formulated (or developed), what is the result of the evaluation of the identified component against the formulated standards?
- What are the client's views regarding the care provided to them?

1.3 OBJECTIVES OF THE RESEARCH

The researcher found no existing standards of care in the primary health care services. It became clear that standards had to be formulated. It also became clear that the nursing component would include the structure of the clinics, the physical examination of the clients and the views of the clients of the service received by them.

The following are therefore set as objectives of the research:

- to formulate relevant standards to evaluate the nursing component of the primary health care service;
- to evaluate the nursing component in selected primary health care services;
- to determine the clients' views regarding the care they received; and
- to make recommendations based on the research findings.

1.4 RESEARCH METHODOLOGY

The research methodology is the scientific basis of the research process and needs to be accurately reflected to improve the value of the study (De Vos, 1998).

1.4.1 Research approach

An explorative, descriptive, non-experimental approach was used to analyse, monitor, evaluate and describe the nursing component in selected primary health care services as identified.

1.4.2 Research design

Triangulation as a technique was used because both quantitative and qualitative data were collected. Triangulation is the use of multiple methods to study the same phenomenon and this method ensures a comprehensive approach to reach the set objectives (Burns and Grove, 1996).

1.4.3 Sampling

The population consisted of primary care clinics and the clients attending the clinics in the Northern Province. A random sampling was used to include clinics and clients into the research.

1.4.4 Data collection

Data was collected over a period of six months by means of structured questionnaires, interviews and direct observations with the researcher as the primary data collector.

Standards were formulated and the identified nursing components were evaluated against the set standards and criteria. Data were collected until data saturation was reached and no new themes emerged.

Data were recorded on field notes. Pre-coding was done where applicable and checked by experts for exclusivity and content validity.

When interpretation of data was necessary during the data-gathering phase, the researcher ensured that experts in the clinical area verified the correctness of the interpretation.

1.4.5 Data analysis

Data analysis was done by using the EXCEL programme as part of the *MSoftware* computer programme and presented in the form of tables and graphs.

1.5 PARADIGMATIC PERSPECTIVES

According to Andrews and Boyle (2001) a paradigm is a way of viewing the world and the phenomena in it. A paradigm includes the assumptions, premises and interrelationships that hold together a prevailing interpretation of reality.

Understanding the ways in which each paradigm shapes the thought processes, values, beliefs and practices of a given culture, will help the nurse appreciate the ways in which people relate to the world around them.

Chaska (1990) supports this by defining a paradigm as a world view; an overall perspective on things.

Nursing, for example, is seen as a science and an art. It also means caring for someone, that someone being the patient/client. Mellish and Paton (1999) defines nursing in the South African context as that service to mankind which enables people to attain and maintain good health and to prevent illness. When illness occurs the nursing process helps and supports the patient/client to overcome it and regain full health. If the latter is not possible, the patient/client is

cared for until he/she dies. The client is thus cared for in totality.

In addition to the above-mentioned, the researcher supports the following:

- the theory of holism;
- nurse-client interaction; and
- the concept of quality client care.

1.5.1 The theory of holism

The words “holism” or “wholism” are synonymous and have been derived from *holo*'s, which means “complete, entire and total”. A holistic health focus requires viewing the living organism as a unit where both health and ill health are reflected throughout its entirety (George, 1990).

Based on the above-mentioned beliefs, the researcher believes that clients as human beings must be treated with respect and dignity. When the nurse is providing services to clients, she must ensure that the physiological, psychological, socio-cultural, developmental and spiritual variables are considered. This will enable the nurse to think and act systematically, which in turn enables her to handle all parts of the system simultaneously in an interrelated manner, for example during the physical examination of clients. This will ensure that the fragmented and isolated nature of the past functioning in nursing will be avoided.

1.5.2 The nurse-client interaction

The basis of a good nurse-client relationship is interaction. The researcher identifies herself with King's beliefs of nurse-client interaction which are based on the following assumptions:

- Individuals have a right to knowledge about themselves.

- Individuals have a right to participate in decisions that influence their life, health and community services.
- Health professionals have a responsibility to share information that helps individuals make informed decisions about health care (George, 1990).

According to King (George, 1990) living nature is seen in terms of an interacting whole and not as a mere sum of individual parts. It means that the human being is holistic, that mind and body function as a whole entity and that for every nursing action the client responds as a total person.

The researcher supports this theory of King and considers these assumptions as forming an integral part of the nurse's practice in health institutions or communities.

1.5.3 The concept of quality client care

Quality care and quality improvement should never be regarded as a given. The setting of standards and criteria with the relevant evaluations of the care given, form the cornerstone of quality care.

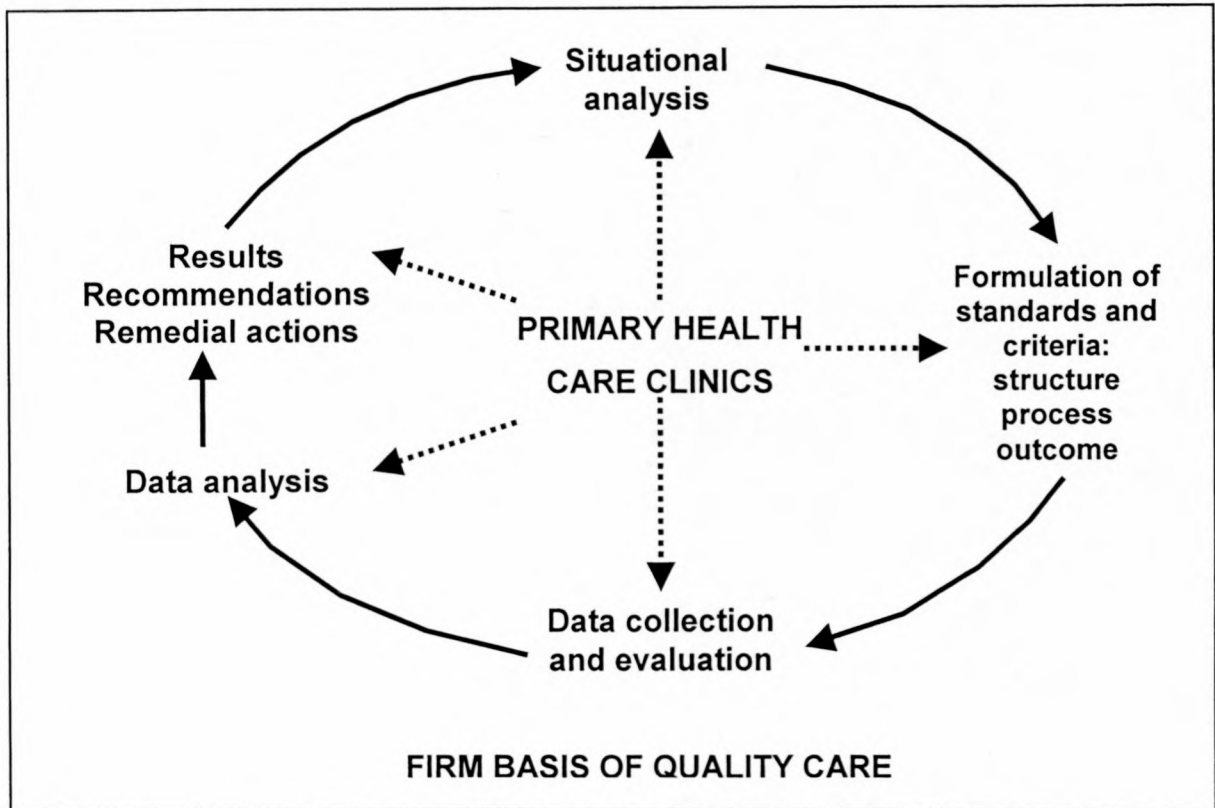
The researcher supports the concept of quality improvement as a continuous process. Quality care also means that the care should be accessible, effective and appropriate.

1.6 CONCEPTUAL FRAMEWORK

The diagram in Figure 1.1 guided the researcher in the research process to achieve the set objectives. In order to start with the process of evaluation of a nursing component of selected primary health care services, it is necessary to do a **situational analysis** to determine if standards exist that could be used to

evaluate a nursing component of selected primary health care services.

FIGURE 1.1
CONCEPTUAL FRAMEWORK



The researcher could not find any existing standards for the situational analysis. The analysis also indicated - as supported by the reasons given in the background to the study - that a selected component of primary health care service should be evaluated first. The diagram/conceptual framework explains the whole process that was followed.

After the situational analysis, **standards with relevant criteria** were set as follows:

- *Structure*, which involved resources, management, equipment, facilities, environment and supplies;
- *Process*, which involved relevant nursing interventions; and
- *Outcomes*, that involved the views of clients about the nursing care

provided to them.

Data collection and evaluation was done, then data was analysed, recommendations were made and remedial actions were recommended.

It is also necessary to revisit the whole process and to re-evaluate selected components of primary health care services on a continuous basis, at least annually, to modify where necessary.

1.7 OPERATIONAL DEFINITIONS

- **Accessibility** refers to the ease with which a client can obtain the care he/she needs. It is the degree to which primary health care service may be obtained at a level of effort and cost that is both acceptable to and within the means of large majority of the population (Bertrand *et al.*, 1995).
- **Affordability** is the degree to which primary health care services may be obtained at a level and cost that the community can afford (Clark, 1994).
- **Attitudes** are the person's beliefs about the object and his/her feelings towards the object (Agzen and Fishbein, 1980).
- **Beliefs** are the knowledge, opinions, and faith that dispose persons towards a certain kind of behaviour.
- **Evaluation** is the measurement by which the service is monitored by using methods of inquiry and judgement, including determining the standards for judging the quality, collecting relevant information as well as applying the standards to determine quantity (Johnson and Olesinski, 1995).
- **Equity** refers to the provision of accessible primary health care services to promote the health populations most at risk to health problems (Stanhope and Lancaster, 1996)
- **Holism** is a theory that the universe and especially living nature are correctly seen in terms of integrating of the whole that is more than merely

the sum of individual parts (George, 1990).

- **Client care** involves four areas in nursing care, which are important to make nursing care effective:
 - nursing knowledge;
 - skills; and
 - level of care required by the client.
- **Quality** is the degree to which clients' services increase the probability of the desired outcomes and reduce the probability of the undesired outcomes, given the current state of knowledge (Kate and Green, 1992).
- **Quality of care** refers to outcomes that are the result of care, or measurable changes in health status or behaviour of clients (Adams and Wilson, 1995).

The concept patient/client is used but for the purposes of this research only client will be used. This is also the accepted term or word commonly used in the clinics.

1.8 ORGANIZATION OF THE STUDY

Chapter 1 serves as an orientation to the study. It covers the rationale for the study, statement of the problem, objectives of the research, methodology of the research, paradigmatic perspective, conceptual framework and operational definitions.

Chapter 2 describes health care in South Africa, Northern Province and current African approaches to primary health care, quality care and standards.

Chapter 3 describes the research methodology of the study.

Chapter 4 describes the analysis of the data and discussion of research findings.

Chapter 5 contains the conclusions and recommendations.

1.9 SUMMARY

The total health service in South Africa changed after 1994 and the concepts of primary health care, quality care and cost effectiveness were emphasized.

It became clear to the researcher that the primary health care services in her area, especially the nursing component, needed evaluation to determine whether the care was of the quality that was required.

CHAPTER 2

LITERATURE STUDY

2.1 INTRODUCTION

“Literature review” refers to the activities involved in searching for information on a topic and developing a comprehensive picture of the state of knowledge on the topic (Polite and Hungler, 1993).

Literature study for the research was done to:

- give an overview regarding health services before and after 1994 in South Africa;
- give an overview regarding health services in the Northern Province;
- review the quality assurance concept; and
- review standards and relate the outcome it to the research.

2.2 HEALTH SERVICES IN SOUTH AFRICA BEFORE 1994

Although South Africa spends a considerable amount of money on health compared to other countries, indicators of general health of the population reveal that they are strikingly poor. Some examples include high infant mortality rates and maternal mortality rates. Furthermore, preventable conditions such as tuberculosis and diarrhoeal diseases remain a major cause of illness and death (Van Rensburg *et al.*, 1992).

Prior to 1994 the health care system in South Africa was largely urban and

curatively based. Large institutions served a small percentage of the patients and were expensive to run in terms of financial and human resource costs and people who benefited were Whites, Coloureds and Indians. Health expenditure was the highest at a tertiary level for the minority of the population, minimal at secondary level and even less at primary level where health care was needed the most (Van Rensburg *et al.*, 1992).

In the early 1980's the National Health Service Facilities plan was introduced. It aimed at ensuring the provision of a comprehensive health service to the entire South African population. It was divided into six levels:

- Level I – provision of basic needs
- Level II – health education
- Level III – primary health care
- Level IV – community hospital care
- Level V – regional hospital care
- Level IV – academic hospital care

(Bouwer, 1997)

The increasing cost of health care, combined with limited resources, has forced South Africa to seek solutions to the potential economic problems. After various summits and conferences and discussions, the government decided to adopt a primary health care strategy for health services delivery and care to clients.

The government hoped that this type of service would decrease the number of patients being admitted to hospitals by preventing illnesses and maximizing health (Reconstruction and Development Plan, 1994).

2.3 HEALTH SERVICES IN SOUTH AFRICA AFTER 1994

According to the National Health Plan that was adopted in 1994, health centres would be the foundation of a National Health Service in a community. These

centres would be situated within the community and as close to other community services and activities as possible. These centres would be staffed by a team of health workers who would be responsible for providing comprehensive health care for all persons living in the area (Reconstruction and Development Programme, 1994).

To achieve the above-mentioned, the health service was organised as follows:

- (1) National Health System
- (2) Community Health Nursing Services

2.3.1 National Health System

The National Health System includes both public and private providers of goods and services, and must be organized at national, provincial, district and community levels. The health system encourages communities to participate actively in the planning, managing, delivery, monitoring and evaluation of the health service in their areas. The whole National Health System is driven by the primary health care approach. To deliver such a service, it must be based on scientific and management principles. This National Health System identified the following areas of services:

- (i) Women and children
- (ii) Mental and psychological health
- (iii) Sexual health and Aids
- (iv) Other health care programmes
- (v) Human resources for the National Health System
- (vi) Finance and drugs for the National Health System
- (vii) Community participation and involvement

2.3.1.1 *Women and children*

Before 1994 women and children were paying for their health services at clinics

and hospitals. After 1994, health care for all children younger than six years and pregnant women was provided free at government clinics and health centres. It also included free in-service training for midwives and traditional birth attendants by the Department of Health (Reconstruction and Development Programme, 1994).

2.3.1.2 Mental and psychological health

According to the Reconstruction and Development Programme (1994), mental illness and substance abuse were not prevented, and many people suffered the consequences, as this concept was not included in the apartheid era's national health system. After 1994 the government's aim in this regard has been to promote mental health and to increase the quality, quantity and accessibility of mental health support and counselling services.

2.3.1.3 Sexual health and Aids

According to the Reconstruction and Development Programme (1994) sexual health care was given to the urban population but it did not reach the rural communities to the extent that it should have. The goal of the National Health System in this regard was to combat the spread of sexually transmitted diseases and Aids. It also planned to launch mass education programmes, involving the mass media, schools and the communities in South Africa.

2.3.1.4 Other health care programmes

The Reconstruction and Development Programme (1994) stressed the launching of programmes to ensure prevention, early detection and treatment of, e.g. tuberculosis, carcinoma of the cervix, hypertension and diabetes mellitus. These

programmes were intended to promote and provide appropriate care of chronic diseases and encourage healthy life styles.

The Reconstruction and Development Programme (1994) also made provision for improved access to emergency health services through the provision of 24-hour emergency services. Programmes focusing on the youths, in particular teenage parents and young people with sexually-transmitted diseases, were to be monitored.

Before 1994, occupational health services benefited the minority Whites (Van Rensburg *et al.*, 1992), but through the Reconstruction and Development Programme, these services were to be expanded by legislation to protect the health workers, including domestic, farm and commercial sex workers. The use of technology and a system of quality control would be developed.

An effective National Health Information System would be introduced. This would be used in planning and data analysis at health facilities at district, peripheral and national levels. Information could thus be shared between different programmes and sectors.

The Reconstruction and Development Programme initiated a programme of essential national health research, which aimed at increasing consultation with patients, and strengthening links between research, policy and action (RDP, 1994).

2.3.1.5 Human resources for the National Health System

The Reconstruction and Development Programme aims at providing core teams for every community health centre and clinic, re-orienting existing health workers to the Primary Health Care approach, and redistributing personnel to work in under-serviced areas. The RDP document further states that throughout the period of reconstruction and development strenuous efforts must be made to

strengthen the public sector, and to attract health workers in private practice back into the public sector. The following should also be addressed, either by in-service training or formal educational programmes:

- Training/teaching staff in the primary health care approaches
- Management
- Primary clinical care
- Environmental health
- Health promotion and advocacy
- Occupational health
- Care of human and other resources and equipment

(RDP, 1994).

2.3.1.6 Finance and drugs for the National Health System

The budget is to be shifted from curative hospital services towards primary health care to address the needs of the majority of the people. Staff are to be reallocated to district health services. RDP advocates free health services to the aged, disabled, unemployed and students who cannot afford health care. There must also be an essential drug list to reduce the current wasteful expenditure on inappropriate drugs (RDP, 1994).

2.3.1.7 Community participation and involvement

The Reconstruction and Development Programme initiates community participation and involvement in planning health care. As this did not happen before 1994, there was no planning in order to meet the real needs of the community (Van Rensburg *et al.* 1992). This new initiative aims at involving everyone and encourages active participation by the community in their health care planning (RDP, 1994).

2.3.2 Community Health Nursing Services

Major challenges confronted the community nurse in the 1990s. It was, for instance, economically impossible to use the registered nurse only to render community nursing. The nursing team had to consist of registered nurses, enrolled nurses, midwives as well as auxiliary nurses. As provision of a comprehensive primary health care is dependent on a multi-skill preparation of health workers (Bouwer, 1997), every nurse and midwife had to be trained to cope with general problems as well as with psychiatric, midwifery and other community health problems. The nurses also had to be trained/educated in the primary health care principles as well as in the clinical part of primary health care.

These primary health care principles were thus incorporated in the services to act as catalyst for the transformation process of primary health care to achieve the equity, accessibility, affordability, availability, effectiveness, and efficiency (Denill, 1997). All this is, however, dependent on a favourable nurse/health worker : client ratio.

2.4 HEALTH SERVICES IN THE NORTHERN PROVINCE

After 1994 the Northern Province accepted the challenges to change the health services. The Department of Health, in consultation with all the other relevant directorates, planned and organized to improve the health status of the country and provide quality care to the clients.

The Department decided that a good point of departure to achieve the above-mentioned, would be to introduce of the Batho Pele principles (Northern Province Health Plan, 1999). The process of introduction and application of these principles is done in five steps as described in 2.4.1 to 2.4.5 below.

2.4.1 Introduction of the Batho Pele generic principles service standards

These standards are classified into two categories:

- Standards to be achieved immediately
- Standards to be achieved within twelve months after the announcement

These generic principles service standards emphasized and re-enforced the approach that members of the public must be treated respectfully, empathetically, promptly, impartially, and transparently. All this had to be done according to the criteria set by the Department of Health (Northern Province Health Plan, 1999).

2.4.2 Introduction of eight Batho Pele standards

These standards were introduced to act as catalyst for the transformation of health care services. The process included consultation with the public about the level, quality and choice of the services they received. Toll free numbers were provided to the public to use in the consultation process. The level and quality of service to be expected were communicated to the public in the Northern Province by means of posters and the mass media (newspapers and radio). The principle of equal access to services is presently being upheld, but is still in the process of transformation. Additional clinics or hospitals that are built adhere to that principle. The clients visiting the health services are treated, irrespective of colour, gender, need of religion, with respect, openness and transparency. All relevant information is made known to the client. This would include information on the management of the health services in the province as well as accurate details about the services they were entitled to.

The minister of health in the Northern Province explains the above-mentioned at various workshops and forums. The province also supports public apologies if a

problem arises and services were not rendered as they should have been. This is also accompanied by effective remedial actions where applicable. The necessary financial support that has to accompany all the actions mentioned here, has not yet been fully realised.

2.4.3 Implementation of Batho Pele according to targets

There are a number of steps to be followed in order to reach these targets. See Figure 2.1.

FIGURE 2.1
STEPS TO REACH TARGETS

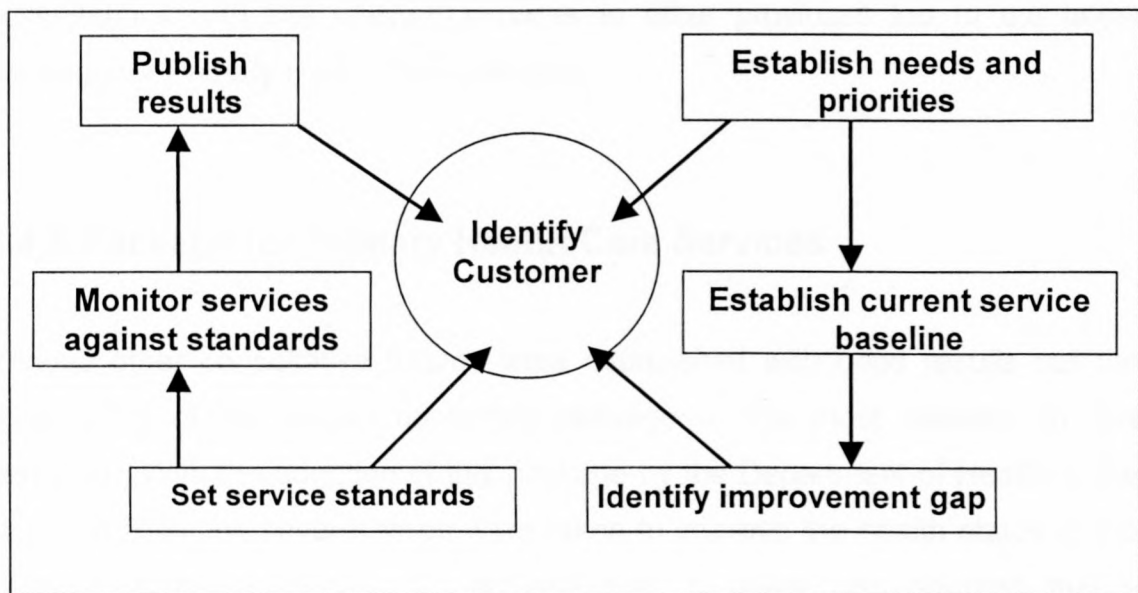


Figure 2.1 shows that both the customer and the needs and priorities for health services should be identified. The base line services should be determined to enable the providers to identify the areas where improvement is necessary. Only after that, the standards should be set and the services evaluated against these standards. In the end the results should be published. The Northern Province is in the process of implementing these principles.

2.4.4 Launching of Batho Pele

The Department of Health of the Northern Province launched Batho Pele formally in May 2000. Commitment was given on that day that the Department of Health would ensure that every staff member would be informed about these principles and that everything in their power would be done to implement it effectively.

2.4.5 Introduction of consultative fora

The first consultation forum was established in the Northern Province after thorough consultations with the relevant stakeholders. This resulted in the compilation of a comprehensive Primary Health Care Service Package. Further consultations with the relevant services in other provinces led to the latest Package for Primary Health Care services.

2.4.6 Package for Primary Health Care Services

Various other consultative forums were established with good results but the compilation of the above-mentioned package is the most relevant to this research. With the adoption of this package by the Department of Health in the Northern Province several steps were taken to improve the health status of the citizens of this province. To achieve that, a policy was adopted that a comprehensive health care service was to be rendered to clients on the different levels of care.

It was further stated that the district management would coordinate the health services between the various levels of service. These services include referrals, outreach services of clinics, environmental health, health promotion and home-based care. The clinic and mobile services were defined not by the size of the facility but according to the level of the skills of the staff.

The definition included services that could be delivered by a professional nurse and additional services that could be delivered if regular visits by a doctor, specialists and other members of the multidisciplinary health team could be organized. This approach is of particular importance in rural areas where clinic health centres and hospitals may be non-existent or very distant (Primary Health Care Package, Northern Province, 1994).

The original Reconstruction and Development Programme (1994) defined a clinic as a point of health service, operating eight hours a day from Mondays to Fridays. The nurses would be on call at night. The Northern Province stated in their policy that 221 clinics would operate on the "eight hour" and "on call" system in case of an emergency. Sixty clinics operate 12 hours a day and 84 clinics would operate on a 24 hour day. All these clinics would deliver a comprehensive health service with special attention to preventive and promotive health interventions.

The health care planners were still left with the very distant rural areas to be served. Outreach sites were identified and health care personnel visited these outreach sites (also called a mobile) on a specific day when clients had gathered there. If the community had constructed a room with all the safety measures in place, the medical supplies could be stored there. If not, the primary health care trained nurse(s) had to carry the supplies with them. These mobile points are, however, potential future clinics (RDP, 1994).

A community health centre serves as a day hospital equipped with 24-30 beds. The services offered here are preventive, curative, promotive and rehabilitative and intermediate level operations/surgery can be performed here. It serves a specific, affected area and those patients with complications who have been referred from adjacent and outlying clinics. In the Northern Province there are 22 of these centres operating 24 hours a day. Some areas do not have community health centres yet, and other some services would, in the short term, be better rendered from existing hospitals (for example, deliveries, casualty and termination of pregnancy). The more complicated cases will be referred to the

district hospital. To achieve this, an effective referral system must be in place. In the Northern Province such a referral system was put in place.

The last issue that was left to consider in the planning and organizing of health services, and possibly the most important one, was the staffing of the health centres. Previously proposed guidelines, which combined concerns for sufficient time spent with a client with the overall productivity of clinical staff, were taken into account. The following factors were also considered because they would influence the staffing norms:

- Period of high staff turnover due to retraining
- Increased workloads resulting from progressively higher packages of services introduced (Primary Health Care Package Northern Province, 1994).

The Department of Health in the Northern Province assessed the clinics and community health centres regarding staff needs and catchments population. They decided on a staffing norm as follows:

- For a high-density area (catchments population of 50 000) – 21 professional nurses and nine enrolled nursing auxiliaries at clinics
- For a high-density area (catchments population of 200 000) – a community health centre: a clinic with 42 professional nurses and referral areas with 19 professional nurses, two doctors and one psychiatric specialized nurse. The 24-hour service area must consist of 13 professional nurses and one doctor.

The statistics of the Department of Health in the Northern Province indicate that the staffing of the different points of health services does not reflect the proposed norm at all.

2.5 QUALITY ASSURANCE/IMPROVEMENT

This section will be discussed under the following headings:

1. Quality of care
2. Quality assurance/improvement.

2.5.1 Quality of care

Various definitions of quality of care exist. Vincent (1997) states that quality of care refers to the appropriate and competent technical care with opportunities for clients to make choices and to discuss concerns and fears, and resulting in an outcome appropriate to the problem.

Stuart Whitaker *et al.* (1996) describe quality of care as the success of the health services in meeting the health-related needs of the population in a manner that is consistent with local goals, national goals and resource constraints. According to these authors quality is all-important and understanding the quality of care thus requires examination of the whole health system, which includes the following:

- the input into the system, for example physical infrastructure, the people and their training, the equipments and drugs;
- the process – as being the way the inputs are applied, for example, the treatment and care of clients; and
- the outcome, for example the change in health status, or the prevention of ill health.

Vincent (1997) included the dimensions of quality of care as effectiveness, efficiency, appropriateness, acceptability, access and equity, and explained that in order for quality of care to be rendered, the above-named component should be considered at all times. The author further explained that by combining structure, process and outcome with the six dimensions of quality, a structure emerges that can be used to compile a series of questions about the quality of a unit.

The World Health Organization (1983) maintains that in order to provide quality care the following elements are required:

- professional practice;
- effective utilization of resources;
- minimum risk to the patient; and
- patient satisfaction.

Vincent (1997) and Meyer and Feingold (1993) agree with the statement above and explain that high quality of care is only possible through the co-ordinated and collaborative efforts of multiple providers, and that partnership between clinicians and hospital management is essential for efforts to enhance quality care whilst controlling cost. Black *et al.* (1995) agree with these authors above that cost awareness includes understanding of accountability for client care decisions.

The above-named elements will be taken into account when standards and criteria are formulated to evaluate the nursing component of a selected primary health care service.

2.5.2 Quality assurance/improvement

Stuart Whitaker *et al.* (1996) describe quality assurance as the measurement of the actual level of the service provided plus the efforts to modify (when necessary) the provision of these services in the light of the results of the measurements. Quality assurance is also defined as a process involving both evaluation and improvement actions (Berger *et al.*, 1980). All these authors agree that in the delivery of health care services, quality assurance is the estimation of the degree of excellence in client health outcomes. Sullivan and Decker (1992) agree that quality assurance consists of a systematic process of evaluating the quality of care. The health care worker, especially the nurse, should become involved in this process of quality assurance. The nurse is by law responsible and accountable for her own acts and is bound by certain regulations under this law to render safe quality care to her client, whose life may ultimately be at risk.

The current status of quality assurance as viewed by the nursing profession appears to focus on setting standards, auditing the process of nursing care and developing outcome measures, whilst looking simultaneously at wider issues such as skill mix (Parsley, 1994).

2.6 QUALITY ASSURANCE MODELS

In South Africa health services were compelled to pay attention to cost-effectiveness and quality of client care. This resulted in the fact that quality assurance became an essential factor in nursing to implement quality assurance programmes (Booyesen, 1993).

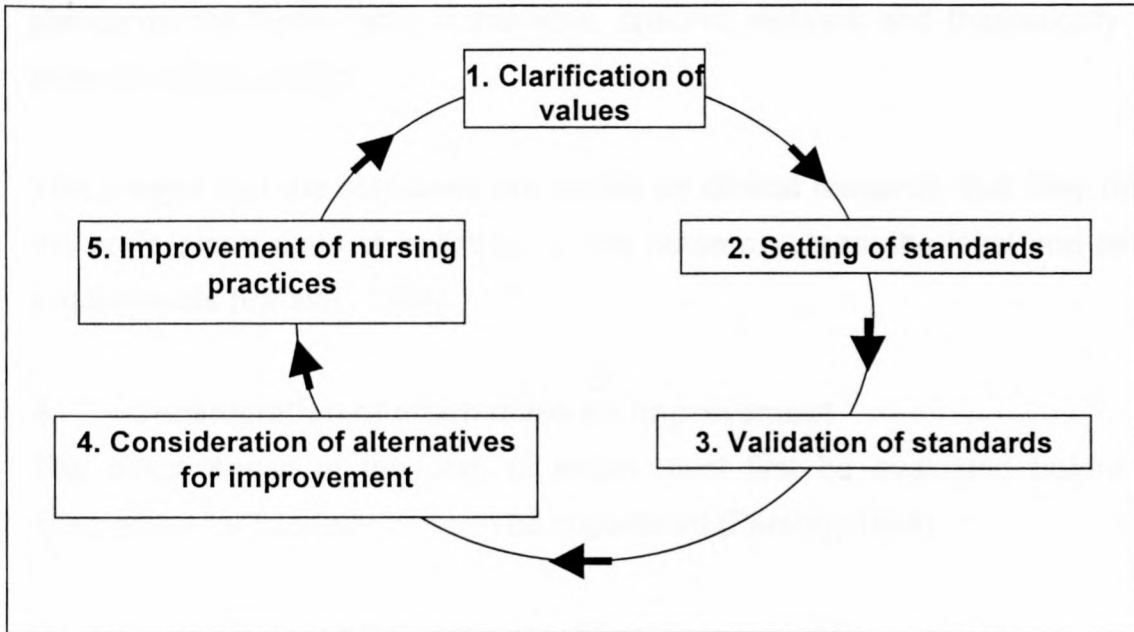
These models provided a scientific base for implementing quality care in nursing. The researcher studied the following models and programmes which also served as a guideline for the setting of the standards used in this study:

- Norma Lang's model
- Ray's Quality Assurance Programme
- Competency Model (JCAH)
- Deming's Quality Improvement Principles

2.6.1 Norma Lang's model

Lang's model was adapted and developed by the American Nurses' Association and consisted of five steps. It was also adapted by the Royal Australian Nursing Federation to consist of eleven steps, but this model can be adapted into a few key steps, for use by a nursing quality assurance committee, ward sister or charge sister (nurse) in a particular clinical area (Sale, 1990). The stages depicted in Figure 3.2 should be followed, and when the cycle is completed, the process should begin again (Parsley, 1994). Figure 2.2 indicates the steps to be followed in Lang's model.

FIGURE 2.2
NORMA LANG'S MODEL



(Booyens, 1993)

The five steps will now be discussed.

