

**AN INVESTIGATION INTO FACTORS INFLUENCING
THE QUALITY OF NURSING CARE IN DISTRICT HOSPITALS IN THE
WEST COAST WINELANDS REGION OF THE WESTERN CAPE**

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of the requirements
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Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained there in is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Abstract

Every patient comes to a hospital with the expectation of getting quality care. It is not always within the ability of nursing personnel to give quality care in the work situation.

Guided by the research question “What are the factors influencing the quality of nursing care in district hospitals in the West Coast Winelands Region of the Western Cape?” a scientific investigation was undertaken.

The goal of this study was to identify the factors which influence the quality of nursing care in the eight (8) district hospitals of the West Coast Winelands Region of the Western Cape.

The objectives set for the study were:

- to determine whether staffing is adequate for all activities;
- to evaluate what the perceptions of the nursing staff is about their current working situation;
- to determine what the effect of the absence of full time doctors are on the management of patient care;
- to evaluate whether adequate equipment is available for the execution of nursing care and to evaluate whether adequate provisions for the execution of nursing care is done.

A descriptive non-experimental design with a quantitative approach was applied. The population for this study was all the nursing staff available at the time of data collection, working in the eight district hospitals of the West Coast Winelands Region.

A structured questionnaire was used to collect the data. The final sample of nursing staff was N= 280 of a total population of 340 – all the members were invited to participate.

Reliability and validity were assured by means of a pilot study and the use of experts in nursing research, methodology and statistics. Data were collected personally by the researcher.

Ethical approval was obtained from Stellenbosch University and various health authorities. Informed written consent was obtained from the participants.

The data was analyzed with the support of the statistician; it was expressed in frequencies, tables and histograms. Comparisons between variables were made using either ANOVA (Analysis of variance) techniques or cross-tabulations with the Chi-square test. The 95% confidence interval was applied to determine whether there was an association between the various variables. The

analysis shows that participants of the separate wards hospitals N=142 (90%) and the mixed wards type hospitals N=113 (95%) disagree that staff provision (numbers) is adequate. From the analysis it is clear that the patient documentation is not up to standard. A statistical significant correlation between hospital type and adequate time for the completion of written records (Chi-square Test $p=0.00$) was shown. Management N=13 (100%), registered nurses N=80 (86%), enrolled nurses N=63 (86%) and nursing assistants N= 81 (83%) disagree that it is not necessary to act beyond their scope of practice.

The following recommendations were made: Safe staffing levels have to be determined; qualify staff with the necessary skills; where unit managers are still lacking, they have to be appointed; to make personnel development possible for staff; continuous auditing of patient documentation.

It is necessary that there is always adequate equipment and consumables. More training is necessary for the effective and efficient implementation of the Batho Pele principles.

Opsomming

Elke pasiënt kom na 'n hospitaal met die verwagting om kwaliteit verpleegsorg te ontvang. Dit is nie altyd binne die vermoë van die verpleegpersoneel om sodanige diens te kan lewer nie.

“Watter faktore het 'n invloed op die lewering van gehalteverpleegsorg in die distrikhospitale van die Weskus Wynlandstreek in die Wes Kaap? het die wetenskaplike ondersoek gelei.

Die doel van die studie is om die faktore te identifiseer wat 'n invloed het op die lewering van gehalteverpleegsorg in die ag (8) distrikhospitale van die Weskus Wynlandstreek in die Wes Kaap.

Die doelwitte van die studie is:

- om te bepaal of personeelvoorsiening voldoende is vir al die aktiwiteite;
- om te evalueer wat die persepsies is van die verpleegpersoneel betreffende hulle huidige werksituasie,
- om te bepaal watter effek die afwesigheid van voltydse geneeshere het op pasiënte sorg;
- om te evalueer of toerusting voldoende is vir pasiënte sorg;
- om te evalueer of daar voldoende voorsiening gemaak is vir die lewering van pasiënte sorg.

'n Beskrywende, nie-eksperimentele ontwerp as metodologie is gebruik met 'n kwantitatiewe benadering. Die bevolking betreffende die studie was alle verpleegpersoneel, werksaam tydens die insameling van die data in die ag distrikhospitale van die Weskus Wynlandstreek.

'n Gestruktureerde vraelys was gebruik om die data te versamel. Die finale steekproef van die verpleegpersoneel was 280 uit die totale bevolking van 340.

Betroubaarheid en geldigheid is verseker deur middel van 'n loodstudie, en deur gebruik te maak van kenners betreffende verpleegnavorsing, metodologie en statistieke. Data is persoonlik deur die navorser ingesamel.

Etiese goedkeuring was verkry vanaf die Universiteit van Stellenbosch en die verskeie gesondheidsowerhede. Ingeligde, skriftelike toestemming is van elke deelnemer verkry.

Data is ontleed met die ondersteuning van die statistikus en is uitgedruk in die vorm van frekwensies, tabelle en histogramme. Vergelykings tussen die veranderlikes was gedoen deur gebruik te maak van ANOVA (analise met betrekking tot variansie) en kruis-tabulerings met die

Chi-kwadraat toets. 95% Betroubaarheidsinterval is toegepas om te bepaal of daar 'n assosiasie was tussen die onderskeie veranderlikes. Die analise het getoon dat deelnemers betreffende die hospitale met aparte afdelings N=142 (90%) en die gemengde sale hospitale N=113 (95%) **verskil**, betreffende die stelling dat daar voldoende personeelgetalle is. Dokumentasie is volgens die analise nie op standaard nie. 'n Statistiese betekenisvolle korrelasie is verkry met betrekking tot die hospitaal tipe en voldoende tyd betreffende volledige geskrewe dokumentasie (Chi-kwadraat Toets $p=0.00$). Verpleegbestuur N=13 (100%), geregistreerde verpleegkundiges N=80 (86%), stafverpleegsters N=63 (86%) en verpleegassistentente N=81 (83%) het **verskil** met die stelling dat dit nie nodig is om buite bestek van hul praktyk te werk nie.

Die volgende aanbevelings is gemaak: die bepaling van veilige personeel vlakke moet gedoen word; voldoende personeel moet gekwalifiseer word met die nodige vaardighede. Eenheidsbestuurders moet aangestel word waar dit ontbreek; personeelontwikkeling moet moontlik wees en deurlopende oudits van dokumentasie moet plaasvind.

Voldoende toerusting en voorraad is nodig om kwaliteit verpleegsorg moontlik te maak. Verdere opleiding in die beginsels van Batho Pele is nodig ten einde effektiewe en doeltreffende implementering daarvan moontlik te maak.

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CHAPTER 1: SCIENTIFIC FOUNDATION OF THE STUDY

1.1 RATIONALE

Every patient comes to a hospital with the expectancy of receiving quality health care. A person's health is one of his or her most important assets; therefore health care delivery should be of the highest quality. Health care costs are increasing rapidly - consumers expect value for money.

Every nursing practitioner is personally, professionally, ethically and legally accountable for the provision of quality nursing care. This accountability is towards the patient, as well as the employer, the professional council and the public courts should they require it.

The right to basic health is part of the South African Bill of Human Rights. The South African Government is under obligation to assist with the realization of this Bill (Verschoor, Fick, Jansen & Viljoen, 1997:35).

Batho Pele refers to "people first" and is a regulated policy that is concerned with service delivery in the public sector. The White Paper on Transforming Public Service Delivery South Africa, after 1997 sets out eight transformation priorities, amongst which Transforming Service Delivery is the key. The principles of service delivery are briefly discussed.

- 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 that are offered. Consultation can help to foster a more participative and co-operative relationship between the providers and the users of public services.
- Setting Service Standards: Citizens should be told what level and quality of public service they will receive so that they are aware of what to expect. National and provincial departments must publish standards and they must be expressed in terms which are relevant and easily understood.
- Increasing access: All citizens should have equal access to the services to which they are entitled. National and provincial departments must develop strategies to eliminate the disadvantages of the disabled who live in remote areas and have to travel long distances. Social, cultural, communicative and attitudinal barriers also need to be taken into account.
- Ensuring courtesy: Citizens should be treated with courtesy and consideration. This concept goes much wider than asking public servants to give a polite smile and to say

“please” and “thank you”, though these are certainly required. The Code of Conduct for Public Servants issued by the Public Commission, makes it clear that courtesy and regard for the public is one of the fundamental duties of public servants, by specifying that public servants treat members of the public as “customers who are entitled to receive the highest standards of service”.

- Providing more and better information: Citizens should be given full, accurate information about the public services they are entitled to receive. Information must be in a variety of media and languages. Written information should be supported by graphical material where this will make it easier to understand.
- Increasing openness and transparency: Citizens should be told how national and provincial departments are run, how much they cost and who is in charge. The importance lies in building trust between the public sector and the public.
- Remedying mistakes and failures: If the promised standards of service are not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic, positive response.
- Getting the best possible value for money: Public services should be provided economically and efficiently in order to give the best possible value for money (South Africa, 1997:18-25).

The Department of Health has formulated a national patient's rights charter, which is a guide to the rights and responsibilities of the patient which is focusing on the following:

- A healthy and safe environment; that will ensure their physical and mental health or well-being. This includes adequate water supply, sanitation and waste disposal as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.
- Access to healthcare which includes: Receiving timely emergency care at any available health care facility, regardless of the ability to pay. Treatment and rehabilitation – the availability of which should be explained to the patient. Provision for special needs – for example those of newborn infants, children, and pregnant women, the aged, disabled persons, patients in pain, and persons living with HIV or AIDS. Counselling – on matters such as reproductive health, cancer or HIV/AIDS. Palliative care – that is affordable and effective in cases of incurable or terminal illnesses. A positive attitude – from health care providers who show courtesy, human dignity, patience, empathy and tolerance. Health information – that includes the availability of health services and how best to use them, in the patient's own language if possible.

- Confidentiality and privacy: information may only be disclosed with the patient's consent, except when required in terms of any law or court order.
- Give informed consent: After being given full and accurate information about the nature of the illness, diagnostic procedure, proposed treatment and the costs involved.
- Be referred for a second opinion: To a health provider of the patient's choice.
- A choice of health services: Provided that any choice is not contrary to the ethical standards of such health care providers or facilities, and the choice is in line with service delivery guidelines.
- Continuity of care: This includes all the healthcare practitioners involved in the treatment/caring of the patient.
- Complaints about health services: And receive a full response to such a complaint.
- Participation in decision-making: In matters affecting the patient's health and treatment regimen.
- Be treated by a named health care provider: This applies to transparency of service providers.
- To refuse treatment: Verbally or in writing provided that such refusal does not endanger the health of others. The right is based on appropriate and adequate information related to this decision by the patient or guardian.
- Information about any health insurance/medical aid scheme: Patients are entitled to detailed and accurate information, especially related to the disclosure of information of all services not covered by the insurance (Booyesen, Erasmus & Van Zyl, 2004:7-8).

According to the *Strategic Plan 2007/08 – 2009/10*, the vision of the Department of Health is to be an accessible, caring and high quality health system. Improving quality of care is one of the five priorities for 2007/08 – 2009/10 that the National Health Council adopted (Department of Health, 2007:9).

According to the *Annual Performance Plan 2008/2009*, the vision, mission and values that guide the Western Cape Department of Health, support those of the National Department of Health. The vision is of equal access to quality health care. The ways in which the vision and mission are achieved are reflected in the core values: integrity, openness and transparency, honesty, respect for people and commitment to high quality service (Western Cape Department of Health, 2008:1).

In the light of the above, it is clear that the vision and mission on National and Provincial levels were highlighted which focus on quality service delivery. This view of quality is aligned with the global context of the World Health Organization (WHO) that provides the

international leadership on quality promotion and improvement. The World Health Organization's objective, as set out in its Constitution, is the attainment of the highest possible level of health by all people (Muller, Bezuidenhout & Jooste, 2008: 494).

According to the Patients Right Charter and Batho Pele Principles it is expected of health care workers to put patients first, and to deliver a quality health care service - but health care workers experience barriers in the present work situation where they have to deal with staff shortages, huge workloads, budget constraints and lack of resources. The researcher included the principles of Batho Pele in the measuring instrument of this study, to evaluate how successful the implementation is.

The meaning of the concept, quality, according to the Macmillan English Dictionary (Rundell, & Fox, 2002:1153) refers to the following:

- how good or bad something is
- a high standard
- a feature of a person's character, especially when it is a positive one such as honesty, kindness, or a special ability
- a feature of a thing, substance or place.

Quality: is described as the degree of excellence, extent to which an organization meets clients' needs and exceeds their expectations (Muller *et al.*, 2008:534).

According to Donabedian (1990:1115) there are seven attributes of health care for defining its quality

- Efficacy: The ability of the science and art of health care to bring about improvements in health and well-being
- Effectiveness: It is the improvement in health that is achieved, or can be expected to be achieved, under the ordinary circumstances of everyday practice
- Efficiency: The ability to obtain the greatest health improvement at the lowest cost
- Optimality: The most advantageous balancing of cost and benefits
- Acceptability: Conformity to patient preferences regarding accessibility, the patient-practitioner relation, amenities, the effects of care, and the cost of care
- Legitimacy: Conformity to social preferences concerning all of the above
- Equity: Fairness in the distribution of care and its effects on health.

Quality assurance: a guarantee of compliance with predetermined standards and usually relates to legal requirements (Muller *et al.*, 2008:534).

Quality improvement: a formal process whereby standards are set, work performance is measured against these set standards, and remedial steps are taken to solve problems in order to improve performance outcomes (Muller *et al.*, 2008:535).

The researcher is the Head Nurse of a district hospital in a rural area of the Western Cape. The hospital is responsible for delivering level one service to patients. Level one care as defined according to the service plan 2010 of the Department of Health, Western Cape Province as the care given by general practitioners or primary health care trained nurses in the absence of specialists. At level one, the patient is stable and uncomplicated. Services include: General Surgery (appendectomies, caesarean sections, tonsillectomies, reduction of uncomplicated fractures, diagnostic dilatations and curettage, termination of pregnancies, tooth extractions and excisions of skin lesions), Medical, Paediatrics, Gynaecology, Obstetrics, Psychiatry, Orthopaedics, Casualties and Trauma, Radiology including diagnostic tests such as ultra sound.

Complicated, unstable patients are referred to level two or three hospitals where specialized care under supervision of specialists is given.

The average occupation of beds averages 64% per month. Despite the low occupation bed rate, the researcher has identified that nursing care is deteriorating. Nursing staff increasingly complain that they cannot manage the workload due to inadequate staff, which in turn influences the quality of nursing care. This hospital is operating with a part time Medical Superintendent who has a very busy schedule and is assisted by part time Medical Practitioners. The Nursing staffs are obliged to render functions for which they are not always trained. This practice is very stressful for nursing staff as it withholds them from rendering nursing care to patients. Consequently, an increase in patient complaints has resulted due to the unsatisfactory nursing care delivered.

The situation is aggravated further by inadequate equipment and provisions which directly influence the execution of nursing care.

Patient documentation reveals serious deficiencies, which could have medical legal implications.

It is against this background that the researcher identified the need for a scientific investigation into the factors influencing the quality of nursing care in the eight (level one) district hospitals in the West Coast Winelands Region of the Western Cape.

The researcher could not find any corresponding study of rural hospitals in terms of background, infrastructure and part-time Medical Superintendents and Doctors. It is a concern that there is no formal quality process – although complaints and negative incidents are monitored and sent to the regional office, nothing is done in terms of remedial steps. It appears that little concern about patient complaints, the quality of nursing care and inadequate nursing documentation is shown. This is illustrated by the lack of inspections of the hospitals from regional office and lack of response to negative or positive incidents.

The researcher reviewed the literature to evaluate the existing available body of knowledge according to the quality of care regarding rural hospitals. The following characteristics are common to rural environments:

- **Physically Isolated** - Rural hospitals are generally physically isolated from urban hospitals and resources which results in reduced networking with other hospitals and a static community of personnel and patients.

Physical isolation can be difficult with unique challenges, including limited access to specialists such as oncologists (Lyckholm, Hackney & Smith, 2001:132).

- **Lack of Health Insurance** - According to Newhouse (2004:351), the patients from rural populations comprise mainly of migrant farm workers who do not have health insurance.
- **Patient Volume and Level of Acuity** - Nursing practice in rural hospitals is diverse as illustrated by the different categories of patients that can present at a rural hospital. These hospitals could get anything from sports injuries, people who fall off horses and motorbikes, as well as farm related accidents. Apart from these, the nursing staff run a surgical list and has a full mix of medical and surgical inpatients.

The challenge is to ensure that rural nurses have the knowledge and skills to manage the diversity of their roles effectively (Kenny & Duckett, 2003:616).

- **Lack of adequate equipment and technology** - A paediatrician from Australia spent some time in South Africa to assist with the development of neonatal resuscitation training in rural areas. This brought to light serious deficiencies in neonatal resuscitation equipment in rural hospitals. In many places the equipment, for instance the laryngoscope blades were not adequate for training. E-mail contact was difficult in

places; because it took several days before e-mail contact was possible (Couper, Thurley & Hugo, 2005:1).

The researcher can relate very well with the barriers of inadequate equipment and technology in her current working milieu. These aspects are included in the measuring instrument of this project to evaluate how personnel in the other rural hospitals of this region are experiencing it.

- ***Inadequate Staffing*** - Currently resources are scarce in all hospitals, more so in rural hospitals. The allocation of human resources was especially challenging in rural hospitals farthest from urban centres: recruitment and retention of qualified registered nurses in these settings were highly problematic and time consuming, even when temporary housing in a hospital owned dormitory or apartment was provided (Henry & Moody, 1986:39).

Inadequate staffing is an aspect very relevant to this research project because of staff always complaining about not being able to cope with the workload brought about by understaffing.

- ***Inadequate competencies in nursing*** - In many ways, nurses practicing in small, rural hospitals must be able to practice more autonomously, have keen assessment skills, be able to recognize signs of impending complications more quickly and plan ahead, because calling for a resident physician or an in-house attending physician is not possible (Deaton, Essenpreis & Simpson, 1998:34).

The researcher included the aspect of professional development in this research to evaluate whether staffs are able to advance professionally by receiving continuing education and adequate opportunities for career development.

- ***Stress Levels among Nurses*** - Nurses reported job stress, both acute and chronic, as the top health and safety concern, followed by disabling back injuries and contracting HIV or hepatitis from a needle stick injury (Foley, 2004:5).

LeSergent & Haney (2005:8) identified in their study the following six categories that cause stress to nursing personnel:

- 46% of the respondents reported workload/overload to be stressful;
- 23% of the respondents reported interpersonal conflict with healthcare staff as stressful;
- 12% expressed concerns about adequate or appropriate nursing care;
- 6% reported on interpersonal problems with patients as stressful;
- 5% of the respondents reported issues around death and dying;
- 4% fear of failure/lack of professional confidence.

1.1.1 Perspectives of quality in health care

A study that was done by Hays, Veitch & Evans (2005:4-7) in Australia which has improved the understanding of the different views rural health professionals and rural patients have about the quality provided in rural hospitals.

Doctors: The practitioner views quality in terms of the knowledge and skills involved in professional practice.

Patients: Views quality in relation to the care received.

Family members: Focused more on the interpersonal communication of hospital staff, staff attentiveness and relationship skills with their relatives.

1.1.2 Quality outcomes

According to Gelinis & Manthey (1997:11) the most frequently cited examples in the literature of objective evidence of quality are the following outcomes:

- increased patient satisfaction
- reduced length of stay
- decreased mortality rates, lower infection rates, fewer patient falls
- increased physician satisfaction
- more personnel available for direct patient care
- fewer patient complaints
- increased staff members' satisfaction
- higher patient volume over a reduced length of stay without increasing full-time equivalents.

1.1.3 Nature of complaints

A study was done by Taylor, Wolfe & Cameron (2004:32) in 67 Victorian hospitals where they analyzed patients' complaints about their care retrospectively.

Communication: poor attention, discourtesy and rudeness accounted for 31.2% of complaints;

Access: no service or inadequate service and delay in treatment accounted for 21.2% and 21.2% of the issues;

Treatment: inadequate treatment and inadequate nursing care accounted for 24.5% and 19.8% issues, respectively.

The study showed that 84.5% of complaints were resolved easily. More than half were resolved with an apology or explanation.

1.1.4 Quality of nursing records

Uys & Naidoo (2004:1-7) did a study to describe and compare the quality of nursing service and care in three health districts in the KwaZulu-Natal Province.

A total of 137 records were audited. The average percentage of the records was 11%. It is evident from the average of the percentage above, that the quality of the nursing records in all three districts was generally poor.

From audits done in the hospital where the researcher is working she can relate very well to bad documentation practices. Personnel reported that there is not adequate time for complete written records due to understaffing. The researcher includes the aspect of nursing documentation in the measuring instrument of this study.

All of the above studies are relevant to the working conditions of nursing staff, working in the district hospitals of the West Coast Winelands Region. Health care workers in this Region are facing difficult challenges:

- rising public expectations and needs
- fiscal constraints
- the demand to provide quality service with fewer resources
- rapid changes in knowledge and expertise required to execute functions.

The researcher has identified that the absence of full-time doctors are influencing the management of patient care adversely, a problem not identified in the literature.

1.2 THEORETICAL MODEL

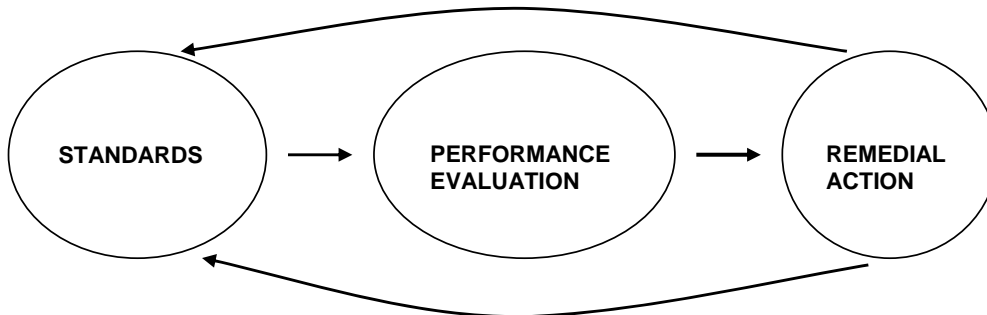


Figure 1.1: Process of Quality improvement (Muller, 2007:203)

According to the above schematic illustration, quality improvement is a formal process where standards are set, work performance is monitored and evaluated and remedial actions are taken to solve problems.

Quality as a process is a cyclic process which implies that standards are continually revised or changed with the evaluation of work performance and the correction of problems.

The quality improvement process therefore consists of inputs (human resources), throughput by utilizing and applying the inputs to achieve certain results (outputs and/or outcomes). The quality improvement process should ultimately impact on the outcome that is the health indicators in a region, province or country (Muller *et al.*, 2008:499).

Standards can be defined as statements of expected performance. There are three different types of standards:

- **Structure Standards:** These are the items (resources) in the organization, which refers to what is necessary for the achievement of tasks. Structure standards include the physical layout, mission, staff members (skills mix, experience, training, adequate staff), information (policies, procedures, regulations) and hierarchical structures.
- **Process Standards:** Refer to the activities (interventions) executed by the staff members to achieve the standards. Assessments, techniques, informing and educating

of patients, documentation of care and utilization of resources are examples of process standards.

- Outcome Standards refer to the results (effects) as experienced by the patients and reflect in the form of patient responses, level of knowledge and health status of the patient (Booyens, 2006:311-312).

Monitoring and evaluation, as shown in the second circle of figure 1.1. is the next step in the quality improvement process where various strategies are used for example: direct observation, auditing of patient records, patient satisfaction reviews or the monitoring of negative incidents. During this phase, data is collected, analyzed and interpreted followed by feedback to the role players.

Remedial steps are the third step in the quality improvement process: Remedial action could include personnel development to improve the knowledge, skills and attitude of personnel, the application of discipline in the unit or group pressure and the revision of standards may be necessary.

1.3 PROBLEM STATEMENT

In the light of the above the researcher is of opinion that there are barriers currently that impacted negatively on the delivering of quality patient care in the district hospitals of the West Coast Winelands Region, Western Cape Province.

1.4 RESEARCH QUESTION

As departure point for this study the following research question is posed as a guide for this research project:

What are the factors influencing the quality of nursing care in district hospitals in the West Coast Winelands Region of the Western Cape?

1.5 GOAL OF THE STUDY

To identify the factors which influence the quality of nursing care in the eight (8) district hospitals of the West Coast Winelands Region of the Western Cape?

1.6 OBJECTIVES

The following objectives are set for the research study namely to:

- a. determine whether staffing is adequate for all the activities

- b. evaluate what the perceptions of the nursing staff are about their current working situation
- c. determine what the effect of the absence of full time doctors are on the management of patient care
- d. evaluate whether adequate equipment is available for the execution of nursing care
- e. evaluate whether adequate provisions for the execution of nursing care is done.

1.7 RESEARCH METHODOLOGY

1.7.1 *Research approach and design*

A descriptive exploratory, non-experimental approach, in the format of a survey will be applied to investigate and describe the factors influencing the quality of nursing in the eight district hospitals of the West Coast Winelands Region of the Western Cape.

A descriptive exploratory, non-experimental approach according to De Vos, Strydom, Fouche & Delport (2005:143) is of a more quantitative nature, requiring questionnaires as a data collection method and is characterized by various aspects such as measuring objective facts and focusing on variables.

1.7.2 *Population and sampling*

All eight (8) district hospitals of the West Coast Winelands region will be included in the survey:

- Vredendal;
- Vredenburg;
- Stellenbosch;
- Clanwilliam;
- Citrusdal;
- Piketberg;
- Porterville;
- Malmesbury.

All the nursing staff will be included in the survey – consisting of 346 members working in these eight hospitals. Because all the nursing staff will be included in the test sample, representation is certain.

1.7.3 Pilot study

The pilot study can be viewed as the dress rehearsal of the main investigation. It is similar to the researcher's planned investigation, though on a smaller scale. A small scale of study will be conducted prior to research on a larger scale to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate. The purpose of the pilot study is of great value to investigate the feasibility of the planned project and to bring possible deficiencies in the measurement procedure to the fore (De Vos *et al.*, 2005:206).

According to the duty rosters, the total staff was 346, working in the eight hospitals. The pilot study was scheduled for Porterville and Citrusdal Hospitals to reach a 36 (10%) target population.

