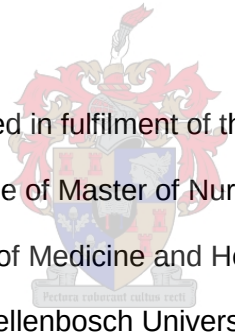
THE EXPERIENCES AND PERCEPTIONS OF CLINICAL STAFF ABOUT TRANSFORMATIONAL CHANGE MANAGEMENT AT AN EMERGENCY CENTRE

SHAHNAZ ADAMS



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Supervisor: Prof Anita van der Merwe

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

Background: The Community Health Centre **-** A primary health care facility in the Western Cape that provides a comprehensive package of care, including a 24-hour emergency and maternity services, faced several systemic challenges that attracted an investigation by the Public Protector's office in 2009. The investigation revealed substantive evidence in support of claims of poor service delivery, bad staff attitude and poor disciplinary conduct, deficient management & control systems, poor team cohesion and low staff morale. In an effort to address these organisational challenges, an improvement strategy based on a transformational change philosophy was initiated in the Emergency Centre.

Aim: To explore the clinic staff's experiences and perceptions of the transformational change management approach introduced in a Community Health Centre.

Methods: A qualitative descriptive phenomenological research design was used. Semi-structured interviews and a focus group discussion with 18purposively sampled Emergency Centre staff members. A follow-up focus group discussion done in 2016 to confirm the perceptions of the participants held overtime. The interviews and focus group discussion were transcribed verbatim and analysed manually. A thematic analysis was done and the findings were organised in Donebedian's framework of structure, process, and outcomes.

Results: The results revealed that systems align the structural and processional aspects resulted in the achievement of better outcomes. These outcomes relate to improvement in working environment, the management of critical resources, employee confidence, morale, discipline, commitment, and teamwork. This ultimately led to the creation of a positive work environment, improved service delivery, enhanced quality of care and positive patient outcomes. The role of visionary leadership was deemed key to the transformation process.

Conclusion: The study confirmed that transformational change occurred through a strong leadership, which promoted a sense of ownership, the empowerment of workers and capacity building. The transformational change led to the adoption of a shared vision, team learning, and professionalism, which resulted in the delivery of quality emergency care The findings supports the principles espoused by a learning organization. The recommendations include strengthening of values-driven leadership competencies and fostering a learning organization with emphasis on shared vision, systems thinking, personal mastery, and team learning.

Key Words: Transformational change management, leadership, vision, teamwork professionalism

ABSTRAK

Die ondervindings en opvattings van Kliniese personeel by n Noodsentrum oor Transformasieveranderingsbestuur

Agtergrond: ‘n Primeregemeenskapgesondheidsorgfasilitieit in die Wes-Kaap wat omvattende gesondheidsorg verskaf, insluitend 24-uur nood- en verloskunde dienste, het verskeie sistemiese uitdagings ervaar wat vervolgens in 2009 gelei het tot ‘n ondersoek deur die Kantoor van die Openbare Beskermer. Dié ondersoek het beduidende getuienis onthul ter ondersteuning van aannames oor swak dienslewering, ongunstige personeelgedrag en swak dissipline, tekortkominge in bestuur en beheerstelsels, swak spaneenheid en ‘n lae moraal onder personeel. In n poging om hierdie organisatoriese uitdagings aan te spreek, is n verbeteringstrategie, gebasseer op ‘n transformasieveranderingsfilosofie, in die Noodeenheid geinisieer.

Doel: Om die ondervindinge en persepsies van die kliniese personeel by die Gemeenskapgesondheidsentrum te verken aangaande die instelling van transformasieveranderingsbestuursbenadering.

Metodologie: ‘n Kwalitatiewe, beskrywende fenomeologiese navorsingsontwerp is gebruik. Semi-gestruktureerde onderhoude met n doelgerigte steekproef van 18 afsonderlike noodsentrum personeellede, sowel as ’n fokusgroepbespreking is gedoen. Die persepsies van in die onderhoude en tydens die fokusgroepbesprekings, is verbatim afgeneem en geanaliseer.’nTematiese ontleding is gedoen en die bevindinge is gerangskik binne Donabedian (1966) se raamwerk van struktuur, proses en uitkomste.

