

DECLARATION

**AN EVALUATION OF HEALTH CARE OF PRISONERS AT
SELECTED INSTITUTIONS:
A NURSING PERSPECTIVE**

I, the undersigned, hereby declare that the work contained in this document is my own original work and that I have not previously submitted it at any University for a degree.

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1 January 2005



**Assignment in partial fulfilment of the requirements for the
degree of Master of Nursing (M.Cur) at the University of
Stellenbosch**

**AT
STELLENBOSCH UNIVERSITY**

SUPERVISOR: PROF B WELMANN

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DECLARATION

A non-experimental descriptive study was conducted in four prisons in the Western Cape. The research focussed on the standard of care within these health care settings in the purposively selected prisons. No international standards existed to measure the quality of care. After an in-depth literature study structure, process and outcome variables were identified.

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- Standards in these three dimensions of care did not meet the proposed level of performance as determined by the researcher.
- The clients were generally satisfied with the hygiene in the clinics.
- Areas of concern were the lack of staff and the lack of resources.

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The researcher recommends the implementation of a health care model for the health care of the prisoners with adequate human and financial resources.

Core words: Quality care, Correctional services health care, Nursing care in prisons.

ABSTRACT

A non-experimental descriptive study was conducted in four prisons in the Western Cape. The research focussed on the standard of care within primary health care settings in the purposively selected prisons. No official written standards existed to measure the quality of care. After an in-depth literature study, structure, process and outcome standards were formulated and validated.

The main findings of the study indicated that:

- Standards in these three dimensions of care did not meet the pre-set level of performance as determined by the researcher;
- The clients were generally satisfied with the hygiene in the clinics;
- Aspects of concern were the lack of explanation offered to the clients before and after consultations and nursing care interventions.

The researcher recommends the implementation of a comprehensive quality care model for the health care of the prisoners with adequate human and non-human resources

Core words: Quality care, Correctional services health care, Nursing care in prisons.

OPSOMMING

'n Nie-eksperimentele beskrywende studie is in vier gevangnisse in die Wes-Kaap uitgevoer. Die navorsing het gefokus op die gehalte van sorg binne primêre gesondheidsorgomgewings in die doelbewuste geselekteerde omgewings. Geen amptelike geskrewe standarde om die gehalte van sorg te meet, het bestaan nie. Na 'n in-diepte literatuurstudie is struktuur-, proses- en uitkomsstandaarde geformuleer en gevalideer.

Die belangrikste bevindings van die studie het aangedui dat:

- Standaarde in hierdie drie dimensies van sorg het nie aan die voorafbepaalde vlak van sorg voldoen het nie soos deur die navorser bepaal is;
- Die kliënte was oor die algemeen tevrede met die higiëne in die klinieke;
- Kommerwekkende aspekte het ingesluit die gebrek aan voldoende verduidelikings aan kliënte voor en na konsultasies en verpleegintervensies.

Die navorser bevel aan dat 'n omvattende gehalteversekeringsmodel vir die gesondheidsorg van gevangenes ingestel word met voldoende beskikbare mens- en ander hulpbronne.

Kernwoorde: Gehaltesorg, Korrektiewe dienste gesondheidsorg, Verpleegsorg in gevangnisse.

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CHAPTER 1 INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Health service delivery is influenced by political, socio-economic and technological factors, both nationally and internationally. Although these factors are discussed separately by various researchers, they are in essence intertwined (Troskie, 1996). Nurses and nurse managers must be aware of and conversant with the changes that occur in the health services, because the health services in general and the delivery of health care in particular are affected by the above-mentioned factors.

Legislation, regulations and policies form the basis of legal or political decisions that impact health services. On coming into power in South Africa, the African National Congress (ANC, 1994) in their policy statements on health care, made it clear that they regarded the apartheid health policies as grossly ineffective and inadequate. Thus new policies were developed that were aimed at the reconstruction of the health care sector and the advancement of norms and standards which would promote efficient and effective delivery of services,. After the ANC health policy was accepted, the approach to health care in general changed from curative to preventative with the focus on primary health care. Wagstaff (1978) views primary health care nursing as a problem-orientated approach that has clear guidelines and protocols for management and referral of clients. Vlok (1991) defines comprehensive primary health care as very comprehensive measures to ensure an improvement in the health of all South Africans. Vlok (1991) recommends that the following measures be put in place to improve the health of the people of South Africa:

- early treatment of minor injuries;

- immunisation;
- family planning and treatment of disease to prevent serious complications.

Primary health care includes primary preventative intervention such as housing, water and sanitation, secondary intervention such as immunisation and nutrition programmes as well as collective health education.

The comprehensive primary health care service was introduced into the Department of Correctional Services where it had to be managed within the limits of the available resources at the state's expense and within a unit management approach. Unit management is a relatively new, multidisciplinary approach in the Department of Correctional Services. The principle of unit management is the rehabilitation of prisoners in units that are easily manageable for custodial, developmental and health care purposes. A nurse as part of the multidisciplinary team is expected to render effective health care which will enhance prisoner rehabilitation (Correctional Services Order B, 2002; National Commissioner, 2002).

In order to render effective health care aimed at the rehabilitation of prisoners, the strategy of the Department of Correctional Services is to train nurses in primary health care (Mti, 2002).

Officially, South African prisons were built to accommodate 110 000 prisoners, but by August 2002 the prisoner population was 179 900, which meant that prisons were filled to a 162% capacity. For the same financial year (2002/2003) the national commissioner allocated R610 182 000 for the health and physical care of prisoners, from a national budget of R7 026 833 000, for the Department of Correctional Services. This amounts to 8,7% of the annual national budget (Mti, 2003).

Western Cape prisons were built to accommodate 19 402 prisoners as a norm

for 100% occupancy. As of October 2002 the occupancy in the Western Cape was 29 412, which was 150% capacity. The nursing personnel component during this financial year consisted of a mere 147 nurses for the Western Cape Province. During this financial year (2002/2003) the Western Cape Province was allocated a budget of R10 21 423 500 for all the correctional services and from that budget, health care was allocated R29 878 800 or 2,9% for medical treatment and R133 300 or 1,3% for the prevention of HIV and contagious diseases (Pool, 2003; Gxilishe, 2003).

It is evident from the above-mentioned that South African prisons are overcrowded, particularly those in the Western Cape. Overcrowding puts strains on all services and resources in the Department of Correctional Services. Health care is one of the services that is impacted negatively, particularly in the sense that there is an increase of preventable diseases like tuberculosis, HIV/AIDS and sexually transmitted infections/diseases. There seem to be an alarming increase in tuberculosis and HIV/AIDS infections in South African prisons as a result of overcrowding which could affect the quality of health care, and cause a continued increase of imprisonment costs, and the cost of health care as well as increased strain on health personnel.

All this has a negative impact on the health care budget, because the bulk of resources, time and human skills are utilised to treat opportunistic infections/diseases like tuberculosis, pneumonia, skin problems, STI, oral thrush, ear infections and abscesses (Joseph, 2003).

In the financial year 2002-2003 147 nurses were tasked to see to the health needs of 29 412 prisoners in the Western Cape. The norm of the Department of Correctional Services is one nurse for every 240 prisoners. In the Western Cape the ratio ranges from 1:54 to 1:652. This ratio becomes worse at weekends when the minimum numbers of nurses are on duty (Joseph, 2003; Gxilishe, 2002).

In a report on prisons in the Western Cape Province, Ellis (2002) stated that the quality of health care in prisons was poor, that a shortage of nursing personnel existed, especially over weekends, and overcrowding was a common phenomenon.

On taking the above-mentioned factors into account, it is evident that the health needs of the prisoners will increase and that this will result in an increased demand in health resources, which includes human and physical resources. This inevitability makes additional demands on the specific allocated part of the budget. The necessary finances are vital in rendering an effective health service in prisons. Without the necessary funds it would be impossible for the nurse manager to deal with health and social challenges and to manage the health of prisoners in general but also within the ambit of new scientific and technological advancement and approaches.

The researcher, an expert and experienced nurse, worked in critical care units where a high standard of patient care was practised. For the past five years the researcher worked in a primary health care setting and experienced the negative impact of all the phenomena mentioned above on the health service delivery in the Correctional Services facility. The researcher further observed a continuous decline in the standard of care delivered to the prisoners, measured against the standards he has informally set himself.

This decline continued despite the area manager's six-monthly inspections and the provincial commissioner's annual inspections. Both inspections are, however, administrative and not clinical by nature. Through the observations and hands-on experience of the researcher it became clear that it was imperative that the health care delivered to these prisons should be evaluated.

1.2 STATEMENT OF THE PROBLEM

In the light of the above-mentioned challenges the following questions arose as an indication for the research:

- Which aspects or components of the prisoners' health care need to be evaluated urgently?
- Are there existing standards that can be used in the above-mentioned evaluation?
- If standards exist, could they be used or do they need modification?
- If new standards need to be developed, what is the result of the evaluation of the prisoners' health care when measured against these standards?
- What are the prisoners' views regarding the care provided to them?

1.3 OBJECTIVES OF THE RESEARCH

The following are set as objectives of the research:

- to do a situational analysis to determine the aspects or components of the prisoners' health care which need to be evaluated;
- to determine if standards exist to evaluate these aspects or components of care;
- to formulate relevant standards to evaluate the identified care;
- to evaluate the identified care of prisoners in selected institutions;
- to determine the views of the prisoners about the care they received; and
- to make recommendations based on the research findings.

1.4 RESEARCH METHODOLOGY

The research methodology refers to the scientific basis of the study regarding the approach, methods, sampling and data collection techniques.

1.4.1 Research approach

This study is a descriptive, non-experimental approach, to investigate and describe the identified health care of prisoners in selected institutions.

1.4.2 Research design

Qualitative and quantitative data were collected. Triangulation as technique was used. According to Mouton and Marais (1993), triangulation refers to the combination of multiple methods of observation, which direct a researcher to utilise more than one method to obtain data.

1.4.3 Sampling

Random sampling was used to include prisons' health care settings into the study. Convenient sampling is used regarding the evaluation of process standards and the prisoners attending the clinic (Wellman and Kruger, 2000).

1.4.4 Data collection

Data collection was done over a period of four month by means of structured questionnaires and interviews as well as direct observations. Standards were formulated and the service was evaluated in light of the set standard and criteria. The concept of data saturation was used. In other words, data collection was terminated when no new information or perspectives were obtained. The researcher was the primary data collector. Field notes were used to record the

data. Relevant precoding and experts in the field were used to test reliability and content validity. A pilot study was undertaken and the primary health care setting and participants were excluded in the final study.

1.4.5 Data analysis

Data analysis was done using the Statistical Package of Social Sciences and the Statistical Analysis System. Data were analysed using descriptive statistics and the data were presented in the form of frequencies, histograms, percentages, means, tables and figures.

1.5 PARADIGMATIC PERSPECTIVE

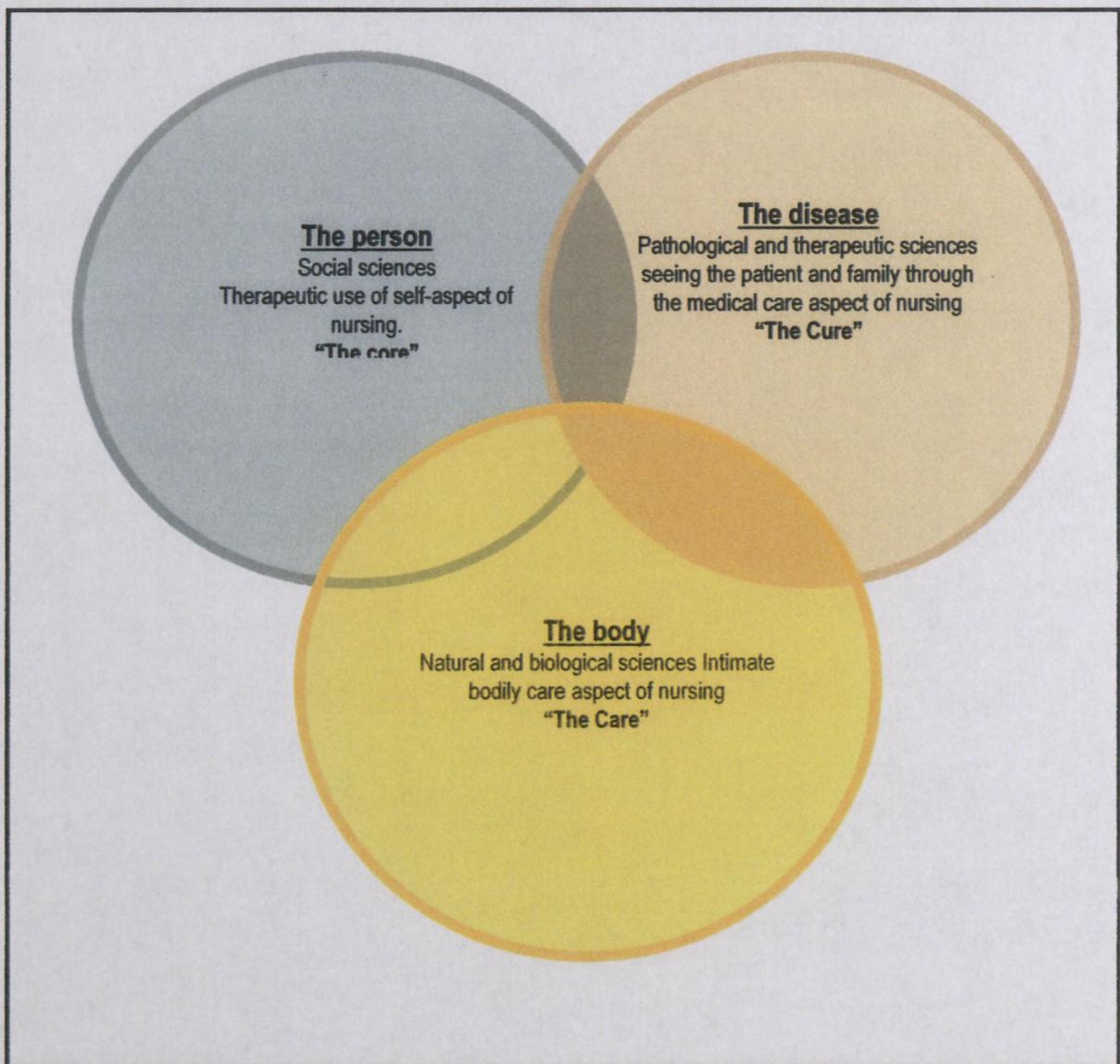
A paradigm is an overall perspective on things; a worldview (Chaska, 1990). Nursing is an art and a science directed at providing a human health care service, which is based on scientific principles. It requires knowledge derived from the biological, natural and social sciences in order to apply personalised treatment and care (Mellish and Brink, 1990).

The researcher believes in Hall's theory of nursing and the concept of quality patient care

1.5.1 Hall's theory of nursing

Hall's theory of nursing consists of three circles, namely the care circle, core circle and cure circle. George (1990) describes these circles as being interrelated to each other (Figure 1.1).

FIGURE 1.1
HALL'S THEORY OF NURSING



(George, 1990)

1.5.1.1 *Care circle*

Within this circle the professional nurse provides bodily care for the patient, which enhances an opportunity of closeness. The nurse helps to complete basic daily biological functions like eating, bathing and dressing. She or he also provides care at the basic needs level by applying knowledge of the natural and biological sciences (George, 1990).

In this circle a nurse develops a rapport with the patient through asking questions regarding the disease, and through providing of privacy, comforting the patient and giving health education for self care management and rehabilitation purposes.

1.5.1.2 *Core circle*

The core of nursing is to use natural and biological sciences, which helps the nurse to use herself therapeutically. The nurse develops interpersonal relationships with the patient in order to help to express feelings regarding the disease process (George, 1990).

The therapeutic self is that personal awareness, knowledge and understanding which when put into operation results in a positive experience for the patient, family and community.

Therapeutic use of self is characterised by the following concepts:

- **Love:** to use oneself to care, and to invest time, effort and knowledge and skills aimed at comforting the patient.
- **Empathy:** In the nurse-patient relationship the nurse must be able to feel with and for the patient, to sense, to share and to accept the patient's emotional point of view.

- **Sympathy:** the recognition by the nurse of the discomfort, pain or distress experienced by the patient.
- **Understanding:** The nurse may convey understanding by listening to the patient, learning about his/her uniqueness, maintaining a non-judgemental position, extending warmth and kindness.
- **Acceptance:** This is the awareness of the patient's pleasant and unpleasant ideas, emotions or behaviour without retaliation.

1.5.1.3 *Cure circle*

Through the help of social sciences like psychology and sociology the nurse helps the patient and the family through the medical, surgical and rehabilitative prescription or treatment (George, 1990).

In the South African context nursing is seen as a human clinical science that constitutes the body of knowledge for the practice of persons, registered or enrolled under the Nursing Act, Act 50 of 1978 as amended, as nurses and midwives (Mellish and Brink, 1990).

Nursing is practised by nurses who render care to human beings in need of care. Caring as art forms the core of nursing, which is based on social, biological, natural and therapeutic sciences which facilitate the curing process in the end.

With reference to the South African perspective and the working environment of nurses in prisons, the researcher is of the opinion that:

- Nursing must be based on a firm knowledge of the prisoners' needs being physical, psychological, social and spiritual;
- Nurses must be able to prioritise the prisoners' needs and to act upon their assessment in order to render nursing care aiming at reaching optimal health status of prisoners and/or cure the disease;

- The nurses need to keep their professional knowledge and skills at optimal level so that excellent health care may be provided in prisons; and
- When the nurses apply the principles of Hall's theory in their daily practice in understanding, prioritising and managing the prisoners' needs, they will always strive to render quality patient care.

During the process standard the researcher evaluated a nurse applying the pathological and therapeutic sciences aimed at improving the health condition of patients, using formulated criteria.

1.5.2 The concept of quality patient care

Sale (2000) defines quality as the degree of excellence, which needs to be measured. She further describes quality assurance as the measurement of the actual level of the service provided plus the efforts to modify the service where necessary.

The researcher believes that measuring quality patient care is a multi-factoral concept, thus the following concepts need to be reflected when measuring quality patient care. During the outcome standards the researcher evaluated these concepts using a patient questionnaire, to get the prisoners' views and a report on their experiences regarding the following concepts:

- Access to health care
- Efficiency of health care
- Confidentiality
- Patient involvement/consultation
- Therapeutic, healthy and safe environment
- Privacy
- Dignity and respect

- Effective referral system
- Standard of health care service received
- Informed consent.

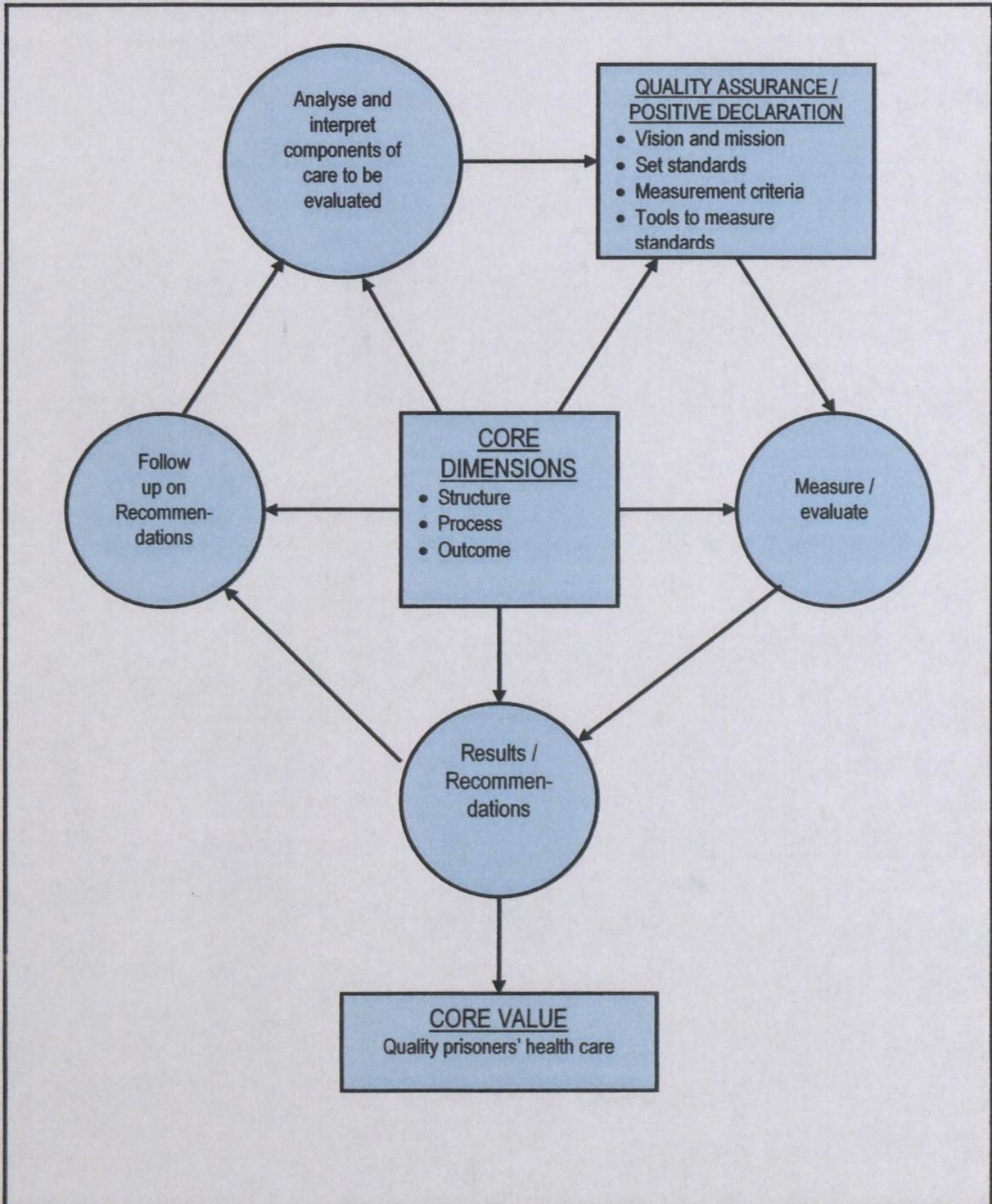
Prisoners must be able to obtain care or the service they need with ease, and the care rendered must be relevant to the prisoners' social, medical and physical needs. Care needs to be provided in the correct manner and should reach the intended goal with minimum effort and expense. Nurses must involve prisoners in the planning of their care, render care in a dignified and respectful manner and maintain privacy at all times. Nurses must get feedback from the prisoners, verbally and in writing, to ascertain the suitability of the nursing care as well as the standard of health care rendered (Parsley and Corrigan, 1994; Maxwell, 1984).

Whilst rendering nursing care nurses should maintain confidentiality regarding information coming to their knowledge and treat the prisoners in a dignified manner while maintaining the prisoners' privacy. Patient involvement is vital during nursing care because co-operation at all levels is vital for optimal care results. A therapeutic environment needs to be maintained at all times by ensuring a clean environment, explaining procedures to prisoners and reassuring prisoners when needed. When these concepts are applied by nurses in the execution of their daily tasks, quality patient care will prevail (Parsley and Corrigan, 1994; Maxwell, 1984).

1.6 CONCEPTUAL FRAMEWORK

The following conceptual framework (Figure 1.2) guided the researcher in the whole research process in order to achieve the set objectives:

FIGURE 1.2
CONCEPTUAL FRAMEWORK: EVALUATION OF PRISONERS' HEALTH CARE



The process starts with the analysis and interpretation of care rendered to prisoners by nursing personnel. The researcher needs to analyse the care given and make judgements regarding the care given. During this step of analysis the researcher analyses and determines which components of the quality of prisoner's health care need to be evaluated urgently and to ascertain if any measurement tools are available.

The next step is about quality assurance whereby a positive declaration is made. The declaration will be based on the vision and mission of the organisation, set standards, measuring criteria and formulated programmes to improve and measure standards.

The quality of care is evaluated by using standards with criteria. The standards are set or formulated in three domains. The structure domain involves the physical (therapeutic) environment, facilities, equipment, personnel complement, skill mix and training, supplies and protocols or procedures. The structural domain and the process domain complement each other, because without the components mentioned the nurse will never be able to carry out the necessary actions which represent the process domain.

Process standards refer to the way actions should be executed, in other words a standard is set or formulated with criteria regarding a specific action which indicates how it should be executed. The process domain involves the type of nursing care rendered, based on efficiency, economy, social acceptability, accessibility and relevance of the service. The process domain also involves accurate recording and compliance to legal documentation and measures instituted to control infection.

The outcome domain relates to patient satisfaction. The patients' view on the care received, as reflected in their level of satisfaction, is generally seen as a measurement tool to evaluate the outcome of care.

After evaluation of the structure, process and outcome dimensions, results are made known. Where good or quality care was rendered, due praise is to be communicated. Recommendations are made which are important to improve on deficiencies.

Lastly, recommendations have to be followed up. The core value of nursing is quality care. The researcher believes that the whole process needs to be revisited at least on an annual basis to assess and ensure that quality care is rendered.

1.7 OPERATIONAL DEFINITIONS

Evaluation refers to the formal way in which information is gathered and assessed in relation to set standards and criteria (Booyens, 1993)

Health care is care rendered to the client/patient to improve his/her state in order for him/her to function optimally.

A prisoner is a person incarcerated in an institution /prison due to criminal behaviour, found guilty by court of law and serving sentence.

Quality assurance is the measurement of the actual level of service provided as well as the efforts to modify service to assure quality.

A structure standard is a standard that concerns the composition of and the resources in a health service which make the provision of service possible (Booyens, 1993).

A process standard is a process showing the way in which a task should be executed; those aspects or factors focusing on the actual way the practice is

conducted (Booyens, 1993).

Outcome standards are the results that have to be achieved (Booyens, 1993). In this study it refers to patient satisfaction.

Criteria are measurable statements reflecting the contents of the standard.

The health care setting refers to the point in prison where health care is rendered. It can be a clinic or an in-patient hospital.

A prison is the institution where prisoners are kept while serving their respective sentences.

1.8 LIMITATIONS OF THE STUDY

The limitations of a study are weaknesses of the entire study as the researcher perceives them (Burns and Grove, 1993; Pilot and Hungler, 1993).

The following could be seen as limitations:

- There were time and financial restrictions.
- The study was done in correctional services in the Western Cape only.

The researcher is of the opinion that the findings are reliable and could be generalised to other prisons because the health service environment is stable throughout all prisons; the nursing staff, irrespective of where they work, completed the same training programme and are registered with the same professional council. This ensures minimal variations and fluctuations in the execution of procedures and interventions. Lastly, the principle of data saturation was also applied throughout the study.

1.9 ORGANISATION OF THE REPORT

Chapter 1: Introduction

This chapter entails the orientation to the study. It covers the background of the study, statement of the problem, objectives of the study, methodology of the research, paradigmatic perspective, conceptual framework, operational definitions and limitations of the study.

Chapter 2: Literature Study

Health care in South Africa and South African prisons, as well as quality care and standards are discussed.

Chapter 3: Research Methodology

This chapter describes the research methodology of the study.

Chapter 4: Data Analysis and Discussion of the Results

Data are analysed and research findings discussed.

Chapter 5: Conclusions and Recommendations

Conclusions are arrived at and recommendations are made.



CHAPTER 2

LITERATURE STUDY

2.1 INTRODUCTION

The literature review refers to the activities involved in searching for information on the topic and developing a comprehensive picture of the state of knowledge on that topic (Polit and Hungler, 1993).

It also enables the researcher to:

- see his or her own study problem in perspective;
- evaluate the significance of findings more effectively;
- carry out a project more purposely; and
- consider the procedures and instruments of research (Uys and Basson, 1991).

A literature study was undertaken to:

- give an overview of health care in South Africa;
- give an overview of health care in Correctional Services in South Africa;
- review literature about relevant existing quality care models; and
- review standards and relate them to the research.

2.2 HEALTH CARE IN SOUTH AFRICA

Health care in South Africa is a basic right enshrined in the Constitution of South Africa (Constitution Act 108 of 1996). Thus all South African citizens have the

right to achieve optimal health and it is the responsibility of the state to provide the conditions facilitating that right (ANC, 1994; White Paper, 1997). To fulfil its social responsibility of optimal health care to the nation, Government has to divide health care into manageable units, namely National and Provincial. These are again divided into different levels of care, namely tertiary, secondary and primary health care levels.

2.2.1 The National Health System

The National Health System as the principal health system has certain responsibilities to fulfil. In order to do so, a vision and mission has been formulated for this system.

2.2.1.1 *Vision of the National Health System*

It is a caring and humane society in which all South Africans have access to affordable, good quality health care (<http://www.doh.gov.za>).

2.2.1.2 *Mission Statement of National Health System*

The mission statement of the National Health System is the following:

- To consolidate and build on the achievements of the past five years in improving access to health care for all and reducing inequality
- To focus on working in partnership with other stakeholders to improve the quality of all levels of the health system especially preventative and promotive health
- To improve the overall efficiency of the health care delivery system (<http://www.doh.gov.za>).

The following are the responsibilities which the National Health System needs to fulfil in order to realise the vision and mission statements:

- Formulating health policy and legislation
- Formulating norms and standards for health care
- Ensuring appropriate utilisation of health resources
- Coordinating information systems and monitoring national health goals
- Ensuring access to cost-effective and appropriate health commodities at all levels
- Liaising with health departments in other countries and international agencies (<http://www.doh.gov.za>).

For effective and strategic management of the above responsibilities, the National Health System developed a strategic plan for the period 1999 to 2004 aimed at provisioning quality of health care in South Africa.

The strategic plan included the following components:

- Reorganisation of certain support services
- Legislative reform
- Improving quality of care
- Revitalisation of hospital services
- Speeding up the delivery of essential health services through district health system
- Decreasing morbidity and mortality rates
- Improving human resources development and management
- Improving communication and consultation
- Strengthening cooperation with international partners
- Improving resources mobilisation and management of resources (<http://www.wcape.gov.za>) (<http://www.doh.gov.za>).

All these components need to be realised in order to ensure that the citizens of South Africa receive quality health care. Due to the fact that this study was done to evaluate the care of prisoners the researcher focused on the 'improving quality of care' component. The Department of Health has set a goal to improve the quality of care provided in the public health sector enabling health service users and providers to play an active role in ensuring that an acceptable standard is obtained and that quality care is rendered.

To improve the quality of health care rendered in the public sector the Department of Health also aims to ensure the availability of affordable, good quality drugs and training of health providers in the rational use of drugs (<http://www.wcape.gov.za>).

The following objectives were also set to improve the quality of care:

- To strengthen the Batho Pele programme that has been implemented
- To develop and operationalise National policy on quality in general
- To launch a patient's charter that spells the rights and obligations of patients
- To establish complaints mechanisms in all health facilities
- To develop and implement clinical management guidelines
- To introduce peer review and clinical audits at all health facilities.
- To establish boards and committees in all health facilities through which communities and users can change the way in which health services are provided in the public sector
- To develop mechanisms to ascertain the views and expectations of users of health services
- To train health personnel in strategies to improve quality of care rendered (<http://www.wcape.gov.za>).

The National Health system or Department of Health is the level at which policies are developed in order to be implemented at lower levels. The Provincial Health

Department or Provincial Health System is the level lead by the Member of the Executive Council (MEC) of Health in that specific province. This Department's main functions are to coordinate and ensure implementation of National and Provincial policies.

2.2.2 Provincial Health System

The Provincial health system is the level at which the policies of National level are implemented, coordinated, controlled and evaluating of the progress thereof. In order to implement such policies the provincial management has the following responsibilities enabling it, to plan strategically, formulate operational plans and to monitor and evaluation of progress of key success/ focus areas (<http://www.wcape.gov.za>):

- To provide and or render health services
- To formulate and implement provincial health policy, standards and legislations
- To plan and manage a provincial health information system
- To research health services rendered in the province to ensure efficiency and quality
- To control the quality of all health services and facilities
- To screen applications for licensing and inspecting private health facilities
- To coordinate the funding and financial management of district health authorities
- To effective consult on health matters at community level
- To ensure that delegated functions are performed

<http://www.doh.gov.za>

Each province has to develop a health plan indicating success/focus areas. The Western Cape Provincial Health Department's health plan was adopted by the cabinet in 1995. The key success/focus areas were:

- Set up new provincial Health Department under new dispensation
- Introduce new legislation and policies at provincial level
- Improve access to services especially at Primary Health Care level
- Build of new clinics and upgrading existing facilities
- Downscale services because of financial constraints

(<http://www.wcape.gov.za>)

The provincial health system will evaluate the progress of implementation of these focus areas in the province and District Health Services.

2.2.3 District Health Systems

District health system is the lowest level in rendering health care in the department of health. This system of health care is also responsible for the implementation of the patients' rights charter and Batho Pele principles. The implementation of these principles are aimed at improving the quality of health care of the communities and is done in collaboration with other governmental, non-governmental and private structures (White Paper, 1997; <http://www.wcape.gov.za>).

District Health System is aimed at providing basic healthcare as a fundamental right by implementing a comprehensive primary health care approach. As the cardinal pillar of a health system it provides the following services:

- Immunisation
- Communicable and endemic disease prevention
- Maternity care
- Screening of children
- Integrated management of child illnesses and child health care
- Health promotion
- Youth health services

- Counselling services
- Chronic diseases
- Rehabilitation
- Diseases of older persons
- Accident and emergency services
- Family planning
- Oral health services

Clients visiting clinics are mainly treated by primary health care trained nurses or by doctors. Patient with complications are referred to higher levels of care such as secondary or tertiary hospitals for further management (<http://www.doh.gov.za>).

District Health Services in the Western Cape are based on the following principles:

2.2.3.1 *Equity of access to health services*

Equity of access to health services is based on three factors namely geographical access, economic access and equity in allocation of resources.

(a) Geographical access

Geographical access to the health service is the accessibility of clients to a facility in terms of distance to the facility and in the facility itself. In order to meet the clients on this right, 3000 clinics were built to access health care to 13 000 of the population. Further more to ensure accessibility facilities were upgraded and improved physical structure especially for disabled persons (<http://www.wcape.gov.za>).

(b) Economic Access

Due to a high unemployment rate and high poverty levels in South Africa and in the Western Cape, health care becomes increasingly difficult to access especially if the clients have to pay for services. In order to help the clients and make health care economically accessible the Western Cape renders primary health care free of charge to non-insured patients. The province further plan to reduce the waiting time for those who can afford it, hence it is costly for them to wait too long.

(c) Equity in the allocation of services

The Western Cape province has developed mechanisms in addressing inequalities in health care. Mechanisms developed are based on the normative model, which deals with norms in terms of admission rate, bed occupancy and staffing norm. Funds are going to be allocated according to the population figure will determine the admission rate and the staff norms which in turn determines the number of nursing staff population ration.

2.2.3.2 *Comprehensiveness of services*

The core package of Primary Health care services defines an approach of integrated, comprehensive services at the primary health care level. The aim of the approach is to ensure that all services for a particular level are rendered including mental health, rehabilitation and forensic services. In essence this need to be an one stop health centre were all services are rendered, this will eliminate unnecessary duplication and unnecessary referral.

2.2.3.3 Integrated referral system

Integrated referral system was developed in order to ensure the following benefits for the client and the health department:

- Speedy referral of a client to the next level if necessary.
- Ensuring that the lowest possible level of service is used for the particular need within technical quality standards
- Quality patient care and improvement of cost efficiency

The following approaches have to be in place to realise the above benefits:

- Developed partnerships with private health facilities to stabilise life threatening emergencies before referring to the public sector.
- Definition of the scope of the facility in terms of which cases to handle and which to refer to the next level.

2.2.3.4 Quality of health care

An improvement of the quality of services has been identified as an important policy focus in the public services generally. It forms the corner stone of the Batho Pele programme and the Western Cape has made this a priority in dealing with Health matters. The principles of Batho Pele programme are the following:

2.2.4 Batho Pele Principles

(a) Consulting users of services

Citizens should be consulted about the level and quality of the public services they receive and, wherever possible should be given a choice about the services

they are offered.

(b) Setting service standards

Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect.

(c) Increasing access

All citizens should have equal access to the services to which they are entitled.

(d) Ensuring courtesy

Citizens should be treated with courtesy and consideration.

(e) Providing more and better information

Citizens should be given a full, accurate information about the public services they are entitled to receive

(f) Increasing openness and transparency

Citizens should be told how national, provincial and local departments are run, how much they cost and who is in charge.

(g) Correction of mistakes and failures

If the promised standard is not delivered, citizens should be offered an apology, a full explanation, speedy and effective remedy and when complaints are made citizens should receive a sympathetic and positive response.

(h) Getting the best possible value for money

Public services should be provided economically and efficiently in order to give citizens the best possible value for money (<http://www.polity.org.za>).

2.2.5 Patients' Rights Charter

(a) A healthy and safe environment

Every citizen has the right to a healthy and safe environment that will ensure their physical and mental health or well-being including adequate water supply, sanitation and waste disposal. They have a right to be protected from all forms of environmental dangers such as pollution, ecological degradation or infection (<http://www.gov.za/yearbook/2004/health>).

(b) Access to health care

Everyone has the right of access to health care services that include:

1. receiving timely emergency care at any health care facility that is open regardless of one's ability to pay;
2. treatment and rehabilitation that must be made known to the patients, for understanding such treatment and consequences thereof;
3. provision of special needs in the following cases newborn infants, disabled persons, pregnant women, the aged, patients in pain, persons living with HIV/AIDS;
4. counselling without discrimination, coercion or violence on matters such as HIV/AIDS, cancer and reproductive health;
5. palliative care that is affordable and effective in cases of incurable or terminal illness;
6. a positive disposition displayed by health care providers that demonstrate courtesy, human dignity, patience, empathy and tolerance;
7. health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient (<http://www.gov.za/yearbook/2004/health>).

(c) Confidentiality and privacy

Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or an order of the court (<http://www.gov.za/yearbook/2004/health>).

(d) Informed consent

Everyone has the right to be given full and accurate information about the nature of one's illness, diagnostic procedures, the proposed treatment and the costs involved for one to make a decision that affects anyone of these elements (<http://www.gov.za/yearbook/2004/health>).