1.7.4 Instrumentation

A questionnaire is compiled to determine the factors influencing the quality of nursing care. The questionnaire is divided into a biographical section and the second part is based on a Likert scale. The Likert section has 4 options to choose from namely "strongly disagree, disagree, agree and strongly agree". Numerical values of 1, 2, 3, and 4 will be awarded. The researcher has consulted a statistician and a nurse expert about the content and feasibility of such an instrument, and has been assured that the instrument will allow for statistical calculation and analysis. The expertise and knowledge of the two persons mentioned will ensure that the instrument test and measure what it is supposed to test and measure.

1.7.5 Reliability and Validity

The researcher will collect the data herself to improve the reliability of the study. The researcher will visit each Hospital in August 2008 and each shift to inform them about the study and how to complete the questionnaire. The questionnaire will be available in Afrikaans and English. A sealed envelope will be enclosed for the completed questionnaire. The researcher will personally collect all envelopes from the participants.

The validity and reliability will further be supported by a pilot study which will be conducted to pre-test the questionnaire for any ambiguity and inaccuracies. The pilot study will be done under similar conditions as the actual study at Citrusdal Hospital (21 members) and Porterville Hospital (15 members) with a total population of 36 members – that is 10% sample of the eight hospitals (346 members) and will be 100% of the staff. Experts will be used in the research methodology, statistics and nursing to evaluate the research.

1.7.6 Data analysis and interpretation

With the help and recommendations of the statistician, the data will be analyzed. Data will be expressed in frequencies, tables and histograms. On a 95% confidence interval associations between various variables will be determined using the chi square test.

1.7.7 Recommendations

Recommendations will be made based on the scientific evidence and communicated to various stakeholders in health institutions.

From the study, recommendations can be made with regard to further studies which might be undertaken or for similar studies in other rural provinces to see if their staffs experience the same problems as in the Western Cape district hospitals.

Recommendations will be made based on scientific evidence obtained in this study. Results will be published.

1.8 ETHICAL CONSIDERATIONS

The protocol for this project was presented to the Committee for Human Research of the University of Stellenbosch in the prescribed format in order to get written consent to proceed with the study. Written consent will also be obtained from the Western Cape Department of Health (Provincial Research Coordinating Committee), as well as from the Medical Superintendent of each hospital that forms part of the study. Informed written consent will be obtained from all the participants.

An information session will be held with the Medical Superintendent and staff of the various hospitals who will be involved in the study to explain the purpose of the study.

Participation is voluntary, anonymity and confidentiality will be maintained. No risks are foreseen in this study.

1.9 OPERATIONAL DEFINITIONS

Quality: is described as the degree of excellence, extent to which an organization meets clients' needs and exceeds their expectations. Generally quality is defined as: doing the right thing, right, the first time – doing it better the next time (Muller *et al.*, 2008: 534).

Quality assurance: a guarantee of compliance with predetermined standards and usually relates to legal requirements (Muller *et al.*, 2008: 534).

Quality improvement: is a formal process whereby standards are set, work performance is measured against these set standards, and remedial steps are taken to solve problems in order to improve performance outcomes (Muller *et al.*, 2008: 535).

Level one care: as defined according to the service plan 2010 of the Department of Health, Western Cape Province is the care given by general practitioners or primary health care trained nurses in the absence of specialists. A level one patient is a stable and uncomplicated patient. Level one service includes stable and uncomplicated cases (Western Cape Department of Health, 2007:95).

1.10 STUDY LAYOUT

TITLE: An investigation into factors influencing the quality of nursing care in district hospitals in the West Coast Winelands Region of the Western Cape.

Chapter 1:

Scientific Foundation of the Study. This chapter describes the background, the focus and rationale of the study. A brief outline of the goals, objectives, research model and methodology is described.

Chapter 2:

Concentrates on the literature study concerning research completed on the quality of care done in rural hospitals.

Chapter 3:

In this chapter the research methodology applied in the study is described, which include the research design, population, sampling and data analysis.

Chapter 4:

The results are discussed, interpreted, and analyzed based on the data collected. The results are presented in the format of simple graphs and tables.

Chapter 5:

In this chapter the conclusions and recommendations are described based on the scientific evidence obtained in this study.

1.11 CONCLUSION

In this chapter the researcher describes the study to be undertaken. The background, rationale and focus are explained. An outline of the methodology is included.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

As described in Chapter One, “**quality**” is a key word in this research project, in essence it refers to the characteristics which are associated with excellence.

Generally **quality** is defined as: doing the right thing, right the first time – doing it better the next time (Muller *et al.*, 2008:534). Booyens (2005:596-597) identified several dimensions of quality in terms of appropriateness, accessibility, effectiveness, efficiency, equity and acceptability. Substantiated by Donabedian (1990:1115), quality is also described in terms of efficacy, effectiveness, efficiency and acceptability. In addition Donabedian added the characteristics of “optimality” which is the most advantageous balancing of costs and benefits and “legitimacy” in terms of conformity to social preferences.

In this chapter the researcher presents a literature study relevant to quality and those barriers which have an effect on delivering a quality service. The aims of the literature study can be described as follows:

- reviewing the existing available body of knowledge to see how researchers have investigated “quality” related to nursing
- definitions of quality, quality assurance and quality improvement in nursing as defined in the literature
- measuring instruments that have been developed to measure quality in nursing
- to identify what actions or programmes can be implemented to manage existing problems and improve the quality of service delivery
- to ensure that one does not duplicate a previous study and waste time and money (Mouton, 2006:87).

Quality improvement is a formal process whereby standards are set, work performance is measured or evaluated against these standards and remedial actions are taken to solve problems in order to improve performance outcomes (Muller *et al.*, 2008:534).

Couper (2004:1) described quality improvement as an important part of developing rural health services. Couper describes quality improvement as a cycle which starts with identifying the problems that need to be addressed and thereafter forming a team to deal with the issues identified. This team sets standards, which provide targets, appropriate to the context and towards which the service should aim. Data is then gathered to assess how the

healthcare service is currently performing in terms of those standards. On the basis of this information, an analysis is made of the problems and their causes, which then allows the team to develop a specific plan to address the important limiting factors in the context. Implementation of the plan continues on an ongoing basis, repeating the steps as needed, with evaluation occurring as part of each cycle to assess whether quality is indeed improving.

2.2 STANDARDS

Donabedian's conceptual framework of the public health system as described in Handler, Issei & Turnock (2001:1236) relates to quality in terms of input, process and outcome standards as a basis for measuring system performances. Standard formulation is a structured process in which the level of excellence in nursing is expressed clearly and precisely in a written format (Van der Merwe, 1997:4).

2.2.1 Structural standards

Structural standards according to Searle (2006:229) relate to the conditions under which nursing care is given, for example organizational issues dealing with facilities, resources, equipment, patient occupancy, availability of other categories of personnel and quality of general and nursing management. In the following paragraphs the literature illustrates how deficiencies in resources could be a barrier to the delivery of quality care.

2.2.1.1 Financial margin and rural strategies

Managing services with a limited financial margin is a challenge. One nurse executive stated that they had gone from a "...4% margin to a negative margin in 6 months" (Newhouse, 2004:353).

Rural hospitals are often inadequately funded, considering their cost structures. Limited mechanisms for raising capital to maintain plant and equipment or to procure new medical technology exist. Rural hospitals tend to serve economically constrained populations that do not have widespread health insurance coverage. These factors have jeopardized the survival of rural hospitals and in many instances led to hospital closures.

Therefore, it is important that nursing directors effectively conduct strategic planning and establish responsive strategies that assist in reconciling these pressures against rural hospital viability (Smith, Mahon & Piland, 1993:23).

Financial management appears to be a major learning need. As the financial management of healthcare changes, nurse leaders need to be able to improve their knowledge of finance not

only to keep up, but also to provide needed leadership to resize the healthcare system, particularly as it relates to clinical improvement (Gelinas & Manthey, 1997:12).

2.2.1.2 Adequacy of human resources

Maintaining an adequately prepared nursing workforce is an important issue in rural hospitals. According to Kenny & Duckett (2003:619) internationally, it has been argued that policymakers do not acknowledge the differences between health care delivery in rural and urban areas. It could be argued that universities have also failed to recognize differences in rural and urban nursing practice.

Nurses in rural areas fulfilled an extremely diverse multi-skilled role, but were often inadequately prepared for this. Nursing practices are characterized by the advanced and extended nature that nurses fulfil in the absence of other health professionals, particularly doctors. The need to maintain an appropriately educated rural nursing workforce emerged as one of the major issues that could impact on rural hospital service delivery.

2.2.1.3 Salary

Nurse executives stated that it is “difficult to be competitive with eroding margins”. Even providing financial incentives such as career ladder pay do not solve the problem (Newhouse, 2004:354). According to Kotzee & Couper (2006:5) increasing salaries and rural allowances – improving the financial situation of rural doctors was one of the most common themes in their study. Some doctors felt that money was the most important factor to retain them in rural hospitals.

2.2.1.4 Nurse-physician conflict

In a study by Zeitz, Malone, Arbon & Fleming (2006:103), conflict with physicians was discussed as an issue in the nursing work environment. Power dynamics are strong, with physicians being perceived as wielding more power than the nursing staff. Nurses further described the challenging situation of calling the doctor in the middle of the night. Some nurses described the general practitioner’s response to after-hours calls as being inappropriate. It was acknowledged that nurses might not call the doctor because being up all night and the busy schedule of the following day. Doctors also expressed frustration about nursing staff that were unable to confidently and clearly articulate their assessment of a patient or to describe adequately what assistance or advice they required.

It was generally agreed that the development of mutual trust and respect between local doctors and nurses were important and these were often directly associated with how long they had known each other as well as past experiences.

A news report in the *Beeld* of 24 March 2008 (Baba sterf na gewag vir arts, 2008:1-2) illustrated how the quality of care could be negatively influenced due to the absence of doctors. A baby of 15 months with symptoms of dehydration and difficult breathing was brought to the casualty department of a hospital in Mpumalanga at 22H00. Two registered nurses attended to the patient and gave the necessary emergency treatment of oxygen, intravenous fluid and Hydracortisone – beyond the scope of their practice. There was no doctor available at the hospital. Despite the fact that the staff tried to contact the doctor, the baby died later that night. The doctor arrived the next morning to certify the patient as dead. The same evening a female patient complained of chest pain, the nursing staff explained to the patient that there was no doctor in the hospital and gave her an Asprin tablet – again beyond their scope of practice.

2.2.1.5 *Continuity of care*

Hoffart, Schultz & Ingersoll (1995:45) illustrated how the functional design of nursing can lead to fragmented care. The functional design method is where the charge nurse does rounds with the physician and applies problem solving skills as a manager. The team leader/medication nurse is the one who passes the medication, assesses patients and serves as a liaison between the charge nurse and staff on the floor. “On the floor”, means the licensed practical nurse or registered nurse provides the direct patient care and administers the treatment. The “float” registered nurse or licensed practical nurses assist others as an extra pair of hands. These nurses have no patient assignment and float to the emergency department or intensive care unit when needed.

According to Booyens (2005:310), the functional design method of personnel assignment for patient care has the advantage that a heavy workload can be completed in a relatively short period of time. It is thus the method of choice when staffing is poor and in emergency and disaster situations. But it could be detrimental to continuity of care, due to the fact that this method focuses more on the technical aspects of nursing care. These staff members experience their work as repetitious and boring, and they often fail to interpret the significance of a particular reaction of a patient to his/her treatment, because they do not really nurse the patient holistically. The patients experience care as being divided among many nurses, each doing one or two tasks, often neglecting to communicate the problems he/she is experiencing to the nurse who is willing, or has the power to attend to them timeously.

2.2.1.6 Education for rural nursing practice

Midwifery and neonatology patients are two of the disciplines that nurses in small rural hospitals have to take care of. This usually includes women who are at low risk for complications in pregnancy, labour and birth and for healthy, full-term newborns. However, unforeseen events can arise. Nurses must have the prerequisite knowledge and clinical skills to assess women and newborns with complications, identify patients who should be transferred to a tertiary referral centre, provide care until the patient is stabilized and can be safely transported.

Education in clinical rural practice has to involve orientation, continuing education and periodic competence validation of all staff members to ascertain a competent and skilled workforce. Unlike nurses in larger metropolitan centres, this must be accomplished without continuous in-house physician coverage (Deaton *et al.*, 1998:34).

Referring to an article released on 22 November 2006 in the *Mail & Guardian* (Sapa, 2006:1-2), "Study highlights baby deaths in Africa" - Africa's infant mortality rate of 1.16 million per year placed it on par with England's figures in the early 20th century. Nigeria alone had over 255 000 newborn deaths a year. The major causes were infections, pre-term birth complications and birth asphyxia. All of these were "highly preventable" according to the study. This study stated that South Africa's neonatal mortality rate is 21 deaths per 1000 births. Lawn, the researcher, stated that there has been virtually no progress in reducing South Africa's newborn death rate in the last ten years. This lack of progress is an important barrier to meeting child survival targets, especially for the Millennium Development Goals.

A study done by Couper, Sondzaba & de Villiers (2004:118), highlighted the fact that district hospitals play a pivotal role in the district health system. The unique nature of district hospital practice and the health needs of the population they serve, make it imperative that health workers staffing these hospitals receive relevant education and training. This study showed how the hospital manager of Manne Dipico District Hospital (Colesberg) made provision for all the professional nurses to acquire theatre skills, twenty learner ships for auxiliary nurses and the training of staff on an ongoing basis in trauma skills in collaboration with Medicity Clinic.

2.2.1.7 Job-Related Injury Rates

According to Foley (2004:2), nurses are exposed to a variety of risks in their daily practices which may pose a threat to their health.

Infectious or biological risks are among the oldest of hazards that nurses have experienced. Severe acute respiratory syndrome and tuberculosis are examples of infectious illnesses (Davis, 2008:218).

Chemical risks refer to serious exposures in the health care environment which can result from sterilizing agents and chemotherapeutic agents. Another common chemical hazard in health care is the risk from Latex.

Environmental or mechanical risks entail that patient handling poses physical risks to nurses and assistants in health.

Physical risks refer to physical agents that cause tissue trauma, such as heat and cold, vibration and noise. In health care, radiation exposure is the most likely physical hazard.

Psychosocial risks. Violent behaviours toward health care workers by hospitalized medical, surgical and psychiatric patients, as well as nursing home patients are well known to those who work in those areas.

Foley (2004:5) further identified in her study that nurses reported job stress, both acute and chronic, as the top health and safety concerns, followed by disabling back injuries and contracting HIV or hepatitis from a needle stick injury. Over three quarters of the nurses reported that unsafe working conditions interfered with the ability to deliver quality care. These findings relate directly to the relationship between nurse safety and patient safety.

During the New Orleans Nursing Congress in 2004 the average cost of one back injury was estimated at \$125,000 (non-complicated), the average cost of one room with overhead lift at \$4,000. Between 600 000 and 800 000 needle stick injuries occur each year in all healthcare settings, with injections (21%), suturing (17%) and drawing blood (16%) the top three exposures. Patient movement and handling – 38% of all nurses are affected by back injuries, which are due to the fact that 98% of the time nurses are lifting and moving patients manually. At this congress it was clearly stated that all possible hazards in the workplace have to be identified and control strategies to be developed to eliminate the exposure possibilities (NSC Congress, 2004:9).

2.2.1.8 Fear of contracting HIV/AIDS

In their study Ncama and Uys (2003:11-17) explored the fear nurses had of contracting HIV/AIDS, its effect on their personal/working lives and how they cope with it. The findings of the study revealed that trauma nurses perceived themselves to be at risk of acquiring HIV/AIDS from their working environment despite the available precautionary measures.

Needle stick injuries appeared to be the main source of fear. They used different coping and defence mechanisms effectively to cope with this fear of contracting HIV and none were in any emotional crisis. They also expressed concern about the reliability of the protective equipment, especially the gloves and felt that the quality should be improved to offer maximum protection against the virus.

2.2.1.9 Characteristics of successful nursing managers

In a study that was done by Henry & Moody (1986:38-42) they identified the following characteristics and type of person that was required to be successful as a nursing manager in rural hospitals:

- ambitious, optimistic, intelligent, personable and high on power and achievement needs
- intelligent, practical, and intensely versatile
- be a jack-of-all-trades
- be able to practice and demonstrate clinically sound nursing, be well informed in several specialties and perform well as manager;
- be a better arbitrator and mediator
- public relations skills are essential
- know their communities and local politics well
- be able to motivate and control subordinates.

Based upon these findings, they endorsed nursing administration education that harmonizes nursing, community, health policy, research and management in hospitals of varying sizes and locations.

Couper & Hugo (2005:12) added the following characteristics to qualify as a successful nursing manager:

- promotes team work
- pro-active approach for problem solving
- involving community representatives in the hospital development and governance.

2.2.2 Process standards

Process standards relate to the actions which must be undertaken by staff, in order to implement the activities of nursing care (Muller, 2007:205).

2.2.2.1 Description of a typical work day in a small hospital

Spearman (1992:262-263) describes in the paragraph below how the working conditions in a small hospital, could influence the process standards, due to understaffing and heavy workloads.

The registered nurse started the day working in the nursery where she assessed the new arrivals of the previous day and assisted the doctor with a circumcision. Soon she was called to the emergency room to assess a patient with chest pain and had to start the necessary emergency treatment. From there she helped the physician and nurse of the intensive care unit. After that, she examined an expectant mother in the emergency room and 15 minutes later she did the delivery. Then she was off to the operation room where she circulated for an abdominal operation. Later that same day she assisted the physician with the delivery of 34 weeks gestation twins. Later the afternoon she had to start augmentation for a labour patient that did not make progress. To finish off this very busy day she had to mop the birthing room floor and clean the equipment. At the end of the day, this registered nurse thanked the Lord that every thing went well, and although she's spent emotionally and physically, she felt good about meeting the needs of her patients.

2.2.2.2 Strategic planning and strategy formulation

In a study done by Gelinas & Manthey (1997:8), the following targets were set for nursing managers working in rural hospitals:

- reduce costs
- maintain quality
- lead change.

The following processes were identified as essential for nursing managers in rural hospitals to implement:

- integration and coordination across departmental lines
- critical path and protocol development
- management restructuring
- multi-skilled worker development
- patient-focused care implementation
- managed care
- knowledge of finance and risk sharing
- advanced team-building skills
- change management expertise.

When a nursing director invests in strategic planning efforts, the anticipated outcomes are:

- higher quality of care
- lower patient care costs
- greater staff satisfaction
- higher contribution to the profit margin of the hospital, due to the fact that these planning efforts enabled staff to effectively carry out the nursing procedures and policies.
- Methods of strategic planning efforts can be: an attempt to enhance continuing education (cost control and managerial topics)
- the improvement of documentation by nursing directors to ensure that nursing care cost is accurately accounted for
- instituting participative management to promote ownership of objectives
- recruitment of capable staff which would lead to higher performance levels
- elimination of overtime paid to nurses; reducing the use of nursing agency personnel
- reducing administrative operational costs (i.e. running the department with fewer nurse managers)
- improving supplies, manage to reduce inventory and ordering costs and to improve the management of waste
- involving staff in the budgeting process to promote group ownership of objectives and to educate staff about fiscal constraints.

These strategies, coupled with strategic planning, are the most significant sources of differences in overall performance in rural hospitals according to the study (Smith *et al.*, 1993:23-24).

2.2.2.3 *Essential activities for delivering a quality nursing service*

- Neonatology

According to Pieper in an article on “addressing infant mortality” (Pieper, 2005:492), each year an estimated 4 million babies die in the first 4 weeks of life (neonatal deaths), with a similar number of stillborns giving an enormous annual burden of perinatal deaths. To improve childhood survival the emphasis must shift to the prevention of neonatal deaths especially in poor communities.

In a study undertaken by Deaton *et al.* (1998:34) the researcher focused on three aspects of perinatal care to ensure a quality service. Perinatal nurses must be knowledgeable and skilled in electronic foetal monitoring, aspects of infection control and neonatal resuscitation.

These nurses must have the requisite knowledge and clinical skills to assess women and newborns with complications, identify patients who should be transferred to a tertiary referral centre, provide care until the patient is stabilized and can be safely transported. In many ways, nurses must be able to practice more autonomously, have keen assessment skills, be able to recognize signs of impending complications more quickly and plan ahead, because calling for a resident physician or in-house attending physician typically is not possible. The nearest primary health care provider may be thirty minutes away.

Couper *et al.* (2005:9) illustrated how neonatal resuscitation as an essential skill is needed for delivering a quality service in neonatology. Outcomes for newborns can be remarkably improved when the doctor and midwife have appropriate resuscitation skills in bag and mask ventilation, cardiac massage and intubations.

This study had brought to light serious deficiencies in neonatal resuscitation equipment in rural hospitals. The course made many managers aware of this problem and interventions were already in place for improving this. In some provinces the course led to the development of a standard list of equipment that is needed in each district facility and hospital.

- Emergency care

According to Booyens (2006:107) triage is a method used to sort patients into priority groups to enhance the use of resources for those patients who need treatment urgently. It is however, necessary for nurses to become familiar with the system of rapid decision-making based on immediate and accurate assessment of the patient on arrival at the emergency department.

Triage in the emergency department includes the following steps:

- a) Initial assessment, where the history should be taken while the physical status of the patient is taken into consideration.
- b) A limited physical examination should be carried out using the skills of observation, auscultation and palpation.
- c) Careful note of the vital signs (body temperature, pulse, respirations and blood pressure) should be taken.
- d) The nurse should be trained to see which signs are grossly abnormal and need immediate attention.

In an article “SA emergency rooms for change” - Dr Clive Balfour, a specialist Emergency Physician and Chairman of the Emergency Medicine Society of South Africa, states that the greatest advantage of the triage system is the reduction in both mortality and morbidity rates. Balfour said that recent studies at a number of emergency units at both private and state facilities have documented significant improvements in the levels of service to patients attending emergency facilities. As a further example, a triage study at a provincial emergency hospital in the Cape demonstrated a 50% reduction in the mortality rate over a two month period according to Medic-Clinic Press release (2006:1-2). According to Dr Balfour the triage system allows for a colour categorization according to the severity of the patients condition.

The colour code as currently implemented in the public hospitals of the Western Cape is as follows:

- a) Red – these patients are suffering from life-threatening conditions and will be taken to the resuscitation area where they will immediately be attended to.
- b) Orange – conditions are serious and patients should be attended to by a doctor within ten minutes.
- c) Yellow – these conditions are less serious, and will be attended to after any red or orange coded patients.
- d) Green – the majority of this category will have acute primary care type medical problems, and will be attended to as soon as possible, but not before yellow coded patients.
- e) Blue categorization indicates death. The professional judgment of the registered nurse and her decision on the priority of steps to be taken should be carefully and accurately documented.

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According to Nielsen & Hillsdale (2004:336) emergency department satisfaction can be improved when triage nurses communicate with the patients as to reasons for delays. The triage system is set to reduce waiting times, improve patient flow and improve the general working environment for the often over-burdened staff working at these emergency facilities.

In 2003 the Rural Doctors Workforce Agency in South Australia facilitated the SA Rural Hospital after Hours Triage Education and Training Program to promote the efficacy, accuracy and education of nurses as the frontline for health service provision in the rural areas. The implementation of telephone triage models in some isolated rural settings has had positive evaluation in relation to the reduction of after-hours workload and clinician satisfaction. It was designed to improve communication between rural general practitioners and nurses undertaking after-hours triage, provide training in triage for rural nurses and

develop local collaborative after hours primary medical care models that can be applied in other settings (Zeitz *et al.*, 2006:99).

- Nursing care of patients with intravenous infusions

According to Van Dyk, Small, Haoses & Ackerman (1994:4) patients on intravenous infusions were commonly seen in their hospitals. There was a concern regarding the type of nursing care these patients received which led to a survey on the quality of care rendered to these patients. The findings showed that care delivered ranged from very poor to good. Some startling information became evident that legal aspects were often ignored and that basic things such as calculating the daily intake and output were omitted.

- Effectiveness of nursing documentation

Booyens & Uys (1989:26-27) undertook a study to investigate the effectiveness of the current nursing-care documentation of hospitalized patients. The results of this study showed that the documentation did not always comply with legal requirements which could be detrimental because a written record is the first line of defence in any claim which may be raised against a nurse or her employer (Verschoor *et al.*, 1997:45). Findings also showed that the documents were not always a complete record of the condition of the patient and the nursing care that was rendered. This could be in terms of medico-legal aspects a very risky practice. Documents were not always an effective record of reality, in terms of false statements. It is clear that these shortcomings regarding documentation showed that deficits might be the result of neglect of recordings or that certain aspects of nursing care are neglected. Poor documentation can influence a patient's care regarding the outcome of care. This study showed that data on allergies were lacking in the documentation. Documentation of life supporting apparatus like ventilators monitors or infusion pumps were lacking. This is very important in case something goes wrong with the patient and the apparatus has to be tested for functionality. Regarding R2598 of 30 November 1984, as promulgated by the old Nursing Act No 50 of 1978 the scope of practice is described in terms of what acts are legally needed in terms of patient care. Regulation 387 of 15 February 1985 described in terms of the acts or omissions in respect of which the South African Nursing Council can take disciplinary steps against a registered person. When recordkeeping is not done, it could be assumed that the patients did not receive the care and the South African Nursing Council could take disciplinary steps against the nursing staff member.

- The importance of correct implementation of nursing care

When nursing activities are poorly implemented medical legal risks could follow which could cost the Department of Health millions of rand as illustrated in *The Times* of 3 December 2007. "A nasogastric (stomach) tube landed with activated carbon in a patient's lung".

R1.2 million was claimed. A claim of R1 million was settled due to gangrene in the thumb and index finger of a patient when the nursing staff failed to monitor a drip. R78 121.23 was successfully claimed after a baby was swapped with another patient's baby following a caesarean section (Sapa, 2007:1-3).

A patient's death may result if nursing care is not implemented and done efficiently as illustrated in a case study in which post-operative observations were not done as prescribed after a patient had a hysterectomy. The patient developed internal bleeding which was missed by the nursing staff (Allen, 2006:16).

2.2.3 Outcome standards

These are standards relating to the measurement of the care provided (Searle, 2006:155). These refer to the expected performances or the results expected after good nursing care has been rendered. Outcome criteria are:

- patient behaviour and responses
- level of knowledge
- health status (Booyens, 2006:312).