1. Clarification of values

The first step is to get together with colleagues in the clinical area to discuss and/or evaluate the mission, vision, objectives and policies for the clinic/institution. This discussion will include personal beliefs and values regarding nursing. This system of value must be formulated and evaluated on a continuous base.

2. Setting of standards

Lang stated that a standard is an agreed - upon level of quality, and criteria are indicators or statements that could be measured whilst reflecting the contents of the standard. Lang is also of the opinion that a person should look at the structure, process and outcome dimensions when determining the effectiveness of nursing care interventions. The standard should also indicate very clearly which individual or group is responsible to maintain standards (Booyens, 1993).

3. Validation of standards

Experts should validate standards. They should thus indicate whether the standards are measurable, achievable, specific, relevant and theoretically and scientifically grounded.

This means that the standards are based on clinical research, that they reflect the profession's code of behaviour of the nurse and meet the legal and ethical requirements (Parsley, 1994).

4. Consideration of alternatives for improvement

The effectiveness of the plan of action must first be evaluated before the alternatives for improvement can be considered (Parsley, 1994).

5. Improvement of nursing practices

Improvements are implemented as applicable.

2.6.2 Ray's Quality Assurance Programme

McFairland and Thomas (1991) describe quality assurance as a programme of systematic evaluation and action to ensure excellence in health care. Gail and Ray developed a Quality Assurance Programme in 1988 to provide meaningful organized information as the basis for guiding actions to maintain or improve the efficiency and effectiveness of the nurse's practice. Ray's Quality Assurance Programme is composed of five principal components: client management, programme implementation, resource utilization, risk management, and staff preparation. Figure 2.3 shows Ray's Quality Assurance Programme (McFarland and Thomas, 1991).

FIGURE 2.3
RAY'S QUALITY ASSURANCE PROGRAMME

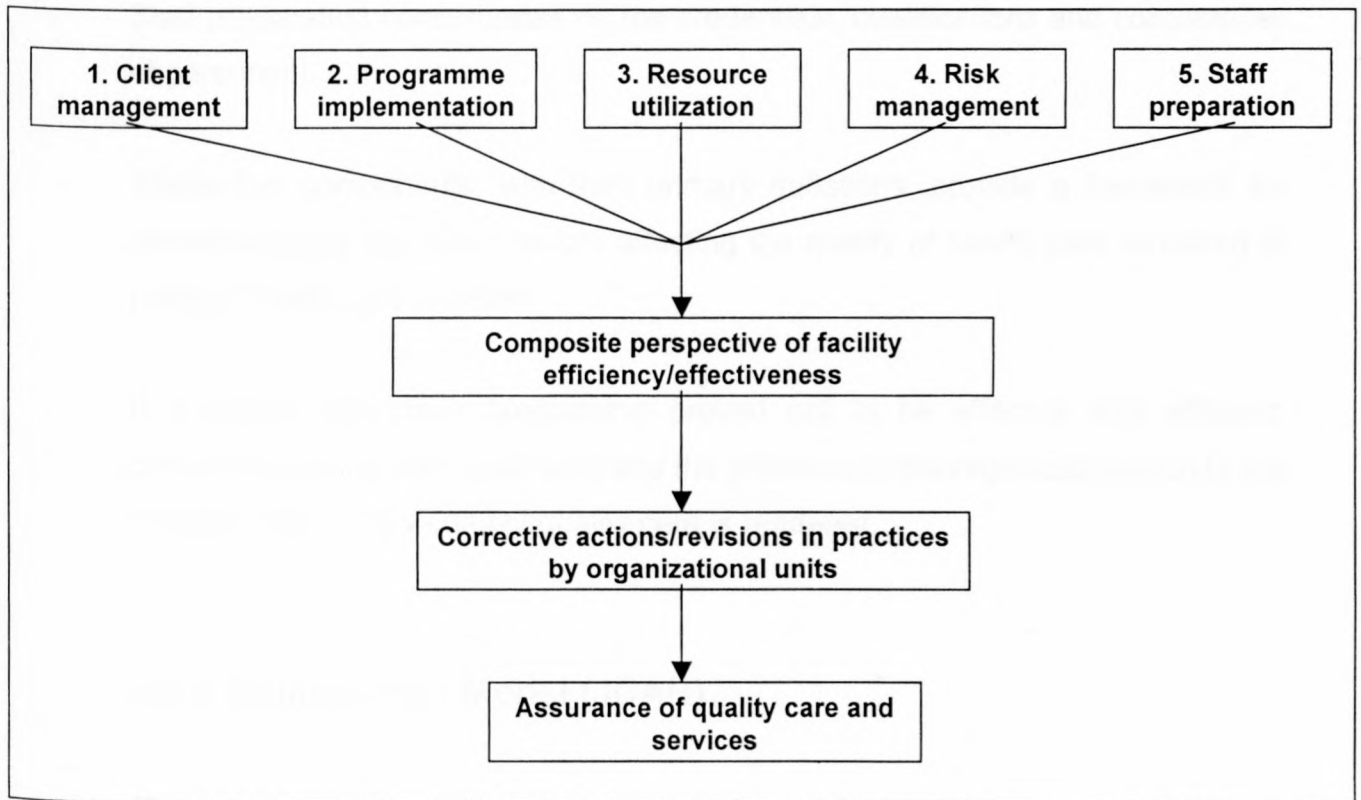


Figure 2.3 is now discussed (McFairland and Thomas, 1991).

Client management focuses on the direct care and services provided to individuals/clients.

Programme implementation targets the operation of systems and procedures for programme and service delivery, including the accomplishment of goals and objectives.

Resource utilization considers the necessity for services as well as the allocation and utilization of resources (human and financial).

Risk management examines measures to protect clients, visitors and staff from injury or personal, material, or economic loss and to protect the organization from

operational, human, material or economic loss.

Staff preparation concentrates on the credentials, qualifications and competency of personnel.

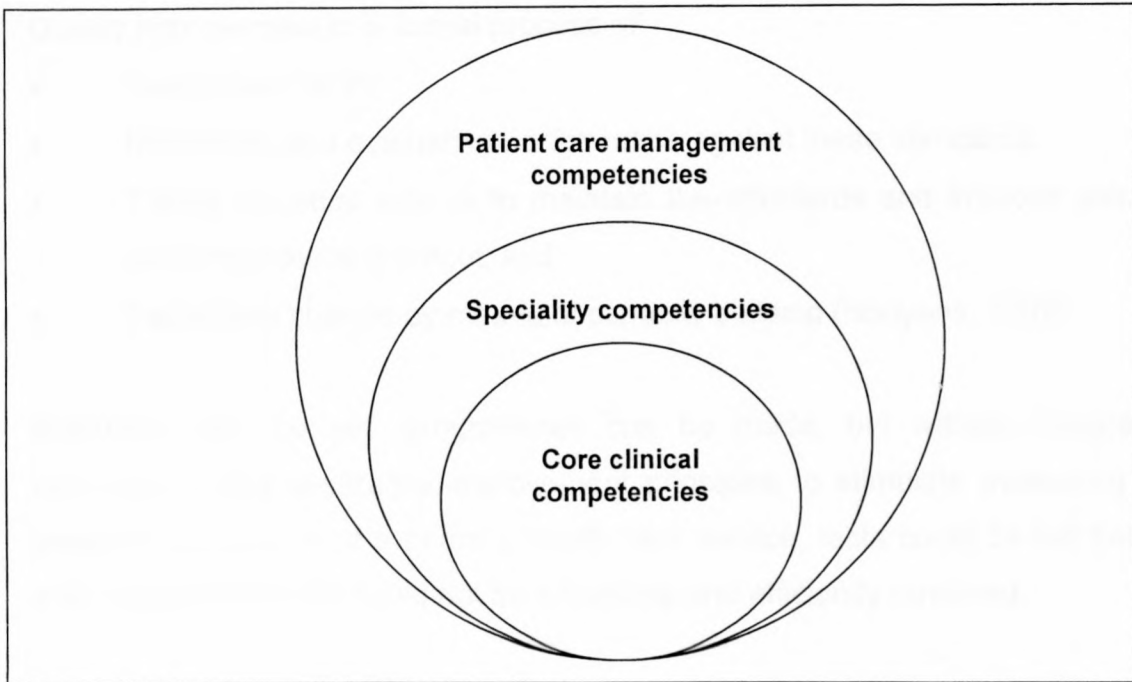
These five components, with their primary questions, provide a framework for conceptualising the many factors affecting the quality of health care rendered at primary health care services.

If a quality assurance programme proved not to be effective and efficient, corrective actions are considered and the practices in the organizational units are revisited and evaluated until quality care is rendered.

2.6.3 Competency Model (JCAH)

The competency model emphasizes that even though standards are set, nurses need to be competent to perform the task to ensure that quality client care is rendered. The leadership in the institution is responsible to ensure that those who deliver client care, are competent to do so. A competency framework should be in place indicating that the relevant nursing staff can integrate knowledge, skills and personal attributes consistently in daily practice to meet established standards of performance. Fey and Mittner (2000) further state that competencies serve a definite purpose of ensuring that quality care is rendered.

FIGURE 2.4
COMPETENCY MODEL



(Fey and Mittner, 2000)

The core clinical competencies reflect the knowledge and skills necessary for the registered nurse to assess a client, develop and implement an individualized plan of care and evaluate that plan based on the client's status.

Both authors further explain that the speciality competencies represent the knowledge and skills required to provide appropriate nursing care to a specific patient population. The final competency level labelled "patient care management competencies" demonstrate that the registered nurse can integrate the range of both care and speciality competencies to provide client care for each patient. They further explain that these competencies address the need for nurses to blend psychomotor skills, psychosocial support, and problem-solving skills to minimize complications and improve the outcomes for each patient.

2.6.4 Deming's Quality Improvement Principles

Quality improvement is a formal process of:

- Setting standards
- Monitoring and evaluating performance against these standards;
- Taking remedial actions to maintain the standards and improve existing performances and output; and
- Facilitating change by means of capacity building (Booyens, 1999).

Standards can be set, programmes can be made, but without integrating Deming's quality assurance/improvement principles to stimulate evaluating the selected component of a primary health care service, facts could be left behind and quality client care could not be effectively and efficiently rendered.

The above-mentioned principles are (Booyens, 1999):

1) Introduction of long-term goals for service improvement

Primary health care service managers should introduce long-term goals and make them known to all employees, including especially all categories of nurses.

2) Adoption of a new philosophy

Primary health care service providers and other professionals and general assistants should develop a positive attitude towards their work, and doing things right the first time should become a matter of handle.

3) Inspection

Inspections should aim at improvement of skills and effective applications of new technology.

4) Purchasing of equipment and supplies and planning if necessary

When purchasing is done the nurse should consider all costs involved. The all-inclusive costs regarding equipment and supplies could be maintained at a lower level. Planning regarding manpower should include retaining initiatives, training

and professional and personal development of all staff members. Staff are seen as an asset for an organization and usually have a positive influence on productivity and quality of service.

5) Improvement of activities

Each employee should be acquainted with the service mission and definition of quality care. They will constantly strive to improve their service when they have internalised those values and norms.

6) Training and personnel development

Continuous training and development of personnel are seen as the key points of ensuring quality improvement in the services.

7) Establishment of leadership

Top-level management should improve to allow improvement at a lower level of management and eventually improvement of the quality of service rendered by all levels of staff. This can only happen if the correct and effective leadership is established and effective leadership is established and maintained.

8) Eliminate fear

A traditional hierarchical structure in a health service makes subordinates fearful to make suggestions. During proposes a flatter structure to and this combined with the leadership mentioned in point 7 would ensure quality improvement in an organization.

9) Break down barriers between departments

Wards and departments should not compete, as this replaces teamwork and quality of service is not rendered. To break these barriers down requires a concerted effort of good leadership and participative management.

10) Eliminate slogans, warnings and targets for personnel

Indirect warnings and slogans in the health centres result in counterproductive behaviour, therefore formal systems of improving quality must be created and

followed.

11) Eliminate work standards that prescribe numerical quotas for the day

Employees will lose sight of the need to continuously improve the overall level of quality especially if there is such a short-term objective.

12) Pride in doing the job

Employees should promote teamwork and group motivation to improve the service as a whole.

13) Introduction of a powerful training and self-development programme

Management should concentrate on the training needs of personnel that will lead to staff motivation and higher productivity and rendering of a high quality service.

14) ?

Everybody in the institution should participate in the transformation from traditional management to modern management that will facilitate quality improvement.

All these models integrate the structure, process and result dimensions of the nursing component of a health service. They also ensure that a comprehensive health service is delivered. This necessitates that standards should be set for all those domains to evaluate the nursing component of a service. In this study the researcher focused on the structure and process standards and the outcome was evaluated by means of a patient satisfaction questionnaire. The research also focused on a specific part of the nursing component of a primary health care service because of financial and time restraints namely, the physical examination of a client.

2.7 STANDARDS

Standards provide a broad framework to the employee, within which the

professional can practise her/his profession. It is a dynamic instrument to achieve a high quality of service (Parsley *et al.*, 1994).

The setting of standards alone is insufficient to obtain a change in perceptions and attitudes of staff. The ability of the professional nurse in charge to communicate the standards to other staff members, and the objective measurement of performance against the set standards are essential to start with the quality improvement circle (Parsley *et al.*, 1994).

The normal process is to set the objectives to be achieved. Hence the nurse has to determine how to achieve these objectives. This is followed by setting general comprehensive standards followed by the setting of criteria or indicators. Then the specific programme, system, practice, nursing care or performance can be measured or evaluated.

For this study criteria/indicators are defined as specific statements/suppositions which could be measured to determine whether a certain standard was achieved or not. The development of criteria is a tedious process and the literature supports the idea that expert and knowledgeable practitioners should develop it. The literature also states that criteria should be:

- Realistic;
- Descriptive of the optimal performance or achievement;
- Specific with indications when they should be used;
- Measurable;
- Formulated in such a way that a yes or no answer is possible;
- Written in positive terms;
- Applicable to a certain group of nurses/practice/care and only the relevant aspects should be covered; and
- Objective (Liddie, 1976).

As discussed under 2.5.1 and 2.5.2 it is necessary to evaluate or examine a whole system to understand or determine the quality of care rendered. This first requires standards with relevant criteria to be set, covering the whole system.

The following standards need to be set:

- Structure standards
- Process standards
- Outcome standards

The researcher identified in Chapter 1 that the nursing component of the selected primary health care service needs to be evaluated. In order to do that, and based on experience, consultation with experts and the literature study, the following standards were set. The relevant criteria were developed accordingly.

2.7.1 Structure standards

Structure is described by Booyens (1993) and Katz and Green (1992) as the rules of the system and its governance, including the mission statement, philosophy statement, goals and policies. Gillies (1992) agrees with the above-mentioned description but adds that it also refers to the support system required for health services to be delivered and that it applies to things we use, for example, human, financial and physical resources. The following standard was formulated:

The supply, organization, utilization and maintenance of facilities, equipments, staff and financial resources enhance the rendering of quality nursing care.

The criteria/indicators relevant to this standard were determined. Accordingly, the following had to be in place to ensure that a high standard of care is rendered.

(a) Facility:

- Mission statement
- Philosophy
- Objective of services

- Circulars
- Protocols for physical assessment
- Procedure manuals
- Quality improvement programme
- Research programme
- Disease control charts
- Infection control programme
- Staff development programme
- Community profile
- Disaster planning map
- Daily report book
- Protocol for general security measures

(b) Equipment and supplies/stock per clinic per room/trolley

All the necessary equipment was listed (Addendum ?). This covered the absolute minimum necessary to ensure safety in quality care to the client.

(c) ??

The facility itself, equipment and instruments need to be cleaned in a specific way to ensure a therapeutic, risk-free environment, safe and quality care to the client. Relevant criteria for this were set (General rules in Addendum ?).

(d) ????

Criteria were also set to evaluate whether medico-legal risks were prevented and infection control measures were in place (Addendum ?)

(e) ???

To achieve the quality of care stated in the main standard, it is necessary to provide enough space or rooms in a clinic, as well as effective communication aids.

(f) Human resources

Effective and sufficient human resources are of the utmost importance. The relevant criteria were set accordingly.

2.7.2 Process standards

According to Katz and Green (1992) and Finkelman (1994) process is the manner in which services will be delivered. It involves procedure, protocols, action plans and a recommendation system. Booyens (1996) describes process standards as the process that describes how specific actions should be performed and thus applies to what we do, and to activities that constitute care, service or management. Mason (1984) defines process standards as the quality of the implementation of nursing care.

The researcher decided (see Chapter 1) that the process in this research would cover the nursing component that entails the physical examination/assessment, and treatment of a client in a primary health care clinic. That includes prescription and documentation/recording. Various authors agree that to obtain data from this, the most direct way would be the observation of care-giving activities and physical examination of clients, record keeping and giving of correct treatment (Bates, 1987; Swartz, 1998).

The researcher is to evaluate this process when professional nurses do the physical examinations of clients visiting the clinic. The researcher used the view of the above-mentioned authors when formulating the process standards of the physical assessment/examination of a client at the selected primary health care services.

2.7.3 Standard

Quality client care is rendered through a complete history taking, physical

examination of the body systems, treatment and record keeping. A complete physical examination includes several steps. These steps were formulated as follows:

- Interviewing the client
- Physical examination of clients with regard to body systems, to enhance treatment and prescription
- Management of the case
- Documentation/record-keeping

Stuart and Sudeen (1987) describe physical examination and history-taking as a brief survey of the client's experiences, and stress that the client's medical history, psychiatric history, family history and personal history should be included. They also state that all aspects of the person contribute to health and illness, thus the balance in all the dimensions of a person is valued. Both authors agree that the holistic framework for health emphasize that all aspects of the person are significant and that the way in which these aspects interact to affect the whole person should be considered.

The researcher based her physical examination standard on her conceptual framework that believes in the theory of holism and nurse-client interaction (Chapter 1). The researcher's conceptual framework is based on seeing clients as an interacting whole and not as a mere sum of individual parts. The researcher based her standards on seeing a client as a multi-dimensional person composed of biological, psychological, social and spiritual components as outlined in Chapter 1 of this research.

The following skills and tasks are very important before, during and after the physical assessment of the client and will now be discussed:

- When the client enters the health service and makes contact with the primary health care nurse the whole process is started with an interview. The nurse needs specific skills to conduct an effective interview.
- According to Collin (1989), Hein (1980) and Rexo (1996) interviewing skills commence with the establishing of a nurse-client relationship in an

effective manner. McFairland (1986), Stuart and Sundeen (1987) agree with the above authors and stress that an interpersonal relationship commences when the nurse and patient reach a common ground of receptivity to each other.

- Both authors further emphasize the importance of listening, observation and the skills of verbal and non-verbal communication in the interviewing process.
- A pleasant atmosphere, and a clean and distraction-free environment should further be ensured. The client should feel comfortable and privacy should be guaranteed.
- Professional attitude and behaviour of nurses towards clients form a cornerstone of effective interviewing practices.
- Attitudes are not directly observable but inferred from the person's overt behaviours.
- The literature emphasizes that a relationship of trust should also develop between the nurse and the client. The foundation for building this trust between the nurse and client relies upon concepts of love, empathy, sympathy, acceptance, assurance and helpfulness. It is further added that trust is the foundation of a therapeutic relationship (Brooking *et al.*, 1992).
- Stuart and Sundeen (1987) add that openness and honesty demonstrate to the client that the nurse can be trusted. They stressed that nurses should ensure confidentiality to clients in order to build trust.
- It is also stated that building a relationship of trust involves the use of a two-way phase strategy which is a demonstration of the nurse's confidence in herself and nurses helping patients develop trust in themselves and others (Perko, 1996).
- The researcher observed and evaluated nurses' professional behaviour during the interview.

2.7.4 History-taking

According to Stuart and Sundeen (1997) history-taking is a brief survey of the client's life regarding health and illness. During history-taking nurses enquire about the emotional, physical, social and intellectual dimensions of the client and his/her family. Varcanolis (1994) agrees that assessment of the interpersonal relationships provides the nurses with more data about the client's needs and level of self-esteem. Both authors explain that history-taking considers the dimensions mentioned above and provides the nurse with more information which will help her to render quality client care in the end. During the history-taking the nurse should ask questions regarding any signs or symptoms present in different systems (No III, Addendum ?). The researcher will evaluate nurses during history-taking according to the standard and checklist (Part B of Addendum ?).

2.7.5 Physical assessment

During physical assessment of the client all the body systems mentioned below will be assessed by the nurse, and the researcher will be evaluating her using the standard with criteria (Addendum ?). The assessment starts with the general system

- Head and neck – glands
- Eye
- Ear, nose and throat
- Ear
- Chest, including heart and lung
- Gastro-intestinal system
- Abdomen
- Rectal examination
- Reproductive system
- Male genitalia

- Female genitalia
- Musculoskeletal system
- Hands
- Legs
- Endocrine system
- Breasts
- Central nervous system

The logical and systematic order of examination will also be evaluated.

2.7.6 Management of the case

Masalanos (1987) and Swartz (1998) states that through physical examination of the systems and history-taking, the correct diagnosis and treatment are given, or the client is referred to health centres and/or hospitals. Nurses will be evaluated according to the above-mentioned.

2.7.7 Record-keeping/documentation

According to Bellack and Edmund (1997) documenting a client's information is an important part of the nursing process, and failure to report and record client information accurately, legibly and objectively can compromise the quality of care. Both authors further emphasize that records serve as a legal document containing confidential information about clients. Brent (2000) states that documentation in the record should occur as soon after the care given as possible and not before a procedure or medication is given.

The researcher observed and evaluated nurses when they recorded client's information using the checklist/standard as in Addendum ?.

2.8 OUTCOMES

Outcomes standards define the results, in terms of the effect of care upon the patient. They are the criteria against which a patient's progress is measured (Sale, 1991). The evaluation is a complex process and runs over a long period of time. The researcher decided to evaluate the outcome in terms of client satisfaction. A questionnaire was developed to evaluate client satisfaction with the services (Addendum ?).

2.9 SUMMARY

An overview of primary health care and services especially in the Northern Province was given. Several quality assurance models, as well as the development of standards, were discussed. The critical standard domains were also determined and the importance and relevance to the research were emphasized.

CHAPTER 3**RESEARCH METHODOLOGY****3.1 INTRODUCTION**

An accurate and systematic description of the methodology is necessary to ensure the scientific correctness of a study. The following aspects are discussed in this chapter:

- Research approach
- Research design
- Population and sampling
- Instrumentation
- Pilot study
- Data analysis

3.2 RESEARCH APPROACH

The literature describes two types of approaches in research, namely a qualitative approach and a quantitative approach (Burns and Grove, 1996). According to these authors a need arose in nursing research to apply a combination of these two approaches. A combination of these approaches is known as triangulation. By using this combination the potential for achieving greater reliability is increased. The integration of two or more methods can also provide an expanded understanding of the scope of the phenomenon and increase confidence in the generalization of results. It also leads to the enhancement of the validity of the study findings (Burns and Grove, 1996).

Triangulation was used in this research. Two types of triangulation were used in this study, namely data triangulation and methodological triangulation. Data triangulation involves the collection of data from multiple sources for the same phenomenon. The intent is to obtain diverse views of the phenomenon under study for the purpose of validation (Burns and Grove, 1996). These data sources provide an opportunity to examine how an event is experienced by different individuals, groups of people or communities, at different times, or in different settings (Mitchell, 1986). In this study data triangulation was done at clinics by evaluating the nursing component.

Methodological triangulation is the use of two or more methods in the same study to obtain data. Methodological triangulation is the most common type of triangulation. Multiple methods are required to generate a rich and comprehensive picture of the phenomenon under study (Burns and Grove, 1996). In addition to the above-mentioned objective data, subjective data was obtained from the client, enabling the researcher to evaluate the nursing component of selected primary health care clinics.

The researcher also believes that combining these methods would increase support for validity of this study, because the results should be stable across multiple measures of caring. Combining these approaches strengthens the results of the study and contributes to the development of knowledge on how similar studies could be approached, as the nursing component of a primary health care service is a complex concept. Burns and Grove (1996) suggest that combining qualitative and quantitative methods will increase support for validity. Construct validity is enhanced when the results are stable across multiple measures of a concept, while statistical conclusion validity is enhanced when the results are stable across many potential threats to causal inferences. External validity is supported when results are stable across multiple settings, populations and times.

3.3 RESEARCH DESIGN

A descriptive design is used to develop theories, identify problems within daily practices, to justify and evaluate practice or to determine what others do in a similar situation (Burns and Grove, 1996). In this study the nursing component in selected primary health care clinics was evaluated. A non-experimental, descriptive design was used to obtain data by means of direct observation, interviews and auditing of records.

3.4 POPULATION AND SAMPLING

Description of the population and sampling methods forms an essential part of any research project. It reflects the scientific nature of the research.

3.4.1 Population

According to Burns and Grove (1996), population implies all elements (individuals, objects, events or substances) that meet the criteria. The population in this study consisted of:

- all the primary health care clinics in the Northern Province
- all patients, 14 years and older, attending the clinic
- registered nurses practising in the clinics

All the clinics in the Northern Province fall under the governance of the province.

3.4.2 Sampling

Burns and Grove (1996) define the sampling as the process for selecting a group of people, events, behaviours or other elements with which to conduct a study. There are mainly two types of sampling methods available, namely non-

probability and probability sampling. A variety of probability sampling and non-probability sampling methods are used in nursing studies. In probability sampling every member has a chance higher than zero of being selected for the sample. With non-probability sampling, not every member of the population has an opportunity for selection in the sample (Burns and Grove, 1996).

Random sampling is a method of probability sampling. Each individual in the population has an equal opportunity to be selected for the sample, thus reducing sampling error (Pollit and Hungler, 1993; Uys and Basson, 1991). The purpose of random sampling is to increase the extent to which the sample is representative of the target population. Random sampling must take place in an accessible population that is representative of the target population. Random sampling leaves the selection to chance and thus increases the validity of the study.

The primary health care clinics of the Northern Province were identified for this study for the sake of convenience. The researcher could not include clinics in other provinces because of time and financial constraints. The researcher identified eight primary health care clinics in the province which met the following criteria:

- Clinics had to provide a comprehensive service with a supermarket approach.
- Clinics had to offer the above-mentioned service to clients 14 years and older.
- Clinics had to attend to an average of at least 30 clients per month with general or chronic ailments.
- The clinics had to be within a 200km radius from where the researcher worked because they should be easily accessible to the researcher, as time and financial constraints had to be considered.

The inclusion criteria were determined after in-depth discussions with nursing experts, the supervisor and a statistician. The names of the eight clinics were thrown into a hat. One name was drawn and this clinic was used for the pilot

study and was thus excluded in the sample of the research.

A further three names were drawn randomly. They constituted the sample regarding the clinics. Convenient sampling was done regarding the clients who attended the clinics as well as those who met the criteria. The researcher believes that the results are trustworthy because no specific persons were included or not included. Data was collected until data saturation was reached. The nursing staff who did the physical examination also changed shifts because they were the permanent staff members of the clinic.

The method of determination of data was as follows:

- The researcher visited each of the four clinics on five randomly selected days per month for a period of six consecutive months.
- The duration of the visits per day was eight hours

During the day the researcher evaluated the nursing component of the service according to the set standards. Data were collected until data saturation was reached.

3.5 INSTRUMENTATION

Instrumentation is a component of measurement and the application of specific rules to develop a measurement device/instrument (Burns and Grove, 1996). Polit and Hungler (1983) define an instrument as the device or technique that a researcher uses to collect data (questionnaires, observations, interviews, scales and tests). The following instruments were developed and used, based on the research questions, objectives and literature study:

- a questionnaire to determine client satisfaction (outcome standards)
- a questionnaire regarding the structure and process standards

3.5.1 Client satisfaction questionnaire

A questionnaire was developed to obtain the opinion of clients regarding the care they received at the selected primary health care services. This is also known as the outcome standards. The clients' views are of cardinal importance in the quality assurance process. The researcher has conducted the interviews herself to make sure that no misunderstandings regarding the interpretation of the questions occurred. Thirty-nine clients were interviewed in clinic A, 36 clients in clinic E and 69 clients in clinic H. Interviews were held until data saturation was reached. The following were covered in each client's view of the care he/she received:

TABLE 3.1
ASPECTS COVERED IN CLIENT'S VIEW OF CARE RECEIVED

Section A: Clinic environment	Questions 1 - 4
Section B: Nursing service	Questions 5 – 13
Section C: Clinic staff	Questions 14 – 15
Section D: Impressions	Questions 16 – 21

3.5.2 Standards

Quality assurance and standards were discussed in depth in Chapter 2. It is generally accepted and is supported by research and the researcher herself, that if a service to the client should be evaluated, it is absolutely necessary to evaluate the institution in totality (clinics in this case). That will include client care activities as well as professional and administrative activities.

3.5.2.1 *Structure standards and evaluation*

Standard setting and evaluation should start with the structure of the institution. The mission, philosophy and objectives are the important structure standards

because they indicate the commitment to rendering a high standard of care. A critical component of structure is policy making and implementation thereof. Monitoring of services is based on policy and they are non-negotiable directives that outline dispensing of care, practice or governance (Kats and Green, 1992).

Structural standards include people, equipment and the environment, when defining or specifying the quality and quantity of inputs into the health systems (Booyens, 1993). That means that these standards provide the foundation of the institution/organization through policy and that the manager is responsible for formulating and shaping that policy.

Structure standards for this study included the following aspects:

- Structure of the clinic (physical)
- Equipment and supplies
- Human resources
- Management: mission and vision
 policies
 procedure manuals

The structure and operational systems may sometimes limit the practice of the nurse. A lack of knowledge of, for example, the science of nursing and managerial aspects such as quality assurance, may also have a negative effect on the standard of care she is rendering.

3.5.2.2 *Process standards*

The term process standards refers to the direct care of the client. It encompasses the actions of the nurse, the care the client is receiving and how the system works (Katz and Green, 1992).

Critical aspects to be taken into account are:

- high volume activities which occur regularly.

- high risk activities which can be advantageous or detrimental if they are performed or not performed.
- Problem-directed activities which may cause problems for the client, staff or system; and
- high-cost activities which involved high cost for the institution (Booyens, 1996).

The nursing component of a service is vast and complex.

After discussions with experts it was decided that the following aspects regarding the nursing component would be evaluated:

- History-taking
- Physical examination
- Prescribing of treatment
- Record-keeping

3.5.3 Validity and reliability

The two concepts, validity and reliability, are cardinal in any instrument of measure. Their presence increases the value of the research. Validity is defined by Polit and Hungler (1991) and Uys and Basson (1991) as an instrument's ability to measure what it is supposed to measure. In order to eliminate ambiguity, inaccuracies or errors, the questionnaire was evaluated by experts in a primary health care department, and some minor adjustments were made to the instrument regarding the clarity of some of the statements. To increase response validity:

- The questionnaires were administered by the researcher herself.
- The questionnaires were completed anonymously.
- Techniques such as not having the clinic staff present during the completion of the questionnaires were used.
- The researcher collected the data herself.
- The questionnaires were written in English

- Participants were interviewed by the researcher who complete the questionnaire.

During focus group interviews the researcher set aside the beliefs, assumptions and suppositions she had about the phenomenon under study. The researcher also avoided relating to participants as a nurse as that could affect their responses. Burns and Grove (1993) state that if the same questionnaire is administered to the same individuals at different times, one hopes that the individuals responses to the items will remain the same. If so, it could be stated that the instruments are reliable.

Reliability is also increased when the researcher has personal knowledge or experience regarding the subject of research, and is familiar with the research environment.

The researcher met both of the above-mentioned criteria. The researcher was also not directly involved in the clinics and thus the reliability and validity of the study was increased. Then, standards were set by the researcher herself. They were discussed and evaluated by experts who approved them. The researcher herself did the observations in the evaluation process against the set standards. The clinic staff who performed the physical examination remained constant. The researcher is of the opinion that this also made an important contribution to validation and reliability.

3.5.4 Data collection

Data collection is a critical phase in the process of triangulation and may be done by observing, testing, measuring, questioning and recording (Burns and Grove, 1993). It is also important to obtain sufficient data. Too little data may give a distorted image of the quality of nursing rendered whilst too much data may be costly and wasteful (Booyens, 1993).

Data collection was done over a period of six months by the researcher herself. Detailed field notes were kept on the observations done but also on the events and factors relating to the data obtained from interviews with the clients. Lastly, the principle of data saturation was applied when no new information or perspectives have become evident.