Bevindings: Die bevindings het onthul dat ‘n sisteembenadering beter uitkomste bereik deur die strukturele- en proses aspekte in beter verhouding tot mekaar te stel./te belyn. Hierdie uitkomste verwys het te make met ‘n verbetering in die werksomgewing, die bestuur van noodsaaklike hulpbronne, personeelvertroue, moraal, dissipline, toewyding en spanwerk. Dit het uiteindelik gelei tot die vestiging van ‘n positiewe werksomgewing, verbeterde dienslewering, verbetering in die gehalte van sorg asook positiewe pasiente-uitkomste. Die rol van visionêre leierskap word beskou as belangrik tot die transformasieproses.

Afsluiting: Die studie bevestig dat transformative teweeg gebring word deur sterk leierskap. Sterk leierskap lei weer tot eienaarskap, die bemagtiging van werkers en kapasiteitsbou. Transformasionele verandering lei tot eienaarskap in die aanvaarding van n gedeelde visie, n span wat gefokus is op leer en professionalisme wat tot gehalte mediese sorg lei. Die bevindings van die studie bevestig die beginsels wat deur n leergerigte organisasie vergestalt word. Die aanbevelings sluit in die versterking van waardegedrewe leierskapsbevoegdhede en die vestiging van ‘n leerorganisasie met ‘n gedeelde visie, stelseldenke, persoonlike bemeestering en spanleer.

Sleutel Woorde

Transformasionele veranderingsbestuur, leierskap, visie, spanwerk, professionalisme

DEDICATION

I dedicate this thesis in honour of the memory of my mother Sharefa Adams and my Grandmother, Kobera Manuel, two remarkable women who was light years ahead of their time, activist for social justice in their own right...who taught me to love, to learn, to care and to always keep my head held high and my feet on the ground.

AND

To the Staff of the Emergency Centre...for your courage in braving the storm with me.

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"The essence of all beautiful art, all great art is gratitude" Nietzsche

This is a story of hope, the strength of the human spirit, the art of possibilities, a vision, determination, transformation and the goodness of people… This was the most humbling; complicated journey that I have ever been on…a bumpy ride indeed. Existentially I was confronted by myself …my values, my beliefs, my self-worth, my strength and weakness, my fears…most of all by my faith. It is only through my own intransigence that I continued to defy all logic in insisting to document the story of the people of the study community, who like the phoenix rose from the ashes.

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ABBREVIATIONS

ACEP	American College of Emergency Practitioners
BCEA	Basic Conditions of Employment Act
CHC	Community health Centre
CSP	Comprehensive Service Plan
DOH	Department of Health
DPSA	Department of Public Service and Administration
EC	Emergency Centre
HPCSA	Health Professional Council of South Africa
HRM	Human resource Management
ICN	International Council of Nurses
M&M	Mortality and Morbidity
MDHS	Metro Health District Services
NDOH	National Department of Health
OSD	Occupational Specific Dispensation
PHC	Primary Health Care
PPE	Positive Practice environment
RWOPS	Remuneration for Work Outside of the Public Service
SANC	South African Nursing Council
SCM	Supply Chain Management
SOP	Standard Operating Procedure
SPMS	Staff Performance Management System
StatsSA	Statistics South Africa
WCDoH	Western Cape Department of Health
WHO	World Health Organization

CHAPTER 1 FOUNDATION OFTHESTUDY

1.1 INTRODUCTION

Across the world emergency centres are overwhelmed by the increasing burden of disease and an escalation in acute emergencies due to road traffic accidents, violence, war and political unrest (Brysiewicz 2011:1). Furthermore, the high patient loads place a huge strain on the workload of staff and critical resources (Mahapi & Basu, 2012:79). According to Awad (2010:38) facilities at primary health care level experience increased challenges with shortages of skilled staff, infrastructure and inadequate resources. These systemic challenges coupled with the global economic and health crisis poses serious challenges in the ability to deliver adequate quality patient centred emergency care. The American College of Emergency Practitioners (ACEP), (2009:1) state this compels emergency departments to make substantial changes in able to provide critical services. Further to this, Anderson (2012:1) of International Emergency Department Leadership Institute agreed that health care reforms are required for leaders in the emergency departments to deal with the inefficiencies and organizational problems.

In South Africa, the national and provincial strategic vision for health service reform is based on a client centred approach. It requires a transformational shift in the way health organisations are managed and services are delivered. Health organisational Managers are responsible for implementing programmes that will improve the quality of services rendered, and achieve the outcomes of health system reform (Western Cape Department of Health (WCDOH: 2012).