2.2.3.1 Perspectives of quality in health care

Quality refers to the attributes or characteristics of excellence. These features of excellence are, however, regarded or perceived differently by the respective role players. Each of these role players has different views concerning excellence. A study that was done by Tasso, Behar-Horenstein, Aumiller, Gamble, Grimaudo, Guin, Mandell & Ramey (2002:4-5) in Florida has improved the understanding and thinking of the different views rural health professionals and rural patients held about the quality provided in rural hospitals.

Physicians and nurses define quality of care differently than patients. To physicians and nurses, quality care refers to how well they treat patients. However, hospital patients place greater emphasis on interpersonal aspects of care.

2.2.3.2 *Outreach specialists' services to rural hospitals*

According to Deaton *et al.* (1998:33) one quarter of the United States population live in areas designated as rural. Delivery of rural health care can be difficult with unique challenges including limited access to specialists such as oncologists.

The Rural Cancer Outreach Program (RCOP) in an alliance with an academic medical centre and five rural hospitals was established. The goal of this alliance was to establish a model of care that would provide state of the art care in rural areas, increase the access to care, generate services and revenue for both rural and academic centres, train health care professionals and serve as a laboratory for intervention. The majority of cancer care is provided at the rural hospital.

A team of two-three oncologists and two nurse practitioners or nurse clinical specialists travel to each site weekly. Examples of success of this program are shown in the use of morphine for cancer patients studied in one hospital. In the preceding 3 years before the study, there had been almost no morphine prescribed. Within 2 years the amount of oral and intravenous morphine increased by over 500%. Breast conservation considered the desired treatment for early stage breast cancer, had been rarely used before the study. By the third year of operation at their first hospital, over 60% of patients were routinely treated with breast conservation. Adjuvant Breast and Bowel programs and other trials, increased from an essential zero to 9% of eligible patients.

The RCOP has a positive financial impact on the rural and academic medical centre hospitals. The RCOP was associated with an increased number of referrals of 330% more cancer patients and 9% more other medical/surgical patients. In total the receipts for both centres increased by 137%. Most of the additional income was from "ancillary" services such as the increased use of the computerized axial tomography or magnetic resonance imaging scan, laboratory and pharmacy (Lyckholm *et al.*, 2001:132-137).

2.3 MONITORING AND EVALUATION

Measurement, evaluation or monitoring whether the care provided does indeed achieve the set of standards and criteria of care, forms an integral part of the quality improvement cycle. If the degree to which the standards and criteria are met is not evaluated, the health service cannot be sure about the quality of care rendered (Booyens, 2006:317).

2.3.1 *Auditing of documentation*

In a study done by Geldenhuys (2005:152-154) the records of 128 intrapartum patients were analyzed and the results showed that record-keeping is not done optimally, that the

partogram which is a comprehensive evaluation of the progress of labour, is not always used and that the records did not indicate that the midwife applied critical and analytical thinking and acted accordingly. The above is a concern because the partogram is an important document to show graphically the progress of labour and allowed for early identification of abnormalities concerning the mother and foetal wellbeing.

It is obvious from this investigation that there are still many areas in nursing documentation which need to be improved.

2.3.2 *Usefulness of prenatal risk assessment*

An assessment was made of the potential usefulness in a small rural hospital of the guidelines for prenatal risk assessment and management of the Newfoundland and Labrador Prenatal Record. A retrospective chart review was done for 266 pregnancies followed at the Baie Verte Peninsula Health Centre prior to the introduction of the guidelines. The results show:

The group at risk showed that 4% of the infants had an Apgar score of 6 or less at one or five minutes and the group at no risk showed that 18% of the infants had a low Apgar score. Non-elective interventions in 40% of the cases were required for both the group at risk and the group at no risk.

It is necessary for small hospitals to have the facilities and the trained staff to handle the problems that occur even in the low-risk patients. To maintain the delivery rate necessary to retain skills, the guidelines may help family practitioners and nursing personnel to select some patients at risk who can be managed in small hospitals (Casson, Edwards & Sennett, 1984:1311).

2.3.3 *Importance of pre- and post training evaluation*

A reduction in the neonatal mortality of most low-birth-weight infants can be achieved by providing basic resuscitation training. In South Africa many of these components of essential newborn care are currently addressed with the teaching of resuscitation of newborns to all staff involved in newborn care. (Pieper, 2005:492).

A paediatrician trainer from Australia spent three months in South Africa to assist with the development of neonatal resuscitation training in rural areas, particularly in district hospitals.

The participants were asked whether they felt more confident in resuscitation. 92% responded positively. The participants, who answered negatively, indicated that more practice was needed. Participants had to write a pre-test and post-test to determine the effect

of the training. The pre-course test's mean score was 57.21% and the post-course average was 67.79%. Thus there was a significant improvement due to the training (Couper *et al.*, 2005:6).

The above tests illustrated how essential it is to assess training programs. The participants' responses are one form of evaluation, but the next step will be to evaluate the impact of the course in terms of what people learnt, how they apply the learning and the impact of the change in the practice on the service, and the outcomes for the patients.

2.3.4 Analysis of complaints

Analysis of the nature of complaints is important to identify problems and assist in their elimination.

A study was done by Taylor *et al.* (2004: 32-34) in 67 Victorian hospitals where they analyzed patients' complaints about their care retrospectively.

The results indicated that 43.2% of complaints were lodged personally. Parents, children and spouses lodged 19.2% of complaints, 7.6% of complaints were lodged on behalf of a patient and members of parliament lodged 1.5% of complaints. The remaining 14.7% of complaints were lodged by a variety of people including friends and other family members, hospital staff and legal representatives.

The main source of the complaints was poor communication, inadequate access and inadequate treatment.

The study showed that 84.5% of complaints were resolved easily. More than half were resolved with an apology or explanation.

A fundamental failure of staff to interact appropriately with patients was seen as a big concern of this study. Furthermore explanation, information provision and resolution of misunderstandings contributed to a successful outcome for many patients, suggesting that communication problems may underpin most complaints lodged. In one respect, this could be encouraging, as relatively simple intervention strategies may have a profound impact on staff-patient interaction.

2.3.5 Evaluation of nursing service

Measurement, evaluation or monitoring whether the nursing service provided does indeed achieve the set standards and criteria of care, forms an integral part of the quality

improvement cycle. Without measurement there are no grounds for instituting remedial action where areas of poor quality are identified.

Uys & Naidoo (2004:1-7) in their study describe and compare the quality of nursing service and care in three health districts in the KwaZulu-Natal Province. In the paragraphs described below, the areas are identified where the quality of care is lacking and where remedial action is necessary.

- Handing over from one nursing shift to another – in hospitals the quality of the work of the team of nurses is dependent on their communication with each other. The average score was 5.8 out of possible 10. It was observed that the nurse's verbal report did not include aspects of psychosocial care.
- In all three districts there is a poor response to issues relating to the correct procedures to be followed with regards to the management of the drug registers and with report writing for negative incidents that may occur.
- Implementation of universal precautions: since the prevalence of HIV/AIDS was high in this province the universal precautions indicator was selected.
- It was evident that the nurses scored poorly with regards to the correct use of protective gear. The average scores obtained from the data gathered from 42 sites were of a possible 10 out of possible 15 as regards to universal precautions.
- Nursing records: a Nursing Records Standards Sheet was used to evaluate the quality of the nurse's documentation. The following aspects were covered: legality, assessment, process, discharge and effectiveness.
- A total of 137 records were audited. The average percentage of the records was 11%. It is evident from the average of the percentage above, that the quality of the nursing records in all three districts was generally poor.
- Management of chronic illnesses. With regards to hypertensive patients in only 27% of the cases the medication was administered to the Essential Drug List (EDL). With regards to the diabetic patients in only 17% of cases, the medication was administered according to the EDL.

2.3.6 Evaluation of nursing care of patients with an intravenous infusion

In nursing the evaluation (audit) process is the process whereby performances are compared with previously set standards of care to reveal shortcomings; these should then be corrected to initiate changes which will result in the improvement of care (Booyens, 2005:610).

There was a concern regarding the type of nursing care patients with intravenous infusions in Windhoek hospital received which led to a survey on the quality of care rendered to these

patients. The findings showed that care delivered ranged from very poor to good (Van Dyk *et al.*, 1994:4-7).

An extract from this study shows that only:

38% of the correct fluid was used according to the prescription

3% of the amount of fluid charted in which medicine was diluted 22% of the total intake for 24 hours had been calculated 15% of the times had the total output for 24 hours been charted.

It is clear from the findings above that these patients do not receive quality care. The value of this study identified that intensive in-service training should be given to all categories of nurses with regard to the normal body fluid constituents (intra- and extra cellular fluid). Ensure the understanding of the physiological actions of intravenous infusions. The rationale for this is to discourage the substitution of one type of infusion with another, as well as include the legal aspects of prescribing. The importance of accurate record keeping of the intake and output for every 24 hours has to be included. Adequate supervision is necessary because most of these “procedural” actions are carried out by junior nurses and sub-professional nurses. Adequate supervision would in many cases be all that is needed.

2.3.7 Evaluation of waiting times

Lack of communication from the staff of the emergency department can sometimes be a greater source of dissatisfaction than the actual wait. Patients do expect to receive service on a “first come first help basis”, everybody is not familiar with the “triage” system which allows for early identification of patients requiring the most urgent care.

Nielsen & Hillsdale (2004:336-338) in their study indicated that providing reasonable explanations to emergency department patients about the nature of their wait for services increased patient satisfaction significantly. Findings in their study show that patient satisfaction increased from 44% to 88% within a month due to more frequent communication about delays and any problems resulting in waiting periods. This study was done in the Emergency Department of Hillsdale Community Health Centre, a small 40 bed hospital in the rural area.

Due to the success of the pilot project the hospital management decided to continue with the initiative. This initiative was easy to implement and has been effective in their small rural hospital setting.

2.4 REMEDIAL STEPS

Taking remedial steps is the final step in the quality improvement cycle and represents problem solving or corrective actions. The following may be necessary to improve the quality of practice:

- personnel development to improve the knowledge, skills and attitude of personnel
- the application of discipline in the unit may be the necessary remedial step
- revision of standards may be necessary (Muller, 2007:212).

Although definitions of quality in healthcare may vary, it is accepted that there are standards that should be adhered to. Thus quality improvement is an important part of developing health services. The quality improvement cycle provides a tool to assist rural practitioners wishing to work towards better quality health care (Couper, 2004:1).

2.4.1 *Possible remedial actions according to South African Human Rights Commission*

The South African Human Rights Commission embarked upon provincial assessments in all nine provinces in preparation for a national enquiry into the right to have access to health care. This report provides a synthesis of the findings and main themes emerging from those assessments:

Monitoring and evaluation of service delivery through regular meaningful site inspections, to prioritize rural areas and to address the persistent structural inequalities caused by the legacy of apartheid

Recommendations are also made in the areas of financing, management, staffing, and transport, including emergency transport, infrastructure, information and psychiatric services

The reviews recorded high levels of staff dissatisfaction. Consideration of patients' rights alone, without attention also being paid to the rights of health workers will be of limited value. There is merit in exploring what efforts to acknowledge and protect health workers' needs and rights are likely to impact positively upon delivery of care, and therefore play a beneficial role in improving patients' rights (Ntuli, 2004:4-5).

2.4.2 *An investigation into the management of public hospitals in South Africa*

NALEDI (National Labour and Economic Development Institute) conducted research into public hospitals spread over KwaZulu-Natal, Gauteng and Northwest Province. NALEDI identified the areas where remedial actions are important:

- public hospitals are stressed institutions due to staff shortages unmanageable workloads and management failures
- changing health environment due to increased patient loads
- dysfunctional management structures due to hospital management structures that are fragmented, preventing integrated management of operations, paralyzing initiatives and preventing accountability
- weak management functions because they are under-resourced in virtually all institutions with the result that scarce human and financial resources are often managed in a wasteful and ineffective fashion
- management skills are lacking in public hospitals
- staff shortages are a critical problem in most public hospitals and are generated by under funding as well as national shortage of professional skills. Shortage of support workers such as cleaners and porters exacerbate the problem of scarce skills, as nurses and doctors have to perform unskilled but essential functions
- staff shortages and management failures compromise patient care and have an impact on clinical outcomes. In many cases the result is increased morbidity and mortality rates.

In conclusion, the high level of institutional stress in the public hospitals is caused by managerial disempowerment and the pressure of work overload.

In an environment of scarce financial and human resources it is all the more important to focus on a sustained investment in management capability so that these resources are managed in as effective a way as possible. Innovative strategies are necessary to increase staffing levels (NALEDI, 2006:2-4).

2.4.3 Opening of the Joe Slovo Hospital – a result of successful remedial action

Garies is situated approximately 446km from Cape Town on the N7, in a very rural and remote area. Joe Slovo hospital serves communities in the vicinities of Hondeklipbaai, Leliefontein, Kharkamas, Bitterfontein, Soebatsfontein, Paulshoek, Nourivier, Roosfontein and Spoerivier. The old and dilapidated hospital is replaced with a new 20 bed hospital which is capable of responding to the latest health challenges. The new hospital is a state-of-the-art facility, which cost in the region of R22 million to build.

It has been projected that there will be no more waiting in dark, narrow corridors and there is privacy, with wards accommodating a maximum of two patients. They will thus no longer have to make do with a second-class hospital. Each bed has its own television set and each

room is fitted with an air conditioner and a shower. Patients also have the opportunity to enjoy the outside garden, a luxury that was not available at the old hospital.

Comfortable overnight accommodation for patients travelling from places like Hondeklipbaai, as well as for staff has been provided. Provision was further made for an emergency landing pad if needed. The facility has an X-ray facility, a mortuary, an in-house pharmacy, a modern kitchen, a laundry depot, and relevant stores, as well as a maternity ward and general wards. Updated equipment, including all standard tools necessary in a public health facility, are now also providing for more effective and accurate service delivery.

Although this hospital was build with state of the art materials, it is now, according to the expectations of the community, an open question as to whether it will deliver quality nursing care (Keynote address by Northern Cape premier, 2008:1-4)

2.5 CONCLUSION

From the literature study it is clear that:

Quality improvement is a continuous (not once only) formal process where standards (structural, process and outcome) are set, work performance is monitored and evaluated (performance evaluation) and remedial actions are taken to solve problems – as illustrated in chapter one, in Figure 1.1.



Figure 2.1: Process of Quality improvement (Muller, 2007:203)

The researcher has tried to organize the literature into the categories of structure, process, and outcome elements, followed by monitoring and evaluation and lastly remedial steps.

From the structure elements it was clear that the rural hospitals have many constraints to challenge for reaching a quality service. Regarding process elements it is clear that nursing personnel have to be skilful and autonomous to perform in a variety of settings, especially in the absence of doctors, for the greater part of the day. The literature demonstrated quite a few ways on how service delivery can improve in rural hospitals so that patients get the

benefit of a better quality service. Monitoring and evaluating throughout, appear to be very important so that remedial actions can be taken when necessary.

Quality is a cyclic process – which implies that standards are continually revised or changed with the evaluation of work performance and the correction of problems.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The purpose of this chapter is to define the research methodology that was applied to investigate the factors that influence the quality of nursing care in district hospitals in the West Coast Winelands Region of the Western Cape.

Research methodology is defined as the methods, techniques and procedures that are employed in the process of implementing the research design or research plan, as well as the underlying principles and assumptions that underlie their use (Babbie, Mouton, Vorster & Prozesky, 2006:647).

In this chapter the researcher describes the following pertaining to the research study:

- Purpose and objectives
- Research question
- Research approach and design
- Population and sampling
- Instrumentation
- Data collection
- Pilot study
- Validity and reliability
- Ethical consideration
- Data-analysis
- Limitations of study

3.2 PURPOSE OF THE STUDY

The purpose of this study was to investigate the factors influencing the quality of nursing care in district hospitals in the West Coast Winelands Region of the Western Cape.

3.3 OBJECTIVES

Objectives set for this study were as follows, to determine:

- whether staffing was adequate for all activities
- the perceptions of nursing about their current work situation
- the effect of the absence of full time doctors on the management of patient care
- whether adequate equipment was available for the execution of nursing care

- whether adequate provision was available for the execution of nursing care

3.4 RESEARCH QUESTION

The research study was guided by the research question “What are the factors influencing the quality of nursing care in district hospitals in the West Coast Winelands Region of the Western Cape”.

3.5 RESEARCH METHODOLOGY

De Vos *et al.* (2005:252) suggest that the following has to be included: the description of the participants, the research design, the sampling plan, data collection procedures, and also the apparatus and measurement instruments.

3.5.1 Research approach and design

A descriptive non-experimental, quantitative approach was applied to investigate the factors influencing the quality of nursing care in the district hospitals of the West Coast Winelands Region.

Burns & Grove (2003:27) documented that descriptive research is the exploration and description of phenomena in real-life situations; it provides an accurate account of characteristics of particular individuals, situations, or groups. Through descriptive studies, researchers discover new meaning, describe what exists, determine the frequency with which something occurs and categorize information. The outcomes of descriptive research include the description of concepts, identification of relationships and development of hypothesis that provide a basis for future quantitative research.

Research design is the plan or structured framework of how you intend to conduct the research process in order to solve the research problem (Babbie *et al.*, 2006:647).

A descriptive exploratory design was used to investigate the factors influencing the quality of nursing care in the eight district hospitals in the West Coast Winelands Region of the Western Cape.

According to Burns & Grove (2003:201), the descriptive quantitative design is seen fit for there is no treatment given. The primary purpose of this study is to investigate the factors that influence nursing care.

This study focused on prospective data that exists or what is experienced in the eight district hospitals of the West Coast Winelands. The primary purpose of the study was to identify the factors that influence nursing care.

3.5.2 Population and sampling

According to Burns & Grove (2003:491), population includes all the individuals that meet the sample criteria for inclusion in a study; it is also sometimes referred to as the target population.

A probability sample is one in which each person in the population has the same known probability of being selected (De Vos *et al.*, 2005:198).

The population for the purpose of this study was all the nursing staff (nursing assistants, staff nurses, registered nurses, unit managers and nursing managers) working in the clinical areas of the eight district hospitals in the West Coast Winelands Region.

According to the duty rosters of July and August 2008 the population consisted of 346 nursing staff. All the members were invited to participate in this research project – personnel on leave or sick leave were **excluded**; six staff members were therefore excluded.

Sampling is the process of selecting a group of people that are representative of the population being studied (Burns & Grove, 2003:496). For this study the total population was used and no sampling was done.

3.5.3 Instrumentation

A questionnaire was compiled to determine the factors influencing the quality of nursing care. The questionnaire was designed by the researcher based on her clinical experience and the appropriate literature. It was validated by an expert in nursing science, a research methodologist, the statistician and ethical committee. The questionnaire was available in English and in Afrikaans (See attached as Appendix B).

The questionnaire was divided into Section A, referring to biographical data and consisting of the following aspects:

- Gender: Male or Female.
- Age in years: above 20 and less than 30 years, above 30 and under 40 years, above 40 and under 50 years, above 50 and under 60 years and above 65 years of age.
- Categories of staff: Management, Chief Professional Nurse, senior professional Nurse, Professional Nurse, Enrolled Nurse, Enrolled Nurse Assistant.
- Qualifications: General, Midwifery, Psychiatry, Community health, Primary Health Care and any other qualification for example Advanced Midwifery, Administration or Education, Staff Nurse and Enrolled Nurse Assistant.

- Total number of years working at this institution: Less than five years, between five and ten years and more than ten years.
- Personnel have to identify the current department in which they are working. The following departments were identified: Paediatrics, Maternity, and Casualty, Out-Patients, Theatre, and Combined Wards for example: Male, Female or and Paediatrics combined with Maternity, Casualty or Out-Patients, any other department or ward – was specified. Space was left for comments.
- Duration of current employment in current department in months could be indicated as: less than six months, between six and twelve months, between twelve and eighteen months, between eighteen and twenty four months and more than twenty four months.

Personnel indicate appropriate answers with ✓ or ✗.

Section B of the questionnaire referred to the factors influencing nursing care

This part of the questionnaire is based on a Likert scale. The Likert section has four options to choose from, namely: strongly disagree, disagree, agree and strongly agree. Numerical values 1, 2, 3 and 4 were accordingly provided which were used for capturing of data on an excel worksheet. Space was left for comments.

The following divisions were included:

- Staff provision (nursing) (referring to numbers 1 to 5): To determine whether there are adequate personnel in terms of numbers and skills. Also to establish whether personnel provision is adequate during the day, at night, on weekends and on public holidays.
- Management of wards or departments (referring to numbers 6 to 8): To evaluate the availability of unit managers and whether all duties delegated to subordinates were adequately supervised.
- Job satisfaction (referring to numbers 9 to 15): Whether respondents are satisfied with their salaries, allowances and staff evaluation. Aspects like job satisfaction of the current work situation, acknowledgement for good performance and enough time for sound nurse-patient relationships were included.
- Professional Development (referring to numbers 16 to 18): These numbers deal with aspects like continuing education, career development and whether there are adequately skilled personnel with Primary Health Care and Theatre qualifications.

- Patient documentation (referring to numbers 19 to 31): It was the aim of the researcher to evaluate how the respondents experience the present documentation system in the form of the Nursing Process.
- Patient care (referring to numbers 32 to 41): To identify whether patients receive nursing care as required. The researcher differentiated between the categories of emergency care, neonatal, labour, debilitated, paediatric, pre- and post-operative patients. The researcher also wanted to know whether patients were treated by an identified health worker.
- Nursing staff (referring to numbers 42 to 45): Included in this part the researcher wanted to identify if it was necessary for Registered Nurses, Staff Nurses and Nursing Assistants to work beyond their scope of practice. The researcher included the Registered Nurse without the qualification of Primary Health Care.
- Equipment and Consumables (referring to numbers 46 to 49): To evaluate whether consumables and equipment were adequate and in a good working condition.
- Work Conditions (referring to numbers 50 to 56): Referring to tea breaks, lunches, relaxation facilities and scheduled leave.
- Shifts (referring to numbers 57 and 58): Dealing with requests according to the needs of personnel regarding duty rosters and whether staffs were able to leave the hospital on time at the end of shifts.
- Doctors (referring to numbers 59 to 65): The researcher wanted to evaluate the availability of the doctors to deal with trauma, medical and maternity emergencies. The aim was to know whether doctors are available in the hospital full time, whether patients must wait a long time before being evaluated and treated by a doctor.
- Batho Pele (referring to numbers 66 to 74): Aspects included in this division were an evaluation of service delivery to the patients in terms of consultation, choice of services, knowledge of what to expect, access to services, accurate and full information, response to complaints. Whether patients were informed of how the institution is run, the cost of services and the person in charge. Lastly the researcher wanted to identify whether services provided were economical and efficient in order to give patients the best possible value for money.

After each division space was left for comments.

Respondents were explained in an information session and in an information leaflet which was handed out how to complete the questionnaire.

3.5.4 Data collection

The researcher visited each of the eight hospitals between the 15th July 2008 and the 22nd August 2008. Information sessions were held with the nursing staff in each ward or department at each of these hospitals. Four sessions were scheduled at each institution to cover day and night shifts. At these sessions the details of this project were discussed and personnel were invited to participate.

The researcher discussed the questionnaire and explained how it should be completed. Each hospital was given a week in which to complete it. Personnel were given a choice: they could either post the questionnaire in an envelope with postage stamp fixed already, or they could hand in the completed questionnaire in a sealed envelope at the Nurse Manager's office. The researcher collected the questionnaires at an agreed time.

Table 3.1: Summary of questionnaires given out and questionnaires returned

Hospital:	Questionnaires Given out:	Questionnaires Returned:
Citrusdal	21	20
Porterville	15	15
Clanwilliam	26	23
Vredendal	47	44
Vredenburg	69	55
Piketberg	19	17
Stellenbosch	80	55
Malmesbury	69	51
TOTAL:	346	280 (81%)

3.5.5 Pilot study

The pilot study is the smaller version of the proposed study conducted to develop and refine the methodology, such as the treatment, instruments, or data collection process to be used in the larger study (Burns & Grove, 2003:491). The purpose of the pilot study was to pre-test the questionnaire for any ambiguity and inaccuracies, and furthermore to determine the feasibility of the study.

Originally the total number of nursing staff working in these eight district hospitals was given to the researcher as 372. At the time of visiting the institutions to hand out the questionnaires, the researcher counterchecked the staff numbers. According to the duty rosters the total number of staff was 346. At the time of data collection six (6) of these staff members were on leave or sick leave and were therefore not included in the study due to the time allowed for completing the questionnaire set at one week. Therefore the population consisted of 340 staff members.

- The pilot study was done at Porterville and Citrusdal Hospitals. 35 Personnel completed the questionnaires. A 10.2 % target was reached of the actual sample.
- According to the pilot study the instrument was found to be accurate and without any ambiguity. The researcher decided to include the data of the pilot study in that of the main study.

3.5.6 Validity and reliability

Validity is the extent to which an instrument accurately reflects the abstract construct (or concept) being examined (Burns & Grove, 2003:500).

According to De Vos *et al.* (2005:160) the definition of validity has two aspects: that the instrument actually measures the concept in question, and that the concept is measured accurately.

Reliability is the extent to which an instrument consistently measures a concept (Burns & Grove, 2003:494).

A pilot study was done to pre-test the questionnaire for any ambiguity and inaccuracy. The pilot study was done under similar conditions as the actual study – a 10.5% response was obtained.

A nursing expert and statistician were consulted to evaluate and validate the questionnaire including the Committee for Human Research Faculty of Health Sciences University of Stellenbosch.

3.5.7 Ethical considerations

The proposal of the research project, together with a proposed informed consent document and questionnaire were submitted to the Committee for Human Research Faculty of Health Sciences University of Stellenbosch as well as to the provincial Research Coordinating Committee of the Department of Health for ethical consideration.

Consent was granted by the Director of the regional office of the West Coast Winelands Region and the Medical Superintendents of the eight district hospitals. The nursing managers were contacted via e-mail to plan and organise the visits at each institution.

The researcher obtained written consent from each participant. Information sessions were held at each of the eight district hospitals – four sessions at each institution. At these information sessions the researcher discussed the background, the purpose of the study and how the questionnaire should be completed.

All participants were assured of their right to confidentiality, anonymity, and privacy. Participation was voluntarily. No risks were foreseen.

For any queries, the researcher could be contacted on cell phone number 083 6301 376.

3.5.8 Data analysis

The data was analyzed with the support of the statistician. It was presented in frequencies, tables and histograms.

Quantitative data was captured on an EXCEL spreadsheet developed by the statistician. Qualitative data was supplied in the space left for comments on the questionnaire.