3.6 PILOT STUDY

A pilot study is a small, preliminary investigation of the same general character as the major study (Treece and Treece, 1986). This means that it is developed similarly to the proposed study using similar subjects, the same setting and same data collection and analysis techniques. Burns and Grove (1996) agree with Treece and Treece (1986) and add that it is conducted to refine methodology. These authors also state that a pilot study is conducted for one or more of the following reasons:

- to determine whether the proposed study is feasible
- to identify problems with the design
- to determine whether the sampling technique is effective
- to examine the validity and reliability of the research instruments
- to develop or refine data collection instruments
- to give the researcher experience with the subjects, settings, methodology and methods of measurement.

A pilot study was done to determine possible problems and shortcomings in the methodological approach and instruments. Major problems were not found. The pilot study contributed to the validity of the research. Clients and clinics included in the pilot study were excluded in the sample of the research. Few adjustments were made, for example the questionnaire was explained in the client's language (North Sotho) and patients who could not write were allowed to answer questions orally. The researcher wrote down the information given.

3.7 ETHICAL CONSIDERATION

Permission to conduct the research was obtained from the clinic supervisors of the selected clinics. The subjects in each clinic consented verbally and in writing (Addendum ?).

By not asking names during the interviews, the researcher assured the subjects that anonymity and confidentiality would be maintained. Participation in the study was voluntary. Participants were not paid for participation. The clinics were also not identified by name.

3.8 LIMITATIONS

The following could be argued as being limitations of the research:

- The results are applicable to the four clinics only.
- The results are only applicable to clients from age 14 and above, and patients younger than 14 years of age were not covered.

The researcher believes, however, that the study is credible because:

- the principle of data saturation was applied, and
- the stability of the staff establishment ensured minimal variances that could affect the execution of procedures and interventions and thus the standard of care.

3.9 CONCLUSIONS

In this chapter the research methodology was discussed in depth. It was indicated that triangulation was the most appropriate approach.

CHAPTER 4

DATA ANALYSIS

4.1 INTRODUCTION

This chapter focuses on the analysis of data obtained from questionnaires and set standards. The process of data analysis is characterised by refining, clarifying and sharpening of statements, concepts and theories found in the literature.

Standards were formulated to evaluate the nursing component (as defined by the researcher) of the relevant primary health care services. In this chapter, the data obtained is thus analysed, interpreted and discussed. The research was done from a nursing perspective and the findings will also be discussed in that way. The results are discussed according the standards in Addendum ? as well as the patient's questionnaire (Addendum ?)

The percentages regarding the standards were calculated as follows:

- The criteria were ticked off
- The total of criteria ticked off (excluding the not applicable ticks) is processed in percentage format
- The final percentage of the standard is calculated
- The questions in patient questionnaires were also separately processed in percentage format and discussed. Where and if the patient had to express his/her view or opinion, central themes, because of the qualitative nature, were identified and discussed.

A definite percentage of what is considered as a high/good/satisfactory and low

standard could not be found in the literature. The researcher or accrediting body decide for themselves as an acceptable percentage according to parameters set by themselves. The researcher, based on her experience as a professional nurse and expertise decided that 100% percent would be accepted as a good acceptable standard. Anything below 80% will need urgent remedial action. A score of 100% is critical because the nurse is examining a patient and she needs the correct data, to make a correct diagnosis and treat the client correctly.

4.2 STRUCTURE STANDARD

A structure standard was formulated: the supplies, organization, utilization and maintenance of facilities, equipments, staff and financial resources enhance the rendering of quality nursing care. Criteria were formulated which covered critical areas. The mean percentage of each critical area was determined and discussion of results was done accordingly (see table 4.1).

TABLE 4.1
STRUCTURE STANDARDS

	Clinic A %	Clinic B %	Clinic H %	Average %
a) Facilities	86,6%	86,6%	86,6%	86,6%
b) Equipment	63,6%	72,7%	42,4%	59,9%
Supplies/stock per clinic per room	65,0%	95,0%	35,0%	65,0%
c) General rules	100,0%	100,0%	76,9%	92,3%
d) Therapeutic safe and risk free environment	85,7%	57,1%	0,0%	47,6%
e) Listed number of rooms and communication aids	68,7%	87,6%	37,5%	64,6%
f) Human resources	56,2%	56,2%	62,5%	58,3%
TOTAL STRUCTURE STANDARD (AVERAGE)	65,0%	72,7%	42,0%	59,9%

4.2.1 Facilities

Both clinic A, E and H scored 86,6% respectively. The researcher found the

mission statement, philosophy statement, objectives, community profile, disaster planning map, clinic circulars, clinic procedure manuals, quality improvement programme, disease control charts, infection control programme, staff development programmes, community projects, daily report book, protocol for: general security measures, and for assessment of the systems of the body in place. The protocol for endocrinology was not available in all clinics. Clinic A was the only one having a research programme in place. Clinic E and H did not have the research programme in place. They did not meet the set standard.

4.2.2 Equipment, supplies and stock

All three clinics obtained percentages below 80,0% with an average of 59,9%. Clinic H obtained the lowest percentage of 42,4% the average percentage is also well below the accepted standard of 80,0%. A well-equipped clinic is necessary to tender optimal and a high standard of care to the patients/clients. The lack of equipment could influence the care negatively. For example if foot scales, delivery beds and glucometers are not available, the care of the patient/client are compromised and the risk for medico legal hazards increases. Although clinic E obtained 95,0% for stocks and supplies, clinic A obtained 65,0% and clinic H a very low percentage of 35,0%. The average percentage of 65,0% is also low. Remedial actions are necessary for clinic A but urgently for clinic H. The care to the patient/client could be influenced negatively in the latter and the risk of medico legal hazards increased.

4.2.3 General rules: Cleaning of facility, equipment and instruments

Clinic A and E scored 100% and clinic H 76,9%. Clinic H did not meet the standard. Remedial actions are necessary. Thorough cleansing of facility, equipment and instruments are critical to prevent medico-legal risks.

4.2.4 Prevention of Medico legal risks and infection control measures

Clinic A scored 8,7%. Clinic E obtained 57,1% and clinic H 0,0%. The low percentages obtained by clinic E and H is of great concern because these two important programmes or instruments are critical to any clinic or unit to monitor and control medico legal risks, morbidity and costs. Patient care could thus be influenced negatively as well.

4.2.5 Listed number of rooms and communication aids

Clinic E scored 87,6%. Clinic A and H scored well below an accepted standard with 68,7% and 37,5% respectively. These clinics did not have the required rooms as compared by the set standard. This leads to a delay in the flow of patients/clients, which could affect the care negatively. All three clinics scored low on communication aids because walkie-talkies and telephones were not available. This causes a communication breakdown with the referral hospital in emergencies and this has a serious negative impact on the health care of the client. This means the staff would not be able to obtain valuable information on example how to manage a seriously ill or injured patient and that could result in serious complications.

4.2.6 Human Resources

All three clinics did not meet the set standard. Clinics A, E and H scored 56,2% (A and E) and 62,5% respectively. Remedial action is necessary because the literature supports research that was done which shows that an organisation should have effective and efficient personnel to guarantee quality care in its institution (Booyens, 1993). If this situation is allowed to go on, a negative growth in staffing is perpetuated and this could influence the quality of care

negatively. These findings concur with the findings on Chapter 2 about the shortage of staff in the clinics.

In summary neither clinic achieved the set norm of 100% as seen in the total average in table 4.1. Therefore the structure standard could be considered as sub-optimal.

4.3 PROCESS STANDARDS

Process standard define what nursing care is and provide specific criteria that can be used to determine whether quality nursing care has been provided. The researcher identified that the nursing component in the clinic service should be evaluated. The process standards therefore covered the physical examination of clients, treatment and record keeping (chapter 1 and 2).

Standard quality patient care is rendered through a complete history taking, physical examination of the body systems, treatment and record keeping. The physical examination process include several steps and criteria were set for each step and the following were evaluated:

- (a) Interviewing the client/patient
- (b) Physical examination of client/patient according to body systems to enhance treatment and prescriptions
- (c) Management of the care
- (d) Record keeping/documentation

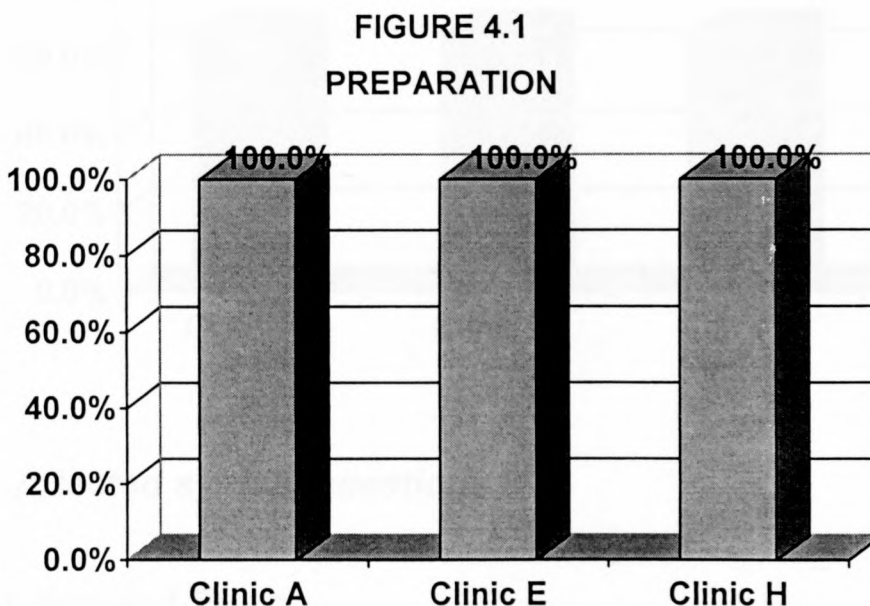
The data are discussed and analysed accordingly.

4.3.1 Interviewing the client/patient

4.3.1.1 Preparation

All clinics scores 100% in this category. The preparation of the environment and

the nurse were compiled as per set standard. Preparation of the environment and reassuring the patient ensure that patient's anxiety is relieved and that an effective interview could be held (Figure 4.1).

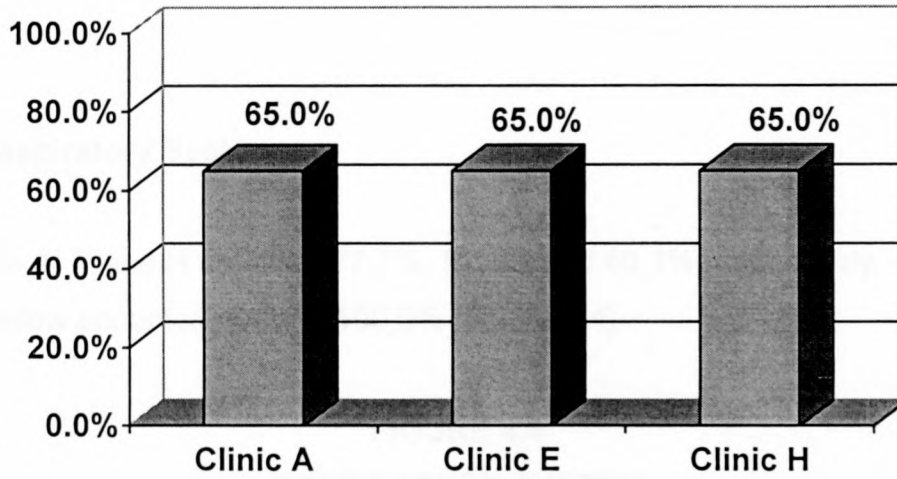


Patients feel at home when the environment is clean, warm enough and well ventilated. This is supported by the nurse explaining procedures to the patient, introducing each other, ensuring privacy, being non-judgemental and showing respect to her.

4.3.1.2 History taking

All three clinics scored 66,6% in this category respectively. Both the pain and system sections were not covered adequately. History taking is one of the most important processes because the information obtained there forms the basis of the other processes to follow. In the end it contributes to the rendering of quality care to the client. It is clear that remedial action is necessary.

FIGURE 4.2
HISTORY TAKING

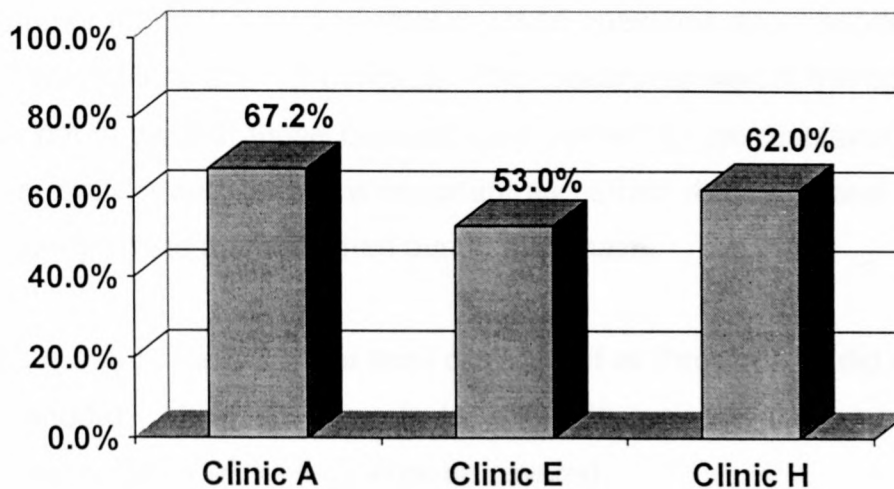


4.3.1.3 Affected system questions

(a) Ear, Nose and Throat

Clinic A and H scored 62,0% and 67,2% respectively and clinic E scored 53,0%. All clinics did not meet the set standard.

FIGURE 4.3
EAR, NOSE AND THROAT

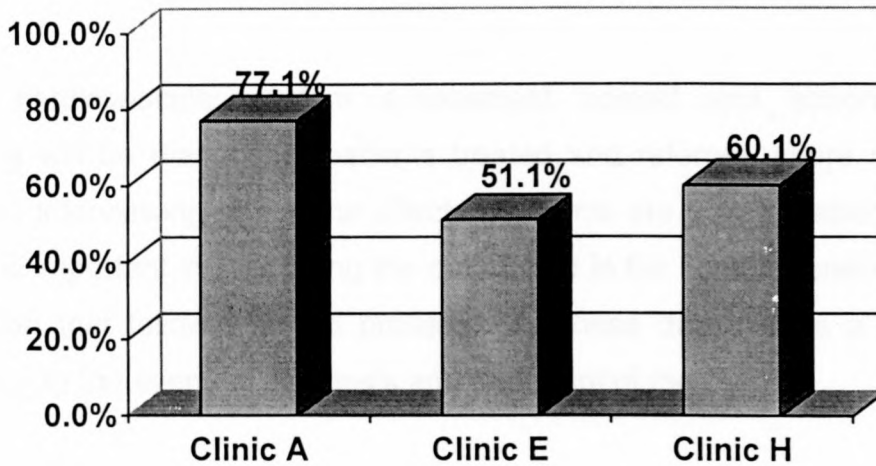


These questions (criteria) need to be asked because the information guides the nurse in her further assessment of the client. This is well below the accepted standard and needs remedial action.

(b) Respiratory System

The Clinic A, E and H obtained 77,1%, 51,1% and 60,1% respectively. All clinics scored below accepted norm of 100,0% (Figure 4.4)

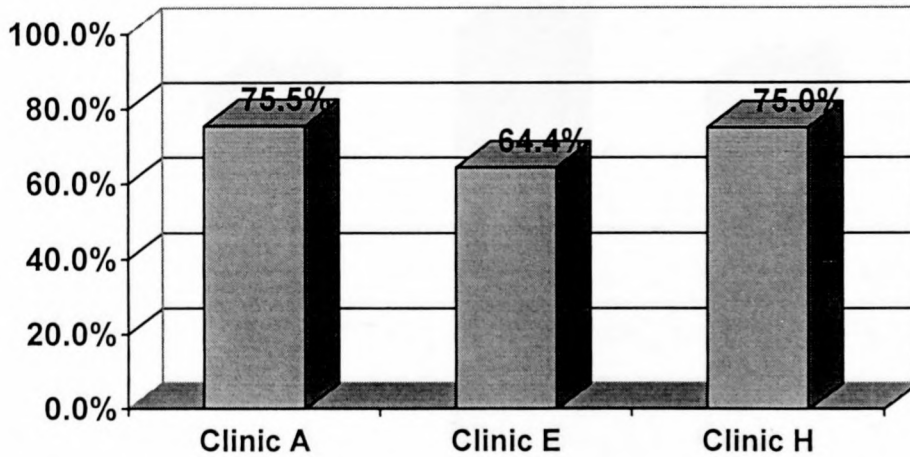
FIGURE 4.4
RESPIRATORY SYSTEM



The researcher found that nurses seldom asked questions about snoring, mouth breathing, weight loss and TB contacts. The researcher was of the opinion that nurses do not know that these questions are related to the respiratory system. Respiratory system questions are important as correct diagnosis and treatment are done partly on the data obtained during this phase.

Both clinic A and H scored better than clinic E but all three clinics did not obtain the set standard. Important aspects for example cyanosis on the mouth and fingertips and oedema of the legs were not covered.

FIGURE 4.5
CARDIOVASCULAR SYSTEM

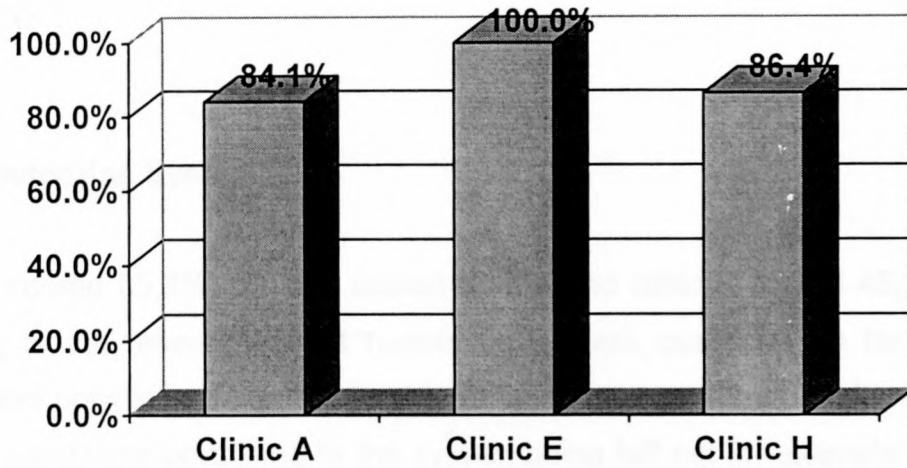


Through cardiovascular system assessment normal and abnormal heart functioning will be diagnosed, patients treated and referred where necessary. During this interviewing phase the affected systems are covered specifically but this data is important in supporting the data found in the comprehensive physical examination that follows on this process. All these data makes a significant contribution to the eventual diagnosis and treatment of the client.

(c) Breasts

Only clinic E met the standard. Clinics A and H scored 84,1 and 86,4% respectively and thus not meeting the set standard. This again is critical information that must guide the nurse in her further examination to detect abnormalities early.

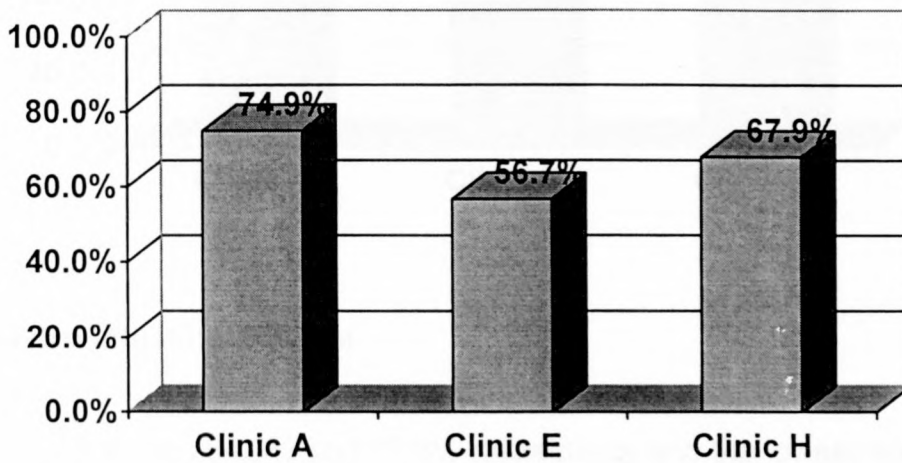
FIGURE 4.6
BREASTS



(d) Central Nervous System

Clinic A scored 74,9%, clinic H 67,9% and clinic E 56,7% which is again below the norm of 100,0%.

FIGURE 4.7
CENTRAL NERCIOUS SYSTEM



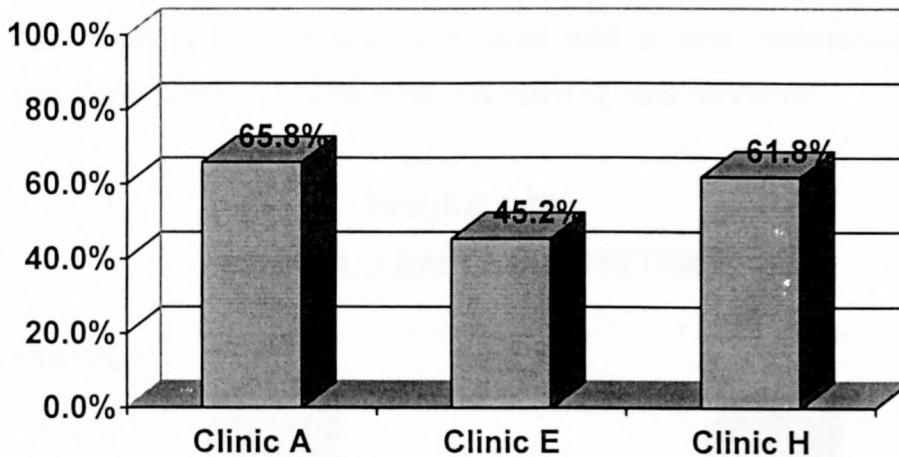
It is a great concern that this aspect did not meet the set standard because this is baseline data that is needed when the nurse does the comprehensive

examination to support her findings. It also seems as if the nurses did not have the necessary knowledge to cover this aspect. Remedial actions is urgently necessary.

(e) Endocrine System

Clinic A scored 65,8%, clinic H scored 61,8% and clinic E scored 45,2%. It is alarming to the researcher that nurses do not ask questions on for example polyria and polydipsia when assessing the endocrine system, as this could lead to more conditions pertaining to the system being left out for example Diabetes Mellitus which is pandemic. Figure 4.8 shows that the standard was not met.

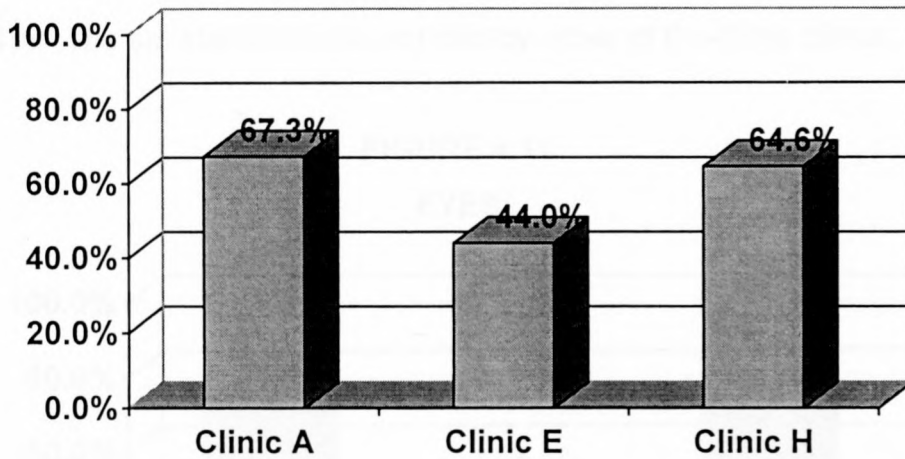
FIGURE 4.8
ENDOCRINE SYSTEM



(f) Gastro-intestinal System

Clinic A and H scored 64,6% and 67,3% respectively and the lowest was clinic E with 44,0%. Again the standard was not met and important data not obtained which could have aided in a correct diagnoses and treatment and eventually a high standard of care to be rendered (Figure 4.9).

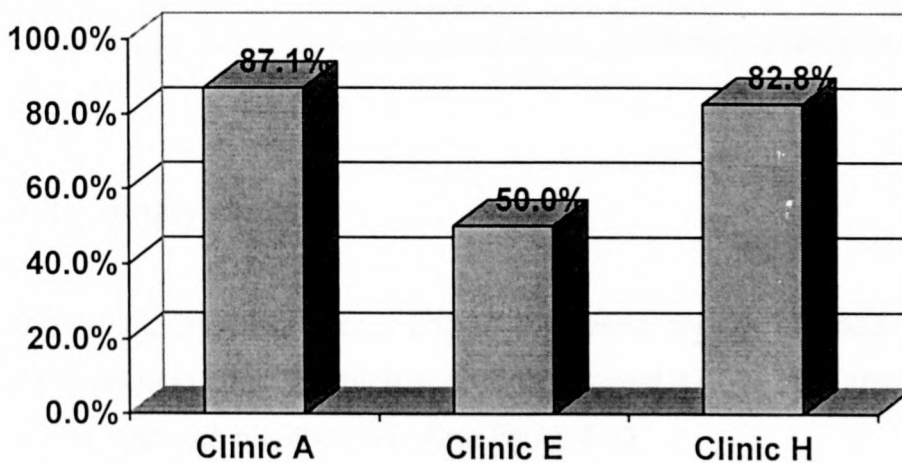
FIGURE 4.9
CASTRO-INTESTINAL SYSTEM



(g) Musculo-skeletal system

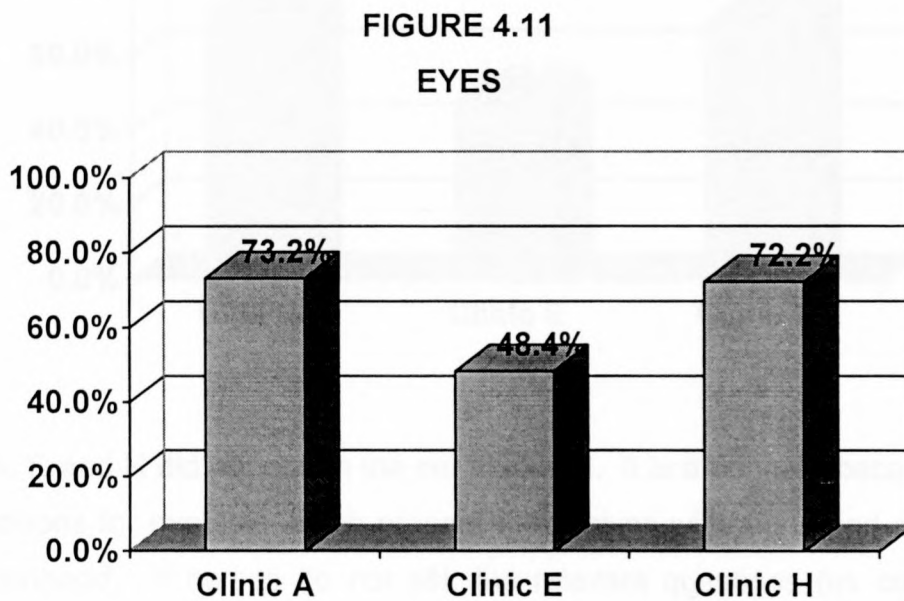
Clinic A and H scored 87,1% and 82,8% respectively. Clinic E obtained only 50,0%. Not meeting the set standard could had to see patient/clients being misdiagnosed and that would affect the standard of care rendered.

FIGURE 4.10
MUSCULO-SKELETAL SYSTEM



(h) Eyes

A score of 73,2% in clinic A and 72,2% in clinic H was achieved. Clinic E scored only 48,4%. The set standard was not met by either of the three clinics.

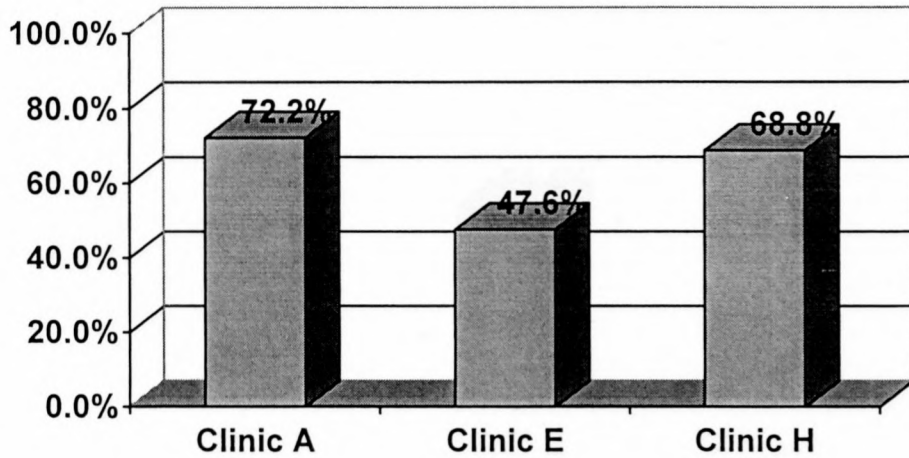


Eyes are organs providing sight to people. Nurses who does not assess eyes accordingly, expose patients to misdiagnosis leading to blindness. Again important data was not obtained regarding one of the most important systems. It is common knowledge that eye-sight problems are common and this was not taken into account by the nurses, according to the percentages obtained.

(i) Genito-urinary system

Clinic A scored 72,2% which according to the researcher is not bad. Clinic H scored 68,8% beating clinic E which scored the lowest 47,6%. Enuresis was not covered during systems questioning. See figure 4.12.

FIGURE 4.12
GENITO-URINARY SYSTEM

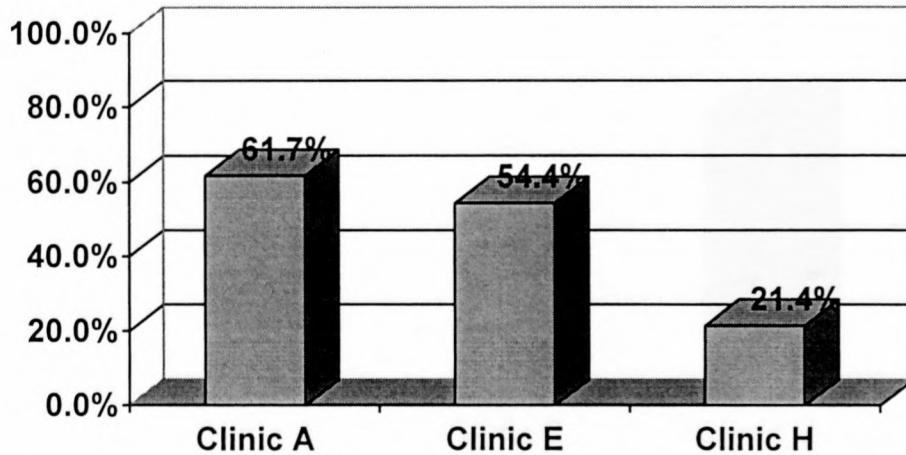


Clinics A, E and H did not obtain the set standard. It is a concern because there are conditions for example which present themselves with signs and symptoms since childhood. If nurses do not ask the relevant questions (as covered by criteria) abnormalities could not be ruled out and treated. The patient could thus be exposed to a life-time disability. Remedial action is necessary.

(j) Menses and fertility

Figure 4.13 shows that clinic A scored 61,7%, clinic E 54,4% and clinic H 21,4%. They did not meet the set standard.

FIGURE 4.13
MENSES AND FERTILITY

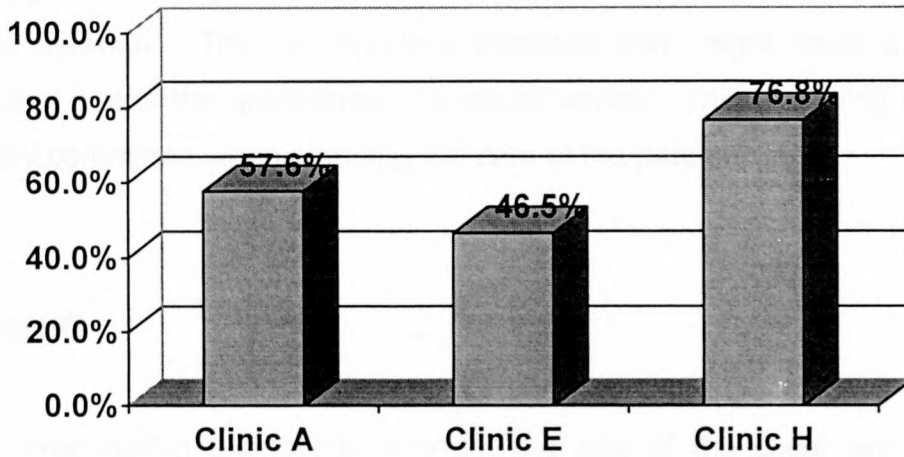


Base-line data regarding the menses and fertility is very important because this could give a good indication of the sexual health status of the client/patient. This is important today with the increasing incidence of sexually transmitted diseases and HIV/AIDS. The data could facilitate early diagnoses and treatment of the abovementioned.