A Community Healthcare facility in the Western Cape experienced several systemic challenges, which led to an investigation about poor service delivery and poor staff discipline by the Public Protector’s office.

Further to this initial operational assessment and needs analysis Emergency Centre by the Operational Manager in 2008 revealed several challenges to the smooth running of the facility. Based on the assessment and analysis, it was concluded that the facility lacked critical operational systems, had gaps in the ability to provide quality emergency care and the existence of poor work ethics amongst the operational staff. Interviews with both the nursing and medical staff highlighted challenges around working as a team, supply chain of required resources, human resource management and poor patient care standards.

Based on these findings, it was concluded that the situation required a comprehensive approach to change management, which was initiated at the Emergency Centre in 2009. As a point of departure, the decision for a transformational change approach to deliver quality patient centred emergency care, to align the unit with national and international emergency care best practices; was made.

The researcher is of the opinion that in order to change an organisation from the *"inside out",* it is important to adopt a significant and radical transformational change approach, which will provide the appropriate platform to achieve the desired outcomes. Hughes and Strickers (2012:190) differentiate between *"outside in"* and "inside out" efforts to change. In their view *"outside in* "approaches focus on changes in structure, systems and processes related to external demands, while *"inside out"* approaches involve changing values, assumptions and beliefs about how to achieve improved direction, alignment and commitment throughout the organisation. The focus on the internal dimensions leads to the potential for new thinking and new beliefs, which in turn result in new decisions and behaviours (McGuire, Rhodes & Palus, and 2008:3).

Therefore, the key to the *"inside out"* approach to change includes inner shifts in people's values, aspirations and behaviour linked to outer shifts in processes, strategies, practices and systems. Critical to the "inside out" approach are the elements of learning and leadership (Senge, Kleiner, Roberts, Roth, Ross and Smith, 1999:15). According to Hughes & Strickers (2012:3), the role of a sound and coherent leadership strategy is critical to a successful transformation.

A multi-pronged – approach was used by the operational manager to address several of these key issues. The first step was to obtain the buy-in and ownership from the staff. This was a challenge and required significant persuading, coaching, mentoring and firm leadership. In consultation with the staff, a coherent multidisciplinary task team was developed to supervise and support transformational change process. The task team consisted of the senior nursing and medical staff. The team was asked to identify current practices in place and to determine practices requiring change.

A member of the nursing staff was nominated by the team to act as second-in-charge in the unit. It was decided that this position would rotate every three to six months so that each team member is empowered with leadership and managerial skills. Weekly unit meetings were held with all the staff to establish a platform to discuss operational matters, quality improvement and to provide feedback.

During the consultations, it was identified that there was a gap between the knowledge, understanding and implementation of general legislative prescriptions, patient care policies and protocols. To this end, several standard operation procedures (SOPs) were developed and communicated to all staff. These SOPs were developed into rules and the implementation of such was monitored by the task team. For instance, issues around uncommunicated absenteeism and abuse of sick leave because there was also no system to monitor how much leave the staff took, were addressed and the staff was expected to complete their leave application forms. An internal SOP was developed in line with the official leave policies and staff was required to adhere to the SOP. In the beginning, there was significant resistance to what the staff perceived as “new” rules. However, consistency in the application of the policies led to compliance.

Other critical support systems such as human resource management, supply chain of resources and equipment maintenance were realigned to required prescriptions and standards. Audits of the various systems were conducted with the assistance of the staff in the unit and control measures were put in place. The practice of daily ensuring the completeness of the emergency trolley and of drugs in stock was put in place. A reliable system of weekly ordering of consumable stock items and the checking of equipment were also put in place.

Owing to the lack of disciplinary structures and guidelines, the facility was rife of unprofessional practices and misconduct. Examples of unprofessional practices and misconduct included among others late coming and drinking on duty. To resolve these issues, the management applied progressive disciplinary steps following the relevant disciplinary procedure and the tightening of rules and regulations.

The Operational Manager also liaised with consultants at other health facilities to compare and learn from their practices. The emergency task team went on a physical fact-finding mission to other clinics and hospitals that provide emergencies services. The team studied equipment standardisation of practices and other useful systems, which could become part of the functioning and systems of care within the unit. It was considered a beneficial exercise and some of the best practices were implemented at the Community Health Centre’s Emergency Centre. Some places also gave much needed equipment and other resources, which they no longer used.

