THE PERCEPTIONS OF CLINICAL NURSE PRACTITIONERS ON SERVICE DELIVERY IN PRIMARY HEALTH CARE FACILITIES IN EDEN DISTRICT, WESTERN CAPE

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DECLARATION

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ABSTRACT

Background

South Africa is facing many challenges in the process of changing the health care system to satisfy society as well as meeting international requirements. Programs were gradually expanded at Primary Health Care (PHC) level, in order to improve the quality of service delivery and patient access to care. Since the implementation of decentralized and integrated models of care, patients were redirected to clinics closer to their residence. Clinical Nurse Practitioners (CNPs) are directly involved in providing care in the expanded programs on a PHC level, since they have authorization under the Nursing Act (No. 33 of 2005) to prescribe drugs. The aim of the study is to explore the perceptions of CNPs regarding factors that influence service delivery in expanded programs in PHC facilities, specifically in the Eden District in the Western Cape.

Methods

A qualitative approach with a descriptive design was utilized to explore and describe the perceptions of CNPs regarding service delivery in expanded programs. The study applied purposive sampling to select participants from four clinics in George sub-district, Western Cape. Permission was obtained from the Health Research Ethics Committee of Stellenbosch University and the Department of Health, Western Cape. Nine semi-structured interviews were conducted, transcribed and analyzed using the five stages described by Denscombe. Sub-themes emerged from six major themes.

Results

The themes that emerged included: expansions in duties/roles, impact of extended duties and the challenges to comply with the changes. Factors that influenced participants' perception of the services rendered at PHC facilities include, for example, the increased workload and the shortage of staff to cope with the constant changes.

Conclusion

The factors that affect service delivery in a PHC setting are interrelated and have an impact on quality of care.

Recommendations were made to contribute positively to the morale of staff and the provision of quality service delivery. Opportunities for further research are recommended.

Key words: CNP, PHC facilities, service delivery

OPSOMMING

Agtergrond

Suid Afrika ondervind baie uitdagings in die proses om die gesondheidsorgsisteem te verander om die gemeenskap tevrede te stel en om aan internasionale vereistes te voldoen. Programme op Primêre Gesondheidsorg (PGS) vlak het geleidelik uitgebrei om die kwaliteit van dienslewering en die toegang tot dienste vir pasiënte te verbeter. Sedert die implementering van gedesentraliseerde en geïntegreerde modelle van diens, is pasiënte na klinieke nader aan hul woning verwys. Kliniese verpleegpraktisyns (KVPs) is direk betrokke by die lewering van dienste in die uitgebreide programme op PGS-vlak omdat hulle deur die Wet op Verpleging (Nr. 33 van 2005) gemagtig is om medikasie voor te skryf. Die doel van die studie is om die persepsies van KVPs oor die faktore wat dienslewering in die uitgebreide programme in PGS-fasiliteite, spesifiek die van die Eden Distrik in die Wes-Kaap, te ondersoek.

Metode

'n Kwalitatiewe benadering met 'n beskrywende ontwerp was gebruik om die persepsie van KVPs met betrekking tot dienslewering in uigebreide programme te ondersoek en te beskryf. Doelgerigte steekproefneming was in die studie gebruik om deelnemers in vier klinieke in die George sub-distrik van die Wes-Kaap te kies. Toestemming om die studie te doen was van die Gesondheidsnavorsing Etiese Kommittee van die Universiteit van Stellenbosch en die Wes-Kaapse Department van Gesondheid verkry. Semi-gestruktureerde onderhoude was met nege deelnemers gevoer, getranskribeer en geanaliseer volgens die vyf stappe wat deur Denscombe beskryf word. Sub-temas het uit ses hoof temas na vore gekom.

Resultate

Die temas wat na vore gekom het, sluit in: uitbreiding van pligte/rol, impak van die uitgebreide pligte en uitdagings om aan die verandering te voldoen. Faktore wat die deelnemers se persepsies oor dienslewering in PGS-fasiliteite beïnvloed het, sluit in byvoorbeeld die verhoging in die werkslading en die personeeltekort om aan die voortdurende veranderinge te voldoen.

Slotsom

Die faktore wat dienslewering in PGS affekteer is interafhanklik en het 'n impak op die kwaliteit van dienslewering.

Voorstelle is gemaak om 'n positiewe bydrae te lewer tot die moraal van personeel en kwaliteit dienslewering.

Sleutelwoorde: KVP, PGS-fasiliteite, dienslewering

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ABBREVIATIONS

CNP	-	clinical nurse practitioner
PHC	-	Primary Health Care
PACK	-	Practical Approach to Care Kit
ART	-	antiretroviral therapy
HIV	-	human immunodeficiency virus
CDC	-	community day centre
ICRM	-	Ideal Clinic Realisation and Maintenance
KTU	-	Knowledge Translation Unit
NCD	-	non-communicable disease
NIMART	-	Nurse Initiated Management of Antiretroviral Therapy

CHAPTER 1

FOUNDATION OF THE STUDY

1.1   INTRODUCTION

In South Africa, Primary Health Care (PHC) services are highly prioritized by the National Department of Health (Saloojee & Thandrayen, 2010:1). Primary care involves the widest scope of health care, including patients of all ages, all socioeconomic and geographic origins as well as patients with acute and chronic diseases (Rasmor, Kooienga, Brown & Probst, 2014:1). South Africa is facing many challenges in the process of changing the health care system to satisfy society as well as meeting international requirements. According to Dr Aaron Matsoaledi, the current Minister of Health of South Africa, better quality of care is essential for improving South Africa's current poor health outcomes and for restoring the confidence of patients and staff in the health care system (Department of Health, 2011:5).

Since 2012, programs were gradually expanded at PHC level, in order to improve the quality of service delivery and patient access to care (DoH, data capturing system, Tier.net, 2010:np). One of the reasons why PHC services expanded was the decentralization of care and the adoption of integrated care models.

Examples of expanded programs are the nurse-led models of management for patients on antiretroviral therapy (ART) and patients with non-communicable diseases. Previously patients on ART were seen at designated clinics or hospitals. Since the implementation of decentralized and integrated models of care, patients were redirected to clinics closer to their residence. However, no additional staff or resources were provided to the PHC clinics where an increased number of patients were now attending. The implementation of the expanded programs increased the roles and responsibilities of clinical nurse practitioners, therefore affected service delivery at PHC level.

CNPs are registered professional nurses with tertiary training in PHC. CNPs are directly involved in providing care in the expanded programs on a PHC level, since they have authorization under the Nursing Act (No. 33 of 2005) to prescribe up to

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schedule 4 drugs. They were therefore uniquely positioned to provide information about how the expanded programs affected service delivery.

Exploring the perceptions of CNPs in PHC facilities, will provide management with insight into the challenges CNPs are facing and the factors impacting on service delivery. Recommendations could be implemented to improve service delivery.

1.2   SIGNIFICANCE OF THE PROBLEM

Patients experienced that the quality of service delivery at PHC clinics is decreasing and are not satisfied with the services rendered. It appears that the increased absenteeism rate might be the result of a low morale amongst staff and the absenteeism and low morale impact negatively on service delivery in PHC facilities. Limited research on the perceptions of CNPs, regarding service delivery, was identified by the researcher during literature reviewed. Understanding CNPs perceptions will enable management to adapt to improve service delivery.

1.3   RATIONALE

The researcher is a CNP working as a training coordinator in one of the sub-districts of the Eden district in the Western Cape. As training coordinator, it is the responsibility of the researcher to coordinate all clinical training in the sub-district. The researcher observed that there were concerns and/or dissatisfaction amongst CNPs relating to service delivery. In the researcher's experience, complaints from the community and patients with regard to service delivery at PHC level had also increased over time. It seems that the following factors might have an effect on service delivery: staff workload, task shifting, low morale, decreased quality, and patient dissatisfaction.

1.3.1   Staff workload

The number of patients attending PHC clinics has increased and the number of service providers is often inadequate to cope with the workload (Mash, Govender, Isaacs, De Sa & Schlemmer, 2013:459). The assessment of patients includes history taking, physical examination, diagnosing, treatment, and dispensing medication. With the increasing prevalence of HIV, the time spent to assess a patient increased from fifteen minutes up to three quarters of an hour, depending on the emotional and

physical status of the patient and the counselling needed. This leads to longer waiting times, patient dissatisfaction, and CNPs working without a break in order to finish their work. The increase in administrative tasks also impacts on less time for effective patient care. Nurses experience frustration about the non-clinical duties and administration tasks, which is time consuming (Keating, Thompson & Lee, 2009:151). The National Health Act (No. 61 of 2003) requires accurate record keeping of all activities performed in respect of patient care. CNPs perceived the reporting on different forms and registers time consuming.

Another aspect that contributes to the increased workload of CNPs working in the district is the management of patients with chronic diseases. Since the management of chronic patients became part of the responsibility of the CNP, the number of patients seen by CNPs increased from 67 to 72% in the last two years (DoH Data capturing system, Sinjani, 2013:np). Keating, Thompson and Lee (2010:148) confirm that the current pressures on health care systems include the growing elderly population, which increases the prevalence of chronic diseases, as well as the shortage of health care professionals. Furthermore, there are now younger people presenting with chronic diseases as well. With the new Practical Approach to Care Kit (PACK), of which the Eden district was the first to implement, the CNPs' roles and responsibilities were extended. PACK was developed by the Knowledge Translation Unit (KTU) at University of Cape Town's Lung Institute. This institute addresses common presenting symptoms and chronic conditions in adults attending PHC facilities in South Africa (WCDoH, 2013:3) Through PACK CNPs have been equipped to manage patients, including chronic patients, comprehensively. Previously, stable chronic patients were seen and followed up by a medical officer. Nkosi, Horwood, Vermaak and Cosser (2009:408) confirm that 49% of the doctor's activities at PHC clinics include the review of chronic medication. This responsibility has been shifted to the CNP.

In South Africa, the public health care sector is being challenged with a decreasing number of nurses on the one hand and an increase in the burden of disease on the other (Democratic Nursing Organisation of South Africa, 2012). DENOSA (2012) describes the nurse-patient ratio as the number of patients each nurse has to care for at any specific point in time. There seems to be a direct correlation between the number of nurses and the quality of care delivered. Due to the growing number of

patients visiting PHC facilities, CNPs are forced to rush through their consultations, which impacts negatively on quality of care. The system is further complicated by an increased level of absenteeism, 0.9% from December 2014 to March 2015 (DoH, 2014:np).

1.3.2   Task shifting

Task shifting is the process whereby tasks are moved to less specialized health workers to make more efficient use of human resources available (World Health Organization, 2007:3). Except for the lack of human resources, the daily tasks of CNPs have been broadened as a result of task shifting. CNPs now feel overloaded with work that was previously considered the responsibility of the medical officer. The management of patients with HIV and patients with chronic diseases are examples of such responsibility. In South Africa, a major obstacle to ART expansion has been the shortage of doctors available to initiate treatment. Efforts to increase access to ART have emphasized task shifting from doctors to other health care workers (Fairall, Bachmann, Lombard, Timmerman, Uebel, Zwarenstein, Boulle et al., 2012:889). A study conducted by Laurant, Hermens, Braspenning, Akkermans, Sibbald and Grol (2007:2691) showed that in many countries aspects of primary care were shifted from doctors to nurses to improve health care efficiency and maintain quality of care.

1.3.3   Low morale

The large scale of service delivery negatively affects the quality of staff performance and contributes to low morale and high levels of absenteeism (DoH, 2014/2015:) Aleshire, Wheeler and Prevost (2012:181) claims that health care around the world is transforming at a high rate and nurses should be leading the change and advancing health in an increasingly complex health system.

The clinical environment is often stressful, yet primary health care workers are expected to be caring and compassionate. Staff attitudes are a common source of complaint. Increased job demands and extensive workloads are associated with job dissatisfaction and absenteeism, which result in more work pressure (Mash et al., 2013:459). This leads to negativity amongst CNPs that causes diminished motivation.

1.3.4   Decreased quality of service delivery

The demand for service exceeds the supply of nurses in the public health care sector and compromises the quality of service delivery. Thandrayen (2008:2) identified several indicators of poor quality of health care. These include management weaknesses, technical incompetence, lack of drugs, poor attitudes and behavior of staff, low motivation and morale, and insufficient supervision. Furthermore, the introduction of free health care at clinics led to a reduction in consultation time (Thandrayen, 2008:3). Due to the increase in patients' access to health clinics, CNPs have to rush through their consultations in order to manage all patients at the end of the day. Health workers feel pressurized and find their jobs frustrating and tiring, resulting in decreased quality in service delivery (Thandrayen, 2008:9).

1.3.5   Patient satisfaction

Nembhard, Yuan, Shabanova and Cleary (2014:1) define a positive care experience as one where patients are satisfied with the service they received. Since patient outcomes have become the ultimate measure of quality, it seems to be a reality that patients are not always satisfied with the care rendered at PHC facilities. Patients are dissatisfied and their complaints are about long waiting times, unfair and disrespectful treatment, and impolite staff attitude (Data capturing system: Sinjani, 2014/2015). The patients do not always log complaints but a sense of negativity with regard to PHC service delivery is perceived amongst patients. A study conducted by Hinderaker, Kahabuka, Kvale and Moland (2012:158) confirms an undesirable behavior amongst health workers and that patients expressed their concerns over how nurses treated them. This study allows an opportunity to explore the perceptions of CNPs regarding the factors influencing service delivery at PHC facilities.

1.4   RESEARCH PROBLEM

The possibility exists that the increasing number of patients who attended the PHC facilities as well as the expansion of CNPs' roles and responsibilities resulted in excessive demands on CNPs. Diminished job satisfaction might also lead to negative attitudes amongst CNPs. Patient complaints, such as long waiting times and staff attitude, were an indication that clients are not satisfied with the services.

Against this background the researcher explored the perceptions of CNPs regarding service delivery in expanded programs. Limited research on the perception of CNPs regarding service delivery in PHC facilities was identified in the literature reviewed. The information gathered can be used to make recommendations on how to improve CNPs' job satisfaction and thus improve service delivery at PHC facilities.

1.5   RESEARCH QUESTION

What are the perceptions of CNPs regarding service delivery in PHC facilities?

1.6   RESEARCH AIM

The aim of the proposed study is to explore the perceptions of CNPs regarding factors influencing service delivery in the expansion of programs in PHC facilities.

1.7   RESEARCH OBJECTIVES

The research objectives are to:

1. Explore the perceptions of CNPs about service delivery at a primary care level.
2. Understand how changed responsibilities of CNPs have affected service delivery.
3. Identify barriers and enablers to quality service delivery.
4. Describe the views of CNPs related to the current versus ideal responsibilities of CNPs.

1.8   RESEARCH METHODOLOGY

A brief overview of the research methodology is provided in this chapter and the full report follows in chapter three.

1.8.1   Research design

A descriptive design with a qualitative approach was applied to explore and describe the perceptions of CNPs regarding service delivery in expanded programs.

1.8.2   Study setting

The research study was conducted in the Western Cape Province in one of the sub-districts of the Eden district. The Eden district is one of the rural districts in the Western Cape and has a population of 605 380 (Western Cape Province data, 2015). The district consists of seven sub-districts and 76 PHC clinics. The research was conducted in one of the sub-districts where the researcher is not part of the clinical staff.

1.8.3   Population and sampling

The population for this study consisted of 48 CNPs working in 18 PHC clinics. Purposive sampling was used to select participants in PHC clinics to be included in this study. CNPs rendering PHC services for six months or more in PHC clinics and who have knowledge and experience about the services at PHC level.

1.8.4   Data collection tool / Instrumentation

The interviews were conducted using a semi-structured interview guide that is based on the objectives of the study.

1.8.5   Pilot interview

A pilot study consisting of one interview was conducted with one participant who met the inclusion criteria within the study setting. The data from the pilot interview were included in the main findings.

1.8.6   Trustworthiness

Trustworthiness refers to the way in which data are collected, sorted, and classified (Athanasou, Di Fabio, Elias, Ferreira, Gitchel, Jansen, Malindi, 2012:140). The criteria to ensure trustworthiness in this study include credibility, transferability, dependability, and conformability.

1.8.7   Data collection

Using purposive sampling, nine participants were interviewed during May 2016. A semi-structured interview guide was used and the interviews were recorded.

Interviews were conducted in a relaxed atmosphere to learn about the participant's ideas, beliefs, views, and opinions. The aim was to acquire rich and descriptive information that enabled the researcher to understand the social reality of the participant (Athanasou et al., 2012:89).

1.8.8   Data analysis

Data analysis was done concurrently with data collection. The researcher listened to the interviews and transcribed the recorded interviews manually. Interviews were transcribed verbatim. The transcriptions reflected the setting of the environment where the interviews took place. The researcher made a concerted attempt to bracket her own preconceived ideas about the management of expanded programs in PHC.