The statistician suggested summarizing the statistics by using the standard techniques. Comparisons between variables were made using either ANOVA (Analysis of variance) techniques or cross tabulations with the Chi-square test. The 95% confidence interval was applied to determine whether there was an association between the various variables.

This information then served as motivation to rectify deficiencies and shortages.

3.5.9 Limitations of the study

The researcher did not experience any limitations that limited the study.

3.6 CONCLUSION

In this chapter the researcher described the methodology of the study and the various steps of the research process applied in the study. These included the research design, population and sampling, instrumentation, data collection, validity and reliability, data analysis applied, as well as the ethical consideration.

CHAPTER 4: ANALYSIS AND INTERPRETATION OF RESEARCH FINDINGS

4.1 INTRODUCTION

In this chapter the results of the research study will be presented and interpreted. The data is predominantly quantitative.

4.2 DESCRIPTION OF STATISTICAL ANALYSIS

The data was presented in the form of frequency distribution tables (one- and two-way). Bar charts were created from the frequency distribution tables. A follow-up confirmatory analysis to test for equality of proportions across the levels of the variables was carried out using the chi-squared test (one-way tables). The chi-squared test for independence was also used to test for associations between demographic variables and the responses to the questions on the biographical data (Section A) and factors influencing nursing care (Section B; two-way tables). Due to the sparseness of the contingency tables for the two-way cross classifications between demographic data and responses to the questions under study, the responses were collapsed to represent agreement and disagreement only. No applicable responses were excluded from the analysis.

The chi-squared tests show that the responses were not equally distributed across the categories of the variables for all the variables (one-way frequency distributions). Only some selected variables had statistically significant associations with the demographic variables.

The chi-square test, a test for significance is used to quantify the degree to which chance variability may account for the results observed in any individual study.

The p-value is the measure reported from all tests of statistical significance. It is defined as the probability that an effect at least as extreme as that observed in a particular study could have occurred by chance alone. If the p-value is greater than 0.05 by convention the chance cannot be excluded as a likely explanation and the findings are stated as not statistically significant at that level (Hennekens & Burning, 1987:108). Therefore the 95% confidence interval will be applied to determine whether there is an association between the variables. The Spearman rank (rho) orders correlation was used to show the strength of the relationship between two continuous variables (Terreblanche, Durrheim & Painter, 2007:197).

The mean and standard deviation as descriptive statistics were used to summarize and represent features of the scores. The mean is known as the arithmetic average of all the values in the data set. It is calculated by summing all the values in the data set and dividing this sum by the number of values (Terreblanche *et al.*, 2007:197). The square root of the variance is known as the standard deviation (Terreblanche *et al.*, 2007:197).

4.3 SECTION A: BIOGRAPHICAL INFORMATION

This section refers to personal data of the participant.

4.3.1 Variable 1: Gender

Participants included in the study were males and females. The majority of participants were females. This could be attributed to their dominance in the nursing profession.

Table 4.1: Gender (N=280)

SAMPLE		
Gender	N	%
Female	272	97
Male	8	3
TOTAL	280	100

4.3.2 Variable 2: Age

Table 4.2 shows the age range of the participants. The majority of participants, that is 95 (34%), are above 40 and 50 years of age.

As shown from table 4.2, the workforce show signs of ageing in the West Coast Winelands Region of the Western Cape. Sixty percent of the nursing workforces are older than 40 years of age.

Kenny & Duckett (2003:614) documented that current workforce difficulties will be exacerbated by the ageing of the rural nursing workforce. Some studies suggest that 50% of the existing rural nursing workforces are older than 40 years of age in Australia.

Table 4.2: Age (N=280)

Age range	N	%
> 20 - ≤ 30	25	9
> 30 - ≤40	87	31
> 40 - ≤50	95	34
> 50 - ≤ 60	66	23
> 60 - ≤ 65	6	2
> 65	1	1
TOTAL	280	100

4.3.3 Variable 3: Categories

Table 4.3 shows the different categories of the participants. The categories that participated in the study, included: management N=13 (5%); registered nurses N=93 (33%); enrolled nurses N=73 (26%) and nursing assistants N=101 (36%).

Table 4.3: Categories of staff (N=280)

Category	N	%
Management	13	5
Registered Nurses	93	33
Staff Nurses	73	26
Nursing Assistants	101	36
Total	280	100

4.3.4 Variable 4: Qualifications

Table 4.4 shows that N=106 (38%) of the respondents are registered nurses with only a general qualification in nursing. Only N=22 (8%) of the participants possess the primary health care qualification.

Table 4.4: Qualifications (N=280)

Qualifications	N	%
General	106	38
Midwifery	95	34
Psychiatry	59	21
Community health	50	18
Primary health Care	22	8
Other	11	4
Staff Nurse	73	26
Nursing Assistant	101	36
Total	280	100

4.3.5 Variable 5: Number of years working at the institution

Table 4.5 shows the number of years participants are currently working at the various institutions. N=162 (57%) of respondents are working more than ten years at their institution;

N=90 (32%) of respondents are working less than five years and N=28 (10%) of respondents are working between five and ten years at their institution.

Table 4.5: Numbers of years working at the institution (N=280)

Years	N	%
< 5 years	90	32
≥5 years < 10 years	28	10
≥ 10 years	162	57
TOTAL	280	100

4.3.6 Variable 6: Departments

Table 4.6 shows the various departments where the participants are currently working. N=172 (61%) of participants are working in “mixed wards” which could be defined as wards accommodating all specialties.

Table 4.6: Departments (N=280)

Department	N	%
Management	13	5
Paediatrics	17	6
Maternity	26	9
Casualty	35	13
Outpatients	8	3
Theatre	9	3
Mixed	172	61
TOTAL	280	100

4.3.7 Variable 7: Hospital type

In the West Coast Winelands Region there are two types of hospitals. Figure 4.7 shows the “separate departments” hospitals. Vredenburg, Stellenbosch and Malmesbury hospitals can be classified as hospitals where separate departments and staff are allocated for the different categories of patients.

Vredendal, Clanwilliam, Citrusdal, Porterville and Piketberg can be classified as the “mixed departments” hospitals where all the categories of patients are allocated in one, two or three departments.

Table 4.7: Hospital type (N=280)

HOSPITAL TYPE	N	%
Separate departments	160	57
Mixed departments	120	43
TOTAL	280	100

4.4 SECTION B: FACTORS INFLUENCING NURSING CARE

4.4.1 Staff provision: Variables B1, B2, B3, B4, AND B5

Table 4.8 shows that the majority of participants (according to staff categories) indicated that they **disagree** that provision of staff is adequate:

- **B1: Participants** N=272 (97%) disagree that provision of staff is adequate in numbers for all activities. A Spearman test identified a weak correlation with significance between age and staff provision ($\rho = -0.18$; $p=0.00$).
- **B2: Participants** N=263 (96%) disagree that provision of staff is adequate in terms of skills. A Spearman test identified a weak correlation with significance between age and staff provision in terms of skills ($\rho = -0.14$; $p=0.02$).
- **B3: Participants** N=255 (92%) disagree that provision of staff is adequate for the day shift during the week. A statistical significant correlation has been identified between the years of experience and adequacy of staff for the day shift (B3) (Chi-square Test $p=0.03$). A Spearman test identified a weak correlation with significance between age and adequate staff provision for the day shift during the week ($\rho = -0.13$; $p = 0.03$).
- **B4: Participants** N=261 (95%) disagree that provision of staff is adequate during the night.
- **B5: Participants** N=259 (94%) disagree that provision of staff is adequate over weekends as well as on public holidays. A Spearman test identified a weak correlation with significance between age and adequate staff provision for staff over weekends and public holidays ($\rho = -0.15$; $p = 0.02$).

Table 4.9 shows that participants of the separate wards hospitals N=142 (90%) and the mixed wards type hospitals N=113 (95%) **disagree** that staff provision (numbers) is adequate referring to the two types of hospitals.

A further analysis under comments:

- **(B1) Participants** indicated that there are too many activities and too few people.
- **(B2) Participants** commented that there is an urgent need for staff with primary health care, theatre technique, trauma and advanced midwifery skills.
- **(B3) Participants** reported that there are much more activities in hospitals during the week.
- **(B4) Staff** commented that it has to be kept in mind that activities in a hospital are not always limited to the day. For example, staffs have no control over emergencies, or the amount of deliveries or admissions to the hospital during the night.

- **(B5)** Over weekends and public holidays the primary health care clinics are closed; consequently primary health care patients have to come to the casualty departments which are already overburdened with trauma cases.
- Existing ward staffs have to cope with the theatre cases after hours and over weekends, as there are no personnel on “call”.

In a study that was done by Kenny & Duckett (2003:614) it was reported that rural nurses need to be multi-skilled generalists because most rural hospitals lack on-site doctors. Nursing staff have to deal with extended practice roles such as advanced assessment and management of trauma and emergencies, because of the absence of full time doctors.

In conclusion variables B1 – B5 show that staff provision is inadequate according to the majority of participants. “Wisdom from tragedy” (Allen, 2006:16) is the story about what can happen when nursing care is undervalued and staff levels are not adequate in terms of numbers and skills mix. It reveals the consequences of employing insufficient numbers of qualified nurses and of overloading the few at the front line and their unqualified colleagues. This is illustrated in a case study of Pauline Freeman who died after post-operative internal bleeding at Eastbourne District General Hospital. Ms Freeman’s twin sister, a former nurse, believes understaffing played a key role in the tragedy.

Table 4.8: Staff provision (Nursing)

STAFF PROVISION (CATEGORIES OF STAFF)		N	%
B1	Provision of staff is adequate (in numbers) for all activities		
	Disagree:	272	97
	Agree:	7	3
	Total:	279	100
B2	Provision of staff is adequate, (in terms of skills) for each department in the hospital		
	Disagree:	263	96
	Agree:	12	4
	Total:	275	100
B3	Provision of staff is adequate for the day shift during the week		
	Disagree:	255	92
	Agree:	21	8
	Total:	276	100
B4	Provision of staff is adequate during the night		
	Disagree:	261	95
	Agree:	13	5
	Total:	274	100
B5	Provision of staff is adequate during weekends, as well as on Public Holidays		
	Disagree:	259	94
	Agree:	18	6
	Total:	277	100

Table 4.9: Hospital types

HOSPITAL TYPE	Disagree	Agree
Separate wards	N=142 (90%)	N=15 (10%)
Mixed Wards	N=113 (95%)	N= 6 (5%)

4.4.2 Management of wards/departments: Variables B6, B7 AND B8

Table 4.10 shows that the majority of participants (referring to categories of staff) indicated that they **disagree** that management of wards/departments is adequate, according to:

- **B6:** Participants N=226 (83%) disagreed that all duties delegated to subordinates are adequately supervised. A statistical significant correlation has been identified between the hospital type and **(B6)** all duties delegated to subordinates are adequately supervised (Chi-square Test $p=0.04$).
- **B7:** Participants N=239 (87%) disagreed that unit managers are always available in the hospital. A statistical significant correlation has been identified between the hospital type and **(B7)** unit managers who are always available in the hospitals (Chi-square Test $p=0.00$). A Spearman test identified a weak correlation with significance between age and (B7) unit management of wards/departments, who are always available ($\rho = -0.15$; $p=0.02$).
- **B8:** Participants N=212 (81%) disagreed that unit managers act as managers and are not part of the production team. A statistical significant correlation has been identified between the hospital type and **(B8)** unit managers who act as managers and are therefore not part of the production team (Chi-square Test $p=0.00$).

Table 4.11 shows that staff of the hospitals with the mixed wards disagreed more than the staff of the separate ward type of hospitals, about the adequacy of management.

A descriptive statistical analysis about the hospital type and management shows the following:

The mean and standard deviation values regarding separate ward hospitals (mean 1.90 and standard deviation 0.61) and mixed ward hospitals (mean 1.51 and standard deviation 0.49) with the Mann -Whitney $p<0.01$, on the 95% confidence interval show a statistical significance between the type of hospitals and management.

A further analysis under comments shows that according to the participants' "unit managers" is a new concept in the West Coast Winelands Region of the Western Cape. Only Stellenbosch, Vredenburg and Malmesbury hospitals have unit managers in place since 2007. Unit managers are currently lacking at Vredendal, Clanwilliam, Citrusdal, Porterville

and Piketberg hospitals. Participants reported that in the hospitals where the unit managers are lacking, it is not always possible to supervise all duties that are delegated to subordinates (B6).

(B8) Participants reported that in the hospitals where there are unit managers, these managers are predominantly busy with patient care activities due to the heavy workload and too few staff, so that the actual management duties are neglected.

Supervision is aimed at ensuring that work is well done and at directing the activities of those engaged in nursing practice towards safe, efficient and compassionate care. Effective and efficient supervision could prevent things from going wrong, for example unethical, negligent behaviour and unprofessional conduct on the part of the nurse which can result in disciplinary action.

In conclusion the majority of participants, variables (B6 – B8) indicated that the management of wards/departments is inadequate. This could be a direct barrier to the delivery of quality nursing care when supervision is inadequate.

Table 4.10: Management of wards/departments (Categories of staff)

MANAGEMENT OF WARDS (CATEGORIES OF STAFF):		N	%
B6	All duties delegated to subordinates are adequately supervised		
	Disagree:	226	83
	Agree:	46	17
	Total:	272	100
B7	Unit managers are always available in the hospital		
	Disagree:	239	87
	Agree:	36	13
	Total:	275	100
B8	Unit Managers act as managers and were not part of the production team		
	Disagree:	212	81
	Agree:	51	19
	Total:	263	100

Table 4.11: Management of wards (Type of hospitals)

DISAGREE: MANAGEMENT OF WARDS (TYPE OF HOSPITAL)		N	%
B6	All duties delegated to subordinates are adequately supervised		
	Separate wards:	123	79
	Mixed wards:	105	88
B7	Unit managers are always available in the hospital		
	Separate wards:	126	79
	Mixed wards:	113	98
B8	Unit Managers act as managers and were not part of the production team		
	Separate wards:	107	70
	Mixed wards:	105	95

4.4.3 Job satisfaction: Variables B9, B10, B11, B12, B13, 14 and B15

Nielsen & Smythe (2008:1) considered job stability, high income, professional development opportunities, work/life balance and provision of social insurance as being important for higher levels of job satisfaction.

The psychologist Abraham Maslow developed a hierarchy of needs model in which basic, low-level needs such as physiological requirements and safety must be satisfied before higher-level needs such as self-fulfilment are pursued. The first level pertains to physiological needs, which requires the sustaining of life; the second level is safety and security needs in order to be free from the threat of physical and emotional harm. The third higher level needs, which are the social needs, are those related to interaction with other people. Once a person feels a sense of “belonging”, the need on the fourth level arises, to feel important, to be recognized. Self –actualization is the fifth level, the summit of Maslow’s hierarchy of needs. It is the quest of reaching one’s full potential as a person (Booyesen *et al.*, 2004:107).

Table 4.12 shows that the majority of participants **disagree** with the statement of job satisfaction in the current work situation:

- **B9: Participants** N=232 (86%) disagreed that nursing staff experience job satisfaction in their current work situation.
- **B10: Participants** N=256 (94%) disagreed that staff are satisfied with the method of staff evaluation (SPMS).
- **B11: Participants** N=254 (92%) disagreed that good performance by staff members is acknowledged.
- **B12: Participants** N=263 (95%) disagreed that workload is such that frustration is reduced and time available to build up sound nurse-patient relationships.
- **B13: Participants** N=253 (92%) disagreed that working conditions are such that high standards are maintained.
- **B14: Participants** N=244 (89%) disagreed that the division for salaries (Occupation Specific Dispensation/OSD) will recruit and maintain personnel.
- **B15: Participants** N=254 (95%) disagreed that all nursing staff working in the rural areas receive a rural allowance.

Table 4.12: Job satisfaction (Disagree)

JOB SATISFACTION: (DISAGREE)		N	%
B9	Nursing staff experience job satisfaction in their current work situation		
	Disagree:	232	86
	Agree:	38	14
	Total:	270	100
B10	Staff are satisfied with the method of staff evaluation (SPMS)		
	Disagree:	256	94
	Agree:	15	6
	Total:	271	100
B11	Good performances by staff members are acknowledged		
	Disagree:	254	92
	Agree:	22	8
	Total:	276	100
B12	The workload is such that frustration is reduced and time available to build up sound nurse-patient relationships		
	Disagree:	263	95
	Agree:	13	5
	Total:	276	100
B13	Working conditions are such that high standards are maintained		
	Disagree:	253	92
	Agree:	21	8
	Total:	274	100
B14	The division responsible for salaries (Occupation Specific Dispensation) will recruit and maintain personnel		
	Disagree:	244	89
	Agree:	29	11
	Total:	273	100
B15	All nursing staff working in the rural areas receive a rural allowance		
	Disagree:	254	95
	Agree:	14	5
	Total:	268	100

Table 4.13 shows that according to the hospital type, participants in mixed and separate wards, **disagree** with the statement that staff do experience work satisfaction.

- **B9:** Participants of mixed wards N=101 (89%) and separate wards N=131 (84%) disagreed that nursing staff experience job satisfaction in their current work situation.
- **B10:** Participants of mixed wards N=104 (91%) and separate wards N=152 (97%) disagreed that staff are satisfied with the method of staff evaluation.
- **B11:** Participants of mixed wards N=109 (92%) and separate wards N=145 (92%) disagreed that good performance by staff members is acknowledged.
- **B12:** Participants of mixed wards N=115 (97%) and separate wards N=148 (94%) disagreed that the workload is such that frustration is reduced and time is available to build up sound nurse-patient relationships.
- **B13:** Participants of mixed wards N=115 (97%) and separate wards N=140 (89%) disagreed that working conditions are of such a nature that high standards are

maintained. A statistical significant correlation has been identified between the hospital type and (B13) working conditions ideal for high standards to be maintained (Chi-square Test $p=0.003$).

- **B14:** Participants of mixed wards $N=104$ (89%) and separate wards $N=140$ (90%) disagreed that the division for salaries will recruit and maintain personnel.
- **B15:** Participants of mixed wards $N=113$ (97%) and separate wards $N=141$ (93%) disagreed that all nursing staff working in the rural areas receives a rural allowance.

Table 4.13: Disagree: job satisfaction (Type of hospitals)

DISAGREE: JOB SATISFACTION (TYPE OF HOSPITAL)		N	%
B9	Nursing staff experience job satisfaction in their current work situation		
	Separate wards:	131	84
	Mixed wards:	101	89
B10	Staff is satisfied with the method of staff evaluation (SPMS)		
	Separate wards:	152	97
	Mixed wards:	104	91
B11	Good performances by staff members are acknowledged		
	Separate wards:	145	92
	Mixed wards:	109	92
B12	The workload is such that frustration is reduced and time is available to build up sound nurse-patient relationships		
	Separate wards:	148	94
	Mixed Wards:	115	97
B13	Working conditions are such that high standards are maintained		
	Separate wards:	140	89
	Mixed wards:	115	97
B14	The division for salaries (Occupation Specific Dispensation) will recruit and maintain personnel		
	Separate wards:	140	90
	Mixed wards:	104	89
B15	All nursing staff working in the rural areas receives a rural allowance		
	Separate wards:	141	93
	Mixed wards:	113	97

Further analysis shows in Figure 4.1 that the management $N=12$ (92%) disagreed the most concerning job satisfaction in the current work situation. The lack of adequate support and insufficient hierarchical structures (unit managers) were given as reasons in the space left for comments. The registered nurses, enrolled nurses and the nursing assistants gave reasons, such as understaffing, too much activity, a heavy workload and a lack of professional development opportunities as reasons for not experiencing job satisfaction.

The majority of participants $N=256$ (94%) **disagreed** with the current method of staff evaluation (**B10**). The reasons for dissatisfaction are that:

- each year the same personnel received the cash incentives, while all personnel work hard

- SPMS is seen as a joke because everyone is trying their best. Only certain staff are acknowledged for good work
- SPMS is an unfair system, because of a great degree of subjectivity.

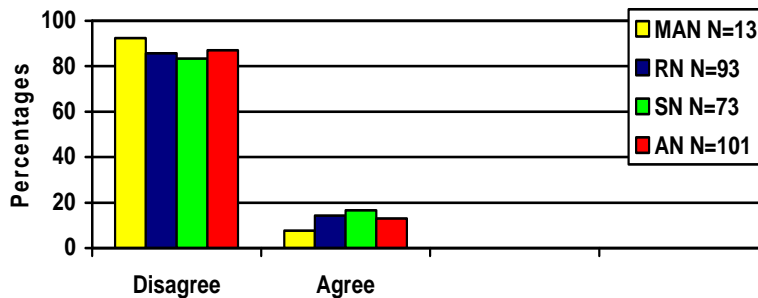


Figure 4.1: Nursing staff experiencing job satisfaction

Participants commented that the lack of acknowledgement (B11) by supervisors is experienced as very demoralizing. In a further analysis Figure 4.2 shows that the Nursing Assistants N=94 (96%) disagreed the most with reference to acknowledgement.

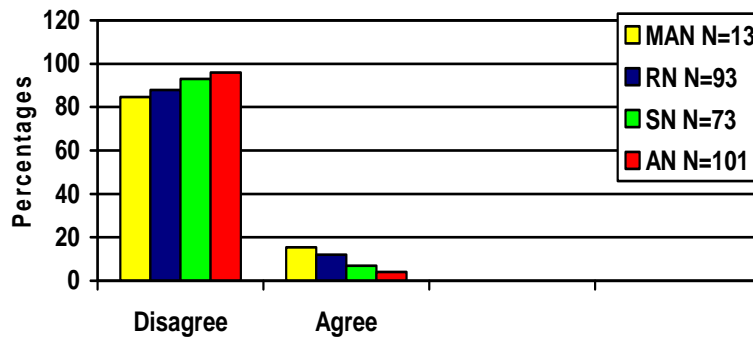


Figure 4.2: Good performance is acknowledged

The high percentage that disagreed out of all the categories is management N=11 (85%), which is a concern.

(B12) Participants N=263 (95%) disagreed out of all categories referring to the workload, the frustration and the need for adequate time to build sound nurse-patient relationships. They reported high frustration levels in the mixed wards hospitals where one team of nursing, consisted of one registered nurse with two nurses who have to cope with both a medical-surgical- maternity and paediatric patients mix in a 34 bed ward or the other combination of medical-surgical-paediatric- *casualty-outpatient* 34 bed ward mix.

Participants reported under comments that it is not possible to maintain high standards when working in the milieu as described in **(B12)**. A concern is again, the high “disagree” percentage scored by management N=13 (100%) as illustrated in Figure 4.3.

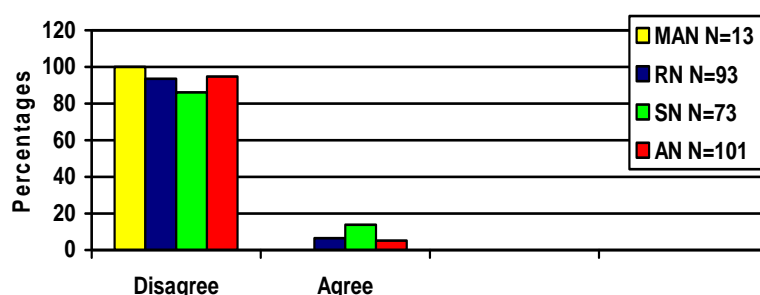


Figure 4.3: Working conditions are such that high standards are maintained

Figure 4.4 shows that all four categories of participants disagreed strongly with the statement that the division for salaries **(B14)** will recruit and maintain personnel. It is especially the nursing assistants N=92 (95%) who are not satisfied with their new “Occupation Specific Dispensation” salary scales, as shown in Figure 4.4. Participants reported that the rural allowances **(B15)** that staffs receive for working in the rural areas are only for the registered nurses. Enrolled and assistant nurses are of the perception that their contribution is undervalued.

In conclusion when job satisfaction (B9 – B15) is interpreted, the majority of the participants do not experience job satisfaction in the current work situation due to: the dissatisfaction with the current staff evaluation system; good performance not being acknowledged, a workload that is too heavy, the impossibility of maintaining high standards in the current working milieu, salaries that are not adequate and each nursing category not receiving the rural allowance. These are major barriers for the delivering of quality nursing care to patients. According to the White Paper on Transformation of the Public Service (South Africa, 1997:109) effective human resource development is described in terms of a framework that has an optimal fit between the needs of the employee, the job, the organization and the environment to meets its goals. A strategic framework for effective human resource development will entail a number of related elements, including staff training. These will include the development of effective and lifelong career development paths for all categories of public servants, the improvement in employment conditions, the introduction of effective appraisal systems, and the use of incentives to reward individual and team performance and the basing of promotion and career advancement on performance rather than on seniority or qualifications.

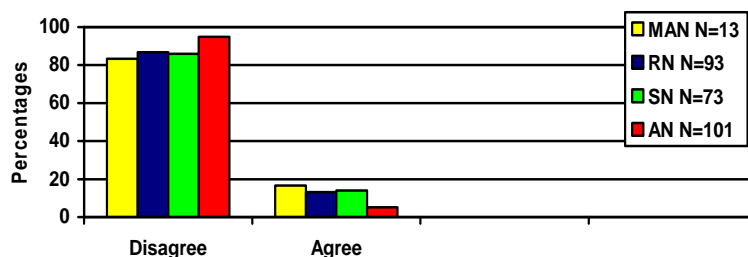


Figure 4.4: Salaries (OSD) will recruit and maintain personnel

4.4.4 Professional development: Variables B16, B17 AND B18

The employer should enable the practitioner to advance professionally by providing continuing education and opportunities for promotion. This is not an obligation, but is what the nurse can expect from an employer who observes sound personnel management principles. According to the Nursing Act no 33 (Republic of South Africa, 2005:32) the South African Nursing Council may determine: conditions relating to continuing professional development to be undergone by practitioners in order to retain such registration; the nature and extent of continuing professional development to be undergone by practitioners; and the criteria for recognition by the Council of continuing professional development activities and accredited institutions offering such activities.

Table 4.14 (page 61-62) shows that the majority of participants disagreed N=212 (76%) about the statement **(B16)** that staff are enabled to advance professionally by receiving continuing education. A statistical significant correlation has been identified between the category of participants and (B16) staff enabled to advance professionally (Chi-square Test $p=0.02$).