(e) Referred for a second opinion

Everyone has the right to be referred for a second opinion on request to a health provider on one's choice.

(f) Exercise choice in health care

Everyone has the right to choose a particular health care provider for services or a particular health facility for treatment provided that such choice shall not be contrary to the ethical standards applicable to such health care facility and the choice of facility in line with prescribed delivery guide lines.

(g) Continuity of care

No one shall be abandoned by a health care professional worker or a health facility which initially took responsibility for one's health.

(h) Participation in decision making that affect his /her health

Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision making on matters affecting one's health (<http://www.gov.za/yearbook/2004/health>).

(i) Be treated by a named health care provider

Everyone has the right to know the person that is providing health care and therefore must be attended to by clearly identified health care providers.

(j) Refuse treatment

A person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others.

(k) To complain about the health service they receive

Everyone has the right to complain about health care services and to have such complaints investigated and to receive a full response on such investigation ([http://www.doh.za/docs/legislation/patientsright/chartere](http://www.doh.za/docs/legislation/patientsright/chartere;); (<http://www.wcape.gov>).

za).

From these patients' rights emanated the following patient's responsibilities in order to protect their own health and that of low citizens:

- To advise the health care providers on his or her wishes with regard to his or her health;
- To comply with the prescribed treatment or rehabilitation procedures;
- To enquire about the related costs of treatment and or rehabilitation and to arrange for payment;
- To take care of health records on his or her possession;
- To take care of his or her health care;
- To take care and to protect the environment;
- To respect the rights of other patients and health providers;
- To utilise the health care system properly and not abuse it;
- To know his or her local health services and what they offer;
- To provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes;

(<http://www.doh.gov.za>; <http://www.wcape.gov.za>)

The researcher evaluated Batho Pele principles and patients' rights charter in the outcome standards, to check if Batho Pele principles and patients' rights are implemented and respected among prisoners in the four selected Western Cape prisons.

In order to make Batho Pele principles and patients' rights a reality the National health system makes policies, guidelines and standards to honour the above mentioned principles and patients' rights. The National Health System's strategic plan, its components will be discussed in details in the next paragraph.

The development of standards specifically refers to medical treatment and

organizational /and clinical protocols. These ensure uniformity in dealing with the condition or a specific issue thus resulting in quality of care, efficiency and effectiveness of the service.

It is important however that communities take ownership for their health matters to address the issues, problems and challenges appropriately. The communities can do this by participating in community health committees and development of community based health workers and volunteers (<http://www.wcape.gov.za>).

It is evident from the abovementioned that the quality of a health service can only improve if the Batho Pele principles and patients rights charter are adhered to and if human resource development and community outreach programmes are launched. One method to improve the quality of the care rendered by a service is to evaluate it by means of standards and to implement recommendations made. This is what is done in this study by evaluating the health service to prisoners in selected prisons..

2.3 HEALTH CARE IN THE CORRECTIONAL SERVICES IN SOUTH AFRICA

Correctional services is a government department which renders certain specific services to the community of South Africa. These services aims are to contribute towards maintaining and protecting a just, peaceful and safe society by enforcing court-imposed sentences, detain offenders in safe custody, and to promote the social responsibility and human development of all offenders and persons subject to community corrections programmes. Through the introduction of rehabilitation concepts in prisons the following are core business/key service delivery areas:

- Corrections
- Development

- Security
- Care
- Facilities
- After-care

The core functions of Correctional services are to provide safe custody of prisoners until they are lawfully released from prison. Rehabilitation of prisoners is done in custody through individual risk and profile assessment of prisoners incorporating development, health care, social services, psychological service and available facilities (<http://www.gov.za/yearbook/2004>).

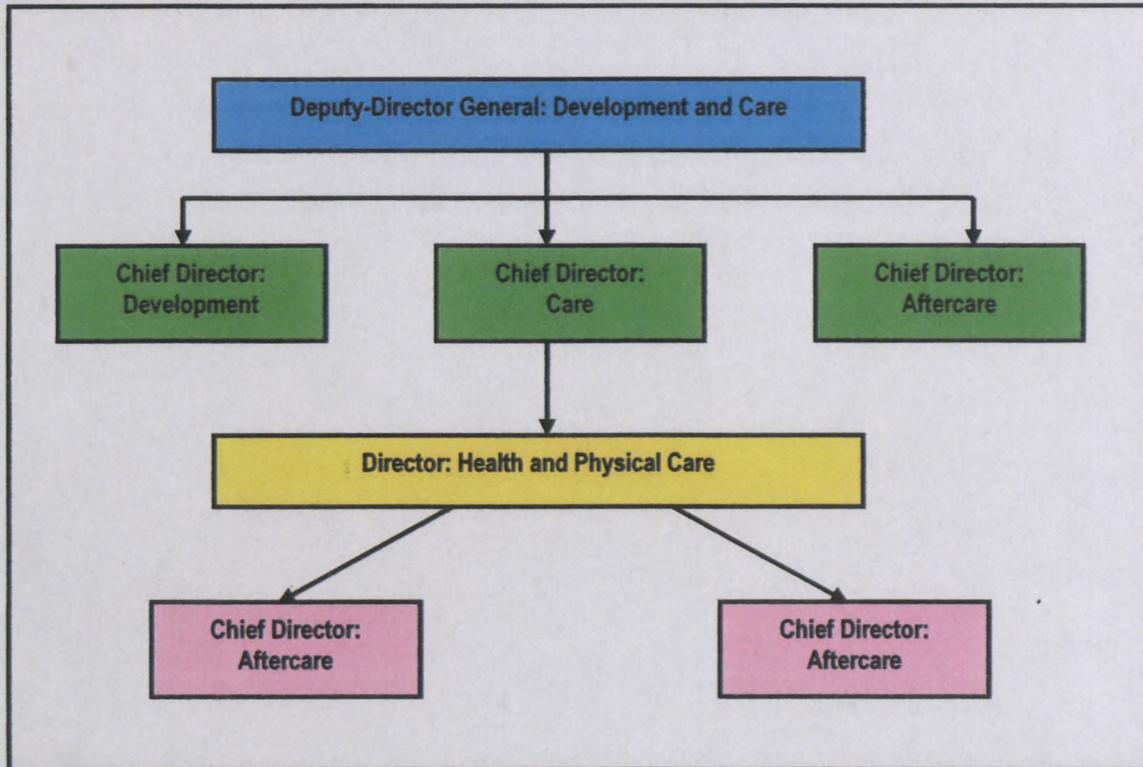
Care as part of the programme of rehabilitation is further divided into the following:

- health care services,
- social services and
- psychological services.

Health care is as previously mentioned, one of the basic rights enshrined in the Constitution of South Africa [Act 108 of 1996, Chapter two section 27 (i)] and is also rendered in terms of norms and standards that comply with constitution, health legislations and correctional legislations. . The right to health care is also mentioned in Correctional Services Act 111 of 1998 section 12.4(b) (Constitution, 1996) (Correctional Act, 1998) (<http://www.gov.za/yearbook/2004>).

The organogram in Figure 2.1 reflects the specific persons responsible for the portfolios Development and Care in the Department of Correctional Services.

FIGURE 2.1
NATIONAL LEVEL STRUCTURE



(<http://www.dcs.gov.za>.2003)

The Deputy-Director General: Development and Care supervises all matters relating to development and care which includes health care. There are three chief directors responsible for development, care and aftercare. The director of health and physical care supervises the two deputy directors responsible for healthcare, nutrition and physical care.

Health care includes physical care, nutrition and accommodation of prisoners which is the focus point of the Department. An independent judicial inspectorate regularly inspects all prisons and reports on the conditions in prisons and the treatment of offenders.

The policy and administrative framework for the maintenance of an adequate,

affordable and comprehensive healthcare service is based on the principles of primary health care. The primary health care services includes mental, dental, reproductive health, health promotion of management of communicable diseases like HIV/AIDS, and Sexually Transmitted Infections. It also includes the referral of the prisoner where necessary in terms of national and international norms and standards and within the limits of available resources.

In order to comply to the norms and standards applied to other patients receiving state health care, the Department of Correctional Services' facilities focused on the following approaches:

- Strict pursuance of ethical codes by health professionals
- Regular health-quality inspections
- Strict compliance with rules of confidentiality and privacy with regard to the medical records of patients
- Continuous evaluation and upgrading of medical emergency services

(<http://www.gov.za/yearbook/2004>)

These approaches were integrated in the standards set for evaluation of the health care of prisoners. For proper and well coordination of events the directorate of health care in the Department of Correctional Services is divided into the following levels: national, provincial and management (<http://www.dcs.gov.za>.2003).

The National health care level is responsible for policy formulation regarding the health care, environmental and physical care of prisoners. The policies of Correctional services' health care are in line with Department of Health 's policies as mentioned above.

The health care policy statement of Correctional Services serves as a guideline to:

- Prevent diseases, by promoting of safe sexual practices, management

and control of STI

- Treat, care and support prisoners
- Respect human rights
- Partner with other government departments, private sector, NGO and educational institutions.
- The introduction of universal precautions principles which provide personnel with guidelines and procedures regarding the handling of body fluids.
- Maintain high standards of personnel hygiene.
- Provide a comprehensive primary health care service which is financially managed by the state.
- Provide accessible health care based on 24 hours service, an effective referral system and emergency services.
- Manage a prison health care service in accordance with sound business principles.
- Provide a service with 24 hours access to general practitioner services and emergency services
- Provide access to a health care service in each province with the following 24 hour services:
 - specialist consultants;
 - ancillary services; and
 - laboratory services.
- Provide a comprehensive health care with the following services:
 - medical treatment
 - Oral health care
 - Mental health care
 - Hospital admission
 - Rehabilitation services
 - laboratory services
 - Pharmaceutical services (Order 3, 2001)

(<http://www.gov.za/yearbook/2004>)

The Department of Correctional Services' health policy encompasses the following structure and process standards which set a standard to a certain extent and which can be used as a basis to evaluate services rendered.

2.3.1.1 Structure Standards

For this policy to be a reality the following structure standards need to be in place:

(a) Personnel

- All categories of nursing staff who are registered or enrolled with the South African Nursing Council can practice nursing.
- All personnel must have a job description outlining their duties and responsibilities in line with their scope of practice.
- All nursing staff should wear their distinguishing devices as prescribed by the Nursing Act (Act 50 of 1978 as amended).
- Nurses are expected to do standby duties (Order 3, 2001).

(b) Infrastructure

- Waiting area/rooms: areas or rooms where clients/prisoners will sit while waiting for health care.
- Assessment/treatment/emergency rooms: rooms where prisoners will be assessed and treated for ailments or emergencies.
- Ablution facilities: facilities needed to wash hands and other resources.
- Sluice room: rooms where body secretions will be discarded.
- Store room (supplies/equipments): rooms where supplies and medicines

are stored safely.

- **Medicine room**
- **Linen room:** the room where clean linen is stored for future use by prisoners.
- **Isolation cells:** cells used specifically to isolate prisoners who may happen to have communicable diseases (Order 3, 2001).

(c) Equipment

- Screening forms
- Weighing scale
- Blood pressure apparatus
- Glucometer
- Stethoscope
- Thermometer
- Scissors
- Screens (Order 3, 2001)

(d) Supplies

- Dressing packs
- Dressings and solutions
- Urine dipsticks
- Haemoglucostix
- Urine glasses (Order 3, 2001).

(e) Medication (Emergency services)

Each prison health centre must have a management plan to cope and manage

all emergencies with the following basic medications and supplies:

- Ambubag with mask
- Mobile and portable oxygen cylinders
- Blood administration set
- Haemacel
- Intravenous set
- Laryngoscope
- Suction apparatus
- Intravenous cannulas
- Intravenous solutions
- Gloves
- Emergency protocol (Order 3, 2001).

2.3.1.2 Process standards

Process standards need to be executed accurately and at certain intervals, the following process standards need to be executed:

(a) Curative care

Execution of curative care is based on the following process:

- **Assessment.** The nurse is expected to assess the prisoner by obtaining subjective and objective data before making a nursing diagnosis.
- **Classification (nursing diagnosis).** It is expected from the nurse to make a nursing diagnosis based on his/her assessment.
- **Treatment.** It is within the nurse's scope to prescribe primary treatment to

the prisoner and to refer the prisoner to the medical officer or to the next level where he/she will be attended to (Order 3, 2001).

(b) Health promotion and disease prevention

Health promotion and disease prevention are to be done weekly in the form of health education specifically addressing the following topics:

- Personal hygiene
- Oral hygiene and plaque control
- Reducing risks of communicable disease like tuberculosis
- Sexually transmitted infections including HIV/AIDS
- Infection control practices
- Nutrition
- Smoking
- Prevention of accidents
- Universal precautions (measures to prevent spread of infection)
- Waste disposal
- Violence prevention
- Basic first aid (Order 3, 2001).

(c) Accurate documentation

Documentation is regarded as a critical issue which always needs to be adhered to according to the policies from the National level of Department of Correctional Services, hence it affects the outcome of any malpractice suit. Such documentation must reflect the following:

- Subjective data
- Objective data

- Nursing diagnosis
- Plan for treatment
- Full name of prisoner
- Full registration of the prisoner
- Legible documentation of treatment regimen
- Document of informed consent for procedures
- Drawing a line when making corrections; sign and insert date of corrections
- Use recognised abbreviations (Order 3, 2001).

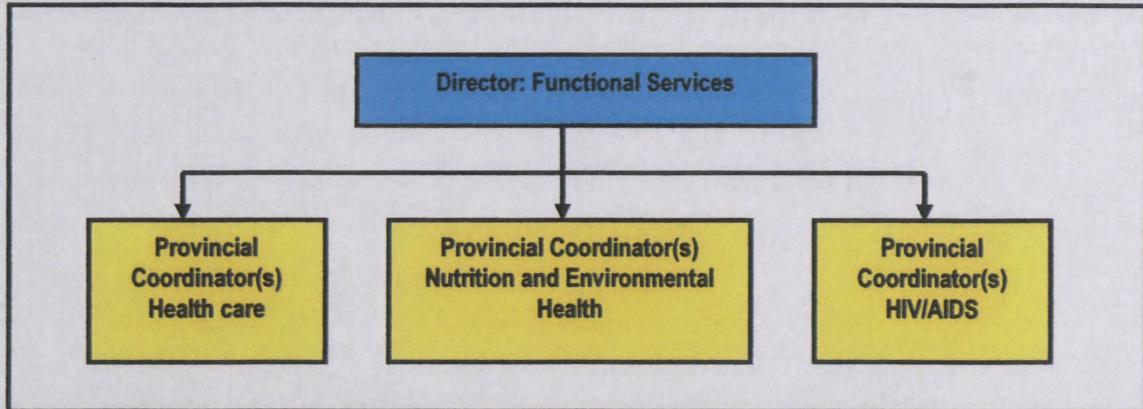
It is clear from the above-mentioned that the Department of Correctional Services has a policy on health care, to ensure provision of comprehensive and quality health services which are accessible and affordable to the state. The Department of Correctional Services base quality of service on the availability and implementation of structural and process standards. During the execution of these standards it is expected from the executor of service to keep accurate records.

The researcher used these standards as a guideline to set detailed standards to evaluate the health care of prisoners in selected health services. The provincial level is tasked to monitor the implementation of these policies and put control measures in place for compliance.

South Africa is demarcated into nine province. In each province there is a Department of Correctional Services Provincial Office. In these offices there are Directors of Functional Services who are direct supervisors of provincial coordinators of health care.

The Western Cape is one of the provinces situated along the southern and western part of South Africa. In this province there are 29 management areas distributed across the province.

FIGURE 2.2
PROVINCIAL LEVEL STRUCTURE



(<http://www.dcs.gov.za>.2003)

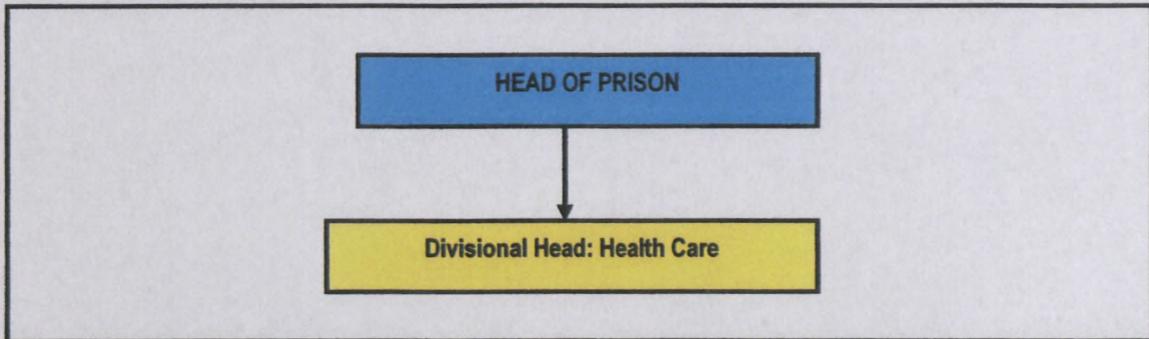
Figure 2.2 shows that provincial coordinators report directly to director functional services, who are in charge of health care, nutrition, environmental health and HIV/AIDS.

The main duties of the provincial health care is to:

- coordinate and oversee that all the affairs of health care in the province are in good order;
- ensure that adherence to the national policies and provincial policies takes place;
- reinforce the updates on the new policies, and conduct inspections to evaluate the efficiency of the province. These inspections are done six-monthly, mainly concentrating on administrative activities on the management areas.

At the management area level, the health care of prisoners is tasked to the head of the prison who supervises the divisional head of health care as shown in Figure 2.3. The divisional head health care reports directly to the head of prison regarding health issues in the prison as shown in Figure 2.3 below.

FIGURE 2.3
MANAGEMENT LEVEL STRUCTURE



(<http://www.dcs.gov.za.2003>)

The divisional head is the supervisor of certain number of nurses under their authority. The divisional head is responsible for implementation of operational as well as strategic policies of the Correctional services. One of the strategic policies of correctional services is the implementation of comprehensive primary health care to prisoners and secondary health care on bigger management areas (<http://www.dcs.gov.za/offendermanagement/healthservices.htm>).

The health care is further divided into three levels of care namely:

- first level of care – providing only primary health care clinic services;
- second level of care – providing both primary health care clinic and in-patient care facilities supported by standby services after hours; and
- lastly the third level of care are provincial prison hospitals for both a primary health care and in-patient care facility providing access to tertiary care institutions in the public sector

(<http://www.dcs.gov.za>)

At these levels of care prisoner, patient is afforded comprehensive primary health care treatment at the states expense with the exclusion of cosmetic

interventions. The comprehensive primary health care is rendered by nurses registered or enrolled by South African Nursing Council and medical officers on part-time or full time basis.

Comprehensive primary health care service is the care which advocates very comprehensive measures to ensure an improvement in global health (Vlok, 1991). Vlok (1991) further describes primary health care as an extension of curative primary health care to include primary preventative intervention, secondary intervention as well as collective health education. Wagstaff (1978) defines primary health care as an approach which is problem-oriented and having clear guidelines and protocols for management and referral.

Primary health care in the correctional services is based on the following:

- Batho Pele principles;
- patients' rights charter; and
- structural, process and outcome standards aimed at quality health care of prisoners.

For effective implementation of a comprehensive primary health care service nurses are expected to do the following:

- Screening and medical examination of offenders on admission to identify injuries, disabilities, communicable diseases, signs of suicidal risks and lice infestation.
- Render health education on admission, when consulting with medical officer and/or during health education sessions on a continuous basis on the following topics:
 - prevention of communicable diseases
 - prevention of sexually transmitted infections
 - personal hygiene
 - cleanliness
 - safe environment
 - attend to sick reporting prisoners

- assess
- make a nursing diagnosis
- plan therapeutic management
- execute therapeutic management
- evaluate response to treatment and maintain accurate recording at all times

(<http://www.dcs.gov.za>)

The Western Cape Province has been divided into 29 management areas and 42 health care centres since January 2003 (see Table 2.1). The number of health care centres per management area is dependent on the size of the specific area.

TABLE 2.1
COMPOSITION OF MANAGEMENT AREAS AND HEALTH CENTRES

MANAGEMENT AREA	REGION	NUMBER OF PRISONS	NUMBER OF HEALTH CENTRES	TOTAL
Allandale	Winelands	1	1	1
Beaufort West	Southern Cape	1	1	1
Brandvlei	Boland/Overberg	3	3	3
Swellendam	Overberg	1	1	1
Caledon	Overberg	1	1	1
Drakenstein	Boland	3	3	3
Dwarsrivier	West Coast	1	1	1
Goodwood	Metropole	1	1	1
George	Southern Cape	1	1	1
Hawequa	Winelands	1	1	1
Helderstroom	Overberg	2	2	2
Knysna	Southern Cape	1	1	1
Ladismith	Southern Cape	1	1	1
Malmesbury	West Coast	2	2	2
Mossel Bay	Southern Cape	1	1	1
Obiqua	West Coast	1	1	1
Oudtshoorn	Southern Cape	2	2	2
Paardeberg	Winelands	1	1	1
Prins Albert	Southern Cape	1	1	1
Buffeljagsrivier	Overberg	1	1	1
Riebeek West	West Coast	1	1	1
Robertson	Boland	1	1	1
Pollsmoor	Metropole	5	5	5
Stellenbosch	Boland	1	1	1
Uniondale	Southern Cape	1	1	1
Van Rhynsdorp	West Coast	1	1	1
Voorberg	West Coast	2	2	2
Warmbokkeveld	West Coast	1	1	1
Worcester	Boland	2	2	2
TOTAL	29	42	42	42

(Gxilishe, 2002)

2.3.2 Ratio: Nursing staff to prisoner populations

This ratio is approved on National level of Correctional Services. An ideal nurse:client ratio in the Department of Correctional Services is seen as 1:240. This ratio differs from prison to prison.

The prisoner population differs from prison to prison and ranges from 36 to 3179 prisoners in Western Cape prisons. The number of nursing personnel differs from prison to prison as well and ranges from 1 to 9 professional nurse per prison. The smaller the prison population the fewer the nursing staff as shown in table 2.2. In January 2003, with 147 nurses to a 29 412 prisoner population showed a ratio of 1 : 200 prisoners. This is a calculated average but the ratio vary from 1:18 to 1:652 as shown in table 2.2 (Anthony.joseph@dcs.gov.za, 2003; Gxilishe, 2003).

TABLE 2.2
DAILY AVERAGE PRISONER POPULATION AND
NUMBER OF NURSING PERSONNEL PER PRISON

MANAGEMENT AREA	PRISON	REGISTERED NURSE	NURSING AUXILIARY	ENROLLED NURSE	DAILY AVERAGE	NURSE-CLIENT RATIO
		NUMBER OF NURSING PERSONNEL	NUMBER OF NURSING PERSONNEL	NUMBER OF NURSING PERSONNEL	PRISON POPULATION	
Allandale	Allandale	3	1	0	828	1:207
Beaufort West	Beaufort West	1	1	0	154	1:77
Brandvlei	Maximum	6	2	0	1204	1:151
	Medium	2	1	0	1093	1:364
	Youth	1	0	0	438	1:438
Buffeljagsrivier	Buffeljagsrivier	1	0	1	469	1:235
Caledon	Caledon	2	0	0	458	1:229
Drakenstein	Maximum	1	2	0	781	1:60
	Medium A	2	2	0	689	1:172
	Medium B	1	0	0	652	1:652
Dwarsrivier	Dwarsrivier	2	0	0	408	1:204
Goodwood	Goodwood	9	2	0	1829	1:166
George	George	4	1	0	1067	1:213

Hawequa	Hawequa	2	0	0	381	1:191
Helderstroom	Maximum	5	0	0	1091	1:218
	Medium	5	0	1	1310	1:218
Knysna	Knysna	2	1	0	294	1:98
Ladismith	Ladismith	1	0	0	97	1:97
Malmesbury	Medium A	4	0	1	1314	1:263
	Medium B	2	0	0	417	1:209
Mossel Bay	Mossel Bay	3	0	0	651	1:217
Obiqua	Obiqua	2	0	0	316	1:158
Oudtshoorn	Medium A	1	1	0	598	1:199
	Medium B	1	0	0	164	1:164

Prins Albert	Prins Albert	2	0	0	1091	1:218
Riebeeck	Riebeeck	1	0	1	294	1:98
West	West	1	0	0	97	1:97
Robertson	Robertson	2	1	0	294	1:98
Stellenbosch	Stellenbosch	1	0	0	97	1:97
Swellendam	Swellendam	1	0	0	97	1:97
Uniondale	Uniondale	1	0	0	97	1:97
Van Rhynsdorp	Rhynsdorp	1	0	0	97	1:97
Voorberg	Medium A	2	1	0	598	1:199
	Medium B	3	0	0	651	1:217
Wambouksieid	Wambouksieid	2	0	0	316	1:158
Worcester	Males	1	1	0	598	1:199
	Females	1	0	0	164	1:164
TOTAL = 29	43	133	14	10	3814	1:291
Total number of personnel		147				

TABLE 2.2: Staff to patient ratio in the 2009/2010 financial year

According to the Department of Correctional Services' norm, the ratio should be 1:240. The ratios as reflected in table 2.2, are ratios during the week for a full complement of staff. Weekends are regarded as overtime, but nursing will be limited due to budgetary constraints and during this period the ratio increases up to 1:800. Seeing that weekends are regarded as overtime it often happens that a nurse works 12 x 40 hours without a day off or even up to 20 x 40 hours without a day off in a 4 week period of time, especially when there is no one to relieve him or her.

TABLE 2.2 (CONTINUED)
DAILY AVERAGE PRISONER POPULATION AND
NUMBER OF NURSING PERSONNEL PER PRISON

MANAGEMENT AREA	PRISON	REGISTERED NURSE	NURSING AUXILIARY	ENROLLED NURSE	DAILY AVERAGE	NURSE-CLIENT RATIO
		NUMBER OF NURSING PERSONNEL	NUMBER OF NURSING PERSONNEL	NUMBER OF NURSING PERSONNEL	PRISON POPULATION	
Pollsmoor	Medium A	5	1	1	1864	1:266
	Medium B	2	0	0	617	1:309
	Medium C	2	0	1	753	1:251
	Admission	10	1	1	3179	1:265
	Female	1	0	0	417	1:417
Paardeberg	Paardeberg	2	0	0	431	1:216
Prins Albert	Prins Albert	1	0	0	101	1:101
Riebeeck West	Riebeeck West	1	0	1	447	1:224
Robertson	Robertson	2	1	0	457	1:152
Stellenbosch	Stellenbosch	1	0	0	122	1:122
Swellendam	Swellendam	1	0	1	109	1:54
Uniondale	Uniondale	1	1	0	36	1:18
Van Rhynsdorp	Van Rhynsdorp	2	0	0	330	1:165
Voorberg	Medium A	2	1	0	522	1:174
	Medium B	3	2	2	1592	1:227
Warmbokkeveld	Warmbokkeveld	2	0	0	343	1:172
Worcester	Males	1	1	0	858	1:429
	Females	1	1	0	231	1:116
TOTAL=29	42	123	14	10	29412	1:200
Total number of personnel		147				

(anthonyj@dcs.gov.za.2003) (Gxilishe, 2002)

According to the Department of Correctional Services' norm, the ratio should be 1:240. The ratios as reflected in table 2.2, are ratios during the week with a full complement of staff. Weekends are regarded as overtime, thus nursing staff is limited due to budgetary constraints and during this period the ratio increases up to 1:800. Seeing that weekends are regarded as overtime it often happens that a nurse works 12 x 40 hours without a day off or even up to 26 x 40 hours without a day off in a 4 week period of time, especially when there is no one to relieve him or her.

The shortage of nursing personnel, high nurse:client ratio and long working hours are critical areas hindering the rendering of a quality health care service in prisons. When there is shortage of nurses, overworked nurses and high nurse-client ratio the quality of care is prone to be poor. With these factors in mind the researcher found it necessary for the quality of health care in prisons to be evaluated and to make recommendations where applied.

The researcher evaluated health care given to prisoners on structure, process and outcome standards, which are seen to be vital for quality health care to prisoners. For improvement of quality health care, health care needs to be based on the quality improvement models which will be discussed in detailed below.

2.4 QUALITY IMPROVEMENT IN HEALTH CARE

The nurse is educated and trained to be accountable for their actions as well as to maintain standards in nursing care and to ensure that quality care is rendered. The nurse is thus also responsible for quality assurance and improvement in her area of practice. Quality improvement as process are discussed under the following headings:

- 2.4.1 Broad definition
- 2.4.2 Quality improvement models
- 2.4.3 Summary of quality improvement models

2.4.1 Broad definition

Booyens (1993) refers to quality improvement as a system in which the quality of the health service is formally monitored and assessed and where deliberate

steps are taken or programmes are instituted to cope with existing problems and to improve the quality of the service provided. It also implies putting quality into practice, but with the assumption that quality can never be completely guaranteed.

During the evaluation, opportunities for improvement are identified and a mechanism is provided for taking remedial steps to bring about and maintain improvements that is constant commitment to health care service of a high quality (Booyens, 1993).

2.4.2 Quality improvement Models

A model provides scientific basis for quality improvement. It also helps a researcher to base his or her conceptual framework on.

The following models of quality improvement will be discussed:

- 2.4.2.1 Systems model.
- 2.4.2.2 Joint Commission on Accreditation of Health care Organisation's Model
- 2.4.2.3 Norma Lang Model
- 2.4.2.4 Bruwer's quality assurance Model
- 2.4.2.5 Donabedian's Model

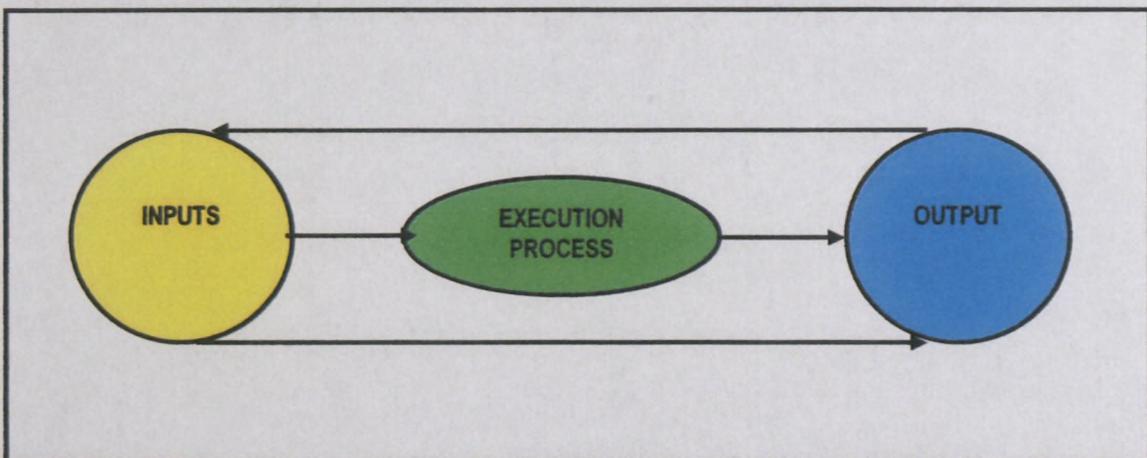
2.4.2.1 Systems Model

It is the model that convert information, energy or materials into a planned outcome or product for use within the system, outside the system or both. The systems model is influenced by an external and internal environment. External environments which determine the success of systems are socio-economic,

political and educational aspects (Booyens, 1993). The internal environment which determine the success of the systems model are knowledge and skills, skill mix and the quality of human resources, management styles, availability of equipment or supplies, manner of communication and safety of the environment (Booyens, 1993).

The systems model is a cyclical process, consisting of the following as shown in Figure 2.4.

FIGURE 2.4
SYSTEMS MODEL



(Booyens, 1993)

Inputs refers to the information and resources needed to execute quality patient care. The resources referred to above are human resources, non-human resources, manner of communication and environment. The researcher believes that adequate, knowledgeable and skilled nursing staff will render quality patient care. The nurses mentioned above also need to work in a safe environment, have adequate supplies and well functioning equipment to render care.

The **execution process** is the manner in which resources are utilised to reach the set objectives. Human resource utilisation, utilisation of knowledge, utilisation of supplies or equipments for the attainment of the goal. The researcher believes that nursing staff (human resources) need to be utilised where they are mostly needed. They must also be utilised according to their skills and knowledge in order to reach organisational objectives. The supplies must also be utilised in the best manner, aiming at attaining the goals.

Output represents the results achieved and or the product produced. The product achieved must be evaluated against the organisational vision, objectives and the set standards. The researcher strongly believes that the product achieved needs to be evaluated against set standards, which are outcome standards. This outcome can be obtained through the feedback session from the client about the care received.

System's model is applied in this research with its all three stages:

The **input** according to the model is the same as structure standards in the research, in which facilities are needed in order to render quality of patient care. This is the most important step in the model and in the research because without the specific facilities the nurse cannot **execute** quality health care and the **output**, which is the result to the patient, will not be pleasant or be of quality.

2.4.2.2 Joint Commission on Accreditation of Health Care Organisation's Model (JCAH)

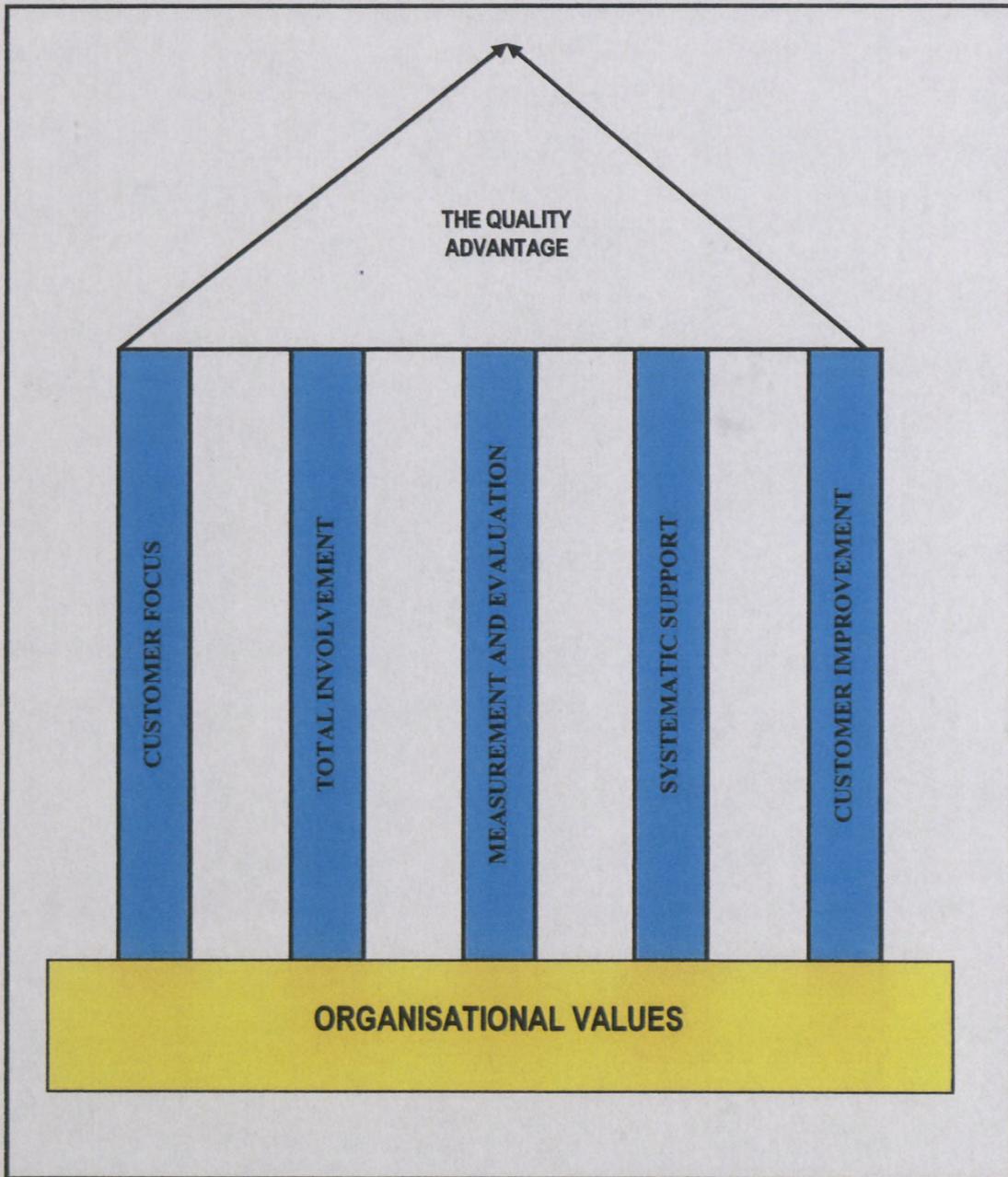
The Joint Commission on Accreditation of Health care uses a quality improvement model focusing on the improved functioning of the organisation as a whole. This quality improvement model consists of five pillars based on the organisational values as shown in Figure 2.5.

According to Ersoz *et al.* (1988) the five pillars are:

(a) Customer Focus Pillar

The first step is to identify the client needs. Then the organisation or the unit needs to define the nature and extent of the services provided. The researcher also believes that the nature and the extent of services can be well outlined on the mission statement of the unit. This is why vision, mission statement and objectives are included in evaluation processes.

FIGURE 2.5
JCAH'S PILLAR MODEL



(Booyens, 1993)

The researcher supports the view that continuous evaluation of health care standards should occur aiming at improving quality of health care.

(b) Total involvement Pillar

In order to render quality patient care, the staff need to be specialists in their field of work. To enhance the quality patient care the experts from externally also need to be involved in striving towards the quality of patient care (Esroz *et al.*, 1988). The researcher believes that someone with the necessary knowledge and skills will be able to render quality patient care. The researcher set standards, that at least 75% of nurses should be qualified in primary health care at the primary health care setting.

(c) Measurement and Evaluation Pillar

The actual measurement and evaluation of the quality of the service is the third step in quality improvement. Practitioners should stipulate and establish priorities for evaluation based on the needs of the clients (Esroz *et al.*, 1988). The researcher believes that there should be set standards against which departmental goals and clients' needs should be evaluated. Such standards need to be reviewed at least annually to determine relevance and priority.