1.9   ETHICAL CONSIDERATIONS

Informed consent was obtained from all the participants prior to commencing interviews. Participants were informed of the purpose of the study. Participation was voluntary. Their names and the names of the clinics in which they work were not recorded and comments were not linked to individuals or specific clinics. All data were handled confidentially. The consent forms were stored in a locked cupboard. No risks were foreseen in this study. Approval was granted from the Health Research Ethics Committee of Stellenbosch University as well as the Department of Health, Western Cape. Additional permission was obtained from PHC management to access the PHC facilities that were involved in the study.

1.10   OPERATIONAL AND CONCEPTUAL DEFINITIONS

Clinical nurse practitioner (CNP): also known as a nurse trained (postgraduate qualification) in diagnosis and treatment prescription in the South African setting as described in the Nursing Act, 2005, section 31(1). Regulation 1379 pertains to the training of CNPs.

Primary Health Care (PHC) is essential care based on practical, scientifically sound, and socially acceptable methods and technology. PHC is made universally accessible to all in the community through their full participation and at an affordable cost, geared toward self-reliance and self-determination (WHO & UNICEF, 1978).

Perceptions in this study refer to the way participants think about the service delivery in PHC facilities.

Factors are circumstances, facts or influences that contribute to a result (Online Medical Dictionary).

Service delivery is the act of providing a service to individuals, families, and the community (Online Medical Dictionary).

PHC setting refers to the clinics that are offering a comprehensive health care service (Department of Health, 2006).

Comprehensive health care service refers to providing the full range of personal health service for diagnosis, treatment, follow up, and rehabilitation of patients (Online Medical Dictionary).

A clinic is defined as a facility from which a range of PHC services are provided, but that is normally open only eight hours a day (DoH, 2006).

Expanded programs in this study refer to programs introduced as part of the management of patients by a CNP.

1.11   DURATION OF THE STUDY

Ethical approval for the study was obtained from the Health Research Ethics Committee of Stellenbosch University on 16 November 2015. Permission to conduct the research study was obtained from the Western Cape Department of Health on 9 March 2016. The PHC management of George sub-district provided permission to do the study during May 2016. Data collection took place on 18 May 2016. Data saturation was achieved with the nine interviews. Data analysis began with the first participants' interviews. The final thesis was submitted on November 2016.

1.12   CHAPTER OUTLINE

Chapter 1: Foundation of the study

In chapter one the background and motivation for the research study is described. A brief overview of the literature, research question, research objectives, research methodology, definition of terms, and the layout of the research study is provided.

Chapter 2: Literature review

In chapter two the literature relevant to PHC service delivery is reviewed and discussed.

Chapter 3: Research methodology

Chapter three provides an in-depth description of the research methodology used to explore the perceptions of CNPs on service delivery in PHC facilities.

Chapter 4: Results

In chapter four the results of the research study are described and interpreted.

Chapter 5: Discussion, conclusions and recommendations

In chapter five there is a discussion of the results with relevance to the study objectives. The researcher concludes the research study and provides recommendations based on the scientific evidence acquired during the research study.

1.13   SIGNIFICANCE OF THE STUDY

The research study provides information on the perception of CNPs of service delivery in PHC facilities. The information gathered in the study could be used to inform management how CNPs experience the outcome of expanded programs in PHC facilities and how it affects service delivery. Recommendations can be made to improve the quality of PHC services rendered.

1.14   SUMMARY

In this chapter, an introduction and background of the study was given. The methodology was briefly described. There was also an explanation of ethical considerations as well as the duration taken to complete the study and the outline of the various chapters as presented in the thesis. Literature relevant to PHC service delivery will be discussed in the next chapter.

1.15   CONCLUSION

PHC facilities are confronted with challenges to provide quality care to an increasing population with more demands. Exploring the perceptions of the CNPs working in PHC facilities provided greater insight regarding the factors and their impact on the quality of services. The study explored how CNPs experience the services rendered at PHC facilities.

CHAPTER 2
LITERATURE REVIEW

2.1   INTRODUCTION

The purpose of a literature review is to summarize what has been published on a topic and present relevant research findings to gain knowledge and improve nursing practice (Grove, Burns & Gray, 2013:97).

Chapter two presents the findings of literature with regards to the perceptions of clinical nurse practitioners (CNPs) on service delivery in primary health care (PHC) facilities. PHC clinics have become the cornerstone of the public health system. They are the first point of entry to the health system. The PHC system focuses on responding more equitably and effectively to basic health needs. The provision of PHC is a basic service that is provided free of charge by the South African government and it is intended that the service should be accessible to the population and be effectively utilized (Nteta, Mokgatle-Nthabu & Oguntibeju, 2010:1). The ultimate goal of PHC is better health for all (WHO, 1998). Health for all is defined as the attainment of such a level of health for all people of all countries to enable them to work productively and participate actively in the community in which they live (WHO, 1998). It is therefore necessary for clinics to have adequate infrastructure, equipment, medicines, and relevant resources to provide quality basic health care to the public. Members of the public should be treated with respect and compassion by the health professionals (Department of Health, 2010:ii).

2.2   SELECTING AND REVIEWING THE LITERATURE

The preliminary literature review was conducted to ascertain if there were any studies done on the topic of interest in the South African setting. The researcher made an effort to bracket any information from the literature that could have influenced her during the data collection and analysis processes.

For this study a variety of electronic databases such as PubMed, CINAHL, Science Direct, MEDLINE, and Google Scholar were searched. To conduct the literature search the following key words were used: nurse practitioner, health care provider,

primary health care, quality service, health care services, and contributing factors influencing service delivery. All these keywords produced results. Materials used in the review were published within the last ten years.

This review has been structured under the following themes: staff workload, task shifting, low morale, decreased quality of service delivery, and patient satisfaction.

2.2.1 Staff workload

The 2010 Health Plan of the Western Cape Province aimed to increase chronic and acute care consultations within the district health system. This implies a higher workload at primary care level and a higher percentage of that care to be delivered by CNPs (Kapp & Mash, 2004:23). A series of articles on health in South Africa, published in The Lancet in 2009, reported challenges with regard to the implementation of PHC (Visagie & Schneider, 2014:2). They furthermore confirmed that the shortage of health care service providers is repeatedly mentioned as specific barriers to provide quality services (Visage & Schneider, 2014:2).

There are an increasing number of patients attending PHC clinics and the number of service providers is often inadequate to cope with the workload (Mash et al. 2013:459). Keating et al. (2010:148) confirm that the growing elderly population with chronic diseases and the shortage of health care professionals increase the current pressure on the health care system.

The majority of chronic patients were previously seen by medical officers in the study sub-district, especially those put on chronic medication for the first time. With the new Practical Approach to Care Kit (PACK, 2015), which the Eden district was the first to implement, the CNP's role and responsibilities were extended. PACK, developed by the Knowledge Translation Unit (KTU) at University of Cape Town's Lung Institute, addresses the most common presenting symptoms and chronic conditions in adults attending PHC facilities in South Africa (Pack Primary Care Guideline for Adults, 2015). The additional responsibility affected particularly staff in small facilities where one CNP is responsible for everything that needs to be done in that clinic. In some clinics the CNP functions independently, without the assistance of a doctor.

A study conducted by Xaba, Peu and Phiri (2012:3) in the Tshwane District, Gauteng Province, South Africa, confirmed that the rapid rise in human immunodeficiency virus (HIV) and other chronic diseases put a huge burden on health care services. The historical imbalances in health care in South Africa, coupled with the disease burden of communicable and non-communicable diseases, place a huge strain on the public health service (Dookie & Singh, 2012:1).

According to Magawa (2012:3) the health sector is experiencing a shortage of health staff and health services, and infrastructure is deteriorating. In addition, there was no action by the government to redistribute the available resources more equitably to districts with the greatest health need, especially in rural areas. Furthermore, South Africa is currently experiencing an increased burden on health care services as a result of HIV. Efforts to improve PHC have proved to be challenging due to the increase in disease burden, as there are shortages of health workers and health infrastructure. This contributes to the poor reflection of health care (Magawa, 2012:3).

Hinderaker et al. (2012:158) confirmed that the number of staff at facilities in Western Tanzania was insufficient to provide the expected services and this was even more aggravated by their frequent absenteeism. Tyagi (2011:1) defines absenteeism as unscheduled employee absences from the workplace. Furthermore, many causes of absenteeism are legitimate, for example illness or family issues, but absenteeism can also often be traced to other factors such as a poor work environment or workers who are not committed to their jobs. Manzi, Schellenberg, Hutton, Wyss, Mbuya, Shirima, Mshinda, Tanner, & Schellenberg, (2012:4) agreed that a high level of absenteeism leads to inadequate staffing levels, which reduced access to services. Muller, Bezuidenhout and Jooste (2006:230) emphasized that the direct results of a shortage of professional nurses increased the workload experienced by the remaining health care personnel.

According to the United States' Institute of Medicine (IOM) 2011 report, health care around the world is transforming at a high rate and nurses should be leading the change and advancing health in an increasingly complex health system (Aleshire et al. 2012:181). Furthermore, the United States is facing a large and growing shortage of CNPs and ensuring adequate access to care is a major concern. The problem is

expected to worsen as the population continues to age (Yee, Boukus, Cross & Samuel, 2013:1).

The literature reviewed revealed that CNPs are overloaded in PHC clinics in South Africa and it has a negative effect on service delivery. Mathibe, Hendricks and Bergh (2015:7) conducted a study in the Tshwane district of Gauteng and their findings revealed that it is difficult to provide quality services and ensure satisfied patients if the workload is too high. The high workload included increased activities such as client examination, routine investigation, the amount of forms to be completed, management of side-effects and complications, and self-dispensing and issuing treatment. The situation is further aggravated by the shortage of staff. Almalki, FitzGerald and Clark (2012:22) found that, despite the shortage of PHC nurses in the Jazan region of Saudi Arabia, the nurses were given additional non-nursing tasks. This may increase the shortage of staff even more and affect their perception of work-life negatively.

The World Health Organisation (WHO) made an assessment of health care in South Africa in 2003 and found that more than 60% of health care institutions in South Africa struggled to fill existing posts. The critical shortage of trained health personnel constitutes a key barrier to achieving the implementation and provision of health services in South Africa. Clinics are disproportionately affected by staff shortages and inequities in resource distribution; thus PHC services are undermined at the most critical point of care. Despite the implementation of a range of initiatives to reduce health worker loss, the persistence of staff shortage is due to longstanding policy gaps (Kautzky & Tollman, 2008:26).

The transformation of the health system has been hampered by inadequate numbers of health workers. There is no clear strategy for addressing the critical health worker shortage, particularly in rural areas (Lloyd, Sanders, & Lehmann, 2010:4). The WHO (2008:2) agreed with the international consensus that, without urgent improvements and strengthening of human resources for health, the world will fail to meet the Millennium Development Goals (MDG). An important set of goals relate to the so-called MDGs. In 1992 the nations of the world committed to achieving the eight clearly delineated goals by the year 2015. Three of the goals relate specifically to health and received priority. These goals are: reduce child mortality; improve

maternal health; and fight HIV/AIDS, malaria, and other diseases (Armstrong, Bhengu, Kotze, Nkonzo-Mtembu, Ricks, Stellenberg, Van Rooyen & Vasuthevan, 2013:7). The health related MDGs on child survival, maternal health, HIV and tuberculosis laid out benchmarks for primary health systems performance against which the services were assessed (Vasan, Ellner, Lawn, Gove, Anatole & Gupta et al. 2014:1).

The eight MDGs agreed upon by governments in 2001 expired in 2015 without having been attained. A new set of goals, targets, and indicators — the sustainable development goals (SDGs) — follow and expand on the MDGs over the next 15 years. Seventeen goals were proposed; the third goal focuses on ensuring healthy lives and promoting well-being for all at all ages. The SDGs were officially adopted at a United Nations (UN) summit in New York in September 2015. The SDGs became applicable from January 2016 and will expire in 2030 (WHO, 2015:2).

Inspections were conducted by the Public Service Commission at PHC clinics in the Western Province during 2009/10 to assess the quality of services rendered to the public. The findings at some of the clinics revealed that, due to staff shortages, clinic managers were mostly involved in patient care which impacted negatively on their administrative duties (DoH, 2010:92).

2.2.2   Task shifting

Task shifting is the process whereby certain tasks are allocated to less specialized health workers to make more efficient use of available human resources (WHO, 2007:3). In 2006 the WHO proposed task shifting as a method to meet MDGs as 57 countries were facing critical shortages of health care workers. The task shifting approach represents a return to the core principles of health services that are accessible, equitable, and of good quality. Furthermore, task shifting provides a framework in which access to health services can be extended to all people in a way that is effective and sustainable. Therefore, task shifting is seen as the vanguard for the renaissance of PHC and is needed to address the health workforce shortages that exist in many countries (WHO, 2008:2).

Task shifting strategies often arise informally at clinic level where providers take on additional administrative and clinical responsibilities in order to ensure continued

provision of services. In the setting of antiretroviral therapy (ART) expansion, a more structured approach is necessary to ensure the provision of quality care (Morris, Chapula, Chi, Mwango, Chi, Mwanza, Manda, Bolton, Pankratz, Stringer & Reid, 2009:3).

The human resource challenge is highlighted in Sub-Saharan Africa and task shifting is increasingly promoted as a coping mechanism (Zachariah, Ford, Philips, Lynch, Massaquoi, Janssens & Harries, 2008:550). The burden of chronic diseases in Sub-Saharan Africa is large, making the challenges to care and prevention substantial. Task shifting, which consists of reallocating tasks among available health care staff, has been implemented. Tasks are shifted to nurses because they are more likely available and in a greater number compared to physicians. The health workforce indicates that Sub-Saharan Africa cannot cope with the growing need for care and prevention of chronic disease together with the HIV endemic. Therefore the expansion of the health workforce is needed. They acknowledged that task shifting is an attractive solution but should be applied in a manner that does not compromise quality of care and patient safety. It requires careful attention to organization, structure, and resourcing of health services (Lekoubou, Awah, Fezeu & Sobngwi, 2010:354-358).

Lehman, Van Damme, Barten and Sanders (2009:2) suggest that the human resource crisis in Africa can be solved by task shifting. Reallocation of responsibility can lead to improvement, coverage, and quality of health services. In addition to task shifting, health systems of Sub-Saharan Africa need an increased human resource pool that is flexible, motivated, and able to respond to the disease burden and the public health needs. Although this study was done in Sub-Saharan Africa, the findings are applicable to the situation in PHC facilities in South Africa. The medical profession should accept change and respect the ideas of others, in order to safeguard both quality and safety, and to prioritize patient needs above those of the profession (Zachariah et al., 2008:556).

The concept of shifting responsibility for primary care from doctor to CNP evolved in South Africa in the 1970s due to a shortage of doctors. The CNP could see patients with minor ailments allowing the doctor to spend time on more complicated patients (Kapp & Mash, 2004:21). Sibbald, Laurant and Scott (2006:149) suggest training

nurses is more resource efficient than doctors. Consequently, the expansion of nurses' roles and competencies is an effective strategy for dealing with medical health care provider shortages. However, this may reduce the continuity and satisfaction with the quality of care by the patient (Sibbald et al., 2006:149).

One of the main constraints in the progress of scaling up HIV services is the serious shortage of appropriately trained health workers. Task shifting arose from the need to address the shortage, anticipating it should be a means of improving the overall quality of services. However, there may be concern that service quality could be negatively affected with the task shifting to an alternative health care provider. For task shifting to improve the quality of care there must be agreed standards governing the recruitment and training of new types of health workers (WHO, 2007:3). No member of staff should undertake tasks unless they are competent to do so (DoH, 2001:7).

A severe shortage of health workers is faced by lower-income countries coupled with an increasing demand for health care, including ART. Task shifting was proposed as a solution to this problem. Babigumira, Castelnuovo, Lamorde, Kambugu, Stergachis, Easterbrook and Garrison (2009:2) confirms that task shifting in Malawi and Zambia did not compromise quality of care. In South Africa task shifting for nurses in ART clinics/services resulted in comparable outcomes.

Babigumira et al. (2009:2) also recognize that task shifting is not without challenges. Appropriate training is needed for lower levels of personnel, to whom tasks are shifted, in order to equip them to perform effectively. Task shifting expands their roles and responsibilities, and they may demand greater remuneration. Babigumira et al. (2009:8) conclude that task shifting has the potential to save money because fewer physicians need to be appointed, thereby mitigating the current health worker shortage. Task shifting increases the levels of responsibility throughout the health care workforce. Additional responsibility, including the responsibility for supervision, can be expected to go along with increased pay. This suggests additional money should be allocated for anticipated salary increases. Therefore, task shifting should generally be promoted for improving services and not for saving money (WHO, 2006:9).

The daily tasks of nurses have been broadened as a result of task shifting and were further increased due to the lack of human resources. The management of patients with HIV and patients with chronic diseases is an example of such task shifting. By March 2013 the number of facilities providing ART services had increased nationally to over 3500 clinics compared to the 490 facilities in 2010 (Mathibe et al., 2015:3).