(k) Skin

Again the optimal standard was not met by all three clinics (Figure 4.14). Important data was not obtained regarding the allergic status of the client. The information could be valuable when planning the treatment of the patient.

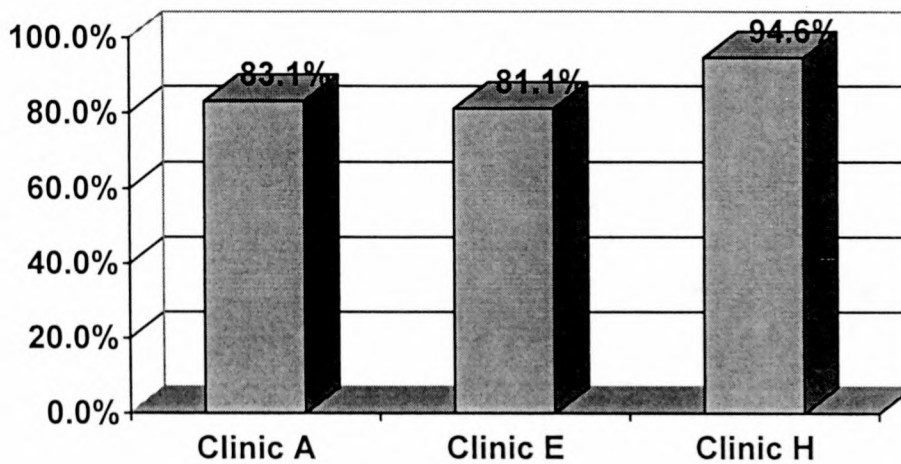
FIGURE 4.14
SKIN



(I) General information

All clinics scored above 80,0%. The researcher needs to report that information concerning travelling during the past 3 months was not obtained in all three clinics. Omitting this question predisposes a patient too misdiagnosis as patients might suffer from conditions like malaria.

FIGURE 4.15
GENERAL INFORMATION



This could result in serious complications like death, especially of patients got malaria during their travelling, because they might not be aware of the disease and the signs and symptoms. Another aspect that was not covered concerned the work situation. This is important because they might have a financial problem that needs the assistance of a social worker. Thus involving the multi-disciplinary committee when planning the care of the patient/client.

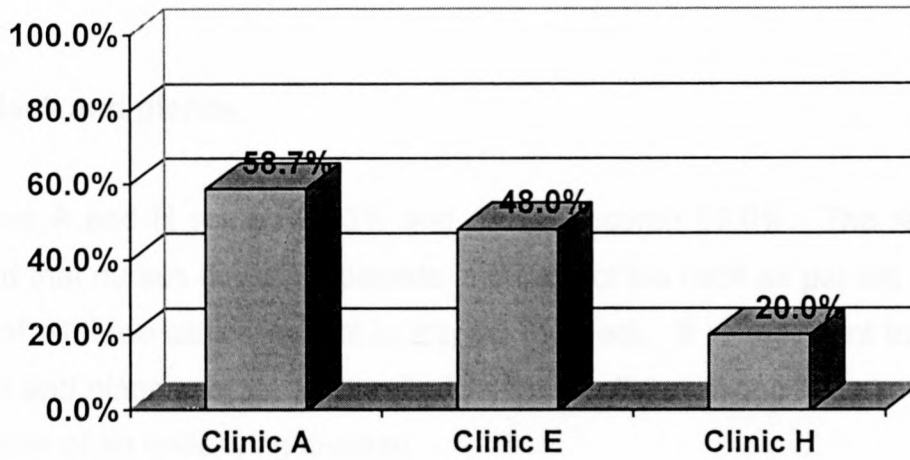
4.4 Part C

Physical examination taking into account the age of the client and systems involved. All the systems of the body were evaluated. The data are analyzed and discussed.

4.4.1 General system assessment

The standard of 80,0% is not reached by any of the three clinics. Clinic H is very low score of 20,0% is very concerning to the researcher. Important aspects for eg. gait, posture, jaundice and neck stiffness were not covered. These are general knowledge aspects to a professional nurse and it seems as if the nurse did not know about it. This could impact very negatively on the management of the patient in the end?

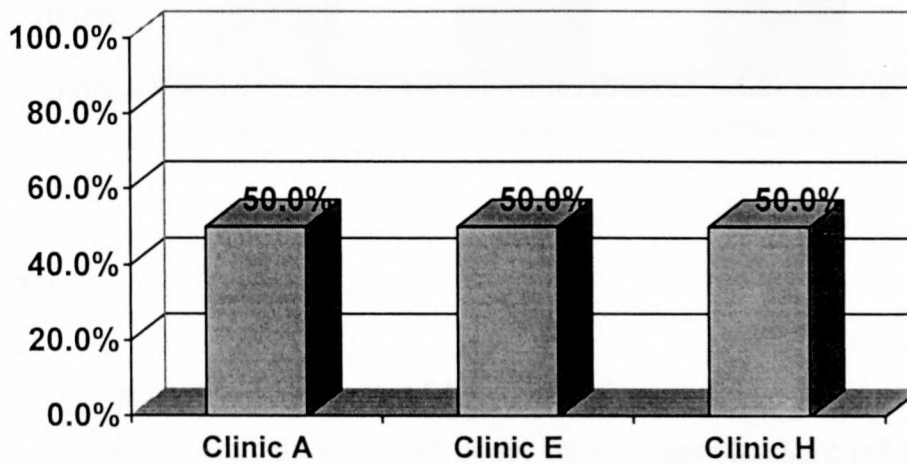
FIGURE 4.16
GENERAL SYSTEM ASSESSMENT



4.4.2 Head

Figure 4.17 shows that all three clinics scored 50,0% on the assessment of the head.

FIGURE 4.17
HEAD



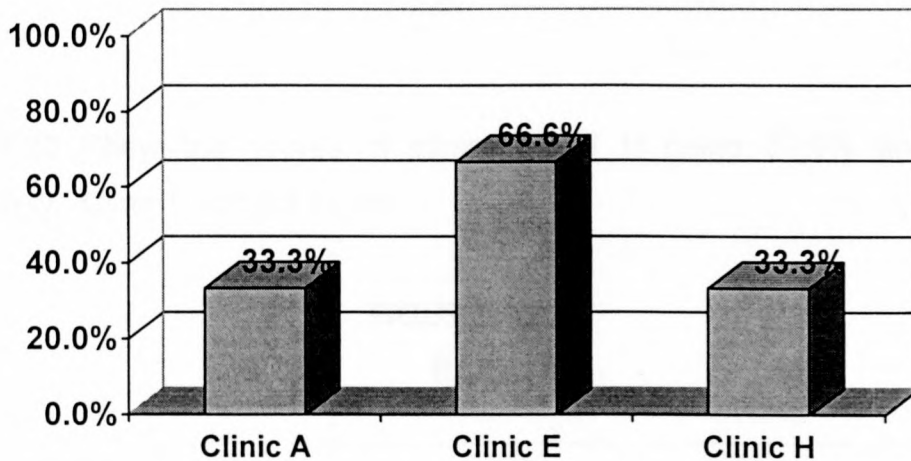
Important aspects left out were covered under both the inspection of the skin and the head itself. They are important because they could be indicative of other

conditions. This could guide the nurse in her examination, diagnosis and management of the client.

4.4.3 Neck and glands

Both clinic A and H scored 33,3% and clinic E scored 66,6%. The researcher observed that nurses could not palpate and inspect the neck as per set standard. Nurses at all three clinics did not inspect the neck. It is important to examine the neck and glands as stated in criteria because the presence of abnormalities is indicative of an underlying disease.

FIGURE 4.18
NECK AND GLANDS

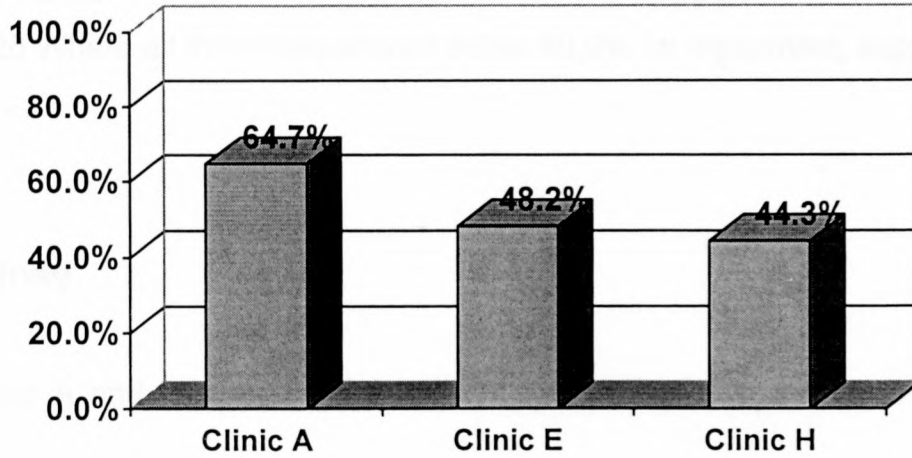


4.4.4 Eyes

Clinic E and H scored 48,2% and 44,3% respectively. Clinic A scored 64,7%. Inspection of the iris, pupil and lens for direct light/consensual light reflex, testing the eye movement were not done as per set standard. Nurses did not know how to assess the eye. They also failed to assess eye movement to the four sides. Eye conditions like conjunctivitis, corneal ulcers, symptoms of other diseases, optical nerve paralysis could thus not be ruled out therefore making it difficult for patients

to receive the care and treatment they need.

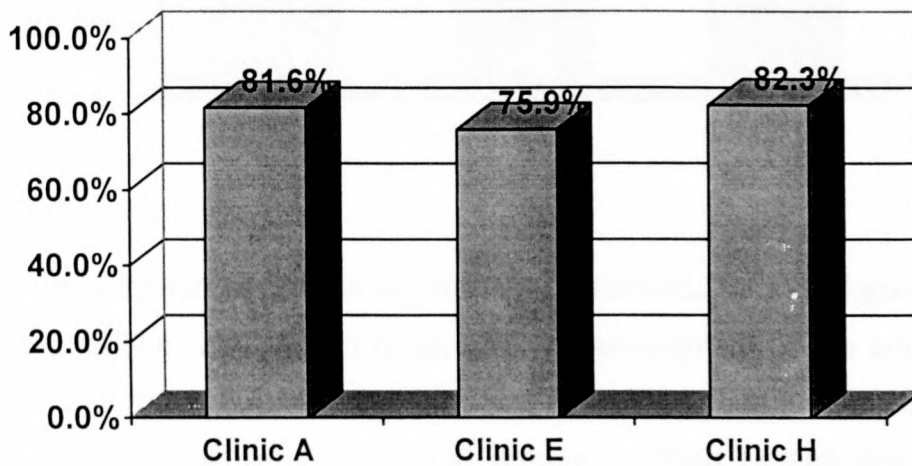
FIGURE 4.19
EYES



4.4.5 Ear

Figure 4.20 Show the scores of clinic A and H being 81,6% and 82,3% respectively. Clinic E scored 75,9%.

FIGURE 4.20
EAR

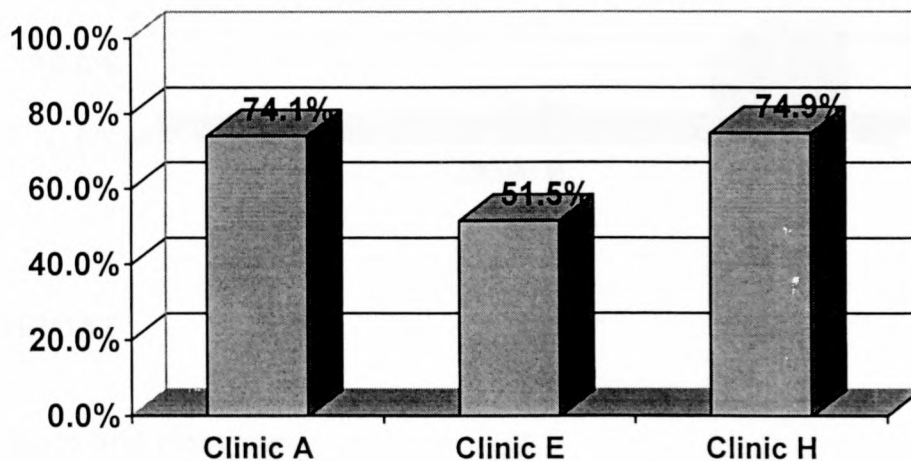


Testing the ear for deafness with a tuning fork, watch test or voice test and palpating the ear for topi was not done by most of the nurses at the clinic. The researcher observed that all three clinics did not have a tuning fork. These tests are important as the nurse is able to detect deafness and early referral to an ear clinic for further management is possible. This is supported by the finding in table 4.20 Where all the clinics scored below 80,0% for equipment, supplies and stock.

4.4.6 Nose

Both clinic A and H scored more than 74,0%. Clinic E scored 51,5% (figure 4.21).

FIGURE 4.21
NOSE

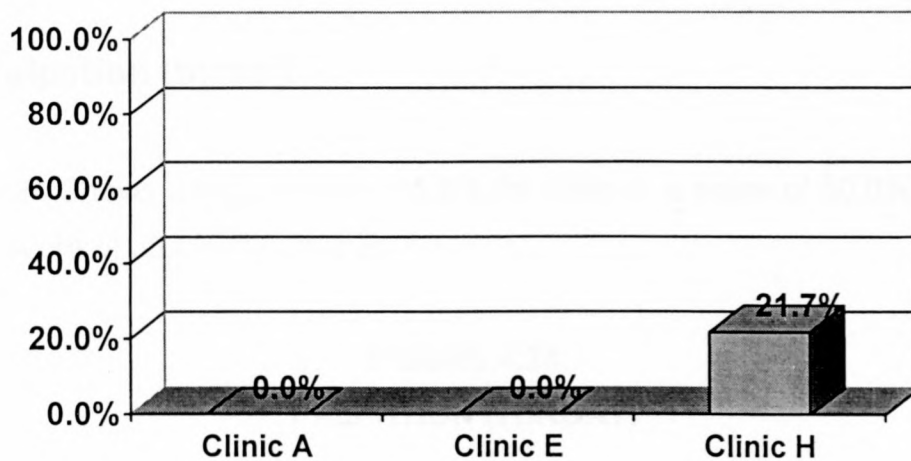


The researcher observed that when nurses performed the examination of the nose, less attention was paid to nasal cavity, displacement of the septum and presence of alar flare. Examining the nasal cavity and septum is necessary for excluding abnormal growth, sores and tumors. When nurses examine the presence of alar flare respiratory distress could be ruled out. Again the set standard was not met.

4.4.7 Sinuses

It is a concerning factor that all clinics scored so low, 0,0%, 0,0% and 21,7% for clinic A, E and H. Sinuses need to be examined because they help in diagnosing and determining treatment and referrals to hospitals or doctors. Remedial actions are needed at all clinics for this standard. Nurses at all three clinics could not examine the frontal and maxillary sinuses. The researcher observed that nurses did not know that sinuses should be examined.

FIGURE 4.22
SINUSES

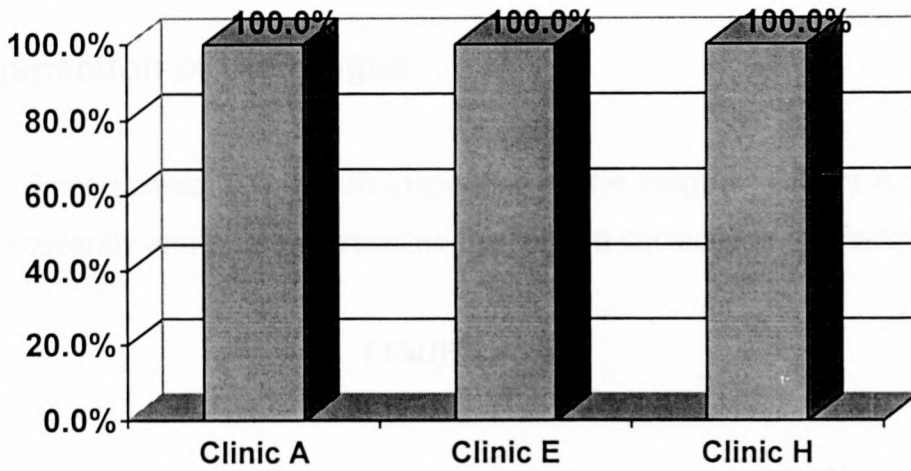


4.5 THROAT

4.5.1 Mouth and Pharynx

All three clinics scored 100,0% on inspection of the mouth and throat. Nurses inspected the mouth for cyanosis, pallor, stomatitis, the floor of mouth, tongue, teeth, gums and buccal mucosa for abnormalities. It is necessary to examine the patient's throat to exclude abnormalities make correct diagnosis and provide care, treatment and refer where necessary.

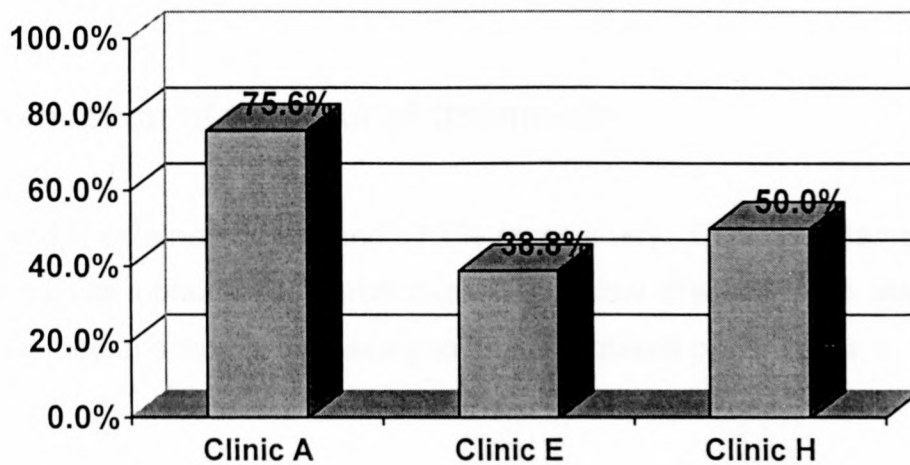
FIGURE 4.23
MOUTH AND PHARYNX



4.5.2 Palpation (throat)

Figure 4.24 Shows a high score of 75,6% for clinic A, a score of 50,0% for clinic H and a score of 38,8% for clinic E.

FIGURE 4.24
PALPATION (THROAT)



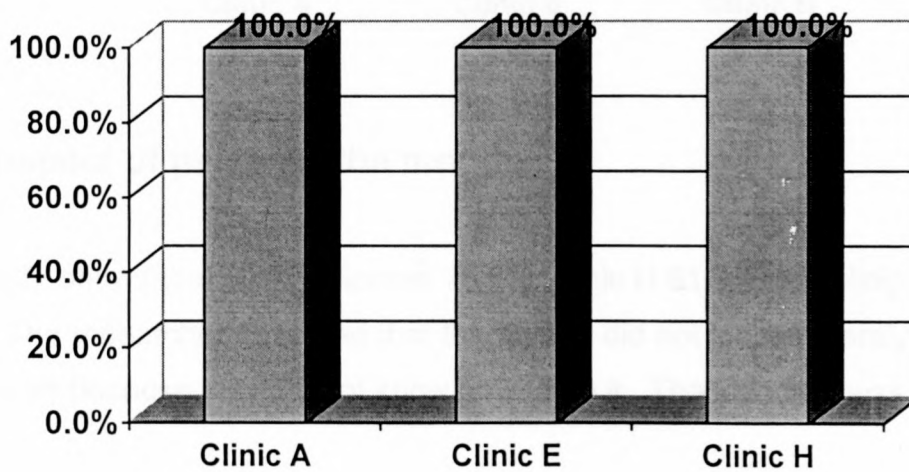
Palpation of the buccal mucosa, hard palate and floor of the mouth for swelling and abnormal growth was not performed. The researcher observed that nurses

did not know that the above-mentioned should be done.

4.5.3 Inspection of the tongue

All three clinics scored 100,0% on inspection of the tongue. Clinics A, E and H scored excellently and nurses inspected the tongue correctly and effectively.

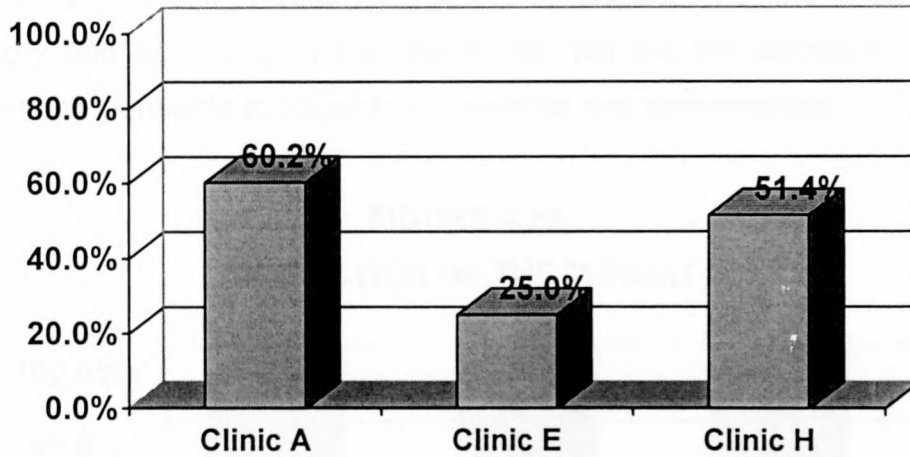
FIGURE 4.25
INSPECTION OF THE TONGUE



4.5.4 Inspection of the floor of the mouth

Clinic A and H obtained 60,2% and 51,4% respectively. Clinic E obtained 25,0%. All three clinics obtained a percentage well below the accepted standard of 80,0%. Remedial action is necessary to improve quality patient care.

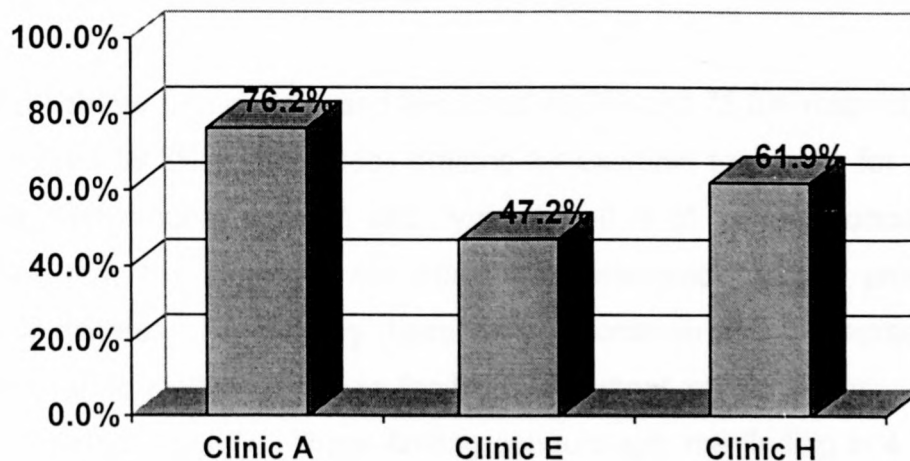
FIGURE 4.26
INSPECTION OF THE FLOOR OF THE MOUTH



4.5.5 Inspect of palate of the mouth

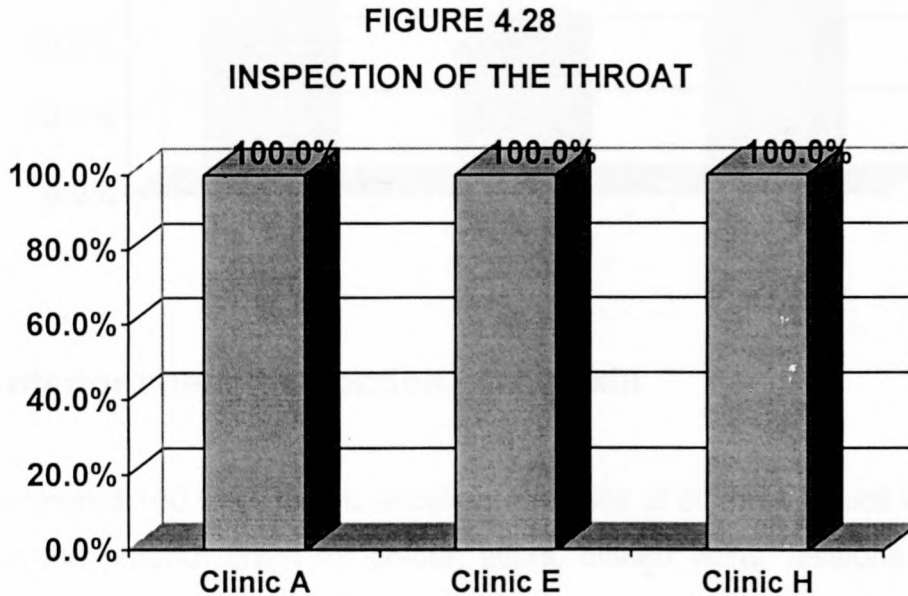
Figure 4.27 shows that clinic A scored 76,2%, clinic H 61,9% and clinic E scored 47,2%. The researcher observed that the nurses did not inspect paralysis of the vagus nerve because they did not know how to do it. The standard was not met.

FIGURE 4.27
INSPECT OF PALATE OF THE MOUTH



4.5.6 Inspection of the throat

All the clinics A, E and H obtained 100,0% on inspection of the throat. This is satisfactory and according to the researcher met the set standard. All three clinics' nurses were able to inspect the throat for any abnormalities.

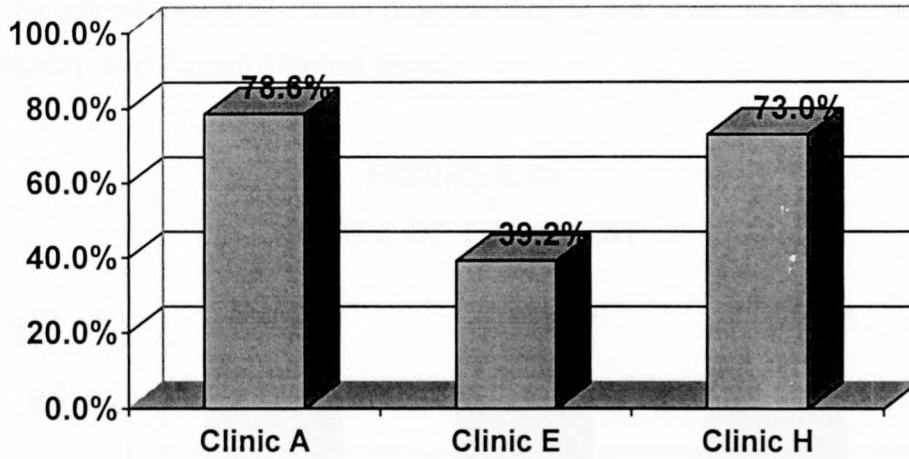


4.6 EXAMINATION OF THE CHEST

4.6.1 Signs of respiratory distress

Figure 4.29 shows that clinic A and H scored 73,6% and 73,0% respectively, and clinic E scored 39,2%. The nurses omitted for example to assess for alar flare, dyspnoea, tachypnoea, distress and cyanosis. It is of a great concern to the researcher that the client is not effectively assessed for the presence of respiratory distress. Respiratory diseases are common and the nurse need to detect any abnormalities early to facilitate treatment of the client. Remedial action is needed urgently. These finding concurs with the finding in 4.29 where all three clinics did not achieve the set standard as well, regarding the respiratory system.

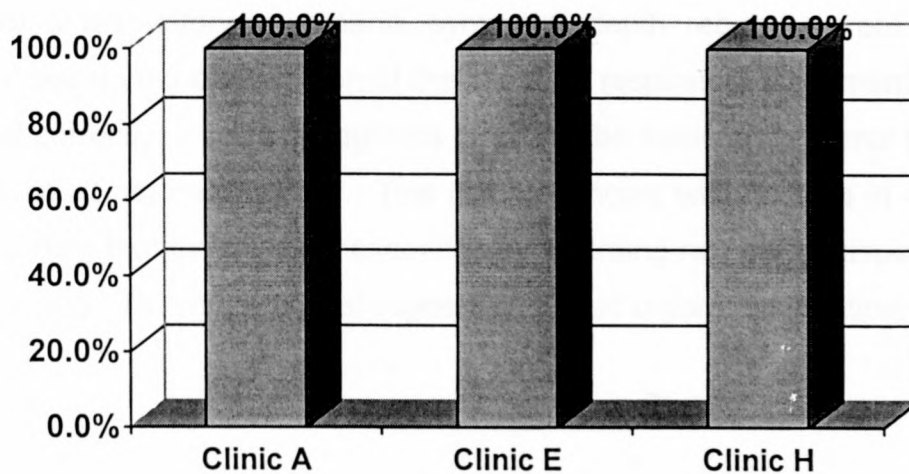
FIGURE 4.29
SIGNS OF RESPIRATORY DISTRESS



4.6.2 Anterior chest: Inspection of the skin

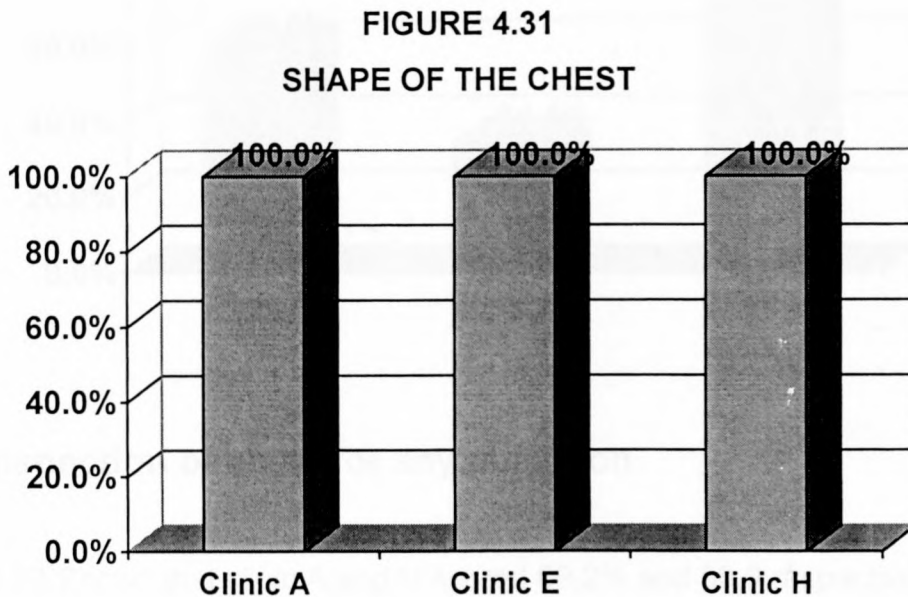
All clinics scored 100,0% which is excellent. Nurses at all three clinics were able to inspect the anterior chest for colour, scars, dilated veins, lesions and hair distribution.

FIGURE 4.30
ANTERIOR CHEST: INSPECTION OF THE SKIN



4.6.3 Shape of the chest

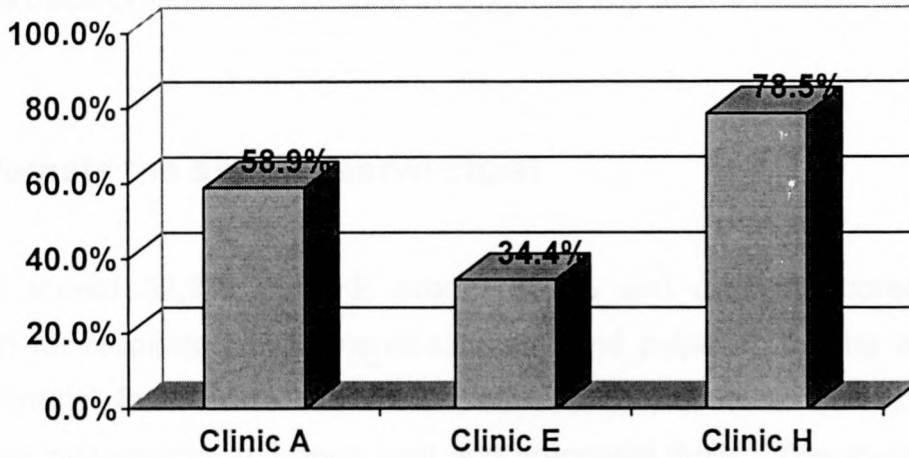
All three clinics scored 100,0% on assessment of the chest for abnormalities like barrel, pigeon, and funnel shaped chest.