(d) Systematic Support Pillar

Systematic support includes consistent organisational support in order to achieve quality improvement. An organisation should demonstrate its commitment to the strategic aim of achieving a high quality service through policies and financial support (Esroz *et al.*, 1988). Quality health care can be a reality only if other support structures are brought into the picture. Support structures like budgeting for evaluation of standards, for in-service training and continued education are

vital in improving the quality of health care. It is for that reason the researcher included the two aspects in the criteria of structure standards.

(e) **Continuous Improvement Pillar**

Quality improvement is not an once off incident but rather a process involving formal monitoring, assessing and deliberate steps or programmes instituted to improve the quality of health care.

This model is applied by the researcher on the evaluation of prisoners health care, see Figure 1.2 and Table 5.1. The researcher strongly believes that the organisation must show its support to quality health through its vision and mission statements. Further more client's needs must be analysed skilled personnel must render care. In order to ensure continuous improvement of care, care must be monitored/measured and evaluated on a regular basis.

2.4.2.3 Norma Lang Model

Parsley and Corrigan (1995) mentioned that Norma Lang's model has been adopted and developed by the American Nurses Association. This framework is used in conjunction with the elements of structure, process and outcomes which are components of Donabedian's framework as well. These three components will be discussed in details in step 2 below. This model consists of five steps as shown in Figure 2.6.

Step 1: Declaration of Values

The first step of Norma Lang model involves statement of values like social and

professional values and scientific knowledge. These values serve as primary inputs to the quality of health care. Such values should reflect in organisational or units' mission statement stating their social, professional or scientific (technological) values in striving towards quality of health care. The researcher is also of the view that the mission statement reflects on the quality of health care of an institution.

Step 2: Setting of Standards: Structure, Process and product (outcome)

Parsley and Corrigan (1995) define standard statement as the statement which influence the setting of the standard. Such a statement should be a clear statement of intent and should have a clearly defined group or resources whom the standard is aimed at. Standards could be set for the following dimensions: structure, process and outcome.

Structural standards are standards which concern the composition of the resources in a health service, which make the provision of a service possible. Such structural standards include among others, hospital equipment, supplies needed and a safe environment (Booyens, 1993)

Process standards refer to the way in which tasks should be executed, that is aspects focusing on the actual way the practice is conducted (Booyens, 1993). In this study standards are set on the following aspects: client management, execution of procedures and accurate recording. The above aspects will be evaluated using the set process standards.

Product standards refer to the results that have to be achieved which are the desired health changes of the client (Booyens, 1993). In this study the views of the clients regarding the effectiveness, efficiency and accessibility of the health care were evaluated using the set outcome standards.

Step 3: Validation of standards

Standards need to meet certain criteria, namely measurable, achievable, specific, relevance and theoretically sound. The set standards must be validated according the above mentioned criteria (Parsley and Corrigan, 1995).

Parsley and Corrigan (1995) further propose that standards need to meet the following requirements:

- Clinical criteria should be based on current research.
- They should reflect the professional code of conduct, as defined by professional bodies.
- They should incorporate legal and statutory requirements.
- They should be ethical.

Step4: Consideration of alternative for improvement

This step is done after re-monitoring the original indicator or after evaluation of the effectiveness of the action plan. The manager decides which is the best solution to solve the problem and which problem must be solved first, then select the most appropriate alternative for improving the nursing care (Katz and Green, 1992).

Step 5: Improving nursing practice

This step is done when the desired results have not been met. Certain problems may have been encountered during the implementation of the strategies to improve the nursing practice. Adjustment of the plan is necessary to meet the desired outcome. Re-evaluation should be done until the exact problem is

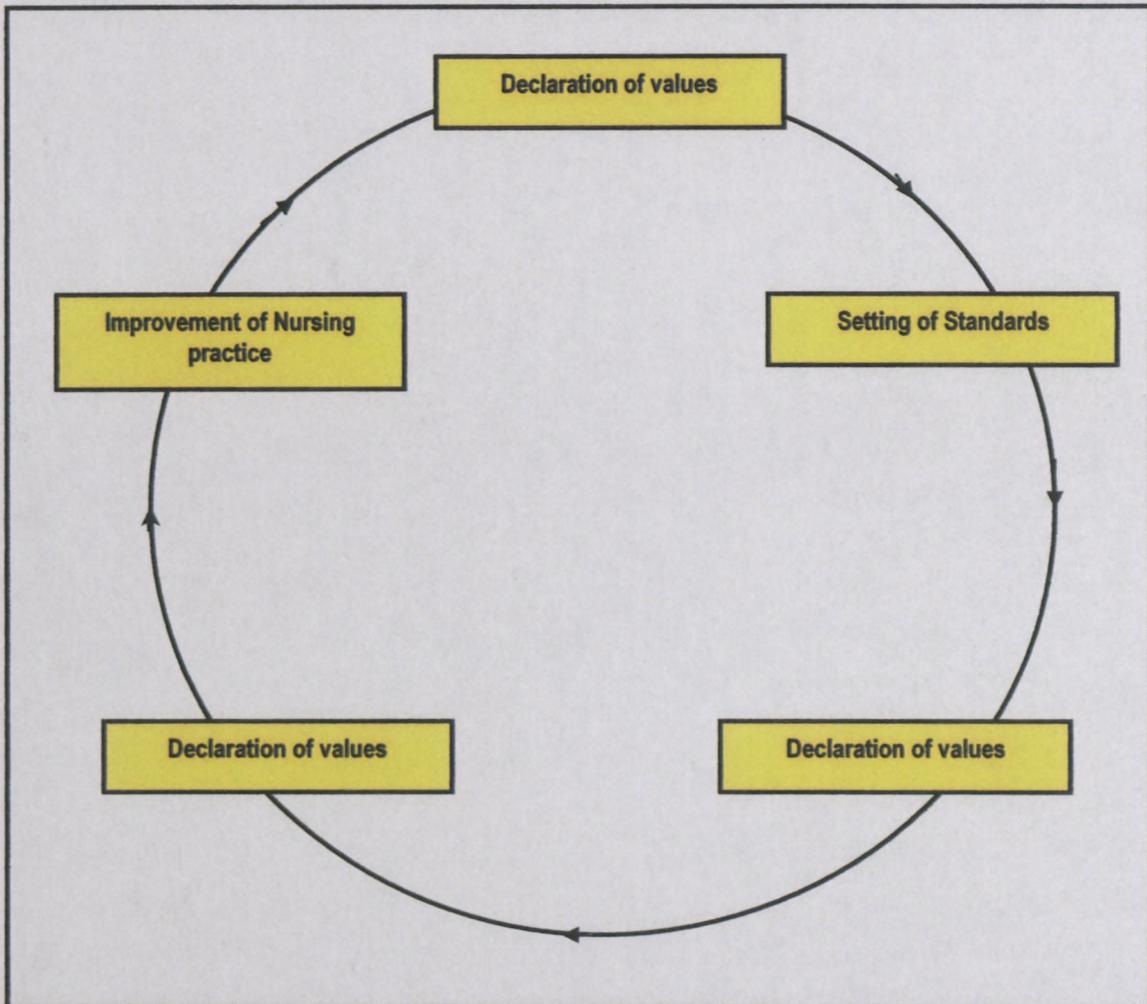
identified and corrected (Katz and Green, 1992).

The researcher is fully in support of this model, as depicted in Figure 1.2. The researcher strongly believes that the nursing department in the prison must declare its vision and mission statements aimed at rendering and improving the quality of health care. The structure standards are vital in achieving the goal of quality health care. These standards are personnel, human resources development programmes, equipment and supplies.



The structure, process and outcome standards must be identified, evaluated and monitored continuously to ensure quality prisoner care. The standards developed by the researcher were set in such a way to adhere to the measurements set by Pasley and Corrigan (1995).

FIGURE 2.6
NORMA LANG MODEL



(Booyens, 1993)

The structure, process and outcome standards must be formulated, evaluated and monitored continuously in ensuring quality prisoner care. The standards developed by the researcher were set in such a way to adhere to the measurements set by Pasley and Corrigan (1995).

2.4.2.4 Bruwer's Quality Assurance Model

Bruwer's quality assurance approach consists mainly of two processes, namely the Quality Assurance Development model and Quality Assurance Process model. The former process consists of the following steps (See Figure 2.7):

- Developmental phase which includes training in quality assurance
- Situational analysis of nursing practice
- Setting strategies for programme implementation
- Formulation of policies and
- Formalisation of quality assurance.

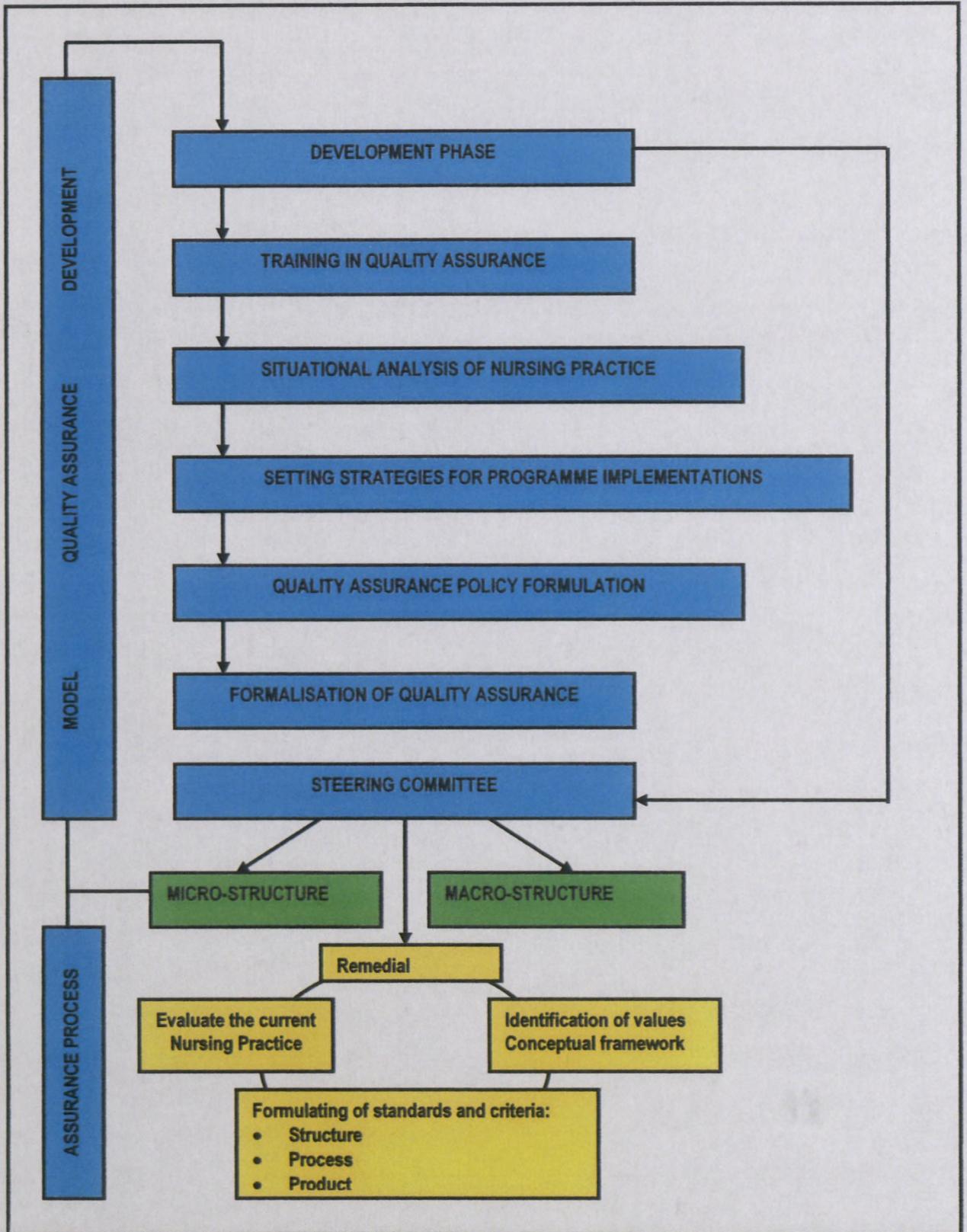
The latter process consists of evaluation of the current nursing practice, identification of values conceptual framework and formulation of standards and criteria, namely structure, process and product.

Bruwer integrates the Norma Lang quality assurance model with the health service's organisational structure, values of the institution and the nursing department regarding patient care.

In this approach standards are formulated, the quality of care is assessed and the necessary remedial steps for quality improvement are taken (Booyens, 1993)

In the second process of Bruwer's quality assurance model, quality assurance process is applied by the researcher. The researcher demonstrates with this model that the values need to be identified in vision and mission statements of the nursing department. Furthermore, the researcher believes in the formulation of standards, process and product standards and criteria which need to be evaluated and recommendations made for remedial actions.

FIGURE 2.7
BRUWER'S QUALITY ASSURANCE MODEL



2.4.2.5 Donabedian's Model

Donabedian's framework of setting standards has been widely adopted by the nursing profession since 1969. According to Donabedian's framework the first part of setting standards is to define the standard statement. Standard statement and criteria statement must provide the detailed information on how the standard statement is to be achieved. Such statements and criteria need to fulfil the following:

- Be specific, meaning need to be clear, understandable and unambiguous.
- Be measurable, that is be objective and with an outcome aim.
- Be achievable
- Be relevant and theoretically sound.

(Parsley and Corrigan, 1995)

Donabedian refers to three different types of criteria to meet the standards namely structural, process and outcome criteria. All of the quality improvement models discussed integrated the three dimensions or domains of nursing practice namely: structure-, process- and outcome domain. Standards should be set for all the domains. The researcher focused on these three domains and set standards for structure and process domain. The outcome was evaluated by means of a questionnaire and interviewed with prisoners.

2.4.2.6 Structure Standards

Modern management theories and styles led to the development of guidelines to organise, standardise and coordinate the practice of the employee. These guidelines are formulated as standards that have to be realistic, achievable and reflecting a minimum level of safe and risk-free practice.

Muller (1996) and Booyens (1993) describe the structure as the rules of the

system and its governance including the mission statement, philosophy and objectives as well as policies. The mission statement addresses the overall business of the nursing division and is in harmony with the mission statement of the institution. The philosophy statement delineates the values and beliefs. The structure further provides what is needed to render care to clients, namely human resources, equipment and supplies.

The above-mentioned structures enhance the rendering of quality of health care to prisoners. The aspects below regarding the structure dimension were taken into account when the researcher formulated and evaluated the standards:

(a) Organisation

General leadership and planning are tasks emanating from the strategic management process. They involve formulation and implementation phases. The formulation phase involves planning and the implementation phase involves organising, leading and control (Rosssouw, 2003). These phases can be realised by adopting the following headings:

(b) Vision Statement

A vision is important, especially in the modern management models and strategic management. A vision is an image of the future position, status and success of an organisation. The realisation of a vision is facilitated if everyone in the organisation idealises the same picture of the future (Pearce and Robinson, 2000; Bruyns *et al.*, 2000)

The formulation of a vision is based on the following principles:

- future orientation

- business values
- role of the organisation in the future world
- factors making an organisation to exist in future environment.

(Bruyns *et al.*, 2000)

Research shows that an organisation without a vision is prone to fail in all its activities.

(c) Mission Statement

A mission statement is regarded as the purpose or reason for the existence of an organisation. It is the fundamental purpose that sets an organisation apart from other organisations of its type and identifies the scope of its operations (Pearce and Robinson, 2000).

An organisational mission statement is designed to accomplish seven outcomes:

- to ensure unanimity of purpose within an organisation
- to provide a basis for motivating the use of the organisation's resources
- to develop a basis or standard for allocating organisational resources
- to establish a general tone or organisational climate, for example to suggest business like operations
- to serve as a focal point for those who can identify with the organisation's purpose and direction
- to facilitate the translation of objectives and goals into a work structure involving the assignment of tasks to responsible elements with the organisation
- to specify an organisational purpose and the translation of these purposes into goals in such a way that cost, time and performance parameters can be assessed and controlled.

(Pearce and Robinson, 2000)

The mission statement was evaluated and had to reflect:

- a target market and clients
- a primary product or service
- the geographical domain
- an organisational philosophy.

It is of an utmost importance for an organisation to have a mission statement because it helps to keep all relevant role players focused on the organisational objectives.

(d) Philosophy

Philosophy or an organisational creed is the statement which reflects or specifies the basic beliefs, values, aspirations and philosophical priorities to which strategic decision makers are committed in managing an organisation (Pearce and Robinson, 2000).

It is generally a pervasive code of behaviour that governs business actions and permits managers and employees to be self-regulated. Philosophy is either formulated separately or in the mission statement. The definition of vision and mission statements allows nursing to be managed for performance. It describes what nursing will be, what it should be and the constituencies to be satisfied (Swansburg, 1990).

(e) Annual operational plans

Annual operational plans are essential for quality health care delivery. Clearly defined objectives form the basis of any operational plan. Objectives are statements which provide specific benchmarks for evaluating the organisation's

progress in achieving its aims. They are statements of the results an organisation seeks to achieve over a specified period (Pearce and Robinson, 2000).

Objectives need to be:

- **Acceptable:** Managers need to pursue objectives that are consistent with their preferences. They need to be acceptable to groups internally and externally of the organisation.
- **Flexible:** Objectives should be adaptable to unforeseen or extraordinary changes in the organisation's competitive forecasts.
- **Measurable:** Objectives must clearly and concretely state what will be achieved and when it will be achieved, thus they should be measurable over time.
- **Achievable:** Objectives must be possible to achieve.

(Pearce and Robinson, 2000)

Organisations which have specific, measurable, achievable, realistic and acceptable objectives are deemed to succeed in the business world. Objectives help an organisation to evaluate progress made against the set objectives:

- Frequency of the services of the clinic
- Responsibility (who is responsible for certain service/tasks)
- Frequency of tasks/service
- Service delivery milestone (target date)
- Service delivery indicator.

(f) Policies

Policies are directives designed to guide the thinking, decisions and actions of managers and their subordinates. Policies can also be referred to as standard operating procedures. Policies increase managerial effectiveness by

standardising many routines decisions and clarifying the discretion of the manager and subordinates may take or exercise.

Advantages of policies are to:

- establish indirect control over independent action by clearly stating how things are to be taken
- promote uniform handling of similar activities
- ensure quicker decisions by standardising answers to previously answered questions
- institutionalise basic aspects of organisational behaviour
- reduce uncertainty in repetitive decision making
- counteract resistance to or rejection of chosen strategies
- offer pre-determined answers to routine problems
- afford managers a mechanism for avoiding hasty and ill-conceived decisions in changing operations.

(Pearce and Robinson, 2000)

An infection control policy should be available, and will be evaluated whether it reflects the following aspects:

- use of barrier precautions like gloves
- hand washing procedure
- availability of resuscitation and ventilation equipments for mouth-to-mouth resuscitation
- prevention of staff having exudates lesions from patient care
- handling of sharps
- immediate cleaning of blood spillage
- handling and treatment of all patients as bio-hazardous
- immediate reporting of sharp injuries
- proper management and proper disposal of sharps and soft waste.

A policy on post HIV-exposure actions should be available. Evaluation is based

on the following:

- Ensure that immediate actions are taken post–exposure.
- Ensure that potential exposures are considered for post-exposure prophylaxis (e.g. needle stick injury, exposure to mucous membrane).
- Ensure that the HIV status of the exposure source has been determined.
- Ensure that follow-up blood samples are taken from victim and source (3 months, 6 months).

Policies empower people to act. They further help in overcoming resistance to change and foster commitment to successful implementation of an organisational objectives.

In summary: Operational plans are written blueprints for achieving objectives, they specify the activities and procedures that will be used to achieve them and set timetables for their achievements (Swansburg, 1990).

(g) Protocols

Protocols are directives designed to guide the clinical nurse in executing his or her daily tasks. Protocols can also be referred to as standard operating procedures.

There are several advantages of a protocol, namely that it:

- ensures an effective and efficient service to the client without having to wait long or receive ineffective service. It ensures pre-determined and well researched care;
- ensures quicker decision by a nurse in executing service to the client; and
- ensures that quality service is rendered by the organisation without delay and using the most economic and effective procedure.

Protocols will be evaluated on the availability and the usage on the situations or conditions which warrant them, for example:

- management of blood pressure;
- management of sexually transmitted infections.

Availability of protocols in the unit ensures that quality health care is rendered and is efficient and effective. The nurse as the health provider renders care in relation to approved or standardised procedures. Protocols are used in the management of human resources, client care and non-human resources.

(h) Equipments and supplies

Equipment and supplies are resources needed in executing quality, and safe health care. The availability, correct quantity and well functioning equipment are necessary to render quality health care, and in order to diagnose correctly. It is essential in planning and implementing appropriate nursing interventions and for the recording thereof. This should be included in the evaluation instruments when evaluating the standard of care rendered and includes the following:

- emergency measures of a unit
- availability, functioning and adequacy of the of equipment in the consulting room, procedure room, dirty store and linen room
- availability and adequacy of medication and supplies
- availability and adequacy of instruments
- stock: security, inventory (cards, recording) and organisation.

(i) Human resources

Human resources management refers to activities, policies, beliefs and the general function that relates to employees or the personnel department (Gerber

et al., 1987).

Human resources activities include the following:

- Human resources provisioning
- Human resources administration and utilisation
- Human resources development.

(Gerber *et al.*, 1987).

(j) Provision of human resources

Provision of human resources is the activity of human resources management which encompasses human resource planning. Human resource planning is the determining of various tasks and jobs at all levels of the organisation. A job description, induction and orientation programmes are essential elements for effective human resources planning and the rendering of an effective and high quality service.

(k) Staff Establishment/Organogram for the Clinic

Organogram/organisational structure can be described as a formal system of working relationship that both separates and integrates tasks. Separation of tasks makes clear who should do what and integration of tasks indicates how efforts should interact and interrelate (Niemann and Bennet, 2002). Certo (1997) describes the purpose of organisational structure as to facilitate the use of each resource individually and collectively as the management system attempts to attain its objectives.

Such organogram need to be displayed for all to see it, and shortages and excess of staff need to be registered.

(I) Job description

A job description is the written document in which is spelled out what the incumbent does, how he or she does it and under what circumstances the task is carried out (Gerber *et al.*, 1987).

Important aspects concerning a job description are:

- Does each staff member have a job description?
- If yes, does a job description have or reflect the certain requirements of the job?
- Does it relate to the vision statement of the clinic?
- Does it relate to the mission statement of the clinic?
- Does it reflect management and supervisory responsibilities?
- Does it contain the objectives of the unit reflected?
- Does it reflect:
 - ⇒ Key customers/clients and/stakeholders inside and outside the organisation for each objective
 - ⇒ Tasks/duties that need to be performed
 - ⇒ Powers and authority
 - ⇒ Standards stipulating how the job should be done
 - ⇒ Output (indicator) measuring the performance in relation to standards
 - ⇒ Frequency of tasks to be performed (daily/weekly)
- Does it reflect inherent requirements of the job, for example:
 - ⇒ job knowledge and skills description
 - ⇒ technical skills e.g. mathematical skills
 - ⇒ communication and interpersonal skills
 - ⇒ description of personal attributes (attitude/understanding/behaviour, reasoning ability)

- ⇒ learning requirements (training/qualifications, e.g. diploma/Bachelor's degree in Nursing)
- ⇒ work environment: dangers of the job
- ⇒ physical demands of the job e.g. long hours of standing
- Does it reflect the essential duties and responsibilities?
 - ⇒ performs a systematic assessment of a client, focusing on physiologic, psychological and cognitive status of the client
 - ⇒ develops a goal-directed plan of care
 - ⇒ involves client and other health care and multidisciplinary team members in nursing process
 - ⇒ implements care by utilising and adhering to established standards
 - ⇒ evaluates effectiveness of care in progressing towards desired outcomes
 - ⇒ demonstrates competency in knowledge base, skills and psychomotor skills
 - ⇒ demonstrates applied knowledge base in structure standards, standards of care, protocols and patient care resources
 - ⇒ demonstrates knowledge of the patient's bill of rights
 - ⇒ organises and coordinates delivery of patient care in an efficient and cost effective manner
 - ⇒ documents the nursing process in a timely, accurate and complete manner
 - ⇒ demonstrates self-directed learning and participation in continuing education to meet own professional development
 - ⇒ establishes and maintains direct, honest and open professional
 - ⇒ establishes relationships with all health care team members, patients and significant others
 - ⇒ supports research and its implications for practice
 - ⇒ adheres to unit and human resources policies
 - ⇒ incorporates into practice an awareness of legal and risk

management issues and their implications.

A job description is therefore an important document which specifies the scope of functions like powers of authority, duties and responsibilities.

(m) Induction

Induction is defined by Hall and Goodale (1986) as the process through which a new employee learns how to function efficiently within a new organisational culture by obtaining the information, values and behavioural skills associated with his or her new role in the organisation.

The objectives of induction are:

- To make a new employee more rapidly productive
- To reduce fears and insecurity
- To reduce labour turnover
- To help create realistic employee expectations
- To create job satisfaction and a positive attitude towards the employer
- To save time of supervisors and colleagues (Gerber *et al.*, 1987)

An induction programme is thus needed to reach the above-mentioned objectives and should include the following aspects:

- functions of the department or section: objectives, organogram, activities of the section
 - tasks and responsibilities: tasks based on job description, performance standards.
 - policy, procedures, rules and regulations: rules unique to the task, safety requirements and accident prevention
 - viewing of the work place
- introduction to employees. (Gerber *et al.*, 1987).

(n) Orientation

Orientation is the personalised training of the individual employee to become acquainted with the requirements of the job itself (Booyens, 1993).

The main aim of orientation is to achieve effective and productive work performance by the new employee as soon as possible.

Aspects to be included in the orientation programme are:

- ⇒ Vision statement of the clinic
- ⇒ Mission statement of the clinic
- ⇒ Operational plan of the clinic
- ⇒ How the clinic is managed
- ⇒ Roles of the colleagues
- ⇒ Role of the supervisor
- ⇒ Responsibilities of the colleagues
- ⇒ Responsibilities of the supervisor
- ⇒ Where supplies are kept
- ⇒ How to access the stock
- ⇒ How to restock
- ⇒ How the transport system works
- ⇒ How the communication works
- ⇒ How to arrange for leave
- ⇒ How to arrange for sick leave

Research shows that induction and orientation are important programmes to make a new employee effective within a short space of time and to prevent accidents or mistakes which may occur to someone who was not orientated.

2.4.2.7 Administration and utilisation of human resources

Gerber *et al.* (1987) state that human resources administration and utilisation is that function of human resources management which looks after the well-being of the personnel. Apart from the components that are managed by the Human Resources Department, the following are also critical and falls on the level of the nursing division for e.g. health and safety (environment and administration of unit).

The human resources department is the cornerstone of any organisation. The institution should be adequately staffed and the staff need to be developed in order to render a quality service. This will all create an environmental/climate of positive management-employee relationships where employees feel valued for their efforts. This will in return facilitate productivity and motivation to render a quality health service (Swansburg, 1990).

(a) Health and safety (Environment)

Health is defined as the physical, mental and social wellbeing of the individual. It is the duty of management to see to the physical wellbeing of employees as well as to their psychological well-being. In order to fulfil this role, management must adhere to the Occupational Health and Safety Act, Act 85 of 1993, which makes provision for the health and safety of people at work.

According to this act the following needs to observed:

- Appointment of health and safety representatives
- Appointment of safety committees

- Conducting inspection at the workplace
- Convening meetings based on the inspection report
- Preventing accidents or exposing employees to illness (Occupational Health and Safety Act, 1993).

Management of sharps and waste is a way of ensuring a healthy and safe environment for employees. Such control measures will be evaluated in structure standards using the following headings with applicable criteria:

(b) Management of sharp equipment and supplies

The management of sharp equipment and supplies is one of the policies which prevents and control infections in a health care facility. In order to fulfil this role it needs to specify the following:

- Ensure that the container is properly assembled before use.
- The container should be kept in an easily accessible place on work table.
- There should be at least one container for each work area.
- When moving the container lid is closed without sealing it.
- Once used the needle and syringes are immediately placed in the container.
- When the container is three-quarters full it is sealed and placed in a safe storage area until collected.

(c) Management of soft waste policy

Management of soft waste policy is one of the policies which prevent and control infections in a health care facility. In order to fulfil this role, the following must be specified:

- that the medical soft waste is properly assembled and lined with a red plastic bag;
- that all work stations have available plastic packets for disposal of used swabs;
- that boxes are kept in safe and accessible places according to clinic needs, e.g. dressing room/sluite;
- that when the container is full, it is kept in a safe storage area until collected; and
- that the clinic has an adequate stock of empty medical soft waste boxes to replace those used.

(d) Post-HIV exposure prophylaxis (PEP) policy for employees and prisoners

A post-HIV exposure prophylaxis policy has to be in place in the prison because it is vital in ensuring the safety of employees and prisoners. It gives direction, when an employee and/or prisoner is exposed to HIV, on how to manage the situation. This policy was evaluated using the following criteria:

- Conduct immediate appropriate actions post exposure.
- Include potential exposures to be considered for PEP (e. g. needle stick injury, exposure to mucous membrane).
- Determine the HIV status of the exposure source.
- Make recommendations for PEP (starter pack of Zidovudine combination).
- Do a follow-up of HIV status from victim and source (3 months, 6 months).

(e) Unit Administration

The following components of unit administration were identified by the researcher as criteria in the health services of the correctional services and need to be evaluated.

(f) Staff qualifications

Swansburg (1990) defines staff development as a management programme to aid staff in developing skills and knowledge which add to their professional goals and also increase their value as employee. In the primary health care setting primary health care is the skill needed by the employer and employee to render quality patient care. The researcher, during his years of experience, determined that it is crucial that at least 75,0% of a staff should hold the specialist qualification applicable to the service area. The evaluation was done using the criteria that 75% of professional nurses hold the primary health care registration in the primary health care setting.

(g) Delegation/task allocation

Delegation means to make use of strengths and abilities of the staff giving them the necessary support and power to make decisions and complete the assigned task (Swansburg, 1990). Steinmetz (1976) defines delegation as the act of parcelling out selected work that may be in the supervisory or upper-management domain, to be done by a staff member who is given full responsibility to carry out the assignment.

The primary health care settings were evaluated on the following criteria:

- the presence/evidence of written allocation of tasks to staff

- existence of a register/diary for tasks.

(h) Staffing

Swansburg (1990) defines nursing staffing methodology as an orderly, systematic process, based upon sound rationale, applied to determine the number and kind of nursing personnel required to provide care of a predetermined standard to a group of patients in a particular setting. Generally speaking, the Department of Correctional Services' norm of staffing is 1 nurse to 240 prisoners. The researcher used this norm as a basis but formulated his own staffing norm based on a literature study and experience as a nurse in the services. This formulated norm was used in the evaluation of the services:

- **For Daily Average Prisoner Population of 500:** 2 professional nurses
- **For Daily Average Prisoner Population of 1 000:** 4 nurses consisting of 3 professional nurses and 1 enrolled or enrolled nursing auxiliary
- **For Daily Average Prisoner Population of 1 100-1 300:** 5 nurses consisting of 4 professional nurses and 1 enrolled or enrolled nursing auxiliary
- **For Daily Average Prisoner Population of 1 400-1 500:** 6 nurses consisting of 5 professional nurses and 1 enrolled or enrolled nursing auxiliary.

(i) Financial management

Financial management is quite a new skill that a nursing manager needs to possess in order to manage the unit on business principles. Drawing up an effective nursing services budget is essential and the knowledge of the different kinds of budgets and monitoring such a budget is essential to promote cost-effectiveness in nursing management (Booyens, 1993; Swansburg, 1990).

Financial management will be evaluated using the following principles:

- Is the clinic budget known for the year?
- If yes, are the following yearly estimates calculated:
 - ⇒ Transport
 - ⇒ Drugs/medication
 - ⇒ Hospitalisation
 - ⇒ Outpatient/specialist
 - ⇒ Personnel costs
 - ⇒ Cleaning materials
 - ⇒ Stationery.
- Monthly recording of expenditure
- If yes does it reflect expenditure of each category:
 - ⇒ Transport
 - ⇒ Drugs/medication
 - ⇒ Hospitalisation costs
 - ⇒ Outpatient/specialist
 - ⇒ Personnel costs
 - ⇒ Cleaning materials
 - ⇒ Stationery
 - ⇒ Telephone.

Financial resources are essential to the well-being of an organisation and the ability to provide quality service. Nurse managers are expected to have effective budgeting skills in order to manage a budget related to human and non-human resources (Swansburg, 1990).

(j) Communication

Communication is a human process involving interpersonal relationships and

therein lies the problem (Swansburg, 1990). Successful communication involves the sender, a receiver and the medium; and reception of the message sent and successful managers to achieve successful communication (Corbett, 1986; Morgan and Barker, 1979).

There are different means of communication, for example meetings, oral communications, written communication, written reports, interviews and organisational publications.

In this study research meetings, written communication and availability of infrastructure for oral communication were evaluated using the following criteria:

(k) Monthly clinic staff meetings

Monthly staff meetings were evaluated on the following criteria, amongst others:

- leave for staff
- training issues
- the roster (staff)
- finances
- drugs and supplies
- feedback of meetings with Regional Health coordinator
- transport.

(l) On call roster

The on call roster was evaluated on the following criteria:

- availability of on call roster
- a daily roster for professional nurse on call (after hours)
- enrolled nurses on call (after hours)

- enrolled nursing auxiliaries on call (after hours)
- evidence that the enrolled nurse on call does not carry scheduled drug cupboard keys
- evidence that enrolled nursing auxiliary does not carry scheduled drug cupboard keys
- evidence that there is a standby professional nurse available to assist an enrolled nurse or enrolled nursing auxiliary on call
- evidence that the contact numbers of the person on call are reflected on on-call roster.

(m) Infrastructure available for oral communication

Are the following criteria numbers accessible:

- ambulance
- medical doctor
- referral hospital
- police.

(n) Health Prisoner Community Committee

Committees are formal groups that can make useful contributions to the organising process of nursing and organisational administration. These committees encourage and involve participation of interested or affected employees or patients in the management of health care. They can promote understanding of objectives and programmes for the patients/clients. They provide face-to-face meetings of individuals for purposes of gathering information, seeking advice, decision making, negotiation, coordination and creative thinking to resolve operational problems and improve the quality of services rendered.

(a) **Prisoner/Community Involvement**

The following was evaluated in this study. Evidence of existence of clinic committee/community health committee involved the following:

- If yes, does it include the attendance register of staff members to these meetings?
- Are clinic issues discussed, e.g. disease patterns and defaulters?
- Evidence of formal minutes of such committee meetings.

(o) **Prisoner/Community Involvement**

Community involvement in health issues, allows the community to become part of the health system and develop ownership of health. In this study the community in question entails the prisoners themselves. The researcher evaluated the primary health care settings on the following:

- Evidence of community involvement
- Evidence of prisoner community assistance with:
 - peer-to-peer HIV/AIDS education
 - referral of prevention care clients e. g. tuberculosis patients.

2.4.2.8 Human resources development

Human resources development is that part of human resources management where employees are offered opportunities to develop professionally and personally. Such an exercise is beneficial to the employee, employer and the client by rendering quality service. This can be done through in-service or continuous education (Gerber *et al.*, 1987). Swansburg (1990) defines staff development as a comprehensive programme which includes orientation, in-service education, continuing education programmes and job related counselling.

(a) In-service Education

In-service education is the education of an employee while she or he is doing her or his job or rendering a service to clients in an organisation. It implies updating, training, educating and informing the person about present requirements of the job (Booyens, 1993).

According to Mellish and Lock (1992) in-service education is that form of education which:

- is given to people while they are employed;
- is planned deliberately;
- is designed to fill gaps in learning or to remedy deficiencies in the skills and the knowledge of employees;
- aims at more efficient functioning of the employee;
- aims at making the organisation function better;
- follows on the period of pre-service education; and
- is only part of continuing education.

For in-service education to achieve its aims, a proper training needs analysis must be done. Such an analysis can be done in a structured manner, for example instituting a training committee, critical incident analysis, performance appraisal, survey or questionnaires. From this acquired information the in-service training which is needs-orientated and aims at improving the quality of service (Meyer, 2002), will be designed.

An in-service training programme should be available and it will be evaluated using the following criteria of structured standards:

- Does the supervisor do a training analysis of the staff?
- Does the supervisor do a critical incident analysis?
- Does the supervisor serve in the in-service training committee?

(b) Continued education

Di'Vincenti (1977) sees continuing education as that phase of the staff development programme aimed at assisting the employees to keep up to date with current health trends, increasing their knowledge and competence. It also aims at developing her/his ability to analyse complex health care problems and to maintain sound interpersonal relationships. The continued education needs to be documented, and the researcher will evaluate whether the following aspects are documented:

- workshop attendance of personnel
- training sessions attendance of personnel
- recording of job-related (functional) meetings attendance.

The researcher has identified critical elements of structure standards and evaluated the service accordingly.

2.4.2.9 Process standards

The process standards according to Booyens (1993) refer to the way which a task should be executed. Nursing interventions as process standards are aimed at improving the health care status of the client.

The process standards in this research are based on the nursing interventions when rendering health care to clients in prisons and the relevant documentation thereof.

The following processes (interventions or actions) were identified by experts after consultations, as critical to be evaluated. Process standards with criteria or indicators were set accordingly:

Management of client with the following conditions:

- Hypertension
- Urinary tract infection
- Diabetes Mellitus
- Tinea Pedis (Athlete's foot)
- Otitis Media
- Abscess
- Pulmonary Tuberculosis
- Herpes Type 1 Viral infection
- Acne Vulgaris
- Injuries, sprains and strains
- Common cold/sinusitis
- Cardiac arrest and cardio-pulmonary resuscitation (simulation).

The initial screening of the client with a problem/disorder will be evaluated by the researcher. This process is vital for the nurse in order to obtain the information needed to make an accurate diagnosis and plan appropriate interventions. The researcher will evaluate the nurse who is screening clients who complain of the following disorders:

- cardiovascular disorders
- respiratory disorders
- gastro-intestinal disorders
- integumentary disorders
- musculoskeletal disorders
- eye disorders
- ear disorders
- genito-urinary disorders

After completing the assessment, the nurse is expected to accurately record the data obtained. Nursing documentation has the following purposes:

- to define the nursing focus for the client or group
- to differentiate the accountability of the nurse from that of other members of the health team
- to provide the criteria for reviewing and evaluating care (quality improvement)
- to provide the criteria for patient classification
- to comply with legal, accreditation and professional standard requirements
- to provide data for administrative and legal review.