In South Africa, a major obstacle to ART provision has been the shortage of doctors available to initiate treatment. Efforts to increase access to ART have emphasized task shifting from doctors to other health care workers (Fairall et al., 2012:889). They also confirm that CNPs can provide high quality care to patients with HIV infection. Global experience suggests that task shifting is the basis for providing effective care for patients with chronic diseases in primary care settings with positive health outcomes (Lekoubou et al., 2010:358).

A study conducted by Laurant et al. (2008:2691), in Southern Netherlands, confirms that, in many countries, aspects of primary care were shifted from doctors to nurses in order to improve health care by increasing efficiency while maintaining quality of care. However, as a result of the increased workload the quality of service may be compromised as staff rush to complete a number of patients in a set time (Mathibe et al., 2015:9).

A situational analysis of mental health services in South Africa suggests that, while there has been progress towards integrated primary mental health care since 1997, there are significant service gaps both within and across provinces. Progress includes the symptom management of psychiatric patients by CNPs. Dedicated health care providers are needed to deliver these services, because CNPs are already overburdened as a result of the high HIV prevalence. Furthermore, the adoption of a task shifting approach is unlikely to succeed as mental health work requires both technical and emotional support and can lead to burnout in unsupported situations (Petersen, Lund, Bhana & Flisher, 2012:42).

2.2.3 Low morale

In South Africa PHC service delivery is primarily government funded. The PHC clinics offer preventative, promotive, curative, and rehabilitative services that are free. In these clinics the majority of the health care workforce is nurses; as such,

they are the gatekeepers of the PHC system (Munyewende, Rispel & Chirwa, 2014:13).

CNPs form the backbone of the PHC system in South Africa; therefore, their well-being is important in the effective provisioning of health services. A study conducted in South Africa by Engelbrecht, Bester, Van Den Berg and Van Rensburg (2008:3) found that the well-being of professional nurses is significantly affected by increased workload and occupational stress. Absenteeism adds to the workload of the remaining staff, increases stress, disrupts work, and lowers their morale.

According to Grier (2008:2) morale is an emotional issue with regard to the function of tasks at hand. If employees are unhappy it will show in negative attitudes, increased absenteeism, and reduced cooperation. Morale problems can quickly affect the quality of service delivery (Welch, 2014:1). Professionals experiencing stress tend to focus on the unpleasant feelings and emotions rather than on the task at hand and as a result their performance suffers (Kotteeswari & Sharief, 2014:19). Satisfaction amongst staff is followed by decreased levels of stress and frustration, and high staff morale.

The morale of personnel plays an important role in effective service delivery. Managers should listen to concerns and respond effectively in order to keep a positive morale that is conducive for the delivery of quality care (DoH, 2010a:92). Satyadi (2014:1) reported that, where there was an increase in employees' workload, the morale decreased. Staff morale can make or break any organization because when the staff morale is low, decreased productivity can result. Grier (2008:6) agreed that low morale can be a sign of a dysfunctional system. Policies that are impossible for the employee to follow can destroy morale. Furthermore, job expectations should be made clear so the employee knows what their roles and responsibilities are. Performance reviews are the perfect time to review and update expectations. The lack of supportive supervision affects staff morale, motivation, and job satisfaction (Zachariah et al., 2008:555).

The large need for service delivery negatively affects the quality of staff performance, and contributes to low morale and high levels of absenteeism amongst staff (DoH, 2014c:13). Mathibe et al. (2015:4) confirm that the additional

activities expected from CNPs cause overburdening and frustration, and is not feasible.

The clinical environment is often stressful, yet PHC workers are expected to be caring and compassionate. The moment employees begin to feel that their feelings are not appreciated and they are only "on board to row", employee morale decreases (Schaefer, 2014:1). PHC health workers also feel that financial and human resources are insufficiently incorporated into the implementation of expanded programs at PHC facilities (Walker & Gilson, 2004:1251).

Kapp and Mash (2004) identified the role of the CNP versus that of the doctor as another key area contributing to and affecting the morale of the CNP. Currently in the PHC setting, doctors and CNPs are seeing patients from the same pool and often working in isolation. This equity of roles appears to lead to the doctors feeling threatened by the expanding role of CNPs, and the CNPs feeling unsupported by the doctors. Demotivation was also found among CNPs in Tanzania because of the increased workload, which affected their morale negatively (Manongi, Marchant & Bygbjerg, 2006:9).

Munyewende et al. (2014:13) define job satisfaction as the perceived relationship between what one expects and obtains from one's job. It represents the degree to which employees enjoy their jobs and there is a correlation between performance and job satisfaction. They have found that job dissatisfaction influences the delivery of quality patient care in PHC clinics. According to Arab, Pourreza, Akbari, Ramesh and Aghlmand (2007:64) job satisfaction varies from person to person and even from time to time. They consider job satisfaction as an evaluation that the employee makes of the job and the environment surrounding the job. In a study conducted in the rural setting of Behvarzes, Iran findings suggest that PHC providers are so dissatisfied with their work that they wanted to leave the workplace or the profession entirely (Arab et al., 2007:69).

The Western Cape Department of Health (WCDoH) has developed a Healthcare 2030 (DoH, 2013) document that sets out the vision, values, and principles guiding the department to 2030. The document presents a strategic framework together with a set of planning parameters and tools that will be applied. Part of the 2030 strategy

is to ensure that employees are engaged, empowered, and happy to be at work. Staff will be encouraged to be more innovative and to look for ways to be more effective and efficient. A recent staff satisfaction survey in the WCDoH reported that staff is dissatisfied with the people management skills of their line managers. They do not believe that they are valued, listened to, or cared for by the organization. Furthermore, high levels of burnout have been identified as a result of heavy workloads and a stressful working environment (DoH, 2013b:77).

2.2.4 Decreased quality of service delivery

Quality can be defined as achieving the best possible outcome with the resources that are available (DoH, 2007:8).

The principles of the PHC approach include equity in service delivery, access to appropriate services, and sustainability of service provision (Dookie & Singh, 2012:3). According to Dr. Aaron Matsoaledi, Minister of Health of South Africa, quality health services must be provided at all health facilities. South Africa's poor health outcomes should be improved in order to restore patients and staff confidence in the health care system (DoH, 2011:6).

There is a huge emphasis in government on ensuring a better outcome of the quality of services. PHC outcomes are the results that should occur from the delivery of services (Wong, Yin, Bhattacharyya, Wang, Liu & Chen, 2010:8). Quality should be patient-centered, equitable, and safe. (Stanik-Hutt, Newhouse, White, Johantgen, Bass, Zangaro, Wilson, Fountain, Steinwachs, Heindel & Weiner, 2013:492). All attempts must be made to better the health status of the population, strengthen the effectiveness of the health system, and improve the quality of care rendered (DoH, 2011:4). An effective health system integrates knowledge and skills and works together to deliver care of high standard to the patient and society (Carey et al., 2013:178).

A study conducted by Mathibe et al. (2015:3) revealed that the main challenges faced by the National Department of Health (NDoH) are the availability of infrastructure, human resources, and management capabilities for coping with the provision of comprehensive PHC services. Furthermore, they also identified poor service delivery and heavy workload as common problems in PHC clinics. The

Constitution of South Africa, 1996, claims health care that is caring, safe, and effective for all people.

Magawa (2012:3) revealed that the current South African public health system is unequal and unsustainable with poor financial resource allocation, inadequate human resources, and uneven access to health care. Furthermore, the system in the public sector is poorly managed; there is decreased quality of health care service delivery and deteriorating infrastructure. In an attempt to eliminate the inequalities, the South African government has introduced National Health Insurance (NHI). The aim of NHI is to promote access to appropriate, efficient, and quality health services and to strengthen the under-resourced public sector (Magawa, 2012:3).

The implementation of NHI has been in process from 2012 through piloting in ten selected districts, including the Eden district. Additional districts will be determined on an annual basis for inclusion in the rollout based on their PHC streams, infrastructure, compliance with standards, and appropriate management level. It will be phased in over a period of 14 years. The first five years of NHI aims at strengthening the health system, including quality improvement, human resources planning, development, and management (DoH, 2015:52). It is expected that NHI will address current challenges and therefore improve service delivery.

A study conducted in the rural Northern Cape Province, by Visagie and Schneider (2014:8), revealed the following: the key factor to ensuring equity and quality services is building relationships with the community and involving them in health care services. However, no evidence of community involvement was found. Furthermore, the setting was not client-centered, and health care providers were not allowed flexibility in clinical decision making. Although prevention and cure of disease were covered, the efforts were hampered by a lack of medication, which is a general finding in other South African studies (Visagie & Schneider, 2014:8).

Most of the complaints about service delivery in PHC facilities includes staff attitude. Increased job demands and extensive workloads are associated with job dissatisfaction. Job dissatisfaction contributes to increased absenteeism, which results in more work pressure (Mash et al., 2013:459). Abdulghafour, Bo-hamra, Al-Randi, Kamel and El-Shazly (2011:352) described burnout syndrome as feelings of

dissatisfaction with work. Burnout results when an employee cannot cope with an excessive workload, which affects the quality of care rendered.

The overworked staff members often have no means of consideration for their quality of work because they focus on getting their work done before the end of the working day. With the staff shortage, CNPs find it difficult to provide quality services including full physical examination, exclusion of opportunistic infections, and proper history taking; this results in poor patient care (Mathibe et al., 2015:7). Mathibe et al.'s study also revealed that although ART integration is the ideal for comprehensive care it resulted in overflow of patients in facilities, increased waiting time, and reduced quality of patient care.

Pera and Van Tonder (2011:135) strongly agreed that nurses may not always be in a position to provide patients with all the care that is needed, which can lead to moral distress. They defined moral distress as "a psychological disequilibrium that occurs when nurses are conscious of the appropriate action a situation requires, but cannot carry out that action". They furthermore confirm that institutionalized obstacles, such as a lack of time, supervisory support, adequately trained and insufficient staff, are some of the reasons why they cannot complete the required action.

A study conducted in England by Staniszewska and Henderson (2004:531) emphasized the importance of patients as evaluators of the quality of care. They further identified a need to put patients in the center of health care and to redesign the service according to the patient's needs. To understand the relationship between quality of care and the utilization of health services, it is critical to view patients' perception of quality of care. Understanding patients' perceptions on quality may allow policy makers to improve the quality of care and hence increase the utilization of services (Baltussen, Haddad & Sauerborn, 2002:42).

A qualitative study conducted by Becker, Dell, Jenkins and Sayed (2012:801) in a hospital in the Western Cape identified reasons why patients go to hospital for treatment instead of going to the PHC facility; the medication at the clinic is not helping, there are no afterhours services available at the clinic, and they have to wait very long to be seen by a CNP. These findings are echoed in the study by Ryan and Rahman (2012:77) who found that the shortage of primary care providers is one of

the reasons why patient's visits to urgent care centers (UCC) increase. These findings are echoed in the study by Hinderaker et al. (2012:158) in Tanzania who found that the reasons why patients bypass PHC facilities was the fact that basic clinical examinations were not performed, insufficiency as well as undesirable behavior of staff.

Sule, Ijadunola, Onayade, Fatusi, Soetan and Connell (2008:98) conclude that community perceptions of poor quality were responsible for low use of PHC services.

Mathibe et al. (2015:9) reported that the introduction of additional PHC services not accompanied with an increase in personnel affect patient care negatively. A study conducted in Sub-Saharan Africa concludes that task shifting may not be readily accepted by various professions. Nurses have resisted taking on doctors' roles without appropriate salary increases. The resistance may impact negatively on the quality of service delivery (Zachariah et al., 2008:554).

According to Kautzky and Tollman (2008:26) the rise in chronic illness will continue to increase demand on services at PHC level. Existing understaffed chronic care services are unable to absorb this burden.

The principle agreed on in the Alma-Ata Declaration of 1978, "Health for all" by 2000, was not achieved and the MDGs for 2015 were not met in most countries (Walley et. al., 2008:1001). Some countries, such as Brazil and Cuba, have successfully implemented the PHC approach to deliver health services, whilst Zambia and South Africa continue to battle with challenges that hamper progress in this regard. In an effort to improve health outcomes following the Alma Ata Declaration most developing countries developed PHC implementation strategies. However, the implementation of these strategies has been met with serious challenges that include shrinking health care budgets and an increased burden on health care services as a result of HIV/AIDS (Magawa, 2012:1).

A study conducted in rural Greece confirms that a decrease in the quality of service delivery is a global problem. The participants in the study expressed concerns about the effect of the deficiencies on the quality of the PHC services due to a lack of personnel. Practitioner burnout was a visible consequence of lack of personnel

(Sbarouni, Tsimtsiou, Symvoulakis, Kamekis, Petelos, Saridaki, Papadakis & Lionis, 2012:4).

The public health system in South Africa has been transformed into an integrated, comprehensive service, but failures in management have led to inadequate implementation of what are often good policies. Fundamental features of PHC are not in place and there is a substantial human resources crisis facing the health sector. The HIV epidemic has contributed to and accelerated these challenges. These factors need to be addressed if health is to be improved (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009:817).

2.2.5   Patient satisfaction

Patient satisfaction is based on the perception of the care they received. What a patient experiences influences their perception of care (Grigsby, 2011:1). Patient satisfaction is central to the delivery of services and should be the main determinant of successful output of services. When the patient is satisfied with the service rendered, health care service is regarded as being of a high standard, the image of the facility improves, and more patients want to make use of it; this results in improved health behaviors. The need to improve quality in health care delivery is increasing. A major component of the quality of health care is patient satisfaction. Furthermore, patient satisfaction is critical to how well patients do; research has identified a clear link between patient outcomes and patient satisfaction scores (Morris, Alex, Jahangir & Sethi, 2013:1).

Bamidele, Hoque and Van der Heever (2011:170) agreed that patient satisfaction has emerged as an increasingly important parameter in the assessment of health care quality. They suggest in order to improve service delivery in PHC clinics there is a need to place a high priority on the patient and their level of satisfaction with the services provided. Furthermore, patients' perception of satisfaction is an aspect of health care quality that is increasingly recognized for its importance. Modern-day consumers of health care are better educated and informed than ever before, and this has led to the need to address the aspects of services most readily appreciated.

Positive perceptions of patients regarding care often results in more positive outcomes in the clinical experience and satisfaction of the health care provider. It is

evidenced that addressing patients' perceptions appropriately leads to improved health care and this will go a long way in increasing their level of satisfaction (Bamidele et al., 2011:170).

Hinderaker et al. (2012:158) summarized the reasons for bypassing PHC facilities in Tanzania as unfulfilled expectations, referring to dissatisfaction and disappointment about the quality of the services offered at such facilities. Mathibe et al. (2015:9) found that one of the reasons for the increase in waiting times was the longer duration of consultations because there are much more to do with an ART patient than with a new patient with diabetes. Their study also revealed that the reasons for patients discontinuing their ART treatment are the poor patient-provider relationship and discrimination. Shortage of medicine, for whatever reason, is identified as another cause of dissatisfaction. Patients, who are unable to receive their treatment, suffer not just the inconvenience and cost but also the worsening of their condition (NDoH, 2011:5).

A study conducted by Nteta et al. (2010:1) indicated that patients have access to community health centers (CHC) and there seems to be effective utilization by patients attending them in the Tshwane Region, Gauteng Province, whilst PHC services in South Africa are experiencing overcrowding. Satisfied patients are more likely to develop a deeper and longer lasting relationship with their PHC facility leading to improved compliance, continuity of care, and ultimately better health outcomes (Margolis, Al-Marzouqi, Revel & Reed, 2003:241).

The health system traditionally used doctors to deliver primary care at PHC facilities. The expanding role of the CNP may be perceived by the community as a lowering in the quality of care and the poor community acceptance may have a negative impact on the CNP's effectiveness (Kapp & Mash, 2004:25).

A study conducted by Leipert, Delaney, Forbes and Forchuk (2011:37) in Canada explored how women in rural areas experience the services rendered by CNPs. The study revealed that the women were highly satisfied with services provided. These experiences created a sense of respect and trust. High patient satisfaction rate is also found in a study conducted in the Lori and Shirak provinces of Armenia, USA. Patients were satisfied with aspects such as waiting times, accessibility of services,

confidentiality, and cleanliness of facilities (Harutyunyan, Demirchyan, Thompson & Petrosyan, 2010:12). The level of patient satisfaction with regard to accessibility and continuity of care is relatively low in Riyadh, Saudi Arabia (Al-Sakkak, Al-Nowaiser, Al-Khashan, Al-Abdrabulnabi & Jaber, 2008:2).

Patients bypass PHC facilities where they experience negative attitudes from staff and these attitudes impact negatively on the reputation of the department. Baltussen et al. (2002:46) agreed that the negative attitude of health personnel decrease patient satisfaction. Patient complaints and satisfaction surveys highlighted that they do not feel they have been treated well and perceive health workers as rude and uncaring towards their patients (NDoH, 2011:4). It is expected that health care staff treat patients with courtesy in a client-orientated manner (DoH, 2001:13). This suggests that improving attitudes towards patients will enhance perceived quality of care, which will ensure satisfied clients and thus improve the morale of health care providers.