Table 4.14 (page 61-62) shows that N=254 (92%) of participants disagree with the statement **(B17)** that there has been adequate opportunities for career development. According to the Spearman test a weak correlation was identified between age and **(B17)** staff who have adequate opportunities for career development, but with significance: ($\rho = 0.14$; $p=0.03$).

In **(B18)** the majority of the categories of participants disagree N=236 (88%) with the statement that there is an adequate number of staff that are qualified to cope in all departments. A statistical significant correlation has been identified between the hospital type and **(B18)** an adequate number of staff members qualified to cope in all the departments (Chi-square Test $p=0.00$).

The descriptive statistical analysis shows the following: The mean and standard deviation values regarding separate ward hospitals (mean 1.76 and standard deviation 0.59) and mixed ward hospitals (mean 1.55 and standard deviation 0.57) with the Mann -Whitney $p < 0.01$, on the 95% confidence interval which show that there is a statistical significance between the type of hospitals and professional development.

A further analysis of comments showed that:

- The qualification of primary health care is a great need, especially in the mixed wards type of hospitals, where they do not have full time doctors on site and where the staffs have to manage primary health care patients after hours when the clinics are not operating.
- Currently there are staff working in the outpatients and casualties that do not have this advanced qualification of primary health care and have to assess, evaluate, diagnose and prescribe treatment without the necessary qualification or authorization – thus they work beyond their scope of practice, which could have medical legal risks or could result in sub-standard care to patients.
- In the mixed ward type hospitals the registered nurses who are working in the theatres, do not have a formal qualifications in theatre technique. While the registered nurses of the wards have to handle the emergency theatre cases after- hours – they do not have the formal qualification.

In conclusion professional development (B16 – B18) when interpreted, suggests that the majority of participants according to all categories and in both types of hospitals are not satisfied with their current status of professional development. This could be a major barrier for the delivering of quality nursing care to patients, due to the lack of skills and knowledge. Consequently this poses a threat to safe and competent patient care. According to Muller (2007:287) the nursing practitioner is professionally and ethically responsible for sustained lifelong learning in order to deliver quality nursing in the unit.

Table 4.14: Professional development

JOB SATISFACTION:		N	%
B16	Staff are enabled to advance professionally by receiving continuing education		
	Disagree:	212	76
	Agree:	66	24
	Total:	278	100
B17	Staff have adequate opportunities for career development		
	Disagree:	254	92
	Agree:	22	8
	Total:	276	100

	N	%
B18 An adequate number of staff members are qualified to cope in all the departments for example in Primary health Care or in the Theatre		
Disagree:	236	88
Agree:	33	12
Total:	269	100

4.4.5 Patient documentation: Variables B19 - B31

Accurate and written records of a patient's treatment are the first line of defence in any claim which may be raised against a nurse or her employer. Claims are often instituted months or even years after the event, when no one can remember enough detail to testify with certainty. If it can be proved however, that the treatment details were noted on the patient card at the time and that notes made on patient- cards are usually accurate and complete, matters will be simplified considerably for nurses and their employers – unless that is, the notes clearly indicate that the wrong treatment was administered (Verschoor *et al.*, 1997:45).

Table 4.15 shows that participants, according to categories who **disagreed** with the following statements:

- **B19: Participants** N=208 (75%) disagreed that there is adequate time to complete a written record of a patient's treatment at the time the treatment is given. A statistical significant correlation has been identified between the category of participants and **(B19)** adequate time for complete written records (Chi-square Test $p=0.00$). A further analysis shows a statistical significant correlation between hospital type and **(B19)** adequate time for complete written records (Chi-square Test $p=0.00$).
- **B20: Participants** N=208 (75%) disagreed that notes on patients' cards are accurate and complete. A statistical significant correlation has been identified between the category of participants and **(B20)** notes on patients' cards that are accurate and complete (Chi-square Test $p=0.01$). Further analysis shows a statistical significant correlation between hospital type and **(B20)** notes on patients' cards that are accurate and complete (Chi-square Test $p=0.03$). According to the Spearman test a weak correlation was identified between age and (B20) notes on patients' cards that are accurate and complete, but with significance ($\rho = -0.14$; $p=0.02$).
- **B21: Participants** N=153 (55%) disagreed that doctor's rounds and orders are always documented. A statistical significant correlation has been identified between hospital type and **(B21)** doctors' rounds and orders which are always documented (Chi-square Test $p=0.01$).
- **B22: Participants** N=158 (57%) disagreed that on admission each patient is assessed to identify problems. A statistical significant correlation has been identified between

hospital type and **(B22)** each patient being assessed on admission to identify all problems (Chi-square Test $p=0.03$).

- **B23: Participants** N=92 (34%) disagreed that a checklist is set up for each patient to cater for his/her basic needs. A statistical significant correlation has been identified between the category of participants and **(B23)** a check list which is set up for each patient to cater for his/her basic needs (Chi-square Test $p=0.02$). According to the Spearman test a weak correlation was identified between age and **(B23)** a check list set up for each patient to cater for his/her basic needs but with significance ($\rho = -0.15$; $p=0.01$).
- **B24: Participants** N=129 (49%) disagreed that nursing care diagnoses are always made.
- **B25: Participants** N=230 (84%) disagreed that the nursing care plan is always prepared by the Registered Nurse, based on the problems identified during the assessment. A statistical significant correlation has been identified between hospital type and **(B25)** the nursing care plan which is always prepared by the registered nurse (Chi-square Test $p=0.00$). According to the Spearman test a weak correlation was identified between age and **(B25)** the nursing care plan always prepared by the registered nurse but with significance ($\rho = -0.19$; $p=0.00$).
- **B26: Participants** N=235 (86%) disagreed that the nursing care plan is always implemented by the Registered Nurse. A statistical significant correlation has been identified between hospital type and **(B26)** the nursing care plan which is always implemented by the registered nurses (Chi-square Test $p=0.00$). According to the Spearman test a weak correlation was identified but with significance between age and **(B26)** the nursing care plan always implemented by the registered nurses ($\rho = -0.23$; $p=0.00$).
- **B27: Participants** N=149 (55%) disagreed that nursing care plans are not updated continuously by the registered nurse. A statistical significant correlation has been identified between the category of participants and **(B27)** nursing care plans that are not updated continuously by the registered nurse (Chi-square Test $p=0.01$).
- **B28: Participants** N=234 (87%) disagreed that the nursing care plan is always evaluated by the registered nurse. According to the Spearman test a weak correlation was identified with significance between age and **(B28)** the nursing care plan always evaluated by the registered nurse ($\rho = -0.18$; $p=0.00$).
- **B29: Participants** N=156 (58%) disagreed that discharge criteria are not always set. A statistical significant correlation has been identified between the category of

participants and **(B29)** discharge criteria that are not always set (Chi-square Test $p=0.00$).

- **B30: Participants** $N=169$ (62%) disagreed that provision is made for rehabilitation of patients. A statistical significant correlation has been identified between hospital type and **(B30)** provision that is made for the rehabilitation of patients (Chi-square Test $p=0.01$).
- **B31: Participants** $N=108$ (40%) disagreed that documentation audits are not done continuously. A statistical significant correlation has been identified between the category of participants and **(B31)** documentation audits that are not done continuously (Chi-square Test $p=0.00$). Further analysis shows a statistical significant correlation between years working at the institution and **(B31)** documentation audits that are not done continuously (Chi-square Test $p=0.03$) and between hospital type and **(B31)** documentation audits that are not done continuously (Chi-square Test $p=0.04$). According to the Spearman test a weak correlation but with significance was identified between age and **(B31)** documentation audits that are not done continuously ($\rho = -0.15$; $p=0.02$).

The descriptive statistical analysis shows the following about hospital type and documentation:

The mean and standard deviation values regarding separate ward hospitals (mean 2.25 and standard deviation 0.42) and mixed ward hospitals (mean 2.08 and standard deviation 0.42) with the Mann-Whitney $p<0.01$, on the 95% confidence interval which show a statistical significance between the type of hospitals and documentation.

A further analysis under comments shows that in the space left for comments on the questionnaire, the staff reported the following regarding patient documentation:

Participants reported that due to the heavy workload and understaffing, there is not always adequate time for complete written records **(B19)**.

Due to the unscheduled time of doctors' rounds or more than one doctor doing a ward round at the same time, notes on the patients' cards are not always complete. It could happen that doctors' rounds **(B21)** are not always documented.

When there are many admissions on one day, it could happen that not all patients are assessed **(B22)** to identify their problems, the staff then managing the patients according to the doctor's prescription cards instead of holistically.

Nursing care diagnosis **(B24)** is not always made, due to the fact that the nursing care plans are set up by the enrolled nurse or nursing assistants who have acquired the knowledge to do it. Therefore the staffs only apply the medical diagnosis as stated on the doctor's prescription card.

The participants commented that the nursing care **(B25)** plan is not prepared and implemented **(B26)** by the Registered Nurse. The nursing care plan is mainly prepared by the enrolled nurse or nursing assistant, especially in the smaller hospitals where the nursing team is comprised of one registered nurse and two or three nurses.

Nursing care plans are not always updated **(B27)** continuously by the registered nurse, due to time limitations and heavy workload of the registered nurses.

The nursing care plans are not always evaluated **(B28)** by the registered nurse, for the same reason as described in **(B27)**;

Discharge criteria **(B29)** are not always set for participants, with reasons given: that the duration of hospital stay is too short. The doctor decides when patients are ready for discharge; therefore participants do not think that it is necessary to set discharge criteria.

Participants do not think that it is necessary to make provision for rehabilitation **(B30)** needs of patients in the nursing documentation, because of the limited length of stay of patients in hospital and when rehabilitation is necessary the patients are referred to the nearest clinic or community based service to help with rehabilitation needs.

Participants reported that audits **(B31)** of nursing documentation are never done. Understaffing and heavy workload was given as reasons.

Participants reported that the current nursing documentation process is not fit for the current work situation of mixed wards type hospitals where personnel provision is limited to one registered nurse working with two nurses in a team. The current documentation is a lengthy and time consuming process and not always practical and workable. For example it takes 45 to 60 minutes to document a delivery with the neonate's records. It could happen in a mixed ward type hospital that five deliveries on one shift has to be documented, making it impossible for one registered nurse to adequately document all deliveries in a limited time schedule. One registered nurse is not able to care for all the patients in a 34 bed ward.

In conclusion when patient documentation (B19 – B31) is interpreted, it is clear that the patient documentation is not up to standard. This could be a major barrier to prove that patients receive quality nursing care – if nursing care is not documented, it can be assumed

that it is not done. According to the Regulation 387 Acts or Omissions regulation as promulgated through the Nursing Act No 50 1978 documentation of all patient care is a requirement and failing to do so subjects the professional nurse to disciplinary action.

According the new Nursing Act No 33 of 2005 the drawing up of nursing care plans by auxiliary nurses are not allowed and is only permissible for trained staff nurses who have been trained in terms of the New Act and only in uncomplicated situations.

Table 4.15: Patient documentation

PATIENT DOCUMENTATION		N	%
B19	There is adequate time for a complete written record of a patient's treatment at the time the treatment is given		
	Disagree:	208	75
	Agree:	69	25
	Total:	277	100
B20	Notes on patients' cards are accurate and complete		
	Disagree:	206	75
	Agree:	69	25
	Total:	275	100
B21	Doctor's rounds and orders are always documented		
	Disagree:	153	55
	Agree:	123	45
	Total:	276	100
B22	On admission each patient is assessed to identify problems		
	Disagree:	158	57
	Agree:	118	43
	Total:	276	100
B23	A check list is set up for each patient to cater for his/her basic needs		
	Disagree:	92	34
	Agree:	176	66
	Total:	268	100
B24	Nursing care diagnoses are always made		
	Disagree:	129	49
	Agree:	134	51
	Total:	263	100
B25	The nursing care plan is always prepared by the registered nurse based on the problems identified during the assessment		
	Disagree:	230	84
	Agree:	43	16
	Total:	273	100
B26	The nursing care plan is always implemented by the registered nurse		
	Disagree:	235	86
	Agree:	38	14
	Total:	273	100
B27	Nursing care plans are not updated continuously by the registered nurse		
	Disagree:	149	55
	Agree:	122	45
	Total:	271	100
B28	The nursing care plan is always evaluated by the registered nurse		
	Disagree:	234	87
	Agree:	35	13
	Total:	269	100

		N	%
B29	Discharge criteria are not always set		
	Disagree:	156	58
	Agree:	114	42
	Total:	270	100
B30	Provision is made for the rehabilitation of patients		
	Disagree:	169	62
	Agree:	103	38
	Total:	272	100
B31	Documentation audits are not done continuously		
	Disagree:	108	40
	Agree:	159	60
	Total:	267	100

4.4.6 Patient care: Variables B32, B33, B34, B35, B36, B37, B38, B39, B40 - B41

The nurse/midwife has to ensure that the patient is nursed or attended to in a physical and psychosocial situation that is conducive to safe care, speedy recovery or peaceful death. Such conditions must be established in every nursing situation in which she practices.

It is essential to provide a clean, well-ventilated, suitably equipped, carefully managed environment with optimal temperature, and control of noise, infection, stress and health hazards. Such an environment is evidence of a competent caring practitioner. In addition, the inculcation of a spirit of friendliness and a high degree of competence on the part of the personnel is essential, to keep risks to a minimum and increase patient and personnel satisfaction (Searle, 2006:200-201).

According to statistics on accidents, the contracting of infections and application of safety measures, the general rule remains that a larger measure of caution is required when working with children, the aged, or persons with some form of disability such as the unconscious, the mentally disturbed, the blind, deaf or frail patients. More caution is also required where hazardous objects or toxic/noxious substances are used, for example an infrared lamp or medication (Verschoor *et al.*, 1997:54).

Figure 4.16 shows those participants, according to categories who **agreed** with the following statements, relating to the type of hospital:

- **B32: Participants** of separate wards N=105 (66%) and of mixed wards N=44 (38%) agreed that patients always receive nursing care as required. A statistical significant correlation has been identified between hospital type and **(B32)** patients who always receive nursing care as required. (Chi-square Test $p=0.00$). According to the Spearman test a weak correlation was identified between age and **(B32)** patients who always receive nursing care as required ($\rho = -0.16$; $p=0.01$).

- **B33: Participants** of separate wards N=84 (53%) and of mixed wards N=45 (38%) agreed that patients are nursed in a healthy and safe environment. A statistical significant correlation has been identified between hospital types and **(B33)** patients who are nursed in a healthy and safe environment. (Chi-square Test $p=0.01$).
- **B34: Participants** of separate wards N=102 (66%) and of mixed wards N=47 (39%) agreed that emergency care is always available to patients. A statistical significant correlation has been identified between hospital types and **(B34)** emergency care which is always available to patients. (Chi-square Test $p=0.00$).
- **B35: Participants** of separate wards N=91(60%) and of mixed wards N=42 (36%) agreed that neonatal patients receive care as required. A statistical significant correlation has been identified between hospital types and **(B35)** neonatal patients who receive care as required (Chi-square Test $p=0.00$).
- **B36: Participants** of separate wards N=102 (67%) and of mixed wards N=46 (39%) agreed that patients in labour receive care as required. A statistical significant correlation has been identified between the category of participants and **(B36)** patients in labour who receive care as required (Chi-square Test $p=0.02$) and between hospital types and **(B36)** patients in labour who receive care as required (Chi-square Test $p=0.00$).
- **B37: Participants** of separate wards N=105 (68%) and of mixed wards N=37 (31%) agreed that debilitated patients receive care as required. A statistical significant correlation has been identified between hospital types and **(B37)** debilitated patients who receive care as required (Chi-square Test $p=0.00$). According to the Spearman test a weak correlation was identified but with significance between age and **(B37)** debilitated patients who receive care as required ($\rho = -0.17$; $p=0.01$).
- **B38: Participants** of separate wards N=104 (66%) and of mixed wards N=42 (36%) agreed that paediatric patients received care as required. A statistical significant correlation has been identified between hospital types and **(B38)** paediatric patients who receive care as required (Chi-square Test $p=0.00$). According to the Spearman test a weak correlation was identified but with significance between age and **(B38)** paediatric patients who receive care as required ($\rho = -0.14$; $p=0.02$).
- **B39: Participants** of separate wards N=100 (66%) and of mixed wards N=43 (36%) agreed that care for patients during death and dying is as required. According to the Spearman test a weak correlation was identified but with significance between age and **(B39)** and care for patients during death and dying who receive care as required ($\rho = -0.15$; $p=0.01$).

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- **B40: Participants** of separate wards N=121 (78%) and of mixed wards N=57 (49%) agreed that pre- and post operative patients do receive care as required. A statistical significant correlation has been identified between hospital types and **(B40)** pre- and post-operative care of surgical patients who do receive care as required (Chi-square Test $p=0.00$). According to the Spearman test a weak correlation was identified but with significance between age and **(B40)** pre- and post-operative care of surgical patients who do receive care as required ($\rho = -0.14$; $p=0.03$).
- **B41: Participants** of separate wards N=101 (66%) and of mixed wards N=63 (54%) agreed that patients are treated by an identified health worker.
- A statistical significant correlation has been identified between hospital types and **(B39)** death and dying patients receiving care as required (Chi-square Test $p=0.00$);

A descriptive statistical analysis shows the following: The mean and standard deviation values regarding separate ward hospitals (mean 2.70 and standard deviation 0.56) and mixed ward hospitals (mean 2.24 and standard deviation 0.59) with the Mann-Whitney $p<0.01$, on the 95% confidence interval shows a statistical significance between the type of hospitals and nursing care.

A further analysis under comments shows that in the space left for comments on the questionnaire, the staff reported the following regarding patient care:

Reasons given why patients do not always receive care as required **(B32)**: One hospital indicated that in the absence of a household aid during nightshift, the nursing staffs are forced to make and serve coffee and tea to the patients in the evenings and mornings. Due to the lack of cleaning staff in this particular hospital, the nurses have to do the mopping of floors at times. Porters are not available everywhere, consequently the nurses have to take laboratory samples to the laboratory and transport patients to radiology and the theatre.

Case managers are not available everywhere consequently nursing personnel, usually the nursing manager, has to capture the necessary data for billing. Furthermore, admission clerks are not available everywhere after hours, thus the nursing staff have to gain access to patients' folders for personal information that is required for admission or billing.

CSSD (central sterilizing service department) operators are not found at each hospital consequently nurses have to leave the ward to wash instruments and to prepare the sterilized packs after they have helped with the tasks in the theatre.

Telephone operators are not available for 24 hours, therefore nursing staff are forced to answer the incoming calls and divert this to the necessary department – this is very

frustrating because nurses have to leave a patient to take on the function of telephone operator.

Regarding **(B33)** that patients are nursed in a healthy and safe environment, participants reported that safety at the hospitals is a concern. One of the mixed wards type of hospitals reported that they do not have security personnel on site. Over weekends and after hours they do not feel safe and secure with aggressive patients.

Noise is a source of irritation and is exhausting to patients. Due to the old infrastructure of these hospitals, it is not possible to contain noise levels especially where the casualty and outpatient department form part of the inpatient wards, or where the maternity ward forms part of the inpatient wards.

Privacy should be respected, but is not always possible. Due to the old infrastructure of these hospitals the privacy of patients in the casualty and outpatients sections is a concern, due to an open plan ward with no private consultation cubicles. Where the maternity department is part of the general ward privacy is a concern, because the intra-partum patient has to walk in the corridor to promote the labour process, she is in pain and does not have privacy, because of paediatric and other categories of patients in the ward.

(B34) refers to the availability of emergency care. The management of emergency cases are problematic due to the absence of fixed oxygen points which are not available everywhere; staff have to make use of heavy mobile oxygen cylinders. The absence or limited number of fixed suction points in the rooms of one of the hospitals forces staff to make use of a mobile suction machine. In one of the hospitals the hospital was issued with a ventilator – it is not in use because the staffs do not have the skills to operate it.

The efficiency and effectiveness of managing emergency services are further hampered by the lack of a medical practitioner on site and inadequate ambulance services which results in long waiting times.

(B35) refers to neonatal patients receiving care as required. Participants reported that part time medical officers are “absent” in evaluating neonates after birth. Newborns are discharged with their mothers without a medical examination or even the necessary documentation. Participants further reported that they lack the necessary knowledge and skills to deliver quality of care to the sick neonate and during emergency situations. This also applies to the management of the many premature babies.

According to **(B36)**, patients in labour receive care as required - in one of the hospitals the participants indicated that they do not have a cardiotocograph (CTG) machine to monitor the foetal heartbeat and contractions of a patient in labour or when receiving augmentation.

This creates concern to them because in one of the smaller hospitals a shift consists of only one registered nurse and two nurses who have to cater for all disciplines of patients.

The lacks of staff make it very difficult to see patients after intra-partum **(B35)** in a general ward, especially when the shift consists of one registered nurse with two nurses. It is not possible to monitor them as expected according to the protocols. The completion of partographs for all patients is lacking.

Respondents reported that in the mixed type of hospitals where one registered nurse with the two or three nurses have to manage all types of patients, it becomes very difficult to provide care as required to the debilitated patients **(B37)**. This is aggravated further during weekends when the personnel are overburdened with the many trauma cases, as well as primary health care patients. This also applies to patients in labour, where one of the nurses usually helps the registered nurse with the delivery, and the second and only nurse remaining, has to manage the patients in the ward. In such cases the domestic staffs have to help with nursing tasks such as bed baths and the lifting of patients.

According to **(B38)** paediatric patients do receive care as required. Participants reported that it is not the ideal situation for them to deliver quality of care to paediatric patients in a “mixed” ward with adult patients, trauma patients and intra-partum patients – it is a concern for a child friendly milieu.

Participants reported that the parents are with the paediatric patients in the ward. They support the nursing staff with the feeding, giving of oral medicines, and observations of the children and hygiene of these patients. However this becomes problematic as no facilities are available for the comfort of parents. During the night they have to sit in a chair. They have to make provision for their own refreshments, while they do not always have the necessary money to do it.

Referring to **(B39)**, care for patients during death and dying could be a problem, especially during weekends and after hours when the nursing staff have to manage the trauma and primary healthcare patients. This also applies to the intra-partum patients. During these extremely busy times it could happen that when the personnel attend to the patient he/she is already dead. To overcome this difficulty families are contacted to stay with the dying **(B39)** patients where possible.

It does not take that much time to prepare the surgical patients (**B40**) for theatre (level one procedure). After the operations the patients are mobile the same day or the following day and are able to help themselves.

After- hour's emergency surgical patients are managed by nursing staff of the wards due to the absence of an "on call" person for theatre after hours in the mixed ward type of hospitals. The registered nurse of the ward with a nurse from another ward has to cope with the procedure in the theatre, which includes preparation of the patient, preparation of the theatre, taking the operation table, helping the anaesthetist, recovering the patient from anaesthetics and the cleaning of the theatre. This is time consuming and is most disturbing to staff.

(**B41**) refers to patients who are treated by an identified health worker; the participants reported that not all of them wear an identification tag. It is the right of every patient to be attended by an identified health worker. According to the South African Patient Rights Charter, the National Plan for patients' rights is the right of a patient to be treated by a named healthcare provider. This applies to transparency of service providers (Muller *et al.*, 2008:8).

In conclusion from the above and according to Table 4.16 the "mixed" type hospitals are experiencing greater challenges than the separate ward type of hospitals to overcome the barriers for the delivering of quality of care to patients. Infrastructure problems, staff shortages and the fact that there is no full time doctor on site are the major challenges to overcome.

Table 4.16: Patient care according to the type of hospital (Agree)

AGREE: PATIENT CARE (TYPE OF HOSPITAL)		N	%
B32	Patients always receive nursing care as required		
	Separate wards:	105	66
	Mixed wards:	44	38
B33	Patients are nursed in a healthy and safe environment		
	Separate wards:	84	53
	Mixed wards:	45	38
B34	Emergency care is always available to patients		
	Separate wards:	102	66
	Mixed wards:	47	39
B35	Neonatal patients receive care as required		
	Separate wards:	91	60
	Mixed wards:	42	36
B36	Patients in labor receive care as required		
	Separate wards:	102	67
	Mixed wards:	46	39
B37	Debililitated patients receive care as required		
	Separate wards:	105	68
	Mixed wards:	37	31
B38	Pediatric patients receive care as required		
	Separate wards:	104	66
	Mixed wards:	42	36

		N	%
B39	Care for patients during death and dying is as required		
	Separate wards:	100	66
	Mixed wards:	43	36
B40	Pre- and postoperative care of surgical patients is as required		
	Separate wards:	121	78
	Mixed wards:	57	49
B41	Patients are treated by an identified health worker		
	Separate wards:	101	66
	Mixed wards:	63	54

4.4.7 Nursing staff

4.4.7.1 Nursing staff: Variable B42

The South African Nursing Council (SANC), act as the controlling body in the nursing profession. SANC serves to safeguard the position of the patient in all health services in the country and has the function of setting standards of performance.

The Nursing Act No 33 (Republic of South Africa, 2005:27) specifies clearly the scope and practice of nursing as follows:

- A professional nurse or midwife is a person who is qualified and competent to independently practice comprehensive nursing in a manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice
- A staff nurse is a person educated to practice basic nursing in the manner and to the level prescribed
- An auxiliary nurse is a person educated to provide elementary nursing care in the manner and to the level prescribed.

Figure 4.5 shows that participants, management N=13 (100%), registered nurses N=80 (86%), enrolled nurses N=63 (86%) and nursing assistants N=81 (83%) disagree with the statement that it is not necessary to act beyond their scope of practice (**B42**). Participants commented that it is a vicious cycle especially where there is no doctor on site – the registered nurse has to perform duties of the doctor, resulting in the enrolled nurse performing duties of the registered nurse and the nursing assistant performing the duties of the registered nurse or staff nurse.

Participants of the separate ward types of hospitals reported that although their wards have a better personnel provision, they also have to work beyond their scope of practice due to heavy workloads and busy schedules. The difference is that there is better control, due to unit managers that are available and more registered nurses in a ward.