Efficient, accurate professional nursing documentation presents the nurse with an optimum defence in the event of litigation proceedings and legal challenges.

The researcher also evaluated the execution of certain procedures by nurses.

The evaluation was done on:

- the determination of the need to carry out the procedure
- adherence to the principles underlying execution of the procedure.

The following procedures were evaluated:

- intramuscularly injections
- wound dressing
- collecting of blood specimen
- instilling ear medication
- collecting and testing a urine specimen
- instilling eye medication
- collecting a sputum specimen
- measuring blood pressure of an adult.

The management of the above-mentioned conditions was evaluated using the

following headings:

- **Assessment:** collecting adequate subjective and objective data and utilising the nursing pathway of branching logic;
- **Nursing diagnosis:** arriving at the most accurate and precise nursing diagnosis according to data obtained;
- **Management of client:** planning of the nursing management of the client that will effectively treat the defined problem, and execution of the medical officer's prescriptions and appropriate health education;
- **Evaluation:** using nursing criteria appropriate to the diagnosis to evaluate the patient's response to the nursing management;
- **Referral:** based on the evaluation - if there is no improvement in the client's condition then he/she needs to be referred;
- **Recording:** recording is vital to prove that the following was executed: assessment of nursing diagnosis, implementation of plan, evaluation and referral. Records are also used when queries are raised and there is a need to go back to the record and answer these.

Effective health care requires a judicious balance of preventative and curative services. A crucial element in preventative care is the health education of the client. The crucial elements in curative care include, among others, the adequacy of personnel, in other words a positive nurse:client ratio, good knowledge base and skilful and competent personnel and an adequate supply of equipments or supplies. The availability of the above elements will ensure:

- a safe, efficient and high-quality health care
- the availability and accessibility of health care to prisoners
- promotion of the concept of the individual's responsibility for health, preventative care and curative care.

Accurate record keeping is important because it serves as evidence that something was done. It also records when, how and by whom it was done. Mellish and Lock (1992) support the statement that from a legal point of view it is

impossible to accept that something had been done or had not been done unless supported by accurate record keeping.

It is the duty of all professional nurses to ensure that patient care is documented responsibly and accurately. Failing to do so, the nurse may be charged with wilful or negligent failure to keep a clear and accurate record of actions or procedures performed in connection with a patient (Verschoor *et al.*, 1996).

Accurate recording is also a critical process. It was evaluated using the following criteria:

- subjective data about the patient
- objective data about the patient
- making and recording of nursing diagnosis
- therapeutic management by the nurse
- health education by the nurse
- follow-up evaluation by the nurse
- referral entry by the nurse where applicable
- proper identification of records by name and folder number
- accurate recording of date and time of execution of care and follow-up care
- legible handwriting
- nurse's name and rank appear on the records as the executor
- changes ruled out with single line and signed.

The under-mentioned procedures were evaluated using the following phases:

- Assessment phase
- Preparation phase
- Execution phase
- Recording phase.
- Follow-up evaluation phase.

The assessment phase is the stage when a nurse obtains subjective as well as objective data necessary for planning and preparing the execution of the procedure. The researcher believes that if no proper assessment was done the nurse will not be able to prepare and plan relevant care.

The preparation phase is the stage when a nurse prepares equipment and supplies in order to execute the procedure. If there are no relevant and adequate equipment and supplies a nurse might as well not execute the procedure. Lack of the above-mentioned equipment results in not following the principles involved in executing the procedure.

The execution phase is the actual execution of the procedure adhering to certain principles pertaining to the procedure. In this study such principles fall under wound management and prevention of infection and aimed at competency.

The follow-up evaluation phase is the evaluation done by the nurse after rendering care to evaluate the effect of care administered to the client.

The importance of the nursing process and nursing care plans lies in the following:

- Prioritising the problems of the patient
- Providing a blueprint for direct charting
- Communication to nursing staff on what to teach, what to observe and what to implement
- Providing outcome criteria for reviewing and evaluating care
- Directing specific interventions for the client, family and other nursing staff members to implement.

Such interventions include the following:

- Using protective wear, for example mask gloves and clothing
- Hand washing, soap/surgical scrub, hand washing and alcohol

2.4.2.10 Wound management

Wound management is an activity that is aimed at protecting the wound from trauma and bacterial contamination, promoting healing and preventing the transfer of organisms from one patient to the next (Aylife *et al.*, 2000).

Attaining such aims requires multi-disciplinary approach comprising of a microbiologist, head nurse, infection control nurse and pharmacist (Castle *et al.*, 1987).

Observing a nurse doing dressing of a wound represents the evaluation of wound management.

2.4.2.11 Prevention of infection

Prevention of infection in a client is important. Substantial costs are incurred through institution-acquired infection (Chaudhuri, 1993). Infections in institutions is spread mainly via the hands. The simple washing of the hands still remains the most effective way of preventing the spread of infection (Quraishi *et al.*, 1994). Wearing gloves also contributes to the prevention of cross-infection, but is as vital to prevent contact with blood and secretions (Oakley, 1994).

The availability of universal precautions for infection control in the clinic helps to control infections. The researcher will evaluate the availability of such precautions in the clinic in the structure standards.

Such universal precautions must include the following:

- Using protective wear, for example latex gloves, masks, eye protection and clothing
- Hand washing: social/surgical clean hand washing and surgical scrubbing

- Proper management of specimens and fluid-stained equipment
- Proper management of medical waste, needles, syringes and sharps
- Adherence to aseptic technique when executing invasive procedures like intravenous therapy, urinary catheter insertion and wound drainage
- Proper management of soiled linen to prevent cross-infection to patients and staff (Department of Health, 1997).

The critical applicable infection control precautions in the clinic evaluated were:

- Washing of hands before and after patient care
- Strict aseptic techniques when doing the following:
 - (a) dressing surgical wounds
 - (b) administering an intramuscular injection
 - (c) collecting blood specimens
 - (d) collecting sputum specimens
 - (e) collecting and testing urine specimens
 - (f) instilling eye and ear medication.

In delivering a high quality of care it remains important to collect the relevant equipment for executing the specific procedure and then to do the procedure/intervention in a skilful, competent manner based on sound knowledge of the relevant subject. Accurate recording of all the relevant information will complete the intervention. It is crucial to meet the professional and legal requirements of record keeping.

2.4.2.12 Outcome standards

Outcomes are the results of care, measurable changes in health status, or the behaviour of the client. Harries (1991), Adams and Wilson (1995) and Jones (1993) mentioned traditional measures and alternative measures of outcome respectively. The former measure is an outcome based on mortality, morbidity,

unscheduled readmission and unnecessary procedures. The latter measure of outcome relates to the clients' views and clients' satisfaction regarding the services rendered to them.

Blair (1995) stresses that satisfaction surveys are very important for the measurement of quality and that these surveys should be done at least annually.

Patient satisfaction is reflected in the outcome standards in this study. It is generally accepted that the patient's view or satisfaction regarding the care received could be used as an indicator to evaluate the outcome.

In this study the researcher introduced the prisoners. The questionnaire consisted of open- and closed-end questions and the questions were based on the following **Batho Pele principles/Patient's rights charter**, which are important to render quality health care:

- Health and safety: environment
- Access to health care
- Efficiency of health care
- Confidentiality
- Patient involvement/consultation
- Privacy
- Dignity and respect
- Referral system
- Standard of health care service received
- Informed consent

2.4.3 Summary of Quality Improvement Models

All the models integrate the three dimensions of nursing practice: structure, process and outcome dimension. A comprehensive approach to client care is thus ensured. To evaluate this comprehensive care requires the setting of

standards for all the above-mentioned domains.

The researcher focused on structure and process standards and the outcome was determined through a questionnaire to clients regarding their views of the care they had received. It was done in this way because of time, logistical and financial constraints.

2.5 CONCLUSION

This literature study gave an overview of the health care in South Africa and in particular in the Correctional Services department. It also gave an overview of the principles of quality care and allowed the researcher to study the existing quality care models in order to conduct the research. Standards were set for the research done.

3.2 RESEARCH APPROACH AND DESIGN

The research approach refers to a broad statement of what the researcher is doing and what is taking place. Two main types of research approaches, namely a qualitative and a quantitative approach, are described in the literature. The researcher used a combination of both. This combination is known as triangulation. A combination of qualitative and quantitative approaches, in other words triangulation, is also used in nursing research. Through the triangulation approach, nursing phenomena are studied from a broader perspective, raising the status of nursing as a science.

CHAPTER 3 RESEARCH METHODOLOGY

3.1 INTRODUCTION

An accurate and systematic description of the research methodology is necessary to ensure the scientific correctness of the research study.

The following is discussed in this chapter:

- Research approach and design
- Population and sampling
- Development of data gathering instruments and application thereof
- Execution of data analysis.

3.2 RESEARCH APPROACH AND DESIGN

The research approach refers to a broad framework in which the research is taking place. Two main types of research approaches, namely a qualitative and quantitative approach, are described in the literature (Burns and Grove, 1993). A need also originated in nursing research to use a combination of approaches. This combination is known as triangulation. A combination of qualitative and quantitative approaches, in other words triangulation, is also used in this research. Through the triangulation approach, nursing phenomena are placed in a broader perspective, raising the status of nursing as a science.

3.2.1 Quantitative Approach

Mouton and Marais (1990) described the quantitative approach in research as more highly formalised, as well as more explicitly controlled. A Quantitative research approach involves the following three concepts: rigour, control and sampling. Rigour is the striving for excellence in research through discipline, adherence to detail and strict accuracy. A rigorous quantitative researcher is striving for precise measurement tools, representative sampling and a controlled study group (Burns and Grove, 2001).

Control, as a concept applied in quantitative research, involves the setting of rules by the researcher to limit possible errors which might jeopardise the ideal of providing findings that give an accurate reflection of reality. The following mechanisms enhance control within the quantitative research approach:

- Subject selection (sampling), i.e. sampling as the process of selecting subjects who are representative of the population.
- Research setting selections which are natural, partially controlled and highly controlled.
- Development and implementation of study interventions to improve the validity of the study design and the credibility of the findings.
- The subjects' knowledge of the study could influence their behaviour and possibly alter the study outcomes, thus threatening the validity and accuracy of the study design (Burns and Grove, 2001).

A quantitative research approach is the traditional approach used in nursing. It includes the following approaches: descriptive, correlational, quasi-experimental and experimental, with a view to developing the knowledge of nursing. Structured observations (observations by means of a control/checklist) and questionnaires were used to describe the phenomena studied in this research.

3.2.2 Qualitative Approach

Mouton and Marais (1990) describe qualitative research approaches as those in which the procedures are not as strictly formalised; the scope is more likely to be undefined; and a more philosophical mode of operation is adopted.

Mouton and Marais (1990) further describe this approach by employing the following concepts:

- operational specificity, whereby meaning or words can be interpreted in a number of ways;
- the hypothesis is undeclared and often emerges from the development of the investigation;
- observation is subjective and spontaneous and occurs in a non-structured manner.

Qualitative research is a systematic, subjective approach used to describe life experiences and give them meaning. It also focuses on the whole, which is consistent with the holistic philosophy of nursing.

This type of research is usually done to describe experiences of pain, comfort and care, and to increase understanding and insight. This usually refers to data obtained from the consumer of the service by means of client questionnaires, as was done in this study.

3.2.3 Combination approach: Triangulation

A triangulation is used for the sake of this study. De Vos (1998) defines the concept of triangulation as the practice of designating a conscious combination of quantitative and qualitative methodologies. Mouton and Marais (1990) define

the term triangulation mainly as the use of multiple methods of data collection, with a view to increasing the reliability of observation.

The advantages of triangulation are:

- It is possible to use multiple data sources, whereby the researcher investigates a number of concrete situations in any specific setting to form an observational basis
- Multiple methods are used, employing any and all techniques that can better unravel the processes being examined
- It is possible to view a concept from multiple perspectives, whereby participants' accounts of their behaviour are compared with alternative theoretical schemes (Mouton and Marais, 1990).

There are different types of triangulation approaches, namely data and methodological triangulation. Methodological triangulation as defined by Burns and Grove (1997) involves the use of two or more research methods in a single study which is helpful in the examination of complex concepts in nursing, such as caring and the promotion of health. Data triangulation is an attempt to collect data by using multiple sources in order to test the theory in more than one way (Burns and Grove, 1997). Data triangulation is applied in evaluating the clinic/care centre structures and auditing of the records.

Burns and Grove (1997) define method triangulation as the form of research used when examining multidimensional phenomena. Methodological triangulation uses two or more methods in the same study to obtain data. In this study, subjective data from the client is obtained in addition to the above-mentioned objective data. The researcher is of the opinion that the combination of these methods will increase the validity of this study, strengthen the results, and contribute to the development of knowledge which can act as a guideline to similar studies in future.

3.3 RESEARCH DESIGN

The research design is the plan according to which the researcher obtained the research participants or subjects, and collected information from them (Welman and Kruger, 1999).

In this research project a non-experimental, descriptive design was used to obtain data by means of direct observation, interviews and the auditing of clients' records. The researcher explored and described clients' satisfaction as reflected in their opinions of the care they had received. The quality of care was evaluated by observing the process and interventions of nursing staff against the set standards whilst rendering health care to prisoners in a clinic setting.

3.4 POPULATION AND SAMPLING

A description of the population and sampling methods is essential for any research project. This reflects the scientific nature of the research.

3.4.1 Population

The population is the study object, which may be individuals, groups, organisations, human products and events, or the conditions to which they are exposed (Welman and Kruger, 1999).

For the purposes of this study the population comprises:

- all prison health care centres in the Western Cape
- All inmates visiting the health centre.

3.4.2 Sampling

The sample refers to the process of selecting a group of people, events, behaviour or other elements to be used for conducting the study. There are mainly two types of sampling methods available, namely probability and non-probability sampling (Burns and Grove, 2001).

The Western-Cape as a province was conveniently identified as target area for the research. The researcher could not, due to financial and time restrictions, include other provinces. The researcher identified 42 prisons in the Western-Cape with primary health care centres operating as a clinic on a daily basis. One prison was excluded on ethical grounds, because the researcher himself was practising as a nurse in that specific health care centre. The 42 prisons differ in size and inmate numbers.

After consultations, and taking into account the financial and time restrictions, it was decided to include prisons that adhere to the following criteria:

- Prisons accommodating 1000 to 1500 inmates per day
- Prisons operating on a daily primary health care clinic basis, without a hospital facility attached
- Prisons within a radius of 100 kilometers from the base of the researcher
- Prisons accommodating male inmates only.

Six prisons that met the above-mentioned criteria were identified. One prison, where the researcher was practising, was eliminated as discussed before. The other 5 names were thrown into a hat and the name of one prison was drawn for the pilot study. This prison and its respondents were not included in the final study. The remaining 4 prisons were included in the sample.

The researcher has formulated structure and process standards to evaluate the primary health care service accordingly. The outcome standards were evaluated

by means of a questionnaire completed by selected inmates.

To evaluate the process standards it was decided, after consultations with specialist nurses and statisticians, to do the evaluation at each clinic (4) as follows:

- 3 days per week, randomly selected for one month. The month is considered as consisting of 4 weeks
- Evaluation was done from 07:00 to 16:00 daily.

The auditing of the records and inmate interviews was done once the data saturation was reached. The records and inmates per clinic were chosen randomly and amounted to 52 records per clinic and 100 inmates interviewed per clinic.

The sample therefore consisted of:

- 4 prisons (purposefully selected)
- 52 records per clinic (randomly selected)
- 100 inmates per clinic (randomly selected) who were interviewed.

3.5 DATA COLLECTIONS

This section gives an overview of the instrument, setting standards, structure standards, process standards and outcome standards.

3.5.1 Instruments

Burns and Grove (2001) define instrumentation as the component of measurement where specific rules are applied, aimed at producing trustworthy

evidence that can be used in evaluating the outcome of the research. Polit and Hungler (1993) also define an instrument as the device or technique that consists of rules or principles like objectivity that a researcher uses to collect data.

Based on the research questions, objectives and literature study, the following instruments were developed and utilised:

- Standards with criteria or indicators to evaluate the structure and process standards in the primary health care setting, as well as one client's health care records
- A questionnaire to determine client satisfaction (outcome standards).

3.5.2 The importance of setting standards

Quality assurance as discussed in Chapter 2, is the systematic process of evaluating the quality of care given in a particular unit or institution. It involves setting standards determining criteria or indicators to meet those standards, the collection of data, an evaluation on how well the criteria have been met, and the planning of changes based on the evaluation. The follow-up is an important phase in the whole process of quality assurance, because it is essential to evaluate the implementation of recommendations (Sullivan and Decker, 1992).

The standards set should be specific and relevant to the service and community served. The standards are the foundation upon which all other measures of quality assurance are based (Sullivan and Decker, 1992). Standards are valid and explicit descriptions of the structure, and include the rules and governance of the system and the desired quality of job performance. They also contain criteria or indicators for assessing the quality of the nursing tasks (Booyens, 1993). Setting standards is thus a pre-requisite for evaluating the quality of any health care service, and in this study it involves the health care service in prisons.

3.5.3 Structure standards

In chapter 2 the quality assurance process was discussed in detail, explaining that the evaluation of the quality of patient care does not only depend on evaluating the process (nursing interventions), but includes the evaluation of the entire organisation. This also includes the evaluation of the professional and administrative activities. When evaluating structure standards, the researcher evaluated the mission, vision, philosophy and objectives, because these indicate the quality of commitment to the delivery of high quality client care.

Policy is an important component of the structure, while monitoring is based on policies which are non-negotiable directives of care delivery. Structure standards also specify the quantity and quality of the inputs into systems responsible for health care delivery. This includes human and physical resources as well as the environment. Structure standards in other words provide the foundation of any organisation through policy, while management is responsible for executing the policy, but also for shaping and formulating these policies.

Standards regarding the structure included the following aspects:

- Organisation
- Human resources development
- Human resources administration and utilisation
- Health community development forums
- Equipment, facilities and environment

3.5.4 Process standards

Process standards describe what nurses do, what clients receive and how the

system works. Process standards do not only refer to the direct care of the client, but they include care plans and client education programmes. The most important activities include the following: diagnostic, preventative, therapeutic and rehabilitative and educational activities, and/or services falling within the scope of practice of the professional nurse (South African Nursing Council Regulation 387, Rule 3 to 6: Practice).

Several critical factors are to be taken into account when process standards are determined, namely:

- **High volume activities:** activities that occur frequently, or those involving a large number of clients, for example the sick parades in prisons where a large number of clients report.
- **High risk activities:** activities in which harm or a lack of significant benefit may occur, whether the activity is performed or not performed. An activity is high-risk if its performance or omission could result in trauma, mortality, litigation or loss of accreditation or licence. Examples are the dressing of a wound, not using aseptic techniques, and failure to render the necessary or relevant care to a patient to prevent complications or even death.
- **High cost activities:** activities involving high costs for the institution. That could for example include the increase of high administrative costs due to absenteeism, a high staff turnover and the use of agency or temporary personnel.
- **Problem-directed activities:** activities causing problems for the institution, staff or client.

(Booyens, 1993).

In evaluating the process standards of the organisation or the nursing division, the researcher evaluated nursing interventions when nursing care was rendered

to the clients in prison, as well as the relevant documentation thereof.

Under these conditions the nurses were evaluated on the diagnosis, management and evaluation of care offered, as well as the keeping of records regarding the following conditions:

- Hypertension
- Urinary tract infection
- Diabetes Mellitus
- Tinea Pedis (athlete's foot)
- Otitis Media
- Abscesses
- Pulmonary Tuberculosis
- Herpes Type 1 viral infection
- Acne Vulgaris
- Injuries, sprains and strains
- Common colds/sinusitis
- Cardiac arrest and cardio-pulmonary resuscitation (simulation)

The initial screening of the client with a problem was evaluated by the researcher. This process is vital for the nurse in order to obtain the information needed to make an accurate diagnosis and plan appropriate interventions. The researcher evaluated the nurses' screening of clients complaining of the following disorders:

- Cardiovascular disorders
- Respiratory disorders
- Gastro-intestinal disorders
- Integumentary disorders
- Musculoskeletal disorders
- Eye disorders
- Ear disorders

- Genito-urinary disorders

The researcher also evaluated the execution of certain procedures by nurses.

The evaluation was done on:

- The determination of the need to carry out the procedure
- Adherence to the principles underlying the execution of the procedure.

The following procedures were evaluated:

- Intramuscular injection
- Wound dressing
- Collecting of blood specimens
- Instilling ear medication
- Collecting and testing of an urine specimen
- Instilling eye medication
- Collecting a sputum specimen
- Measuring blood pressure of an adult.

Lastly, accurate record keeping was evaluated by the researcher by means of auditing the records. Accurate and legal record keeping serves as evidence that something was done, when, how and by whom. Mellish and Lock (1992) state that from a legal point of view it is impossible to accept that something has been or has not been done, unless supported by accurate records. The former statement is also supported by Correctional Services Order B Chapter 3, paragraph 35.3.4. It is the duty of the all professional nurses to ensure that patient care is documented responsibly and accurately. In failing to do so, the nurse may be charged with wilful or negligent failure to keep an accurate record of all actions or procedures performed in connection with a client (Verschoor *et al.*, 1996; Correctional Services Order B, 2002). The criteria used in evaluation processes were discussed and stated in chapter 2.

3.5.5 Outcome Standards

A patient satisfaction questionnaire was developed to obtain the opinion of the clients in prison regarding the care they received. The client's view or opinion on the care he/she had received is of vital importance in the quality assurance process. It is also known as outcome standards.

The researcher conducted the interviews himself to ensure that no misunderstanding or misinterpretation of questions existed. The following aspects were covered and the questions were based on the Batho Pele Principles and Patient Rights Charter as described in chapter 2.

3.6 Summary

In this chapter a detailed overview is given on the research methodology that formed the basis for the study. The sampling method and data-instruments are discussed. A sound, scientific outlay of the research processes and principles is essential in any study to enhance the validity and reliability of a study.

<p style="text-align: center;">CHAPTER 4 DATA-ANALYSIS AND DISCUSSION OF RESULTS</p>

4.1 INTRODUCTION

Following the collection of data, the discovery phase of research begins as the meaning of the data is determined through analysis (Burns & Grove, 2001). Data analysis is that step in the research process in which data collected are analysed using statistical analysis, which is then interpreted into meaningful results. In this chapter, the data collected are analysed, interpreted and discussed. This applies to the structure process and outcome dimensions. The findings are discussed from a nursing perspective, as this approach was also employed by the researcher who is also a member of the nursing profession.

4.2 PRESENTATION OF RESULTS

The data are discussed according the standards set in Addendum A as well as the client questionnaire in Addendum B. The percentages regarding the standards were calculated as follows:

- The criteria were ticked off as applicable.
- The total number of criteria (after illuminating the “not applicable” items) was calculated in percentage format.
- The final percentage for each standard was calculated.
- Individual questions of the client questionnaire were also calculated in percentages and discussed individually. Where the opinion of the client is discussed central themes were identified and discussed as such.

A definite percentage which could be regarded as good/high, satisfactory or suboptimal regarding the standard under evaluation, could not be found in the literature. The researcher or accrediting bodies decide which percentage will represent the above-mentioned categories.

Based on his experience as a professional nurse and expert, the researcher decided that 80% and above would be accepted as a good standard, while anything below 80% would need urgent remedial action. If 100% is expected from any specific standard, it will be indicated as such.

4.3 STRUCTURE STANDARDS

As discussed in Chapter 2, Muller (1996) and Booyens (1993) described the structure as the rules of the system and its governance, including the mission statement, philosophy, objectives and policies. The mission statement addresses the overall business of the nursing division and is in harmony with the mission statement of the institution. The philosophy statement delineates the values and beliefs.

The structure further provides what is needed to render care to clients, namely human resources, equipment and supplies.

The researcher developed structure standards to evaluate the existence of these structures. The researcher believes that the organisation, supply, maintenance and utilisation of facilities, staff, equipment and stock enhance the rendering of quality health care.

Structure standard was formulated which focused on the following aspects:

- Organisation

- Human resources development
- Human resources administration and utilisation
- Health community development forums
- Equipment, facilities and environment.

Discussion of raw findings regarding the above-mentioned will be done in this sequence.

4.3.1 Organisation

Table 4.1 shows that the mean percentage for organisation was 16%. All four primary health settings scored far below the acceptable standard of 100%. Communication scored the highest, with a mean of 95%. It was found that important emerging contact numbers were in place.

The researcher found that the vision statement, mission statement, annual operational plans, and the budget and finance meetings were not in place at all. Annual operational plans and objectives, as well as financial data, should be available to the staff in order to manage the unit cost-effectively and to render a high standard of care.

The absence of the above aspects in the health setting is a great concern, because these structures are essential to give direction and to monitor the progress of the setting in meeting its targets. The absence of such important aspects will have a negative effect on the quality of care, in which case the organisations are prone to fail in all their activities.

4.3.2 Human Resources Development

Table 4.2 shows that all four primary health settings scored the mean percentage of 4%, which is well below the set standard of 100%. Neither of the four primary health settings had programmes in place for continued education or in-service training. Primary Health setting B, C and D did not have orientation programmes

and induction programmes in place. Primary health setting A do had an orientation and induction programme in place, but in general it did not meet the set standard in general for Human Resources Development.

TABLE 4.1
STRUCTURE STANDARDS

Organisation	Primary health care setting				Total Average %
	A	B	C	D	
1. Vision statement	0%	0%	0%	0%	0%
2. Mission statement	0%	0%	0%	0%	0%
3. Annual operational plans	0%	0%	0%	0%	0%
4. Finance: Budget known	0%	0%	0%	0%	0%
5. Finance: Meetings	0%	0%	0%	0%	0%
6. Communications	100%	80%	100%	100%	95%
Average for the Organisation	17%	13%	17%	17%	16%

It is a major concern to find institutions without human resources development programmes in place. These are of critical importance to personnel, as quality patient care enables them to function efficiently within a new organisation. The objective is the development of staff member in order to render quality patient care, and if that does not happen a negative impact on staff morale and patient care is inevitable.

TABLE 4.2
HUMAN RESOURCES DEVELOPMENT

Organisation	Primary Health care setting				Total Average %
	A	B	C	D	
1. Orientation programme	13%	0%	0%	0%	3%
2. Induction programme	50%	0%	0%	0%	13%
3. Continued education	0%	0%	0%	0%	0%
4. In-service training	0%	0%	0%	0%	0%
An Average for Human Resources Development	16%	0%	0%	0%	4%

4.3.3 Human Resources Administration and Utilisation

Table 4.3 reflects that all four institutions scored 100% in only one aspect, namely staff health and safety, which indicates that the physical and psychological well-being of the staff is attended to. Table 4.3 further shows a mean score of 31%, which is well below the set standard of 100%.

The researcher found that none of the following existed in all four institutions:

- Organogram
- Monthly staff meetings
- Infection control policy
- Management of sharps policy
- Management of waste policy.

The researcher further found that a percentage below 54% had been given to all clinics regarding the presence of job descriptions. Primary health care setting A did have a task allocation register in place, but the other three institutions did not. This low percentage that was allocated is a cause for concern, because it cannot of them. They need a job description and task allocation to guide them in their nursing activities in order to render a high quality of care in the primary health care setting. Primary health care setting C and D were understaffed, and scored below 80% and 57% respectively. The latter is well below the norm of 100%.

It is generally accepted that an effective health service cannot be run without the necessary trained staff. Nursing care will be negatively affected if a staff shortage exists, as in the case of institution D. Primary health care setting C and D scored well below the accepted score of 100%, with 60% each in respect of the on call roster. The researcher found that nursing auxiliaries are put on standby on their own while they are tasked to manage the scheduled 5 and higher medications. This immediately creates a legal risk, because these staff members function beyond their scope of practice. The low percentages in

general and the very low mean percentage of 31% for the institutions are alarming, because the standard of patient care as well as the occupational safety of staff is compromised.

TABLE 4.3
HUMAN RESOURCES ADMINISTRATION AND UTILISATION

	Primary Health care setting				Total Average %
	A	B	C	D	
1. Organogram	0%	0%	0%	0%	0%
2. Job description	53%	15%	53%	53%	44%
3. task allocation	50%	0%	0%	0%	13%
4. Work load estimation (staffing)	100%	100%	80%	57%	84%
5. On call roster	100%	100%	60%	60%	80%
6. Monthly staff meetings	0%	0%	0%	0%	0%
7. Staff qualifications	20%	60%	0%	33%	28%
8. Staff health and safety	100%	100%	100%	100%	100%
9. Infection control policy	0%	0%	0%	0%	0%
10. Management of sharps	0%	0%	0%	0%	0%
11. Management of soft waste	0%	0%	0%	0%	0%
12. Post-exposure policy	60%	0%	60%	0%	30%
An Average for Human Resources Administration and Utilisation	40%	31%	29%	25%	31%

4.3.4 Health community development forums

The prisoners are seen as a community and Table 4.4 shows that this community in institution A is the only one who is involved in the health system and management of their own health. No further prison community involvement in health matters exists in any of institutions A, B, C and D. Such committees are vital in discussing health-related issues and to involve communities in health matters which affect them.

TABLE 4.4
HEALTH COMMUNITY

	Primary Health care setting				Total Average %
	A	B	C	D	
1. Health prisoner community committee	0%	0%	0%	0%	0%
2. Prisoner community involvement	100%	0%	0%	0%	25%
An Average for Health Community Development Forums	50%	0%	0%	0%	13%

4.3.5 Equipment and supplies

The critical value of the correct quality and properly functioning equipment and supplies to ensure a high standard and safe patient care, was discussed in chapter 2. A standard of 100% was thus accepted for this purpose.

The average percentage for each institution regarding equipment and supplies was well below the required 100%. This is alarming, because it cannot be expected of the nursing staff to render a high quality health service if they do not have the necessary or even minimum equipment and supplies at their disposal. Table 4.5 shows that 100% was achieved by all four institutions, only with the availability and adequacy of instruments and the correct storing of stock.

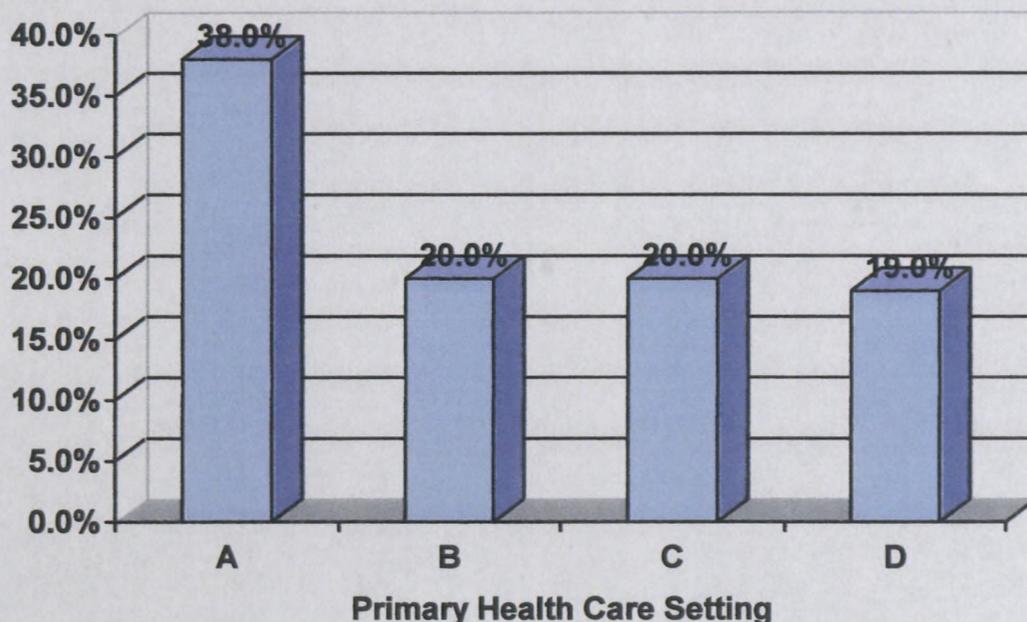
TABLE 4.5
EQUIPMENT AND SUPPLIES

Organisation	Primary Health care setting				Total Average %
	A	B	C	D	
1. Equipment in Consulting room	80%	90%	100%	90%	90%
2. Equipment in Procedure Room	50%	70%	70%	50%	60%
3. Linen and linen room	0%	20%	0%	0%	5%
4. Dirty utility	20%	60%	0%	0%	20%
5. Instruments	100%	100%	100%	100%	100%
6. Emergency measures	86%	46%	90%	83%	76%
7. Stock secure	100%	100%	100%	100%	100%
8. Stock cards	50%	0%	0%	0%	13%
9. Accurate stock recording	100%	0%	100%	100%	75%
10. Stock organisation	100%	0%	0%	33%	33%
11. Supplies	56%	28%	32%	40%	39%
12. Medications	58%	17%	75%	50%	50%
An Average for Equipment and supplies	67%	55%	56%	54%	55%

Average on all structure standards	38%	20%	20%	19%	24%
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It is clear from Figure 4.1 that the structure standards are suboptimal, and therefore require urgent attention.

FIGURE 4.1
MEANS ON ALL STRUCTURE STANDARDS



4.4 PROCESS STANDARDS

Process standards define what nursing care is, and they provide specific criteria that can be used to determine whether quality nursing care has been provided. During the evaluation process the criteria were ticked off and eventually processed in percentage format. A definite percentage of what is considered as a good/high, satisfactory and low could not be found in the literature. Researchers or accrediting bodies themselves decide on an acceptable percentage, according to parameters set by them.

The researcher, based on his experience as a professional nurse and expert, decided that 80% and above will be accepted as a good standard; anything below 80% needs urgent remedial action.

For cardio-pulmonary resuscitation, however, the researcher accepted 100% as

an acceptable standard because this is a life-saving procedure and each and every nurse should be competent in executing this procedure. To ensure competency the nurse is evaluated at least every 6 months in simulation. In this study, process standards involved the following nursing interventions, data will be analysed and discussed accordingly.

4.4.1 Screening of Patients

Standards for the initial screening of patients were developed and used in the evaluation, if the nurse was able to obtain the vital information needed to make an accurate diagnosis and plan appropriate intervention(s). Screening of the following systems was evaluated:

- Cardiovascular
- Respiratory
- Gastro-intestinal
- Integumentary
- Musculo-skeletal
- Eye
- Ear
- Genito-urinary

TABLE 4.6
SCREENING OF PATIENTS

	Primary Health Setting				MEAN
	A	B	C	D	
1. Cardiovascular	2%	6%	2%	2%	3%
2. Respiratory	4%	10%	3%	4%	5%
3. Gastro-intestinal	1%	4%	2%	2%	2%
4. Integumentary	6%	11%	5%	5%	7%
5. Musculoskeletal	10%	21%	11%	10%	13%
6. Eye	5%	9%	3%	3%	5%
7. Ear	9%	14%	6%	4%	8%
8. Genito-urinary	3%	11%	2%	3%	5%
Average	5%	11%	4%	4%	6%

4.4.1.1 Cardiovascular screening

Table 4.6 shows that all four primary health settings obtained less than 7% in this category, with the mean percentage at 3%. At primary health care setting A and B the subjective and objective data were assessed, though it was not adequate to make a nursing diagnosis. At primary health care setting C and D, only subjective data were obtained and no recording of subjective as well as objective data was done.

4.4.1.2 Respiratory screening

Primary health care setting A, C and D obtained less than 5% in this category; only the subjective data were obtained but not recorded; no objective data were assessed or recorded. Institution B obtained less than 11%; the gathering and recording of subjective data was done, but no gathering and recording of objective data was done. A mean of 5% for the four institutions was found.

4.4.1.3 Gastro-intestinal screening

An extremely low score at each of the four primary health care institutions was obtained, with a mean percentage of 2% (see Table 4.6). Clients were not assessed on objective data, and no recording was done. Incomplete recording of subjective data was done at primary health care setting B.

4.4.1.4 Integumentary screening

All four institutions obtained less than 12% with the mean percentage of 7% (see table 4.6). At institution C and D no objective data were assessed and no

recording of subjective and objective data was done.

4.4.1.5 Musculoskeletal screening

Musculoskeletal screening in all four institutions obtained less than 22% with the mean percentage of 13. In all four institutions incomplete assessments of subjective as well as objective data were done. Incomplete recording of subjective and objective data was also done in all four institutions.

4.4.1.6 Eye screening

Screening of the eye in all four primary health care settings scored less than 10% with a mean percentage of 5%. At primary health care setting A, no objective data were obtained nor was a recording of subjective and objective data done. At primary health care setting C and D incomplete subjective and objective data were assessed but no recording was obtained, while at primary health care setting A only subjective data were assessed. At primary health care setting B, both subjective and objective were obtained and recorded.

4.4.1.7 Ear screening

Table 4.6 depicts that all four primary health care settings obtained a mean percentage of 8% in this category. Primary health care setting B obtained 14%, slightly better than the other settings because subjective and objective data were obtained and recorded. At the other three institutions, objective data were not obtained, and recording of subjective and objective data was not done. At institution A incomplete objective data were obtained.

4.4.1.8 Genito-urinary screening

Table 4.6 depicts that all four primary health care settings obtained a mean percentage of 5% in this category. Primary health care setting B obtained 11%, which is slightly better than the other settings, as no subjective and objective data were obtained and recorded. At the other three institutions objective data were not obtained, and neither were subjective and objective data recorded. At institution A incomplete objective data were obtained.

Carpenito (1995) defines assessment as the deliberate collection of data about the client, family or group. The nurse obtains the data by interviewing, observing and examining the patient. The author further describes two types of assessments namely admission screening and focus assessment. The first assessment involves determining the client's present health status and ability to function. The latter assessment involves the physical examination using the skills of inspection, auscultation and palpitation. Proper assessment of clients provides the nurse with a clear framework to diagnose the unique response and condition of a client as well as minimising the misuse of human and non-human resources. After the diagnosis is made, priorities are set and goals and/or expected outcomes are formulated to guide the planned nursing interventions aimed at solving or minimising the identified problem (Kozier *et al.*, 1984). The implementation of nursing care plans now follows with the necessary recording and re evaluation.