In the Northern Cape it was found that a lack of an adequate referral system negatively affects patient satisfaction (Visagie & Schneider, 2014:8). They also found that patients were dissatisfied with the management of conditions that needed more intervention than what could be provided at a CHC in a rural area in the Northern Cape Province (Visagie & Schneider, 2014:8).

Improving patient satisfaction leads to increased productivity. Physicians and staff often spend a lot of time reacting to complaints, and dealing with non-compliant patients, which negatively impacts office efficiency. In contrast, satisfied patients are easier and more rewarding to care for, take up less physician and staff time, and are more compliant with treatment plans. Improved patient satisfaction decreases the length of patients' visits and waiting times, and reduces treatment costs (Llioudi, Lazakidou & Tsironi, 2013:68).

The aim of patient-centered care is to put the patient in the center of service delivery. Annual patient satisfaction surveys are used to measure how well the department is meeting the expectations of patients. This also involves engaging with the patient during each visit to the health facility as well as listening to the concerns and needs of the patient (DoH, 2013b:78).

2.3   SUMMARY

The literature review conducted relates to the perceptions of CNPs on service delivery in PHC facilities, nationally, and internationally. Studies suggest that CNPs experience high job demands with limited resources. Studies conducted in South Africa, other African countries, and developed countries reported that various factors contribute to a decrease in service delivery at PHC facilities. The researcher identified limited information in the published literature regarding the perceptions of CNPs on service delivery within a local Western Cape community, Eden district. The present study provides information that will contribute to this body of knowledge.

2.4   CONCLUSION

CNPs are facing numerous challenges that hinder the fulfillment of their goal; that is, quality patient care as supported by the literature reviewed in chapter two. Shortage of staff is a reality, and by looking at the effect of expanded programs on service delivery, it highlights the need for alternative measures. Challenges should be addressed to improve the quality of care rendered.

CHAPTER 3
RESEARCH METHODOLOGY

3.1   INTRODUCTION

Research methodology refers to the approach and strategies the researcher uses to answer the research question (Athanasou et al., 2012:36). This chapter describes the research design, research instruments, sampling criteria and techniques, data collection, and data analysis. The design and methodology were used to explore the perceptions of clinical nurse practitioners (CNP) on service delivery in Primary Health Care (PHC) facilities in the Eden District, Western Cape.

3.2   AIM AND OBJECTIVES

The aim of the proposed study is to explore the perceptions of CNPs regarding factors influencing service delivery in the expansion of programs in PHC facilities.

The research objectives are to:

1. Explore the perceptions of CNPs about service delivery at a primary care level.

2. Understand how changed responsibilities of CNPs have affected service delivery.
3. Identify barriers and enablers to quality service delivery.
4. Describe the views of CNPs related to the current versus ideal responsibilities of CNPs.

3.3   STUDY SETTING

The research study was conducted in George, a sub-district of Eden within the Western Cape Province. The Eden district is one of the rural districts in the Western Cape, and has a population of 605 380 (Western Cape Province Data, 2015). The district consists of seven sub-districts and 76 PHC clinics. George is the most densely populated sub-district and consists of eighteen PHC facilities. Participants were drawn from three clinics and one community day centre (CDC). This was done to explore the experiences of CNPs working in facilities where there is/are doctor/doctors available and where there is not.

3.4   RESEARCH DESIGN

The research design is a plan that guides the researcher in achieving the study's desired outcomes (Burns & Grove, 2011:49). A qualitative descriptive design was used to explore the perceptions of CNPs regarding the factors that influence service delivery in expanded programs. A qualitative descriptive design provides a picture of a situation as it naturally happens (Burns & Grove, 2011:256). Burns and Grove (2011:75) also define a qualitative approach as capturing "the lived experiences of study participants".

This qualitative exploratory approach allowed the researcher to look for patterns that emerged from the data. The approach also allowed participants' voices to be heard. Following the interview guide, open-ended questions were used to collect data during one-to-one interviews with study participants. Interviews are interactions between the participant and the researcher that produce data in the form of words (Grove, Burns & Gray, 2013:271). The use of a semi-structured interview guide ensured that the same information was asked from each participant. The questions were however open-ended to gain detail into the participant's experiences (Burns & Grove, 2011:85). The interviews were recorded verbatim and transcribed.

3.5   POPULATION AND SAMPLING

Burns and Grove (2011:51) describe a study population as all the individuals that meet certain criteria for inclusion into a specific study. In the sub-district under study there were, at the time of the study, 48 CNPs working in eighteen PHC clinics.

A sample is part of the population that is selected for the specific study (Burns & Grove, 2011:51). The sampling focuses on selecting participants who are considered experts in the area of study (Burns & Grove, 2011:312). Furthermore, sampling defines the process of selecting a group of people, behaviours, events or other elements with which to conduct the study (Burns & Grove, 2011:51). The sample is determined by what the researcher wishes to know, the purpose of enquiry, and what will be useful and feasible within the available time and resources.

In this study, purposive sampling was used. Purposive sampling in qualitative research allows the researcher to consciously select certain participants to participate (Burns & Grove, 2011:313). The sampling strategy that was used was

designed to ensure that participants included in this study are those who have the most experience of the expanded programs in PHC facilities. The researcher arranged a meeting with the operational managers of three of the largest PHC clinics and one CDC in order to explain the process. The operational manager is the person assigned to manage the overall PHC activities and personnel in the PHC facility (DoH, 2010a:5). Nine (n=9) of the CNPs who met the inclusion criteria were available in the clinic at the set date and they volunteered to participate in the study. Individual interviews were conducted with nine (n=9) CNPs who met the inclusion criteria.

3.5.1   Inclusion criteria

The inclusion criteria for the sample were CNPs who had rendered PHC services for six months, or more in PHC facilities as they have experienced the impact of expanded programs on service delivery.

3.5.2   Exclusion criteria

CNPs excluded from the study were those who were not able to participate due to ill health, vacation, or study leave during data collection.

3.6   INSTRUMENTATION

A researcher-developed semi-structured interview was used to gain a detailed picture of the perceptions of CNPs with regard to service delivery in PHC facilities (De Vos, Strydom, Fouche & Delport, 2011:351). The interview guide is a set of prompts to guide the interview, and to make sure the researcher gets answers to the research question (Denscombe, 2007:176). The questions were designed to be appropriate, complete, and in a logical sequence to ensure that the research aim and objectives are meaningfully represented (De Vos et al., 2011:352). The semi-structured interview guide consisted of seven open-ended questions concerning the perceptions of CNPs regarding service delivery in PHC facilities. The interview questions were prepared in both English and Afrikaans, and were used according to the participant's choice of language. Only two (n=2) of the nine (n=9) participants preferred the interview to be conducted in English.

The interview is a meeting intended to produce material that will be used for research purposes. The interviewee is guided to understand the purpose of the study

and has to voluntarily agree to participate in the study (Denscombe, 2007: 173). The interview was considered the appropriate method to meaningfully explore the perceptions of CNPs concerning service delivery in PHC facilities. In general, the aim of interviews is to acquire rich and descriptive information (Athanasou et al., 2012:89). It is considered an important tool for data collection in qualitative research studies where the researcher asks participants pertinent open-ended questions to explore their ideas, beliefs, views, and opinions.

The interviews were conducted in the operational manager's office where there was limited disruption. Three of the interviews were conducted in the morning hours while patients were obtaining their folders and being prepared to be in consultation with the CNP. The other three interviews were conducted later in the morning. Only one interview was conducted at the one clinic and two at the following clinic. The other CNPs continued with their work while one CNP was being interviewed. This ensures minimal disruption in service delivery. The information gathered reflected the full richness of the views held by the participant (Denscombe, 2007:165). The one-to-one interview enabled the researcher to focus and engage meaningfully in a dedicated period of time.

The interviews were audio recorded to enable the researcher to give her full attention to the participant, and to reflect on the spoken words as transcribed afterwards.

3.7   PILOT INTERVIEW

A pilot interview was conducted in order to determine whether the questions were clear and to refine the researcher's interviewing skills (Burns & Grove, 2011:49). The researcher's supervisor, a member of the academic staff of the Division of Nursing from Stellenbosch University, guided and supported the researcher in terms of interviewing skills. The researcher also attended an interviewing skills course, presented by the Department of Health. The pilot interview was conducted in one of the clinics not selected for the main study with one participant who met the inclusion criteria. The pilot interview assisted in determining the time needed for subsequent interviews. The questions were found to be relevant so no changes were made to the interview guide. The pilot interview data related to the data collected in the main study, and was included in the analysis process.

3.8   ETHICAL CONSIDERATIONS

According to De Vos et al. (2011:114), the researcher has an ethical responsibility to those who participate in the study. The researcher adhered to the ethical principles as follows: respectfulness, beneficence, confidentiality and anonymity, and informed consent.

3.8.1   The principle of respect for persons

The process of informed consent was set firmly within the principle of respect for autonomy, as participation in the study was voluntary and participants could withdraw at any stage without any penalty. Each participant was given the opportunity to refuse to participate in the study without any prejudice or harmful effects. The informed consent provided the tool for participants taking part in the data collection sessions, were informed, willing to take part and prepared to offer data freely (Shenton, 2004:67). Participants taking part in the data collection sessions were given a consent form to sign to show that they were informed, willing to take part in the sessions, and prepared to offer data freely.

Participants were also ensured that the information would not have negative consequences for them in future because the information will be reported on in a collective way without the possibility to relay any responses to individuals. No names or facilities would be mentioned in any report or feedback.

3.8.2   The principle of beneficence

Participants might not have been comfortable sharing information regarding service delivery with someone else. The researcher assured participants that limited, if any, discomfort or harm would arise from taking part in the study. The participants could end the interview at any stage when they felt uncomfortable. Provision was made to refer participants for counselling should they experience any undue distress. However, such support proved to be not necessary for any of the participants. Although it may take time to see any beneficial effects in the greater context, the study may have been beneficial to the participants (De Vos et al., 2011:116) as the researcher will support identified matters further on a range of platforms.

3.8.3   Confidentiality and anonymity

As indicated above, the anonymity of participants and the confidential nature of their inputs were of paramount importance. Participants were assured of anonymity and that the information would not be connected to them personally when feedback and recommendations were given to, for example, health care management. An example of such is that participants' names were replaced with numbers when the transcriptions were done in order to ensure confidentiality. Clinic settings were also not identified by name. The audio recordings will be kept for a period of five years in a secured and locked location. The audio recordings will be then discarded in a safe and secure way. The transcribed data are kept on the researcher's computer where it is password protected for a period of five years, to be available to document the validity of analysed data (Grove, Burns & Gray, 2013:532).

3.8.4   Informed consent

Each participant was given an information leaflet with a clear explanation of what the study entailed, and written informed consent was obtained before commencing the interview. Participants were legally and psychologically competent to give consent and did it out of their own free will.

Participants had tertiary qualifications and were thus able to fully grasp the nature and extent of the informed consent. However, ample opportunity was given to ask questions to confirm their understanding. Permission to conduct the study was obtained from the Health Research Ethics Committee of Stellenbosch University, protocol number S15/10/237. Permission was also obtained from the Department of Health, reference number WC-2015RP12-443.

3.9   DATA COLLECTION

The researcher first met with the operational manager of the various clinics, to introduce the study, and then a meeting was arranged with the potential participants to explain the process. The researcher explained that the interview would be used as a data collection tool. Participants needed to provide informed consent if they agreed to participate in the study. It was also explained that the interviews would be approximately thirty minutes in duration. The three largest PHC clinics and one CDC in the sub-district were selected for the study. CNPs available in the clinics, and who

were willing to participate, were interviewed. Because the interviews took place during working hours, it was easier to select the bigger clinics with more staff, so services could continue while conducting the interviews. Once permission was obtained to enter the PHC facilities, a date and time was set with the participants of each facility. Nine (n=9) CNPs were interviewed at the various clinics in the Eden district during May 2016.

Semi-structured interviews were used as a data collection method with face-to-face encounters between the researcher and the participant. With semi-structured interviews, the questions were open-ended and the responses facilitated to be free-flowing. Adequate room were provided for reflection and elaborating on points of interest (Denscombe, 2007:176). The questions provided the space for the participants to talk about their experiences, raise their opinions, and provide suggestions. The researcher endeavoured to make participants feel heard, and of being valued for their inputs as meaningful and important.

Interviews took place in an office at each of the five facilities, which was quiet and private. The participants regarded the venues at the various clinics as convenient, and the operational managers consented that their offices be used for that purpose. Each interview lasted about thirty minutes.

The interviews were meant to be comfortably exploratory and descriptive. For this reason, seven of the interviews were conducted in Afrikaans and two in English according to the participant's language preference. Seven open-ended questions were asked to CNPs who had agreed to be interviewed. The interviews were aligned with the research questions, aims and objectives. The researcher used probing words to encourage participants to elaborate on the topic. Recordings were done to ensure that no information was lost due to the researcher writing notes when interviewing.

After nine interviews no new information was forthcoming indicating that data saturation had occurred. Thus the final sample size was nine.

Backup copies of the recordings were made because qualitative data tend to be irreplaceable (Denscombe, 2007:289).

3.10   DATA ANALYSIS

Data analysis is the process of bringing order, structure, and meaning to the collected data (Denscombe, 2007:302). The data analysis process begins with the first participant's interview, so that ideas could be integrated into questions and probes in subsequent interviews (Burns & Grove, 2011:94). The data included all audio recordings and participants' information and was thus stored in the form of written documents and audio recordings. The data analysis was done according to the five stages described by Denscombe (2007:288).

3.10.1 Preparing data for analysis

Data were prepared, organized, processed, and filed in a way that makes them amenable to analysis. Backup copies were stored safely on the researcher's computer, which is password protected.

3.10.2 Familiarity with the data

The researcher repeatedly listened to the tape recordings to ensure that all data were captured. Observations and experiences were recalled while listening to the tapes. The researcher transcribed the audio recordings verbatim within 24 hours of recording. Verbal cues such as facial expressions and gestures by participants were noted in the transcriptions. The principle of bracketing was applied. Bracketing means putting aside what the researcher knows about the experience being studied (Burns & Grove, 2011:96).

The researcher became thoroughly familiar with the data by reading and re-reading the transcriptions. Re-reading involved reading between the lines to identify implied meanings in the data that are significant in terms of the research topic. Consideration was given to the circumstances surrounding the interviews and to events that might have influenced what was said during the interview. By becoming familiar with the data, the researcher could identify appropriate codes to apply to the data (Denscombe, 2007:291).

3.10.3 Interpreting the data

Interpreting the data involves a series of four tasks.

3.10.3.1 Coding the data

Coding is the process of breaking text down into sub-parts to identify and label relevant categories of data (Burns & Grove, 2011:94). Codes are tags that are attached to the raw data. The data were searched for commonly occurring themes and patterns. Words and phrases representing these patterns were written down. These words and phrases formed the coding categories. Codes were used to link bits of data to an idea that relates to the analysis.

3.10.3.2 Categorizing the codes

Codes were then grouped into categories that act as an umbrella term under which a number of individual codes were placed (Denscombe, 2007:292). Relationships between the codes and categories are identified and the researcher becomes aware of patterns and themes related to the research aim.

3.10.3.3 Identifying themes

The researcher identified relationships between the codes and categories of data. Themes and sub-themes were generated and applied to the data.

3.10.3.4 Developing concepts

The researcher developed a generalized conclusion based on the themes, relationships, and patterns that have been identified in the data.

3.10.4 Validity of the data

Trustworthiness refers to the accurate and truthful way in which qualitative research data are collected, analyzed, and reported (Athanasou et al., 2012:140). Trustworthiness was enhanced through concerted efforts to attain credibility, transferability, dependability, and conformability.

3.10.4.1 Credibility

Credibility of data refers to the way in which the study was conducted to ensure that the area of interest has been accurately identified and described (De Vos et al., 2011:420).

The semi-structured interview was based on the aim and objectives of the study and validated by the supervisor from the Division of Nursing at Stellenbosch University during a proposal presentation that was attended by PHC experts, as well as resultant follow-up meetings.

Interviews were audio taped and transcribed verbatim and the transcriptions were checked for accuracy against the tapes. To further enhance the credibility, an in-depth description of the research process – including sample selection, research setting, data collection, and data analysis – was given.

3.10.4.2 <u>Transferability</u>

Transferability refers to the applicability of findings to other situations (Pilot & Beck, 2008:539). When research is conducted within the same parameters, they can determine whether or not the findings can be generalized and transferred to other situations (De Vos et al., 2011:420). Sufficient description of the phenomenon under investigation was provided to allow readers to have proper understanding and to compare it with their situation (Shenton, 2004:70).

3.10.4.3 <u>Dependability</u>

Dependability refers to the stability and consistency of the research process and the methods used (Athanasou et al., 2012:140). A detailed record of the research process was kept. This enabled a monitoring and review process by the supervisor and, if necessary, by the Health Research Ethics Committee of Stellenbosch University. The interviews were transcribed verbatim.