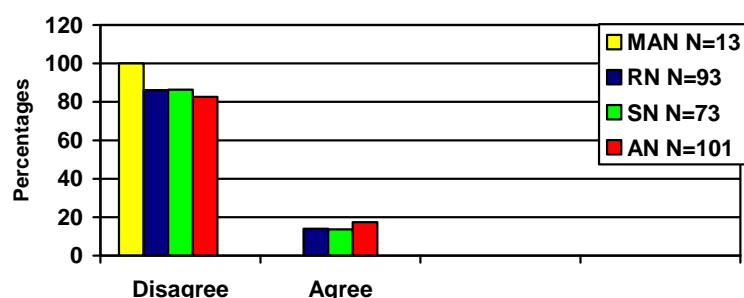


Figure 4.5: It is not necessary for nurses to act beyond their scope of practice

A professional nurse is a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (Republic of South Africa, 2005:27)

To practice as a primary health care nurse, the registered nurse has to meet the prescribed qualification and training needs as stipulated in the Nursing Act No 33 (Republic of South Africa, 2005:42). She has to obtain authorization from the health authority and apply for a license to Council which is valid for three years.

4.4.7.2 Nursing staff Variable B43

Figure 4.6 shows that the participants, management N=9 (69%), registered nurses N=56 (62%), enrolled nurse N=46 (64%) and nursing assistants N=52 (57%) disagree with the statement that it is not expected of the registered nurse to assess, diagnose and prescribe treatment without the qualification of primary health care.

- Participants reported in the space left for comments, that in the hospitals where there are inadequate staff trained in primary health care (**B43**) in the region, the registered nurse without the qualification of primary health care has to assess, diagnose and treat patients, especially in the hospitals where there are no full time medical practitioners on site. A statistical significant correlation has been identified between hospital type and (**B43**) where it is not expected of the registered nurse to assess, diagnose and prescribe treatment to patients without the prescribed qualification of Primary Health Care (Chi-square Test $p=0.00$).

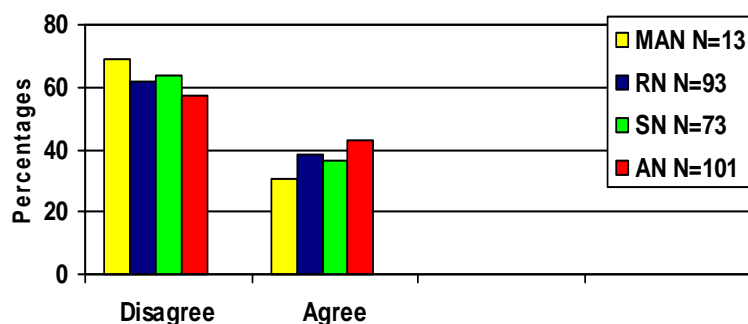


Figure 4.6: It is not expected of the registered nurse to assess, diagnose and prescribe treatment without the qualification in primary health care

4.4.7.3 Nursing staff variable B44

- Figure 4.7 shows that the participants, management N=10 (77%), registered nurse N=54 (58%), enrolled nurse N=40 (56%) and nursing assistants N=56 (60%) disagree with the statement **(B44)** that it is the primary responsibility of the staff nurse to provide basic nursing care. A statistical significant correlation has been identified between hospital type and **(B44)** the primary responsibility of the staff nurse to provide basic nursing care and treatment to patients with stable and uncomplicated health conditions in all settings (Chi-square Test $p=0.00$). According to the Spearman test a weak correlation was identified with significance between age and **(B44)** the primary responsibility of the staff nurse to provide basic nursing care and treatment to patients with stable and uncomplicated health conditions in all settings ($\rho = -0.13$; $p=0.04$).
- A staff nurse is a person educated to practice basic nursing in the manner and to the level prescribed (Republic of South Africa, 2005:27).

Participants reported that, due to understaffing and heavy workload, it could happen that where the registered nurse is very busy, for example with a delivery, the staff nurse is then forced to start with emergency treatment. The staff nurse will insert an intravenous catheter, commence intravenous therapy and also give intravenous medication. The same when there is an emergency Caesarean section to be done; the staff nurse has to do the pre-operation preparation, while the registered nurse organizes the theatre and doctors. It could also happen that the staff nurse does a delivery while the registered nurse is busy with another delivery. These actions could have consequences when something goes wrong – the staff nurse will have to face the consequences, because she is acting outside her scope of practice. The staff nurse is not supposed to put up drips and to give intravenous medication.

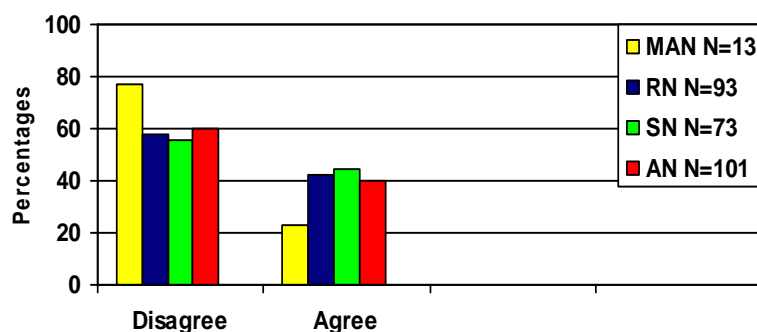


Figure 4.7: The primary responsibility of the staff nurse is to provide basic nursing care and treatment to patients with stable and uncomplicated health conditions

An auxiliary nurse is a person educated to provide elementary nursing care in the manner and to the level prescribed (Republic of South Africa, 2005:27).

4.4.7.4 Nursing staff variable B45

- Figure 4.8 shows that the participants, management N=8 (62%), registered nurse N=51 (55%), enrolled nurse N=34 (47%) and nursing assistants N=56 (57%) disagree with the statement in **(B45)** that it is the primary responsibility of the nursing assistants to provide elementary nursing care. A statistical significant correlation has been identified between hospital type and **(B45)** the responsibility of the auxiliary nurse to provide assistance and support to patients for the activities of daily living and self-care (Chi-square Test $p=0.00$).

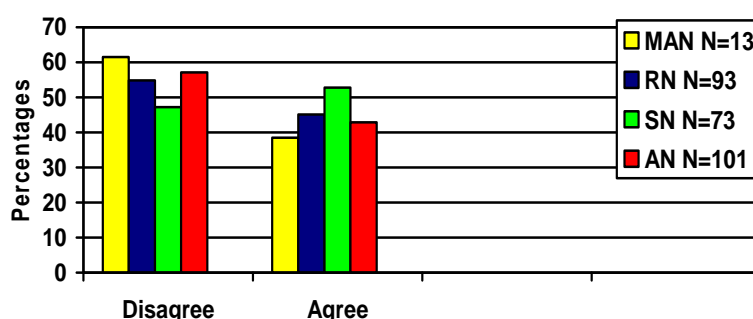


Figure 4.8: The responsibility of the auxiliary nurse is to provide assistance and support to patients

Table 4.17 shows the impact of the type of hospital (separate wards and mixed wards) on the scope of practice of the nursing staff. According to Table 4.17 the chance is greater in the mixed type of hospitals for nurses to act beyond their scope of practice.

Table 4.17: Nursing staff (Disagree)

DISAGREE: NURSING STAFF (TYPE OF HOSPITAL)		N	%
B42	It is not necessary for nurses to act beyond their scope of practice		
	Separate wards:	132	83
	Mixed wards:	107	90
B43	It is not expected of the registered nurse to assess, diagnose and prescribe treatment to patients without the prescribed qualification of primary health care		
	Separate wards:	73	48
	Mixed wards:	92	79
B44	The primary responsibility of the staff nurse is to provide basic nursing care and treatment to patients with stable and uncomplicated health conditions in all settings		
	Separate wards:	76	49
	Mixed wards:	86	74
B45	The responsibility of the auxiliary nurse is to provide assistance and support to patients for the activities of daily living and self-care (elementary nursing)		
	Separate wards:	70	44
	Mixed wards:	81	69

The descriptive statistical analysis shows: the mean and standard deviation values regarding separate ward hospitals (mean 2.23 and standard deviation 0.68) and mixed ward hospitals (mean 1.8 and standard deviation 0.68) with the Mann-Whitney $p < 0.01$, on the 95% confidence interval which shows a statistical significance between the type of hospitals and nursing staff.

In conclusion it is clear from the above that especially in the mixed wards type of hospitals, where the nursing team of a ward or department consists of one registered nurse working with two nurses, with no full time doctors on site and inadequate numbers of primary health care nurse practitioners, the staff work beyond their scope of practice.

This is a grave concern because safe patient practice is seriously being compromised placing the staff at risk of facing litigation.

4.4.8 Equipment and consumables: Variables B46, B47, B48 and B49

Figure 4.18 show that both types of hospitals (mixed and separate wards) do experience problems with equipment and consumables.

- **B46:** Participants of both hospital types, separate N=131 (82%) and mixed N= 108 (91%) disagreed about the adequacy of equipment and consumables. A statistical significant correlation has been identified between hospital type and (**B46**) equipment and consumables being always adequate (Chi-square Test $p = 0.04$).
- **B47:** Participants of both hospital types, separate N=133 (84%) and mixed N= 109 (92%) disagreed that equipment is always in a working condition..

- **B48:** Participants of both hospital types, separate N=126 (79%) and mixed N=106 (90%) disagreed that maintenance of equipment is done on a regular basis. A statistical significant correlation has been identified between hospital type and **(B48)** maintenance of equipment that is done on a regular basis (Chi-square Test $p=0.01$).
- **B49:** Participants of both hospital types, separate N=119 (74%) and mixed N=98 (82%) disagreed that adequate consumables are available to ensure that cross infection measures are always strictly maintained. According to the Spearman test a weak correlation was identified but with significance between age and **(B49)** maintenance of equipment done on a regular basis ($\rho = -0.18$; $p=0.00$).

A descriptive statistical analysis shows the mean and standard deviation values regarding separate ward hospitals (mean 1.84 and standard deviation 0.65) and mixed ward hospitals (mean 1.67 and standard deviation 0.54) with the Mann-Whitney $p=0.02$, on the 95% confidence interval with a statistical significance between the type of hospitals and equipment, and consumables.

A further analysis indicates the participants' comments, as follows:

- **B46:** Equipment such as blood pressure apparatus, inhalation machines, glucometers, and haemoglobin meters are inadequate for the number of patients. Blankets, as well as linen, are in short supply. Sterilized instruments that are needed for wound stitching and for deliveries are inadequate especially during weekends. Participants reported that from time to time the necessary consumables are out of stock or inadequate numbers of stock in wards compromise the delivery of patient care.
- **B47:** Equipment that is usually defaulted according to the participants:
 - Blood pressure apparatus
 - Glucometers
 - Haemoglobin meters
 - Electronic Blood pressure apparatus
 - Suction bottles
 - Nebulisers

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According to participants it is very frustrating that broken equipment are sent to the workshop in Bellville (Cape Town) for repair and take a long time before it is back at the institution.

- **B48:** Participants reported that maintenance at the institutions is not done on a regular basis due to staff shortages.

- **B49:** One hospital reported that the sterilized instruments for wound stitching and for deliveries are not adequate during weekends. From the participants reported that the amount of blankets are inadequate, consequently blankets are used for more than one patient before it is washed or disinfected. This is a hazardous practice for the safety of patient care due to the risk of cross infection.

In conclusion deficiencies regarding consumables and equipment in both types of hospitals could be a barrier for the delivery of quality care to patients. The mixed types of hospitals do experience these deficiencies more intense than the separate ward type hospitals.

Table 4.18: Equipment and consumables (Disagree)

DISAGREE: EQUIPMENT AND CONSUMABLES (TYPE OF HOSPITAL)		N	%
B46	Equipment and consumables are always adequate		
	Separate wards:	131	82
	Mixed wards:	108	91
B47	Equipment is always in a working condition		
	Separate wards:	133	84
	Mixed wards:	109	92
B48	Maintenance of equipment is done on a regular basis		
	Separate wards:	126	79
	Mixed wards:	106	90
B49	Adequate consumables are available to ensure that cross infection measures are always strictly maintained		
	Separate wards:	119	74
	Mixed wards:	98	82

4.4.9 Working conditions: Variables B50, B51, B52, B53, B54, B55 and B56

Table 4.19 shows that participants' variables B50, B51, B52, B53, B54, B55 and B56 disagreed on various issues about their working conditions.

- **B50:** Participants of separate wards N= 60 (38%) and mixed wards N=77 (65%) disagreed that staff are able to have tea breaks and lunches. A statistical significant correlation has been identified between hospital type and **(B50)** staff able to have tea breaks and lunches (Chi-square Test $p=0.00$). According to the Spearman test a weak correlation was identified but with significance between age and **(B50)** staff able to have tea breaks and lunches ($\rho = -0.18$; $p=0.00$).
- **B51:** Participants of separate wards N=125 (82%) and mixed wards N=107 (91%) disagreed that it is not necessary for staff to work overtime. According to the Spearman test a weak correlation but with significance was identified between age and **(B51)** that it is not necessary to work overtime ($\rho = -0.14$; $p=0.03$).
- **B52:** Participants of separate wards N=122 (79%) and mixed wards N=81 (72%) disagreed that remuneration is adequate when it is necessary to work overtime. A statistical significant correlation has been identified between hospital type and **(B51)** it

is not necessary to work overtime (Chi-square Test $p=0.03$), between years of working at the institution and **(B52)** remuneration is adequate when working overtime is necessary (Chi-square Test $p=0.01$).

- **B53:** Participants of separate wards $N=111$ (70%) and mixed wards $N=90$ (78%) disagreed that nursing staff are always able to work within the ethical and legal framework. A statistical significant correlation has been identified between categories of participants and **(B53)** nursing staff always able to work within the ethical and legal framework (Chi-square Test $p=0.01$).
- **B54:** Participants of separate wards $N=122$ (79%) and mixed wards $N=81$ (72%) disagreed that relaxation facilities for staff are adequate for example adequate tea/rest rooms.
- **B55:** Nurses are able to schedule their leave according to their needs – Figure 4.9 shows that according to the categories of participants management $N=9$ (75%), registered nurses $N=69$ (75%), enrolled nurses $N=49$ (69%) and nursing assistants $N=77$ (78%) disagreed.
- **B56:** Participants of separate wards $N=90$ (57%) and mixed wards $N=88$ (77%) disagreed that nurses are able to take their leave as scheduled. A statistical significant correlation has been identified between hospital type and **(B56)** nurses are able to take their leave as scheduled Chi-square Test $p=0.00$).

In a further analysis of comments, the participants reported that:

- **B50:** It is extremely difficult in the mixed wards type of hospital to break for tea and lunch, especially when the registered nurse is busy with a delivery or trauma patient.
- **B51:** Participants of both types of hospitals indicated that it is necessary to work from time to time overtime due to short staffing and a heavy workload.
- **B52:** Participants of both types of hospitals indicated that remuneration for overtime is not adequate, due to the great percentage of the payment that goes for tax. Participants indicated that they have to wait a long time before receiving their overtime money due to the PERSAL payment process.
- **B53:** Participants of both types of hospitals indicated that they are not always able to work within the ethical and legal frameworks. Nursing patients who are treated for termination of pregnancies were given as the main reason for ethical objections. Another concern for the nurses according to legal parameters was that nurses have to act beyond their scope of practice due to shortage of registered nurses and heavy workloads.

- **B54:** In some of the institutions participants reported that staff do not have a rest room; others reported that the rest room is totally inadequate. They do not have comfortable chairs, a microwave oven, a kettle or a refrigerator. Staffs have to bring their own coffee, tea, milk and sugar plus their own cup or jug. When specialists visit the hospitals, they occupy the rest room for their lunch breaks making it unavailable to the staff.
- **B55:** Nurses are able to schedule their leave according to their needs. Managers commented that they are trying to schedule leave according to the needs of the personnel. However most personnel want to take leave during festive seasons and school holidays, therefore it is not always possible to accommodate everyone's needs, due to operational needs.
- **B56:** Nurses are able to take their leave as scheduled. Unexpected absenteeism's are given as reasons why it is not always possible to take leave as scheduled.

In conclusion the results show that the working conditions in both hospital types show deficiencies for the needs of the nursing staff. When staffs are not satisfied with their working conditions it could reflect negatively on their motivation to deliver quality of care to patients.

Table 4.19: Working conditions (Disagree)

DISAGREE: WORKING CONDITIONS (TYPE OF HOSPITAL)		N	%
B50	Staff are able to have tea breaks and lunches		
	Separate wards:	60	38
	Mixed wards:	77	65
B51	It is not necessary to work overtime		
	Separate wards:	125	82
	Mixed wards:	107	91
B52	Remuneration is adequate when working overtime is necessary		
	Separate wards:	122	79
	Mixed wards:	81	72
B53	Nursing staff are always able to work within the ethical and legal framework		
	Separate wards:	111	70
	Mixed wards:	90	78
B54	Relaxation facilities for staff are adequate for example an adequate tea/rest room		
	Separate wards:	127	79
	Mixed wards:	84	72
B55	Nurses are able to schedule their leave according to their needs		
	Separate wards:	114	73
	Mixed wards:	90	76
B56	Nurses are able to take their leave as scheduled		
	Separate wards:	90	57
	Mixed wards:	88	77

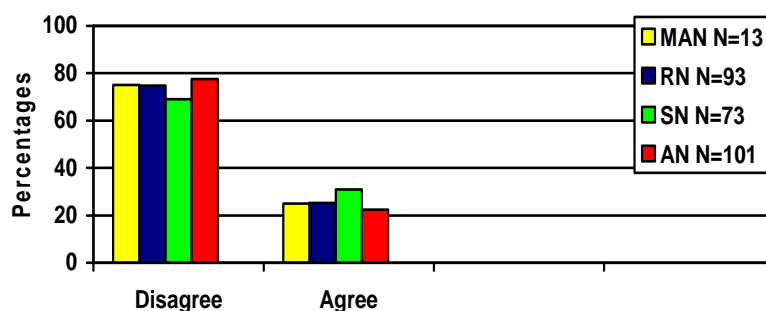


Figure 4.9: Nurses are able to schedule their leave according to their needs

4.4.10 Shifts: Variables B57 – B58

Table 4.20 (page 83) shows that participants of both types, separate wards N=105 (66%) and mixed wards N=102 (86%) of hospitals indicated that they disagreed with the statement that at the end of shifts, personnel are able to leave the hospital on time.

Figure 4.10 shows the categories of participants, management N=10 (83%), registered nurses N=73 (79%), enrolled nurses N=47 (66%) and nursing assistants N=76 (77%) who disagreed that they are able to leave the hospital on time at the end of shifts. A statistical significant correlation has been identified between types of hospitals and **(B57)** at the end of shifts, personnel are able to leave the hospital on time (Chi-square Test $p=0.00$); and between years working at the institution and **(B57)** at the end of shifts, personnel are able to leave the hospital on time (Chi-square Test $p=0.03$). According to the Spearman test a weak correlation but with significance was identified between age and **(B57)** at the end of shifts, personnel are able to leave the hospital on time ($\rho = -0.21$; $p=0.00$).

Participants of both separate wards in both types of hospitals N=114 (74%) and mixed wards N=85 (71%) disagreed that the needs of staff are taken into account when rosters are planned,

Figure 4.11 shows the categories of participants, management N=7 (54%), registered nurses N=68 (74%), enrolled nurses N=49 (69%) and nursing assistants N=76 (77%) disagreed that their needs are taken into account when rosters are planned.

Further analysis of comments, reported by participants as follows:

- **B57:** Staff could not leave the hospital on time due to the heavy workload. The one shift has to hand over to the next shift, and then staff could leave the hospital.

- **B58:** Participants indicated that managers are trying to accommodate staff needs when rosters are planned, but due to understaffing and operational requirements it is not always possible.

In conclusion both the participants of the separate ward type, as well as the participants of the mixed type hospitals do experience that their needs and requests are not always taken into account when duty rosters are planned. In the mixed type of hospitals staffs experience more difficulties to leave the hospitals on time at the end of shifts. Both **(B57)** and **(B58)** can be demoralizing for staff and can impact negatively on the motivation of staff to deliver quality of care to patients

Table 4.20: Shifts (Disagree)

DISAGREE: SHIFTS (TYPE OF HOSPITAL)		N	%
B57	At the end of shifts, personnel is able to leave the hospital on time		
	Separate wards:	105	66
	Mixed wards:	102	86
B58	When rosters are planned, requests and needs of staff are taken into account		
	Separate wards:	114	74
	Mixed wards:	85	71

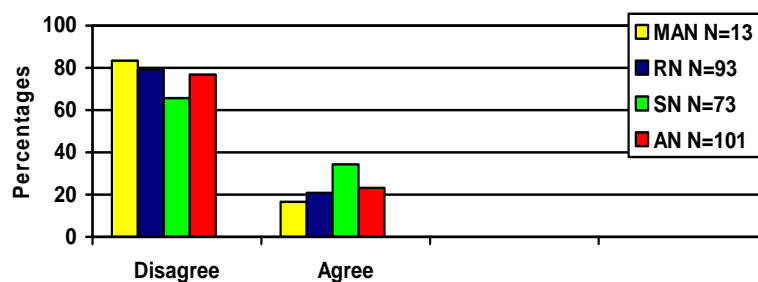


Figure 4.10: At the end of shifts, personnel are able to leave the hospital on time

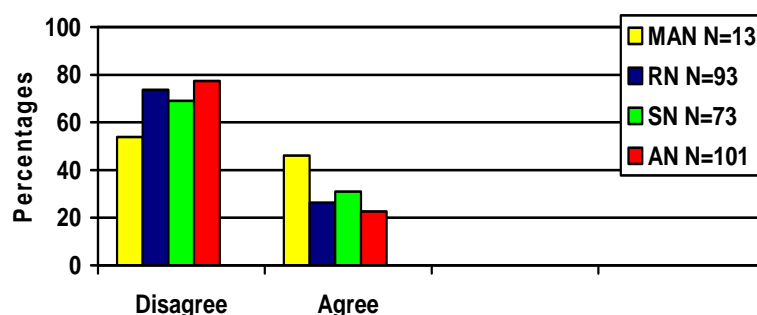


Figure 4.11: When rosters are planned, requests and needs of staff are taken into account

4.4.11 Doctors: Variables B59, B60, B61, B62, B63, B64 and B65

Figure 4.21 shows that:

- **B59:** Participants in the two types of hospitals, separate wards N=83 (53%) and mixed wards N=118 (99%) disagreed about the statement that full time medical officers are available in the hospitals. A statistical significant correlation has been identified between types of hospitals and **(B59)** medical officers who are available in the hospital full time (Chi-square Test $p=0.00$).
- **B60:** Participants in both types of hospitals, separate wards N=110 (69%) and mixed wards N=102 (86%) disagreed with the statement that staff are always able to cope with medical emergencies due to the availability of doctors. A statistical significant correlation has been identified between types of hospitals and **(B60)** staff always able to cope with medical emergencies due to the availability of doctors (Chi-square Test $p=0.01$).
- **B61:** Participants in both types of hospitals, separate wards N=109 (69%) and mixed wards N=98 (82%) disagreed with the statement that staff always able to cope with trauma emergencies due to the availability of doctors. A statistical significant correlation has been identified between types of hospitals and **(B61)** staff always able to cope with trauma emergencies due to the availability of doctors (Chi-square Test $p=0.00$) and between years working at the institution and **(B61)** staff always able to cope with trauma emergencies due to the availability of doctors (Chi-square Test $p=0.03$).
- **B62:** Participants in both types of hospitals, separate wards N=110 (71%) and mixed wards N=92 (79%) disagreed with the statement that staff are always able to cope with maternity emergencies due to the availability of doctors.
- **B63:** Participants in both types of hospitals, separate wards N=104 (66%) and mixed wards N=97 (82%) disagreed with the statement that in cases of emergency, doctors are immediately available in the department. A statistical significant correlation has been identified between types of hospitals and **(B63)** in cases of emergency, doctors are immediately available in the department (Chi-square Test $p=0.00$).
- **B64:** Participants in both types of hospitals, separate wards N=137 (86%) and mixed wards N=105 (88%) disagreed with the statement that patients do not have to wait a long time to be evaluated by a doctor.
- **B65:** Participants in both types of hospitals, separate wards N=138 (87%) and mixed wards N=99 (85%) disagreed with the statement that patients do not have to wait a long time to be treated by a doctor.

The descriptive statistical analysis shows the following with reference to:

The mean and standard deviation values regarding separate ward hospitals (mean 2.06 and standard deviation 0.59) and mixed ward hospitals (mean 1.63 and standard deviation 0.60) with the Mann-Whitney $p < 0.01$, on the 95% confidence interval shows a statistical significance between the type of hospitals and doctors.

A further analysis of comments by the participants reported as follows:

- **B59:** Malmesbury, Vredenburg and Stellenbosch Hospitals do have full time Medical Superintendents and Medical Officers. Vredendal, Porterville, Piketberg, Citrusdal and Clanwilliam Hospitals make use of part time Medical Superintendents and part time Medical Officers.
- **B60, B61, B62 and B63:** Participants reported that it is not always easy to cope with medical, trauma and maternity emergencies, due to the fact that the registered nurse is not always experienced enough to cope without the immediate presence of the doctor. It is especially stressful in the mixed type of hospitals where the medical officers are not full time on site. When the doctor is not staying in the same town where the hospital is situated, it can take twenty to thirty minutes for the doctor to arrive at the hospital.
- **B64 and B65:** Participants of both types of hospitals reported that they disagree with the statement that patients do not have to wait a long time before being evaluated - separate wards $N=137$ (86%) and mixed wards $N=105$ (88%), and separate wards $N=138$ (87%) and mixed wards $N=99$ (85%) treated by a doctor.

Mixed wards participants reported that due to the fact that the doctors are part -time they have to service their private practices and the clinics, therefore they do a ward round in the mornings and in the evenings. When patients arrive at the hospitals in the course of the day, the registered nurse evaluates them and according to her evaluation the doctor will decide when to see or treat the patient.

In conclusion the mixed types of hospitals staff are much more under pressure without full time doctors on site. However it is interesting to note that the staff of hospital types where full time medical officers are on site, reported that they were also under pressure and that the patients also had to wait, because the one full time doctor on site had to cope with all the patients of the hospital. In addition to his work at the hospital, this doctor usually has to work in the section for outpatients or clinics during the day.