4.6.4 Respiratory movements

Clinic A scored 58,9%, clinic H scored 78,5% and clinic E scored 34,4%. Evaluation of respiratory movements, symmetry, depth, recession were not done by the nurses during examination of the chest. If respiratory movements are not examined correctly, a correct diagnosis could not be made and optimal treatment and care could not be rendered. This finding concurs with findings in 4.6.1 and 4.32 Indicating that the physical examination regarding respiratory aspects is not up to standard. These are critical aspects and need urgent remediation.

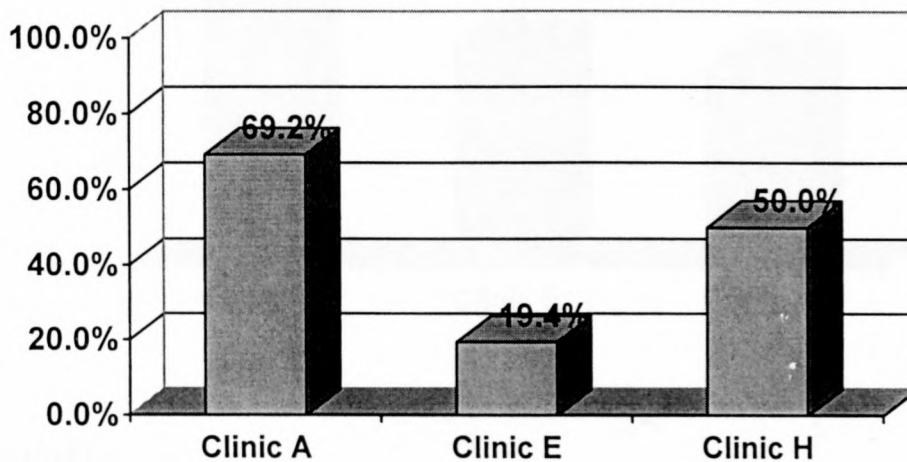
FIGURE 4.32
RESPIRATORY MOVEMENTS



4.6.5 Inspection of chest for any pulsation

Figure 4.33 Shows that clinic A and H scored 69,2% and 50,0 respectively, whilst clinic E scored only 19,4%.

FIGURE 4.33
INSPECTION OF CHEST FOR ANY PULSATION



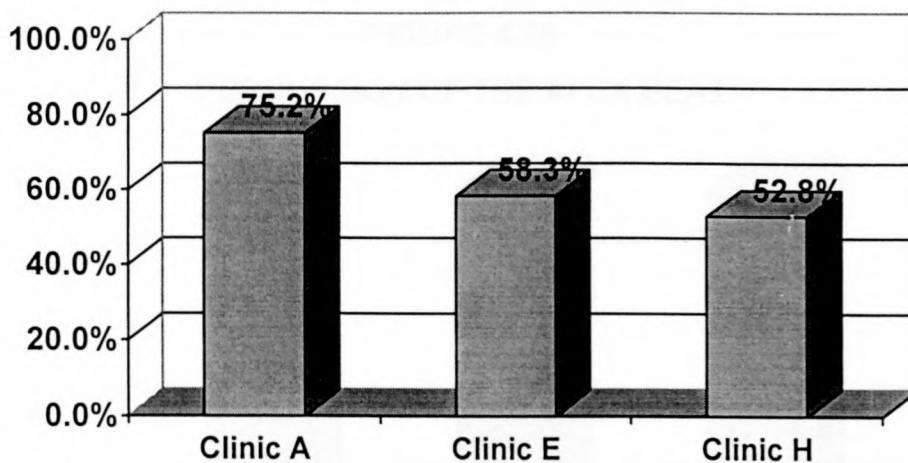
The researcher observed that the apex beat and pulsations outside the precordium were not assessed. Remedial actions are urgently needed for clinic

E, with clinic A and H to follow. Again there are critical aspects to be assessed because they form an important part of the comprehensive assessment and forms the basis of other data needed to diagnose and treat a client correctly.

4.6.6 Palpate the skin: observe chest

Clinic H scored 52,8%, clinic E scored 58,2% and clinic A scored 75,2%. Palpation for respiratory movements-symmetry and palpation for the apex beat and precordial thrills were not done. Nurses do not know how to palpate respiratory movements and apex beat and precordial thrills. The standards not meeting the set standard of 100,0% concur with the previous standard on respiratory system and cardio-vascular system (par. 4.?). Urgent remedial action is necessary.

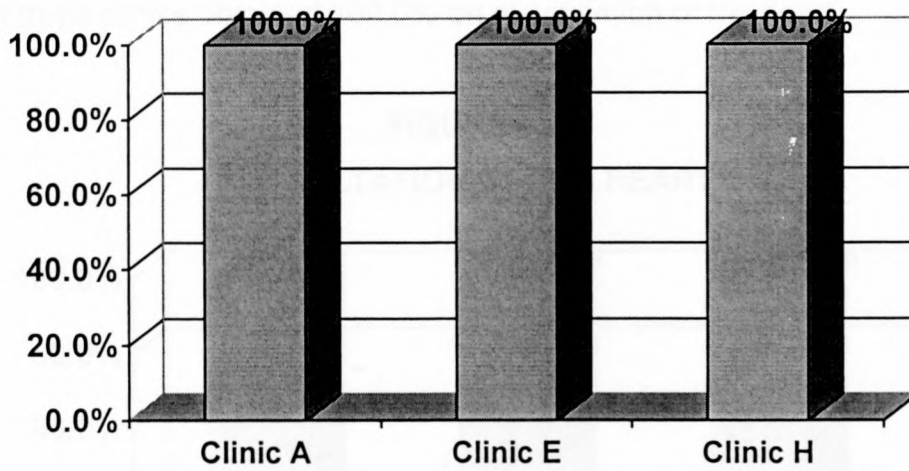
FIGURE 4.34
PALPATE THE SKIN: OBSERVE CHEST



4.6.7 Breasts

All clinics scored 100,0% which is excellent. Inspection and palpation of breast for abnormalities were done at all clinics.

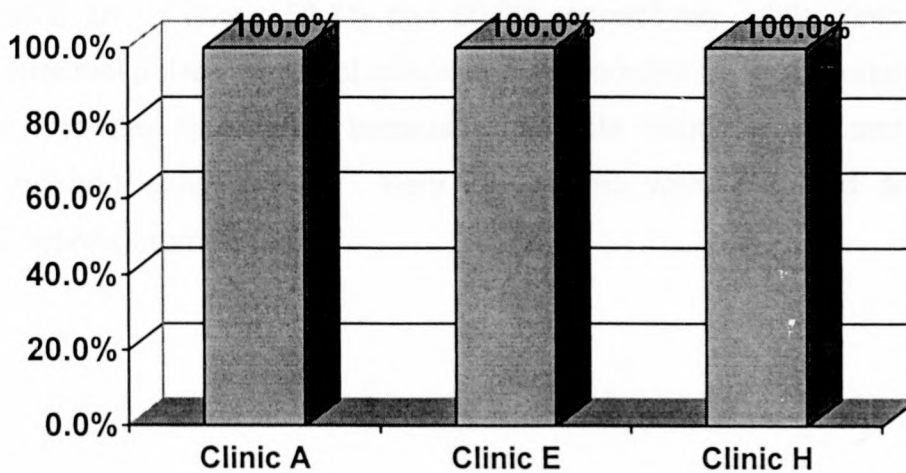
FIGURE 4.35
BREASTS



4.6.8 Percussion of the apex beat

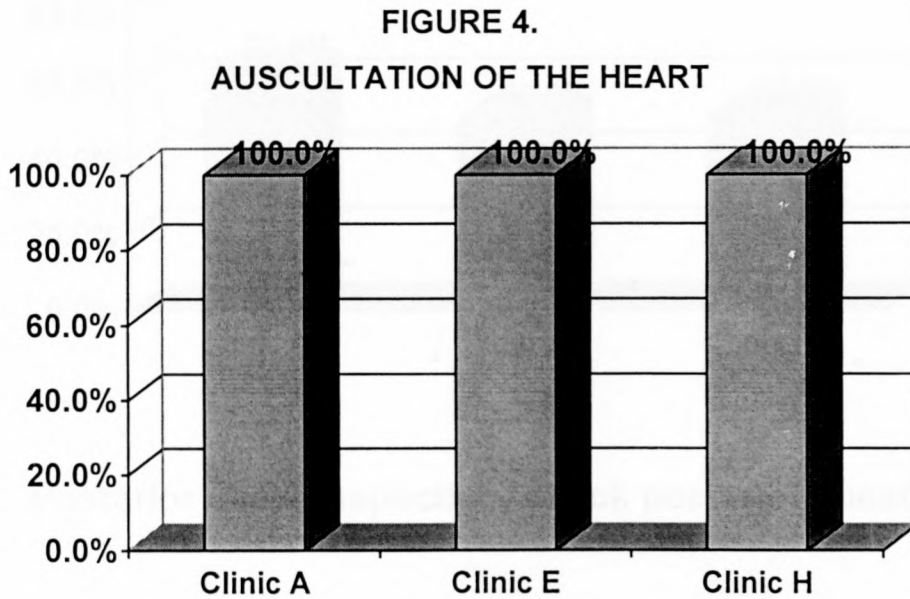
All three clinics obtained 100,0% which is excellent and shows that nurses were able to percuss the apex beat to identify abnormal cardiac position.

FIGURE 4.36
PERCUSSION OF THE APEX BEAT



4.6.9 Auscultation of the heart

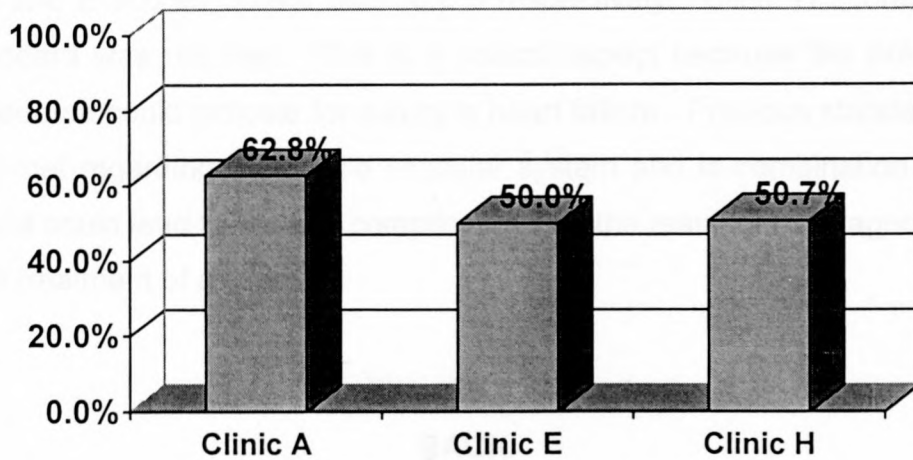
Again all three clinics obtained 100,0% on auscultation of the heart.



4.6.10 Check and record: Palpation of pulses

Both clinic E and H obtain 50,7% and 50,0% respectively, while clinic A scored 62,8%. Brachial pulses were not checked and recorded by most nurses. This is a concern to the researcher because this data obtained is used in other procedures and examinations. Very low scores were obtained and urgent remedial actions are needed.

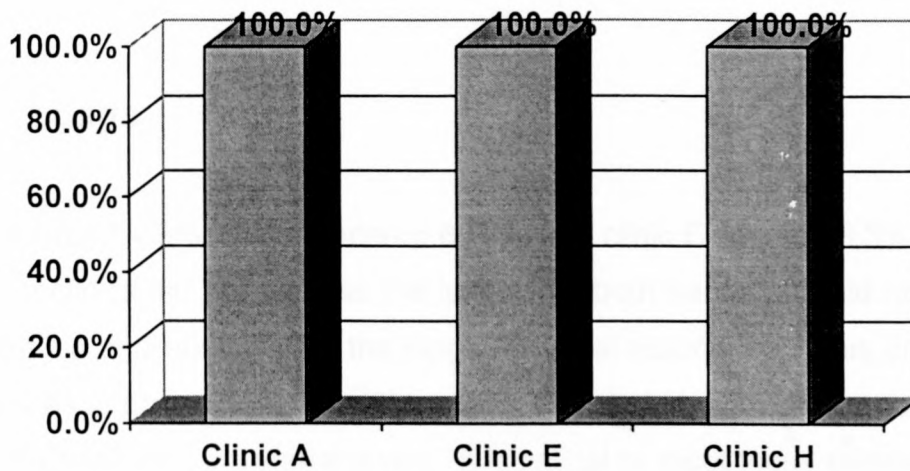
FIGURE 4.38
CHECK AND RECORD: PALPATION OF PULSES



4.6.11 Posterior chest inspection; check posterior chest

All three clinics A, E and H scored 100,0%. The nurses inspected the posterior chest according to the set criteria.

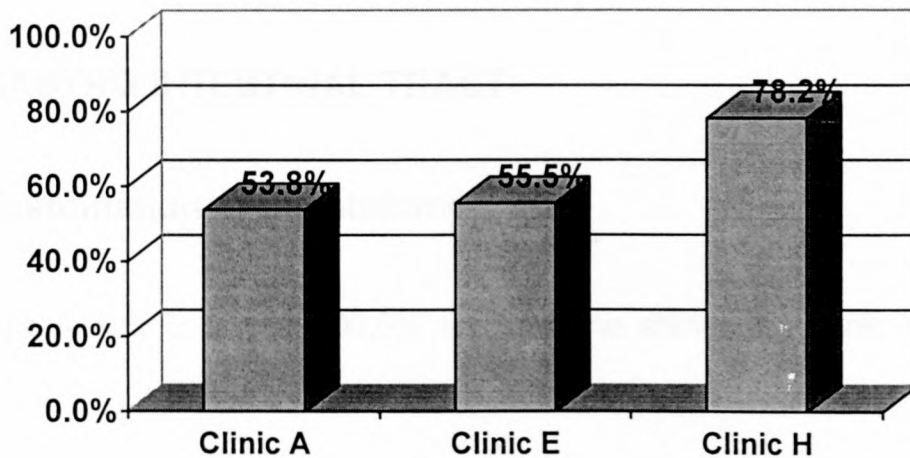
FIGURE 4.39
POSTERIOR CHEST INSPECTION; CHECK POSTERIOR CHEST



4.6.12 Back

Clinic A and E scored 53.8% and 55.5% respectively. Clinic H scored 78.2%. The standard was not met. This is a critical aspect because the presence of sacral oedema could indicate for example heart failure. Previous standards were also not met regarding the cardio vascular system and in combination with this standard it could lead to serious complications as the result of misdiagnosing and incorrect treatment of a client.

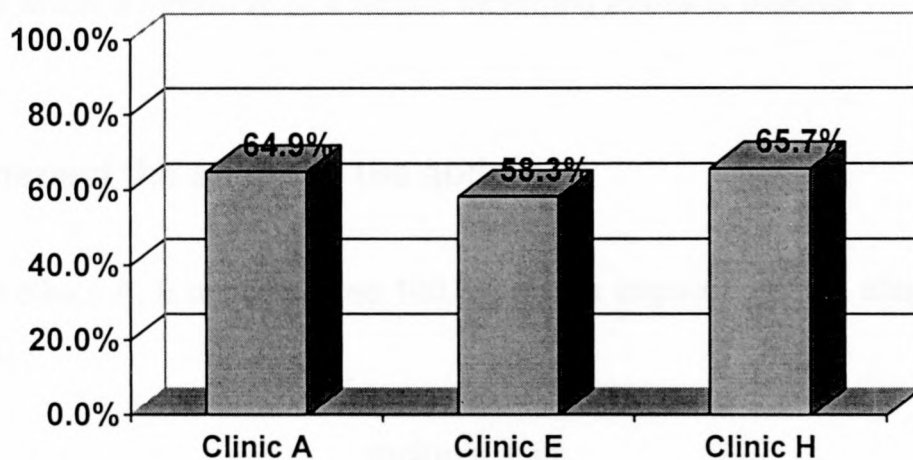
FIGURE 4.40
BACK



4.6.13 Lungs

Clinic A scored 64.9%, clinic H scored 65.7% and clinic E scored 58.3%. Nurses at all three clinics did not percuss the lungs with both hands and did not feel for vocal fremitus and auscultating the lungs for vocal resonance. This criteria are necessary as abnormal lung conditions will be excluded, correct diagnosis made and correct treatment or referral given. It is critical to meet these criteria and the standard because these are vital observations that serve as a data base for further examinations and investigations.

FIGURE 4.42
LUNGS: PERCUSSION AND AUSCULTATION

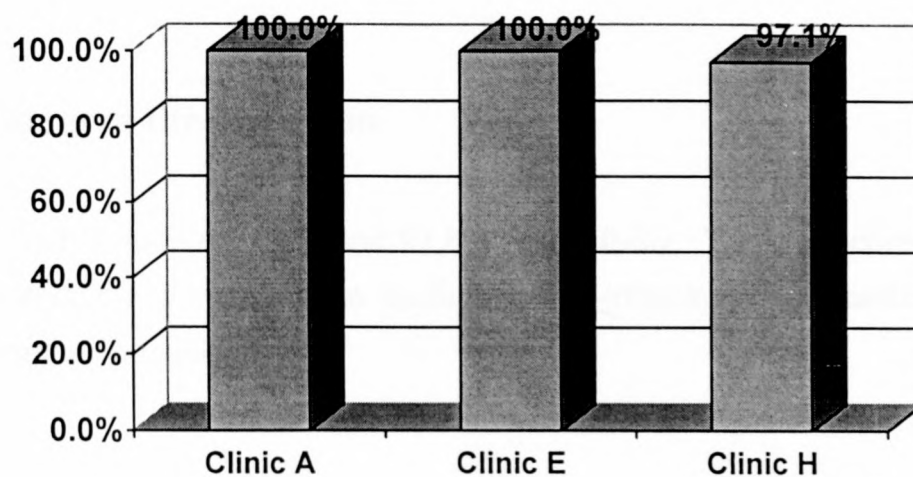


4.7 GASTRO INTESTINAL TRACT

4.7.1 Examination of the abdomen

Both clinic A and E scored 100,0% and met the standard. Clinic H scored 97,1%.

FIGURE 4.42
ABDOMEN: SKIN

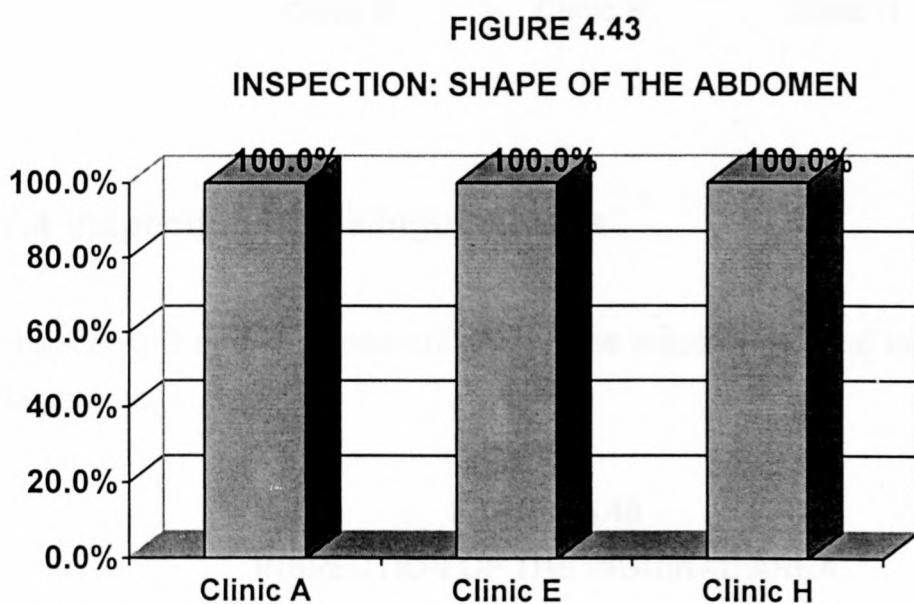


Clinic H scored 97,1% because the following were for example not observed:

swelling, lesions and scars. It is important to examine the abdomen for lesions and scars as this indicate previous surgery and or injuries. Swelling may be due to ascitis which is indicative of a serious inderlying illness or disease

4.7.2 Inspect the shape of the abdomen

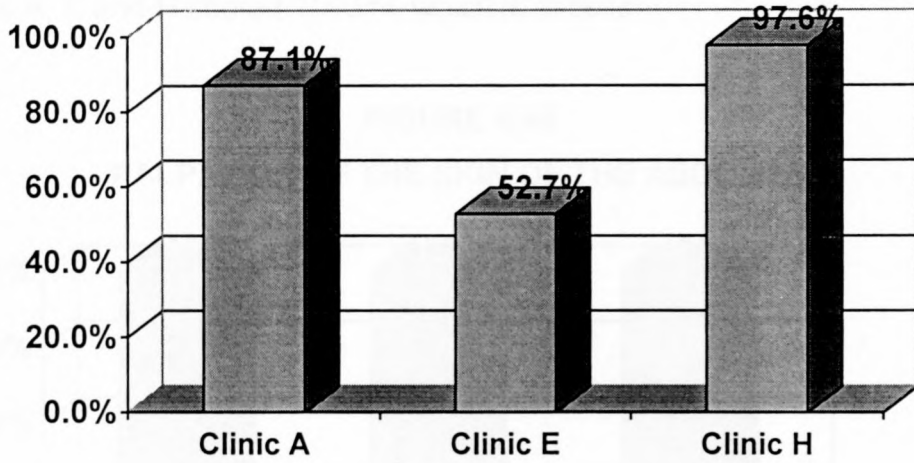
All three clinics A, E and H scored 100,0% on the inspection of the shape of the abomen.



4.7.3 Observe the abdomen

Clinic A and H scored 87,1% and 97,6% respectively. Clinic E scored 52,7%. This observation is important to exclude gastro-intestinal tract, cardiovascular and respiratory conditions.

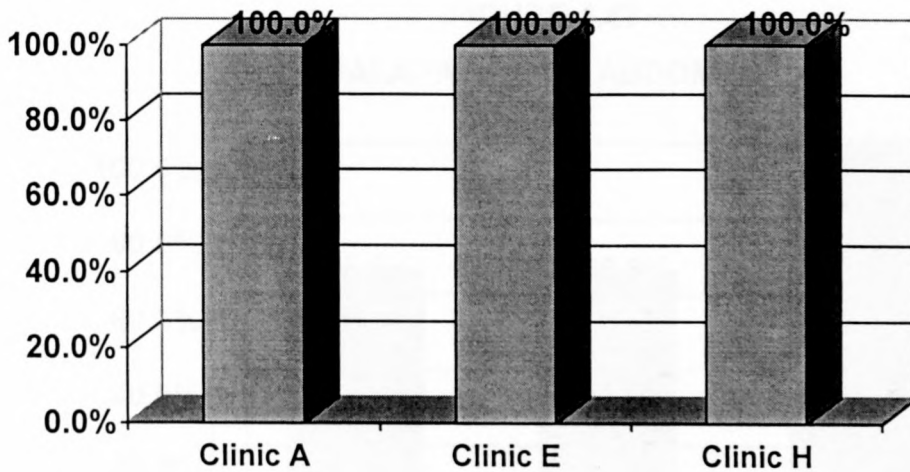
FIGURE 4.44
OBSERVE THE ABDOMEN



4.7.4 Inspection of the inguinal area

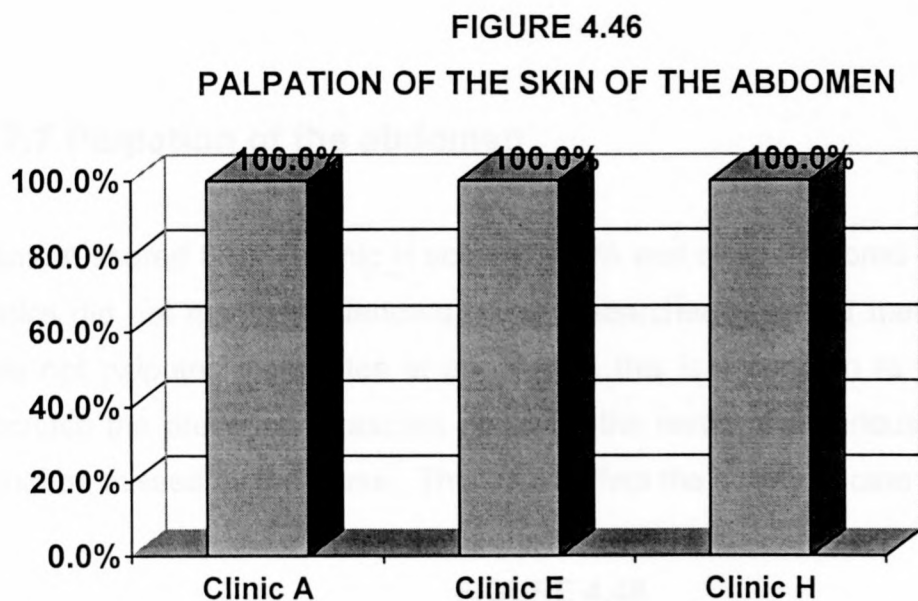
All clinics A, E and H scored 100,0% on the inspection of the inguinal area for enlargement.

FIGURE 4.45
INSPECTION OF THE INGUINAL AREA



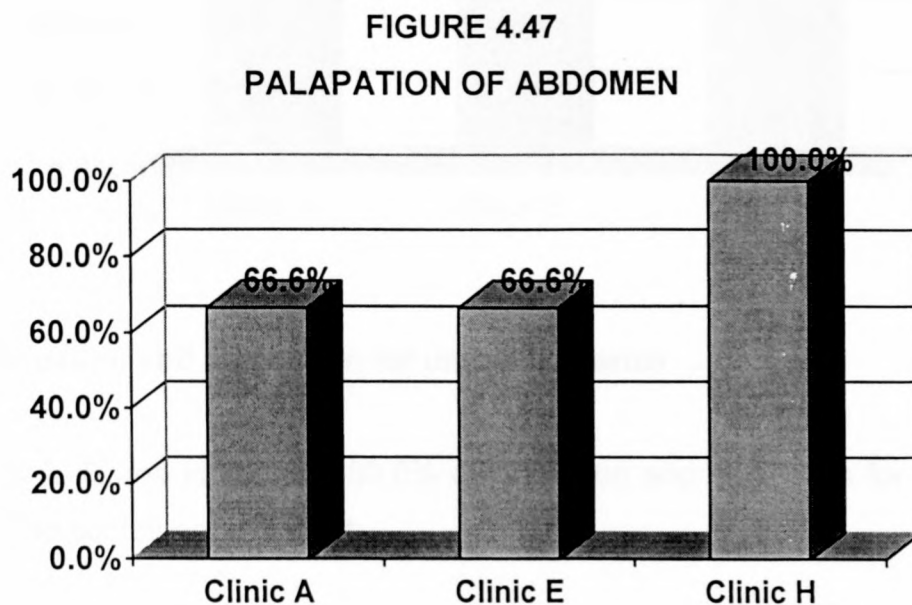
4.7.5 Palpate the skin of the abdomen

All clinics A, E and H scored 100,0% which is excellent.



4.7.6 Palpation of abdomen

Both clinic A and E scored 66,6% on abdominal palpation.

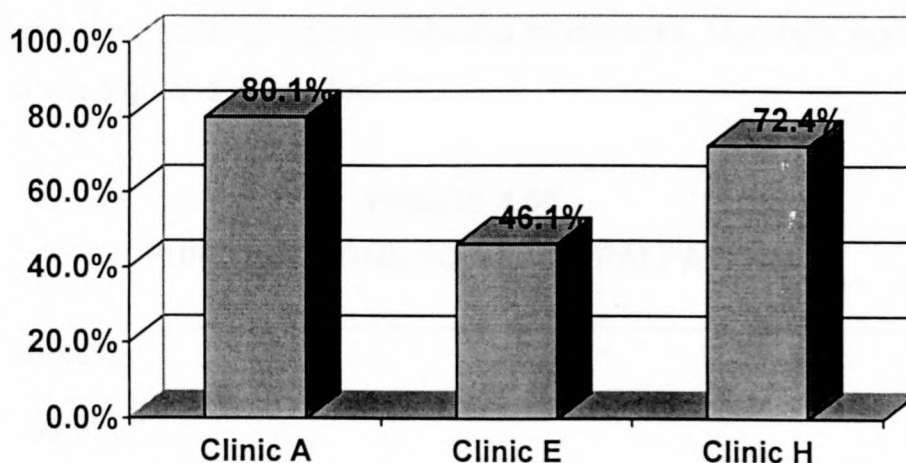


Clinic H scored 100,0% which is excellent. Nurses at clinic A and E did not palpate Mc Burney's point, ascending, transverse and the descending colon. It is necessary to do these specific palpations to exclude serious conditions that may require specialized intervention.

4.7.7 Palpation of the abdomen

Clinic A scored 80,1%, clinic H scored 72,4% and clinic E scored 46,1%. These clinics did not meet the standard. The researcher observed that the abdomen was not palpated for ascites at all. Again, this is a concern to the researcher because the presence of ascites could be the result of a serious condition that could be missed by the nurse. This could affect the quality of care negatively.

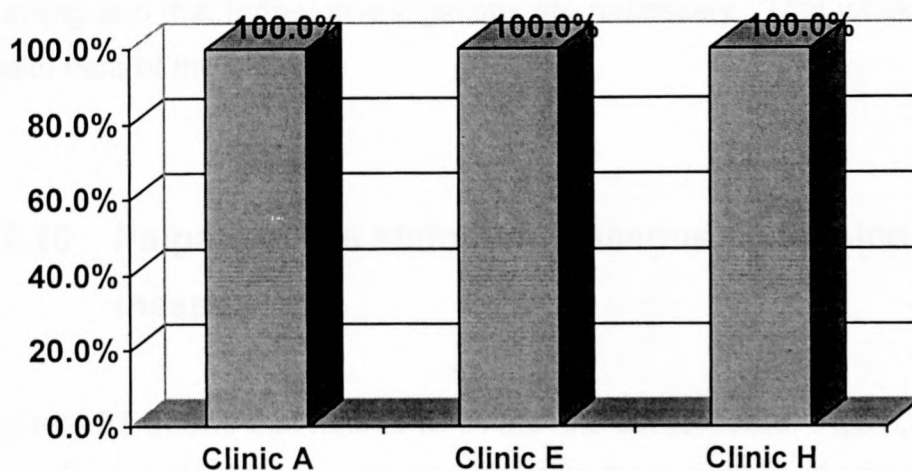
FIGURE 4.48
PALPATION OF THE ABDOMEN



4.7.8 Palpation and inspection for umbilical hernia

All clinics A, E and H scored 100,0% on palpation and inspection for umbilical hernia. The scores are excellent.

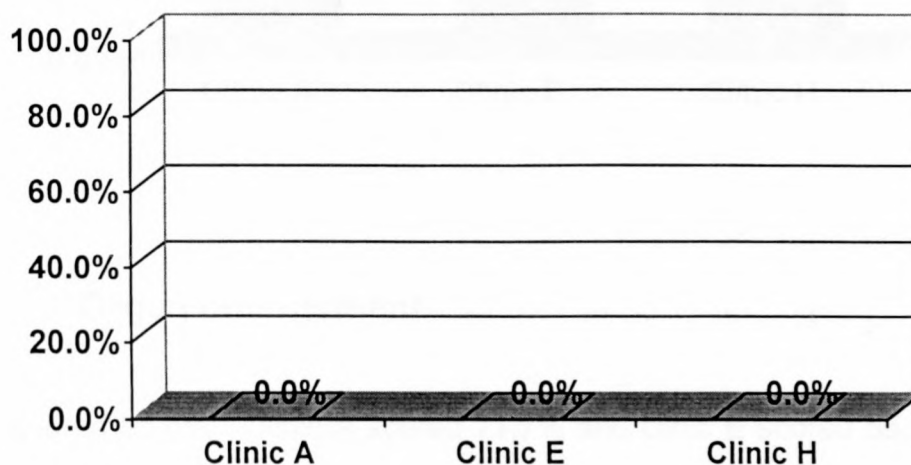
FIGURE 4.49
PALPATION AND INSPECTION FOR UMBILICAL HERNIA



4.7.9 Further signs found on palpation

All clinics A, E and H scored 0,0% respectively. Remedial action is urgently needed. All three clinics showed that nurses did not palpate the abdomen for further signs like guarding, rigidity, rebound tenderness, Murphy's sign Rovsig's sign, obturator sign and Psoas test.