The supervisor and the researcher discussed the transcripts and clarified differences of opinions to ensure that the interpretation of the transcripts was consistent with the recorded interviews.

3.10.4.4 <u>Conformability</u>

Conformability refers to the absence of research errors and the objectivity of the data (Athanasou et al., 2012:140). The audio recordings were compared with the transcriptions, and then followed by a reflection on the categories and themes as deduced from the data. The research process was supported and verified by the

supervisor. The study findings are the results of the experiences and ideas as voiced by the participants, and not the preferences of the researcher (Shenton, 2004:72).

3.10.5 Representing the data

This refers to the description of the processes used to move from raw data to the findings of the study (Denscombe, 2007:301). The researcher compiled a written account of the interpretations that emerged from the data analysis.

3.11 SUMMARY

This chapter entails a report regarding the research methodology applied in the study. A description of the goal, the objectives, research design, population, and sampling method, including the ethical considerations, are presented. A detailed account of the data collection and analysis processes are provided. The interpretations of the findings are provided in chapter 4.

CHAPTER 4
FINDINGS/RESULTS

4.1   INTRODUCTION

This chapter details the perceptions of clinical nurse practitioners (CNPs) concerning aspects of service delivery in Primary Health Care (PHC) facilities in the Eden district, Western Cape. The CNPs perceptions were obtained from in-depth interviews conducted in May 2016. A total number of nine (n=9) participants were interviewed. To ensure confidentiality, participants were not referred to by name but were assigned a number from one to nine.

Qualitative data analysis involves the careful structuring and interpretation of collected data (Denscombe, 2007:302). In this study, data collection and interpretation occurred simultaneously. The data was analyzed according to an approach described by Denscombe (2007:288) and detailed in chapter 3 (Section 3.9).

Data were collected by means of audio recordings. The researcher became immersed in the data by listening to the recordings and by reading and re-reading the transcribed interviews to obtain both an overall and specific understanding of the data as presented. The researcher used a manual method to analyze the transcripts according to the outline as provided by the interview structure. The findings are presented in two sections. Section A presents the biographical data of participants and Section B focuses on the themes and sub-themes that emerged from the data.

4.2   SECTION A: BIOGRAPHICAL DATA

4.2.1   Age

The ages of participants ranged from 30 to 60 years with one (n=1) participant being 30 years old. The majority (n=7) of the participants were in the age group 35 to 55 years of age and one (n=1) participant was 60 years old.

4.2.2   Gender

One (n=1) male and eight (n=8) female CNPs were interviewed. The high ratio of female to male participants is consistent with a female dominated nursing workforce in South Africa.

4.2.3   Work experience

The length of employment of participants varied from 2 to 20 years as a CNP. One of the participants was working in a hospital setting as a theatre nurse before qualifying as a CNP. Another participant worked in a PHC setting as a registered nurse before training further to become a CNP. The other seven participants were working in PHC settings at different facilities since they obtained their PHC qualification.

4.2.4   Qualification in PHC

All nine (9) participants were in possession of a diploma in PHC for more than two years.

4.3   SECTION B: THEMES EMERGING FROM THE INTERVIEWS

Sub-themes emerged from the six major themes. The themes and their sub-themes are summarized in table 1 below and are then discussed in detail.

Table 1: Themes and sub-themes

Themes	Sub-themes
Expansions in duties / roles	Treatment initiation Specialized care Increased responsibility
Impact of extended duties on day to day Services	Increased workload Low morale Quality of service delivery Decreased job satisfaction
Challenges to comply with the changes and impact on service delivery	Available resources Infrastructure Long waiting time Staff shortage
Barriers and enablers	Quality of service delivery Teamwork Commitment Appreciation from management
Ideal responsibilities of CNP	Manageable workload Appointment system

4.3.1   Theme 1. Expansion in duties / roles

This theme relates to participants' perceptions and experiences related to an expansion or increase in their duties and roles. This specifically focused on treatment initiation, specialized care, and resultant increased responsibility.

4.3.1.1 <u>Treatment initiation</u>

The participants noted treatment initiation as a specific area where their duties and roles had expanded. According to the participants, medical practitioners previously initiated patients' treatment, for example, for hypertension and diabetes. Currently the expanded roles of CNPs include detailed clinical assessment, treatment initiation, prescription of scheduled drugs, and follow-up which was seen as placing a significant responsibility on the CNP. Participant 1 stated that

> "*In the past the CNP didn't start a patient on diabetic treatment, nor with blood pressure treatment. We used to refer them to a doctor but now, with the PACK training, the CNP can start those patients.*"

Participant six specifically referred to the increased responsibility and expansion of duties and acknowledged the past where it was considered easy to only refer a patient to a medical practitioner:

> "*I had to start with the chronic hypertension clients and diabetic clients … so for me it has extended … it placed much more responsibility upon me with that client, whereas before I could easily refer him to the doctor.*"

4.3.1.2 <u>Specialized care</u>

Participants noted that they deal with a large number of clients with diverse and often specialized needs. Specific note was made of patients with HIV-related conditions and who are on antiretroviral therapy (ART). In order to manage these patients, PHC nurses need to undergo short course training in HIV/ART/TB and are clinically mentored to the mentor's satisfaction. Participants found themselves competent to render such services, but felt the pressure and intensity of providing this specialized care. Participant 1 emphatically stated that "*you must work more intensely with that*

patient". Another participant provided insight into what transpired in terms of such a specialized service:

> *"Initially ARVs were treated as a specialized clinic, where you had a separate ARV clinic … now they've decanted that function to the clinics as well." (Participant 4)*

4.3.1.3 <u>Increased responsibility</u>

Participants expressed the concern that their responsibilities have increased as they need to navigate a number of matters: for example, initiate new treatment, provide health education for a respective patient, and provide the necessary follow-up:

> "*So the responsibility is more, yes, because if you send the hypertension patient out of the clinic, then you must know he's been treated well and correctly in order to be able to carry on; and also that he has the correct information on how to use the medication and so on." (Participant 1)*

Participant 2 emphasized the fact that it is a challenge to be consistently informed of the latest protocol and to provide the best possible care for your patient:

> *"So it's a challenge to always be alert; it's a challenge to always be wide awake, to be up to date on our protocol, and always to know that I am doing what is best for the patient".*

The CNP with the registered post basic qualification in PHC is an authorized prescriber who can treat chronic patients according to the Practical Approach to Care Kit (PACK) guideline for adults (PACK, 2015). The PACK guideline was developed by the Knowledge Translation Unit (KTU) at the University of Cape Town's Lung Institute. This guideline addresses the most common presenting symptoms and chronic conditions in adults attending PHC clinics. It became evident during the interviews that participants currently perceive these as added responsibilities, as stated by participant 6:

> *"It placed much more responsibility upon me with that client".*

Participants acknowledged the value of the PACK program and the included manual that provided them with the necessary support and competency to manage a patient

comprehensively. Participants felt comfortable and safe to manage chronic patients. Participant 2 stated:

> *"Because without my PACK I actually feel, you know I cannot work comfortably and if they tell me to go relieve somewhere today, then I pack in all books and my PACK goes with me wherever I go. … But for me, it has helped, really, it helps because there's a reference with every illness, there's a reference. I go and refer with anything that I'm not sure of. I feel much more comfortable."*

4.3.2 Impact of the expansions on day to day services

Participants considered the expansions affected their ability to meet all of their obligations, leaving them feeling overloaded and unable to meet all demands. They experienced an increase in their workload, low morale, and a decrease in the quality of service delivery.

4.3.2.1 Increased workload

Participants perceived the management of patients with chronic diseases as extra and an extension of their roles and duties. One participant described the treatment initiation and management of chronic patients as contributing to the increase in their workload.

> *"The load has become much heavier you know, because now there are all these new things that have been added … the chronic patients … that are also an extra job that has come to us." (Participant 9)*

Participant 6 was also concerned that the patient to nurse ratio was unrealistic and that they cannot always cope with the extended roles and responsibilities.

> *"I don't know if the ratio that they worked out, the sister/patient ratio in South Africa, you know, if that is realistic, if it's humanly possible to attain with all these other things."*

Participants experienced the completion of different forms and documents time consuming. They need to complete different documents for patients on chronic medication and patients on ARVs.

Participants pointed out the positive improvement in the management of children under five using the IMCI strategy (Integrated Management of Childhood Illnesses). The IMCI strategy was developed by the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) in 1995. IMCI offers a set of interventions that promote the recognition and effective treatment of children under five (Xaba, Peu & Phiri, 2012:6). The completion of IMCI documents together with chronic and HIV care documentation were perceived to be challenging.

"In the beginning they only examined the sick children and then the IMCI program came in. Now it's chronic: the asthma, the epilepsy, diabetic, and hypertension. All have a tick sheet of all that must be done for those patients in order to deliver a better service." (Participant 4)

The writing of notes on different documents/sheets was experienced by the participant as extra work and time consuming.

"Because you have pages and pages to fill in, then you have the observations here, and especially in PACK, right, you do it there. Then you must go to the file and do it again. Whereas if it was only one thing that you had to fill in, rather than all these duplicates." (Participant 8)

Participants remarked that the HIV and AIDS pandemic places immense strain on the national health system and overwhelms the PHC setting. Participant 4 stated that ARV patients need significantly more time to be managed comprehensively:

"So that takes up a lot of one's time, because it's not only initiating the patient, but other things that is coupled to it, counselling, and the paperwork with the consultation and so forth."

4.3.2.2 Low morale

Participants were concerned that staff shortage is one of the contributing factors that cause a low morale among staff. They emphasized the shortage of nursing staff as a major contributor to poor staff morale. Participants experienced a feeling of failure; this made them feel bad about themselves and the quality of service they rendered. Participant 9 noted:

> *"Sister the personnel are hopelessly too few. Mean for the amount of patients that we're seeing, and I think that's why the personnel's morale is so low."*

Participants described the expectations of the health care system as unrealistic with regard to the targets they are supposed to meet, taking into account the shortage of staff. They feel that they need to rush through their consultations, and do not always find the time to do important investigations such as, for example, cervical smears. Participants understand that to meet the set targets, is considered to be evidence of quality service delivery. They are of the opinion, however, that due to such limitations within the system, quality service delivery is not always achievable. The participants mentioned that they experience a high workload and that they do their best to deliver a quality service, but are still not able to meet stated targets. This impacts negatively on their morale.

> *"It does actually bring your morale down a bit because, in the first place, if you give quality care and you do your best and then they come tell you that you didn't meet your target and all that, then it feels as you've done nothing but you know you've done your best for that patient." (Participant 8)*

At the time of the interview participants did not feel appreciated by their managers. Although participants receive remuneration for the services rendered they experienced a need to be thanked.

> *"If those in higher positions … can just boost the nurses a bit, and say to us, thank you very much for the good work you've been doing, and thank you to those who have actually been working. But I mean we are all tarred with the same brush, and that makes one negative. The morale is really very low here." (Participant 2)*

Job satisfaction represents the degree to which employees enjoy their jobs and how much importance or value is attributed to the job (Munyewende et al., 2014:2). Participants expressed the feeling that their work goes unnoticed:

> *"You are only there to do your job; you don't need to do anything extra, because no-one notices it." (Participant 2)*

Participants stated that the constant changing of protocols and standard operating procedures also causes a further increase in pressure. They have just managed to understand one set of protocols, then it changes again and they need to put in more effort to understand and implement the changes. One such example is the frequent changes in HIV management. The participants described frequent changing of management protocols as a contributing factor to increased pressure.

"I think it adds extra pressure on the sisters, and things are changing all the time. So they are snowed under with changes." (Participant 6)

Some participants have training needs but due to staff shortage they are not always able to attend the training events. Participants felt deprived of opportunities to broaden their knowledge and improve their skills. This contributes to their feeling of negativity. A participant, who is an operational manager, stated that due to the shortage staff cannot be released to attend training:

"Sometimes you can't even send someone for training, because then who is going to perform the services at the clinic." (Participant 4)

Participants acknowledge that the quality of service delivery is compromised by the high patient load and staff shortage. They seem to rush through important aspects of patient care such as a comprehensive assessment and do not always manage the patient comprehensively due to limited time and the number of patients waiting. Participants acknowledge that patients return to the health facility repeatedly because they were requested to come back, or their health care problem was not meaningfully attended to, and/or they were not satisfied with the service they received.

"That patient did not always receive everything they need. It does sometimes happen that the patient must come back again." (Participant 2)

Participants directly link limited staff and increased workload to their inability to attend to all the needs of their patients. Time is limited whilst the needs of patients and what constitutes meaningful quality care is not addressed.

"You're expected to see this number of patients, with a limited number of staff. We're expected also to do pap smears. You now, when you're rushing to see

the patient sitting there for a whole day, you really don't have time to….”
(Participant 3)

Participants highlighted the significant pressure they are under in a system that tries to meet and emphasizes the fast tracking of patient appointments that are also increasing significantly. Under such circumstances participants state that, due to such expectations, so-called "next" patients receive less and less quality care.

"It places one under a lot of pressure, because the amount of patients isn't getting less, so sometimes the next client would get less time, because I must finish up quickly so that I can get through the next few patients." (Participant 6)

This further contributes to feelings of despair.

"You must look at everything, but with the amount of time we had, if you look at the files, oh I'm not going to make it." (Participant 7)

4.3.3   Challenges to comply with changes and the impact on service delivery

Participants described unavailability of resources, poor infrastructure, and staff shortage as challenges to comply with changes. Participants noted that a fully equipped examination room containing all the necessary equipment is a prerequisite for quality service delivery.

4.3.3.1 <u>Availability of resources</u>

Participants were of the opinion that for a CNP to render a quality service, the area where the patient is to be examined should be equipped and comfortable. Furthermore, all medication needed to treat the patient should be available, so that patients do not need to come back or be referred.

"She must have space, and all her equipment must be in that room, all the equipment – a well-equipped room. She must have the necessary medication, and the guidelines, the SOPs must be there, and everyone should know them." (Participant 6)

The prescribed medication for the treatment of a condition is not always available and it happens that patients do not receive prescribed medication, and sometimes then visit another health facility to obtain such. Pharmaceutical treatment options as well as diagnostic and medical equipment are considered essential to provide quality service delivery. The participants were of the opinion that they sometimes cannot deliver the appropriate service to the patient because resources are not available. A participant stated that the necessary equipment is not always available in all the examination rooms and that participants need to literally go and find certain equipment, which is time consuming. Patients sometimes leave the facility without the required investigations being done as a result of the unavailability of equipment. Participant 1 noted:

> *"Like at the moment I share an HB meter with the curative section and today I'm at antenatal, so we share, and we have to walk up and down."*

Participants stated that the medication needed to treat a condition is not always available due to pharmaceutical stock limitations. Participant 1 emphasized that

> *"To us it would be ideal if the medication is always available … if our equipment was in good working condition."*

The same participant noted that so-called "medication stock outs" are frequently experienced. This causes inconvenience for the patients because they need to be referred to another facility where such medication is available. This was also reiterated by participant 6.

> *"The medications are ordered at specific times, and then you get this thing of a certain medication is not available. … He can't get his medication here and then we have to refer the client to the closest clinic with a pharmacy. The doctors are here twice a week, which also, as I said, makes it difficult, because some patients need to be referred." (Participant 6)*

Participants expressed the need and the importance of support staff. The Department of Health (DoH) also acknowledges that the lack of administrative and information management staff increases nursing staff's workload (DoH, 2014c), but the situation on the ground seems to be the lack of adequate human resources. Participant 8 states a "wish list" of human resource needs.

"I would say there must be a pharmacist, there must be a doctor, reception staff, nurses who can climb in, because if there aren't nurses, then you must do the nurse's job as well. So there must be nurses to do the observations. And your cleaners are also important, because it must be clean and tidy here, and your health promoters, counsellors." (Participant 8)

4.3.3.2 Infrastructure

Participants described some of the facilities as overcrowded. This was evident to the researcher when she visited facilities over time and during the data collection phase. A study conducted in Gauteng found similar conditions and that, due to limited resources that affected the availability of space, some programs could not be introduced in certain clinics (Xaba et al., 2012:5). Participants noted that overcrowding has a negative impact on their service delivery as they could not always examine patients properly:

"The clinic is overcrowded; it's small for the number of patients, so some of the things you are unable to do." (Participant 3)

Participant 2 was of the opinion that because of lack of privacy, patients did not receive comprehensive health care services:

"*But now I can't lock my door, so I must move to another office where the door can be locked, where I can do family planning and pap smears. At this stage I can't do it, because I'm alone, I can give you an injection in the arm, you understand, but I can't do pap smears.*"

Some of the participants reported a lack of privacy, especially in some clinics where two patients are separated only by a curtain in the observation room. They could hear one another. Lack of privacy has an impact on history taking because patients do not feel comfortable to reveal personal information, if they know somebody else can listen in on confidential information.