It is evident from the data analysis above that patients in all four primary health care settings initially received suboptimal screening. This could only result in suboptimal care being given, because the nurse has practically no data on which to base the nursing management of the relevant patients. Records are also incomplete, which weakens the defence of the nurse in case of litigation.

4.4.2 MANAGEMENT OF HEALTH CONDITIONS

Standards for management of health conditions were formulated and used in the evaluation of care to determine if the primary health care nurse had rendered quality primary care in order to achieve and maintain the optimal health of prisoners, and to promote the restoration of the patients' normal functioning of all body systems free of preventable complications. It was decided that a score of 90% and above would be regarded as a high standard of care rendered. The following health conditions were identified as critical and most prevalent among the prison population:

- Hypertension
- Urinary tract infection
- Diabetes Mellitus
- Tinea Pedis
- Otitis Media
- Abscess
- Pulmonary Tuberculosis
- Herpes Type 1 Viral Infection
- Acne Vulgaris
- Injuries, sprains and strains
- Common cold/Sinusitis.

4.4.2.1 Hypertension

Table 4.7 depicts that all four institutions scored less than 20% in this category, obtaining the mean percentage of 15. None of the four institutions formulated and recorded nursing diagnoses, and health education and follow-up evaluation did not meet the criteria at any of the four institutions.

4.4.2.2 Urinary tract infection

Table 4.7 depicts that all four institutions scored less than 26% in this category with the mean percentage of 17. None of the four institutions formulated and recorded nursing diagnoses, and health education and follow-up evaluation were not done at any of the four institutions.

TABLE 4.7
MANAGEMENT OF HEALTH CONDITIONS

	Primary Health Setting				MEAN
	A	B	C	D	
9. Hypertension	18%	17%	13%	13%	15%
10. Urinary Tract Infection	10%	25%	10%	7%	13%
11. Diabetes Mellitus	28%	21%	21%	13%	21%
12. Tinea Pedis	13%	8%	10%	10%	10%
13. Otitis Media	14%	12%	11%	10%	12%
13. Abscess	12%	7%	8%	8%	9%
14. Pulmonary Tuberculosis	30%	22%	24%	24%	25%
15. Herpes Type 1 Virus	9%	9%	8%	8%	9%
16. Acne Vulgaris	23%	15%	15%	16%	17%
17. Injuries, sprains and strains	13%	12%	10%	12%	12%
18. Common Colds/Sinusitis	4%	6%	4%	4%	5%
Average	16%	14%	12%	11%	13%

4.4.2.3 Diabetes Mellitus

Table 4.7 depicts that all four institutions scored less than 29% in this category with the mean percentage of 21. None of the four institutions formulated and recorded nursing diagnoses, and health education and follow-up evaluation were not done at any of the four institutions.

4.4.2.4 Tinea Pedis

Table 4.7 depicts that all four institutions scored less than 14% in this category,

with the mean percentage of 10. Not one of the four institutions formulated and record nursing diagnoses, and health education and follow-up evaluation were not done at any of the four institutions.

4.4.2.5 Otitis Media

Table 4.7 depicts that all four institutions scored less than 15% in this category with the mean percentage of 12. None of the four institutions formulated and recorded nursing diagnoses, and health education and follow-up evaluation were not done at any of the four institutions.

4.4.2.6 Abscess

Table 4.7 depicts that all four institutions scored less than 13% in this category with the mean percentage of 9. None of the four institutions formulated and recorded nursing diagnoses, and health education and follow-up evaluation were not done at any of the four institutions.

4.4.2.7 Pulmonary Tuberculosis

Table 4.7 depicts that institution A scored 30%, which is relatively better than the scores of institutions B, C and D. The latter institutions scored less than 25%. This is extremely alarming in view of the fact that tuberculosis was identified as a national health priority by the Minister of Health as far back as 1996. Furthermore, the Western Cape has the highest notification figure in South Africa. Tuberculosis is a very contagious disease and should be managed with the utmost care whilst the patients should adhere to the prescribed measures very strictly.

4.4.2.8 Herpes Type 1 Viral Infection

Table 4.7 shows that all four institutions scored less than 10% in this category with the mean percentage of 9. None of the four institutions formulated and recorded nursing diagnoses, and health education and follow-up evaluation were not done at any of the four institutions.

4.4.2.9 Acne Vulgaris

All four institutions scored less than 24% in this category with the mean percentage of 17 (Table 4.7). None of the four institutions formulated and recorded nursing diagnoses, and health education and follow-up evaluation were not done at any of the four institutions.

4.4.2.10 Injuries, sprains and strains

Table 4.7 shows that all four institutions scored less than 14% in this category with the mean percentage of 12. None of the four institutions formulated and recorded nursing diagnoses, and health education and follow-up evaluation were not done at any of the four institutions.

4.4.2.11 Common Cold/Sinusitis

Table 4.7 shows that all four institutions scored less than 7% with a mean percentage of 5. None of the four institutions formulated and recorded nursing diagnoses, and health education and follow-up evaluation were not done at any of the four institutions.

The nursing process is a systematic, rational method of planning and providing nursing care. Its goal is to identify a client's actual or potential health care needs, to establish plans to meet the identified needs, and to deliver specific

nursing interventions to meet those needs and evaluate the effect of nursing interventions (Kozier *et al.*, 1989). It is critically important to document all the components of the nursing process. This process was used as basis of the standards and evaluation process. It is also critically important to document all the components throughout all the phases of the process.

4.4.3 Execution of Nursing Procedures

Standards for the execution of nursing procedures was formulated and used in the evaluation of care to determine if the procedures were carried out effectively, with a view to improving the quality of patient care. It was decided that 100% should be regarded as a good standard, because these are procedures that could harm the patient if not done correctly.

The following nursing procedures were covered in the set criteria:

- Cardiopulmonary resuscitation (Simulation)
- Administering of intramuscular Injection
- Application of dressing
- Collection of blood specimen
- Instilling ear medication
- Collection and testing urine specimen
- Instilling eye medication
- Measuring of blood pressure

TABLE 4.8
EXECUTION OF PROCEDURES

	Primary Health Setting				MEAN
	A	B	C	D	
19. Cardiopulmonary resuscitation (Simulation)	35%	0%	45%	32%	28%
20. Injecting intramuscular medication	40%	39%	40%	41%	40%
21. Application of dressing	21%	20%	15%	17%	18%
22. Collecting blood specimen	26%	36%	43%	37%	36%
23. Instilling ear medication	9%	29%	12%	9%	15%
24. Collecting and testing urine specimen	24%	28%	34%	32%	30%
25. Instilling eye medication	7%	17%	12%	11%	12%
26. Collecting sputum specimen	35%	31%	28%	27%	30%
27. Measuring blood pressure	23%	32%	38%	43%	34%
Average	24%	26%	30%	28%	27%

4.4.3.1 Cardiopulmonary Resuscitation (Simulation)

Table 4.8 shows that institution B scored 0%. The nurses were too busy to simulate cardiopulmonary resuscitation. All other three institutions scored below 45% in cardiopulmonary resuscitation. This is very alarming, because this is a life saving procedure and nurses should achieve 100% in this evaluation.

4.4.3.2 Administering of Intramuscular Injection

Table 4.8 shows that all four institutions scored less than 42% in administering intramuscular injection. They mainly lacked skills in making and recording an appropriate diagnosis: recording subjective and objective data; and recording of follow up evaluation. Although the procedure itself seemed to be correctly executed, it forms only a part of the whole procedure. The administration of an

injection is based on the correct diagnosis made. The follow-up valuation is of crucial importance to determine if the treatment was effective. No part or section of the procedure could be neglected, because this will eventually be detrimental to the patient and it will be indicative of a low standard of care rendered by the nurse.

4.4.3.3 Application of dressing

Table 4.8 shows that all four institutions scored less than 22% in application of dressing. A correct diagnosis was not made, while subjective and objective data as well as the follow up evaluation were not recorded. The critical principles of aseptic technique were not followed and adequate supplies for the execution of these procedures were not available. These included critical supplies like sterile gloves, sterile dressing packs and necessary solutions: This is a cause of great concern, because the patient can be negatively affected and it shows that quality care is not rendered.

4.4.3.4 Collection of blood specimens

Table 4.8 shows that all four institutions scored less than 44% in the collection of blood specimens. This is a potential risky procedure regarding the exposure to blood products, and it should be carried out correctly. The score is well below the acceptable 100% and remedial actions are necessary.

4.4.3.5 Instilling ear medication

Regarding instilling of ear medication, Table 4.8 shows that institution B scored 29% which is better in comparison to the other three institutions which scored less than 13%. Regarding the instilling of eye medication, all four institutions

scored less than 18% (See table 4.8). The following was not done: nursing diagnosis, doing a follow-up evaluation and recording of nursing diagnosis, subjective and objective data and follow up evaluation. This data forms the basis of the treatment regimen and the correct treatment cannot be given if base information is lacking. This inevitably leads to poor patient care.

4.4.3.6 Collection and testing of urine specimen

All four of the institutions scored less than 35% (see Table 4.8). They lacked in the making of nursing diagnosis, doing a follow-up evaluation and recording of nursing diagnosis, subjective and objective data and follow-up evaluation. This could be problematic, because a potential problem or abnormality is not followed up and the patient does not receive the appropriate treatment.

4.4.3.7 Collection of sputum specimen

Table 4.8 shows that all four institutions scored less than 36%. They lacked in the making and recording of nursing diagnosis. This could lead to inappropriate nursing care and waste of resources.

4.4.3.8 Measuring of blood pressure

Table 4.8 shows that all four institutions scored less than 44%. This is a procedure that provides vital information to the nurse regarding a patient's condition. If not executed correctly, vital information is lacking and the nurse could misdiagnose, so that the appropriate life-saving treatment could possibly not be administered. Correct and effective execution of the procedure is beneficial to the client, organisation and the nurse. Moreover, incorrect

execution of the procedure might have serious negative effects on the client. Incorrect execution of the procedures makes an organisation and nurse vulnerable to lawsuits.

It is critically important for nurses to be aware of the legal aspects of administering medication, physiological factors and individual variables affecting drug action. It is equally important for nurses to be aware of and maintain surgical and aseptic techniques in executing relevant nursing procedures in order to prevent infections and complications that might arise from non-compliance of these techniques. Health education for clients is an equally important aspect in the care of these patients. In summary, the researcher concludes that the standard of care regarding the execution of procedures is altogether suboptimal.

4.4.4 Recordkeeping

Critical points were selected and set to evaluate whether recordkeeping met the standard. The results are discussed accordingly. The researcher, based on reasons given below, determined 100% as an accepted standard for recordkeeping. The reasons are:

- The increase in medico-legal/disciplinary cases necessitates complete recordkeeping to safeguard the patient as well as the nurse.
- The patient's record is a legal document and reflects the total care of the patient as well as the continuity of care. Thus, it does not allow for incomplete recordkeeping as an acceptable standard.
- The record forms the basis of any planning of future treatment and care of the patient.

The researcher acknowledges the fact that complete records do not necessarily guarantee that care was given or vice versa. The researcher could, however, not compromise this standard, because it is assumed that care, actions or

interventions not recorded were not executed or rendered. Discussion of the results of the auditing of recordkeeping as set in Annexure D follows.

TABLE 4.9
AUDITING RECORDKEEPING

	Primary Health Setting				MEAN (n=208)
	A (n=52)	B (n=52)	C (n=52)	D (n=52)	
Subjective data	90%	92%	65%	73%	80%
Objective data	58%	58%	37%	44%	49%
Nursing diagnosis	4%	2%	0%	2%	2%
Therapeutic management	56%	79%	60%	44%	60%
Health education	0%	0%	6%	2%	2%
Follow-up evaluation	8%	37%	10%	6%	15%
Referral entry	33%	53%	81%	73%	60%
Identification of file by name	100%	100%	100%	100%	100%
Identification of cardex by name	100%	100%	100%	100%	100%
Identification of file by number	100%	100%	100%	100%	100%
Identification of cardex by number	100%	100%	98%	98%	99%
Date and time of each entry	100%	94%	27%	73%	74%
Legible handwriting	98%	92%	31%	71%	73%
Entry identified by name of nurse	0%	0%	0%	0%	0%
Entry identified by rank of nurse	0%	0%	0%	0%	0%
Changes ruled out by single line and indicated as such by nurse	0%	17%	14%	14%	11%
Mean:	53%	58%	46%	50%	52%

4.4.4.1 Subjective data

All four primary health care settings scored less than 100% on recording of subjective data, with a mean of 80% (see Table 4.9). Such a low percentage indicates that minimum subjective data were obtained and recorded, which is not beneficial to the client. From such data a nurse cannot make a diagnosis and plan appropriate care.

4.4.4.2 Objective data

All four primary health care settings scored less than 100%, with a mean of 49% on recording of objective data (see Table 4.9). Such a low percentage indicates that minimum objective data were obtained and recorded, which is not beneficial to the client and the nursing process with appropriate interventions.

The researcher needs to mention that the nurses in all institutions render therapeutic management based only on subjective or objective data. This is a great concern, because with only subjective data at his/her disposal, a nurse cannot diagnose and plan nursing care appropriately.

4.4.4.3 Nursing Diagnosis

Table 4.9 it shows that institutions A, B and D scored below 5% and institution C scored 0% on recording as the diagnosis. The diagnosis is vital for the planning, implementation and evaluation of care given. Table 4.10 shows a mean of 2%.

4.4.4.4 Therapeutic management

As shown in Table 4.9, institution B scored 79%, which is reasonable in comparison with the scores of 56%, 60% and 44% of institutions A, C and D respectively. When therapeutic management is not recorded, it is detrimental to the safety of the client, because the next nurse may, for example, render the same treatment because he/she may be unaware that it has already been administered. The mean was 60% (Table 4.9). Recording of all therapeutic interventions is absolutely critical, because it forms the basis of the continuity and the reviewing/evaluating of care. This ensures that an appropriate and high

standard of care is rendered.

4.4.4.5 Health Education

Table 4.9 shows that health education is non-existent at institutions A and B, whilst institutions C and D scored 6% and 2% respectively. Non-existence of health education is a great concern, because without health education for the client, the prisoners' health will eventually deteriorate.

4.4.4.6 Follow-up evaluation

Table 4.9 reflects that institution B scored 37%, which is reasonable in comparison to institutions A, C and D, which scored 8%, 10% and 6% respectively on follow-up evaluation. It is of vital importance that the findings of the follow-up evaluation of the client are recorded. This is information vital to the follow-up rendering of care.

4.4.4.7 Referral entry

Table 4.9 shows that primary health care settings C and D scored 81% and 73% respectively. The researcher needs to mention that the nurses refer clients to the medical officer without managing the client or obtaining further objective data. The client then has to wait for a week or more to see the medical officer who only instructs the nurse(s) at that stage to do the laboratory tests that could have been taken care of by the nurse. This leads to ineffective management of health care in the prison.

4.4.4.8 Identification of patient

Table 4.9 shows that all four institutions met the set standards of the patients' file cardex, namely the nursing notes by the name and the patients' file by number.

4.4.4.9 Identification of cardex/nursing notes by number

Table 4.9 shows that institutions A and B met the set standards on identification of patients' cardex/nursing notes by number.

4.4.4.10 Date and time of entry

Table 4.9 shows that primary health care setting A met the set standards. Institution C scored the lowest score of 27% in the documentation of date and time. The mean was 74%. The date and time of each entry are of utmost importance because this information acts as a guideline in the evaluation and continuous planning of a patient's care.

4.4.4.11 Legible handwriting

Table 4.9 reflects that institution A, B and D scored 98%, 92% and 71% respectively, which is reasonable in comparison to institution C. It is, however, important that the handwriting in the records should be legible, because important and sometimes life-saving information and data are conveyed in the records, therefore the nurse should be in the position to read and react to that information immediately.

4.4.4.12 Entry identified by the name of the nurse

Table 4.9 shows that all institutions scored 0%. This is of great concern, because of the fact that the record is a legal document and any person should be identifiable when the need arises.

4.4.4.13 Changes ruled out with single line and indicated as such by the nurse

Institution A scored 0% and the other institutions scored less than 18% (see Table 4.9). Accurate recordkeeping and the purpose thereof is discussed in Chapters 2 and 4. It is alarming that recordkeeping scored well below the accepted standard of 100%.

In summary: all four institutions scored the mean percentage of 51,75% (see Table 4.9). The legal status of records cannot be over-emphasized and if recordkeeping is neglected, as proved by the researcher, the nurse and institution are put in a precarious situation when it comes to litigation.

4.5 OUTCOME STANDARDS

The outcome standard was evaluated by means of a patient questionnaire. The results will be discussed under the subheadings as indicated.

4.5.1 Biographical data

4.5.1.1 Gender

All prisoners interviewed were males, as reflected in Table 4.10 and explained in Chapter 3.

TABLE 4.10
GENDER

	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Male	100	100	100	100	400
TOTAL	100	100	100	100	400

4.5.1.2 Age

Table 4.11 shows that between 63% and 77% of prisoners in the four institutions were in the age group 31 to 45 years.

TABLE 4.11
AGE

	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
18-25 years	5	5	1	15	21
26-30 years	8	10	3	22	43
31-35 years	14	14	3	22	53
36-40 years	20	42	21	25	108
41-45 years	43	21	52	16	132
46 years and older	10	8	20	0	38
TOTAL	100	100	100	100	400

4.5.1.3 Duration in prison

TABLE 4.10
DURATION IN PRISON

Duration in Prison	Primary Health Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Less than 1 year	4	5	1	25	35
Between 1 and 2 years	10	11	1	14	36
Between 2 and 4 years	21	21	6	14	62
Between 4 and 6 years	27	36	19	23	105
Between 7 and 10 years	27	17	32	14	90
11 years and more	11	10	41	10	72
TOTAL	100	100	100	100	400

Table 4.33 depicts that 27% of the prisoners in institution A spent between 4 to 6 years, while 27% spent between 7 and 10 years in prison, and 36% of the prisoners at institution B and 23% of the prisoners in institution D served between 4 and 6 years in prison. Of all the prisoners in institution C, 41% served 11 years or more in prison.

4.5.2 Hygiene and safety

4.5.2.1 Cleanliness of the clinic

Primary health settings A, B, C and D obtained 84%, 83%, 84% and 81% respectively in the "clean" categories. This is an acceptable standard.

TABLE 4.11
CLEANLINESS OF THE CLINIC

Cleanliness	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Very clean	7	13	8	1	29
Clean	84	83	84	81	332
Dirty	8	4	7	14	33
Very dirty	1	0	1	4	6
TOTAL	100	100	100	100	400

4.5.2.2 Health conditions in the cells

Table 4.11 reflects that the majority of prisoners regarded the health conditions in their cells as bad and very bad: (81,0% for institution A, 90% for institution C and 96 for institution D). Reasons cited for these conditions were overcrowding, cold water, toilets not functioning, broken windows and paint peeling off the walls. Institution B was rated 80% ranging between very good and good health conditions. The reason for this rating was that this is a newly build prison with no overcrowding and two prisoners sharing a room/cell.

TABLE 4.11
HEALTH CONDITIONS IN THE CELLS

	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Excellent Health conditions	0	19	0	0	19
Very good health conditions	0	53	1	2	56
Good health conditions	19	27	9	3	58
Bad health conditions	31	1	54	63	149
Very bad health conditions	50	0	36	32	118
TOTAL	100	100	100	100	400

4.5.3 Access to health care

4.5.3.1 Access to a nurse

Table 4.12 shows that prisoners at primary health care setting A and D do not find it difficult to consult a nurse when experiencing a health problem, because the nurses do medicine rounds daily in their sections or their units. Prisoners at primary health setting B and C find it difficult to consult a nurse when experiencing health problems. They stated that the nurse is only available every second day for consultations.

TABLE 4.12
ACCESS TO A NURSE

Duration in Prison	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Yes	18	80	52	43	193
No	82	20	48	57	207
Not applicable	0	0	0	0	0
Total	100	100	100	100	400

4.5.3.2 Access to a medical officer

Table 4.13 shows that prisoners at primary health settings A, B, C and D find it difficult to consult a medical officer when experiencing a health problem. The medical officer visits the prison on alternative weeks only and there is usually a long waiting list for the medical officer to see. The medical officer also visits only certain units at a time.

TABLE 4.13
ACCESS TO A MEDICAL OFFICER

Duration in Prison	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Yes	62	60	79	79	280
No	36	40	21	21	118
Not applicable	2	0	0	0	2
Total	100	100	100	100	400

4.5.4 Health care

4.5.4.1 Satisfaction level about waiting time

According to Table 4.14 it shows that the majority of prisoners at all four institutions are not happy about the time they wait before they are attended to by a nurse. They also mentioned that they have to stand in long queues and have a small number of nurses to attend to them all. They are prepared to wait a maximum of 20 minutes only.

TABLE 4.14
SATISFACTION LEVEL ABOUT WAITING TIME

Satisfaction about waiting time	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Yes	38	32	25	15	110
No	59	66	75	85	285
Not applicable	3	2	0	0	5
Total	100	100	100	100	400

4.5.4.2 Confidentiality

Table 4.15 reflects that the majority of prisoners at institutions A, B, C and D feel that their health-related issues are not kept confidential by nursing personnel.

Breach of confidentiality by nurses is a serious ethical-professional problem, which may result in disciplinary action or litigation against the nurse and/or the institution concerned.

TABLE 4.15
CONFIDENTIALITY BY NURSING STAFF

Maintenance of confidentiality	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Kept confidentiality	36	42	40	32	150
Did not keep confidentially	64	58	60	68	250
Not applicable	0	0	0	0	0
Total	100	100	100	100	400

4.5.4.3 Privacy

Table 4.16 shows that the right to privacy of prisoners at institutions A, B, C and D is not honoured, as reflected in percentages of 77, 63, 60 and 88 respectively. Prisoners mentioned that nurses render health care in the passages and in open spaces and they stand in a queue where the next person is within reach and can hear all about their health problems. They prefer to be treated in a room behind closed doors where they can communicate freely.

TABLE 4.16
PRIVACY BY NURSING STAFF

Honouring of privacy	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Privacy honoured	22	37	40	12	111
Privacy not honoured	77	63	60	88	288
Not applicable	1	0	0	0	1
Total	100	100	100	100	400

4.5.4.4 Dignity and respect

According to Table 4.17, prisoners feel they are not treated with dignity and respect, since nursing staff swear at them and call them degrading names like *bandiet*.

TABLE 4.17
TREATED WITH DIGNITY AND RESPECT

Dignity and respect	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Treated with dignity and respect	31	20	15	3	69
Not treated with dignity and respect	69	80	85	97	331
Not applicable	0	0	0	0	0
Total	100	100	100	100	400

4.5.4.5 Referral system to a medical officer

Table 4.18 reflects that prisoners are not referred to a medical officer if the initial health worker cannot solve the prisoners' problems. This is reflected by the following rating: 56%, 47%, 61% and 66% for institutions A, B, C and D respectively. The respondents did not motivate their answer.

TABLE 4.18
REFERRAL SYSTEM TO A MEDICAL OFFICER

Referral for second opinion	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Referred to medical officer	44	53	39	34	200
Not referred to medical officer	56	47	61	66	200
Not applicable	0	0	0	0	0
Total	100	100	100	100	400

4.5.4.6 Consultation/Participation

Table 4.22 shows that the majority of the prisoners in institution A and B were not involved or did not participate in decision making and the planning of their health care, as reflected by 61% and 45% respectively. Institutions C (46%) and D (47%) were involved only once. If nurses want cooperation and adherence to nursing and care regimen, they need to involve the clients/patients at all levels.

TABLE 4.22
PARTICIPATION IN DECISION MAKING

Involvement in planning health care	Primary Health Care Setting				
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	TOTAL (n=400)
Always involved	1	1	2	1	5
Rarely involved	13	17	35	9	74
Once involved	25	37	46	47	155
Not at all involved	61	45	17	43	166
Total	100	100	100	100	400

4.5.4.7 Complaints/comments from clients

Table 4.23 reflects that 89%, 92%, 89% and 93% of prisoners at institutions A, B, C and D respectively were not given an opportunity to complain about the standard of health care received. They stated that a questionnaire would be the most effective mechanism of rating the standard of health care and medium to raise their complaints.

TABLE 4.23
RAISING OF COMPLAINTS ABOUT THE STANDARD OF HEALTH CARE

Raise complaints about standard of health care	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Given an opportunity	11	8	11	7	37
Not given an opportunity	89	92	89	93	363
Total	100	100	100	100	400

4.5.4.8 Informed consent

Table 4.24 shows that 77%, 51%, 66% and 61% of the prisoners in Institutions A, B, C and D respectively received an explanation regarding the drawing of blood. In institutions B and C, only 56% and 70% of prisoners received information regarding the administration of eye medication. In institution C, only 62% of prisoners were told about the blood pressure assessment and 55% and 63% of prisoners in B and C respectively were informed about the administration of oral medication. It is clear from Table 4.21 that no information was given regarding the rest of the procedures and tests. Prisoners indicated that information was either not given or not applicable.

TABLE 4.24
EXPLANATION OF PROCEDURES BEFOREHAND

		Primary Health Care Setting			
		A (n=100)	B (n=100)	C (n=100)	D (n=100)
Drawing of blood	YES	45 (77%)	30 (51,5%)	35 (66,0%)	16 (61%)
	NO	13 (22%)	28 (48,5%)	18 (33,0%)	10 (38%)
	N/A	42 (0%)	42 (0%)	47 (0,0%)	74 (0,0%)
Changing of dressing	YES	20 (35%)	8 (22%)		
	NO	37 (64%)	27 (77%)		
	N/A	43 (0%)	65 (0%)	67 (0%)	50 (0%)
Instilling of eye drops	YES	25 (35%)			
	NO	45 (64%)			
	N/A	39 (0%)			
Assessing of blood pressure	YES				
	NO				
	N/A				
Administration of oral medication	YES				
	NO				
	N/A				
Administration of intramuscular injection	YES				
	NO				
	N/A				
Taking of temperature	YES				
	NO				
	N/A				

DATA NOT REFLECTING IS DUE TO THE FACT THAT THESE PROCEDURES WERE NOT OBSERVED/EXCECUTED DURING THE PERIOD THE RESEARCHER UNDERTOOK THE FIELDWORK. However, the findings of the three procedures that are reflected in Table 4.24 are concerning and indicate an unacceptable situation.

This situation is not acceptable, because research proved that if information is given to clients they tend to cooperate and comply with medical and nursing regimens. Furthermore, it allays anxiety (Richford and Lyall, 1995; Ley, 1988).

4.5.4.9 Consent

TABLE 4.25
CONSENTING FOR A PROCEDURE WHILST RECEIVING HEALTH CARE

Duration in Prison	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Gave consent	56	54	84	97	
Did not give consent	3	0	0	0	
Not applicable	41	46	16	3	
Total	100	100	100	100	

Table 4.25 shows that only 5% of prisoners in institution A (only) did not give consent. In the other institutions 100% of the prisoners gave consent where applicable.

The prisoners at institutions A, B, C and D gave written consent for an HIV test and for other tests they gave verbal consent. It is expected that any patient should give written consent for any procedure or test. That supplies proof of consent if any problem should occur.

4.5.5 Nursing process framework

4.5.5.1 Assessment

(a) Assessment of health condition on admission

The prescribed scope for practice obliges the nurse to assess a patient on admission or first contact. Table 4.26 shows clearly that the prisoners were not assessed. This aspect is professionally unacceptable, because scientific planning of nursing and treatment regimens cannot be done in the absence of

the necessary data.

TABLE 4.24
ASSESSMENT OF HEALTH CONDITION ON ADMISSION

Assessed by the nurse on admission	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Yes	60	46	68	71	
No	40	54	32	29	
Total	100	100	100	100	

(b) Assessment to clients' satisfaction

Table 4.25 shows that the prisoners were not satisfied with their assessment by the nurse and said that only their weight had been determined.

TABLE 4.25
ASSESSMENT TO YOUR SATISFACTION

Assessed to your satisfaction	Primary Health Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Satisfied	19	13	15	14	
Not satisfied	47	34	54	58	
Not applicable	34	53	31	28	
Total	100	100	100	100	

4.5.5.3 Implementation

(a) Comfort need attended to by the nurse

Table 4.26 shows clearly that their comfort need was not attended to by nurses when they are were in need thereof.

TABLE 4.26
COMFORT NEED ATTENDED TO BY THE NURSE

Duration in Prison	Primary Health Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Attended	28	30	48	29	
Not attended	72	70	52	71	
Total	100	100	100	100	

(b) Nutritional need attended to by the nurse

Table 4.27 reflects that prisoners were not happy with the attention to their nutritional needs. Those suffering from diabetes mellitus indicated that they were not getting a diabetic diet, and tuberculosis and HIV positive clients stated that they were not getting a well-balanced, high protein diet. They were further dissatisfied because the food was overcooked and the meat was not well prepared and served. The response therefore varied from not receiving the appropriate diet relevant to their disease, to receiving food that is overcooked, poorly prepared and badly served.

TABLE 4.27
NUTRITION NEED ATTENDED TO BY THE NURSE

Nutrition need attended	Primary Health Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Yes	37	22	21	9	
No	63	78	79	91	
Not applicable	0	0	0		
Total	100	100	100	100	

4.5.5.4 Health education

(a) Health education on health maintenance

Table 4.28 shows an alarmingly high percentage of prisoners in all four institutions, who do not receive health education. Health education is vital to educating clients on what to avoid, what to watch out for and what to report to nurses.

TABLE 4.28
HEALTH EDUCATION ON HEALTH MAINTENANCE

Taught health maintenance measures by the nurse	Primary Health Care Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Yes	26	18	13	13	
No	74	82	87	87	
Total	100	100	100	100	

(b) Self-care management by the nurse

Tables 4.29 and 4.30 show that prisoners are not taught self-care management principles at all. This finding continues with the finding that the prisoners are not

involved in the placing of their care and treatment.

TABLE 4.29
SELF-CARE MANAGEMENT BY THE NURSE

Taught self-care management by the nurse	Primary Health Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Yes	39	40	29	21	
No	61	60	71	79	
Total	100	100	100	100	

TABLE 4.30
SELF-CARE MANagements TAUGHT BY THE NURSE

	Primary Health Setting											
	A (n=100)			B (n=100)			C (n=100)			D (n=100)		
	Yes	No	Not applicable	Yes	No	Not applicable	Yes	No	Not applicable	Yes	No	Not applicable
Changing of dressing	9	12	79	11	8	81	4	13	83	1	9	90
Diabetes Mellitus	3	19	78	1	1	98	0	1	99	1	0	99
Personal hygiene	18	23	59	33	6	61	21	3	76	10	13	77
Skin care on Acne Vulgaris	4	17	79	3	17	80	6	7	87	6	14	80
Food to avoid:hypertension	6	14	80	3	5	92	2	6	92	0	11	89
Precipitating factors to avoid; epilepsy	5	16	79	0	0	100	1	3	96	0	3	97
Any other item	0	0	0	0	0	0	0	0	0	0	0	0

Table 4.31 shows that the majority of prisoners are not taught illness prevention measures by the nurses hence, the rating of 64% for institution A, 83% for institution B, 67% for institution C and 82% for institution D. Illness prevention measures are important to promote health and prevent sickness.

TABLE 4.31
ILLNESS PREVENTION MEASURES BY THE NURSE

Taught illness prevention measures by the nurse	Primary Health Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Yes	36	17	33	18	
No	64	83	67	82	
Total	100	100	100	100	

4.5.6 Evaluation of response

Table 4.32 shows that nurses do not evaluate response to therapy after therapeutic management has been executed, as reflected by 84%, 82%, 78% and 80% for institutions A, B, C and D respectively. All this supports the finding in 4.3.4.5 and 4.3.4.6 that health education is non-existent in the institutions and that follow-up evaluations are not done.

TABLE 4.32
EVALUATION OF RESPONSE TO THERAPY

Response to therapy evaluated by the nurse	Primary Health Setting				TOTAL (n=400)
	A (n=100)	B (n=100)	C (n=100)	D (n=100)	
Frequently	2	0	0	0	2
Rarely	2	2	1	1	6
Once	12	16	21	19	68
Not at all	84	82	78	80	324
Total	100	100	100	100	400

4.6 Summary

Data analysis showed that all four institutions lacked organizational skills, human resources development programmes, human resources administration skills, and human resources. This needs to be rectified as a matter of urgency in order to ensure that a quality prisoner health service is provided in future.

It also showed that the supplies and equipment were inadequate to render safe and quality patient care. It was also found that the nursing process was not applied when nursing procedures were being executed. Nursing personnel lacked skills in obtaining subjective and objective data, in making nursing diagnoses, in executing therapeutic measures, and in providing health education and follow-up evaluation. Accurate and complete recording of these components was lacking as well. The above-mentioned findings were supported by the findings after the analysis of outcome standards. Prisoners indicated that they were not satisfied with the manner in which they were assessed on admission, that they were not involved in the planning of their care, had not been taught self-care measures or illness prevention measures, and received no health education. Prisoners also indicated that nurses never evaluated the care given to them.

Evaluation and analysis of the data regarding process standards showed that the set standard had not been met at all. The structure, process and outcome standards did not meet the set standard at all.

CHAPTER 5 CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The researcher was concerned with the setting of standards to evaluate the care of prisoners in selected prisons in the Western Cape. Based on the findings, conclusions and recommendations are made to solve the identified problems.

5.2 Conclusions

The main conclusions are:

5.2.1 *Structure standards*

In all the selected prison primary health settings, the standards were below the standard set by the researcher.

The average for all structure standards were as follow for the four prisons A,B,C and D respectively: 38%,20%,20% and 19% as reflected in Table 4.1. This implies that the organization and leadership, human resource management and and equipment and supplies necessary for rendering of quality nursing care, do not meet the pre-set standard. Sub-standard structure affects nursing care negatively.

5.2.2 *Process standards*

The quality of screening of health disorders, management of health conditions and execution of nursing procedures were evaluated by using the set standards.

The researcher needs to mention that nursing care is rendered in the corridors and rooms next to the dining halls. Inmates stand in queues to receive health care and are treated with no privacy and dignity, as reflected in the low average of process standards. The specific standards where a low percentage was obtained, were the following:

- Screening of health disorders
- Management of health conditions
- Execution of nursing procedures
- Auditing of records

5.2.3 Outcome standards

This standard was evaluated by means of a patient's satisfaction questionnaire based on Batho Pele principles, patients' rights charter and nursing care. The hygiene of the clinic was acceptable to prisoners.

The prisoners were not happy with the following aspects:

- Health conditions in their cells
- Accessibility of health care(nurse and medical officer)
- Confidentiality
- Privacy
- Dignity and respect
- Participation in planning of health care
- Opportunity to raise complaints about the standard of health care
- Assessment on admission
- Comfort
- Food
- Health education

- Self care management
- Illness prevention measures
- Evaluation

The researcher concluded that the outcome standard was not satisfactory hence prisoners are not happy with the most important aspects of nursing care.

5.3 Recommendations

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

5.3.1 *Development of Quality/Health improvement model*

The Department of Correctional Services needs to develop a correctional services' health/quality improvement model which is comprehensive to cover the different aspects in ensuring quality health care (Table 5.1). These aspects are inter-related to each other and is a cyclic process.

6.3.1.1 Infrastructure; human and non-human resources

• Health information system(policy/protocol):

- The Department of Correctional Services needs to develop a primary health care policy.

Table 5.1: Quality improvement model

INFRASTRUCTURE	Human and non-human resources	<ul style="list-style-type: none"> • Health information system • Communication • Finance • Medical staffing • Nursing staffing • Pharmacy staffing • Human resource development
CORE SERVICES	Clinical services	<ul style="list-style-type: none"> • Reception screening • Comprehensive primary health care • Health promotion • Clinical risk reduction • Accurate record keeping
MANAGEMENT	Performance management	<ul style="list-style-type: none"> • Vision statement • Mission statement • Philosophy • Critical performance areas • Operational plan • Health care standards
EVALUATION AND MONITORING	Performance evaluation and monitoring	<ul style="list-style-type: none"> • Clinical governance and research • Operational plan • Health care standards • Client satisfaction • Critical performance areas • Key success factors • Objectives • Service delivery indicators and milestones • Deviations

5.3.1.1 Infrastructure: human and non-human resources

- **Health information system(policy/protocol):**

- The Department of Correctional Services needs to develop a primary health care policy.

- Each institution needs to develop an universal precaution policy and post- HIV exposure policy.
- Each institution should have protocols in place to manage health conditions and human resources.

- **Communication**

Nursing personnel should have monthly personnel meetings to update each other and to prevent any communication barriers.

- **Finance/Capital**

The finance should be known by the divisional head at least first month of financial year in order to avoid under and over-expenditure of funds.

- **Medical staffing**

Employ medical officers in order to meet the client's medical needs.

- **Nursing staffing**

Employ nurses to maintain optimal staffing in order to render quality health care.

- **Pharmacy staffing**

Employ a fulltime pharmacist in order to render efficient and effective pharmaceutical services to prisoners.

- **Human resource development**

Programmes should be instituted in the health centres to update personnel.

- **Accurate recordkeeping:** Auditing of patient records should be done at least three monthly.

5.3.1.2. Core services: clinical personnel

- **Reception screening**

Develop a screening protocol for all conditions and on admission in the prison.

- **Comprehensive primary health care**

Manage a comprehensive primary health care clinic concentrating on the following:

- **Preventative care:** nurses should do health promotion campaigns with the aim of preventing medical and mental diseases.
 - **Curative services:** nurses should do a proper assessment by taking a full history and complete physical examination, make a nursing diagnosis, prescribe a nursing regimen and evaluate the effect of the nursing regimen.
 - **Chronic diseases:** chronic diseases' care clinics should be held by nursing staff once a month for sufferers from chronic diseases like hypertension, asthma, epileptic and diabetic.
- **Health promotion:** initiate health education programmes aimed at promoting good health and the prevention of illness.
 - **Clinical risk reduction/management:** establish or strengthen a risk management programme concentrating on internal audits of clinic procedures, educational activities and effective patient representative programmes. Set standards must reflect a minimum level of safe and risk-free of practice.
 - **Accurate recordkeeping:** Auditing of patients records should be done at least three monthly.