Hence, it was considered important to evaluate the overall effect of this transformational change process on service delivery as experienced and perceived by clinical members of staff.

The focus of the study is thus to explore the experiences and perceptions of the clinical staff in the Emergency Centre about the transformational change process.

The rationale and background, research problem, research question, purpose and objectives, conceptual theoretical framework and a brief description of the research methodology as it pertains to this study will be discussed in this chapter

1.2 BACKGROUND AND RATIONALE

The vehicle for providing primary health care (PHC) is through the district health system care model. The aim of the district model is to provide a comprehensive, integrated package of care and to provide better quality services by utilizing a developmental, holistic, inter-sectorial approach. It also gives recognition to the pivotal role of the healthcare worker in the health system and ensures teamwork as a central component (DOH, 2000:3).

Within the Western Cape Province, the district model makes provision for 24-hour emergency centres in each district (WCDOH 2007:7). The Community Health Centre (CHC) in the Klipfontein Sub-district of the Western Cape Province is one of the nine clinics providing 24 Hour emergency services. The CHC, which opened in 1965, provides health services to the extended impoverished communities of five townships on the Cape Flats with a combined population of 264 026 (Census StatsSA, 2011).The population figure is also influenced by migration from other provinces and informal settlements

The CHC provides a comprehensive package of care and two 24-hour units for Emergency Care and Maternity Services. (CSP, 2007:8) The Emergency Centre was opened in 1996. Women's Health and Oral Health services are provided at satellite sites. In addition, the clinic is surrounded by three 8-hour service clinics, which feed into the service area. According to the district's Plan do Review report, (2011) an average of 24000 patients access the services at the clinic per month, between 2700-3200 patients are attended to at the Emergency Centre per month. The acuity levels of the patients range from minor ailments to very serious life-threatening conditions.

Prior to 2008, the district management designed several strategies to improve the situation at the clinic. An example of this is a turn-around strategy in 2007. The focus of this strategy was on creating more posts for registered nurses, improving the infrastructure of the trauma and pharmacy units, strengthening the quality assurance processes to improve service delivery, providing adequate staff to manthe24-hour service and improving training strategies.

The Researcher was appointed at the CHC in November 2008 as Operational Manager in the Trauma Unit (here in referred to as Emergency Centre). An initial operational assessment indicated systemic challenges such as deficient control and management systems as well as concerns related to service delivery and quality of care. Interrelationship problems existed between different categories of staff. It was observed that the staff members were demotivated and their morale low. The mortality and morbidity reports for the period 2005-2007 reflected that the patients with life-threatening conditions had a limited chance of survival. The number of patients who died in the unit was also higher than the expected norm (Metro District Health Service [MDHS]: 2007).

Areas of concerns highlighted through client satisfaction surveys, complaints and reporting of negative incidents through the media included poor service delivery and standard of care, inadequate staffing, poor scheduling of staff and supplies, poor staff attitude, discipline and confirmation to ethical standards, poor environmental hygiene.

The challenging situation at this clinic resulted in an investigation conducted by the Office of the Public Protector. This report gained media coverage and negatively influenced the image of the health service. The investigation found substantive evidence in support of these concerns (Public Protectors report, 2009:3).The source of these challenges was attributed to the lack of a formal leadership, vision and sound management processes and systems in the Emergency Centre.

Globally, provision of emergency care is an essential part of health systems and there is an increased emphasis on and concern re the escalation of the burden of medical, surgical and trauma emergency conditions (Stewart et al., 2013:e9). The burden of medical emergencies is higher in high-income countries (HICs) due to cardio-vascular disease whereas the occurrence of trauma related emergencies is high in low to middle-income countries (LMICs). The low-income countries are not well prepared or equipped to evaluate and treat emergency conditions (Stewart et al. 2013; Mock 2011; Hardcastle et al. 2016). A study done by Wong et al. (2014:10) confirms that the above is due to insufficiency in organisation and planning, trained staff and limited physical resources. According to this study, PHC clinic and district level hospitals in LMICs is extremely under resourced and less than one third of facilities have the necessary resources to provide basic resuscitation procedures and to ensure definitive airway management. In 2004 the WHO developed the Guidelines for essential trauma care toolkit which was used by Ghana Health services where the results indicated a critical lack of job-specific training for staff and shortage or lack of many of the essential surgical supplies and medicine (Japiong et al., 2016:33). Trauma and emergency healthcare facilities in South Africa face similar challenges according to Wallis (2014:1) who