Table 4.21: Doctors (Disagree)

DISAGREE: DOCTORS (TYPE OF HOSPITAL)		N	%
B59	Medical Officers are available in the hospital full time	83	53
	Separate wards:	118	99
	Mixed wards:		
B60	Staff are always able to cope with medical emergencies due to the availability of doctors		
	Separate wards:	110	69
	Mixed wards:	102	86
B61	Staff are always able to cope with trauma emergencies due to the availability of doctors		
	Separate wards:	109	69
	Mixed wards:	98	82
B62	Staff are able to cope with maternity emergencies due to the availability of doctors		
	Separate wards:	110	71
	Mixed wards:	92	79
B63	In cases of emergency, doctors are immediately available in the department		
	Separate wards:	104	66
	Mixed wards:	97	82
B64	Patients do not have to wait a long time to be evaluated by a doctor		
	Separate wards:	137	86
	Mixed wards:	105	88
B65	Patients do not have to wait a long time for treatment by a doctor		
	Separate wards:	138	87
	Mixed wards:	99	85

4.4.12 Batho Pele: Variables B66 – B74

Figure 4.22 shows that participants in both types of hospitals, separate wards N=101 (64%) and mixed wards N=81 (69%) **disagreed** with the statement that patients are consulted (B66) about the level and quality of service they receive.

- **B67: Participants** in both types of hospitals, separate wards N=91 (58%) and mixed wards N=71 (60%) disagreed with the statement that patients are given a choice about the services on offer.
- **B68: Participants** in both types of hospitals, separate wards N=96 (61%) and mixed wards N=70 (59%) disagreed with the statement that patients are told what level and quality of service they will receive so that they are aware of what to expect.
- **B69: Participants** in the separate ward type of hospital disagreed that all patients have equal access to all the services N=72 (46%) and participants of the mixed type of hospitals disagreed with N=59 (50%).
- **B70: Participants** of both hospitals separate wards N=57 (37%) and mixed wards N=48 (40%) disagreed that patients are treated with courtesy and consideration in both types of hospitals.

- **B71: Participants** in both separate type N=79 (50.32%) and mixed type of hospitals N=60 (50.42%) disagreed that patients are given full and accurate information about the services they are entitled to receive.
- **B72: Participants** in both types of hospitals, separate wards N=108 (70%) and mixed wards N=76 (64%) disagreed with the statement that patients are told how the institution is run, how much the services cost and who is in charge.
- **B73: Participants** of both types of hospitals in the separate ward types of hospitals N=82 (53%) and of the mixed ward type of hospitals N=52 (44%) disagreed that when complaints are made, patients do receive a sympathetic, positive response.
- **B74: Participants** of both types of hospitals in the separate ward types of hospitals N=86 (55%) and mixed type of hospitals N=59 (50%) disagreed that services are provided economically in order to give patients the best possible value for money.

A further analysis of comments by the participants reported as follows:

Participants agreed that they try to act in the interest of the patients and always try to put the patient first, but due to heavy workloads, understaffing and limited budgets there is not always a very wide choice, **(B67)** of services to offer to patients.

Participants try to treat patients with courtesy and consideration, **(B70)** which is a big challenge to overcome especially over weekends in the trauma units where a lot of patients are under the influence of alcohol.

Participants try to attend to complaints, **(B73)** in a sympathetic and positive way.

Table 4.22: Batho Pele (Disagree)

DISAGREE: BATHO PELE (TYPE OF HOSPITAL)		N	%
B66	Patients are consulted about the level and quality of service they receive		
	Separate wards:	101	64
	Mixed wards:	81	69
B67	Wherever possible patients are given a choice about the services on offer		
	Separate wards:	91	58
	Mixed wards:	71	60
B68	Patients are told what level and quality of service they will receive so that they are aware of what to expect		
	Separate wards:	96	61
	Mixed wards:	70	59
B69	All patients have equal access to all the services they are entitled to receive		
	Separate wards:	72	46
	Mixed wards:	59	50
B70	Patients are treated with courtesy and consideration		
	Separate wards:	57	37
	Mixed wards:	48	40

		N	%
B71	Patients are given full, accurate information about the services they are entitled to receive		
	Separate wards:	79	50
	Mixed wards:	60	50
B72	Patients are told how the institution is run, how much the services cost and who is in charge		
	Separate wards:	108	70
	Mixed wards:	76	64
B73	When complaints are made patients receive a sympathetic, positive response		
	Separate wards:	82	53
	Mixed wards:	52	44
B74	Services are provided economically in order to give patients the best possible value for money		
	Separate wards:	86	55
	Mixed wards:	59	50

4.5 CONCLUSION

The researcher has successfully addressed the research question:

“What are the factors influencing the quality of nursing care in district hospitals in the West Coast Winelands Region of the Western Cape?”

Through this scientific investigation the factors influencing the quality of patient care in the rural environment specifically the West Coast Winelands Region of the Western Cape Province have been successfully identified.

The following objectives which were set for this study as listed below were all met by determining:

- whether staffing is adequate for all activities
- the perceptions of nursing staff about their current working situation
- the effect of the absence of full time doctors on the management of patient care
- whether adequate equipment is available for the execution of nursing care
- whether adequate provisions are made for the execution of nursing care.

CHAPTER 5: RECOMMENDATIONS

5.1 INTRODUCTION

“BETTER HEALTH FOR ALL” The government of the Western Cape has set the goal of achieving better health for all. The Annual Performance Plan (APP) for 2008/09 not only sets down service delivery targets, but gives practical effect to the Comprehensive Service Plan for the implementation of Healthcare 2010.

The APP of 2008/09 focuses extensively on improving the quality of care provided by the health services. A quality assurance unit monitors the quality of care by attending to matters such as complaints and compliments, as well as to client satisfaction surveys.

The shortage of nurses in the Department hampers service delivery in some service areas. However, the occupation specific dispensation (OSD) for nurses will improve the recruitment and retention of nurses during the 2008/09 financial year and beyond.

The APP is the roadmap for service delivery for the period 2008/09. What remains is to fulfil commitments to improve the public health care system (Western Cape Department of Health, 2008: ix-x).

The researcher appreciates the vision of the department for assuring a quality health service in the public sector, but is concerned about the barriers that nursing staff in the district hospitals experience when it comes to delivering quality nursing care.

The following objectives were set for the research study, namely to determine:

- whether staffing is adequate for all activities
- the perceptions of nursing staff about their current work situation
- the effect of the absence of full time doctors on the management of patient care
- whether adequate equipment is available for the execution of nursing care
- whether adequate provision for the execution of nursing care is made.

These objectives were met through an in-depth research study with the aim of identifying the factors which influence the quality of nursing care in the eight district hospitals of the West Coast Winelands Region of the Western Cape.

The data analysis and interpretations based on the questionnaire used in this research are described in chapter 4. The recommendations based on the findings as described in chapter 4 are discussed in this chapter.

5.2 RECOMMENDATIONS

5.2.1 Staff provision (B1-5)

The analysis shows that according to table 4.9, both types of hospitals (separate ward and mixed ward types) indicate that staff numbers are inadequate. Table 4.8 shows the inadequacy of staff in numbers and in skills, on day and night shifts during the week, over weekends and on public holidays.

Recommendation:

5.2.1.1 Adequate staff in terms of numbers and skills

Health care service managers are responsible for the providing of sufficient numbers of qualified nursing personnel to ensure adequate, safe nursing care for all patients. Urgent attention has to be given to staffing norms, especially where maternity/neonatology and casualty/outpatients are combined with or are part of the general wards. According to the analysis, there is a need for staff with primary health care, theatre, advanced midwifery and trauma skills. Full time doctors are limited to hospitals in Vredenburg, Stellenbosch and Malmesbury. It is recommended that staff working in the mentioned departments, without the support of full time doctors, should be motivated to obtain these qualifications. Staff levels have to be adjusted according to the activities during the day, night and over weekends, as well as on public holidays – the delivery of primary health care services after hours and over weekends have a great impact on the workload in district hospitals. Infrastructure deficiencies have to be taken into account. Where maternity/neonatology, casualty/outpatients form part of the ward, separate (extra) staff have to be provided. Provision has to be made for staff rendering support to the outreach specialists who run clinics at these hospitals.

5.2.2 Management of wards/departments (B6-8)

According to table 4.10 and table 4.11, both types of hospitals (separate ward and mixed ward types) indicate that the management of wards is inadequate.

Table 4.11 shows the inadequacy of management according to these criteria: all duties delegated are adequately supervised, unit managers are always available and unit managers act as managers and do not form part of the production team.

Cognizance should be taken of the fact that the supervisor remains accountable after he/she has delegated a task. The supervisor is still responsible for inspecting, supervising and ensuring the correct performance of the task. It is a concern that the analysis shows that delegated duties are not adequately supervised. It is imperative that staffing numbers are adjusted for the required supervision to take place and therefore ensure safe patient care.

Recommendations:

5.2.2.1 Appointment of unit managers

The appointment of unit managers is encouraged at the institutions where they are still lacking, as proposed in the Comprehensive Service Plan for 2010. It is recommended that unit managers are utilized in such a way that they will always be available in hospitals. Participants working in one of the hospitals where there are currently five unit managers, have a concern that four of these managers are working on one shift and the fifth also on one shift, is working night duty. A revised schedule is therefore recommended to cover all shifts.

5.2.2.2 Supervisory training

Unit managers are concerned that they are primarily utilized in production. Management tasks, for example, infection control, auditing of documentation and other supervisory tasks, are neglected. Supervisory training is essential for first line managers to operate at their maximum potential, especially if a good functional worker has been promoted to the level of supervision without management experience. Apart from the technical skills, supervisors also require skills and knowledge to manage people effectively. Leadership and management development modular certificate courses specifically designed for nurse managers are recommended

5.2.3 Job satisfaction (B9-15)

Nursing is inherently a demanding profession where the focus is on the client / patient rather than on the nurse. It is a concern that the analysis reveals that the majority of participants indicated that they do not experience job satisfaction. Management, N=12 (92%), was the category that scored the highest percentage of “disagreement” according to job satisfaction as shown in figure 4.1. This could be detrimental in delivering quality care to patients. Lack of adequate support and insufficient hierarchical structures (unit managers) were given as reasons for the dissatisfaction of the managers.

Recommendations:

5.2.3.1 Support structures

It is recommended that unit managers are introduced where it is currently still lacking. This will enhance better hierarchical structures and support to the nursing managers of the district hospitals. More direct involvement between Medical Superintendents (as the overall manager of each hospital) and nursing managers at the distinctive hospitals will be of great value. More support and contact from the district offices will keep hospital management enthusiastic and motivated.

5.2.3.2 Staff evaluation

Increased involvement from supervisors will promote the current method of staff evaluation. It is necessary to spend more time with individual employees for an in-depth discussion about their job descriptions, development and performance plans. Continuous training sessions by the district and head office of the human resource department are needed so that everybody is familiar with the policies and processes. Currently the staff performance monitoring system (SPMS) process occurs secretly and nobody knows who receives cash incentives for good performance. This atmosphere of secrecy does not promote a trustworthy relationship. The participants indicated that this procedure is not transparent enough, therefore transparency is recommended. Introduction of various types of incentives such as gift vouchers, the encouraging of social contact and the promoting of team spirit are suggested. By displaying photographs of top performing nurses or teams at strategic points in the hospital every six months - acknowledgements of staff will take place on a more regular basis.

5.2.3.3 Acknowledgement of good performance

Collegiality among staff is encouraged. Peers and supervisors should lend personal support and acknowledgement to colleagues. This will improve staff morale and will promote feelings of worth among staff. Quality assurance could further be enhanced by the recognition of nursing teams for outstanding performance annually. This will also create opportunities in promoting team building and cohesiveness among team members. Management and unit managers can play an important role in being role models of inspiration, motivation and enthusiasm.

5.2.3.4 Working conditions

The implementation of the Comprehensive Service Plan of 2010 will address the staff levels and if implemented as planned the nursing staff will experience much better working

conditions. Low staff levels, especially in the mixed ward type hospitals is a great frustration for staff and is a barrier for delivering quality service to patients.

5.2.3.5 Salaries and allowances

The only way to promote better salaries will be for peers and supervisors to encourage colleagues to improve their qualifications which may result in possible promotions to higher posts with better salaries.

Furthermore, only the registered nurses are receiving rural allowances currently. The researcher recommends that this is extended to staff nurses and nursing assistants.

5.2.4 Professional development (B16-18)

The analysis in table 4.14 shows that the majority of participants, N=254 (92%) disagreed with the adequacy of professional development.

The unit manager and other personnel have to be responsible for the establishment of a positive learning climate in the ward. Every nurse practitioner is professionally and ethically responsible for sustained, lifelong learning in order to deliver quality nursing in the unit.

Recommendations:

5.2.4.1 Job related training

Personnel development in terms of personal and professional development is very important. Formal and informal training in line with his or her job requirements and job descriptions are recommended, which will ensure that patients receive quality nursing care.

The greatest barrier for continuous education is inadequate staffing numbers, especially for the mixed type hospitals where the nursing team consists of one registered nurse and two nurses. Staff cannot always participate in continuing education while on duty, because they have to do it on their resting days and the participants do not always find this acceptable.

The regulations for continuous professional development (CPD) in terms of the Nursing Act No. 33 (2005:32) will soon be promulgated. Implementation of this regulation will compel staff to continuously develop professionally. It is therefore recommended that the employer takes cognizance of this need and provides adequate support for the development of staff.

When staffing levels are adjusted the problem to set staff free for essential CPD will be met.

5.2.4.2 *Career development*

Career development at the institutions is currently very limited, because it is linked to available posts. It is recommended that staffs are given career guidance and support with their personal development. This will consequently promote opportunities for staff and for further growth in their nursing profession.

5.2.4.3 *Skills needed*

As already discussed, participants indicated that there are inadequate numbers of skilled staff in primary health care, theatre techniques, advance midwifery and trauma.

It is recommended that emphasis be placed on the development of individuals in these scarce skills.

5.2.5 ***Patient documentation (B19-31)***

The analysis according to table 4.15 shows that nursing documentation is not done appropriately, which could have legal implications. Documentation reveals evidence of the care that patients have received or not, especially when required in litigation. Reasons such as understaffing, too many activities and not enough time are unacceptable in a court of law. According to Verschoor *et al.* (1997:45) when it can be proved that treatment details were noted on the patient card at the time and that notes made on patient cards are usually accurate and complete, matters will be simplified considerably for nurses and their employers in court. It is every nurse's responsibility to see that his or her documentation is accurate, correct and complete at all times, because everybody is accountable for his/her own actions and omissions according to Regulation 387 of 15 February 1985 as promulgated through the Nursing Act No 50 of 1978.

Recommendations:

5.2.5.1 *Adjusting of staffing levels*

Understaffing is given as the reason why the above is not done or not properly done. It is a matter of urgency, that staffing levels are adjusted to enable the nursing staff to do their job as it is expected. The safety of patients is seriously compromised by inadequate staffing and furthermore the staff are subjected and made vulnerable to litigation.

5.2.5.2 *Continuous education in documentation*

Continuous education about the nursing process and documentation is imperative in order to enable the staff to enhance their knowledge in the assessment, planning, implementation,

evaluation and record keeping of patient care. These measures will ensure that a nursing care plan will be developed to suit the individual needs of every patient, consequently ensuring that every patient receives the personal care necessary for attaining the highest possible level of health care. Everything that a member of the nursing team does, observes and hears, affects the patient's treatment, negatively or positively. This must be documented to avoid duplication of actions and could also serve as evidence in court cases.

5.2.5.3 Auditing of patient documentation

Audits of patient documentation at least monthly are of critical importance. Audits are a reflection and measure of nursing care provided and is required to improve patient care and outcomes, by identifying and minimizing risks. It is very important to communicate the results of audits to the nursing staff. It can be of great value to obtain records that were part of litigation processes in court and discuss these with the staff as part of in-service training. The researcher recommends that the district office participates in developing a suitable audit tool that could be used in district hospitals.

5.2.6 Patient care (B32-41)

The analysis in table 4.16 shows that the mixed hospital types experience more difficulties in providing the required patient care, in comparison to those hospitals with separate departments and separate personnel.

Recommendations:

5.2.6.1 Improvement in support staff numbers

It is recommended that non-nursing duties be done by the specific support staff and not by nurses. The current shortage of staff is aggravated by nurses having to perform tasks of porters, clerks, domestics and so forth resulting in valuable patient care time being lost to non-nursing duties. Staff appointments have to be made in terms of the necessary household aids, porters, case managers, admission clerks, operators for the sterilizing units and telephone operators for after hour services.

5.2.6.2 Health and Safety Committees

It is recommended that health and safety committees, according to the Occupational Health and Safety Act 85 of 1993, be more active in the hospitals. The relevant health and safety inspections should be carried out regularly and management should be provided with written reports of the necessary recommendations.

It is further recommended that security staff should be appointed at each institution.

5.2.6.3 *Quality Assurance Committees*

Quality assurance committees, with the participation of the facility board members can play a major role in ensuring that patients receive a high quality service. These committees can provide valuable inputs as demonstrated in the paragraphs described below:

- It is recommended that maternity, casualties and outpatients be separate departments and not be included as part of a general ward.
- Paediatric patients to be separated from casualties and maternity patients.
- The privacy of patients should be ensured by having the necessary consultation rooms where patients can be treated in private.
- Fixed oxygen and suction points should replace mobile oxygen and suction machines.
- Appointment of a community service doctor or two, to support the nursing staff and part time medical doctors on site.
- The current outreach specialist services could assist the part time doctors with the necessary protocols, training and support.
- Training in midwifery and neonatology is essential for nursing staff to promote more effective and efficient care to patients.
- The provision of a cardiotocograph machine to institutions without one, to improve monitoring and evaluation of intra-partum patients.
- Specific personnel should be allocated to the various disciplines such as for midwifery and neonatology patients; including general patients and casualty/outpatients.
- Facilities have to be provided for parents who have to stay with their children.
- The researcher recommends that staff “on call” deal with after hour theatre cases.
- Nursing managers have to see that all staff members are in possession of identification tags to improve a transparent service.

5.2.7 *Nursing staff (B42-45):*

The analysis in table 4.17 shows that participants working in the mixed type hospitals have to work beyond their scope of practice more intensely.

Understaffing and too many activities are the main reasons why staffs have to work beyond their scope of practice. Participants commented that it is an aggravating situation where there is no doctor on site – this gives rise to all staff working beyond their scope of practice such as the registered nurse who has to perform some of the duties of the doctor, the enrolled nurse has to perform the duties of the registered nurse and the nursing assistant has to perform the duties of the registered nurse or staff nurse.

Participants reported in the separate ward type hospitals that despite the presence of a full time doctor, staffing is still inadequate as this doctor has to cover other departments, for example clinics and outpatients, consequently nursing staff still have to work beyond their scope of practice which places the nurses at risk to liability.

Recommendations:

5.2.7.1 Correct skills mix

The skills mix should be corrected to allow every category to act within his/her scope of practice. Adjustments to the nursing staff numbers and skills according to the activities in the department are recommended. The appointment of community service doctors in the institutions where they are still lacking is recommended, and the appointment of full time medical superintendents with the necessary clinical skills will improve the situation and will prevent nursing staff from working beyond their scope of practice.

It is recommended that staff be enabled to gain the necessary qualifications and skills to render the services according to the needs of the patients, in particular referring to primary health care, advanced midwifery and trauma.

5.2.8 Equipment and consumables (B46-49)

Figure 4.18 show that both types of hospitals (mixed and separate wards) experience problems with equipment and consumables in terms of adequacy, its operating ability and the regular maintenance of equipment.

Recommendations:

5.2.8.1 Adequate stock levels

The cost of replacements and repairs of equipment could be minimized through the training of nursing staff by the company from which the equipment is bought. Negotiated service contracts with suppliers of expensive equipment will be of great value. "Stock outs" have to be prevented with the estimation of adequate stock levels in the stores and wards.

The correct estimation of equipment is needed according to the type and amount of patients, so that the necessary equipment is available and in a working condition.

5.2.8.2 Maintenance of equipment

The handyman at each institution has to receive the necessary training in maintenance and the repairing of equipment. Introduction of a decentralized workshop according to the various

regions should be introduced for example in Malmesbury. This would be of great value, resulting in equipment being repaired in the region of Malmesbury and completed in a shorter time.

Unit managers have to promote the correct utilization and maintenance of equipment and consumables. Supervisors have to assure that equipment is always cleaned and safely stored after usage. Staffs have to be made aware of the costs of the items that they use to prevent misuse, overstocking and theft of supplies.

Keeping equipment in good working condition is the responsibility of each member of staff. Staff should therefore be trained in the use, maintenance, cleaning and storage of equipment. It will be of value to regularly write reports about the condition of equipment in the unit. In accordance with this report equipment can be either replaced or repaired.

All broken equipment should be sent for repairs and not be kept in the unit as this could result in equipment being out of order in an emergency situation;

A special record has to be kept for equipment sent for repairs. The name and the code of the equipment have to be recorded, as well as the date it was sent and to whom it was sent. The necessary control and follow up has to be done monthly to ensure that broken equipment is replaced at each hospital.

5.2.9 Working conditions (B50-56)

The analysis in chapter 4 indicated that participants felt that it is not always possible to have tea breaks and lunches, that it is necessary to work overtime, that remuneration for overtime is not always adequate, that staff are not always able to work within ethical and legal frameworks, that relaxation facilities for staff are not always adequate, and that nurses are not always able to schedule and take leave according to their needs.

Recommendations:

5.2.9.1 Rest periods for staff

The district office has to ensure that staffing levels are adequate and safe according to the activities at a hospital. It is necessary that staff have to take tea and lunch breaks on time. According to The Basic Conditions of Employment Act, No.75 (Republic of South Africa, 1997:16) it is expected of an employer to give an employee who works continuously for more than five hours, a meal interval of at least one continuous hour.

5.2.9.2 Limitation of overtime

The Basic Conditions of Employment Act (Republic of South Africa, 1997:14) is very clear about overtime, it states that an employer may not require or permit an employee to work overtime except in accordance with an agreement. Further more, it is important that employers have to stay within the boundaries of three hours' overtime a day, or ten hours overtime a week.

Overtime has to be limited – “burnout” is a reality, because nursing is a career with high demands, therefore it is essential that staff relax on their resting days. The resulting fatigue, increased stress levels, and reduced time spent with their families and communities may all have negative effects on the quality of their working environment and on their perceived job satisfaction. Overtime payment has to be arranged with staff beforehand, so that they are sure of the pay rates, the maximum and minimum hours and when they would receive their money. The Basic Conditions of Employment Act No. 75 (Republic of South Africa, 1997:14) is clear about how overtime should to be remunerated – at least one and one-half times the employee's wages for overtime worked.

5.2.9.3 Function with an ethical and legal framework

When staff levels are adjusted to the correct norms according to the activities, it should not be necessary for the nurses to work beyond their scope of practice in the various nursing categories. When there is an unethical event, staff must be encouraged to communicate it to their supervisors so that they could be excluded from the activity.

5.2.9.4 Relaxation facilities

Relaxation facilities need urgent attention - supervisors have to see that the realistic needs, expectations and desires of staff are met.

5.2.9.5 Needs of staff

When staffing levels are adjusted, it will be possible for supervisors to accommodate the needs of staff and then it would be possible to take leave as scheduled.

Unit managers could facilitate a better quality of work-life in the ward by promoting positive communication, building team-spirit, promoting participative management in the ward and effectively managing conflict.

5.2.10 Shifts (B57-58)

The analysis in table 4.20 shows that the participants in both types of hospitals (separate and mixed wards) indicated that they are not able to leave the hospital on time at the end of shifts, and when rosters are planned, their requests and needs are not taken into account.

Recommendations:

5.2.10.1 Handover of shifts

Services have to be delivered in a hospital for 24-hours, seven days a week. Staffs have to discipline themselves to set time aside and keep to the time for handover, for example from 06H45 to 07H15 and from 18H45 to 19H15. Unfinished tasks have to be carried over to the next shift.

5.2.10.2 Operational needs

Scheduling of shifts has to be done according to the needs of the patients in the unit and consideration must be given to predictable peak times. It is very important that a balance has to be maintained between the needs of the employer for predictable and adequate staffing, and the needs of the employee for personal and job satisfaction.

As far as requests and needs for the duty rosters are concerned, everybody is aware that operational needs are a priority. When the staff levels are adjusted to the correct norms, the needs and requests of staff members could be dealt with more effectively. Staff must be able to negotiate with each other when it is not possible to accommodate their requests according to the duty roster.

It would be of great help if duty rosters are displayed in advance so that staff members are able to plan their extra-mural activities.

5.2.10.3 Participative decision-making

It is advisable to apply the principle of participative or interactive decision-making and problem -solving so that every member has a say in the method of shift scheduling and accept ownership for it.

5.2.11 Doctors (B59-65)

The analysis in table 4.21 shows that both types of hospitals experience the effect of inadequate service by doctors. Despite the fact that Vredenburg, Malmesbury and Stellenbosch hospitals have full time doctors, their responsibilities include working in the clinics and in outpatients and they are therefore not always available. From table 4.21 it is

clear that the staff experience a more inadequate service in the mixed wards type hospitals where there are part time medical superintendents and doctors.

The analysis shows that participants could not always cope with the medical, trauma and maternity emergencies. In cases of emergency it is not always possible for the doctors to be in the department immediately.

The inadequate number of doctors results in patients experiencing long waiting hours before being evaluated and treated by a doctor.

Recommendations:

5.2.11.1 Full time doctors

The appointment of full time medical superintendents with clinical functions can improve the service delivery during the week (during office hours). Furthermore, the appointment of a full time doctor and (a) community service doctor(s), will improve service delivery.

5.2.11.2 Advance qualifications

When adequate numbers of staff are trained in primary healthcare, advanced midwifery and trauma, nursing staff will be able to cope better with emergencies and patients.

5.2.11.3 Presence of doctors during peak times

During the busy times, on Friday, Saturday and Sunday nights, it will be of great value for the doctor on call to be in the hospital. The presence of doctors will contribute to patients' satisfaction and improve service delivery and will enable the nursing staff to render patient care in stead of being a mini-doctor.

5.2.12 Batho Pele Principles (B66-74)

The analysis in chapter 4 (table 4.22) indicated that participants experience deficiencies regarding the implementation of Batho Pele principles. Table 4.20 shows that Batho Pele principles are not always adhered to.

Recommendation:

5.2.12.1 Implementation of the Batho Pele principles

Posters about the principles of Batho Pele have to be visible in all departments in the hospital. Each hospital has to compile an information pamphlet in the three official languages of the Western Cape Province about the services at the particular hospital. Regular talks on the local radio, reports in the local newspaper, meetings of the facility boards and open days

will keep the community informed about the happenings and future planning of the hospital. The facility board members have to be present in the hospital on a regular basis, so that they know what is happening and what the working conditions and needs of the staff are.

5.3 CONCLUSION

An in depth study was undertaken to identify the factors influencing the quality of nursing care in the district hospitals of the West Coast Winelands Region of the Western Cape.