5.3.1.3 Management: Performance Management

- **Vision statement:** formulate a vision statement which indicates the intention/direction of the nursing division/unit in response to changes in the environment.
- **Mission statement:** formulate a mission statement which tells the existence of the nursing division or unit in relation to the practice of nursing and of self care as defined by the nursing staff and in relation to the service being provided to the community/prisoners.
- **Philosophy:** formulate a written statement of philosophy in collaboration with nursing employees, the clients and other health care workers, reflecting the clinical practice of nursing, recognition of rights of individuals responsibilities of personnel and external forces (laws and community) and research and education.
- **Critical success areas/factors:** identify and analyse limited number of areas in which high performance will ensure success of the nursing/health division.
- **Operational plan:** develop the written blueprint for achieving objectives, specifying the activities and procedures that will be achieved, the responsible person, set the timetables for their achievement and cost involved
- **Health care standards:** Standards should be formulated for nursing care of prisoners.

5.3.1.4. Performance evaluation and monitoring

- **Clinical governance and research:** Primary health settings must develop their own research programmes in order to identify and solve problems in a scientific manner.
- **Operational plan:** annually review operational plans to check their relevance in attaining goals.
- **Health care standards:** Standards nursing care of prisoners should be reviewed annually.
- **Client satisfaction:** Prisoner care should be evaluated annually according to set standards and initiate service delivery questionnaire at each centre.
- **Critical success areas/factors:** evaluate the critical success areas annually.
- **Objectives:** evaluate the objectives annually.
- **Service delivery indicator and milestones:** evaluate service delivery indicators and milestones yearly.
- **Deviations:** analyse the deviations from attaining objectives yearly.

5.3.2. Communication of findings

The research findings should be made known to the institutions to enable them to start with remedial actions.

5.4. Summary

A need was identified to evaluate prisoner' health care in selected primary health settings in Western Cape prisons. The study focussed on structure, process and outcome standards. In this chapter the applicable conclusions and recommendations were discussed.

On overview,negative findings were obtained but the situation could be rectified by necessary remedial actions.

Quality nursing care can be rendered to prisoners if there are adequate and effective structures to produce quality processes and product.

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ADDENDUM A

DEPARTEMENT VAN
KORREKTIEWE DIENSTE



DEPARTMENT OF
CORRECTIONAL SERVICES

FAKSTRANSMISSIE
FAX TRANSMISSION

AAN: TO: UNIVERSITY OF STELLENBOSCH
VAN: FROM: U.K. SONTJALE.

U VERW.: DATUM: MY VERW.: DATUM:
YOUR REF: DATE: 2003-02-10 MY REF.: DATE: 2003-02-10

VIR AANDAG: PROF. EB NEUMANN NAVRAE: U.K. SONTJALE TEL.: 028-215861
FOR ATTENTION: ENQUIRIES: FAX: 028-215863

AFDELING: Dept of Nursing AANTAL BLADSTE: 40 AFDELING: NURSING SERVICES
DIVISION: DIVISION: NR. OF PAGES: DIVISION:

INSAKERE: RESEARCH PROPOSAL, PERMISSION FROM DEPARTMENT OF
CORRECTIONAL SERVICES AND AGREEMENT.

1. Refers to the above matter.
2. Attached find copies of Research Proposal (Chapter 1),
Permission and an agreement forms for Department of
Correctional Services.
3. For your attention and further handling

U.K. SONTJALE

U.K. SONTJALE

2003-02-10.

ADDENDUM B

21/11/2003 15:14 012-3285111

CORPORATE PLANNING

PAGE 01/01



DEPARTMENT: CORRECTIONAL SERVICES
REPUBLIC OF SOUTH AFRICA

Private Bag 6116, Pretoria, 0001, Tel: 012-307 2500 Fax: 012-307 2111
121 Church Street West, Pretoria Building West Block, 1116/1117

Reference: 6/7/1
Enquiries: Mr C Smith
Date: 2003-11-21

Mr. LK Sontysia
Private Bag x 051
Caledon
7230

Dear Mr. Sontysia

RE: PERMISSION TO CONDUCT RESEARCH ON "AN EVALUATION OF HEALTH CARE OF PRISONERS AT SELECTED INSTITUTIONS: NURSING PERSPECTIVE"

It is with pleasure that I wish to inform you that your request to conduct research in the Department of Correctional Services has been approved.

Please note that for purposes of sound research practice your research cannot be done in the prison where you are employed. It will be your responsibility to make arrangements for your visiting times. It is recommended that your identity document and the approval letter be in your possession when visiting the center.

Ms KM Mabens, Director Health, at telephone 012 307 2351 has been appointed as your internal guide. You are requested to contact her before you commence with your research project.

Should you have any enquiries regarding this process, please contact the research unit for assistance at telephone number 012-307 2171.

Your co-operation is highly appreciated.

Yours faithfully

For COMMISSIONER: CORRECTIONAL SERVICES
CHIEF DEPUTY COMMISSIONER: CENTRAL SERVICES
JA SCHRIBER (Ms)

PAGE 02/02

HELDERSTROOM

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ADDENDUM C

Structure standards

The organization, supply, maintenance and utilization of facilities, staff, equipments and stock enhances the rendering of quality health care.

Criteria	Present/Yes	No	Not applicable/N/A
1. Unit/Clinic			
1.1. Vision Statement			
If yes is it based on the following principles:			
• Is it future –oriented			
• Does it have business values			
• Does it state the role of the organization in the future world			
• Does it state factors making an organization to exist in the future			
Subtotal:5			
1.2. Mission statement			
If yes is it based on the following principles:			
• Does it have a target market and clients			
• Does it state the primary product or service			
• Does it include the geographical domain			
• Does it have an organizational philosophy			
Subtotal:5			
1.3. Annual operational plans			
If yes does it include the following:			
• Objectives:			
- Are they specific			
- Are they practical			
- Are they implementable			
- Are they realistic			
- Are they measurable			
• Frequency of the services of the clinic: services rendered daily, monthly or yearly			
• Responsibility: person responsible for certain service/tasks			
• Frequency of tasks/service: daily/monthly/weekly/continuously			
• Service delivery milestone: target date			
• Service delivery indicator: percentage/numbers to be achieved over specific period.			
Subtotal:12			
1.4. Finance			
• Is the clinic's budget known for the year?			
• If yes are the following yearly estimates calculated:			
-Transport			

-Drugs/medication			
-hospitalisation			
-outpatient/specialist			
-personnel costs			
-cleaning materials			
-telephone			
-stationary			
• Monthly recording of expenditure			
If yes does it reflect the following expenditure of each category:			
-Transport			
-Drugs/medication			
-hospitalisation			
-outpatient/specialist			
-personnel costs			
-cleaning materials			
-stationary			
-Telephone			
Subtotal:19			
1.5.Communication			
Is a list of the following numbers available:			
-Ambulance			
-Doctor			
-Referral hospital			
-Police			
Subtotal:5			
Total(1)			
2.Human Resource Development			
2.1.Orientation programme			
If yes does it include the following:			
• Vision statement of the clinic			
• Mission statement of the clinic			
• Operational plan of the clinic			
• How the clinic is managed			
• Roles of the colleagues			
• Role of the supervisor			
• Responsibilities of the colleagues			
• Responsibilities of the supervisor			
• Where supplies are kept			
• How to access the stock			
• How to restock			
• How the transport system works			
• How the communication works			
• How to arrange for leave			
• How to arrange for sick leave			
Subtotal:16			

2.2.Induction programme			
If yes must include the following:			
• Functions of the department or section			
• objectives			
• organogram			
• activities of the section			
• Tasks and responsibilities			
• based on the job description			
• performance standards			
• Policies,procedures,rules and regulations:-rules unique to tasks			
• Safety requirements and accident prevention			
• Viewing of the work place			
• Introduction to the employees			
Subtotal:12			
2.3.Continuous education			
• Is a continuous education programme in place?			
If yes is there records of:			
• Workshop attendance for personnel			
• Training sessions attendance of personnel			
• Job related(functional)meetings attendance recorded			
Subtotal:4			
2.4.In service training for personnel			
• Is there an in service training programme in operation			
• If yes does the supervisor do:-training analysis of the staff			
• Critical incident analysis			
• serve in the in-service training committee			
Subtotal:4			
Total(2):			
3.Human Resource Administration and Utilisation			
3.1.Staff Establishment/Organogram for the clinic			
If yes is it:			
• Displayed for all to see it			
• Is shortage of staff registered			
• Is excess staff registered			
Subtotal:4			
3.2.Job descriptions			
• Does each staff member have a job description			
If yes does a job description have or reflect the following:			
• Relates to the vision statement of the clinic			

• Relates to the mission statement of the clinic			
• Reflect management and supervisory responsibilities			
• Objectives of the unit			
• Each objective having:-Key customers/clients and/stakeholders inside and outside the organisation			
-tasks/duties that need to be performed			
-Reflect powers and authority			
-standards stipulating how the job should be done			
-Output(indicator)measuring the performance in relation to standards			
-frequency of tasks to be performed(daily/weekly)			
• Inherent requirements of the job:-job knowledge and skills description			
-technical skills e.g mathematical skills			
-communication and interpersonal skills			
-Description of personal attributes(attitude/understanding/behaviour,reasoning ability)			
-learning requirements(training/qualifications) e.g.diploma/Bachelors degree in Nursing			
-work environment:dangers of the job			
-physical demands of the job e.g long hours of standing			
• Reflect the essential duties and responsibilities:			
-perform a systematic assessment of client focusing on physiologic,psychologic and cognitive status of the client			
-Develops a goal directed plan of care			
-Involves client and other health care and multidisciplinary team members			
-Implements care by utilization and adhering to established standards			
-Evaluates effectiveness of care in progressing toward desired outcomes			
-Demonstrate competency in knowledge base,skills and psychomotor skills			
-Demonstrate applied knowledge base in structure standards,standards of care,protocols and patient care resources			
-Demonstrate knowledge of patient bill of rights			
-Organise and coordinates delivery of patient care in an efficient and cost effective manner			
-Documents the nursing process in a timely,accurate and complete manner			
-Demonstrate self-directed learning and participation in continuing education to meet own professional development			
-establishes and maintains direct,honest and open professional relationships with all health care team members,patients and significant others.			
-Supports research and its implications for practice			
-Adheres to unit and human resources policies			
-Incorporates into practice an awareness of legal and risk management issues and their implications			
Subtotal:34			

3.3..Task allocation			
• Written allocation of tasks to staff			
• Is there tasks diary/register			
Subtotal:2			
3.4.Work load estimation(norm is 1 nurse:240 prisoners)			
• For Daily Average prisoner population of 500: -Are there 2 professional nurses			
• For Daily Average prisoner population of 1000: -Are there 4 nurses consisting of: -3 professional nurses -1 enrolled or enrolled nursing auxillary			
• For Daily Average Prisoner Population of 1100-1300: -Are there 5 nurses consisting of: -4 professional nurses -1 enrolled or enrolled nursing auxillary			
• For Daily Average prisoner population of 1400-1500: -Are 6 nurses consisting of: -5 professional nurses -1 enrolled or enrolled nursing auxillary			
Subtotal:			
3.5.On call roster			
If there is on call roster does it reflect the following:			
• A daily roster for professional nurse on call for after hours :duty			
• Enrolled nurses on call after hours as well.			
• Enrolled nursing auxillaries on call after hours as well.			
• The enrolled nurse on call does she/ he carry scheduled drug cupboard keys?			
• The enrolled nursing auxillary on call does she/he carry the scheduled drug cupboard keys?			
• When enrolled nurse/enrolled nursing auxillary on call, is there standby professional nurse available to help him or her:			
• Are the contact numbers of person on call reflect on on-call roster?			
Subtotal:			
3.6.Monthly Clinic staff meetings			
• Are unit meetings held monthly?			
• Are minutes available?			
• Do the minutes reflect discussion of the following: -Leave for staff -Training issues -The roster -Finances -Drug and supplies			

-Feedback re-meeting with Regional Health co-ordinator			
-Transport			
Subtotal:10			
3.7.Staff qualifications			
<ul style="list-style-type: none"> Is there one professional nurse qualified in Primary Health Care per shift? 			
Subtotal:1			
3.8.Staff Health and Safety			
3.8.1 Compliance to Occupational Health and Safety Act(85 of 1993):-appointment of health and safety representatives			
-appointment of safety committees			
-conduction of inspections			
-convening of meetings by committee members:monthly			
Subtotal:3			
3.8.2.Infection control(universal precautions)			
Is there infection control policy available?			
Is infection policy reflect the following:			
-Use of barrier precautions:gloves			
-Hand washing(before and after patient care,after removing gloves)procedure			
-Resuscitation and ventilation equipment for mouth-to-mouth resuscitation availability			
-Preventing staff having exudates lesions or weeping dermatitis from patient care			
-Correct handling of sharps			
-Immediate cleaning of blood spills with gloves on			
-Handling all patients specimens as biohazardous			
-Immediate reporting of sharp injuries,mucosal splashes			
Subtotal:9			
3.8.3.Management of sharps			
Sharps management procedure in place?			
Covers and measures to :			
-ensure that container is properly assembled before use			
-ensure accessibility of containers			
-Have one container for each work area			
- ensure that when moving the container, the lid is closed according to procedure			
-ensure that the needle and syringes are immediately placed into the container after used it			
-ensure that when the container is three quarter full ,sealed and placed in a safe storage area until collected			
Subtotal:7			

3.8.4.Management of soft waste			
Is soft waste management procedure in place?			
Includes measures to:-Ensure that the medical soft waste is assembled and lined with a red plastic bag according to procedure			
-ensure that all work stations have available plastic packets for disposal of used swabs			
-ensure that boxes are kept in safe and accessible places according to clinic needs e.g.dressing room/sluite			
-ensure that when the container is full,it is kept in a safe storage area until collected			
-Ensure that the clinic has an adequate stock of empty medical soft waste boxes to replace those used.			
Subtotal:6			
3.8.5.Post HIV exposure prophylaxis(PEP) policy for employees and prisoners			
PEP policy in place?:			
Includes measures to :			
-ensure immediate actions post exposure			
-ensure that potential exposures are considered for PEP(e.g.needle stick injury,exposure to mucous membrane,rape)			
-ensure that the HIV status of the exposure source are determined			
-ensure that follow up tests for HIV blood from victim and source(3 months,6months) are done			
Subtotal:6			
Total(3):			
4.Health Community Development Forums			
4.1. Health Prisoner- community Committee			
• Does a clinic committee/community Health committee Exist?			
• Are minutes of such committee available?			
• Does the minutes reflect the following:			
-attendance register of staff members to this meetings			
-attendance of inmates in this meetings			
-Do staff present clinic issues like disease pattern			
-Do staff present clinic issues like problems with defaulters that the community members may assist with			
Subtotal:7			
4.2.Prisoner Community involvement			
• Is prisoner community involve with clinic/facility needs?			
If yes does prisoner community assist with:			
• Peer to peer HIV/AIDS education			
• Referral of clients displaying symptoms of disease e.g.Tuberculosis.			
Subtotal;3			

Total(4):			
5.Equipment and facilities			
5.1.Consulting Room			
• 1 examination couch			
• 1 table			
• One chair			
• One small dressing trolley			
• One scale			
• One examination light			
• One baumanometer(wall/desk/mobile)			
• One stethoscope			
• One Patella hammer			
• One diagnostic set			
Subtotal:10			
5.2.Procedure Room			
• One haemoglobin metre			
• One examination light			
• One kickabout			
• One diagnostic set			
• One eye chart			
• One baumanometer(wall/desk/mobile)			
• One stethoscope			
• Non-touch taps with basin			
• Paper towel dispenser with paper towels			
• Soap dispenser with liquid soap			
Subtotal:			
5.3.Linen Room			
• One Linen room with:			
• Sheets:10			
• Blankets:20			
• Pillows:10			
• Patient Gowns:5			
Subtotal:5			
5.4.Dirty/Utility store			
• One bedpan			
• One urinal			
• One soiled linen receiver			
• Sputum mug			

Subtotal:5			
5.5.Instruments			
<ul style="list-style-type: none"> • One stich scissors/Scapel blade holder • One mayo scissors • One needle holder • One tissue forceps • One Artery forceps 			
Subtotal:5			
5.6.Emergency measures			
<ul style="list-style-type: none"> • One emergency trolley at the clinic 			
If yes does it have the following:			
(a)solutions			
<ul style="list-style-type: none"> • Ringer's lactate 1Litre:2 • Haemacel 500ml:2 • Dextrose in Water 1L:2 • Sodium Chloride 0.9% 1Litre:2 			
(b)Equipment and supplies			
<ul style="list-style-type: none"> • Syringes 2ml:5 • Syringes 5ml:5 • Syringes 10ml:5 • Blood administration set:1 • Strapping(transparent):2 • Torniquet:1 • Webcols:10 • Cannula size 16G,18G,20G:2each • 15 dropper IVI administration set:1 • one way valve resuscitator • Airway size 2,3,4:1 each • Laryngoscope with batteries:1 • Laryngoscope's blades: size 2,3,4:one each • Endotracheal tubes size 7,7.5,8,8.5:1 each • Ambubag with reservoir:1 • Oxygen tubing:1 • Oxygen cylinder with oxygen:1 			
©Medication			
<ul style="list-style-type: none"> • Adrenaline 1:1000 ampoules:5 • Antihistamine 5mg/ml:5ampoules • Dextrose 50% ampoules:1 • Sodium Chloride 0.9% 10ml :5 • Atrovent 0.5mg/ml • Berotec 1.25mg/ml 			
(d)Checking and controlling			
<ul style="list-style-type: none"> • Daily checking of emergency trolley done 			
Subtotal:28			

5.7. Drugs and Supplies			
5.7.1. Stock secure			
• Locked in the secure place			
• Are drugs and supplies protected from excess heat			
• Are drugs and supplies protected from water damage(on shelf)			
Subtotal:3			
5.7.2. Stock cards			
• Are stock cards used?			
• Are stock cards up to date(real total correlate with stock on cards)?			
Subtotal:2			
5.7.3. Record of monthly stock usage			
Record in place :			
• If yes is it done weekly on:			
• Computer and or			
• Monthly stock register(issued)?			
Subtotal:3			
5.7.4. Organisation of stock			
• Oral suspension kept away from parenteral preparations			
• Stock packed on the principle of first expiry, first out			
• Kept on the clearly marked shelves			
Subtotal:3			
5.7.5. Supplies			
• Sterile 2ml syringes: 50			
• Sterile 5ml syringes :50			
• Sterile 10ml syringes : 50			
• Sterile needle size 21G:100			
• Sterile needle size 22G:100			
• Sterile needle size 20G:100			
• Intravenous needle size 14G:10			
• Intravenous needle size 16G:10			
• Intravenous needle size 18G:10			
• Intravenous needle size 20G:10			
• Intravenous Administration Set:15dropper:5			
• Adult Blood Administration set:5			
• Savlon antiseptic solution5L:5			
• 4%Chlorhexidine Gluconate 5L:5			
• Haemacel 500ml:5			

• Ringers Lactate 1L:5			
• Normal Saline 1L:5			
• Normal Saline 200ml:2			
• Sterile Packs for dressing:50			
• Sterile Packs for catheterisation:5			
• Liquid soap 5L:5			
• Bandages 50mm:50			
• Bandage 75mm:50			
• Bandages 100mm:50			
• Sterile cotton wool packs:50			
• Sterile gloves:10boxes			
• Unsterile gloves :10boxes			
Subtotal:25			

• Ringers Lactate 1L:5			
• Normal Saline 1L:5			
• Normal Saline 200ml:2			
• Sterile Packs for dressing:50			
• Sterile Packs for catheterisation:5			
• Liquid soap 5L:5			
• Bandages 50mm:50			
• Bandage 75mm:50			
• Bandages 100mm:50			
• Sterile cotton wool packs:50			
• Sterile gloves:10boxes			
• Unsterile gloves :10boxes			
Subtotal:			
Total(5):			
GrandTotal(5):			

ACCURATE AND LEGAL DOCUMENTATION

The primary health care nurse at all times ensures accurate and legal documentation to promote safe and high quality patient care.

.Accurate recording

Criteria	Observed/D one	Not observed /not done	Not applicable
1.Recording of:			
• Subjective data about the patient			
• Objective data about the patient			
• Nursing diagnosis			
• Therapeutic management by the nurse			
• Health education by the nurse			
• Follow up evaluation of nursing management			
• Referral entry by the nurse			
• Name of patient on file			
• Name of patient on each cardex			
• Number of patient on file			
• Number of patient on each cardex			
• Date and time of each entry by the nurse			
• Legible handwriting by the nurse			
• Each entry is identified by name of the nurse			
• Entry identified by rank of the nurse			
• Changes are ruled out with single line and indicated as such by the nurse			
SUBTOTAL:			

Abscess

Criteria	Observed/ Done	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Sbjective data					
• Localized pain					
• Fever,chills					
• Malaise					

• headache					
1.2.Objective data					
• redness					
• swelling					
• tenderness of skin					
• Drainage:-amount					
-colour and odour					
• tachycardia					
• increased temperature					
2.Nursing diagnosis made and recorded					
2.1.Impairment of skin integrity related to altered turgor,circulation and oedema					
2.2.Alteration in comfort:pain related to tissue inflammation					
2.3.Knowledge deficit regarding self care management					
3.Management of client					
3.1.Therapeutic management(:optimal level of client's skin integrity and prevention of further infection)					
• Bed rest maintained with extremity elevated and immobilised					
• Cool compressions applied					
• Warm compressions applied					
• Area assessed for ulceration and skin breaks					
• Wound dressing :- aseptic technique maintained					
- sterile dressing applied					
-wound isolated:(bandage/plaster)					
• Medical management:- antibiotics administered as ordered					
• -Antipyretic					

administered as necessary					
3.2. Therapeutic management (:Expression of minimal discomfort or absence of pain)					
<ul style="list-style-type: none"> affected extremity maintained in ordered position 					
<ul style="list-style-type: none"> need for immobilization for 48—72 hours explained 					
<ul style="list-style-type: none"> Analgesics administered as ordered or per pain 					
<ul style="list-style-type: none"> position frequently(4hourly) changed to prevent pressure and fatigue 					
<ul style="list-style-type: none"> exercises to unaffected extremities encouraged 					
3.3. Health education :demonstrate understanding of self care management					
<ul style="list-style-type: none"> Demonstrate wound care and dressing change procedure 					
<ul style="list-style-type: none"> Stress importance of aseptic technique 					
<ul style="list-style-type: none"> Discuss maintaining elevation and immobilization of extremity 					
<ul style="list-style-type: none"> Explain signs and symptoms to report:- wound pain 					
-increased drainage					
-fever chills					
-headache					
-foul odour from dressing and wound					
<ul style="list-style-type: none"> Stress importance of nutritional diet to promote wound healing 					

Measuring Blood Pressure:Adult

Criteria	Observed/D one	Not observed/ not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective and objective data					
<ul style="list-style-type: none"> Determine the usual blood pressure for this client and note if this is within normal limits for the client's age and sex 					
<ul style="list-style-type: none"> Determine the time the client last :-ate 					
smoked -					
exercised -					
<ul style="list-style-type: none"> Assess for evidence signs of hypertension:-frequent nose bleeding 					
-irritability					
moderate headache -Mild or					
-flushing					
-ringing in the ears					
<ul style="list-style-type: none"> Observe client for other evidence indicating risks of blood pressure changes:-chest pains 					
-difficult in breathing					
-severe headache					
- tachycardia or bradycardia					
2.Nursing diagnosis					
2.1.Altered tissue perfusion related to changes in the systolic or diastolic blood pressure					
3.Planning					
3.1.Supplies and equipment					
<ul style="list-style-type: none"> Stethoscope 					
<ul style="list-style-type: none"> Sphygmomanometer with intact arm band with inflation cuff 					
4.Implementation					
4.1.For an arm blood pressure					
<ul style="list-style-type: none"> Explain the procedure to the client 					

<ul style="list-style-type: none"> • Wash hands 					
<ul style="list-style-type: none"> • Let the client sit down for 5 minutes before taking blood pressure 					
<ul style="list-style-type: none"> • Help the client assume an appropriate position :sit down or lie down 					
<ul style="list-style-type: none"> • Expose the upper arm 					
<ul style="list-style-type: none"> • Place the exposed arm straight on the flat surface 					
<ul style="list-style-type: none"> • Wrap the deflated adult cuff evenly around the upper arm so that the centre of the bladder is applied directly over the medial aspect of the arm 					
<ul style="list-style-type: none"> • Perform a preliminary palpatory determination of systolic pressure 					
<ul style="list-style-type: none"> • Check the mercury level to ensure it is at zero 					
<ul style="list-style-type: none"> • Position yourself within 3 feet of sphygmomanometer so that the meniscus is at eye level 					
<ul style="list-style-type: none"> • Palpate the brachial artery with the fingertips at the antecubital space 					
<ul style="list-style-type: none"> • Close the valve on the pump by turning the knob clockwise 					
<ul style="list-style-type: none"> • Pump up the cuff until you no longer feel the brachial pulse 					
<ul style="list-style-type: none"> • Note the pressure on the sphygmomanometer at which the pulse is no longer felt 					
<ul style="list-style-type: none"> • Release the pressure completely in the cuff and wait for 1-2 minutes before further measurement are made 					
<ul style="list-style-type: none"> • Insert the ear attachment of the stethoscope in your ears so that they tilt slightly forward 					
<ul style="list-style-type: none"> • Ensure that the stethoscope hangs freely from the ears to the diaphragm 					
<ul style="list-style-type: none"> • Place the diaphragm of the stethoscope over the brachial artery 					
<ul style="list-style-type: none"> • Pump up the cuff until the sphygmomanometer registers about 30mmHg above the point where the brachial pulse disappears 					
<ul style="list-style-type: none"> • Release the valve on the cuff carefully so that the pressure decreases at the rate of 2-3mmHg 					

per second					
<ul style="list-style-type: none"> As the pressure falls identify the manometer readings at each phase 					
<ul style="list-style-type: none"> Deflate the cuff rapidly and completely 					
<ul style="list-style-type: none"> Remove the cuff from the client's arm 					
<ul style="list-style-type: none"> Inform the client of his or her blood pressure readings 					
<ul style="list-style-type: none"> Reposition the client comfortably 					
5.Documentation					
<ul style="list-style-type: none"> Document blood pressure readings:-systolic/diastolic 					
6.Recording/report					
<ul style="list-style-type: none"> Systolic blood pressure>140mmHg 					
<ul style="list-style-type: none"> Diastolic blood pressure >90mmHg 					
<ul style="list-style-type: none"> Systolic blood pressure <100mmHg 					
7.Evaluate					
<ul style="list-style-type: none"> client's systolic and diastolic blood pressure measurement for values within normal ranges for his or her age and sex 					
Subtotal:					

Acne Vulgaris

Criteria	Observed /Done	Not observed/n ot done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective data					
<ul style="list-style-type: none"> Client complains of lesions on face or neck 					
1.2.Objective data					
<ul style="list-style-type: none"> comedones on the face or 					

neck or					
• pustules on the face or neck or					
• cysts on the face or neck					
2.Nursing diagnosis made and recorded					
2.1.Impaired skin integrity due to pilosebaceous plugging, inflammation and potential cyst formation					
2.2.Knowledge deficit regarding disease process and self care management					
3.Management of client					
3.1.Therapeutic management(:(skin integrity to return to almost normal condition)					
• Antibiotics administered as ordered					
• 5% benzoyl treatment administered as ordered to prevent new lesions					
3.2.Health education:					
• patient verbalises understanding of disease process and self care management					
• Assess client's skin care practices					
• Reinforce compliance with topical or systematic therapy and appropriate skin cleaning methods					
• Teach client to avoid skin damage by not squeezing,pricking or picking on lesions					
• Wash face with soap and water 2-3times a day					
• Avoid cosmetics and hair spray					
4.Follow up evaluation					
• Improvement of conditions					
• Understanding of disease process and self care management					
5.Referral done if:					

• No improvement after 3 months					
• Development of severe complications					
SUBTOTAL:18					

Applying dressing

criteria	Observed/ done	Not observed/ Not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective and objective data					
• Note location,size and shape of wound					
• Inspect current dressing if present					
• Note presence of moisture or drainage on the outside of dressing					
• Inspect wound for :-volume					
-colour					
-viscosity					
-odour of exudate					
• Determine presence of wound pain,ask the client to describe it					
• Note elevation of temperature or pulse					
• Determine the client willingness to be involved in the dressing change					
2.Nursing diagnosis					
2.1.Impaired skin integrity actual or potential					
2.1.High risk of infection related to the presence of wound					
2.3.Pain					
2.4.Health seeking behaviour related to knowledge deficit of wound care					
3.Planning					
3.1.Supplies and Equipment					
• Sterile gloves					
• Sterile dressing set:-sterile drapes					
-cotton balls					

or swabs					
pads(4x4 or 2x2s)	-Gauze				
pads	-abdominal				
container	-basin or				
	-forceps				
proof bag	-water				
• Scissors					
• Sterile solution					
• Dressing material like nonadherent or transparent dressing					
• Ointment					
• Elastic bandages					
• Linen saver					
4.Implementation					
4.1..Preparing for a dressing application or change					
• Explain to the client what will be done and why					
• Administer pain relief measures as necessary					
• Bring equipment in the client's room or dressing room					
• Instruct the client not to touch sterile supplies during the procedure					
• Provide privacy					
• Position the client for comfort and accessibility to the wound					
• Drape with a linen saver					
• Wash hands					
• Place the waterproof bag within easy reach, fold the top of the bag back to create a cuff					
4.2.Removing the dressing,cleaning the wound and reapplying sterile dressing					
• Remove the dressing binder or untie straps					
• Loosen the tape (if used)by holding skin and peeling the edge of the tape					
• Remove tape by pulling parallel with and toward the dressing					

• Put on disposable gloves					
• Grasp a corner of the dressing at the edge away from the client's face					
• Roll it back to remove					
• Observe the amount and character of drainage on the dressing					
• Fold the dressing inward on itself and dispose in the bag					
• Remove gloves and dispose in the bag					
• Wash hands					
• Open sterile dressing tray on the trolley and add supplies					
• Fill the basin with cleaning solution					
• Use sterile forceps or sterile gloves to remove contact dressing					
• Discard them in the bag					
• If the dressing adheres to the wound moisten it with cleaning solution					
• Note the colour, odour, amount of dressing					
• Discard forceps or remove gloves and discard in the bag					
• Put on sterile gloves					
• Pick up cotton balls or gauze					
4.3. Clean the wound					
• With cotton balls or gauze stroke firmly from proximal to distal					
• First over the incision and then adjacent to the incision					
• Discard used gauze or cotton balls after each stroke					
• Firmly stroke an irregular wound from centre outward with circular motions					
• Dry the wound or incision in the same manner using dry cotton balls or gauze					
• Apply ointment or solution to the wound as ordered using a sterile technique					
• Apply sterile gauze directly over the wound in sufficient amounts to absorb drainage					

<ul style="list-style-type: none"> Remove and discard gloves in the bag 					
<ul style="list-style-type: none"> Secure dressing with tape or straps or binders 					
<ul style="list-style-type: none"> Discard the remaining materials and supplies 					
<ul style="list-style-type: none"> Remove the drape/linen saver 					
<ul style="list-style-type: none"> Position the client comfortably 					
<ul style="list-style-type: none"> Wash hands 					
5.Evaluation					
<ul style="list-style-type: none"> Client's wound dressing adheres smoothly to the skin and does not drain solution or exudates 					
<ul style="list-style-type: none"> Client's ability to move freely and unrestricted by the applied dressing 					
<ul style="list-style-type: none"> Verbal and nonverbal responses indicating client is comfortable during and after the procedure 					
<ul style="list-style-type: none"> Client's ability to explain the reason for and the technique of removing and applying the dressing 					
Subtotal:					

<p>1. Nursing diagnosis made and recorded</p> <p>1.1 Anxiety</p> <p>1.2 Impaired gas exchange</p> <p>1.3 Knowledge deficit regarding self care management</p>					
<p>2 Management of client</p> <p>2.1 Therapeutic management (reduction of anxiety or fear by the client)</p> <p>- emotional support provided</p> <p>- remain with the client when anxious</p> <p>- prior reassurance provided</p> <p>- bedrest maintained in quiet environment</p>					

Asthma

Criteria	Observed/done	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective data					
<ul style="list-style-type: none"> Increased tightness of the chest(dyspnoea Anxiety Restlessness Attack history:contact with allergen 					
1.2.Objective data					
<ul style="list-style-type: none"> Tachcardia Tachypnoea Dry,hacking,persistent cough Respiratory assessment:-audible expiratory wheeze -use of accessory muscles for inspiration General appearance:-cyanosed -distended neck veins Diagnostic test:-reduced vital capacity -decreased forced expiratory volume 					
2.Nursing diagnosis made and recorded					
2.1.Anxiety					
2.2.Impaired gas exchange					
2.3.Knowledge deficit regarding self care management					
3.Management of client					
3.1.Therapeutic management(:reduction of anxiety or fear by the client)					
<ul style="list-style-type: none"> emotional support provided -remain with the client when anxious -quiet reassurance provided - bedrest maintained in quiet environment 					

<ul style="list-style-type: none"> • patient reassured that oxygen and medical therapy can control attacks 					
<ul style="list-style-type: none"> • procedures explained 					
<ul style="list-style-type: none"> • Relaxation techniques taught 					
<ul style="list-style-type: none"> • sips of water encouraged 					
<ul style="list-style-type: none"> • Remain with the client during coughing episodes/attacks 					
3.2. Therapeutic management (:maintenace of patent airway caused by bronchospasm)					
<ul style="list-style-type: none"> • head of bed elevated 60 to 90 degrees 					
<ul style="list-style-type: none"> • back supported with pillows 					
<ul style="list-style-type: none"> • well-padded overbed table provided to lean over 					
<ul style="list-style-type: none"> • side rails placed up for safety and support 					
<ul style="list-style-type: none"> • low flow of oxygen administered by nasal catheter 					
<ul style="list-style-type: none"> • oxygen mask avoided 					
<ul style="list-style-type: none"> • medication administered as prescribed 					
3.3. Health education :aimed at demonstrating understanding of self care					
<ul style="list-style-type: none"> • avoid known irritants like dust 					
<ul style="list-style-type: none"> • avoid stressful situations 					
<ul style="list-style-type: none"> • express anxieties and fears 					
<ul style="list-style-type: none"> • stop smoking if smoking 					
<ul style="list-style-type: none"> • avoid persons who smoke 					
<ul style="list-style-type: none"> • explain importance of breathing exercises 					
<ul style="list-style-type: none"> • encourage medication compliance 					
4. Follow up evaluation					
4.1.Reduction in fear and anxiety evidenced by:					
<ul style="list-style-type: none"> • relaxed facial expression 					
<ul style="list-style-type: none"> • verbalizes feeling less 					

anxious					
• normal breathing pattern					
• blood pressure and pulse rate normal					
4.2.Maintain a patent airway evidenced by:					
• improved breath sounds					
• normal rate and depth of respirations					
• absence of dyspnoea					
• absence of cyanosis					
4.3.Demonstrate knowledge in self care management					
• verbalizes principles of self care management					
5.Referral done if:					
• No improvement:-tight chest					
-short of breath					
-dyspnoea					
Subtotal:					

• Dyspnoea					
• Cyanosis					
1.Nursing diagnosis made and recorded					
2.1.Ineffective airway clearance related to increased mucous secretions					
2.2 Ineffective breathing pattern related to increased lung expansion					
2.3.Low-levels of self care management					
3.Management of client					
3.1.Therapeutic management:patient will maintain a patent airway					
• Position patient in comfortable position; head elevated 45 to 60 degrees					
• Humidified oxygen provided					
• Fluids 30ml .3L to 3L daily unless					

Bronchitis

Criteria	Observed/D one	Not observed/not done	not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective data					
<ul style="list-style-type: none"> • Malaise • Anorexia 					
1.2.Objective data					
<ul style="list-style-type: none"> • elevated temperature • Cough:-nonproductive -mucopurulent sputum • Breath sounds:-crackles -decreased -absent -rhonci • Haemoptysis • Wheezing respirations • Bronchospasms • Dyspnoea • Atelectasis 					
2.Nursing diagnosis made and recorded					
2.1.Ineffective airway clearance related to increased tracheobronchial secretions					
2.2.Ineffective breathing pattern related to decreased lung expansion					
2.3.knowledge deficit regarding self care management					
3.Management of client					
3.1.Therapeutic management(:patient will maintain a patent airway)					
<ul style="list-style-type: none"> • Position patient in comfortable position: head elevated 45 to 60 degrees • Humidified air provided • Fluids forced :2L to 3L daily unless 					

contraindicated					
<ul style="list-style-type: none"> • Patient is assisted and taught to turn, cough, and deep breathing 2 hourly 					
<ul style="list-style-type: none"> • Chest is auscultated for breath sounds 8 hourly 					
<ul style="list-style-type: none"> • Oral hygiene administered after productive cough 					
<ul style="list-style-type: none"> • Temperature, pulse and respiration checked 4 hourly 					
<ul style="list-style-type: none"> • Suctioned as necessary 					
<ul style="list-style-type: none"> • bronchodilators administered as ordered 					
<ul style="list-style-type: none"> • antibiotics administered as ordered 					
3.2. Therapeutic management (:patient will resume an effective breathing pattern)					
<ul style="list-style-type: none"> • signs and symptoms of ineffective breathing monitored:-shallow respirations 					
-dyspnoea					
-use of accessory muscles					
<ul style="list-style-type: none"> • Oxygen therapy administered as ordered 					
<ul style="list-style-type: none"> • Fluids intake is encouraged to keep secretions thin if not contraindicated 					
<ul style="list-style-type: none"> • Suction if necessary 					
<ul style="list-style-type: none"> • Patient is placed in High-fowler's position to maximize chest expansion 					
<ul style="list-style-type: none"> • Medication administered as ordered 					
3.3. Health education (:Patient will demonstrate understanding of self care management)					
<ul style="list-style-type: none"> • Explain the importance of not smoking or avoid persons who smoke 					
<ul style="list-style-type: none"> • Explain need to reduce exposure to air pollution 					
<ul style="list-style-type: none"> • Explain importance of 					

taking more fluids					
<ul style="list-style-type: none"> Explain the importance of maintaining weight within normal limits for age and height 					
<ul style="list-style-type: none"> Explain need to exercise to tolerance to avoid fatigue 					
<ul style="list-style-type: none"> Discuss symptoms to report to clinic:-elevated temperature 					
-cough					
-respiratory distress					
-flu or cold					
<ul style="list-style-type: none"> Discuss medications:-name 					
-Dosage					
-time of administration					
-purpose					
-side-effects					
<ul style="list-style-type: none"> Explain avoidance of following situations:-persons with URI 					
-crowds					
-chilling					
4..Follow up evaluation					
<ul style="list-style-type: none"> Improved breath sounds 					
<ul style="list-style-type: none"> Normal rate and depth of respiration 					
<ul style="list-style-type: none"> Absence or improvement of dyspnoea 					
<ul style="list-style-type: none"> Absence of cyanosis 					
<ul style="list-style-type: none"> Patient demonstrate increased knowledge regarding self care management 					
5.Referral done if:					
<ul style="list-style-type: none"> Infections of the respiratory tract 					
<ul style="list-style-type: none"> Respiratory insufficiency 					
<ul style="list-style-type: none"> Respiratory failure 					
Subtotal:					