FIGURE 4.50
FURTHER SIGNS FOUND ON PALPATION

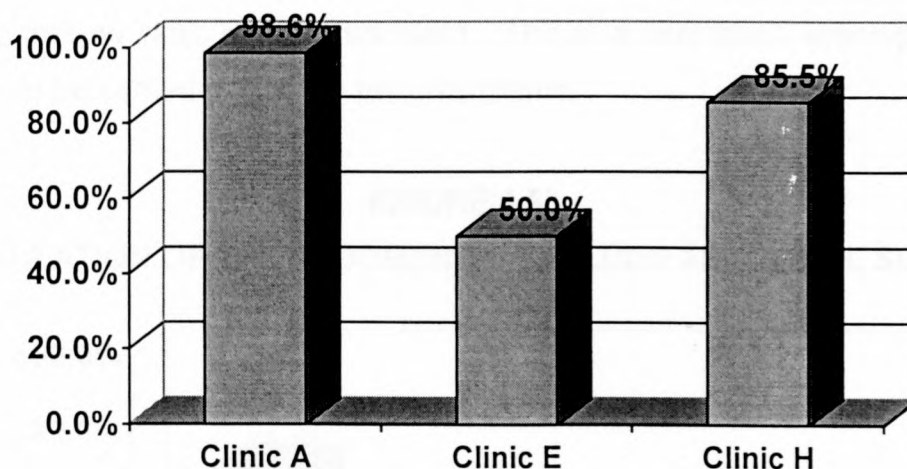


It is critical that the nurse should palpate the abdomen to determine if these signs are present or not because this gives the nurse a good indication that something is wrong and that further investigations are necessary. That would result in good health care of the patient.

4.7.10 Palpate of the abdomen: gaseous distension and masses

Figure 4.51 Shows that neither clinic met the set standard. Again, this is a critical aspect in the physical examination because the presence of either one of the two indicate that something is wrong.

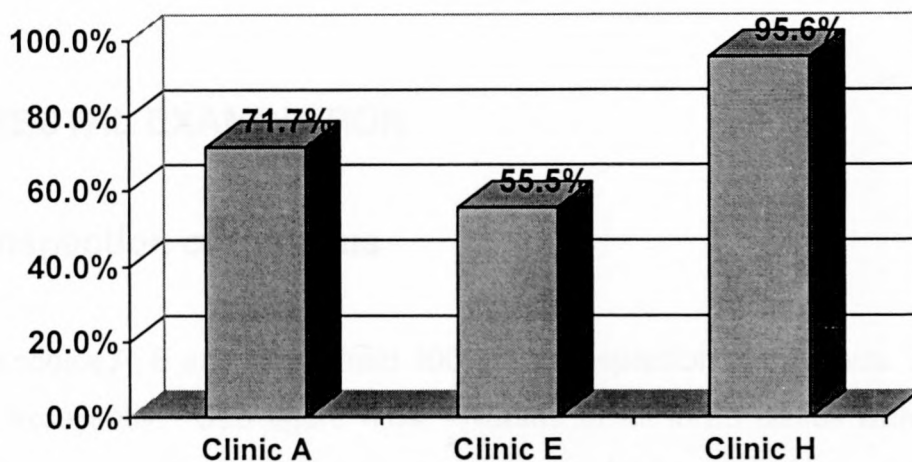
FIGURE 4.51
PALPATE OF THE ABDOMEN: GASEOUS DISTENTION AND MASSES



4.7.11 Organ enlargement

Clinic H scored 95,6%. Clinic A scored 71,7% and clinic E scored 55,5%. The presence of enlargement of the liver or spleen should be determined because it could be indicative of a pathology. The data obtained from this examination could only have a positive impact on the nurses decisions and actions.

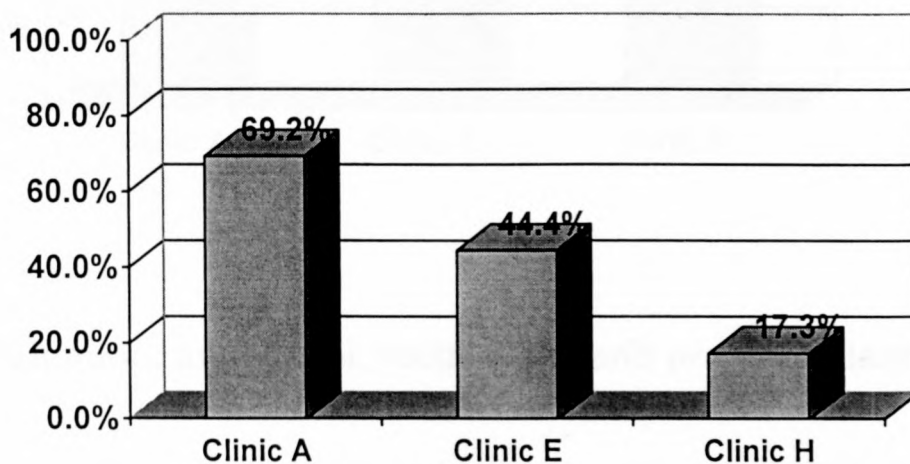
FIGURE 4.52
ORGAN ENLARGEMENT



4.7.12 Auscultation of the abdomen

Clinic A scored 69,2%, clinic E scored 44,4% and clinic H scored 17,3%. It is alarming that no clinic met the standard. This is a very basic action/procedure and should be carried out on the patients/clients.

FIGURE 4.53
AUSCULTATION OF THE ABDOMEN TO EXCLUDE ABNORMAL SOUNDS



Abnormal sounds are again indicative of the fact that something is wrong and

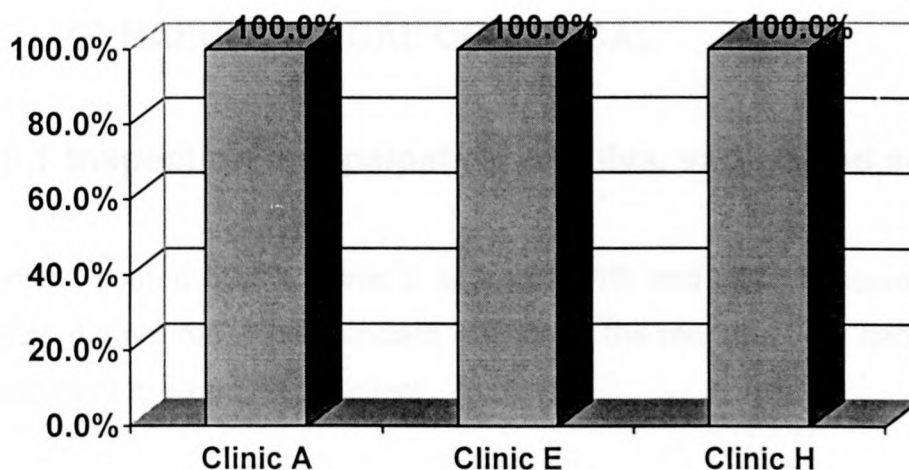
that the nurse must pay attention to it. This will influence her decisions and planning of the care of the patient.

4.8 RECTAL EXAMINATION

4.8.1 Inspection of the anus

All three clinics A, E and H obtained 100,0% on inspection of the anus. All clinics worked excellently. See figure 4.54. Nurses at all three clinics were able to inspect the anus on the exterior and peri-anal area, for hemorrhoids and wounds.

FIGURE 4.54
INSPECTION OF THE ANUS

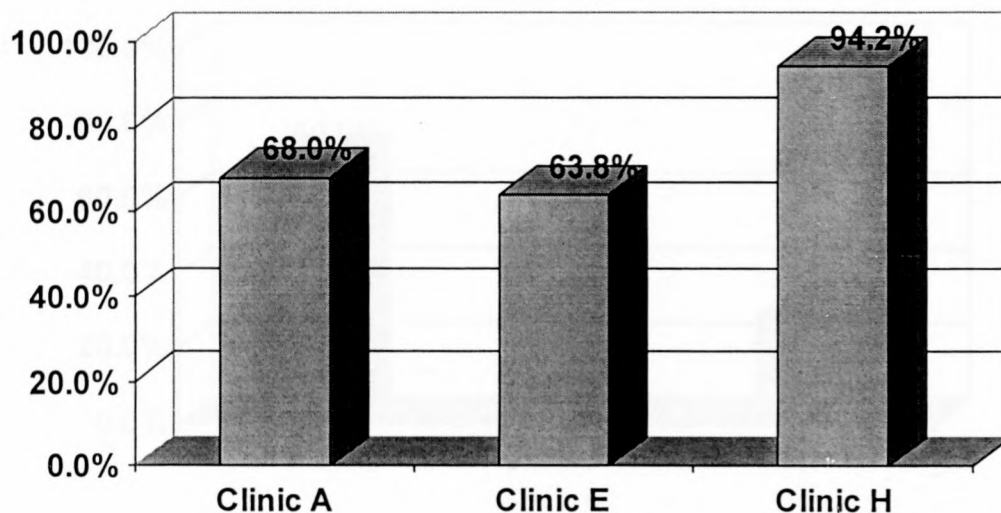


4.8.2 Palpation: anal canal, rectal walls and prostate gland

Clinic H scored the highest 94,2%, while clinic A and E scored 63,8% and 68,0% respectively. It is necessary to do these palpations in order to detect any abnormalities.

FIGURE 4.55

PALPATION: ANAL CANAL, RECTAL WALLS AND PROSTATE GLAND

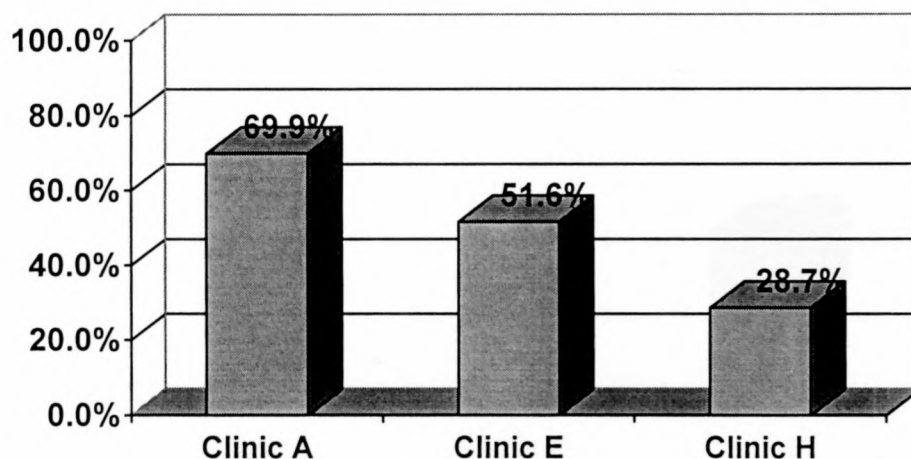


4.9 REPRODUCTIVE SYSTEM GENITOURINARY AND GYNAECOLOGICAL COLOGICAL

4.9.1 Inspection and palpation of vulva, vagina and servix

Clinic A scored 69,9%, clinic E scored 51,6% and clinic H scored 28,7%. The clinics did not meet the standard in spite of the fact that they had the necessary equipment to examine the client.

FIGURE 4.56
INSPECTION AND PALPATION OF VULVA, VAGINA AND SERVIX

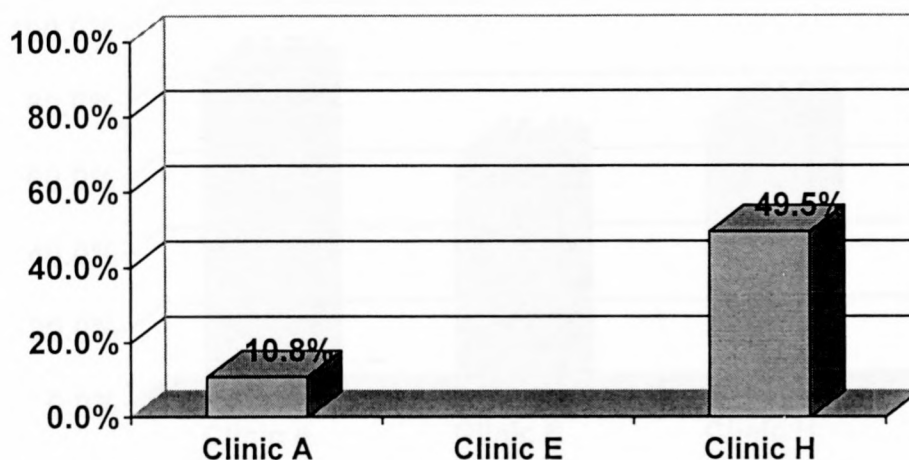


Inspection/palpation of the female reproductive system is necessary to exclude abnormalities and sexually transmitted diseases. Speculum examination was not properly done and some patients were not examined with a speculum. It seems that nurses did not know how to use the speculum.

4.9.2 Male genitalia

Clinic A scored 10,8%, and clinic H scored 49,5%. This part of the physical examination was not evaluated in clinic E because all the patients were female on those days that the researcher obtained data. Examining according to the above-named criteria is important to exclude abnormalities, malfunctioning and sexual transmitted diseases. Neither clinic met the standard.

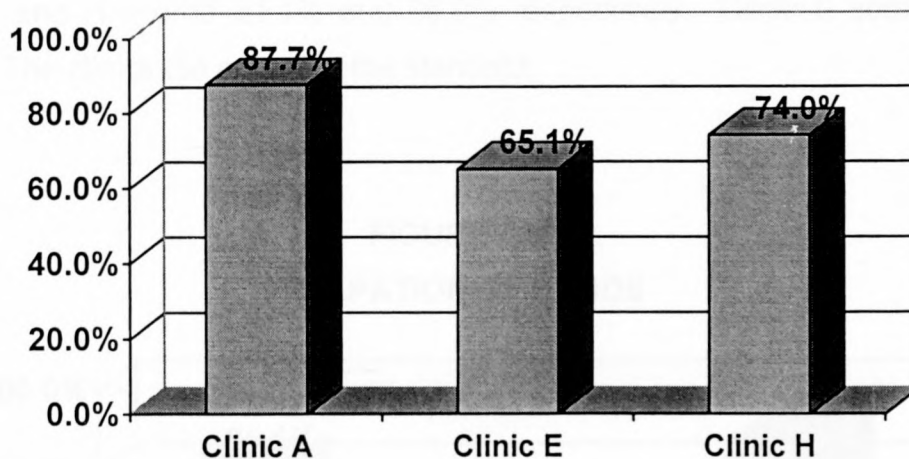
FIGURE 4.57
INSPECTION OF MALE GENITALIA



4.9.3 Breasts: Examination inspection and palpation of the breasts, nipples and glands

Clinic A, E and H scored 87,7%, 65,1% and 74,0% respectively. The clinics did not meet the standard. The nipples were inspected correctly and the patients were positioned correctly for the examination. It is alarming though that the palpation part of the examination was not done correctly and this is the method where abnormalities like tumors are detected. It is common knowledge that breast cancer could be successfully treated if detected and diagnosed early. Urgent remediation is necessary.

FIGURE 4.58
BREASTS

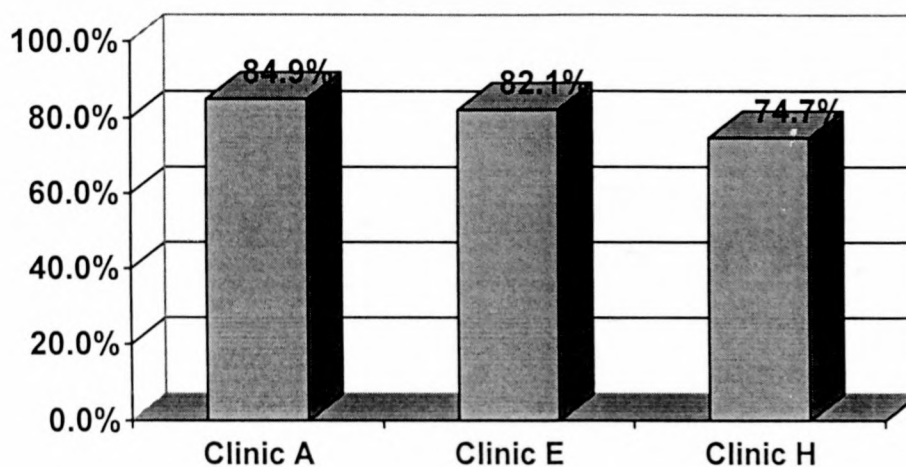


4.10 MUSCULOSKELETAL

4.10.1 Inspection of hands

All three clinics scored between 74,7% and 84,9% and did not meet the set standard. (See figure 4.59)

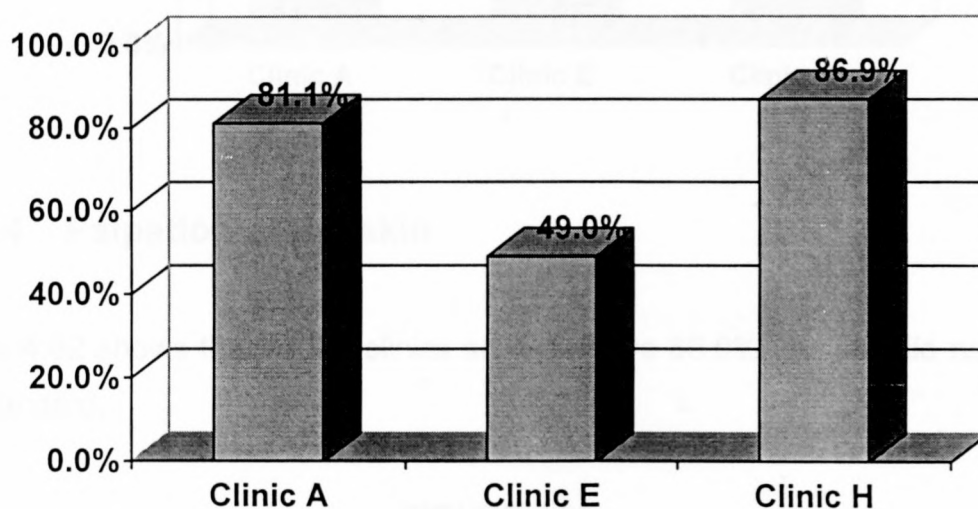
FIGURE 4.59
INSPECTION OF HANDS



4.10.2 Palpation of hands

Clinic A and H scored 81.1% and 86.9% respectively. Clinic E scored a low 49.0%. The clinics did not meet the standard.

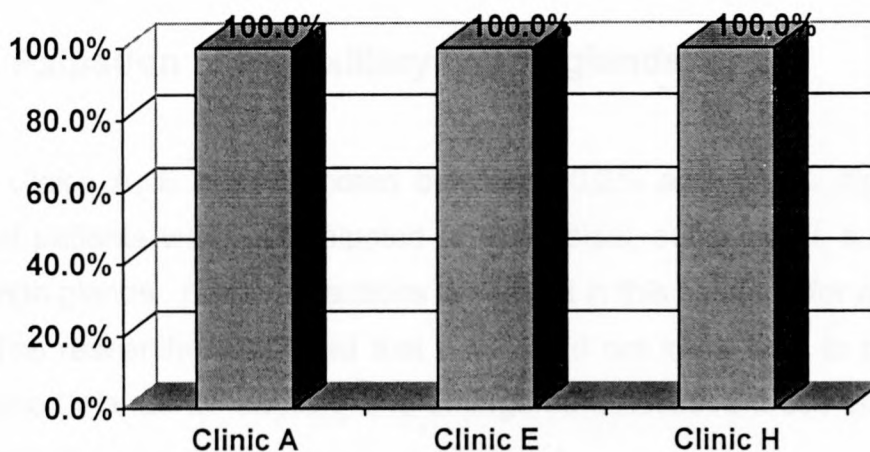
FIGURE 4.60
PALPATION OF HANDS



4.10.3 Inspection of the rest of arm, front and back

All three clinics scored 100,0% and thus met the standard in this aspect.

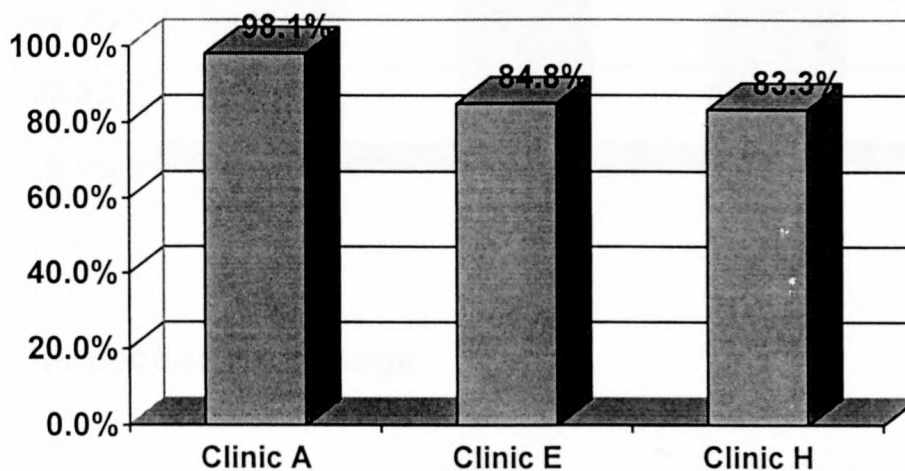
FIGURE 4.61
INSPECTION OF THE REST OF ARM, FRONT AND BACK



4.10.4 Palpation of the skin

Figure 4.62 shows that all the clinics scored above 80,0%, but still did not meet the standard.

FIGURE 4.62
PALPATION OF THE SKIN



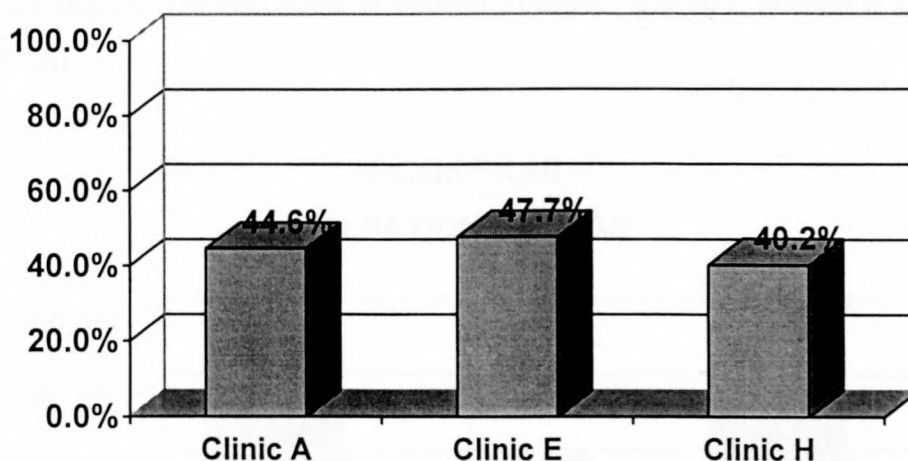
Nurses at all clinics were unable to palpate skin of hands for moisture and epitrochlear lymph nodes. Palpation of the above criteria is necessary to diagnose and treat correctly and to refer patients to specialized services when

necessary.

4.10.5 Palpation of the axillary lymph glands

All three clinics A, E and H scored between 40,2% and 47,7% (figure 4.63). Majority of patients were not palpated on the apical, subpectoral, subscapular, lateral lymph glands. Remedial actions is needed in this category for all the three clinics. The researcher observed that nurses did not know how to palpate the above-named glands for swelling and enlargement because these changes are always indicative of a disease process in the body.

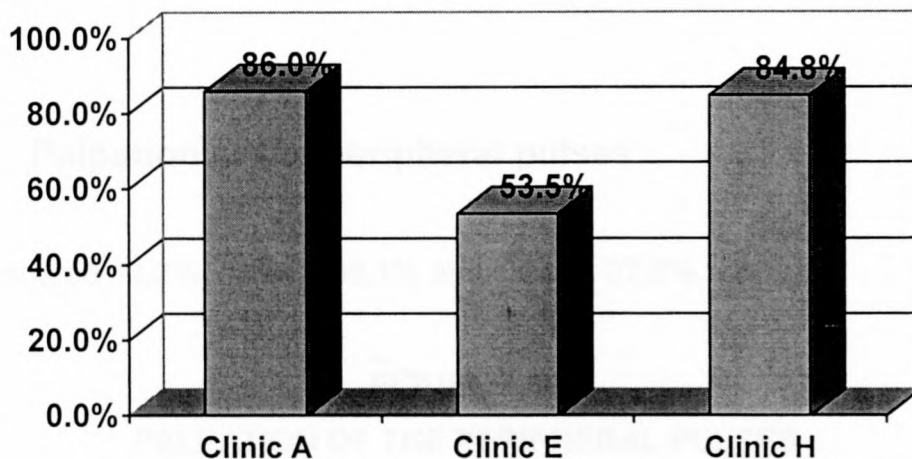
FIGURE 4.63
PALPATION OF THE AXILLARY LYMPH GLANDS



4.10.6 Inspection of the legs

Both clinic A and H scored above 80,0% and clinic E scored only 53,5% (figure 4.64). Majority of patients were not examined for gait abnormalities and the nurses were unable to inspect for swelling, hardening and other abnormalities and to rotate the legs clock/anti-clockwise.

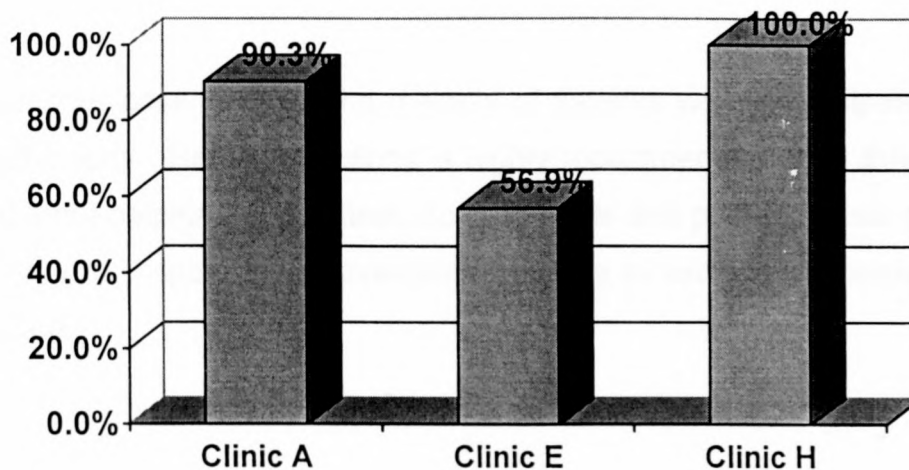
FIGURE 4.64
INSPECTION OF THE LEGS



4.10.7 Palpation of legs

Clinic A scored 90,3% and clinic H scored 100,0%. Clinic E scored a low 56,9% (Figure 4.65).

FIGURE 4.65
PALPATION OF LEGS

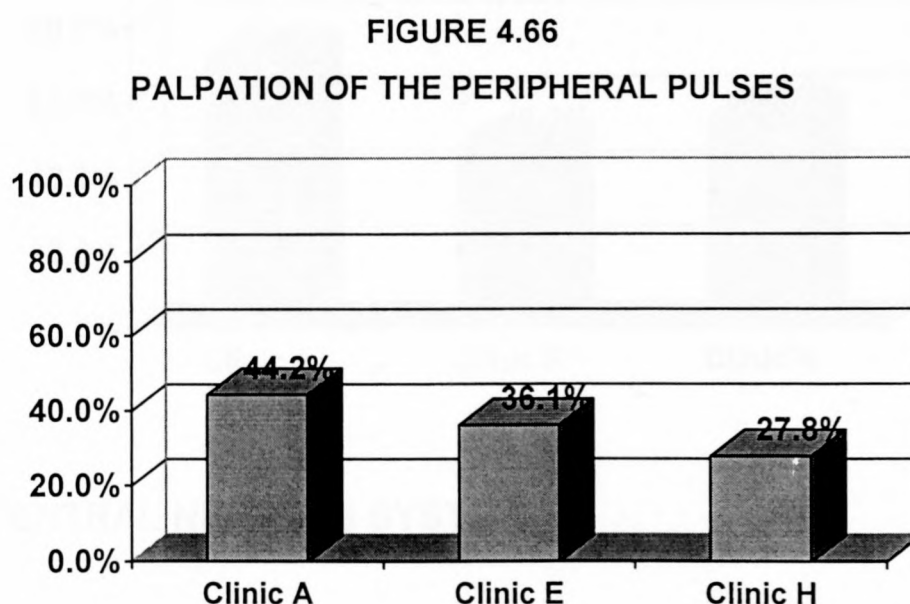


Majority of patients were not palpated on muscles and tendons for abnormal areas at clinic E and clinic A. The researcher observed that nurses did not know

how to palpate muscles and tendons for abnormalities. Palpating the above-named criteria is necessary to exclude muscle weakness, abnormalities and deformation.

4.10.8 Palpation of the peripheral pulses

Clinic A scored 44,2%, clinic E 36,1% and clinic H 27,8%.



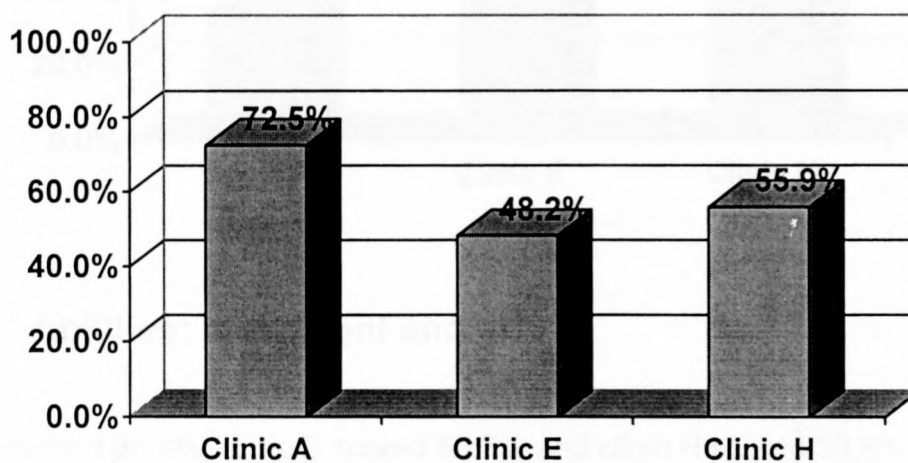
The researcher observed that the majority of patients were not palpated on the peripheral pulses. Remedial actions is highly recommended at all three clinics. Nurses did not palpate the popliteal, dorsalis pedis and posterior tibial pulses. It is necessary to palpate the above-named criteria to exclude abnormalities and plan for care.

4.10.9 Joints: Inspection, palpation and range of passive movement

Clinics A, E and H scored 72,5%, 48,2% and 55,9% respectively and thus not

meeting the standard. This section of the physical examination was not done thoroughly and important deviations from the normal could not be determined. This limits the nurse in her diagnosing and treating the clients effectively.

FIGURE 4.67
JOINTS

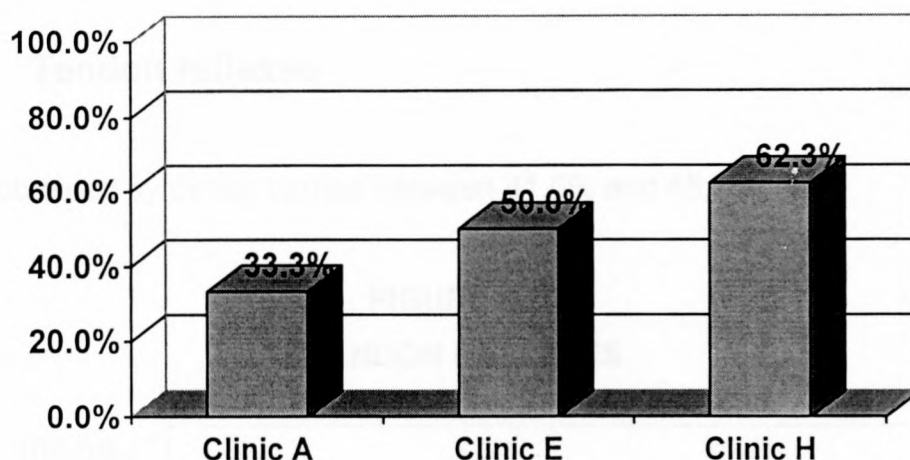


4.11 CENTRAL NERVOUS SYSTEM

4.11.1 Examination of central nervous system

Figure 4.68 shows a score of 62,3% for clinic H, 50.0% for clinic E and 33,3% for clinic A. The majority of patients were not examined regarding cerebellar function test and Romberk test at all three clinics. Examination of the central nervous system is important to exclude abnormalities and plan treatment and care.