states that "*the burden of trauma has been given low priority by government and institutional apathy and government's PHC focus resulted in the neglect of this disease and the trauma crisis...nobody talks about it, it's not part of the millennium goals, there are no global funding and WHO has devoted few resources to it. This needs to change*" A study done in Kwazulu-Natal confirms that injury and violence place a huge strain on the health system nationally and the lack of infrastructure, human and other critical resources adds to the burden. It recommends transformation of the primary care pathway and strengthening of emergency care at all levels (Hardcastle et al 2016:185). To address the deficiencies experienced by LMIC's requires global collaboration and emergency healthcare strengthening in order to reduce the high incidence of trauma-related mortality and morbidity in these countries. The World Health assembly, in response to a global call to strengthen and to find affordable ways to ensure improvement in organisation and planning of emergency healthcare in LMIC's adopted resolution WHO60.22 on trauma and emergency services (WHO,2010:iii).

Emergency centres internationally and nationally also face similar systemic challenges such as increase in demands for care giving raise to overcrowding which in turn can result in long waiting times, maintaining quality of care standards, medico-legal risks, low staff morale, resource limitations, poor communication and dissatisfied patients (Hemeida,2014; Dos Santos,2013). Other operational challenges include budgetary constraints, staff shortages, high absenteeism rate, knowledge and skills deficits, lack of proper equipment, and bureaucratic procurement systems (Hardcastle; 2016; Brysiewicz; 2008 and Hemeida; 2014).

To resolve the myriad of challenges faced by the CHC's Emergency Centre, the new management adopted a transformational change management approach. The transformational process where mainly influenced by Senge's Learning Organization (1990) and Barrett's New Leadership Paradigm (2010).

Transformational change management approach is a radical organisational wide approach on how to operate and manage a public health department. It requires breaking through the current organisational framework to achieve dramatic improvements in the quality of services provided and other performance measures. This involves the alterations of the leadership's mind-set and the adoption of quality improvement methods to change teamwork and the culture of the organisation (Riley, et al., 2010:1). Dasko and Sheinberg (2005:1) state that all transformation is change but not all change is transformational.

When health services have to deal with monumental changes, it requires effective leadership. According to Boudreau (2011:87), this visionary leadership should come from

within the healthcare profession in order to address the various challenges. The leader needs to possess the ability to transfer the vision to others through effective communication. Furthermore, Booyens (2008:436) is of the opinion that transformational change process should be facilitated through a transformational leadership style, due to the main challenge being in effecting change in the views, attitudes, needs and values of the healthcare workers. In addition, the leader should have the attributes and skills to mould the organisational change in the desired direction and be able to deal with individual reactions towards change process (Boudreau, 2011:87).

An essential focus area in transformational change management is that of organizational climate and its impact on organisational performance. According to Global Health Technical Brief (2006:1), factors, which influence the organisational climate, are history, organizational culture, management competencies, as well as leadership and management practices. The report stipulates that good leadership and management practices contribute to a positive work climate. Ultimately, a positive work climate leads to sustained employee motivation, improved performance, and results. A negative work climate attracts high absenteeism, lack of motivation, reduced interest in work and unmet performance. Therefore, managers need to design and implement strategies to improve the organisational climate (Ajmal et al. 2013:115).

The main aim of healthcare organisations is to provide quality care to its clients through highly effective and efficient healthcare workers. Thus, the delivery of high quality services depends on the competency of health workers and work environments, which support performance excellence (International Council of Nurses (ICN), 2007:1). A positive practice environment (PPE) is work environments, which support excellence and decent work. It strives to ensure the health, safety and personal wellbeing of staff, support quality patient care and improved motivation, productivity and performance of individuals and organizations (ICN) (2007).

Only organizations that are flexible, adaptive and productive will excel in situations of rapid change (Senge, 1990:3).The transformation of the Emergency Centre at CHC was based on the philosophy of the learning organization. The quest of a learning organization is towards an organisational culture, which is reflective of effective management practices, good peer support, joint decision making and shared values (Senge; 1990:3).

While governments and international health organizations are developing smarter policies in order to achieve the Alma Ata goal and to address the deficits in achieving the Millennium Development Goals, cognizance must be given to the fact that Emergency Centres will

always be the gateway to healthcare services - hence the need for strengthening of emergency departments through National healthcare reform. (ACEP; 2008: VI).