Knowledge:Preparation of medication during Resuscitation

Criteria	Known/Correct	Unknown/Incorrect	Not applicable	Recorded	Not recorded

1. Medication preparation: Resuscitation					
<ul style="list-style-type: none"> Set up an IV infusion line: Sodium Chloride or Ringer's Lactate 					
<ul style="list-style-type: none"> Use 10ml syringe to draw 1ml of Adrenaline 1:1000 and dilute in 9ml of Sodium Chloride to make 10ml 					
<ul style="list-style-type: none"> Use 10ml syringe to draw 1mg/ml of Atropine and dilute with 9ml of Sodium Chloride to make 10ml 					
Total:					

Collecting and testing urine specimen

Criteria	Observed/Done	Not observed/not Done	Not applicable	Recorded	Not recorded
1. Assessment					
1.1. Subjective and objective data					
<ul style="list-style-type: none"> Determine the purpose of urine test :-burning micturition -Lower back pain 					
<ul style="list-style-type: none"> Determine the client's physical and mental ability to collect specimen independently 					
<ul style="list-style-type: none"> Note the last time the client voided 					
2. Nursing diagnosis					
2.1. Inability to void normally due to possible infection					
2.2. Health seeking behaviour related to knowledge deficit of urine test					
3. Planning					
3.1. Supplies and equipments					
<ul style="list-style-type: none"> Urinal/bedpan or collecting jar 					
<ul style="list-style-type: none"> Specimen container 					
<ul style="list-style-type: none"> Toilet tissue 					
<ul style="list-style-type: none"> Disposable wash cloth 					
<ul style="list-style-type: none"> Antiseptic solution or soap 					
<ul style="list-style-type: none"> Testing kit(urine dipstix) 					

• Gloves					
• Sterile cotton balls					
4.Implementation					
4.1.Obtainng clean urine specimen					
By the client					
• Ask the patient to void into the large plastic cup					
• Pour a small amount into the small plastic cup					
• Place the cover on it and discard the remaining urine in the toilet					
• Leave the covered specimen in the bathroom/sluiice room					
• Wash your hands					
• Tell the nurse when he is finish for the nurse to send specimen for to the laboratory.					
• Provide the client with privacy.					
• The nurse place specimen in plastic bag					
• The nurse label the specimen;-client's name					
folder number -client's					
time of collection -date and					
By the nurse					
• Put on gloves					
• Place urinal or bedpan in position and instruct the client to void					
• Remove bedpan when the client is finish voiding					
• Take urine to the bathroom or utility room					
• Pour designated amount of urine into the specimen receptacle and cover it					
• Discard gloves and wash hands					
• Place specimen in plastic bag					
• Label the specimen;-client's name					
folder number -client's					
time of collection -date and					

4.2.Instructing the client to collect a midstream specimen					
• Wash hands thouroughly					
• Clean the perineal area around urinary meatus using the disposable washcloth					
• Wah hands again					
• Soak the cotton balls with the antiseptic soap					
• Using a cotton ball, clean around external meatus with a single stroke					
• Discard the cotton bal after one use, continue cleansing until clean					
• Void a small amount ;hold the urinary stream					
• Void urine into the sterile specimen container					
• Holding the container only on the outside					
• Stop voiding when the container is three quarter full					
• Void the remaining urine in the toilet/urinal/bedpan					
4.3.Testing urine for contents					
• Explain to the client what will be done					
• Wash hands					
• Put on gloves					
• Collect the urine specimen					
• Take the specimen to a work area					
• Follow instructions on the test package exactly					
• Discard urine and test materials when the test is complete					
• Inform the client of the results					
5.Evaluation					
• Client's understanding of the need for urine specimen and ability to provide a specimen unaided in the future					
• Clean or sterile urine specimen is provided by the client in the manner described					

6.Referral					
<ul style="list-style-type: none"> Any abnormalities in the urine 					
<ul style="list-style-type: none"> Unable to void despite bladder full 					
Subtotal:					

Collecting of blood specimen

	Observed/ done	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective and objective data					
<ul style="list-style-type: none"> Determine the reason for the blood specimen 					
<ul style="list-style-type: none"> Determine the client understanding of the blood test 					
<ul style="list-style-type: none"> Check client's history for haemorrhage factors 					
<ul style="list-style-type: none"> Determine client's ability to cooperate with the procedure 					
2.Nursing diagnosis					
2.1.Anxiety					
2.2Health seeking behaviour related to knowledge deficit of blood test					
3.Planning					
3.1.Supplies and equipment					
<ul style="list-style-type: none"> Antiseptic swab 					
<ul style="list-style-type: none"> Tourniquet 					
<ul style="list-style-type: none"> Sterile lancet 					
<ul style="list-style-type: none"> Sterile syringe of the desired size 					
<ul style="list-style-type: none"> Sterile needle:20 to 22 gauge for adults 					
<ul style="list-style-type: none"> Vacuum container tube with needle holder 					
<ul style="list-style-type: none"> Correct vacuum container blood tubes 					
<ul style="list-style-type: none"> Sterile gauze/sterile plaster 					
<ul style="list-style-type: none"> Disposable gloves 					
4.Implementation.					
4.1.Drawing blood from a vein					

<ul style="list-style-type: none"> • Explain to the client what will be done 					
<ul style="list-style-type: none"> • Properly identify the client 					
<ul style="list-style-type: none"> • Check the Dr's orders 					
<ul style="list-style-type: none"> • Wash hands 					
<ul style="list-style-type: none"> • Put on gloves 					
<ul style="list-style-type: none"> • Attach needle to syringe or attach vacuum container needle to the needle holder and insert vacuum container tube 					
<ul style="list-style-type: none"> • Place extra vacuum container tubes next to the venipuncture site 					
<ul style="list-style-type: none"> • Position the client so that the arm is extended with palm up on the table or pillow 					
<ul style="list-style-type: none"> • Inspect the client's antecubital fossa for visible veins 					
<ul style="list-style-type: none"> • Secure the tourniquet approximately 5 to 6 inches above the site 					
<ul style="list-style-type: none"> • Check for distal pulse 					
<ul style="list-style-type: none"> • Instruct the client to open and clench fist several times 					
<ul style="list-style-type: none"> • Select the vein that is visible and firm on palpitation 					
<ul style="list-style-type: none"> • Clean the site with the antiseptic swab 					
<ul style="list-style-type: none"> • Place the thumb of your hand distal on the vein to the puncture 					
<ul style="list-style-type: none"> • Press down lightly until skin over the vein taut 					
<ul style="list-style-type: none"> • Insert needle with bevel at a 30 degree angle approximately 1/2 inch distal to the vein site 					
<ul style="list-style-type: none"> • If using a syringe draw gently on the syringe plunger and watch for blood return 					
<ul style="list-style-type: none"> • If the blood tube is filled remove the needle quickly 					
<ul style="list-style-type: none"> • Release tourniquet with the free hand 					
<ul style="list-style-type: none"> • Place a gauze pad/sterile plaster and apply pressure for 1 to 2 minutes 					
<ul style="list-style-type: none"> • Transfer blood drawn by syringe to specimen tubes 					

allow suctioning to occur					
• Label the specimen tube correctly					
• Inspect the puncture site for bleeding					
• Assist client to comfortable position					
• Discard used needles and syringes in a closed biohazard container					
• Discard gloves					
• Wash hands					
• Place specimen in the plastic bag and sent to the lab					
5.Evaluation					
• Client's verbal and nonverbal responses indicating limited discomfort or pain when blood was drawn					
• Clot formation occurs within 3 minutes of venipuncture indicating minimal residual bleeding after the withdrawal of blood					
SUBTOTAL:					

Collecting sputum specimen

Criteria	Observed/ Done	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective and objective data					
• Determine the purpose of sputum specimen					
• Identify number of specimens needed					
• Note signs and symptoms of respiratory infection:-cough					
-fever					
-chest pain					
• Observe client's ability to cough deeply					

• Instruct client to place cover tightly on the container					
• Let the client place specimen in the protective plastic bag, close and secure					
• Provide comfort measures to client as necessary					
• Wash hands					
• Complete laboratory form					
• Send specimen to the laboratory or keep it in the fridge until collection date to the laboratory.					
5.Evaluation					
• An amount for testing has been collected by the client's deep coughing					
• Client's respiratory rate is within normal limits					
Subtotal:					

Common Cold/Sinusitis

Criteria	Observed /Done	Not observed/ not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective data					
• Feeling of burning in the nasopharynx					
• Feeling of irritation in the nasopharynx					
• Sneezing					
• Chilliness					
• Copious nasal discharge					
• Muscular aching					
• Malaise					
• Mild fever					
• Headache(frontal)					
• Sore throat					
• Blocked nose and congestion					
• Lack of appetite					
• Nausea					
• Cough					
• Pain over the sinusses					

1.2.Objective data					
• pyrexia					
2.Nursing diagnosis made and recorded					
2.1.Ineffective airway clearance					
2.2.Alteration in comfort due to pain and anxiety					
2.3.Alteration in nutrition due to difficulty in swallowing					
3.Management of client					
3.1.Therapeutic management:(relieve pain)					
• Heat is applied over infected sinuses					
• Analgesics administered as ordered					
3.2.Therapeutic management:Promote sinus drainage					
• Adequate fluid intake done/advised					
• Medication administered as prescribed to promote vasoconstriction and reduce congestion					
• Mucolytic agents administered as prescribed					
• Excessive use of decongestions avoided may result in rebound effects					
3.3.Therapeutic management:(infection control)					
• Broad spectrum antibiotics administered like tetracycline or ampicillin					
3.4.Health education:Increase resistance					
• Encourage rest					
• Encourage taking adequate fluids					
• Encourage taking well balanced diet					

• Encourage client to reduce stress					
• Avoid chilling					
4.Followup evaluation					
• Nostrils unblocked					
• Client breathing normally through nose					
5.Referral done if:					
• No improvement of blocked nose					
• pyrexial					
Subtotal:39					

Cardiac Arrest:Cardio-Pulmonary Resuscitation:SIMULATION TECHNIQUE

	Observed /done	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Objective data					
• Cyanosis					
• Gaspings					
• Respiration:-rapid					
-shallow					
-absent					
• Pulse:-weak					
-thready					
->120 beats/minute					
-absent					
• Muscle twitching					
• Skin cold,clammy					
• Loss of consciousness					
2.Nursing diagnosis made and recorded					
2.1.Altered tissue perfusion due to cardiac arrest					
3..Management principles of CPR(A-B-C-D-E-F-G-H)					

3.1.Therapeutic management:optimal tissue perfusion					
3.1.1.Pre Cardio Pulmonary resuscitation					
*A=Airway					
• Position flat on back					
• Check if conscious if not shake the person gently					
• Shout to wake him					
• Rub the sternum with knuckles					
• Open airway by putting hand on the forehead and tilting the head backwards					
• Lift the chin forward					
• Clear obvious foreign bodies from the mouth					
• Call for help					
3.1.2.*B=Breathing					
• Kneel close to head of victim					
• Check for breathing by observing the chest wall's movement					
• Listen and feel for air flowing from the nose and mouth					
• If no breathing pinch the nostrils closed					
• Blow two full effective breaths into victim's mouth or use an ambubag with oxygen					
• Watch chest for adequate expansion					
• Lips must form airtight seal around mouth or one way valve					
• Check pulse if present breath into mouth every 5 seconds					
• No pulse continue with next step					
3.1.3*C=Circulation					
• Check for carotid pulse,if pulse present					

and no breathing ventilate					
• If pulse is absent do cardiac massage and ventilate					
• Ratio for 1 Rescuer:15 effective cardiac massages:2 effective mouth-to-mouth do this four times					
• Recheck the pulse if no pulse repeat above step					
• Ratio for 2 Rescuers:5 effective cardiac massages :1 mouth-to-mouth /ambubag					
• Recheck pulse after 1minute if no pulse repeat the above step					
• Check pupils to determine effectiveness of CPR:-constriction good sign of effective CPR					
-dilation bad sign of CPR not effective					
• If heart beat returns:assist respiration with ambubag with oxygen					
4. Monitor vital signs every 10min until stable					
• Respiration :rate ,pattern					
• Pulse: rate,rhythm					
• Blood Pressure					
• Level of consciousness					
• Colour of skin for any cyanosis					
SUBTOTAL:					

3.1. Therapeutic

management (Diabetes Mellitus)

Diabetes Mellitus

Criteria	Observed/D	Not	Not	Recorded	Not recorded
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	one	observed/No t done	applicable		
1.Assessment					
1.1.Subjective data					
• Blurred vision					
• Increased thirst					
• Lethargy					
• Weakness					
• Increased irritability					
1.2.Objective data					
• Glycosuria					
• Polyuria					
• polydipsia					
• polyphagia					
• weight loss					
• hypoglycaemia					
• dizziness					
• hunger					
• cold and clammy skin					
• fast thready pulse					
• convulsions					
• irritability					
• lethargy					
• nausea and vomiting					
• ketonuria					
• sweet fruity odor to breath					
• hyperpnoea					
2.Nursing diagnosis made and recorded					
2.1.Ketoacidosis					
2.2.Fluid volume deficit related to polyuria					
2.3.Electrolyte imbalance related to increased renal excretion					
2.4.Knowledge deficit regarding self care management of disease					
3.Management of client					
3.1.Therapeutic management(:Ketoacidosis)					
• nil per os maintained					
• Parental fluids					

administered to correct dehydration:glucose and electrolyte fluids					
<ul style="list-style-type: none"> Insulin continuously administered to maintain blood glucose <10mmol/l 					
<ul style="list-style-type: none"> Finger stick glucose monitored 					
<ul style="list-style-type: none"> regular insulin administered based on sliding scale 					
<ul style="list-style-type: none"> Indwelling catheter inserted 					
<ul style="list-style-type: none"> Intake and output recorded 					
<ul style="list-style-type: none"> Urine testing done for sugar and acetone 					
<ul style="list-style-type: none"> Clear fluids administered as tolerated 					
Therapeutic management (:hydrate patient with balanced intake and output)					
<ul style="list-style-type: none"> nil per mouth is maintained if patient is lethargic or comatose 					
<ul style="list-style-type: none"> Hydrate slowly by administering accurate parental fluids as prescribed 					
<ul style="list-style-type: none"> blood glucose level hourly monitored 					
<ul style="list-style-type: none"> vital signs hourly monitored 					
<ul style="list-style-type: none"> serum electrolyte values monitored 					
<ul style="list-style-type: none"> sodium and potassium replacements administered as prescribed 					
<ul style="list-style-type: none"> urine tested for acetone 					
<ul style="list-style-type: none"> clear fluids commenced when patient is alert 					
<ul style="list-style-type: none"> intake and output recorded 					

<ul style="list-style-type: none"> • patient is weighted daily 					
3.3. Health education: patient will demonstrate understanding of self care management					
<ul style="list-style-type: none"> • Begin teaching during acute stage; explain tests results, treatment and signs and symptoms as they relate to the disease 					
<ul style="list-style-type: none"> • The nature of disease and treatment 					
<ul style="list-style-type: none"> • The names and types of insulins to be used, purpose, dosage, time and side effects 					
<ul style="list-style-type: none"> • Teach glucose monitoring 					
<ul style="list-style-type: none"> • Teach urine testing and acetone 					
<ul style="list-style-type: none"> • Teach insulin injection 					
<ul style="list-style-type: none"> • Explain site rotation 					
<ul style="list-style-type: none"> • Explain food exchange diet and need to give three meals and three snacks 					
<ul style="list-style-type: none"> • Explain glucagons usage and teach technique for administration 					
<ul style="list-style-type: none"> • Explain record keeping 					
<ul style="list-style-type: none"> • Discuss symptoms of diabetic ketoacidosis to report at the clinic:- - continual elevation of blood sugar 					
-presence of acetone in urine					
-polyuria					
-polydipsia					
-weight loss					
-drowsiness					
<ul style="list-style-type: none"> • Discuss symptoms of hypoglycaemia to report to clinic:- - decreased blood sugar 					
-excessive hunger					
-cold, clammy perspiration					

<ul style="list-style-type: none"> Explain need to avoid giving injection in limb used for exercise 					
<ul style="list-style-type: none"> Have patient demonstrate prior discharge:-how to draw insulin correctly 					
4.Follow up evaluation					
<ul style="list-style-type: none"> patient blood sugar is between 3-6mmol/l and stable 					
<ul style="list-style-type: none"> Patient electrolyte values are 135-145 and 3,5-4,5 for sodium and potassium respectively 					
<ul style="list-style-type: none"> Urine is negative to sugar and acetone 					
<ul style="list-style-type: none"> Patient is eating a regular diet 					
<ul style="list-style-type: none"> Patient understand self care management and use of equipment 					
5.Referral done if:					
<ul style="list-style-type: none"> Insulin dependent diabetes mellitus 					
<ul style="list-style-type: none"> Pregnant 					
<ul style="list-style-type: none"> Dehydrated with hypotension 					
<ul style="list-style-type: none"> Nausea and vomiting 					
<ul style="list-style-type: none"> Heavy ketonuria 					
<ul style="list-style-type: none"> Disturbed consciousness 					
<ul style="list-style-type: none"> Serum glucose >20mmol/l 					
SUBTOTAL:					

GONORRHEA(Sexually Transmitted infection)

Criteria	Observed/ Done	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective data					
<ul style="list-style-type: none"> Pain on micturition 					
<ul style="list-style-type: none"> Frequency on micturition 					

• Nocturia					
• Sore throat					
1.2.Objective data					
• urethral discharge:-scanty to thick					
white,creamy may be yellow or green					
• Red swollen meatus					
• Elevated temperature					
2.Nursing diagnosis made and recorded					
2.1.Infection related to presence of gonorrhoea bacteria					
2.2.Anxiety related to diagnosis of venereal disease					
2.3.Knowledge deficit related to disease process and self care management					
3.Management of client					
3.1.Therapeutic management (:patient will exhibit no signs of gonorrhoea evidence by absence of vaginal and or urethral discharge)					
• Sterile technique maintained when coming in contact with open draining lesions					
• Hands are washed before and after coming in contact with infected patient					
• Gloves are worn if there is any broken skin on care giver's hands					
• Urine specimen obtain and observed:-character					
- culture obtained as ordered					
- cloudy and malodorous urine reported					
• When emptying urine of patient newly diagnosed with gonorrhoea avoid splashing urine in eyes					
• Antibiotics administered:as ordered					
3.2.Therapeutic					

management (:patient is able to discuss disease process ,discuss feelings of embarrassment of having gonorrhoea)					
<ul style="list-style-type: none"> • A nonjudgemental attitude and an atmosphere of acceptance maintained 					
<ul style="list-style-type: none"> • Do not force patient to disclose sexual contact if not coming voluntarily from him/her 					
<ul style="list-style-type: none"> • Do not discuss patient's condition with staff and friends(Maintain confidentiality) 					
<ul style="list-style-type: none"> • Patient is encouraged to express feelings 					
<ul style="list-style-type: none"> • Actively listen to patient 					
<ul style="list-style-type: none"> • Privacy is provided during examination 					
<ul style="list-style-type: none"> • Patient is taught about disease process and prevention 					
3.3.Health education: Patient will verbalise understanding of disease process,prevention and self care management					
<ul style="list-style-type: none"> • Teach patient the importance of completing course of antibiotic therapy 					
<ul style="list-style-type: none"> • Encourage patient to identify sexual contacts 					
<ul style="list-style-type: none"> • Instruct patient to avoid sexual activity with untreated previous partners until they are examined and treated 					
<ul style="list-style-type: none"> • Urge patient to have sexual contacts present themselves for treatment 					
<ul style="list-style-type: none"> • Instruct patient to use condom to help prevent infection in the future 					
<ul style="list-style-type: none"> • Teach patient that there is no immunity to gonorrhoea 					
<ul style="list-style-type: none"> • Teach patient symptoms of gonorrhoea 					
<ul style="list-style-type: none"> • Instruct patient to report to clinic in the presence of these symptoms 					
<ul style="list-style-type: none"> • Teach patient about the 					

medication:-name of the medication					
-dosage					
-purpose					
-side-effects					
4.Follow up evaluation					
• There are no signs of gonorrhoea present					
• Patient verbalizes feelings related to diagnosis					
• Patient identifies sexual contacts					
5.Referral done if:					
• Male:					
• Periurethritis					
• Epididymitis					
• Prostatitis					
• Conjunctivitis					
• Meningitis					
• Sterility					
• Endocarditis					
Subtotal:					

Herpes Type 1 viral infection

Criteria	Observed/ Done	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective data					
• Early sensations at edges of lips or nose or other site of contact					
• Tingling sensation					
• Ache					
• Feeling of pressure					
• Chills					
• Headache					
1.2.Objective data					
• red macules					
• fluid filled vesicles(fever blisters)					
• yellow crusted lesions					

• Elevated temperature					
2.Nursing Diagnosis made and recorded					
2.1.Impairment of skin integrity related to contagious lesions					
2.2.Knowledge deficit regarding disease process,precautions and self care management					
3.Management of client					
3.1.Therapeutic management:(patient will exhibit healing of lesions)					
• procedure for wound and skin precautions initiated					
• gloves worn when contact is made at site of lesions or with secretions					
• patient instructed not to touch lesions or secretions and to wear gloves when washing face					
• lesions washed gently					
• temperature checked 4 hourly and report elevation					
• patient kept dry,avoid chills					
• antipyretics and antibiotics administered as ordered					
• giving client hot ,spicy or acidic foods avoided					
• acyclovir administered as ordered					
3.2.Health education:patient will verbalise understanding of self care management					
3.2.1.Disease process					
• Explain about infective virus transmission					
• Explain symptoms to report to the clinic					
• Explain importance of avoiding persons with herpes viral infection,flu chicken pox					
3.2.2.Precautions					
• Instruct patient to wash hands					

prior to care					
<ul style="list-style-type: none"> Have patient wear gloves when cleaning or applying medication to affected area to avoid autoinfection or infection of others 					
<ul style="list-style-type: none"> Explain need to keep materials for cleaning lesions separate :towels,soap,cloths 					
<ul style="list-style-type: none"> Caution patient to avoid direct contact with others e.g kissing 					
3.2.3.Self care					
<ul style="list-style-type: none"> Instruct patient to wash skin area with soap and water and dry gently 					
<ul style="list-style-type: none"> Explain need to perform oral care 2-4 hourly while awake 					
<ul style="list-style-type: none"> Demonstrate how to apply medication as ordered 					
<ul style="list-style-type: none"> Instruct patient to always use gloves when touching infected areas 					
4. Follow up evaluation					
<ul style="list-style-type: none"> Lesions remain localized,are healed or are in a process of healing 					
<ul style="list-style-type: none"> No symptoms are noted in other areas 					
<ul style="list-style-type: none"> Patient demonstrate cleaning of and medication application to affected areas 					
5.Referral done if:					
<ul style="list-style-type: none"> Recurrent infections 					
<ul style="list-style-type: none"> Herpes affecting large areas of body 					
Subtotal:					

Hypertension

Criteria	Observed/ Done	Not observed/n ot done	Not applicable	Recorded	Not recorded
1.Assessment					

1.1. Subjective data					
• Early morning occipital headache					
• Light-headedness					
• palpitations					
• fatigue					
• insomnia					
• altered vision:					
-blurred vision					
-white spots					
• neck stiffness					
• nausea					
• vomiting					
1.2. Objective data					
• Nose bleeding					
• Elevated blood pressure: systolic > 140mmHg					
-diastolic > 90mmHg					
2. Nursing diagnosis made and recorded					
2.1. Altered peripheral tissue perfusion					
2.2. Potential for injury related to altered vision					
2.3. Alteration in comfort related to increased vascular pressure					
2.4. Knowledge deficit regarding disease process and self care					
3. Management of client					
3.1. Therapeutic management (:returning client Blood pressure < 140/90 mmHg)					
• Blood pressure on both arms checked					
• Blood pressure lying or sitting checked					
• Bed rest maintained					
• Head of the bed elevated					
• Respiration rate checked					
• Pulse rate checked					
• Pulse rhythm checked					
• Medication administered as ordered or per					
• <u>Drug protocol</u> Step 1: Hydrochlorothiazide 12.5-25mg daily if diastolic is > 100mmHg for a week					

<ul style="list-style-type: none"> Step 2:Atenolol 50mg and Hydrochlorothiazide 12.5-25mg or Reserpine 0.125mg if diastolic >100mmHg for a week 					
<ul style="list-style-type: none"> Step 3:Add ACE inhibitors on step 2:Enalapril 5mg-20mg,Add Calcium Antagonist(remove beta-blockers):VerapamilSR 80mgbd-120mg bd,Adalat XL 30mg-60mg daily if diastolic is >100mmHg for a week 					
<ul style="list-style-type: none"> Quiet environment maintained 					
<ul style="list-style-type: none"> Low calorie diet maintained 					
<ul style="list-style-type: none"> Low sodium diet maintained 					
<ul style="list-style-type: none"> Fluid intake restricted 					
<ul style="list-style-type: none"> Smoking not allowed 					
<ul style="list-style-type: none"> Urinalysis done 					
<ul style="list-style-type: none"> Intake and output recorded 					
3.2.Therapeutic management (:patient will be free from injury)					
<ul style="list-style-type: none"> Safety precautions maintained:-put side rails up 					
-bed in low position					
<ul style="list-style-type: none"> Level of consciousness monitored:-orientation to place 					
--person					
-place					
<ul style="list-style-type: none"> Patient is orientated to environment as needed 					
3.3.Therapeutic management (:achievement of comfort by the patient)					
<ul style="list-style-type: none"> Quiet,low-lighted environment is maintained 					
<ul style="list-style-type: none"> Activities are limited 					
<ul style="list-style-type: none"> Periods of help are provided and maintained 					
<ul style="list-style-type: none"> Analgesics are administered as necessary or as ordered 					
<ul style="list-style-type: none"> Comfort measures administered :-ice packs 					
-reassure and frequent					

simple explanations					
-position comfortably					
-assist with turning gently					
• Avoid constipation					
3.4.Health education(: patient demonstrate increased understanding of disease process.)					
• Explain nature of disease					
• Explain purpose of treatment					
• Explain importance of quiet environment and non stressfull environment					
• Explain need to avoid fatigue and heavy lifting					
• Explain importance of decreasing weight or maintaining stable weight					
• Explain importance of not smoking					
• Explain importance of planned daily exercise program and rest periods					
• Explain need for low calorie and low salt diet					
• Limit on caffeinated coffee or tea					
• Explain importance of taking medication as prescribed					
• Avoid constipation and straining					
• Report immediately to clinic:severe headache					
-dizziness					
-faintness					
-nausea and vomiting					
4.Follow up evaluation					
• Blood pressure return to acceptable limits<90mmHg diastolic					
• Patient is alert and oriented					
• Patient verbalizes absence of discomfort					
• Patient appears calm					
• Verbalises knowledge and skills in self care					

5.Referral done if:					
<ul style="list-style-type: none"> Blood pressure not responding to treatment diastolic>130mmHg 					
<ul style="list-style-type: none"> Decrease level of consciousness Glasgow Coma Scale<10/15 					
<ul style="list-style-type: none"> Urinalysis with proteinuria 					
<ul style="list-style-type: none"> Urinalysis with 1+ haematuria 					
SUBTOTAL:					

Injecting medications:Intramuscular

Criteria	Observed/ done	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective and objective data					
<ul style="list-style-type: none"> Check the client's history of allergy to this medication and similar drugs 					
<ul style="list-style-type: none"> Observe the client for anxiety when she or he learns of impending injection 					
<ul style="list-style-type: none"> Check the physician's order for:-drug 					
dose					
date and time of administration					
-route and method of administration					
-validity of prescription					
-Signature of doctor					
-legibility of prescription					
<ul style="list-style-type: none"> Inspect previous sites for redness,swelling 					
<ul style="list-style-type: none"> Inspect proposed site for lesions,rashes,swelling,redness 					
<ul style="list-style-type: none"> Palpate for adequate muscle mass at proposed site before injecting intramuscular 					

injection					
2.Nursing diagnosis					
2.1.High risk for injury					
2.2.High risk for infection					
2.3.Health seeking behaviour related to knowledge deficit about medications and administration					
3.Planning					
3.1.Supplies and Equipments					
<ul style="list-style-type: none"> Medication administration record 					
<ul style="list-style-type: none"> Disposable needle and syringe of the correct size and volume 					
<ul style="list-style-type: none"> Medication ampoule,vial or cartridge 					
<ul style="list-style-type: none"> Antiseptic swabs 					
4.Implementation					
4.1.Preparing an injection from an ampoule					
<ul style="list-style-type: none"> Wash hands 					
<ul style="list-style-type: none"> Prepare for the administration of the drug 					
<ul style="list-style-type: none"> Select the correct needle and syringe for the type of administration 					
<ul style="list-style-type: none"> Attach the hub of the needle to the tip of the syringe without touching the shaft of the needle 					
<ul style="list-style-type: none"> Select the correct ampoule:- dosage 					
not expired					
<ul style="list-style-type: none"> Place all the fluid of the ampoule by flickering a fingertip against the tip of the ampoule 					
<ul style="list-style-type: none"> Hold a dry antiseptic swab or gauze pad at the top of the ampoule with one hand and hold the base of the ampoule with the other 					
<ul style="list-style-type: none"> Break open the ampoule by bending its neck away from you 					
<ul style="list-style-type: none"> Remove the cap of the needle 					
<ul style="list-style-type: none"> Insert the needle into the 					

ampoule so that the bevel is in the fluid					
<ul style="list-style-type: none"> • Pull back on the plunger and withdraw the correct volume of solution 					
<ul style="list-style-type: none"> • Examine the barrel of the syringe to determine if any air bubbles are present 					
<ul style="list-style-type: none"> • If so gently expel the bubbles and withdraw any further solution necessary to correct the volume 					
<ul style="list-style-type: none"> • Examine the barrel of the syringe to confirm that the correct volume is present, correct as necessary 					
<ul style="list-style-type: none"> • Replace the cap on the needle 					
4.2. Administering an injection					
<ul style="list-style-type: none"> • Check the client's record to determine where he or she last had an injection if this is repetition 					
<ul style="list-style-type: none"> • Take the prepared syringe to the client's room 					
<ul style="list-style-type: none"> • Positively identify the client 					
<ul style="list-style-type: none"> • Explain to the client that he or she is to receive an injection 					
<ul style="list-style-type: none"> • Provide privacy 					
<ul style="list-style-type: none"> • Ask the client as to the preference of the injection site 					
<ul style="list-style-type: none"> • Position the client for injection:- ventrogluteal:supine,lateral.prone 					
dorsogluteal:prone,lateral,upper knee or hip flexed					
-deltoid:lower arm flexed but relaxed					
<ul style="list-style-type: none"> • Expose the injection site while draping the remainder of the body, cleanse the site with an antiseptic swab 					
<ul style="list-style-type: none"> • Apply the swab at the centre of the site and gently rotate it outward in a circular fashion 					
<ul style="list-style-type: none"> • Hold the swab between the fingers of your nondominant hand 					

<ul style="list-style-type: none"> Remove the cap from the needle and set it within reach 					
<ul style="list-style-type: none"> Grasp the syringe between the forefinger and thumb of your dominant hand 					
<ul style="list-style-type: none"> Stretch the client's skin taut between the thumb and forefinger of your nondominant hand 					
<ul style="list-style-type: none"> Inject the needle firmly and swiftly into the centre of the prepared site until all or upper part of the needle shaft has penetrated the tissues 					
<ul style="list-style-type: none"> Grasp the syringe with the nondominant hand 					
<ul style="list-style-type: none"> Move the finger and thumb of the dominant hand to the plunger 					
<ul style="list-style-type: none"> Pull back gently on the plunger to aspirate the medication 					
<ul style="list-style-type: none"> If blood appears withdraw and discard the entire syringe 					
<ul style="list-style-type: none"> Prepare a new dose of medication 					
<ul style="list-style-type: none"> If no blood appears inject the medication slowly and evenly 					
<ul style="list-style-type: none"> Hold the antiseptic swab just above the insertion site 					
<ul style="list-style-type: none"> Withdraw the syringe quickly and evenly 					
<ul style="list-style-type: none"> Move the antiseptic swab over the puncture site and massage gently 					
5.Evaluation					
<ul style="list-style-type: none"> Verbal and nonverbal behaviour indicating discomfort from the injection 					
<ul style="list-style-type: none"> Demonstration of the expected therapeutic effect of the medication within the expected time of onset 					
<ul style="list-style-type: none"> Absence of symptoms or signs of an allergic or inflammatory response to the medication 					
Subtotal:					

Injuries, sprains and strains

Criteria	Observed/ done	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective data					
• Pain					
• Oedema in muscles/joints or bone without movement					
• Weakness in extremities					
• Unsteady gait or stance					
• Sensory changes					
• Anorexia					
• Numbness or tingling					
1.2.Objective data					
• Joints inflamed or warm to touch					
• Difficult in breathing					
• Deformities					
• Abnormal body alignment					
• Abnormal gait					
• Tachycardia					
• Skin open or intact					
• Bleeding or haematoma					
2.Nursing diagnosis made and recorded					
2.1.Impairment physical mobility related to injury,sprain, strain or fracture					
2.2.Potential for infection related to immobility					
2.3.Alteration in comfort :pain related to injury/trauma					
2.4.Knowledge deficit regarding self care management					
3.Management of client					
3.1.Therapeutic management:					
• Maintain bedrest in ordered position to facilitate healing					
• Affected extremity elevated					
• First aid management:"ICED"					
Ice or any cold:- cold compression applied to lessen and prevent oedema,inflammation and to decrease pain					
-wrapped in cloth or a cold					

wet bandage and applied within 12 hours of an injury					
-repeat abovementioned for several days					
-Ice not directly applied to the skin					
Compression :the injured area compressed with a firm bandage to limit swelling					
Elevation : injured part elevated to decrease the oedema					
Drug : analgesics or anti-inflammatory drug administered					
<ul style="list-style-type: none"> Affected extremity supported above and below injured part when moving,turning and lifting 					
<ul style="list-style-type: none"> Assess pulse distal to injury 					
-colour of limbs					
-temperature of limbs					
-sensation of limbs					
3.2.Therapeutic management (:patient's skin/wound integrity will remain clean,dry and intact)					
<ul style="list-style-type: none"> Wound integrity assessed and observed for signs of infection or discharge 					
<ul style="list-style-type: none"> Antibiotics administered as ordered 					
<ul style="list-style-type: none"> Monitor wound when changing dressing 					
<ul style="list-style-type: none"> Monitor body temperature 					
3.3.Therapeutic management (:patient will express minimal discomfort or absence of pain)					
<ul style="list-style-type: none"> Assess location and type of pain 					
<ul style="list-style-type: none"> Administer analgesics 					
<ul style="list-style-type: none"> Assess effectiveness of pain relief measures 					
3.4.Health education (:patient demonstrate understanding of self care management)					
<ul style="list-style-type: none"> Patient verbalizes understanding of self care 					
<ul style="list-style-type: none"> Importance of prescribed rehabilitation plan of activity,rest 					

and exercise explained					
<ul style="list-style-type: none"> • Discuss medication: name, purpose, dosage and side-effects 					
<ul style="list-style-type: none"> • Discuss signs and symptoms to report to clinic :-severe pain 					
- Changes in temperature					
-changes in colour or sensation in extremity					
-foul odour					
-drainage from wound					
4. Follow up Evaluation					
<ul style="list-style-type: none"> • Complications are absent or controlled 					
<ul style="list-style-type: none"> • Pain is manageable 					
<ul style="list-style-type: none"> • Mobility is at upper limits of restriction 					
<ul style="list-style-type: none"> • Self care management is understood 					
5. Referral done if:					
<ul style="list-style-type: none"> • Decreased or absent of pulse distal to injury 					
<ul style="list-style-type: none"> • Blue discolouration of the skin 					
<ul style="list-style-type: none"> • Decrease or no sensation of affected area 					
<ul style="list-style-type: none"> • Decrease in perfusion(cold on touch) 					
Subtotal:59					

Instilling medication :Ears

Criteria	Observed/D one	Not observe d/Not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective and objective data					
<ul style="list-style-type: none"> • Check the client's history of allergy in general 					
<ul style="list-style-type: none"> • Determine specific allergy of mucous membrane to 					

substances					
<ul style="list-style-type: none"> Inspect ears for any drainage 					
2.Nursing diagnosis					
2.1.Possible noncompliance to treatment regimen					
2.2.Health seeking behaviour related to knowledge deficit about medication					
3.Planning					
3.1.Supplies and equipments					
<ul style="list-style-type: none"> Medication container Medicine dropper Sterile gauze pad cotton balls or tissues clean disposable gloves lubricant medication applicator 					
4.Implementation					
<ul style="list-style-type: none"> examine the label of the container to determine that it is specifically indicated for ophthalmic use Positively identify the client Explain the procedure to the client Bring medication and equipment to the client bed side Wash hands Position the client laterally with the ear to be medicated uppermost Fill the medication dropper with correct amount of medication Pull the auricle of the ear upward and backward Insert the medication dropper without touching the ear and instill the correct amount of medication into the auditory canal Instruct the client to remain on his or her side for 5 minutes Place a small amount of cotton into the auricle:avoid absorbing medication with the cotton Replace the cap of the medication and cleanse the dropper as necessary 					