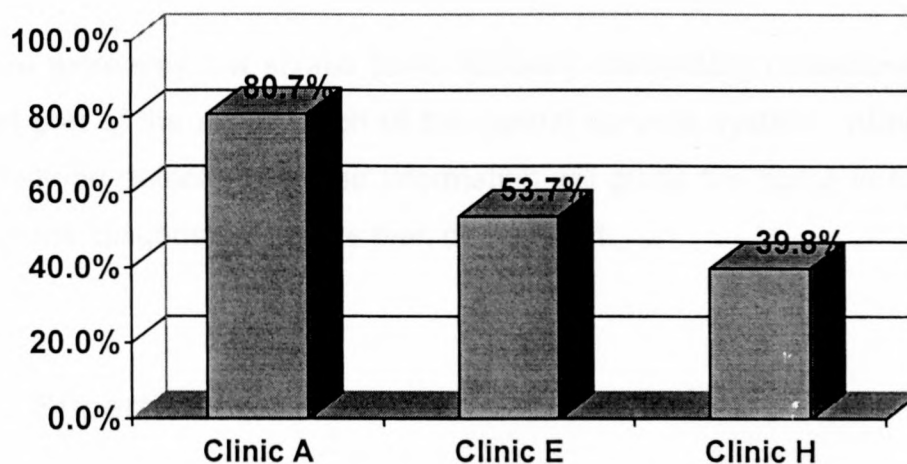
FIGURE 4.68
EXAMINATION OF CENTRAL NERVOUS SYSTEM



4.11.2 Abilities: movement and grip

Clinic A scored 80,7%, clinic E scored 53,7% and clinic H scored 39,8%.

FIGURE 4.69
ABILISICS: MOVEMENT AND GRIP



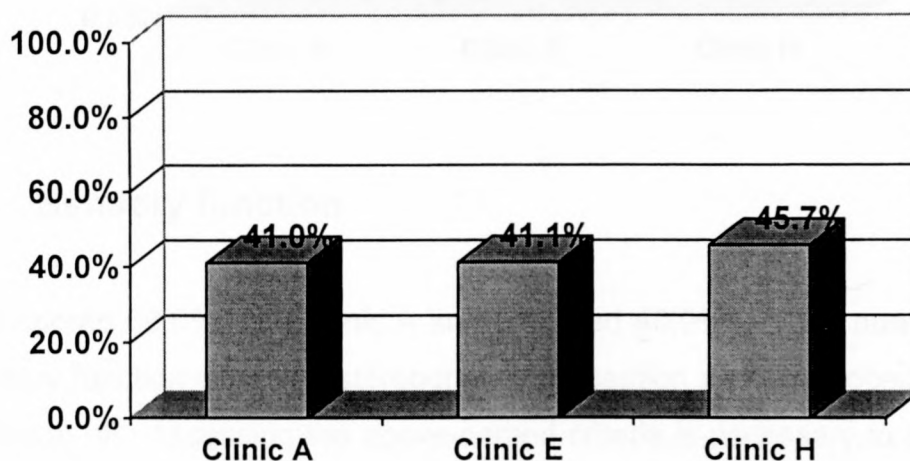
The majority of patients were not assessed if they are able to hop, walk on toes and heels and maintain arms in the extended position at clinic E and H. Nurses at clinic A did not assess patients if they can grip the examiners' finger. All these

are important for diagnosing, treating, carrying and referring correctly.

4.11.3 Tendon reflexes

Scores obtained by clinics varried between 41,0% and 45,7%.

FIGURE 4.70
TENDON REFLEXES

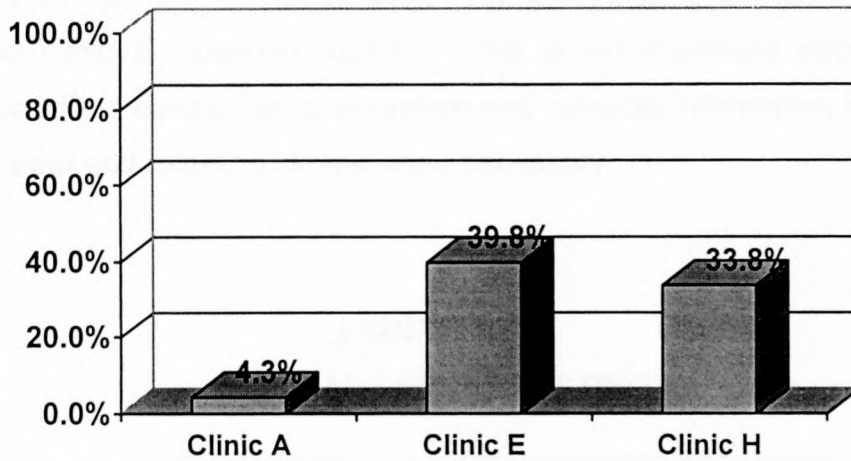


These are extremely low scores for a relatively elementary procedure but very important part of the examination of the central nervous system. Abnormalities could easily be detected and the information will guide the nurse in her further examinations, diagnosis and care plan of the client.

4.11.4 Superficial reflexes

Figure 4.71 shows a score between 4,3% and 39,8%. Clinic a scored a very low 4,3%. It is important to assess the above-named criteria to exclude abnormal superficial reflexes and to diagnose and plan the treatment of the client effectively.

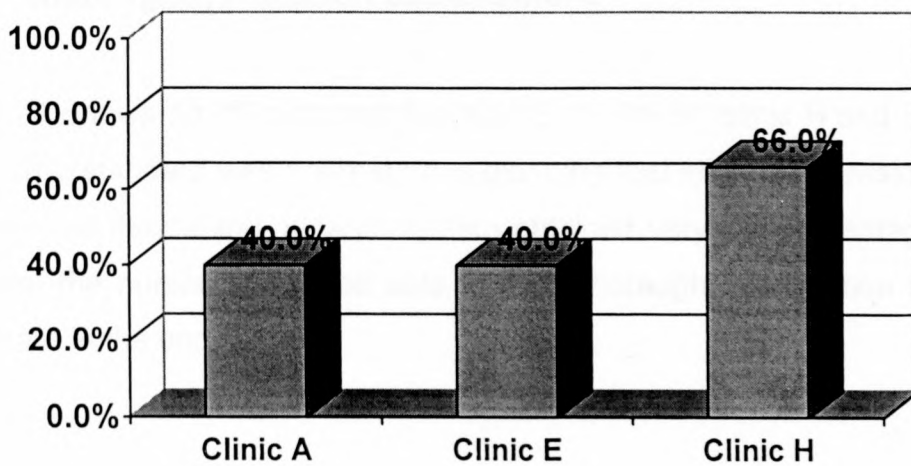
FIGURE 4.71
SUPERFICIAL REFLEXES



4.11.5 Sensory function

Clinic H scored 66,0%, both clinic A and E scored 40,0%. When nurses tested the sensory function vibration; stereognostic perception and proprioception were not tested at all. Assessing the above-named criteria is necessary to detect the patient's response to plan the care and treatment effectively.

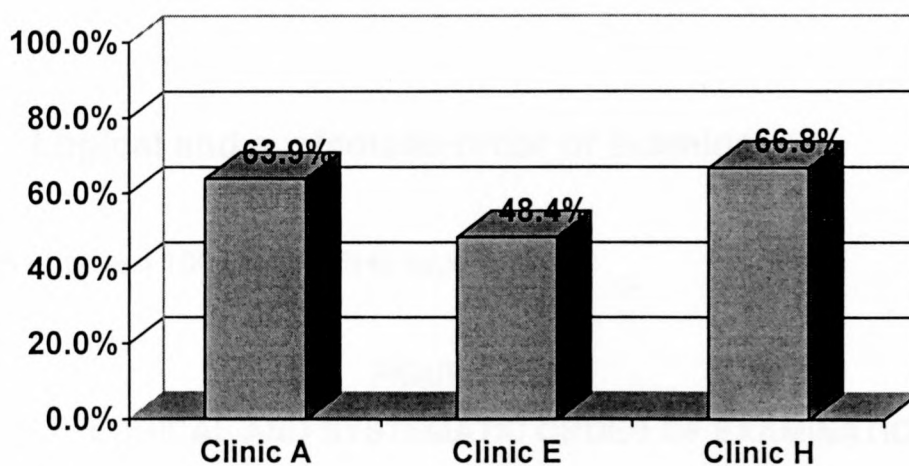
FIGURE 4.72
SENSORY FUNCTION



4.11.6 Cranial nerves testing

Figure 4.73 Shows the scores of clinic A and H ranging between 63,9% and 66,8% and clinic E obtained 48,4%. This is an important section of the examination of the central nervous system and valuable information is gained to diagnosis, treat and refer the clients when necessary.

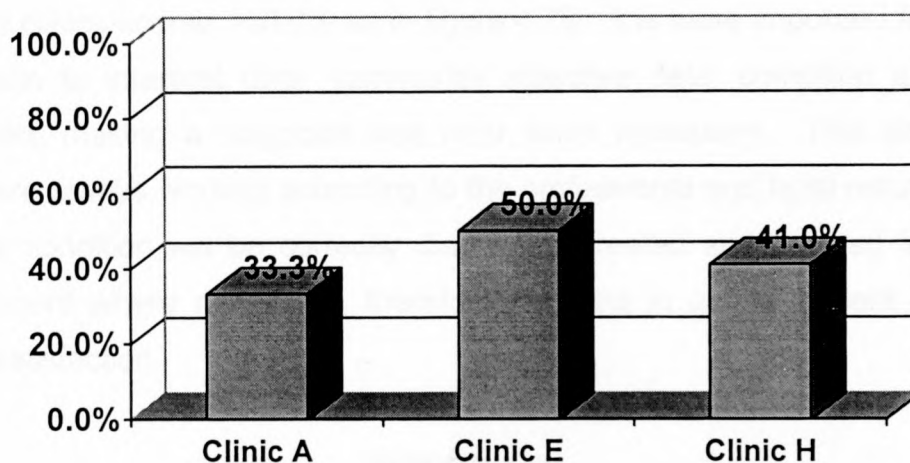
FIGURE 4.73
CRANIAL NERVES TESTING



4.11.7 Meningeal irritation assessment

Figure 4.74 Shows 50,0% obtained for clinic E, 41,0% for clinic H and 33,3% for clinic A. The standard was not met. It is alarming that all the subdivisions in the examination of the central nervous system obtained very low percentages. It is critical that the nurses should be able to do a thorough examination to render optimal care in the end.

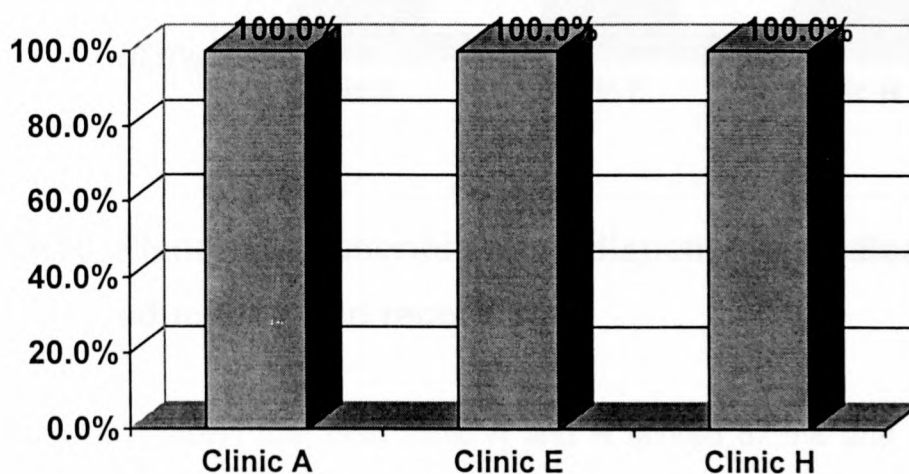
FIGURE 4.74
MENINGEAL IRRITATION ASSESSMENT



4.11.8 Logical and systematic order of examination

All clinics obtained 100,0% which is excellent.

FIGURE 4.75
LOGICAL AND SYSTEMATIC ORDER OF EXAMINATION

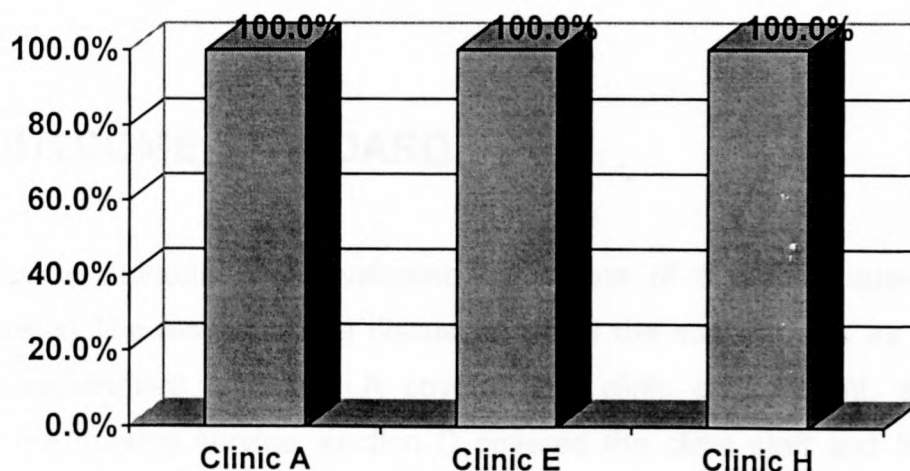


Logical and systematic order of examination is necessary as the criteria guides nurses how to examine patients logically and systematically. The patient's fear is allayed and the whole process is done in a relaxed but effective manner.

4.11.9 Management

Again all clinics scored 100,0% as in figure 4.76. It is more important for nurses to be able to interpret data, summarize objective data, compiling a problem priority list, making a diagnosis and refer when necessary. This shows that nurses are always working according to the professional and legal requirements. Patient's condition will be correctly diagnosed, treated and referred for further management where necessary, therefore resulting in quality patient care and patient satisfaction.

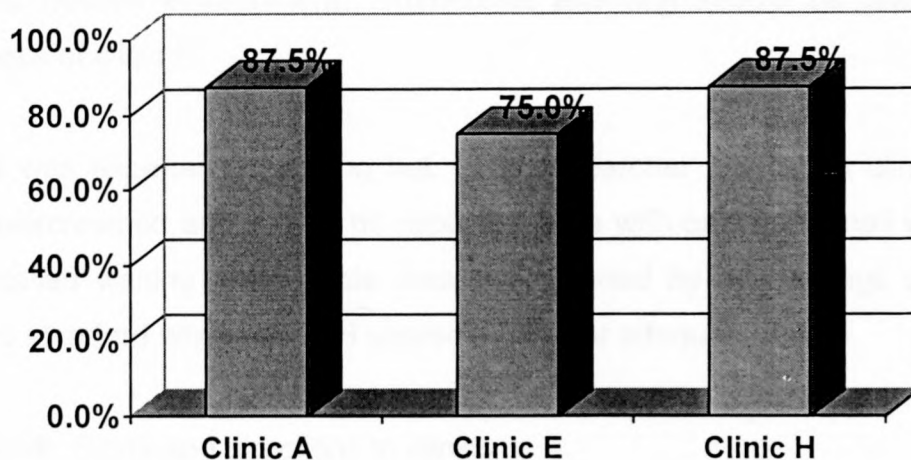
**FIGURE 4.76
MANAGEMENT**



4.11.10 Planning, prescribing and dispensing medication, health education and recording

Figure 4.77 shows that both clinic A and H scored 87,5% and clinic E scored 75,0%. Health education was not done. Recording however was done effectively and correctly.

FIGURE 4.77
PLANNING, PRESCRIBING AND DISPENSING MEDICATION, HEALTH
EDUCATION AND RECORDING



4.12 OUTCOME STANDARD

The outcome standard was evaluated by means of a patient questionnaire (Annexure B) The results will be discussed under the subheadings as indicated in the questionnaire. Section A covered the clinic environment, section B covered the nursing service, section C covered the clinic staff and Section D covered the personal views of the patients regarding the service received. The researcher interviewed the patients/clients until data saturation was reached.

4.12.1 Section A: Clinic Environment

Questions 1 and 2: All the clients interviewed in clinic A and H said the cleanliness of the clinics was good (100,0%). Only 38,9% said that the cleanliness of clinic E was good. All the clients said that the environmental temperature of clinics A and E was comfortable. Clinic H's environmental temperature was however too hot accordingly to all the clients interviewed.

The clinic environment should be clean and comfortable for the clients. Cleanliness will facilitate infection control and reduce medico-legal risks. This data is supported by structure standard data where clinic E scored 57,1% for a safe and riskfree environment. Immediate attention should be given to the cleanliness of clinic E.

Clinic H was experienced as too hot. The researcher found that clinic H was totally overcrowded and having no reception area with only one small window in the so-called waiting area. This data is supported by the findings under the structure standard where clinic H scored 37,5% for adequate rooms.

Question 4: Signs and directions to clinic

The signs and directions to clinic E were excellent according to the clients interviewed. Clinic A was rated fair and clinic H poor by the clients respectively. Clinic A and H need urgent attention because it is a well known fact that a big percentage of the population served by these clinics are also illiterate. Signs and directions have to guide literate and illiterate people. Confusion and anxiety are thus limited.

4.12.2 Section B

Questions 5, 6, 7 and 8: All the clients interviewed in clinics A, E and H responded that the staff attended to their problem(s) promptly and gave them information regarding their illness and treatment. All the clients were also given return dates, for follow up visits. The impression was that the staff communication well with the clients.

Question 9: Attitude of nurses.

All the clients experienced the staff as friendly. This is a positive attitude which facilitates communication between clients and nurse.

Question 10 to 11: Privacy available.

The staff of all three clinics provided privacy to the client when discussing the relevant problem(s). This is important for patients/clients because it allows anxiety and clients feel free to express their feelings and problems.

Question 12 to 13. All three clinics are offering a 9 hour service. The need is for 24 hours because the clients was referred after closing of the clinic to the closest hospital which could be 20km or more from the clinic.

4.12.3 Section C

Questions 14 and 15: All the clients interviewed (clinics A, E and H), responded that they were treated "good" by the nurses. "They could communicate with everyone ..." " They speak to us in our own language." "They greet us friendly." "They attend to your problem without judging ...".

The clients of clinic A and H also responded that the general assistants treated them good. Clinic E did not have any general assistant working there.

4.12.4 Section D

Question 16. The clients interviewed from all three clinics, responded positively regarding their impression of the service received.

"I was impressed even though the clinic is too small" "Nurses are skilled" " The nurses manage to give a good service ..."

Questions 17 and 18. All the clients interviewed from clinic A and E responded that they will choose this clinic again to be treated. 50,0% of the clients of clinic H however said they would not choose clinic H again.

Question 19. Things liked at the clinic. The responses of the clients interviewed

were transcribed and grouped together in themes emerging from the responses. The responses from the clients of clinic A showed that they liked the fact that the nurses showed respect to them and that the staff portrayed a positive attitude continuously. This is supported by the data obtained with question 9.

Clinic E had youth health services and good health promotional materials and efforts that was positively identified by the clients. The clients also liked the privacy they experienced while consulting with the nurse in the clinic.

The clients of clinic H reacted positively on the health education programmes, youth involvement in health services, good communication and contact with the councillors and committee.

Although it seems as if different themes emerged from the three clinics, they are actually integrated and dependent on each other in delivery a high standard of care. All these aspects should be addressed at all the clinics to lift the standard of care rendered.

Question 20. Things liked least. The data again was transcribed and grouped into themes. It became clear that all the responses evolved around the structure standards. According to the clients the clinics were too small and overcrowded and did not have enough toilets. Clinic E was the only clinic not delivering the chronic medicines on time. This response is supported by the data obtained under structure standard.

Question 21. Additional comments/suggestions. None were received.

4.13 SUMMARY

The standard of care regarding the structure and process was suboptimal in both cases. Physical examination audits at all clinics was not performed according to the set standards, which indicate that suboptimal care was rendered to the

patients.

It is alarming that the clinics in general did not meet the set standard. Serious attention to these aspects are needed with good planning how and when to institute remedial actions.

CHAPTER 5**GENERAL CONCLUSIONS AND
RECOMMENDATIONS****5.1 INTRODUCTION**

The research was concerned with the setting of standards to evaluate the nursing component of primary health care service in the Northern Province. Based on the findings, conclusions and recommendations are made to solve the identified problems.

5.2 CONCLUSIONS**5.2.1 Structure standards**

Major problems were found and in general the standard was suboptimal for all three clinics.

The total structure standard average was 65,0% for clinic A, 72,7% for clinic E and 42,0% for clinic H (see Table 4.1). This implies that critical physical and human resources necessary to render quality nursing care were not up to standard and that affected the nursing care negatively.

5.2.2 Process standards

The physical examination of patients was evaluated according to the set standards. The data analysis showed that patients in all three clinics were not fully assessed. Apart from not being fully assessed, the systems that was assessed did not meet the set standard. In order to render a high quality of care it is critical that each body system should be assessed correctly. The data obtained from the assessment/examination forms the basis of the nurses scientific knowledge base which enables her to diagnose, treat and plan correctly and effectively sets.

5.2.3 Outcome standard

The outcome standard was evaluated by means of a patient questionnaire. The patients responded that the clinics cleanliness was good but one clinic was too hot. Clients indicated that they are satisfied with the staff members attitude and management in all three clinics.

The following were identified as problems

- Poor toilet facilities at one clinic.
- Clinic building not built according to clinic standards.
- All clinics not offering 24 hour service.
- Security officers not working 24 hours at clinics.

Generally it could be concluded that the outcome standard was satisfactory as patients did not experience problems in areas which are critical to the total nursing care process of the patient.

The management of the patient and recording of data in patient's file was done correctly. The research wants to stress the fact that the nurses did not act on sufficient data.

5.3 RECOMMENDATIONS

The following recommendations are made based on the analysis and discussion of the data in chapter 4.

1. A quality improvement system/mode; should be developed for the total health services in the Northern Province.
2. Standards should be formulated for specifically the physical examination of clients.
3. Standards should be reviewed annually.
4. Patient care should be evaluated annually according to the set standards.
5. Staff development programmes should be instituted at all clinics to update staff.
6. The research findings should be made knowing to clinics or institutions to enable them to start with remedial actions so urgently needed.
7. Clinics/hospitals must develop their own research programmes in order to identify and solve problems in a scientific manner.

5.4 SUMMARY

A need was identified to evaluate selected component of primary health care services. This was done in this study by means of set structure and process standards as well as a patient's questionnaire.

Predominantly negative findings were obtained but the situation could be rectified by the necessary remedial actions, which include the professional development and updating of staff.

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PART A

STRUCTURE STANDARDS

A STRUCTURE STANDARDS

The supply, organization, utilization and maintenance of facilities, equipments, staff and financial resources enhances the rendering of quality nursing care.

I. FACILITIES

CRITERIA	YES	NO	N/A
1.1 Mission statement			
1.2 Philosophy			
1.3 Objectives of the clinic services			
1.4 Clinic circulars in the file			
1.5 Clinic protocols for assessment of the following systems:			
ñ Respiratory			
ñ Reproductive			
ñ Cardiovascular			
ñ Endocrinology			
ñ Ear, nose and throat			
ñ Neurological			
ñ Gastro intestinal			
ñ Skeletal			
ñ Genito-urinary			
1.6 Clinical procedure manuals			
1.7 Quality improvement programme			
1.8 Research programme			
1.9 Disease control charts			
1.10 Infection control programme			
1.11 Staff development programme			
1.12 Community profile			
1.13 Disaster planning map			
1.14 Daily report book			
1.15 Product for general security measures			
TOTAL FACILITIES OUT OF 15:			

II. EQUIPMENT PER CLINIC PER ROOM/TROLLEY

CRITERIA	Room	Number	Yes	No	N/A
1. Emergency Trolley (1)	Emergency room	1			
▪ Adrenalin (not expired)		4			
▪ Soluortef injections (not expired)		4			
▪ Sodium bicarbonate ampules (not expired)		4			
▪ Anthisan injections (not expired)		4			
▪ Ringer lactate 1000ml vacolitre (not expired)		2			
▪ Dextrose 5% 1000ml vacolitre (not expired)		2			
▪ Normal saline 0,9% vacolitre (not expired)		2			
▪ ½ strengten darrows 200ml (not expired)		2			
▪ Normal saline 0,9% 200ml (not expired)		2			
▪ Glucose powder in small contrainer (small packets)		4			
▪ Needles of different sizes		4 each			
▪ Syringes of different sizes		4 each			
▪ Ambubag with mask		2			
- adults		1			
- peadiatrics		1			
▪ Stethoscope		1			
▪ Baumanometer		1			
▪ Glycometer		1			
▪ Haemoglobinometer		1			
▪ Suction machine		1			
▪ Diagnostic set		1			
▪ Patella hammer		1			
▪ Examination light		1			

CRITERIA	Room	Number	Yes	No	N/A
2. Stethoscope	Delivery	1			
	Lying in	1			
	Consulting	1			
3. Foot scale	Delivery	1			
	Lying in	-			
	Consulting	-			
	Emergency	1			
	History room	1			
4. Baby scale	Delivery	1			
	History room	1			
5. Drip stands	Delivery	1			
	Emergency	1			
	Lying in room	1			
6. Diagnostic set	Emergency	1			
	Lying in room	1			
	Consulting	1			
7. Patella hammer	Consulting	1			
	Maternity/ delivery	1			
8. Screens/curtains attached to wall	Consulting	4 sides			
	Emergency	4 sides			
	Dressing room	4 sides			
	Delivery room	4 sides			
	Lying in room	4 sides			
9. Delivery beds	Delivery room	6			
10. Cradles	Delivery room	6			
	Lying in	6			
11. Bed side lockers	Delivery room	6			
	Lying in	6			
12. Autoclave - radiation type	Delivery/ dressing room	1			
13. Speculum all sizes in sterile packs	Consulting	1 pack			
	Delivery	1 pack			
	Lying in	1 pack			
	Emergency	1 pack			

CRITERIA	Room	Number	Yes	No	N/A
14. Feto scope	Emergency	1			
	Consulting	1			
	Store room	1			
	Delivery	2			
15. Examination couch	Consulting	1			
	Emergency	1			
16. Patient's beds	Lying in	6			
17. Laryngoscopes and blades - all sizes	Emergency	3			
	Consulting	3			
	Delivery	1			
18. Oxygen cylinder wall mask	Emergency	1			
	Delivery	1			
	Lying in	1			
	Store room	2			
19. Glucometer	Delivery	1			
	Consulting	1			
	Lying in	1			
	Emergency	1			
	Store room	1			
20. Suction machine	Emergency	1			
	Delivery	1			
	Store room	1			
21. Examination light	Consulting	1			
	Delivery	1			
	Lying in	1			
	Emergency	1			
	Store room	1			
22. Desk	Consulting	1			
	Duty	1			
	Office	1			
23. Patient's chairs	Reception area	200			
	Consulting room	3			
	Lying in	2			
	Delivery	2			
	Office	6			
	Duty room	6			

CRITERIA	Room	Number	Yes	No	N/A
24. Mobile screens	Consulting	1			
	Emergency	1			
	Dressing room	1			
25. Bed elevators	Delivery	2			
	Emergency	2			
	Lying in room	2			
26. Stitch scissors	Consulting	1			
	Delivery	2			
	Emergency	1			
	Lying in	1			
	Store room	1			
27. Snellen's charts	Consulting	1			
28. Urine glasses	Dirty utility room	6			
29. Bedpans	Dirty utility room	6			
30. Urine measuring jug	Dirty utility room	3			
31. Urinals	Dirty utility room	2			
32. Bin for disposing soiled linen	Dirty utility room	2			
33. Sheets	Store room				
ñ Blankets	Store room				
ñ Draw sheets	Store room				
ñ Bedspread	Store room				
ñ Endotracheal tubes different sizes	Emergency	3			
	Delivery	3			
TOTAL = 33					

III GENERAL RULES

CRITERIA	YES	NO	N/A
1. GENERAL RULES OF CLEANING EQUIPMENT AND INSTRUMENTS USED TO RENDER QUALITY PATIENT CARE			
(1) All equipment should be ...			
dust-free			
• Sterilized after use			
• Cleaned with antiseptic solutions after each use			
(2) All instruments should be			
• Clean/sterile			
Soaked in antiseptic solutions after each use			
Sterilized after use			
(3) Damaged instruments should be			
discarded for condemning			
presently not in use for patients			
TOTAL = 3			

2. CRITICAL ASPECTS RE MEDICO-LEGAL RISKS PREVENTION AND INFECTION CONTROL NOT MENTIONED OTHERWISE			
1. Staff using the EDL list (essential drug list)			
2. Medicine available according to Essential Drug list			
3. Patient education regarding taking of medicines			
4. Staff washing hands before and after attending to each patient.			
5. Sharps discarded correctly in a Sharps container			
6. Waste disposal burnt in incinerator			
7. Side ward or separate rooms for patients with communicable diseases.			
8. Medicines locked in cupboards at all times.			
9. External and internal medicines labelled accordingly.			
10. Correct labelling of medicine.			
TOTAL = 10			

IV SUPPLIERS/STOCK PER CLINIC PER ROOM

CRITERIA	Room	Number	Yes	No	N/A
1. Intravenous administration. sets - adult, - paediatrics, - blood each room	Delivery	5			
	Lying in	5			
	Emergency	5			
	Store	5			
2. Ringer lactate solution 1000m ³ vacolitre (not expired)	Delivery	5			
	Emergency	5			
	Store room	5			
	Lying in	5			
3. Half strength Darrows 200m ³ vacolitres (not expired)	Delivery	5			
	Lying in	5			
4. Normal saline 0,9% 1000m ³ vacolitre (not expired)	Delivery	5			
	Lying in	5			
5. Sterile stitch pack (not expired)	Emergency	5			
	Delivery	5			
	Lying in	5			
	Stock room	20			
6. Sterile eye pads (not expired)	Consulting	4			
	Store room	20			
7. Sterile pack for insertion of IUD (not expired)	Consulting	2			
	Store room	12			
8. Sterile pack for catherization (not expired)	Emergency	4			
	Consulting	-			
	Delivery	4			
	Lying in	4			
	Store room	12			
9. Syringes - 5m ³ Boxes of 50	Consulting	1 box			
	Delivery	1 box			
	Lying in	1 box			
	Store room	4 boxes			
10. Syringe - 2m ³ Boxes of 50	Consulting	1 box			
	Delivery	1 box			
	Lying in	1 box			
	Store room	4 boxes			

CRITERIA	Room	Nr per room	Yes	No	N/A
11. Syringes: 20mL	Delivery room	5			
	Consulting	1			
	Lying in	5			
	Emergency	10			
12. Syringes 10mL	Store room	56			
	Emergency	10			
13. Pink needles (20 x 40 mm)	Consulting	1 box			
	Delivery	1 box			
	Lying in	1 box			
	Store room	4 boxes			
14. Yellow needles (45 x 16 mm)	Consulting	1 box			
	Delivery	1 box			
	Lying in	1 box			
	Store room	4 boxes			
15. Green needles (80 x 40 mm)	Consulting	1 box			
	Delivery	1 box			
	Lying in	1 box			
	Store room	1 box			
16. Crepe bandages (75 mm)	Consulting room	5			
	Maternity room	4			
	Lying in	4			
	Emergency	4			
	Dressing room	20			
17. Gauze swabs packets	Consulting	5			
	Maternity	20			
	Lying in	20			
	Emergency	5			
	Store room	40			
18. Cotton wool swabs packets	Consulting	5			
	Maternity room	20			
	Lying in	20			
	Emergency	5			
	Store room	40			
19. Hibitane in water 2 litre containers	Consulting	1			
	Delivery	1			
	Lying in	1			
	Store room	4			

CRITERIA	Room	Nr per room	Yes	No	N/A
20. Hibitane and alcohol 2 litre containers	Emergency	1			
	Delivery	1			
	Store room	9			
	Lying in	1			
	Consulting room	1			
TOTAL = 20					

V **QUALITY PATIENT CARE IS RENDERED IN A THERAPEUTIC, SAFE AND RISKFREE ENVIRONMENT**

CRITERIA	YES	NO	N/A
1. Rooms: Duty, Receptions, Consulting, Dispensary			
ñ Tiled walls, no cracks or damages			
ñ Swept twice daily			
ñ Mopped twice daily			
ñ Damp-dusted twice daily			
ñ Wet floor warning signs: when floor is mopped			
ñ Ventilations: windows/doors open/close as appropriate			
2. Dressing room			
ñ Tiled wall fitting tiles and no cracks or damages			
ñ Swept twice daily			
ñ Mopped three times daily			
ñ Damp-dusted three times daily			
ñ Wet floor warning signs: when floor is mopped			
ñ Footpedal dustbin			
ñ Running water with arm handle taps			
ñ Soap disinfector for hands			

CRITERIA	YES	NO	N/A
Rooms: Lying in and delivery			
ñ Tiled wall fitting tiles and no cracks or damages			
ñ Swept three times daily			
ñ Damp-dusted three times daily			
ñ Mopped after each delivery			
ñ Wet floor warning signs when floor is mopped			
ñ Footpedal dustbin			
ñ Running water with arm handle taps			
ñ Soap disinfectant for hands			
ñ Free from odours			
ñ Instruments cleaned and sorted after used			
ñ Linen seitched and sorted after used			
ñ Temperature control led			
4. Bathroom and toilets			
ñ Tiled wall, fitting tiles and no cracks or damages			
ñ Free from odours/good ventilation			
ñ Mounted mirrors clean with no dust			
ñ Swept at least twice daily			
ñ Damp-dusted at least twice daily			
ñ Mopped at least twice daily			
ñ Mopped after each patient has bathed			
ñ Lockable doors			
ñ At least one facility for physically disabled			
ñ Damp dusted three times a day			
5. Store room			
ñ Tiled wall, fitting tiles and no cracks or damages			
ñ Swept at least once daily			
ñ Mopped at least once daily			
ñ Damp-dusted at least once daily			
ñ Locked at all times			

6. Medicine store			
ñ Dark and cool			
ñ Temperature controlled			
ñ Locked			
ñ Medicine control charts correct completed after each issue of medicine			
ñ Floor mopped once daily			
7. Emergency room			
ñ Tiled with fitting tiles and no cracks or damages			
ñ Swept before each shift change and after each emergency			
ñ Mopped before each shift change and after each emergency			
ñ Damp dusted before each shift change and after each emergency			
ñ Footpedal dustbin			
ñ Wash/hand basins			
TOTAL = 7			

VI QUALITY OF CARE IS RENDERED EFFECTIVELY, CONSIDERING LISTED NUMBER OF ROOMS AND COMMUNICATION AIDS/CLINIC

CRITERIA	Number	YES	NO	N/A
1. Duty room/office	2			
2. Communication:				
* Clinic telephone	12			
* Walkie talkie	2			
* Government subsidised cellphones for chief professional nurses at clinics	6			
* Telkom card phones in clinic yard	6			
* Telkom cash phones in clinic yard	6			
3. Staff tearoom	2			
4. Kitchen	1			
5. Dressing room	1			
6. Delivery room	1			
7. Lying in room	1			
8. Daily utility rooms	1			
9. Reception room	1			
10. Consulting rooms	6			
11. Dispensary	1			
12. Patient toilets	4			
13. Patient's toilet for disabled	1			
14. Patient's bathrooms	2			
15. Store room	1			
16. Emergency room	1			
TOTAL: 16				

VII HUMAN RESOURCES PER CLINIC

CRITERIA	Number	YES	NO	N/A
1. Chief professional nurses	2			
2. Senior professional nurses	4			
3. Professional nurses	8			
4. Enrolled nurses	4			
5. Enrolled nursing assistants	4			
6. General assistants	4			
7. Security officer	4			
8. Recruitment policy				
9. Job description for each category				
10. Allocation list				
11. Staff development policy				
12. Induction programme				
13. Orientation programme				
14. Continuous education programme				
15. Staff appraisal programme				
16. Time register book				
TOTAL: 16				

PART B**PROCESS STANDARDS**

Quality patient care is rendered through a complete history taking, physical examination of the body systems and proper record keeping.