4.3.3.3 Staff shortage

Participants described staff shortage as a critical challenge – especially in the context of the expansion of roles and duties and to render quality services. The

perceptions of participants were clear that staff shortage at all levels impact negatively on service delivery. The Ideal Clinic Realisation and Maintenance (ICRM) report revealed a shortage of personnel highlighted by a sub-optimal distribution of existing resources. The already constrained resources are compounded by the mismatch of existing capabilities and the workload (DoH, 2014). One participant stated that the patient numbers are too high for the number of available staff.

> *"Patient numbers … it's so vast, for the number of staff we're having here. And you know the pressure and tension it's going to cause. But once again that revolves around staff shortages." (Participant 3)*

Participant 1 expressed the concern that clinics are not always sufficiently covered with staff to ensure quality service delivery.

> *"If we can get more personnel, then at least our departments would be covered, because today, for instance at primary health care, I was moved to another section. So that leaves curative with one less sister."*

Participants experienced high levels of pressure in the management of patients on ARTs because all CNPs are not yet trained to initiate ARVs and the number of patients needing ARVs increased. Participant 2 stated that

> "*There are many patients and the pressure is terrible, especially because we are only two trained sisters and there are a lot of ARV patients.*"

Participants expressed the need for training of all CNPs. This will prevent patients from being sent away to appropriately trained CNPs:

> *"So now I must refer them to the women's health, but if we were more sisters…." (Participant 2)*

According to participants, staff shortage is a challenge within the expanded programs:

> *"I think that the challenge, to me, is the staff shortages." (Participant 3)*

Participants were of the opinion that the staff shortage is experienced more intensely when a colleague is absent due to planned/unplanned leave, ill health, or had to attend in-service training.

"There are sometimes people on leave, someone off sick, and someone gone for training. So the pressure on those who remain behind becomes greater." (Participant 6)

4.3.3.4 <u>Long waiting time</u>

Participants have the perception that patients often require lengthy consultations as a result of the expansion in their roles and duties. This, according to them, increases the waiting time for patients to see the practitioner.

"The impact that it had on our service is that we now spend more time with that patient. If you diagnose a patient with hypertension, after you've tested his blood pressure three times, and by the third time, not on the same day though, three times in a row, we could refer the patient to a doctor. But now you sit with that patient, you work longer with the patient." (Participant 1)

Participants experienced an increase in their consultation time with patients following the implementation of expanded programs. Participant 2 noted:

"*Because the patients are still sitting here for a long time and I don't get to all of them.*"

It is the perception of the participants that an increase in the staff component will improve the quality of service delivery and decrease waiting time for patients.

"If there are more of us, then you help the patients – then the waiting periods are also shorter." (Participant 4)

Participants expressed the need for more staff to attend to patient's' needs. The availability of more staff will reduce the long waiting time for patients.

4.3.4   Barriers and enablers to the quality of service delivery

4.3.4.1 <u>Barriers</u>

Barriers are obstacles that prevent or complicate the desired outcome**.** Participants identified a high workload, aggravated by the staff shortages, as a barrier to render quality service. They acknowledged that the quality of service delivery is

compromised by the high patient load and staff shortage. They seem to rush through important aspects of patient care such as a comprehensive assessment and do not always manage the patient comprehensively due to limited time, and the number of patients waiting. Participants acknowledged that patients return to the health facility repeatedly because they were requested to come back, or their health care problem was not meaningfully attended to, and/or they were not satisfied with the service they received.

"That patient did not always receive everything they need. It does sometimes happen that the patient must come back again." (Participant 2)

Participants directly link limited staff and increased workload to their inability to attend to all the needs of their patients. Time is limited whilst the needs of patients and what constitutes meaningful quality care is not addressed.

"You're expected to see this number of patients, with a limited number of staff. We're expected also to do pap smears. You now, when you're rushing to see the patient sitting there for a whole day, you really don't have time to…." (Participant 3)

Participants highlighted the significant pressure they are under in a system that emphasizes the fast tracking of patient appointments that are also increasing significantly. Under such circumstances participants state that, due to such expectations, so-called "next" patients receive less and less quality care.

"It places one under a lot of pressure, because the amount of patients isn't getting less. So sometimes the next client would get less time, because I must finish up quickly so that I can get through the next few patients." (Participant 6)

This further contributes to feelings of despair.

"You must look at everything but, with the amount of time we had, if you look at the files, oh I'm not going to make it." (Participant 7)

Participants expressed the need for patients to take responsibility for their own health. Patients who do not adhere to their prescribed medication and scheduled follow-ups cause participants to feel demoralized. Participant 1 stated:

"And now from the heart of a nurse, you want to help the patient, but now the patient comes to you and he hasn't helped himself. But your service that you have already given to him also falls by the wayside, because now you have to start all over again with that person. So it's the same thing over and over again, and that's demoralizing for a person, a nurse in white, who at the end of the day is also only human."

4.3.4.2 Enablers

Enablers are capabilities, forces, practices, and personal beliefs that make things possible and contribute to the success of a program or project. Participants express teamwork, commitment, and appreciation from management as enablers to render quality services.

4.3.4.2.1 Teamwork

Participants identify teamwork as one of the contributing factors that enable them to deal with the challenges of expanded programs. Participants expressed the value of good teamwork and the effect it has on service delivery. One participant noted that good teamwork and the dedication of the group encouraged them to deliver quality service.

"If you have dedicated staff, and if you have all your equipment, then you can do it … if you have a group who work well together." (Participant 6)

4.3.4.2.2 Commitment

A number of participants spoke about ethical commitments to the patient and what the essence thereof is. Their love for human beings and the need to treat them with respect came through in the words of participant 1.

"When I think of the promise we made years ago when we first became sisters, and to me personally it's my love for people. … It is by treating the patients with respect."

Being part of the community is also seen as a plus factor. Participant 5 stated that

> "*…to know your community also makes it easier. It's a fairly stable community, being that you do get a few new people into the service, but you know your clients because they are here, they don't move in and out.*"

One participant emphasized her love for the community and the enjoyment she feels from giving back to a community where she grew up.

> "*I enjoy the work that I do, and I am from this area, or I used to live around here. I used to live here and I went to school here, so to me it's like giving back to the community.*" (Participant 6)

Participants enjoy being working in PHC clinics, and experience this as an opportunity to serve their community.

4.3.4.2.3 Appreciation from management

It became evident that even the smallest sign of appreciation from management inspires and encourages participants to give their best, regardless of the circumstances. An environment that fails in incentivizing the desired behavior leads to a lack of motivation (DoH, 2014:5). Participants described the feeling of upliftment they experienced on days when they received special attention, for example on occasions such as International Nurses Day.

> "*When we are uplifted on Nurses Day, then we feel we are worth … I believe it helps every nurse on her way forward.*" (Participant 1)

4.3.5 Ideal responsibilities of CNP

4.3.5.1 <u>Manageable workload</u>

CNPs are specialists who offer the first level of nursing care that patients receive. They are considered competent to independently render an appropriate and skilled PHC service. CNPs conduct physical assessments, diagnose illnesses, provide direct care to patients, and refer patients for further treatment if necessary. CNPs prioritize and effectively manage their own patient load (South African Nursing Council, 2014). It is the perception of participants that they should be able to focus on patient care and that their workload should be managed effectively.

"I think the responsibilities, it would be, I mean, to be able, to manage my workload, and manageable workload. Be able to manage my patient, to be able to diagnose. That is an ideal responsibility. Then anything that is above, you cannot manage, then there's somebody who's available for you to refer." *(Participant 6)*

Participants stated that assessment, diagnosis, and treatment of patients are their key responsibilities, but the other extra duties make it impossible to render quality service at all times. Participant 4 stated:

"If only they could do that, then that would be the ideal yes, then she could spend more time with her patients, or perhaps even see more patients."

Some participants revealed little job satisfaction because of the increased workload. They would like to render a more comprehensive service but, due to the number of patients they need to manage, they feel that they run out of time. Participant 3 expressed her wish to

"*…be able, to manage my workload, and be able to manage my patient.*"

The participants needed to cope with the increased patient load and therefore perceive any other responsibility as additional and problematic. An example would relate to one of the CNPs' core responsibilities that are to keep and share accurate statistical data (SANC, 2014). Because their patient load is not always manageable, they sometimes neglect some of such responsibilities. Participant 4 described "statistics" as "extra work".

"So there's also extra work, some people have to submit statistics at the end of each month, over and above the CNPs work."

4.3.5.2 <u>Appointment system</u>

Participants working in facilities where an appointment system was not implemented suggested the implementation of such a system. This will enable them to plan their duties for the day. The participants were of the opinion that the appointment system will improve the long waiting times for patients as well.

"The appointments, if you book a patient for an appointment, then the patient won't have to sit here so long, you understand?" (Participant 2)

Participants also raised their opinion regarding the fact that CNPs move swiftly through their consultations in order to see all the waiting patients. This sometimes leads to missed opportunities and possible misdiagnosing of ailments due to the fact that the CNP is in a hurry. She might have not noticed certain signs or symptoms that needed attention. Special investigations/tests could also be omitted because the CNPs are in a hurry and do not have time to do or request necessary tests. A participant stated that appointments will ensure quality time with each patient, which will improve the quality of service delivery.

"To be able to work on an appointment basis and to be able to give quality time to the patient." (Participant 2)

4.3.6   Proposed recommendations

4.3.6.1 <u>Sufficient staff</u>

All participants passionately expressed their desire to have sufficient staff that, according to them, will improve the quality of service delivery. Sufficient staff, including nursing staff of all categories, and administrative staff was considered important. The ICRM report revealed that services of all other categories of staff are performed by CNPs, including pharmaceutical services. Sufficient staff will enable CNPs to focus on their duties/roles.

"One huge recommendation', and we keep banging our heads against a brick wall on this one, is personnel." (Participant 1)

It became evident that the staff shortage reflected negatively on the participants' perception, which was aggravated by the expansion of roles and duties. Participant 3 noted:

"Recommendations? Not really; except, you know, providing staff."

One participant described the ideal clinic in terms of sufficient staff in the first place followed by cooperation amongst staff:

"Ideal clinic, oh if I … enough staff, that's the first thing, if there could be enough staff and enough cooperation amongst the staff." (Participant 8)

Participants realized that it is not possible to simply appoint staff because of budgetary constraints, but they acknowledge the impact of staff shortages on service delivery.

"I know we can't always ask for more personnel, but I do think it plays a big role." (Participant 4)

4.3.6.2 Appropriately trained staff

The training of CNPs to manage patients on ARV therapy was expressed as an essential consideration. Participants stated that the workload, with regard to the management of ARV clients, will be less stressful if more CNPs are trained to initiate ARVs. The ideal will be that all CNPs be appropriately trained to initiate ART. This will lessen the waiting time and patients will receive a one stop service and thus do not need to be referred. Participants described a feeling of frustration when patients are referred to them because they are the only practitioner trained to initiate ART. Participant 2 stated:

"We have PHC sisters, like CNPs, but they can't prescribe ARV, you understand? Now the patient must be sent to me."

4.3.6.3 Infrastructure

The quotes demonstrate that more should be done to ensure that facilities can accommodate the community, especially in rural areas. Participants identified a need for more space for the escalating client numbers. All services cannot always be rendered in some of the smaller clinics. These needs were stated as follows:

"At the moment we are fully staffed, but space is a problem. As you can see they are busy building on, so that's a problem." (Participant 6)

Some participants who work in smaller clinics indicated the need for space, privacy, and an appropriate waiting area. They consider space as a necessary requirement to render certain programs such as Prevention of Mother to Child Transmission (PMTCT) and Voluntary Counseling and Testing (VCT).

"We really get people who say no, I'm rather going to come back another day, or was here this morning, and it was too full. So the space at this moment…" (Participant 6)

Participants acknowledged the need for a suitable building to render appropriate services to the community:

"The first thing I would put on that list is a new clinic. A new clinic with enough waiting areas; enough toilets that aren't blocked up every two weeks, that's the first thing I would put on that list." (Participant 9)

4.4   SUMMARY

In this chapter the findings were discussed. The findings confirm that the expanded programs have an impact on service delivery. Factors that influence participants' perception of the services rendered at PHC facilities include, for example, the increased workload and the shortage of staff to manage the constant changes. Chapter 5 provides a reflection of the findings and recommendations in line with the stated objectives; the limitations of the study are also identified and discussed.

CHAPTER 5

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1   INTRODUCTION

This chapter focuses, amongst others, on the discussion of findings supported by insights from expert authors and relevant research studies. The aim and objectives, as stated in Chapters 1 and 3, guided the structure of this discussion – focusing on the interpretation of interview data as collected and analyzed in Chapter 4. Clinical nurse practitioners (CNPs) shared their perceptions of service delivery, especially in the light of expanded programs. The rest of the chapter includes recommendations for service delivery in Primary Health Care (PHC) facilities, research and education, followed by a description of limitations and a conclusion.

5.2   DISCUSSION

The aim of the study was to explore the perceptions of CNPs regarding factors that influence service delivery in expanded programs in PHC facilities in the Eden District of the Western Cape. The specific objectives set out for the study were to

1. Explore the perceptions of CNPs about service delivery at primary care level.
2. Understand how changes in the responsibilities of CNPs have affected service delivery.
3. Identify barriers and enables to the quality of service delivery.
4. Describe the views of CNPs related to the current versus ideal responsibilities of CNPs.

These objectives were pursued using semi-structured interviews with CNPs that focused on exploring their perceptions regarding the factors that influence service delivery in expanded programs in PHC facilities.

The findings of the study are discussed in relation to each of the study objectives.

5.2.1 Objective 1: Exploring the perceptions of CNPs about service delivery at primary care level

The perceptions of CNPs with regard to staff shortage and their negative impact on service delivery support the literature, claiming that the main challenges faced by the National Department of Health (NDoH) are the availability of infrastructure and human resources (Mathibe, Hendricks & Bergh, 2015:3). The efficiency of PHC services, as described by all the participants interviewed, was influenced by factors such as adequate staff, proper infrastructure, and the availability of resources. Participants raised their concern regarding the decreased quality in service delivery, which is a result of an expansion of their roles and responsibilities. This was aggravated by the shortage of staff. Kautzky & Tollman (2008:26) confirmed that clinics are disproportionately affected by staff shortages and inequities in resource distribution. Participants experienced an increase in their responsibilities following the shifting of roles and duties from doctors to CNPs. This shifting of responsibility specifically refers to the initiation of chronic medication in patients with non-communicable diseases (NCDs) and on antiretroviral therapy (ART). Key aspects emerged such as increased workload and the shortage of appropriately trained staff.

5.2.2 Objective 2: Understanding how changes in the responsibilities of CNPs affect service delivery

The summary of the health status of South Africa reported a rising burden of (NCDs) including diabetes and hypertension. The growing health workforce shortage to manage the burden contributed to task shifting. Task shifting describes the transferal of tasks normally performed by a physician to a health professional with a different level of education and training (Lekoubou, Awah, Fezeu & Sobngwi, 2010:355). This approach was intended to help strengthen the health force to respond to the changing public health needs (Word Health Organization, 2016). The shortage of doctors to initiate ART to patients with HIV was one rationale for applying task shifting.

CNPs are registered with the South African Nursing Council (SANC) to conduct physical assessment, diagnose illnesses, and prescribe treatment (SANC, 2014:1). The initiation of chronic medication was previously the responsibility of a physician. Following training in the management of patients with NCDs, CNPs were authorized

to initiate and re-prescribe chronic medication. The aim was to increase the capacity of primary care services to prescribe medication appropriately to common life-threatening conditions (DoH, 2013b). CNPs were trained to assume responsibility for ART initiation and re-prescribing (Fairall et al., 2012:890). Task shifting strategies often arise informally in the clinic when providers take on additional administrative and clinical responsibilities in order to ensure continued provision of services (Morris et al., 2009:3). The effects of task shifting increased the responsibilities, roles, and duties of the CNP. Expanding CNPs' role has the potential to improve access to and quality of care, but the overall responsibilities of the CNP should be reviewed.

The findings of the study demonstrated that the changes in the responsibility of CNPs affected service delivery in the following ways: increased workload, low morale of the participants, and decreased quality in service delivery and job dissatisfaction.

5.2.2.1 <u>Increased workload</u>

The majority of participants agreed that the expansion in their roles and responsibilities increased their workload tremendously. The initiation of medication in a HIV-positive patient takes more time, and CNPs are then still responsible for a number of other duties. Similar to a study conducted in PHC facilities in Tshwane, Gauteng Province, high workload has a negative effect on the quality of care rendered. Reasons for high workload included staff shortages and increased activities such as counselling, examination, routine investigations, the amount of forms to be completed, management of side effects and complications, self-dispensing, and issuing treatment from consulting rooms. Because participants sometimes need to rush through consultations in order to help all the patients, it happens that they just focused on priorities and did not manage the patient comprehensively. Mash, Mayers, Orayen, Kuiper, Cornelissen and Titus (2007:17c), stated that CNPs felt responsible for managing all the patients who visit the facility whereas doctors concentrated on seeing only a certain number of patients in the time they were available.