This study has identified the various modifiable factors influencing the quality of nursing care in these hospitals. When these factors are addressed, there will be a remarkable positive change in the quality of service delivery.

A healthy nation not only requires that the emphasis is placed on urban areas but more so the rural areas, due to the scarcity of resources.

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ANNEXURES

ANNEXURE A: CONSENT FORM

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: An investigation into factors influencing the quality of nursing care in district hospitals in the West Coast Winelands Region of the Western Cape.

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR: Mrs. J.E Eygelaar

ADDRESS: 44 Central Street
Vredendal
8160

CONTACT NUMBER: 0836301376

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask Mrs JE Eygelaar any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Committee for Human Research at the University of Stellenbosch** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

- *Where will the study be conducted; are there other sites; total number of participants to be recruited at your site and altogether.*
- ***The study will be done at all the District Hospitals of the West Coast Winelands Region; the pilot study will be done at Citrusdal en Porterville Hospital.***
- *Explain in participant friendly language what your project aims to do and why you are doing it?*
- ***Nursing personnel are increasing complaining that they can't manage the workload. The researcher wants to investigate the factors influencing the workload of nursing staff to establish a plan of action which would enable nursing staff to handle the workload and to assure patients of quality nursing care.***
- *Explain all procedures.*
- ***A questionnaire is compiled to determine the factors influencing the quality of nursing care. The questionnaire is divided into a biographical section and the second part is based on a Likert scale. The Likert scale section has questions with 4 options to choose from, namely "strongly disagree, disagree, agree and strongly agree". Numerical values of 1, 2, 3 and 4 will be awarded. The researcher will hand out this questionnaire to each member of the nursing staff working in these hospitals. Space is available after each question to give comments.***
- *Explain any randomization process that may occur.*

- *The population for the purpose of this study will be all of the nursing staff working in these hospitals in this region of the Western Cape. The size of the sample will be 367 members.*
- *Explain the use of any medication, if applicable.*
- *Not applicable – nursing personnel will be used as subjects.*

Why have you been invited to participate?

- *You're working in the hospitals where the research is undertaken. You experience the working conditions and workload which influence the output to the patients.*

What will your responsibilities be?

- *The researcher will hand out a structured questionnaire to complete – she will ask biographical questions and a second part with questions related to the working conditions that you have to rate with numerical values of 1, 2, 3 or 4. You have opportunity to comment on each question.*

Will you benefit from taking part in this research?

- *Explain all benefits objectively. If there are no personal benefits then indicate who is likely to benefit from this research e.g. future patients.*

Deficiencies in nursing practises will be identified to establish a plan of action which would enable nursing staff to manage the workload and to assure patients of quality nursing care.

Are there in risks involved in your taking part in this research?

- *Identify any risks objectively.*

No risks are foreseen.

If you do not agree to take part, what alternatives do you have?

- *Clearly indicate in broad terms what alternative treatment is available and where it can be accessed, if applicable.*

You have the right to withdraw without any disadvantage.

Who will have access to your medical records?

- *Information collected will be treated as confidential and protected. If it is used in a publication or thesis, the identity of the participant will remain anonymous. Only the researcher team will have access to the information.*

What will happen in the unlikely event of some form injury occurring as a direct result of your taking part in this research study?

Not applicable

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

Is there any thing else that you should know or do?

- You can contact *Dr E. Stellenberg* at telephone number *021 938 9244* if you have any further queries or encounter any problems.
- You can contact the *Committee for Human Research* at *021-938 9207* if you have any concerns or complaints that have not been adequately addressed by your study doctor.
- You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I agree to take part in a research study entitled *(insert title of study)*.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at *(place)* on *(date)* 2008.

.....
Signature of participant

.....
Signature of witness

Declaration by investigator

I **Mrs JE EYGELAAR** declare that:

- I explained the information in this document to

- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. *(If a interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) On (*date*) 2008.

.....
Signature of investigator

.....
Signature of witness

Declaration by interpreter

I (*name*) declare that:

- I assisted the investigator (*name*) to explain the information in this document to (*name of participant*) Using the language medium of Afrikaans/English.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) On (*date*) 2008.

.....
Signature of interpreter

.....
Signature of witness

ANNEXURE B: QUESTIONNAIRE/VRAELYS

DATA COLLECTION FORM

Section A: Biographical Data

For office use: _____

1. Gender:

<input type="checkbox"/>	Male	<input type="checkbox"/>	Female
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2. Age (in years):

<input type="checkbox"/>	> 20 - ≤ 30	<input type="checkbox"/>	>30 - ≤40	<input type="checkbox"/>	> 40 - ≤50	<input type="checkbox"/>	> 50 - ≤ 60	<input type="checkbox"/>	> 60 - ≤ 65	<input type="checkbox"/>	> 65
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3. Categories of staff:

<input type="checkbox"/>	Management	<input type="checkbox"/>	Chief Professional Nurse	<input type="checkbox"/>	Senior Professional Nurse
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<input type="checkbox"/>	Professional Nurse	<input type="checkbox"/>	Enrolled Nurse	<input type="checkbox"/>	Enrolled Nurse Assistant
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4. Qualifications:

<input type="checkbox"/>	General	<input type="checkbox"/>	Midwifery	<input type="checkbox"/>	Psychiatry
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<input type="checkbox"/>	Community Health	<input type="checkbox"/>	Primary Health Care	<input type="checkbox"/>	Any other qualification for example Advanced Midwifery, Administration or Education.
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<input type="checkbox"/>	Staff Nurse	<input type="checkbox"/>	Enrolled Nurse Assistant
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5. Total number of years working at this institution:

<input type="checkbox"/>	< 5 years	<input type="checkbox"/>	≥5 years < 10 years	<input type="checkbox"/>	≥ 10 years
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6. Identify the department that you are currently working in, and the duration of your employment (in months).

	< 6	≥ 6 – < 12	≥12 – < 18	≥ 18 – < 24	≥ 24
Paediatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Casualty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out Patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theatre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
"Mixed departments" for example: Male, Female or/and Paediatrics combined with Maternity, Casualty or Out Patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Hospital type:

<input type="checkbox"/>	Separate departments	<input type="checkbox"/>	Mixed departments.
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Section B: Factors Influencing Nursing Care				
	Strongly Disagree	Disagree	Agree	Strongly Agree
	①	②	③	④
<u>Staff provision (nursing):</u>				
1. Provision of staff are adequate (in numbers) for all activities.				
2. Provision of staff are adequate, (in terms of skills) for each department in the hospital.				
3. Provision of staff are adequate for the day shift during the week.				
4. Provision of staff are adequate during the night.				
5. Provision of staff are adequate during weekends as well as on Public Holidays.				
Comment:				
<u>Management of wards/Departments:</u>				
6. All duties delegated to subordinates are adequately supervised.				
7. Unit Managers are always available in the hospital.				
8. Unit Managers act as managers and are not part of the production team.				
Comment:				
<u>Job satisfaction:</u>				
9. Nursing staff experience job satisfaction in their current work situation.				
10. Staff are satisfied with the method of staff evaluation (SPMS).				
11. Good performance by staff members is acknowledged.				
12. The workload is such that frustration is reduced and time is available to build up sound nurse-patient relationships.				
13. Working conditions are such that high standards are maintained.				
14. Salaries (Occupation Specific Dispensation) will recruit and maintain personnel.				
15. All nursing staff working in the rural areas receives a rural allowance.				
Comment:				

	Strongly Disagree	Disagree	Agree	Strongly Agree
	①	②	③	④
<u>Professional Development:</u> 16. Staff are enabled to advance professionally by receiving continuing education.				
17. Staff have adequate opportunities for career development.				
18. An adequate number of staff members are qualified to cope in all the departments, for example in Primary Health Care or in the Theatre.				
Comment:				
<u>Patient documentation:</u> 19. There is adequate time for a complete written record of a patient's treatment at the time the treatment is given.				
20. Notes on patients' cards are accurate and complete.				
21. Doctors' rounds and orders are always documented.				
22. On admission each patient is assessed to identify all problems.				
23. A check list is set up for each patient to cater for his/her basic needs.				
24. Nursing care diagnoses are always made.				
25. The nursing care plan is always prepared by the Registered Nurse based on the problems identified during the assessment.				
26. The nursing care plan is always implemented by the Registered Nurse.				
27. Nursing care plans are not updated continuously by the Registered Nurse.				
28. The nursing care plan is always evaluated by the Registered Nurse.				
29. Discharge criteria are not always set.				
30. Provision is made for rehabilitation of patients.				
31. Documentation audits are not done continuously.				
Comment:				
<u>Patient care:</u> 32. Patients always receive nursing care as required.				

	Strongly Disagree	Disagree	Agree	Strongly Agree
	①	②	③	④
33. Patients are nursed in a healthy and safe environment.				
34. Emergency care is always available to patients.				
35. Neonatal patients receive care as required.				
36. Patients in labour receive care as required				
37. Debilitated patients receive care as required..				
38. Paediatric patients receive care as required.				
39. Care for patients during death and dying is as required.				
40. Pre- and post-operative care of surgical patients is as required.				
41. Patients are treated by an identified health worker.				
Comment:				
<u>Nursing staff:</u>				
42. It is not necessary for nurses to act beyond their scope of practice.				
43. It is not expected of the Registered Nurse to assess, diagnose and prescribe treatment to patients without the prescribed qualification of Primary Health Care.				
44. The primary responsibility of the staff nurse is to provide basic nursing care and treatment to patients with stable and uncomplicated health conditions in all settings.				
45. The responsibility of the Auxiliary nurse is to provide assistance and support to patients for the activities of daily living and self-care (elementary nursing).				
Comment:				
<u>Equipment and consumables:</u>				
46. Equipment and consumables are always adequate.				
47. Equipment is always in a working condition.				
48. Maintenance of equipment is done on a regular basis.				
49. Adequate consumables are available to ensure that cross infection measures are always strictly maintained.				
Comment:				

	Strongly Disagree	Disagree	Agree	Strongly Agree
	①	②	③	④
<u>Working conditions:</u> 50. Staff are able to have tea breaks and lunches.				
51. It is not necessary to work overtime.				
52. Remuneration is adequate when working overtime is necessary.				
53. Nursing staff are always able to work within the ethical and legal framework.				
54. Relaxation facilities for staff are adequate, for example an adequate tea/rest room.				
55. Nurses are able to schedule their leave according to their needs.				
56. Nurses are able to take their leave as scheduled.				
Comment:				
<u>Shifts:</u> 57. At the end of shifts, personnel are able to leave the hospital on time.				
58. When rosters are planned, requests and needs of staff are taken into account.				
Comment:				
<u>Doctors:</u> 59. Medical Officers are available in the hospital full time.				
60. Staff are always able to cope with medical emergencies due to the availability of doctors.				
61. Staff are always able to cope with trauma emergencies due to the availability of doctors.				
62. Staff are able to cope with maternity emergencies due to the availability of doctors.				
63. In cases of emergency, doctors are immediately available in the department.				
64. Patients do not have to wait for a long time to be evaluated by a doctor.				
65. Patients do not have to wait for a long time for treatment by a doctor.				
Comment:				
<u>Batho Pele:</u> 66. Patients are consulted about the level and quality of service they receive.				
67. Wherever possible, patients are given a choice about the services on offer.				

	Strongly Disagree	Disagree	Agree	Strongly Agree
	①	②	③	④
68. Patients are told what level and quality of service they will receive so that they are aware of what to expect.				
69. All patients have equal access to all the services they are entitled to receive.				
70. Patients are treated with courtesy and consideration.				
71. Patients are given full, accurate information about the services they are entitled to receive.				
72. Patients are told how the institution is run, how much the services cost and who is in charge.				
73. When complaints are made patients receive a sympathetic, positive response.				
74. Services are provided economically and efficiently in order to give patients the best possible value for money.				
Comments:				

INLIGTINGSVORM

AFDELING A: PERSOONLIKE INLIGTING

Vir Kantoorgebruik: _____

1. Geslag:

<input type="checkbox"/>	Manlik	<input type="checkbox"/>	Vroulik
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2. Ouderdom (in jare):

<input type="checkbox"/>	> 20 - ≤ 30	<input type="checkbox"/>	>30 - ≤40	<input type="checkbox"/>	> 40 - ≤50	<input type="checkbox"/>	> 50 - ≤ 60	<input type="checkbox"/>	> 60 - ≤ 65	<input type="checkbox"/>	> 65
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3. Personeelkategorie:

<input type="checkbox"/>	Bestuur	<input type="checkbox"/>	Hoof Professionele Verpleegster	<input type="checkbox"/>	Senior Professionele Verpleegster
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<input type="checkbox"/>	Professionele Verpleegster	<input type="checkbox"/>	Ingeskrewe Verpleegster	<input type="checkbox"/>	Ingeskrewe Verpleegassistent
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4. Kwalifikasies:

<input type="checkbox"/>	Algemeen	<input type="checkbox"/>	Verloskunde	<input type="checkbox"/>	Psigiatrie
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<input type="checkbox"/>	Gemeenskapsgesondheid	<input type="checkbox"/>	Primêre Gesondheidsorg	<input type="checkbox"/>	Enige ander kwalifikasie, bv <i>Gevorderde Verloskunde, Administrasie of Opvoeding.</i>
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<input type="checkbox"/>	Stafverpleegster	<input type="checkbox"/>	Ingeskrewe Verpleegassistent
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5. Totale aantal jare werksaam by hierdie instansie:

<input type="checkbox"/>	< 5 jaar	<input type="checkbox"/>	≥5 jaar < 10 jaar	<input type="checkbox"/>	≥ 10 jaar
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6. Dui die afdeling aan waar u tans werksaam is, asook die aantal jare diens (in maande).

	< 6	≥ 6 – < 12	≥12 – < 18	≥ 18 – < 24	≥ 24
Pediatrie					
Kraam					
Noodgevalle					
Buitepasiënte					
Teater					
Gekombineerde Sale bv: Mans, Vroue en/of Pediatres gekombineerd met Kraam, Noodgevalle of Buitepasiënte					

7. Hospitaal tipe:

<input type="checkbox"/>	Aparte departemente	<input type="checkbox"/>	Gekombineerde departemente
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AFDELING B: Faktore wat 'n invloed uitoefen op Verpleegsorg				
	Verskil Beslis	Verskil	Stem saam	Stem beslis saam
	①	②	③	④
<u>Personeelvoorsiening (verpleging):</u>				
1. Personeelvoorsiening vir alle aktiwiteite is voldoende (in getalle).				
2. Personeelvoorsiening vir elke departement in die hospitaal is voldoende (ten opsigte van vaardighede).				
3. Personeelvoorsiening vir dagskotte is voldoende gedurende die week.				
4. Personeelvoorsiening is voldoende gedurende nagskotte.				
5. Personeelvoorsiening oor naweke en Openbare Vakansiedae is voldoende.				
Opmerkings:				
<u>Bestuur van Sale of Afdelings:</u>				
6. Alle pligte aan ondergeskikte personeel gegee, word voortdurend gemonitor.				
7. Eenheidsbestuurders is altyd in die hospitaal beskikbaar.				
8. Eenheidsbestuurders tree as bestuurders op en is nie deel van die produksiespan nie.				
Opmerkings:				
<u>Werksbevrediging:</u>				
9. Verpleegpersoneel ondervind werksbevrediging in hulle huidige werksituasie.				
10. Personeel is tevrede met die manier waarop personeel geëvalueer word (SPMS).				
11. Personeel kry erkenning vir goeie werk.				
12. Die werkslading verminder frustrasie en daar is genoeg tyd om goeie verhoudings tussen verpleegsters en pasiënte op te bou.				
13. Werksomstandighede is van so 'n aard dat hoë standaarde gehandhaaf kan word.				
14. Salarisse (Beroepspesifieke Vergoeding) lok en behou personeel.				
15. Alle verpleegsters op die platteland kry 'n plattelandse toelaag.				
Opmerkings:				

	Verskil Beslis	Verskil	Stem saam	Stem beslis saam
	①	②	③	④
<u>Professionele Ontwikkeling:</u> 16. Personeel kan professioneel ontwikkel as gevolg van deurlopende onderrig.				
17. Personeel het genoeg geleentheid vir beroepsontwikkeling.				
18. Daar is genoeg gekwalifiseerde personeellede om in alle departemente te werk: bv Primêre Gesondheidsorg of in die Teater.				
Opmerkings:				
<u>Pasiënt dokumentasie:</u> 19. Daar is genoeg tyd om 'n volledige verslag van 'n pasiënt se behandeling te skryf wanneer behandeling gegee word.				
20. Aantekeninge op pasiënte se kaarte is akkuraat en volledig.				
21. Dokters se rondtes en –bevele word altyd gedokumenteer.				
22. Elke pasiënt word tydens Toelating geassesseer om alle probleme te identifiseer.				
23. 'n Kontrolelys is saamgestel om aan elke pasiënt se basiese behoeftes te voldoen.				
24. Diagnoses tov verpleegsorg word altyd gemaak.				
25. Die verpleegsorgplan word altyd deur die Geregistreerde Verpleegster voorberei en is gebaseer op die probleme wat tydens assessering geïdentifiseer is.				
26. Die verpleegsorgplan word altyd deur die Geregistreerde Verpleegster in werking gestel.				
27. Die Geregistreerde Verpleegster dateer nie die verpleegsorgplanne voortdurend op nie.				
28. Die Geregistreerde Verpleegster evalueer altyd die verpleegsorgplan.				
29. Kriteria vir ontslag word nie altyd gespesifiseer nie.				
30. Daar word voorsiening gemaak vir die rehabilitering van pasiënte.				
31. Dokumentasie oudits vind nie altyd plaas nie.				
Opmerkings:				
<u>Pasiëntesorg:</u> 32. Pasiënte ontvang altyd verpleegsorg waar nodig.				

	Verskil Beslis	Verskil	Stem saam	Stem beslis saam
	①	②	③	④
33. Pasiënte word in 'n gesonde en veilige omgewing versorg.				
34. Nooddienste is altyd tot pasiënte se beskikking.				
35. Neonatale pasiënte ontvang sorg soos benodig.				
36. Pasiënte in kraam ontvang sorg soos benodig.				
37. Verswakte pasiënte ontvang sorg soos benodig..				
38. Pediatryse pasiënte ontvang sorg soos benodig.				
39. Pasiënte ontvang sorg voor en gedurende sterfte soos benodig.				
40. Pre- en post-operatiewe sorg word waar nodig aan chirurgiese pasiënte verleen.				
41. Pasiënte word deur 'n geïdentifiseerde gesondheidswerker behandel.				
Opmerkings:				
<u>Verpleegpersoneel</u>				
42. Verpleegsters hoef nie buite hulle opleidingsveld te werk nie.				
43. Die Geregistreerde Verpleegster hoef nie te assesser, diagnoseer of behandeling aan pasiënte voor te skryf sonder die voorgeskrewe Primêre Gesondheidsorg-kwalifikasie nie.				
44. Die primêre verantwoordelikheid van die stafverpleegster is om onder alle omstandighede basiese verpleegsorg en behandeling aan pasiënte met stabiele en ongekompliseerde gesondheidstoestande te verleen.				
45. Die verantwoordelikheid van die verpleeg-assistent is om hulp en ondersteuning aan pasiënte te verleen ten opsigte van daaglikse aktiwiteite en selfsorg (basiese verpleging).				
Opmerkings:				
<u>Toerusting en Verbruiksgoedere:</u>				
46. Daar is altyd genoeg toerusting en verbruiksgoedere beskikbaar.				
47. Toerusting is altyd in 'n werkende toestand.				
48. Onderhoud van toerusting vind op 'n gereelde basis plaas.				
49. Daar is genoegsame verbruikersgoedere beskikbaar om te verseker dat kruis-infeksie beheermaatreëls ten alle tye streng nagekom word.				
Opmerkings:				

	Verskil Beslis	Verskil	Stem saam	Stem beslis saam
	①	②	③	④
<u>Werkstoestande:</u>				
50. Daar word voorsiening vir tee-pouses en etenstye vir personeel gemaak.				
51. Dit is nie nodig om oortyd te werk nie.				
52. Wanneer dit nodig is om oortyd te werk, is die vergoeding toereikend.				
53. Dit is vir die verpleegpersoneel moontlik om altyd binne die etiese en wetlike raamwerk te werk.				
54. Ontspanningsfasiliteite vir die personeel, bv 'n tee-/ruskamer is voldoende.				
55. Verpleegsters kan verlof skeduleer na gelang van hul behoeftes.				
56. Verpleegsters kan verlof neem soos geskeduleer.				
Opmerkings:				
<u>Skofte:</u>				
57. Aan die einde van skofte kan personeel die hospitaal op die regte tyd verlaat.				
58. Personeel se versoeke en behoeftes word in ag geneem wanneer werkroosters beplan word.				
Opmerkings:				
<u>Dokters:</u>				
59. Daar is voltyds dokters in die hospitaal beskikbaar.				
60. Personeel kan al die mediese noodgevalle hanteer as gevolg van die beskikbaarheid van dokters.				
61. Personeel kan al die trauma noodgevalle hanteer agv die beskikbaarheid van dokters.				
62. Personeel kan al die kraam noodgevalle hanteer agv die beskikbaarheid van dokters.				
63. In noodgevalle is dokters altyd en onmiddellik in die afdeling beskikbaar.				
64. Pasiënte hoef nie lank te wag om deur 'n dokter geëvalueer te word nie.				
65. Pasiënte hoef nie lank te wag om deur 'n dokter behandel te word nie.				
Opmerkings:				

	Verskil Beslis	Verskil	Stem saam	Stem beslis saam
	①	②	③	④
<u>Batho Pele:</u>				
66. Pasiënte word ingelig oor die vlak en kwaliteit diens wat hulle ontvang.				
67. Waar moontlik het pasiënte 'n keuse tov dienste wat beskikbaar is.				
68. Pasiënte word ingelig oor die vlak en kwaliteit diens wat hulle gaan ontvang sodat hulle weet wat om te verwag.				
69. Alle pasiënte het gelyke toegang tot alle dienste waarop hulle geregtig is.				
70. Pasiënte word met respek en konsiderasie behandel.				
71. Pasiënte ontvang volledige en akkurate inligting oor die dienste waarop hulle geregtig is.				
72. Pasiënte word ingelig hoe die instansie bestuur word, hoeveel die dienste kos en wie in beheer is.				
73. Wanneer klagtes ontvang word, word dit simpatiek en positief hanteer.				
74. Dienste word ekonomies en doelgerig gelewer sodat pasiënte die beste moontlike waarde vir geld kan kry.				
Kommentaar:				

**ANNEXURE C: PERMISSION FROM THE WESTERN CAPE DEPARTMENT OF
HEALTH**



Verwysing
Reference
Isalathiso

19/18/RP52/2008

Navrae
Enquiries
Imibuzo

Dr T. Naledi

Telefoon
Telephona
ifowuni

021 483 9901



**Departement van Gesondheid
Department of Health
iSaka IsakMila**

Mrs E. Eygelaar
PO Box 619
Vredendal Hospital
8160

Fax to 027 2132741

Dear Mrs Eygelaar

An Investigation into factors influencing the quality of nursing care in district hospitals in the West Coast Winelands Region of the Western Cape

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following members of staff to assist you with access to the facilities:

- 1) Ms L. Phillips at lphillips@pgwc.gov.za tel: 023 3841301 (Cape Winelands)
- 2) Ms C. Bester at cwbester@pgwc.gov.za tel: 022 4879306 (West Coast)
- 3) Mr T. Mabuda at tmabuda@pgwc.gov.za tel: 021 483 8453 (D: Nursing Services)

We look forward to hearing from you.

Yours sincerely


DR J CUPIDO

DEPUTY-DIRECTOR GENERAL
DISTRICT HEALTH SERVICES AND PROGRAMMES

DATE: 24/06/2018

CC: MR T. MABUDA

D: NURSING SERVICES

Dorpstraat 4
Posbus 2060
KAAPSTAD
8000

4 Dorp Street
PO Box 2060
CAPE TOWN
8000

**ANNEXURE D: PERMISSION FROM THE WEST COAST WINELANDS
REGIONAL DIRECTOR**

Me E Eygelaar, hiermee word toestemming verleen dat u kan voortgaan met u Navorsing studie soos versoek, by genoemde Instansies.

U kan direk met die betrokke personeel skakel.

Sterkte

Carine bester

>>> "Elsa Eygelaar" <elsaeygelaar@telkomsa.net> 2008/07/01 10:23:19 AM >>>

Me CW Bester

Sien aangeheg skrywe m.b.t. toestemming vir Navorsing in u Streek.

Ek verneem graag.

Vriendelike Groete.

Elsa Eygelaar

(elsaeygelaar@telkomsa.net)

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**ANNEXURE E: PERMISSION FROM THE COMMITTEE FOR HUMAN RESEARCH
OF STELLENBOSCH UNIVERSITY**



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6 June 2008

Ms JE Eygelaar
Department of Nursing

Dear Ms Eygelaar

RESEARCH PROJECT: "An investigation into factors influencing the quality of nursing care in district hospitals in the West Coast Winelands Region of the Western Cape."

PROJECT NUMBER : N08/05/129

It is my pleasure to inform you that the abovementioned project has been provisionally approved on 5 June 2008 **for a period of one year from this date**. You may start with the project, but this approval will however be submitted at the next meeting of the Committee for Human Research for ratification, after which we will contact you again.

Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary to make their final decision.

Please note that a progress report (obtainable on the website of our Division) should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.

I wish to remind you that patients participating in a research project at Tygerberg Hospital will not receive their treatment free, as the PGWC does not support research financially. The nursing staff of Tygerberg Hospital can also not provide extensive nursing aid for research projects, due to the heavy workload that is already being placed upon them. In such instances a researcher might be expected to make use of private nurses instead.



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Fakulteit Gesondheidswetenskappe • Faculty of Health Sciences



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Afdeling Navorsingsontwikkeling en -steun • Research Development and Support Division

Posbus/PO Box 19063 • Tygerberg 7505 • Suid-Afrika/South Africa

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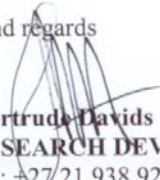
E-pos/E-mail: rdsinfo@sun.ac.za



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Please quote the abovementioned project number in all future correspondence.

Kind regards


Mertrude Davids

RESEARCH DEVELOPMENT AND SUPPORT (TYGERBERG)

Tel: +27 21 938 9207 / E-mail: mertrude@sun.ac.za

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