I. PREPARATION

CRITERIA	YES	NO	N/A
1. Pleasant atmosphere - Room is clean and well ventilated			
2. Comfortable chair/couch			
3. Privacy ensured by closing the door/screen			
4. Adequate lighting to be able to see when doing physical exam			
5. Patient warm enough			
6. Introduces parties to each other			
7. Explain procedures to the client			
8. Display genuine interest in client and his/her concerns, taking into account age and condition of client.			
9. Reassuring the patient about keeping information confidential			
10. Showing respect by opening the door for patient, letting her sit down and by calling him/her by his name			
11. Non-judgemental			
TOTAL: 11			

II. HISTORY

CRITERIA	YES	NO	N/A
1. Ask the patient's account of his problem(s)			
2. Clarify the patient's problem(s)			
3. Verified the summary of problem(s) with the patient			
ñ Pain questioning			
* Exact site			
* Duration			
* Character			
* Intensity			
* Time of the day			
* Radiation			
* Aggravating factors			
* Relieving factors			
* Associating factors			
ñ System questioning			
* headache			
* cough, if productive and the nature of sputum			
* Dyspnoea			
* Pain in the chest			
* Palpitations			
* Indigestion			
* Bowel habits for example diarrhoea and/or constipation			
* Abdominal pain			
* Discharges for example eyes, ear, penile, vagina			
* Urinary system for example burning on micturition frequency			
* Menstruation period			
* Last menstrual period			
TOTAL: 3			

III AFFECTED SYSTEM QUESTIONS

Questions are asked to determine the presence of the following (only the relevant systems are examined)

(a) EAR, NOSE AND THROAT

CRITERIA	YES	NO	N/A
1. Earache			
2. Itching of the ear			
3. Discharges from the ear			
4. Deafness			
5. Sneezing			
6. Itching nose			
7. Blocked nose			
8. Mouth breathing			
9. Snoring			
10. Nasal discharge			
11. Sore throat			
TOTAL = 11			

(b) RESPIRATORY SYSTEMS

CRITERIA	YES	NO	N/A
1. Cough			
2. Sputum			
3. Haemoptysis			
4. Pain when coughing			
5. Dyspnoea			
6. Tachypnoea			
7. Wheezing			
8. Snoring			
9. Mouth breathing			
10. Night sweats			
11. Weight loss			
12. TB contact			
TOTAL = 12			

(c) **CARDIO-VASCULAR SYSTEMS**

CRITERIA	YES	NO	N/A
1. Chest pains			
2. Dyspnoea			
3. Palpitations			
4. Cyanosis on the mouth and fingertips			
5. Oedema of the legs			
TOTAL = 5			

(d) **BREASTS**

CRITERIA	YES	NO	N/A
1. Pain in breasts			
2. Lesions on breasts (lumps)			
3. Wounds on breasts			
4. Nipple abnormalities			
5. Discharge from nipples			
6. Previous operations of breasts (scar)			
TOTAL = 6			

(e) **CENTRAL NERVOUS SYSTEM**

CRITERIA	YES	NO	N/A
1. Headaches			
2. Muscular weakness			
3. Change in sleeping habits			
4. Hearing voices			
5. Convulsions			
6. Decrease in visual acuity			
7. Squint			
8. Stiff neck			
9. Double vision			
TOTAL = 9			

(f) ENDOCRINE SYSTEM

CRITERIA	YES	NO	N/A
1. Lymphadenopathy			
2. Polyuria			
3. Polydipsia			
TOTAL = 3			

(g) Gastro Intestinal Systems

CRITERIA	YES	NO	N/A
1. Dyspepsia			
2. Abdominal pain			
3. Appetite changes			
4. Worms in the faeces			
5. Nausea			
6. Vomiting			
7. Irritations of the bowel/distension/gas			
8. Rectal pains			
TOTAL = 8			

(h) Musculo-skeletal system

CRITERIA	YES	NO	N/A
1. Pain in joints and muscles			
2. Swelling of arms and legs			
3. Abnormal gait			
4. Tremor of the hands			
5. Loss of function of hands, arms and legs			
TOTAL = 5			

(i) Eyes

CRITERIA	YES	NO	N/A
1. Vision impairment			
2. Pain in the eyes			
3. Redness of the eyes			
4. Photophobia			
5. Red and discharging eyes			
6. Lacrimation of the eyes			
7. Squint which is recent/longstanding			
TOTAL = 7			

(j) Genito-Urinary system

CRITERIA	YES	NO	N/A
1. Pain on micturition			
2. Frequency of micturition			
3. Dysuria			
4. Haematuria			
5. Patient's bladder able to control micturition with no stress			
6. Enuresis			
TOTAL = 6			

(k) Menses and Fertility

CRITERIA	YES	NO	N/A
1. Alive babies			
2. Abortions			
3. Last menstrual period			
4. Regular/irregular periods of menstruation			
5. Number of days menstruation takes			
6. Stress incontinence			
7. Enuresis			
8. Post-menopausal bleeding			
9. Discharge from the Urethra/Vagina			
10. Dyspareunia			
TOTAL = 10			

(I) Skin

CRITERIA	YES	NO	N/A
1. Eczema			
2. Skin conditions in the family			
3. Medicines prescribed by the clinic/hospital/doctor			
4. Exposure to allergens like chemicals			
TOTAL = 5			
SUBTOTAL = 12			

IV GENERAL INFORMATION

CRITERIA	YES	NO	N/A
1. Previous illnesses - TB			
2. Other chronic diseases			
3. Previous operations			
4. Allergies - ask for any food, medication adverse reactions			
5. Drugs that the patient/client is taking presently			
6. Family history of heart disease, epilepsy, porphyria, diabeters mellitus			
7. Sosial history - smoking, drinking, type of housing			
8. Travelling during the past 3 months			
9. Work situation			
TOTAL = 9			

PART C

**PHYSICAL EXAMINATION TAKING INTO ACCOUNT THE AGE OF THE
CLIENT AND SYSTEM(S) INVOLVED**

(a) LOGICAL AND SYSTEMATIC ORDER OF EXAMINATION:

CRITERIA	YES	NO	N/A
1. Part adequately exposed			
2. Patient does not verbalize or indicate any discomfort during physical examination			
3. Starts palpation away from painful area, works towards it			
4. Compares one side with the other			
5. Examines normal side first			
6. Inspection/palpation, percussion and auscultation order			
TOTAL = 6			

(b) MANAGEMENT

CRITERIA	YES	NO	N/A
1. Interpretation of data			
2. Make summary of objective data			
3. Compiled problem priority list			
4. Making of diagnosis			
5. Refer if necessary			
TOTAL = 5			

(c) **PLANNING AND IMPLEMENTATION REQUESTS FOR SPECIAL EXAMINATION**

CRITERIA	YES	NO	N/A
1. Making nursing diagnosis			
2. Referrals if necessary			
3. Completes forms correctly			
4. Correct medication prescribed according to:			
* Age			
* Condition			
* Scope of practice			
* Policy of the authority			
5. Dispense medication correctly: Correct labelling			
* Name of medication			
* Schedule			
* Patients name			
* Folder number			
* Supplier			
* Batch number			
* Amount of tablets			
* Dosage of tablets/medication			
* Frequencies of taking tablets/medications			
* Expiry date of medication/tablets			
* Date of issue of medications/tablets			
6. Dispensed medication correctly: Correct recording of patients file:			
* Name of item (medication) dispensed			
* Strength of medication/tablets			
* Schedule number of medication/tablets			
* Dosage of tablets/medication			
* Frequency of taking medication/tablets			
* Duration/quality of medication tablets			
* Signature of nurse dispensing medications/tablets			
7. Health education regarding prescribed medication. Adverse reaction, storage, when to come back to clinic			

CRITERIA	YES	NO	N/A
8. Check list: Patient information carried out:			
* Condition of patient written according to history			
* Treatment and preventive measures			
* Rehabilitative measures			
* Date for follow-up visits			
* Sick leave granted			
TOTAL: 8			

(d) GENERAL SYSTEM ASSESSMENT

CRITERIA	YES	NO	N/A
1. General assessment			
* Gait			
* Posture			
* Head and hair			
* Complexion			
* Obvious skin rashes			
* Weight and hydration			
* Mental state			
* Abnormal movement			
* Abnormal sounds			
* Vision			
* Hearing			
* Oudours			
* Looks ill			
2. Basic data			
* Height measurement			
* Weighing			
* Temperature taking and charting			
* Pulse taking and charting			
* Respiratory rate taking and measurement			
* Blood pressure taking and charting			
* Urine testing and charting			
3. Neck stiffness			
4. Hydration			
5. Jaundice			

CRITERIA	YES	NO	N/A
6. Anaemia, checking eyes, tongue and finger nails			
7. Clubbing of nail			
8. Cyanosis of the mouth and nose			
9. Oedema of upper and lower extremities			
10. Lymphadenopathy			
TOTAL = 10			

(e) Head

CRITERIA	YES	NO	N/A
1. Inspection of the skin of the head for:			
ñ Scars			
ñ Lesions			
ñ Dilated veins on the scalp			
ñ Colour of the skin			
ñ Hair distribution - alopecia			
2. Inspection of the head for:			
ñ Shape of the head			
ñ Fontanelles of infants			
ñ Texture of hair should be assessed for coarseness or thinning			
ñ Measure the head circumference and enter on a chart for children			
TOTAL = 2			

(f) Neck

CRITERIA	YES	NO	N/A
1. Inspect neck for:			
ñ Dilated veins			
ñ Lymphadenopathy			
ñ Lesions			
ñ Scars (operation)			
ñ Stiffness			
2. Palpate the neck for:			
ñ Lymphadenopathy			
ñ Growth and abnormalities			
ñ Pulsations			
ñ Thyroid			
3. Inspect skin for:			
ñ Dehydration			
ñ Texture and temperature			
TOTAL = 3			

(g) Eyes

CRITERIA	YES	NO	N/A
1. Inspect the eyes for:			
ñ Alignment of the eyes - horizontally and obvious squint			
ñ Swelling under and around the eyes			
ñ Compare both eyes for size, shape and position			
ñ Inspect for exophthalmos			
ñ Inspect for enophthalmos			
ñ Inspect for proptosis			
2. Inspect and palpate lid margins			
3. Inspect the palpebral and bulbar conjunctiva			
4. Inspect the eyes with an ophthalmoscope			
5. Inspect cornea of the eyes			
6. Inspect iris, pupil, lens for direct light/consensual light reflex			
7. Test eyes for coördinal movement by letting the patient follow your finger to four sides, for example, forward, backwards and sideways			

CRITERIA	YES	NO	N/A
8. Use the Snellens chart to check the distance that the patient is able to see at 6 meter			
TOTAL = 8			

(h) EAR

CRITERIA	YES	NO	N/A
Ear: Always examine the normal ear first for comparison. Inspect the ear for:			
1. Lesions			
2. Discharges			
3. Abnormalities			
4. Palpate the ears for topi			
5. Test the ear for deafness with a tuning fork, watch test or voice test			
6. Inspect the internal ear with a diagnostic set, for swelling, redness and presence of foreign body			
TOTAL = 6			

(i) NOSE

CRITERIA	YES	NO	N/A
(a) Nose: Inspect nose for:			
1. The shape of the nose			
2. Presence of alar flare			
3. Lesions			
4. Wounds			
5. Sores			
6. Nose discharge and bleeding			
7. Swelling			
8. Growth and abnormalities			
9. Foreign body			
10. Displacement of septum			
11. The nasal cavity			
TOTAL = 11			

CRITERIA	YES	NO	N/A
(b) Sinuses:			
1. Examine the frontal sinuses by pressing upwards in the angle formed by the supra-orbital ridge and the nose			
2. Examine the maxillary sinuses by pressing upwards at the junction of the maxilla and the zygoma			
TOTAL = 2			

(j) THROAT**(a) Mouth and Pharynx: Inspect the following:**

CRITERIA	YES	NO	N/A
1. Lips, for cyanosis, pallor, angular, stomatitis			
2. Buccal mucosa for koplik spots, lumps			
3. Gums for swelling and redness			
4. Teeth for decay and dislocation			
5. Tongue for sores, lesions white patches and protusion including other abnormalities			
6. Floor of the mouth for sores and lesions			
TOTAL = 6			

(b) Ralpatrien of the following:

CRITERIA	YES	NO	N/A
(h) Lips and gums for swelling			
(i) Buccal mucosa, hard palate and floor of the mouth for swelling and abnormal growth			
TOTAL = 2			

(c) Inspect the tongue:

CRITERIA	YES	NO	N/A
1. Colour - pallor in anaemia			
2. Cyanosis			
3. Lesions on the tongue			
TOTAL = 3			

(d) Inspect the floor of the mouth:

CRITERIA	YES	NO	N/A
1. For any cysts			
2. Blockage of the submandibular salivary gland			
TOTAL = 2			

(e) Inspect the palate of the mouth

CRITERIA	YES	NO	N/A
1. For cleft palate			
2. Perforation			
3. Peritonsillar abscess			
4. Paralysis of the vagus			
TOTAL = 4			

(f) Inspection of the throat for:

CRITERIA	YES	NO	N/A
1. Previous operations (scar)			
2. Swelling			
3. Growth			
4. Redness			
5. Enlarged tonsils			
6. Abnormalities			
7. White patches indicated infection			
8. Presence of pus especially tonsils			
9. Inspecting the pharynx using word tongue depressor to exclude abnormalities, swelling and redness			
10. Inspecting and palpating the submandibular glands, and thyroid for swelling, growth and abnormalities			
TOTAL = 10			

(k) EXAMINATION OF THE CHEST**1. General assessment of the following. Signs of respiratory distress:**

CRITERIA	YES	NO	N/A
1. Alar flare			
2. Grunting			
3. Tachycardia			
4. Stridor			
5. Dyspnoea, tachyphnoea, distress			
6. Wheezing			
7. Cyanosis, chest recession, restlessness			
TOTAL = 7			

2. Anterior chest. Inspection of the skin for:

CRITERIA	YES	NO	N/A
1. Colour			
2. Lesions			
3. Scars			
4. Dilated veins			
5. Hair distribution			
TOTAL = 5			

3. Shape of the chest for example:

CRITERIA	YES	NO	N/A
1. Abnormalities: Barrel, funnel, pigeon			
TOTAL = 1			

4. Respiratory movements:

CRITERIA	YES	NO	N/A
1. Rate			
2. Recession			
3. Rhythm			
4. Depth			
5. Symmetry			
TOTAL = 5			

5. Inspect the chest for any pulsations:

CRITERIA	YES	NO	N/A
1. Apex beat			
2. Pulsations outside the precordium			
TOTAL = 2			

6. Palpate the skin. Observe chest for:

CRITERIA	YES	NO	N/A
1. Texture			
2. Hydration			
3. Temperature			
4. Palpate for respiratory movements - depth			
5. Palpate for respiratory movements - symmetry			
6. Palpate the apex beat and precordial thrills			
TOTAL = 6			

7. Breasts:

CRITERIA	YES	NO	N/A
1. Inspection and palpation of the breasts for any abnormalities			
2. Palpate the axillae for enlarged glands			
TOTAL = 2			

8. Percussion of the lungs:

CRITERIA	YES	NO	N/A
1. To identify abnormal sounds			
TOTAL = 1			

9. Percussion of the apex beat:

CRITERIA	YES	NO	N/A
1. To identify any abnormal cardiac position			
TOTAL = 1			

10. Auscultation of the heart:

CRITERIA	YES	NO	N/A
1. Listen to the heartbeat - identify any irregularities			
2. Listen to the different heartsounds (valves) for murmurs and friction rub.			
TOTAL = 2			

11. Auscultation of the lungs:

CRITERIA	YES	NO	N/A
1. Listen to the breath sounds			
TOTAL = 1			

12. Check and record the following: Auscultation of the lungs:

CRITERIA	YES	NO	N/A
1. Radial pulse			
2. Brachial pulse			
TOTAL = 1			

13. Posterior chest inspection. Check the posterior chest for:

CRITERIA	YES	NO	N/A
1. Dilated veins			
2. Lesions			
3. Operation scars			
4. Scoliosis			
TOTAL = 4			

14. Back:

CRITERIA	YES	NO	N/A
1. Palpate back for sacral oedema			
TOTAL = 1			

15. Lungs:

CRITERIA	YES	NO	N/A
1. Percuss the lungs with both hands and feel for vocal fremitus			
2. Auscultate the lungs with a stethoscope for other lung abnormalities			
3. Auscultate the lungs for vocal resonance			
TOTAL = 3			

SUBTOTAL = 15			
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(I) GASTOINTESTINAL TRACT

1. Examination of the abdomen. Inspection of the skin for the following:

CRITERIA	YES	NO	N/A
1. Colour			
2. Lesions and scars			
3. Pubic hair distribution - Male and female			
4. Dilated blood vessels			
5. Swelling, hernias			
TOTAL = 5			

2. Inspect the shape of abdomen for the following:

CRITERIA	YES	NO	N/A
1. Enlargement			
2. Flat abdomen			
3. Scaphoid abdomen			
TOTAL = 3			

3. Observe the abdomen:

CRITERIA	YES	NO	N/A
1. For any movement with respiration and pulsation			
TOTAL = 1			

4. Inspect the inguinal area:

CRITERIA	YES	NO	N/A
1. For enlargement			
TOTAL = 1			

5. Palpate the skin of the abdomen for:

CRITERIA	YES	NO	N/A
1. Temperature			
2. Texture			
3. Dehydration			
4. Oedema			
TOTAL = 4			

6. Palpation of the following:

CRITERIA	YES	NO	N/A
1. McBurney's point, then ascending, transverse and the descending colon			
2. Superficial palpation			
3. Deep palpation			
TOTAL = 3			

7. Palpate the abdomen:

CRITERIA	YES	NO	N/A
1. The liver			
2. The spleen			
3. The kidney			
4. For ascites or fluid thrills			
TOTAL = 4			

8. Palpate and inspect for:

CRITERIA	YES	NO	N/A
1. Umbilical hernia			
TOTAL = 1			

9. Further signs found on palpation:

CRITERIA	YES	NO	N/A
1. Guarding, rigidity, rebound tenderness, Murphy's sign, Rovsig's sign, obturator sign, Psoas test			
TOTAL = 1			

10. Palpate the abdomen:

CRITERIA	YES	NO	N/A
1. For gaseous distension			
2. For masses			
TOTAL = 2			

11. Organ enlargement:

CRITERIA	YES	NO	N/A
1. Liver, spleen, full bladder			
TOTAL = 1			

12. Auscultation of the abdomen:

CRITERIA	YES	NO	N/A
1. To exclude abnormalities like accumulation of gas			
TOTAL = 1			

SUBTOTAL = 12			
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(m) RECTAL EXAMINATION

(1) Inspection of the anus:

CRITERIA	YES	NO	N/A
1. Exterior and peri-anal area, haemorrhoids and wounds			
TOTAL = 1			

(2) Palpation of the following:

CRITERIA	YES	NO	N/A
1. Anal canal			
2. Rectal walls			
3. Prostate gland			
TOTAL = 3			

(3) Speculum Examinations

CRITERIA	YES	NO	N/A
1. Correct use of speculum (not facing opposite direction)			
2. Inspection of the lower part of the rectum			
3. Inspection of the anal canal			
TOTAL = 3			

SUBTOTAL = 3			
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(n) REPRODUCTIVE SYSTEM / GENITOURINARY GYNAECOLOGICAL**(1) Equipment**

CRITERIA	YES	NO	N/A
1. Speculums of different sizes			
2. Light			
3. Gloves and KY jelly			
4. Privacy of the patient by closing the door and putting the patient behind the screen			
TOTAL = 4			

(2) Inspection of the skin for the following:

CRITERIA	YES	NO	N/A
1. Colour			
2. Lesions			
3. Hair - any parasites			
4. Dilated vessels			
5. Inspection of the vulva for discharge and sores			
6. Speculum examination - relevant size according to the vaginal size			
7. Inspection of cervix			
8. Inspection of vaginal walls			
9. Identification of vaginal discharge			
10. Milking the urethra			
11. Inspect the Bartholin glands			
12. Vaginal palpation - vaginal walls palpation			
13. Palpation of the cervix with index finger			
14. Bimanual palpation of the uterus			
15. Bimanual palpation of the fornix			
TOTAL = 15			

SUBTOTAL = 2			
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(o) Male Genitalia

1. Inspection of the skin for the following:

CRITERIA	YES	NO	N/A
1. Colour			
2. Lesions			
3. Hair-parasites			
4. Dilated vessels			
5. Inspection of the penis and urethra for discharge			
6. Inspection and palpation of the scrotum			
7. Testes			
8. Epididimis			
9. Spermatic cord			
TOTAL = 9			

(p) Breasts

1. Inspection of the breast for the following:

CRITERIA	YES	NO	N/A
1. Enlargement			
2. Bulging areas or surface flattening			
3. Redness			
4. Eczema			
5. Dimpling			
6. Ulceration			
7. Peau de orange			
8. Dilated vessels			
TOTAL = 8			

2. Inspection of the nipples for the following:

CRITERIA	YES	NO	N/A
1. Swelling			
2. Nodules			
3. Ulceration			
TOTAL = 3			

3. Palpation of the breast while the patient adopted the following position:

CRITERIA	YES	NO	N/A
1. Sitting with hand behind neck			
2. Lying down			
3. Compare right breast with left breast			
TOTAL = 3			

4. Examine breast:

CRITERIA	YES	NO	N/A
1. Systematically in circular manner as follows:			
2. Covering whole breast area			
3. Consistency			
4. Tenderness			
5. Hardening			
TOTAL = 5			

5. Examine abnormalities if present:

CRITERIA	YES	NO	N/A
1. Size of breast increasing			
2. Shape of breast changing			
3. Surfaces of breast increasing in size			
4. Sides of breast			
5. Single/multiple breast abnormalities			
6. Whether abnormality spreading or not			
7. Solid/fluctuating mass			
TOTAL = 7			

6. Examine nipples

CRITERIA	YES	NO	N/A
1. Consistency			
2. Discharge			
3. Mobile/fixed			
TOTAL = 3			

7. Examine glads:

CRITERIA	YES	NO	N/A
1. Apical			
2. Supraclavicular			
3. Subscapular			
4. Subpectoral			
5. lateral			
TOTAL = 5			

SUBTOTAL = 7			
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(g) MUSCULOSKELETAL SYSTEM

(1) HANDS. Inspection of the following: Skin and nails:

CRITERIA	YES	NO	N/A
1. colour			
2. dilated veins			
3. lesions			
4. scars			
5. muscles and tendons			
6. bones and joints			
7. tremors of hands			
TOTAL = 7			

(2) Palpation of the following

CRITERIA	YES	NO	N/A
1. skin, nails, finger tips for abnormalities and swelling			
2. muscle and tendons for weaknesses and abnormalities detection and swelling			
3. Bones and joints for weaknesses and abnormalities detection and swelling			
TOTAL = 3			

(3) Rest of arm: Front and back. Inspection of the skin ...

CRITERIA	YES	NO	N/A
1. Lesions			
2. Scars			
3. Muscles and tendons for abnormalities			
4. Bones and joints for abnormalities			
TOTAL = 4			

(4) Palpate skin for:

CRITERIA	YES	NO	N/A
1. Temperature			
2. Hydration			
3. Texture			
4. Oedema of the arms			
5. Moisture			
6. Radial pulses palpated			
7. Epitrochlear lymph nodes palpated			
TOTAL = 7			

(5) Axillary lymph glands palpated namely:

CRITERIA	YES	NO	N/A
1. Subpectoral			
2. Subscapular			
3. Lateral			
4. Apical			
5. Active and passive movements of the hands			
TOTAL = 5			

SUBTOTAL = 5			
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(r) LEGS

(1) Inspection of:

CRITERIA	YES	NO	N/A
1. Front and back, with patient standing			
2. Gait abnormalities, inspected			
3. Skin and nails for colour, lesions and scars			
4. Muscle and tendons for abnormalities			
5. Bones and joints for abnormalities			
6. Soles (patient lying down) for swelling, hardening and other abnormalities			
7. Rotate - clock/anti-clockwise			
TOTAL = 7			

(2) Palpation:

CRITERIA	YES	NO	N/A
1. Patient lying down			
2. Skin and nails for colour			
3. Muscles and tendons for abnormalities			
4. Bones and joints for abnormalities			
TOTAL = 4			

(3) Pheripheral pulses palpated:

CRITERIA	YES	NO	N/A
1. Dorsalis pedis			
2. Posterior tibial			
3. Popliteal			
4. Femoral			
TOTAL = 4			

(4) Joints: Inspection of the following:

CRITERIA	YES	NO	N/A
1. Surrounding skin, muscle for swelling and abnormalities			
2. Joint for swelling, deformation			
3. Range of active movement of joints inspected			
TOTAL = 3			

(5) Palpation of the following:

CRITERIA	YES	NO	N/A
1. Surrounding skin, muscles for swelling and abnormalities			
TOTAL = 1			

(6) Inspection joints for the following:

CRITERIA	YES	NO	N/A
1. Tenderness especially along jointline			
2. Swelling			
3. Deforming			
4. Synovial thickening			
5. Fluid in joint			
6. Fluid in adjacent bursae			
TOTAL = 6			

(7) Range of passive movements observed as follows:

CRITERIA	YES	NO	N/A
1. Painfull joints			
2. Crepitus/clicks			
3. Joint stability			
4. Stiffness of the joints			
TOTAL = 4			

SUBTOTAL = 7			
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(s) **CENTRAL NERVOUS SYSTEM**

(1) Examination of central nervous system - adult. Performing the following tests for assessing central nervous system

CRITERIA	YES	NO	N/A
1. Cerebellar function test for abnormalities			
2. Romberg's test			
3. Motor function test			
TOTAL = 3			

(2) Ability to:

CRITERIA	YES	NO	N/A
1. Hop			
2. Walk on toes and heels			
3. Maintain arms in the extended position			
4. Grip the examiners finger			
TOTAL = 4			

(3) Tendon reflexes

CRITERIA	YES	NO	N/A
1. Biceps			
2. Triceps			
3. Supinator			
4. Knee			
5. Anckle			
TOTAL = 5			

(4) Superficial reflexes:

CRITERIA	YES	NO	N/A
1. Abdominal			
2. Cremastere			
3. Plantar			
TOTAL = 3			

(5) Sensory function:

CRITERIA	YES	NO	N/A
1. Pain test			
2. Touch			
3. Vibration			
4. Stereognostic perception			
5. Proprioception			
TOTAL = 5			

(6) Cranial nerves test - Motor ...

CRITERIA	YES	NO	N/A
1. Facial movements (7 th)			
2. Temporal mscles (5 th)			
3. Masseter muscles (5 th)			
4. Lateral movement of the jaw (5 th)			
5. Opening of jaw against resistance (5 th)			
6. Shoulder shrugging (11 th)			
7. Turning head against resistance (11 th)			
8. Light touch (5 th)			
9. Extra-ocular movements (3 rd , 4 th , 6 th)			
10. Nystagmus			
11. Pupil reflexes (3 rd)			
12. Prostrusion of the tongue (12 th)			
13. Palate movement (10 th)			
14. Gag reflex (9 th , 10 th)			
TOTAL = 14			

(7) Meningeal Irritation Assessment

CRITERIA	YES	NO	N/A
1. Neck stiffness			
2. Brudzinski's sign			
3. Kernig sign			
TOTAL = 3			

SUBTOTAL = 7			
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OUTCOME STANDARD

Section A: Clinic environment

1. What do you think about the cleanliness of the environment?
2. What do you think of the room temperature?
3. What is your opinion on the overall size of the rooms and clinic in general?
4. Were the clinic clearly marked with signs, indicating where you had to go?

Section B:

5. Did the staff attend to your problem promptly? Motivate.
6. Did you receive information from the nursing staff about your illness and the subsequent treatment thereof?
7. Were return dates given for follow up visits? Yes/No.....
8. How would you describe the communication between you and the nursing staff in general?
9. Please describe the nurses' attitude towards you.....
10. Did the nursing staff provide privacy e.g. when consulting/ assessing you?
11. Did the nursing staff maintain privacy when examining you? Yes/ No. If no, please motivate.....
12. What hours are the clinic open?
13. Do you need a 24 hour service at the clinic?

Section C:

14. How were you treated in general by the nurses?
15. Did you experience that any nurse at any point during your visit was judgemental?

Section D:

16. What is your impression of the service you received?
.....
.....
.....
17. Will you choose to come back to the clinic if future treatment is needed?
18. If you answer "no" in 17, please explain.
.....
.....
19. What were positive things about the clinic? Explain.....
.....
.....
19. What were the things you disliked the most during your visit at the clinic?
20. Additional information.....
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