CNPs are apparently not able to provide care to all the patients as they expect from themselves – essentially contradicting the requirements of an ideal clinic that is

described as a clinic that provides quality services to the community (DoH, 2015:13). An increase in administrative tasks results in frustration, as CNPs need to spend time on activities that they perceive as less important, leaving the CNPs feeling dissatisfied with their own performance.

5.2.2.2 <u>Low morale</u>

Participants expressed an increased work pressure due to staff shortages. These pressures lowered their morale and decreased job satisfaction. They felt that they are not rendering a quality service to patients because they need to speed through consultations. Similar to findings reported by Satyadi (2014:1), participants also experienced a low morale because of an increase in their workload. Some participants perceived and experienced targets as unrealistic and unachievable. They stated that they worked hard to reach such targets, but ended up feeling that they have failed or were inadequate. Therefore, instead of motivating improved performance, targets may have the effect of demoralizing the CNPs. According to Owen (n.d.) targets do not motivate public servants because they already want to perform well and such target setting is perceived to not be able to help someone work harder. Instead, targets cause people to behave in a contrary way to meet the numerical target and may lead to behavior that corrodes the quality of the service to the client. Targets also become associated with measurement, reporting, and validation – all of which may divert energy away from the task practitioners need to focus on.

Participants expressed the need that managers should at times appreciate good work. This will make them feel that their efforts are noted and will contribute to a feeling of worth. This will uplift their morale, increase their job satisfaction, and improve service delivery. Hertzberg (1966) distinguishes between intrinsic and extrinsic factors where intrinsic factors, called motivators, are associated with the experience and nature of doing work. Therefore, satisfaction with intrinsic factors may contribute to job satisfaction. A good salary is widely perceived as a prerequisite for improving job satisfaction, but studies have indicated that non-financial incentives, like appreciation, may be equally effective in improving motivation (Delobelle, Rawlinson, Ntuli, Malatsi, Decock & Depoorter, 2010:372). Ray (2016:1) is of the opinion that job satisfaction increases when practitioners can enjoy a stress-

free environment in which they know they are appreciated. Low job satisfaction, coupled with low employee morale, equals a lack of productivity in the workplace. When someone is unhappy, they do not focus well and they do not pay attention to their tasks (McFarlin, 2016:1).

Participants expressed difficulty in managing frequent changes in protocols, as it adds pressure to the practitioner and on service delivery. It takes some time to grasp new information and CNPs have just come to understand and implement new guidelines before it then changes again. This phenomenon makes them feel insecure and affects their management of patients. Participants mentioned, for example, the PMTCT (Prevention of Mother to Child Transmission) protocol where the timeframes of certain interventions changed frequently.

5.2.2.3 <u>Quality in service delivery</u>

A similar study was conducted in Tshwane by Mathibe et al. (2015:9). The study found that the introduction of expanded programs into PHC services, which have not been accompanied by an increase in personnel, affect patient care negatively. Additionally, the present study reflected that the increased workload and staff shortage impede the quality service delivery. The expansion of CNPs' duties means that the time spent with individual HIV-positive patients have increased, particularly at the time of initiation of treatment. Therefore, the consultation of individual patients takes longer, but the amount of patients for which CNPs are responsible remains the same. This resulted in longer patient waiting time.

The quality of services is compromised as participants are apparently rushing through their consultations in order to manage all the patients before the end of the day. As a result, some patients leave the facility without comprehensive care. Patients need to visit the facility several times before they are satisfied and may even visit other facilities with the hope that they will get help. Patients may experience a feeling of dissatisfaction with the services that they received. It can be accepted that patients wish to be treated with dignity and respect and want the health provider to take their concerns seriously. Patient satisfaction is driven by experience and perception and is achieved through a patient-centered approach

(Grigsby, 2011:11), which is not always achievable with the expanded responsibility of participants.

5.2.3   Objective 3: Barriers and enablers to comply with changes

Limitations of human and other resources were identified as key barriers, which made it more difficult for CNPs to respond to the expansion of roles. The unavailability of medication hinders quality service delivery. When a chronic condition is diagnosed, the importance of treatment initiation to manage the condition is paramount. However, as stated by participants, the medication to treat the specific condition of the patient is at times not available. This results in patients being partially treated or not at all with the added possible reality of the patient needing to return to the facility for the initiation of treatment. A general finding in other studies in South Africa was that a lack of medication hampered efforts to manage patients comprehensively (Visagie & Schneider, 2014:8).

The increased absenteeism rate aggravates the staff shortage. The low morale of staff is possibly one of the contributing factors for increased absenteeism. The high rate of absenteeism makes it difficult to comply with the expanded responsibility of CNPs and affect negatively on service delivery.

Similar to a study conducted by Mathibe et al. (2015:9) some participants reported difficulty in managing patients because of the high patient load and the lack of appropriately trained staff. The shortage of appropriately trained staff relates to the inability of facilities to release practitioners to attend continuing education programs, especially those of longer duration. Other studies linked the lack of appropriately trained staff to increased waiting times. Practitioners not trained to manage patients on ART had to consult knowledgeable (trained) practitioners repeatedly – often a time consuming and interruptive process (Mathibe et al., 2015:13).

However, there are enablers that help CNPs perform their expanded duties. Participants remembered the promise they made years ago (Nursing Pledge) and that they render services because of their love for people. Two of the participants revealed that they enjoy what they are doing. Participants noted that appreciation was a key enabler for meeting their work obligations and being able to perform their expanded roles. Appreciation from management and patients, which may have been

expressed as a simple "thank you", contributed to motivating participants. Linked to this was the sense of satisfaction those participants experienced by being able to positively influence people's lives.

5.2.4   Objective 4: Ideal responsibilities of CNPs

Overall, the ideal responsibilities for a CNP were described as a manageable workload; that the CNP should diagnose, treat, and care for their patients, as set out by the SANC (2014:3), without any rush or pressure. Participants felt competent to take on the work previously done by doctors but noted that this responsibility takes more time per patient and thus require adjustment of workload.

Limited or well-managed administrative tasks would ensure more quality time available to spend with the patient. The implementation of a system that makes, for example, provision for recording data on a single document, and not reporting on different documents, would enable CNPs to spend more time with the patient.

The research setting in which the interviews were conducted may have also not been ideal and conducive to engagement. The busy realities of a clinic providing services in less than ideal settings may have had a limiting effect on the quality and, specifically, depth of the interviews.

5.3   RECOMMENDATIONS

Based on the findings of this study and the themes identified, the following recommendations were proposed.

5.3.1   <u>Staff shortage</u>

Shortage of staff was one of the major causes identified in every problem contributing to the decrease in the quality of service delivery. Most of the participants requested additional staff to reduce the waiting time and to improve the quality of service delivery.

Sufficient funding for the Department of Health (DoH) to fill vacant posts and to recruit suitably qualified staff is required. Non-filling of critical vacancies increases the workload of staff members and impacts on staff well-being (DoH, 2014c). A

method should be in place to revise frozen posts regularly, and to assess the staff situation in terms of the expansion of services.

Job descriptions of the different categories may need to be revised in order to ensure appropriate allocation of duties. Delegation of administrative duties to qualified staff suitably qualified will allow CNPs, with the necessary professional qualification in treatment, to focus more on such a specialized function. CNPs should identify areas of duplication and make specific suggestions to streamline administrative tasks and responsibilities.

Appropriately trained staff is needed in order to integrate services and to assist staff to work smarter. Clients do not need to wait in different queues to obtain services, but a comprehensive service should ideally be rendered by one service provider. All CNPs should be trained in managing HIV-positive clients and initiating treatment in order to prevent the discomfort that patients experience in a queue where they spend significant periods of time to have access to such a qualified CNP.

Staff should be included in the solutions by involving them in the implementation of projects to improve service delivery. Provision of innovation awards will contribute to continuous improvement through the development of new ideas to reach departmental goals (DoH, 2013b:77).

5.3.2 <u>Available resources</u>

On-site inspection of service delivery by the Public Service Commission (PSC) revealed a general lack of medicine, medical equipment, and human resources in most clinics visited. This hampered the rendering of effective services to the community (DoH, 2007:106).

CNPs needed to leave their consultation rooms in order to look for basic equipment such as a hemoglobin meter. It is recommended that every consultation room is equipped with what is needed for a comprehensive PHC examination. Managers of PHC facilities should advocate that the necessary equipment is available in all facilities.

The availability of medication is also very important. There is limited value in diagnosing a patient and being unable to provide treatment because the medication

is not available. Systems should be in place to ensure that facilities do not run out of stock. Training of pharmacy staff in medicine supply management will prevent patients being referred to other facilities or to return later to collect medication that was not available.

5.3.3 Infrastructure

Some of the clinics are small and overcrowded because the structural layout poses a challenge to functionally integrate services. Addressing minor aspects may improve patient and staff satisfaction (Xaba, Peu & Phiri, 2012:4).

5.3.4 Education

Competent CNPs, well-versed in the management of patients on ART, would contribute meaningfully to patient welfare – ensuring competent assessment and treatment, inclusive of the timeous identification of side effects. This will ensure that CNPs manage patients on ART confidently and lessen the stress caused by the increased workload (Delobelle, Rawlinson, Ntuli, Decock & Depoorter, 2009:1062). Health care personnel should be able to reflect on their education concerning HIV to promote better quality of life (PHC Supervision Manual, 2012). Nurse Initiated Management of Antiretroviral Therapy (NIMART) training should ideally be included in the PHC curriculum. This will ensure that all CNPs enter the PHC field with the necessary competence and lessen the need for immediate attendance of further short courses.

Training all CNPs to manage patients according to the Practical Approach to Care Kit (PACK) would ensure optimal treatment of patients with chronic conditions. Staff should be released to attend training and updates in order to improve their knowledge and attitudes. There are concerns regarding the ability to release staff for training due to the shortage of staff. Options to address the challenge are to initiate a relief worker program when planned training is scheduled. The SANC (2014:5) also requires CNPs to take responsibility to update them on the latest legislation regarding the assessment, diagnosis, and management of acute, chronic, and emergency conditions, including prescribing medication.

5.3.5 <u>Clinical practice</u>

In this study participants mentioned that they cannot examine patients properly because of the high workload and/or poor infrastructure. Nevertheless, the SANC (2014) emphasizes the competencies and clinical practices to which a qualified CNP need to adhere. The requirement is that CNPs conduct a comprehensive and holistic health assessment and appropriately refer patients to other members of the team. CNPs are expected to follow evidence-based practice and to keep updated and skilled with the consultation and management of patients (SANC, 2014:5).

It seems as if the development of a positive spiral is important – satisfied clients may improve the morale of health care providers and vice versa.

5.3.6 <u>Policy formulation</u>

The DoH's priority is to improve the health status of the entire population and to realize its vision of a long and healthy life for all South Africans (DoH, 2016:1). Naledi, Barron and Schneider (2011:23) agreed that policy should be in place to shift the PHC system from a passive, curative, and individually oriented system to a more proactive, integrated, and population-based approach. This includes the consideration of the human resources needed to meet the needs of the population in a comprehensive manner – with special emphasis on prevention, promotion, and good quality care. Policy makers need to pay closer attention to the social, economic, and environmental factors that impact on health to reach the overarching goal of a healthy population.

5.4   Further research

The researcher explored the perceptions of CNPs and identified the following that may contribute to provide answers to some of the challenges found in the study:

- Exploring the effect of work space on the integration of expanded programs in the PHC setting.
- Reflecting on factors and ways to enhance job satisfaction.
- Investigating the impact of inadequate skills on the quality of service delivery.

5.5   LIMITATIONS OF THE STUDY

This was a qualitative research study that has limited generalization prospects. It is also true that the study was conducted in an urban sub-district, which may be different to the more rural settings of some of the other sub-districts in Eden. Because three clinics and one community health centre were included in the study, it is not possible to generalize the results to the whole district. A broader understanding and insight would be valuable but beyond the scope of this study. CNPs from other clinics may have had different perceptions.

Although the findings provide insight into the context in which the study has been conducted, it cannot be generalized to, for example, the context of the mobile clinic services in the area.

The researcher is well known in the district, but was not working in the sub-district where the study was conducted. It might, however, have had an impact on the openness of the participants. The conducting of more than one interview with the same participant might also have led to deeper engagement and thicker descriptions.

The research setting in which the interviews were conducted may have also not been ideal and conducive to engagement. The busy realities of a clinic providing services in less than ideal settings may have had a limiting effect on the quality and, specifically, depth of the interviews.

5.6   DISSEMINATION

The researcher plans to share findings with the Health sub-district management as well as Western Cape Research Department. The researcher plans to share the findings with the management of the clinics where the research was conducted. The findings will also be published as an article in a peer reviewed journal.

5.7   CONCLUSION

The findings of this study were discussed in relation to the study objectives. It is clear from the findings of this study, that the factors that affect service delivery in a PHC setting are interrelated and have a negative impact on quality of care.

The objectives of the study were to explore the perceptions of CNPs regarding factors that influence service delivery in expanded programs in PHC facilities in the Eden District. Based on the findings of the study, it can be concluded that the objectives of the study have been achieved. The improvement of human resources by ensuring appropriate appointments as well as adequate training and accountability measures are included in the DoH's five-year strategic plan (DoH, 2015:22). It is hoped that these goals will be met in order to improve service delivery in the PHC environment.

Recommendations were made to include a training package into the PHC curriculum that will contribute to a comprehensively trained practitioner. Training packages for the expansion of programs need to be integrated to reduce the problem of releasing staff for educational purposes. The morale of staff is an important contributing factor to effective service delivery. Members of management teams are requested to be attuned to the concerns of staff and measures to be taken to address them. This will hopefully contribute to the positive morale of staff and the provision of quality service delivery.

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APPENDICES

Appendix 1: Ethical approval from Stellenbosch University

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

Approval Notice
New Application

26-Nov-2015
Moses, Katy KS

Ethics Reference #: S15/10/237

Title: The perceptions of clinical nurse practitioners on service delivery in primary health care facilities in Eden District, Western Cape.

Dear Ms Katy Moses,

The **New Application** received on **21-Oct-2015**, was reviewed by members of **Health Research Ethics Committee 2** via Expedited review procedures on **16-Nov-2015** and was approved.
Please note the following information about your approved research protocol:

Protocol Approval Period: **16-Nov-2015 -16-Nov-2016**

Please remember to use your **protocol number** (**S15/10/237**) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and 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 for an external audit.
Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at 219389819.

Included Documents:
Participant information leaflet & consent form
Protocol
CV A van der Merwe

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CV K Moses
Participant information leaflet
Checklist
Investigator declarations
Protocol Synopsis
Application form
CV H Woolgar

Sincerely,

Ashleen Fortuin
HREC Coordinator
Health Research Ethics Committee 2

Investigator Responsibilities

Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1.Conducting the Research. You are responsible for making sure that the research is conducted according to the HREC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research.

2.Participant Enrolment. You may not recruit or enrol participants prior to the HREC approval date or after the expiration date of HREC approval. All recruitment materials for any form of media must be approved by the HREC prior to their use. If you need to recruit more participants than was noted in your HREC approval letter, you must submit an amendment requesting an increase in the number of participants.

3.Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the HREC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least fifteen (15) years.

4.Continuing Review. The HREC must review and approve all HREC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the HREC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in HREC approval does not occur.** If HREC approval of your research lapses, you must stop new participant enrolment, and contact the HREC office immediately.

5.Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the HREC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written HREC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the HREC should be immediately informed of this necessity.

6.Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the HREC within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the HRECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch Universtiy Health Research Ethics Committee Standard Operating Procedures www.sun025.sun.ac.za/portal /page/portal/Health_Sciences/English/Centres%20and%20Institutions/Research_Development_Support/Ethics/Application_package All reportable events should be submitted to the HREC using the Serious Adverse Event Report Form.

7.Research Record Keeping. You must keep the following research-related records, at a minimum, in a secure location for a minimum of fifteen years: the HREC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the HREC

8.Reports to the MCC and Sponsor. When you submit the required annual report to the MCC or you submit required reports to your sponsor, you must provide a copy of that report to the HREC. You may submit the report at the time of continuing HREC review.

9.Provision of Emergency Medical Care. When a physician provides emergency medical care to a participant without prior HREC review and approval, to the extent permitted by law, such activities will not be recognised as research nor will the data obtained by any such activities should it be used in support of research.

10.Final reports. When you have completed (no further participant enrolment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the HREC.

11.On-Site Evaluations, MCC Inspections, or Audits. If you are notified that your research will be reviewed or audited by the MCC, the sponsor, any other external agency or any internal group, you must inform the HREC immediately of the impending audit/evaluation.

Appendix 2: Permission obtained from institutions / department of health

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857: fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_2015RP12_443
ENQUIRIES: Ms Charlene Roderick

Stellenbosch University
Private Bag X1
Matieland
7602

For attention: **Ms KatyMoses**

Re: **THE PERCEPTIONS OF CLINICAL NURSE PRACTITIONERS (CNP'S) ON SERVICE DELIVERY IN PRIMARY HEALTH CARE FACILITIES IN EDEN DISTRICT, 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 **Dr Terence Marshall on (044 803 2752)** to assist you with any further enquiries in accessing the following sites:

Blanco Clinic
Conville CDC
Pacaltsdorp Clinic
Rosemoor Clinic
Thembalethu CDC

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely

AJ HAWKRIDGE.

DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 9 / 3 / 2016.
CC: H SCHUMANN   DIRECTOR: EDEN& CENTRAL KAROO

Appendix 3: Participant information leaflet and declaration of consent by participant and investigator

INFORMED CONSENT

PRINCIPLE INVESTIGATOR: Katy Selina Moses

ADDRESS:

26 Mecurius Street

Toekomsrus

Oudtshoorn

6625

CONTACT NUMBER: 083 367 2328

You are invited to participate in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher 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 did agree to take part.

This study has been approved by the Committee for Human Research at Stellenbosch University 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.

TITLE OF THE RESEARCH PROJECT:

The perceptions of clinical nurse practitioners on service delivery in primary health care facilities in Eden District, Western Cape

AIM:

The aim of the study is to explore the perceptions of clinical nurse practitioners (CNPs) working in primary health care (PHC) facilities, regarding factors that influence service delivery in expanded programs.

PARTICIPATION:

Participation in this research study is strictly voluntary and involves semi-structured interviews that will take you approximately thirty minutes to one hour. There are no consequences if you wish to withdraw from the study.

PROTECTION OF THE PARTICIPANTS:

All the information obtained from this research study will remain confidential. Your name will not appear in the typed information. The information cannot be traced back to you. The researcher will not listen to or transcribe the audio-taped interviews and thus will not recognize participants' voices. You can contact Helen Woolgar (Supervisor) at 021 938 9298 or Professor Anita van der Merwe (Co-supervisor) at 021 938 9760 if you have any further queries or encounter any problems. You can contact the Research Ethics Committee at 021 938 9207 if you have any concerns or complaints that have not been adequately addressed. You will receive a copy of this information and consent form for your own records.

BENEFITS:

All CNPs rendering care in the PHC facilities and ultimately the patients who utilize the services, will benefit from this study.

RISKS:

There are no risks associated with this study, but should you experience any distress or anxiety during the interview, the researcher will refer you to a counselor.

REMUNERATION

You will not be paid to take part in the study and there will be no costs involved for you, if you do take part. Refreshments will be provided after interviews.

Declaration of participant

By signing below, I ……………………………………. agree to take part in this research project entitled:

I declare that:

- I have read or had read to me this information and consent form and it is written in a language in 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 pressurized to take part.

- I may choose to leave the study at any time and will not be penalized or prejudiced in any way.

Signed at (place)……………………. on (date)………………………2016

…………………………   ………………………

Signature of participant   Signature of witness

Declaration of investigator

I (name) …………………………. 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.

Signed at (place) …………………………. on (date) …………………….2016

……………………………..   …………………………

Signature of investigator   **Signature of witness**

Appendix 4: Instrument / interview guide / data extraction forms

ADDENDUM B

INTERVIEW GUIDE

TOPIC:

The perceptions of clinical nurse practitioners on service delivery in primary health care facilities, Eden District, Western Cape.

AIM

The aim of the study is to explore the perceptions of clinical nurse practitioners (CNPs) in primary health care (PHC) facilities regarding the factors that influence service delivery in expanded programs.

I want to thank you for taking the time to meet with me today. My name is Katy Moses and I would like to talk to you about your perceptions as a CNP working in a PHC setting. The interview should take approximately thirty minutes to one hour. The interview will be tape recorded during the session. Notes will be taken as well. Because we're on tape please be sure to speak up so that we don't miss your comments.

All responses will be kept confidential.

You don't have to talk about anything you don't want to and you may end the interview at any time.

Are there any questions about what I have just explained?

Are you willing to participate in this interview?

………………………………   ……………………………   …………………..

Interviewee   Witness   Date

Interview Questions:

- What services are rendered at the clinic and what are your responsibilities?
- Have there been any changes / expansion in your duties / roles and responsibilities in the past months / years?
- If any, how have the changes / expansion influenced your day to day service delivery in the facility?
- What are the challenges / barriers to comply with such changes and their impact on service delivery?
- What are the enablers?
- What would be the ideal responsibilities of a CNP?
- What do you think are the possible recommendations that will help to deal meaningfully with these changes and enhance service delivery?

Appendix 5: Extract of transcribed interview

<u>**Interview with Participant 5**</u>

R   All right thank you Sister.

I   Okay Ma'am.

R   Okay my first question is, what services are rendered at this clinic and what are your responsibilities?

I   Okay, generally I'm the operational manager, but I've got clinical functions as well, yes, so it's supposed to be 80% administrative and 20% clinical, but because of other challenges, it is staff absences, training and… I don't really have that component. At best I would say I would say 60, 70% clinical and the other 30, 40% administrative. You know I have to be actively involved in the clinical management of the clients, you see. We are a comprehensive health service, the full package, being your TB treatment, ART prescription diagnosis, HIV care, anything that you see there, we've got the comprehensive primary health care, curative clinic, the sick clinics as people mention it, and then you've got your immunisation, well baby clinic, we've got antenatal services, we've got rehabilitative services as well. And those have, you know, not necessarily not only our clientele, but referrals from other clinics as well.

R   Referrals from other clinics, okay.

I   Yes. So that's basically, and then the number of things like psychiatry, chronic disease management.

R   Okay and how long are you now with this clinic?

I   At this clinic I'm about 7 years now, so – is it 7? Time flies, no, it's 8 years, 8 full years, I moved here 2007 June, so this is the 9th year.

R   All right, okay. Now have there been any changes or expansions in your role the past months or years?

I   I think so because for example the rehabilitative services as a component, as in dietician phase, your full time operating from this clinic is a new thing, it only started this year. I think the management of ARV patients as well has started about, I'm not so sure now, 2009, you know when the decanting started that they were part of the primary health care package. Remember initially ARV's were treated as a specialised clinic, where you had a separate clinic. Now for example at George Hospital, and then it moved over to Harry Comay hospital,

which is our sub district TB hospital. But now they've decanted that function to the clinics as well.

R   So you do that as well?

I   Yes, yes, that is not new, but relatively new as in the last 3 years or so, 4 years.

R   Okay, for the clinic?

I   Yes it's for the clinic, I mean in 2007 when I started it was not part of the function then.

R   All right. And tell me, do you have sisters to manage the ARV patients, trained sisters?

I   Yes we have trained sisters, we have trained sisters that manage the already on ART, we have trained sisters that initiate with you know, the criteria that the Department of Health gives, that there is patients that will be aided by a professional nurse, but there is those that will still have to go to a doctor. So those that are pretty straightforward like your antenatal first episode, not an ARV newly diagnosed HIV patient, that sort of thing yes.

R   Okay so the sister will initiate that?

I   The sister will initiate that yes.

R   Okay. So how do you think the expansion and the changes, how influence the day to day service at the clinic?

I   I think for one thing the structural challenges are in the building itself, okay. Our building was formerly a municipal well baby clinic building, it was …

R   Okay so it was only preventative services?

I   Yes, preventative services then. So it was not really you know, constructed to cater for the huge volumes that we are seeing now. We have got an average head count of about plus minus 4000 a month you see, even the very structure, the very passages and the waiting area is a challenge. And the fact that we have, we run a one-stop service, so all services are functioning at any one time. That is, and it has an effect also on our waiting times, because there's only three clinical practitioners. We have doctor sessions two times a week, so we don't have a doctor full-time so we do a lot of referrals to either George Hospital or CDC at Conville. We don't have a full time pharmacist based here, so anything that is not for prescription by CNP's has to go

to Conville where there's a pharmacist there. So there's also our chronic packages are not packed here, so the ARV packages would be packed at Harry Comay and the other chronic disease is from the CDU for stable patients. And the unstable patients then would be on a monthly basis from Harry Comay.

R   Okay and the other chronic patients, the stable chronic patients?

I   We've got an off-site, it is managed by what they call community health workers now, they used to call them on-base care workers okay but that has now changed. It's two times a week, it's not here. It's at the old age home sort of thing, Aca Cross so the medicine are dispensed, or not really dispensed, distributed from that area.

R   All right, and the patients going there is the patients from this clinic, this specific area?

I   Yes, this area, this facility. Patients that we are seeing here referred from this clinic, Rosemore clinic, or otherwise it would be the old age patients.

R   Okay, all right. So what do you think are the challenges and the barriers to comply with such changes, and what is their impact on service delivery?

I   I think the first challenge is the fact that it's a one-stop service, all services at the same time should be happening, and sometimes there will be a challenge in the waiting times. What do I mean? For example part of a curative service you get an antenatal clinic, who hasn't booked. We try as much as possible because that is also one of our ABP targets, booking people before 20 weeks, yes. And ideally also before 14 weeks, because 14 weeks is the first challenge, the target, and then the second target before 20 weeks. So that means that that whole procedure will take you about 45 minutes to an hour, which means now that the flow of the rest of the clinic is affected. That is the one thing. The second thing is I know we do a lot of health education, but I don't think our community realises the importance of compliance with chronic medication. So clients that should normally be out at a non-medical site, cannot be referred to the non-medical, because their vital signs are still in the dangerous area, e.g. uncontrolled hypertension, uncontrolled diabetes.

R   So they need to come to the clinic?

I   They need to come to the clinic on a monthly basis. The other thing I think, there's a lot of social (indistinct) as in drug and alcohol abuse in the community itself, so it does have an influence on our…

R   On adherence as well?

I   On adherence, it has an influence on the sort of client that we see, because we might not see children first, do you understand what I'm trying to say? But there's a lot of poor nutrition or nutritional challenges in your child under 5, yes. That is the sort of thing. And to a certain extent then unemployment. We know that we are struggling with unemployment in our country, so we also have that challenge, that people are unemployed and they begin stressing, they develop stress symptoms and they are actually stressing because of unemployment, than being really sick, yes.

R   Okay. And do you get many, or how much complaints do you get from the community complaining about the services?

I   The service delivery … I mean for example for the past 3 months we haven't had any complaints as in lodged written complaints. There is a few like during a clinic where people tell you they are waiting, they feel they've been waiting too long. And then you ask around. Some were not here when they were called, you know, that sort of thing, but as in generally speaking we don't have a lot of complaints from our client.

R   All right.

I   The other challenge would be, we've got a reasonably big clientele from your Somali people, so that is also, sometimes, but at least now they know they should bring somebody who can speak English, so history with them is normally a challenge.

R   Because of the language?

I   Because of the language yes.

R   Okay. All right, and what are the enablers, what are the things that enable you to deliver your service, or to…?

I   It's a fairly stable community, being that you do get a few new people into the service, but you know your clients because they are here, they don't move in and out. I've worked previously in Themba, and there people move in and out. You know this here, they are here, next year they are not there. But with Rosemore the beauty is that it's a fairly stable, like people that I saw in 2007 with their first children, I'm seeing now with their second children, you understand, so in a way you are able to build up a relationship with your… yes.

R   Okay.

I   Sometimes there is an advantage with having health services in residential areas, but I think the easy access also makes them prone to abuse.

R   Ja, to come to the clinic for everything.

I   For everything. Have you taken a Panado, something for pain? No. Whereas you know, in what we call home remedies, people who would at home, I mean like for simple things, like for a headache or anything, you would start with your home remedies, your bit of Panado, resting and everything, but now here you find that the little abrasion when a child falls from a bicycle, comes to the clinic, whereas we used to, you know, salve or cream, or any other cream…

R   Because the clinic is here.

I   Yes.

R   All right, okay. And what would you say will be the ideal responsibilities of the CNP?

I   Of a CNP? I think I don't know, perhaps I'm being subjective, I think the challenge comes with free services. Free services, unfortunately, it's a good thing, but I think it's being abused. If you think in terms of I'm sorry to say, when last you were at a doctor, then you will know what I mean. We are now at May, there's people that we saw in January, in February, in March, in April. Every month. And you know like it's, this also comes with what I was saying about the unemployment and the stress symptoms that are manifesting. And you find that it's not really anything, you know, that they should be – but unfortunately they have to go through the whole system. In the old days we used to have what we call minor ailments, and the minor ailments you could treat with sort of a Codex card, without opening a folder and having – these days we have to do the paper trail, because we have to count head counts, we have to account for the medication, not that we didn't have to account then, but a person has to go right through the system to just get a packet of Panado, that's so simple. And I mean Panado is something that we can buy, so if it's available, if there's a shortage then not, so there isn't really any legal requirements, you know, that sort of thing. But other than that I think a CNP, sometimes you find that the rule says if you are not sure, refer. Now it depends on the sort of person that you are referring to. Some people feel you are referring unnecessarily. Perhaps because they have got the skills that you do not have. I mean the CNP course is only a year, a doctor's course is how many years, 5 to 6, you understand? So I personally feel if you are uncomfortable with making a decision on a patient's health, then you should be able to

access a second opinion. It's working out now well with us, because then we ask our patients to come when the doctor is here for a second opinion. But then there is some critical you know, issues where you feel you need to do …

R   To make the decision?

I   Yes.

R   Okay.

I   That is all.

R   And …

I   And you see, we as CNP's work with guidelines, you understand? If IMCI says if a child is not drinking and the child has got pyrexia and the child's respiration rate is abnormal, refer to hospital. Then you…

R   Is this what your guideline says?

I   This is what your guidelines say. And if you fail to do that, should anything happen to that child, you know, then you have … yes. Whereas now a doctor who is sitting in a trauma full (indistinct) why couldn't they give an anti-pyrexia and start antibiotics, and let the child come back? You see that is the other problem. Our definitions perhaps for referral are perhaps not what they understand.

R   And because they don't know your guidelines ja, all right.

I   Yes, yes. And the guidelines, any of them are there to protect you. You follow the guidelines, then you have done, you have acted correctly, you understand, and you are not negligent.

R   Okay. Is there something that you want to tell me about the PACK guideline specifically?

I   About?

R   The PACK is okay. PACK has given us a broader spectrum of clients. For example chronic clients we are able to initiate treatment on PACK of all the chronic conditions. It is helping because with the amount of doctors that we have, or doctors' hours that we have, we are able to cover more. That when a patient does have to go, then at least you know the initial stages you have covered. You've covered compliance, you have covered, you know, screening off for any other complications and that sort of thing. But PACK is useful for me, it's very clear.

R Okay but do you think the PACK guideline has an impact on the workload maybe of the CNP in terms of the fact that …?

I I think in terms of anything, we always complain, I'm almost how much, 40 plus years in the nursing career, so there's a great change, there's a lot of paperwork now. That is the one thing that we complain about, e.g. with antenatals, you know admitting an antenatal it's this form, it's that form, it's that form. So although there isn't really a change in your function, but the administrative function there's a lot that has changed. Perhaps we have to live with the fact that the world outside is changing and there's a much more you know, a move towards suing, Government, citizens as well. So we have to put in you know, structures in place that would stand for legal implications so that is all. It's okay, but like it, in a full clinic or when you're short-staffed, it's a challenge because of all the paperwork that we have to do.

R All right. Okay, and what are the possible recommendations you will make, recommendations to help to deal meaningfully with all this changes and all this workload and all this stuff, what recommendations do you make?

I You know it's, impossible as it might seem to be, I personally still think the services location work better, e.g. we have a family planning time, we have a well-baby clinic time, we have an antenatal clinic time, so whoever is there, we all focus on this one thing and we finish. Then you know within the service there are things that will still continue, but like things that are not an emergency, e.g. family planning, why should we have a family planning client come in at any time? That is, you know? In the old days we used to have time allocated for them, I don't know.

R And is this impossible to work like that at the moment with the services?

I I think it's because we cannot tell patients, we cannot turn patients away, that is the challenge. So because we cannot defer them, you know, patients feel they've got rights and they know. That is the thing. But the other thing that we've always said, for example, with even the specialist activity like the antenatal clinic, there are a lot of special efforts that you have to focus on when you are seeing an antenatal, so it would be nice if you were just going to deal, say for the morning, whoever is there would deal with antenatals, then for that date they know that …

R The antenatal, ja.

I   Yes. But otherwise, I personally feel, this is really personal, personal, as in really personal, I think we, I don't know if I should say our communities are not ready for free service, I think they are abusing the services. I don't mind free services for children under 5, because they are vulnerable, and for your senior citizens. But somewhere in between, I think we should be having a limit about…

R   A fee?

I   A fee or whatever it is. For especially for those people that can prove that they are working.

R   All right, something else that you want to recommend?

I   I think – I see that the State is busy taking care of its workers, but I think you know we should have more effort, you know, not from training skills, not from the educational point of view, but just from social emotional support for our workers. I think sometimes they bear the brunt of abuse, especially from patients and things.

R   Okay. All right. So you think you are done now, nothing else?

I   Yes. Thank you.

R   All right, thank you very much.

Appendix 6: Declarations by language and technical editors

DECLARATION BY LANGUAGE EDITOR

To whom it may concern

This letter serves as confirmation that I, Selene Delport, proofread and edited Katy Moses's thesis for language correctness.

Sincerely,

Selene Delport

Freelance editor