• Wash hands					
5.Evaluation					
• Medication absorption in the ear without an allergy or inflammatory response					
• Ability to demonstrate or explain the application of the instilled medication to the ear					
Subtotal:					

Instilling medication: Eyes

Criteria	Observed/ Done	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective and objective data					
• Check the client's history of allergy in general					
• Determine specific allergy of mucous membrane to substances					
• Inspect eye for exudates or crusts					
2.Nursing diagnosis					
2.1.Possible noncompliance to treatment regimen					
2.2.Health seeking behaviour related to knowledge deficit about medication					
3.Planning					
3.1.Supplies and equipments					
• Medication container					
• Medicine dropper					
• Sterile gauze pad					
• cotton balls or tissues					
• clean disposable gloves					
• lubricant					
• medication applicator					
4.Implementation					
• examine the label of the container to determine that it					

is specifically indicated for ophthalmic use					
• Positively identify the client					
• Explain the procedure to the client					
• Bring medication and equipment to the client bed side					
• Wash hands					
• Place the client in the sitting position with his or her head tilted back or supine position with the pillow under the neck					
• If the client has crusts or exudates around the eye moisten a cotton ball with sterile saline and remove them					
• Open the medication container					
• Fill the dropper with the correct amount of medication					
• Pull gently downward on the skin below the lower eyelid					
• Drop the correct number of drops directly into the lower conjunctival sac					
• Avoid touching the eye with the dropper					
• Instruct the client to close and roll his or her eyes from side to side					
• Instruct the client to remove excess medication and tears with the tissue					
• Wash hands					
• Teach client self instillation of medication					
5.Evaluation					
• Medication absorption in the eye without an allergy or inflammatory response					
• Ability to demonstrate or explain the application of the instilled medication to the eye.					
Subtotal:					

Pulmonary Tuberculosis

Criteria	Observed/ Done	Not observed/ not done	Not applicable	Recorded
1.Assessment				
1.1 Subjective data				
<ul style="list-style-type: none"> • Cough for 3 weeks and longer • Loss of appetite • Loss of weight • Weakness or loss of energy • Pain, knife like chest • Night sweats 				
1.2 Objective data				
<ul style="list-style-type: none"> • Loss of axillary lymph nodes • Enlarged nodes • Respiratory assessment - crackles over apex of lung • Productive cough haemoptysis • Respiratory increased depth • Difficulty in percussion • Diagnostic test - sputum positive to acid fast bacilli • Sputum positive to culture after 6 weeks • CXR infiltration cavitation 				
2.Nursing diagnosis made and recorded				
2.1 Acute dyspnoea				
2.2 Ineffective breathing pattern related to decreased lung capacity				
2.3 potential for infection transmission related to poor compliance				
2.4 Alteration in nutrition				
2.5 Knowledge deficit regarding disease and self care				
3.Management of client				
3.1 Therapeutic management (chemotherapy treatment to prevent infection)				
<ul style="list-style-type: none"> • Obtain sputum tests for cytotoxic • Isolate the prisoner for 3 days • Notify the disease to the 				

Pulmonary Tuberculosis

Criteria	Observed/ Done	Not observed/n ot done	Not applicabl e	Recorded	Not recorded
1.Assessment					
1.1.Subjective data					
<ul style="list-style-type: none"> • Cough for 3 weeks and longer • Loss of appetite • Loss of weight • Weakness or loss of energy • Pain :knife like chest • Night sweats 					
1.2.Objective data					
<ul style="list-style-type: none"> • Low grade temperature • Increased pulse • Respiratory assessment:-cracles over apex of lung -Productive cough,haemoptysis -Respiration increased depth -Dullness to percussion • Diagnostic test:-sputum positive to acid fast bacilli -sputum positive to culture:myobacterium -xray:infiltration cavitation 					
2.Nursing diagnosis made and recorded					
2.1.Active Tuberculosis					
2.2.Ineffective breathing pattern related to decreased lung capacity.					
2.3.potential for infection transmission related to non compliance					
2.4.Alteration in nutrition					
2.5.knowledge deficit regarding disease and self care					
3.Management of client					
3.1.Therapeutic management (:chemotherapy treatment to prevent infection)					
<ul style="list-style-type: none"> • Obtain sputum tests for contacts • Isolate the prisoner for 3 days • Notify the disease to the 					

Department of Health					
<ul style="list-style-type: none"> Drug protocol:Regimen1:Intensive phase(2 months) 					
<ul style="list-style-type: none"> Rifafour e-200 tablet:4 tabs for client <50kg 					
<ul style="list-style-type: none"> Rifafour e-200 tablet:5 tabs for client >50kg 					
<ul style="list-style-type: none"> Regimen 1:Continuation phase:(4 months)Rifampicin/INH 150/100mg:3tabs for client <50kg 					
<ul style="list-style-type: none"> Rifampicin/INH 300mg/150mg:2tabs for client of >50kg 					
<ul style="list-style-type: none"> Regimen 2:Intensive phase(3 months):Rifafour 4 tabs for <50kg and 5tabs for >50kg 					
<ul style="list-style-type: none"> Streptomycin 750mg for <50kg and 1000mg for >50kg(2 months) 					
<ul style="list-style-type: none"> Regimen 2:continuation phase(5 months):Rifinah 300mg:1tab and 3 EMB 400mg tabs for <50kg,2and 3 for >50kg respectively 					
<ul style="list-style-type: none"> Monitoring measures: 					
-Diaries sputum/take sputum for 2 nd month for regimen 1(intensive phase)					
-Diarises sputum/take sputum for 3 rd month for regimen 2(intensive phase)					
-If sputum negative continue to continuation phase					
-If sputum positive prolong intensive phase by 1 month more					
-Weight monitored monthly to check improvements					
-Collect /diarises sputum for 5 th or 7 th month					
<ul style="list-style-type: none"> Management of sputum outcome 					
-If sputum is negative discharge as cured					
-If sputum positive re- register as treatment failure					
3.2.Therapeutic management(:achievement of full lung expansion with adequate ventilation)					

<ul style="list-style-type: none"> • quality and depth of respiration checked 					
<ul style="list-style-type: none"> • chest for breath sounds auscultated 					
<ul style="list-style-type: none"> • patient assisted to turn or cough 					
<ul style="list-style-type: none"> • frequent rest periods provided 					
<ul style="list-style-type: none"> • temperature ,pulse and respiration 4 hourly checked 					
3.3.Therapeutic management (:potential for infection transmission will be decreased)					
<ul style="list-style-type: none"> • respiratory isolation maintained for at least 2 months 					
<ul style="list-style-type: none"> • direct contact with sputum avoided 					
<ul style="list-style-type: none"> • patient taught to cough into tissue 					
<ul style="list-style-type: none"> • Turn head with coughing 					
<ul style="list-style-type: none"> • Taught how to dispose tissues 					
<ul style="list-style-type: none"> • Collect and care for sputum 					
<ul style="list-style-type: none"> • Patient taught importance of not stopping treatment 					
3.4.Therapeutic management(:maintenance of optimal nutritional status)					
<ul style="list-style-type: none"> • admission(base line)weight obtained and monitor monthly 					
<ul style="list-style-type: none"> • high protein,high carbohydrate diet maintained 					
<ul style="list-style-type: none"> • stool softners administered if neccessary 					
3.5.Health education :demonstrate understanding of self care					
<ul style="list-style-type: none"> • Explain nature of disease and purpose of treatment and procedures 					
<ul style="list-style-type: none"> • Explain the importance of good hygiene and hand washing 					
<ul style="list-style-type: none"> • Explain the importance of maintaining high protein,high carbohydrate diet 					
<ul style="list-style-type: none"> • Explain need to force fluids to 2L-3L a day 					

<ul style="list-style-type: none"> Explain importance of maintaining respiratory isolation until sputum conversion 					
<ul style="list-style-type: none"> Discuss symptoms to report to the nurse:-haemoptysis 					
-chest pain					
- Difficulty in breathing					
- Hearing loss					
- dizziness					
<ul style="list-style-type: none"> Discuss medication:-name 					
-dosage					
-time of administration					
- Purpose					
-side-effects					
<ul style="list-style-type: none"> Discuss importance of not stopping medication without nurse's or physician's approval. 					
4. Follow up evaluation					
<ul style="list-style-type: none"> Patient maintains effective breathing as evidenced by :- normal respiratory rate 					
-decreased dyspnoea					
<ul style="list-style-type: none"> Maintenance of adequate nutritional status as evidenced by weight gain or stable 					
<ul style="list-style-type: none"> Follow up sputum results evidenced by smear conversion:second month/third month 					
-5 th /7 th month					
<ul style="list-style-type: none"> Patient demonstrate increased level of knowledge by verbalizing principles of health /self care management 					
5.Referrals done if:					
<ul style="list-style-type: none"> Persistent haemoptysis 					
<ul style="list-style-type: none"> Hearing loss 					
<ul style="list-style-type: none"> Development of multi drug resistance evidenced by sputum culture and sensitivity results 					
SUBTOTAL:					

Otitis Media(Chronic Suppurative)

Criteria	Observed/D one	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					

1.1. Subjective Data					
• Earache					
• Decreased or absent hearing acuity in one ear or both					
• Dizziness					
• Fever					
• Own voice echoes					
• Itching in ears					
• headache					
• nausea					
1.2. Objective data					
• Foul smell					
• ear drainage: dark, red, yellow/clear					
• elevated blood pressure					
• elevated temperature					
• elevated pulse					
• elevated respiration					
• ear examination: -pus					
- perforated ear drum					
• no light reflex					
2. Nursing diagnosis made and recorded					
2.1. Pain related to pressure of pus or purulent material on eardrum					
2.2. Potential for injury or infection					
2.3. Knowledge deficit regarding self care					
3. Management of client					
3.1. Therapeutic management (:eradication of infection and prevent further complications)					
• Amount and type of drainage observed					
• Aseptic technique since drainage is purulent maintained					
• Universal precautions instituted					
• Strict handwashing enforced					
• Ear canal dry mopped using fluffed out cotton wool to					

remove pus					
<ul style="list-style-type: none"> Antibiotics administered as prescribed 					
<ul style="list-style-type: none"> Blood pressure monitored 					
<ul style="list-style-type: none"> Temperature monitored 					
<ul style="list-style-type: none"> Pulse monitored 					
3.2. Therapeutic management (:relieve pain and promote comfort)					
<ul style="list-style-type: none"> Analgesics offered to provide symptomatic relief and to decrease fever 					
3.3. Health education: patient demonstrate understanding of self care					
<ul style="list-style-type: none"> Discuss special precautions and restrictions:-keep water out of ear 					
-place petroleum jelly covered cotton plug before showering					
-demonstrate ear drop instillation					
<ul style="list-style-type: none"> Instruct client to complete course of oral or ear drop antibiotic 					
<ul style="list-style-type: none"> Report immediately at the clinic: 					
-fever					
-increased pain					
-increased drainage					
-further decrease in hearing acuity					
-bleeding					
-headache					
-dizziness					
4. Follow up evaluation					
<ul style="list-style-type: none"> Pain or discomfort is controlled 					
<ul style="list-style-type: none"> Patient demonstrate knowledge of self care 					
5. Referral done if:					
<ul style="list-style-type: none"> Large perforation 					
<ul style="list-style-type: none"> Moderate to severe hearing loss 					

• Foul smelling discharge					
SUBTOTAL:50					

Outcome Standards:Patient Questionnaire

Health care center:-----

Date of interview:-----

Interviewer:-----

Client's Biographic information:

Sex

Male
1

Age

18-25years	26-30years	31-35years	36-40years	41-45years	46years and older
1	2	3	4	5	6

Duration in prison

Less than 5 months in prison	5-12months	13-2years	25months-4years	49months-6years	7years-10years	11years and more
1	2	3	4	5	6	7

CLINIC

PATIENT'S RIGHTS CHARTER(BATHO PELE PRINCIPLES):RATE

1.Healthy and Safe environment

(a).How would you rate the cleanliness of the health care facility(clinic)?

Very clean	clean	dirty	Very dirty
1	2	3	4

(b).Motivate your answer.

2. How would you rate the health conditions in your cell (single or communal cell)?

Excellent health conditions	Very good health conditions	Good health conditions	Bad health conditions	Very bad health conditions
1	2	3	4	5

Motivate/Explain what you mean.

3. Access to health care

(a) Do you find it difficult to see a nurse when you are experiencing a health problem?

Yes	No
1	2

Motivate/Explain your answer.

(b) Do you find it difficult to see a medical officer when you are experiencing a health problem?

Yes	No
1	2

Motivate/Explain your answer.

4. Health care

(a) Are you satisfied with the waiting time before seeing a nurse at the waiting room/area?

Satisfied	Not satisfied
1	2

Motivate and explain how long are you prepared to wait before see a nurse at the waiting room/area.

5. Confidentiality

13. Do you feel health related issues are kept confidential by the nursing staff?

Kept confidentially	Not kept confidentially
1	2

Motivate your answer

6. Privacy

(a). Do you feel your right to privacy is /was honoured by a nursing staff?

Honoured	Not honoured
1	2

Motivate/Explain your answer.

(b). If you answered not honoured how would you like your right to privacy be honoured by the nursing staff.

7. Dignity and respect

(a). Do you feel you are treated with dignity and respect by nurses?

Treated with dignity and respect	Not treated with dignity and respect
1	2

Motivate/Explain your answer

8. Referral system(second opinion) to another health care worker

(a). When the nurse could not handle /treat your health problem ,were you referred to a medial officer?

Referred to medical officer	Not referred to medical officer
1	2

Motivate your answer.

9. Consultation (participation in decision-making)

(a). Do nurses involve you in planning your health care?

Always involved	Rarely involved	Once involved	Not at all involved
1	2	3	4

Motivate/Explain your answer

10. Complaints/comments from clients

(a). How do you complain about the health service you receive.

(b). Do you get an opportunity to raise your complaints about the standard of health care?

Given an opportunity	Not given an opportunity
1	2

Motivate/Explain your answer.

(c) How would you like to raise your complaints about the standard of health care.

11. Informed Consent

(a). Were the following procedures explained to you beforehand:

Procedures	Yes	No	Not applicable
Drawing of blood	1	2	3
Changing of dressing	1	2	3
Instilling eye drops	1	2	3
Assessing of blood pressure	1	2	3
Administration of oral medication	1	2	3
Administration of intramuscular injection	1	2	3
Taking of temperature	1	2.	3

Motivate/Explain your answer.

(b) Did you give consent for a procedure whilst receiving health care?

Gave consent	Did not give consent
1	2

(c). If you answered gave consent to question 11(b) above, how was the consent?

verbal	Written
1	2

(d) If you answered written consent to question 11(c) above, state two procedures which you signed a consent for:

(e). If you answered verbal consent to question 11(c) above, state two procedures/treatment you gave verbal consent for.

NURSING PROCESS FRAMEWORK

12. Assessment

(a). Was your health condition assessed by the nurse on admission?

Yes	No
-----	----

1	2
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(b).If you answered yes to question 12(a) above,were you assessed to your satisfaction?

Satisfied	Not satisfied
1	2

Motivate your answer.

13..Implementation

(a)..Do you feel your comfort need is/was attended to by the nurse?

Attended to	Not attended to
1	2

Motivate your answer.

(b).Do you feel your nutrition need is/was attended to by the nurse?

Yes	No	Not applicable
1	2	3

Motivate/Explain your answer

14.Health education(information)

(a).Were you taught measures of health maintenance by the nurse?

Yes	No
1	2

(a) After receiving health care from the nurse, does the nurse evaluate your response to the care?

(b).If you answered yes to question 14(a) above,please explain what health maintenance measures were you taught by the nurse.

(c).If you answered no to question 14 (a) above,please explain what health maintenance measures would you like to be taught by the nurse.

(d)Were you taught self care management by the nurse?

Yes	No
1	2

(e).What self care management were you taught by the nurse from below:

Self care Management	Yes	No	Not applicable
Changing of dressing	1	2	3
Diabetes mellitus	1	2	3
Personal hygiene	1	2	3
Skin care on acne vulgaris	1	2	3
Food to avoid:hypertension	1	2	3
Precipitating factors to avoid:Epilepsy	1	2	3
Any other item:			

(f). Please explain self care management you were taught by the nurses.

(g). Were you taught illness prevention measures by the nurse?

Yes	No
1	2

(h).If you answered yes to question 15(g) above,please explain what illness prevention measures were explained to you.

(i).If you answered no to question 15(g) above ,please explain what illness prevention measures would you like to be taught by the nurse.

15.Evaluation.

(a).After receiving health care from the nurse,does the nurse evaluate your response to therapy?

Frequently	Rarely	Once	Not at all
1	2	3	4

(b).If you answered not at all to question 16(a) above,what would you like the nurse to ask you regarding response to therapy.Please explain.

ADDITIONAL COMMENTS/SUGGESTIONS:

THANK YOU FOR PARTICIPATION IN THIS RESEARCH.

Pneumonia

Criteria	Observed/ Done	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective data					
• Cough:productive/non productive					
• Restlessness					
• Anorexia					
• Vomiting					
• Chest pain					
• Shortness of breath					
• Dizziness					
• Sweating					
1.2.Objective data					
• Cyanosis					
• Tachycardia					
• Tachypnoea(>16-20 breath /min)					
• Fever/pyrexia					
• Auscultation:rales sounds					
-rhonchi					
-decreased breath					

sounds					
• Nasal discharge					
• Wheeze					
2.Nursing diagnosis made and recorded					
2.1.Ineffective airway clearance related to thick mucous production in lungs and ineffective cough					
2.2.Potential fluid volume deficit related to fever,insensible water loss from tachypnoea and poor fluid intake					
2.3.Knowledge deficit regarding disease process and self care management					
3.Management of client					
3.1.Therapeutic management(t:patent airway,clear breath sounds)					
• Effective,sputum raising cough encouraged					
• Chest percussions reformed					
• Lungs auscultated 2 hourly to determine need for suctioning and or positioning					
• Patient is allowed to assume posture of most comfort 30 degree elevation of head					
• Medical management:- humidified oxygen initiated					
-Antipyrexial medication administered for fever					
-drug allergy ascertained					
-Antibiotics administered :penicillin group for pneumococcal and streptococcal bacteria or Erythromycin					
• Vital signs done:temperature					
-heart rate and rhythm					
-Blood pressure readings					

3.2. Therapeutic management: (patient will be afebrile and well hydrated)					
• Hydration status assessed					
• Fluids intake encouraged as tolerated					
• Cooling measures conducted when necessary					
• Cool environment maintained					
• Parental fluids administered as ordered or as necessary					
• Antipyretic therapy administered					
• Intake and output recorded					
3.3. Health education: patient will demonstrate understanding of disease process and self care management					
• Explain need to rest					
• Explain need for nourishing diet					
• Discuss signs and symptoms of respiratory distress					
• Teach name of antibiotic ,dosage and side -effects					
• Teach the importance of completing course of antibiotic					
4. Follow up evaluation					
• Patient is afebrile					
• Airway is patent and breath sounds are clear					
• Patient resumes normal diet and fluid intake					
5. Referral done if:					
• Temperature remaining >39.5 degree celsius					
• Hypotensive:-<90mmHg systolic					
-<50mmHg diastolic					
• Tachypnoea >20 breath					

/minute					
• Tachycardia>120beats/min					
• Flaring of nostrils					
• Rib recession					
Subtotal:					

Protocol for initial screening of client:Ear assessment

Criteria	Observed/ Done	Not observed/ not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective data					
• Earache					
• Decreased hearing acuity in one or both ears					
• Tinnitus					
• Feeling of fullness in the ear					
• Own voice echoes					
• Popping noise when yawning or swallowing					
• Dizziness					
• Itching in ear					
• Ear drainage:type					
1.2.Objective data					
• General appearance					
• Vital signs:temperature					
-blood pressure					
-pulse					
-respiration					
• Ability to hear					
• Ability to lip read					
• Tolerance of loud sounds					
• Ear drainage:type					
-colour					
-amount					
• Medication used:gentamycin					
-streptomycin					
-Salicylates					
• Allergies					
Subtotal:					

Protocol for initial screening of client :Eye assessment

Criteria	Observed/	Not	Not	Recorded	Not recorded
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	Done	observed/Not done	applicable		
1.Assessment					
1.1.Subjective data					
• Blurred vision					
• Double vision					
• Light or flashes or halo seen					
• Decreased or absent vision					
• Objects held too near or too far					
• Eye fatigue or strain					
• Tenderness or pain					
• Eye waters or itch					
• Inability to see in bright light					
• Headache					
• Frequent falls					
1.2.Objective data					
• Wears glasses or contact lenses					
• Position of reading material					
• Conjunctivitis					
• Drainage :-amount -type					
• Haemorrhage					
• Rubbing eyes					
• Oedema of eyelids					
• Visual acuity					
• Opaqueness of eyeball					
• Amount of tearing					
• Allergies					
• Nystagmus					
• Chalazion					
• laceration					
Subtotal:					

Protocol for initial screening of client:Genitourinary assessment

Criteria	Observed/ Done	Not observed/ not done	Not applicable	Recorded	Not Recorded
1.Assessment					
1.1.History taking(physical factors)					
• Usual pattern of micturition:frequency -amounts -times of day or night					

• Change in usual pattern of micturition					
• Artificial orifice:-what kind					
-for how long					
-why was it necessary					
-how is it managed					
• Difficulty in starting or maintaining stream					
• Feeling that the bladder is empty					
• Feeling of urgency					
• Urine character:-colour					
-odour					
• Incontinency:-amount					
-frequency					
-type of dribbling					
• Pain:-location					
-kind					
-severity					
-duration					
-painful urination					
• Relevant medication:-diuretics					
-antibiotics					
-narcotics					
-how is					
person taking medication					
• Allergy:to medication					
1.2.Objective data					
• Kidney:fullness					
-pain					
• Bladder :-pain					
-distended					
• Urethra:discharge					
• Oedema					
• External genitalia:redness					
-sores					
-pain					
-inflammation					
Subtotal:					

Protocol for initial screening of client:musculoskeletal assessment

Prepared for initial screening of client: Respiratory assessment

Criteria	Normal	Not	Not	Not
	1.4.1.1	1.4.1.2	1.4.1.3	1.4.1.4
1.4.1.1				
1.4.1.2				
1.4.1.3				
1.4.1.4				
Five main systems				

• Current respiratory problem					
• When did each symptom start					
• How did each symptom start					
• When do symptoms affect you					
• What have you found relieves your symptoms					
1.2.Indications of respiratory disorders(Subjective data)					
• Rapid breathing					
• Cough:non-productive indicative of Pulmonary Tuberculosis					
• Cough productive :indicative of Acute lung infection					
• Dyspnoea					
• Haemoptysis					
• Chest pain					
• wheezing					
• fever					
• chills					
• sweating					
• dizziness					
• tiring easily					
• Amount of exercises tolerated					
• Swelling of hands and feet					
1.3.Objective data					
• Anxious					
• flaring nostrils					
• red swollen nose					
• nasal discharge					
• colour:cyanose of tongue/lips/eyes					
• pallor:gray blue					
• clubbing of extremities:nailbeds					
• elevated temperature					
• Respiration pattern:tachycardia/dyspnoea					
• Confusion,restlessness					
• Cough –non productive					
• Cough-productive					
• Sputum-colour					
-amount					
-charateristics					
• Use of accessory muscles on breathing					
• Respiration:-stridor					
-wheeze					
-normal					

• Speech pattern:-normal					
-telegraphic					
• Eyes:-engaged veins					
-papiloedema					
• Diaphoresis					
• Anorexia					
• Weight loss					
• Ascites					
• Rib retractions					
Subtotal:					

Protocol for initial screening of clients:Gastro-intestinal assessment

Criteria	Observed/D one	Not observed/ not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective data					
• Mouth,tongue or lips:-painful					
-tender					
• Difficulty in swallowing(dysphagia)					
• Use of laxatives					
• Abdominal Pain:-aching					
-burning					
-cramplike					
-gnawing					
-relationship to eating					
-location of the pain					
• Anorexia					
• Loss of appetite					
• Nausea					
• Vomiting					
• Diarrhoea					
• Flatulence					
• Chronic indigestion					
• Fatty food intolerance					
• Constipation					
• Melena stool					
• Clay coloured stool					
• Steatorrhoea(bulky,foul,fatty stool)					
• Nose bleeding					
• Haemorrhoids					
1.2.Objective data					

• General appearance					
• Vital signs:Blood pressure					
-pulse					
-temperature					
-respiration					
• Weight					
• Urinary output					
• urinalysis					
• Allergies					
• Mouth:-stomatitis					
-Condition and colour of tongue,gums or mucous membrane					
-halitosis					
• Abdomen:-distention					
-symmetry					
-bowel sounds:present or absent					
• Perinial area:-haemorrhoids					
-colour and condition of area					
• Skin:-jaundice					
-turgor					
-peripheral oedema					
Subtotal:					

Protocol for initial screening of client:Cardiovascular disorder.

Criteria	Observed/ Done	Not observed/ not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Cardiovascular History(Subjective data)					
• shortness of breath(with ,without activity)					
• chest pain or discomfort:dull radiating to the left arm					
• Indigestion					
• dyspnoea on exertion/nortunal					
• palpitations					
• fainting/syncope					
• Generalised body fatigue					
• peripheral skin changes					
• fever					
• Cough,wheeze,haemoptysis					
• numb extremities,cold					
• changes in vision					
• headaches					
• oedema of extremities					

• Cyanosis					
• Nausea					
1.2.Objective data					
• general appearance:colour					
-respiration					
-assumed position					
• Arterial pulse: -rate					
-rhythm					
-					
presence/absence					
• Respiration :-rate					
-type					
• Neck veins:-distended					
-pressure					
Pulsation					
• Blood pressure:systolic					
-diastolic					
• Urinary output: - amount/frequency					
-colour					
• Heart sounds:frequency of s1,s2					
• Breath sounds: -wheezes					
- bronchial rales					
-rubs					
• Skin:-colour					
-temperature					
-diaphoresis					
-turgor					
-dryness					
• Extremities:-capillary filling time					
-clubbing					
-nail shape					
-colour					
-temperature					
• Precordium:-point of maximal impulse					
• Mentally alert					
• Oedema:-pitting of extremities					
-pitting of sacral area					
-Eyelids					
-ascites					
Subtotal:					

Urinary Tract infection

Criteria	Observed/D one	Not observed/not	Not applicable	Recorded	Not recorded
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<ul style="list-style-type: none"> • Antibiotic administered as ordered or 					
<ul style="list-style-type: none"> • Per Sexually Transmitted infections: Doxycycline 500mg stat and then Doxycycline 500mg B.D for 7 days 					
<ul style="list-style-type: none"> • Analgesics administered as ordered 					
<ul style="list-style-type: none"> • Followup urine collection for culture and sensitivity to determine response to treatment done 					
3.2. Therapeutic management (:patient will void with pattern of urinary elimination as near normal as possible)					
<ul style="list-style-type: none"> • Urine output with each voiding is measured and documented 					
<ul style="list-style-type: none"> • Voiding every 2-3hours is encouraged 					
<ul style="list-style-type: none"> • Bladder is palpated 4 hourly to check distention 					
<ul style="list-style-type: none"> • Easy access to bathroom, bedpan or urinal provided 					
<ul style="list-style-type: none"> • Patient is helped to assume a comfortable position for urination 					
<ul style="list-style-type: none"> • Patient is instructed to avoid drinking fluids for 2-3 hours before bedtime 					
<ul style="list-style-type: none"> • Fluid intake of up to 3l per day is encouraged 					
<ul style="list-style-type: none"> • Patient is instructed to avoid coffee or tea before bed time 					
3.3. Therapeutic management (:patient will report and experience decrease in pain and decrease in burning on micturition)					
<ul style="list-style-type: none"> • Nature, intensity, location, duration and precipitating and alleviation factors of pain assessed 					
<ul style="list-style-type: none"> • Relaxation techniques taught 					
<ul style="list-style-type: none"> • High oral fluid intake to dilute urine encouraged 					
<ul style="list-style-type: none"> • Analgesics administered as ordered 					
<ul style="list-style-type: none"> • Vital signs prior and after administration of analgesics is 					

assessed					
<ul style="list-style-type: none"> Pain relief is monitored and documented 					
3.4. Health education (:patient verbalizes understanding of disease process ,methods of prevention and self care management)					
<ul style="list-style-type: none"> Instruct patient to drink 3L of fluid per day unless contraindicated 					
<ul style="list-style-type: none"> Instruct patient to avoid coffee or tea 					
<ul style="list-style-type: none"> Teach methods of preventing recurrence of U.T.I:-abstinence from sex 					
-use a condom for protected sex					
-empty bladder 4 hourly,avoid prolonged bladder and distention					
-Teach symptoms of recurrence of U.T.I and instruct patient to report their presence to clinic					
-Instruct patient to complete prescribed course of antibiotics					
-Teach name of medication,dosage,purpose and side-effects					
-Notify partner to be treated					
4. Follow up evaluation					
<ul style="list-style-type: none"> Patient is voiding clear,bacteria free urine 					
<ul style="list-style-type: none"> No signs or symptoms of U.T.I are present 					
<ul style="list-style-type: none"> Patient's voiding pattern has returned to normal 					
<ul style="list-style-type: none"> Patient verbalizes decrease in pain and absence of burning micturition 					
<ul style="list-style-type: none"> Patient verbalizes understanding of disease process,methods of prevention and self care management 					
5. Referral done if:					
<ul style="list-style-type: none"> Haematuria 					
<ul style="list-style-type: none"> Culture still positive(untreated) 					

• High serum sodium and potassium					
• High urea and creatinine levels of serum					
SUBTOTAL:					

Tinea Pedis(Athlete's foot)

Criteria	Observed/D one	Not observed/not done	Not applicable	Recorded	Not recorded
1.Assessment					
1.1.Subjective data					
• Itching					
• Burning and stinging between toes spreading to the sole					
1.2.Objective data					
• secondary eczema of the hands					
• scaling					
• maceration					
• vesicles eruption					
2.Nursing diagnosis made and recorded					
2.1.Impaired skin infection due to fungal infection and inflammation.					
2.2.Knowledge deficit regarding disease and self care management					
3.Management of client					
3.1.Therapeutic management(:skin integrity to return almost to normal stage before infection and prevent further damage)					
• The crusts and debris of acute tinea are removed by soaking feet/foot					
• Involved areas are dried carefully					
• Thin layer of antifungal medication is applied as ordered					
• Instruct client to continue treatment for at least three weeks to discourage recurrence					

<ul style="list-style-type: none"> • Systematic antifungal are administered as prescribed e.g.Griseofulvin orKetaconazole 					
<ul style="list-style-type: none"> • Importance of compliance is explained 					
<ul style="list-style-type: none"> • The side-effects of medication are explained to client 					
3.2.Health education: patient will demonstrate understanding of disease process and self care management					
<ul style="list-style-type: none"> • Instruct client to avoid environment which exacerbate the condition:-heat -Moisture -maceration -trauma 					
<ul style="list-style-type: none"> • Teach client to dry thoroughly after bathing especially between toe webs,breasts ans axillae 					
<ul style="list-style-type: none"> • Wear absorbent materials such as cotton underwear and socks 					
<ul style="list-style-type: none"> • Do not wear same shoes each day 					
<ul style="list-style-type: none"> • Wear sandals on a warm weather 					
<ul style="list-style-type: none"> • Discuss the treatment :name -dosage application -side-effects:headaches and gastrointestinal upset 					
<ul style="list-style-type: none"> • Promote personal control of and active involvement in treatment and care 					
4.Follow up evaluation					
<ul style="list-style-type: none"> • Improvement on treatment • Understanding of disease,prevention and self care management 					
5.Referral done if:					
<ul style="list-style-type: none"> • Severe infection • Secondary infection • No improvement after 4 					

weeks					
• Involvement in the nails					
Subtotal:36					

Date of transcription: _____

Interviewer: _____

Client's Biographic Information:

Sex

Male	
Female	

Age

18-25years	26-30years	31-35years	36-40years	41-45years	46 years and over
1	2	3	4	5	6

Duration in prison

Less than 5 months in prison	6-12months	13-2years	23 months-4years	5months-6years	7years-10years	11 years or more
1	2	3	4	5	6	7

CLINIC

PATIENT'S RIGHTS CHARTER/BATHO PELE PRINCIPLES/RATE

1. Health and safe environment

(a) How would you rate the cleanliness of the health care facility (sheds)?

Very clean	clean	dirty	Very dirty
1	2	3	4

(b) Motivate your answer

2. How would you rate the health conditions in your cell (single or communal cell)?

ADDENDUM**Outcome Standards:Patient Questionnaire**

Health care center:-----

Date of interview:-----

Interviewer:-----

Client's Biographic information:

Sex

Male
1

Age

18-25years	26-30years	31-35years	36-40years	41-45years	46years and older
1	2	3	4	5	6

Duration in prison

Less than 5 months in prison	5-12months	13-2years	25months-4years	49months-6years	7years-10years	11years and more
1	2	3	4	5	6	7

CLINIC**PATIENT'S RIGHTS CHARTER(BATHO PELE PRINCIPLES):RATE****1.Healthy and Safe environment**

(a).How would you rate the cleanliness of the health care facility(clinic)?

Very clean	clean	dirty	Very dirty
1	2	3	4

(b).Motivate your answer.

2.How would you rate the health conditions in your cell(single or communal cell)?

Excellent health conditions	Very good health conditions	Good health conditions	Bad health conditions	Very bad health conditions
1	2	3	4	5

Motivate/Explain what you mean.

3. Access to health care

(a). Do you find it difficult to see a nurse when you are experiencing a health problem?

Yes	No
1	2

Motivate/Explain your answer.

(b). Do you find it difficult to see a medical officer when you are experiencing a health problem?

Yes	No
1	2

Motivate/Explain your answer.

4. Health care

(a). Are you satisfied with the waiting time before seeing a nurse at the waiting room/area?

Satisfied	Not satisfied
1	2

Motivate and explain how long are you prepared to wait before see a nurse at the waiting room/area.

5. Confidentiality

13. Do you feel health related issues are kept confidential by the nursing staff?

Kept confidentially	Not kept confidentially
---------------------	-------------------------

1	2
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Motivate your answer

6. Privacy

(a). Do you feel your right to privacy is /was honoured by a nursing staff?

Honoured	Not honoured
1	2

Motivate/Explain your answer.

(b). If you answered not honoured how would you like your right to privacy be honoured by the nursing staff.

7. Dignity and respect

(a). Do you feel you are treated with dignity and respect by nurses?

Treated with dignity and respect	Not treated with dignity and respect
1	2

Motivate/Explain your answer

8. Referral system(second opinion) to another health care worker

(a). When the nurse could not handle /treat your health problem ,were you referred to a medial officer?

Referred to medical officer	Not referred to medical officer
1	2

Motivate your answer.

9. Consultation(participation in decision-making)

(a).Do nurses involve you in planning your health care?

Always involved	Rarely involved	Once involved	Not at all involved
1	2	3	4

Motivate/Explain your answer

10. Complaints/comments from clients

(a).How do you complain about the health service you receive.

(b).Do you get an opportunity to raise your complaints about the standard of health care?

Given an opportunity	Not given an opportunity
1	2

Motivate/Explain your answer.

(c) How would you like to raise your complaints about the standard of health care.

11. Informed Consent

(a).Were the following procedures explained to you beforehand:

Procedures	Yes	No	Not applicable
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Drawing of blood	1	2	3
Changing of dressing	1	2	3
Instilling eye drops	1	2	3
Assessing of blood pressure	1	2	3
Administration of oral medication	1	2	3
Administration of intramuscular injection	1	2	3
Taking of temperature	1	2.	3

Motivate/Explain your answer.

(b) Did you give consent for a procedure whilst receiving health care?

Gave consent	Did not give consent
1	2

(c) If you answered gave consent to question 11(b) above, how was the consent?

verbal	Written
1	2

(d) If you answered written consent to question 11(c) above, state two procedures which you signed a consent for:

(e) If you answered verbal consent to question 11(c) above, state two procedures/treatment you gave verbal consent for.

NURSING PROCESS FRAMEWORK

12. Assessment

(a) Was your health condition assessed by the nurse on admission?

Yes	No
1	2

(b) If you answered yes to question 12(a) above, were you assessed to your satisfaction?

Satisfied	Not satisfied
1	2

Motivate your answer.

13. Implementation

(a). Do you feel your comfort need is/was attended to by the nurse?

Attended to	Not attended to
1	2

Motivate your answer.

(b). Do you feel your nutrition need is/was attended to by the nurse?

Yes	No	Not applicable
1	2	3

Motivate/Explain your answer

14. Health education(information)

(a). Were you taught measures of health maintenance by the nurse?

Yes	No
1	2

(b). If you answered yes to question 14(a) above, please explain what health maintenance measures were you taught by the nurse.

(c).If you answered no to question 14 (a) above.please explain what health maintenance measures would you like to be taught by the nurse.

(d)Were you taught self care management by the nurse?

Yes	No
1	2

(e).What self care management were you taught by the nurse from below:

Self care Management	Yes	No	Not applicable
Changing of dressing	1	2	3
Diabetes mellitus	1	2	3
Personal hygiene	1	2	3
Skin care on acne vulgaris	1	2	3
Food to avoid:hypertension	1	2	3
Precipitating factors to avoid:Epilepsy	1	2	3
Any other item:			

(f). Please explain self care management you were taught by the nurses.

(g). Were you taught illness prevention measures by the nurse?

Yes	No
1	2

(h).If you answered yes to question 15(g) above,please explain what illness prevention measures were explained to you.

(i).If you answered no to question 15(g) above ,please explain what illness prevention measures would you like to be taught by the nurse.

15.Evaluation.

(a).After receiving health care from the nurse,does the nurse evaluate your response to therapy?

Frequently	Rarely	Once	Not at all
1	2	3	4

(b).If you answered not at all to question 16(a) above,what would you like the nurse to ask you regarding response to therapy.Please explain.

ADDITIONAL COMMENTS/SUGGESTIONS:

THANK YOU FOR PARTICIPATION IN THIS RESEARCH.



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