1.3 PROBLEM STATEMENT

An unhealthy environment existed in the CHC, which lead to challenges in the delivery of quality emergency care, low staff morale, and teamwork. The staff attitude and morale were identified as a critical obstacle, which prevented the success of previous improvement strategies. A transformational change management approach was used to ensure quality improvement in service delivery, patient care outcomes, and to create a positive practice environment in the unit.

It was, therefore, important to determine scientifically what impact the transformational change process had on the clinical staff in terms of how they view the process, the influence of the process on their current functioning and the value they attached to the changes, which took place.

1.4 RESEARCH QUESTION

How did the clinical staff experience and perceive the transformational change management approach introduced at an Emergency Centre of a Community Healthcare Centre in the Western Cape?

1.5 RESEARCH AIM

To explore the clinical staff's experiences and perceptions of the transformational change management process introduced at an Emergency Centre of a Community Healthcare Centre in the Western Cape.

1.6 RESEARCH OBJECTIVES

- To describe the clinical staff's experiences of the transformational change process at an Emergency Centre.
- To explore the changes as perceived by the clinical staff in terms of its value and contribution to the delivery of quality healthcare in the unit.

1.7 ASSUMPTIONS

The following assumptions were made by the researcher during the planning and development of the research project.

1. The process of transformational change took place in the Emergency Centre as an initiative to improve the operations of the unit.

2. The success of transformational change process was mainly due to
   a) Visionary leadership
   b) The commitment of the staff to take ownership of the change initiatives
3. The focus of the process was an *"Inside Out"* approach.
4. The transformational change process resulted in improvement in the quality of care, patient outcomes, and creating a positive practice work environment.
5. The experiences and perceptions as voiced by clinical staff and facilitated by an independent (external) fieldworker would provide insights into how the change process was experienced.

1.8 THEORETICAL FRAMEWORK

Burns and Grove (2007:171) regard a framework as a brief explanation of a theory or portions thereof to be tested as it relates to a quantitative study. De Vos et al. (2011:304) is of the opinion that phenomenologist enters the study environment with a framework to determine what will be studied and how it will be done. Creswell (1998) supports the view that the "orienting framework" is usually based on a philosophical perspective. Such a framework would for example guide, the data collection and analysis phases whilst the literature review is done after data collection as a measure of literature control (De Vos et al. 2011:305)

Evans (2011:5) suggests that one uses an eclectic combination of more than one theory and/or model for a more effective approach to organisational change management. Health systems are highly context-specific and require a combination of best practice models to ensure improved performance (WHO, 2007: iii). The combination of transformational change management approaches used in this study should be supported by a sound value system, which relates to ethical leadership through shared vision, worker empowerment, and quality assurance in service delivery. Therefore, an integrative approach was used as the theoretical foundation for this study using the Learning Organisation (Senge, 1990) and Barrett's New leadership paradigm (Barret; 2010).

Senge's (1990) Learning Organisation theory provides the elements required to move the organisation towards change. Barrett's New Leadership paradigm reflects the consciousness of the organisation in its need for change. It links the disciplines of mental models and personal mastery as a spiritual framework of transformational change

The Quality of Care framework of Donabedian (1966) emerged during the data analysis phase as a suitable model to present the findings in a structured manner.

1.8.1 The Learning Organisation

Learning organisation as a concept in organisation change relates to the ability of the organisation to be receptive, dynamic and responsive to environmental influences (Huber, 2010:59). The learning organisation is based on five learning disciplines, namely personal mastery, mental models, shared vision, team learning, and systems thinking. Senge (1990) defines the learning organisation as an organisation where people continually expand their capacity to create the desired results, where new expansive patterns of thinking are nurtured, where collective aspirations are set free and where people are continually learning how to learn together. When rapid change is required, it is important to develop the commitment and ability to learn at all levels. This will enhance the flexibility, adaptability, and productivity needed the organisation to excel (Senge, 2006:4)

1.8.2 Barrett's New Leadership Paradigm

The Barrett Model describes the development of human consciousness as it applies to individuals and human group structures e.g. leaders, teams, organisations, communities, and nations. It captures the visionary aspects of modern leadership approaches, which incorporates goal achievement supported by an ethical value system that incorporates integrity and accountability as key drivers (Barret, 2010:24). According to Barrett, this is a paradigm focusing on full spectrum sustainability by targeting the success of the organisation as well as the wellbeing of all stakeholders, for example, employees, customers, investors, partners, society and the environment.

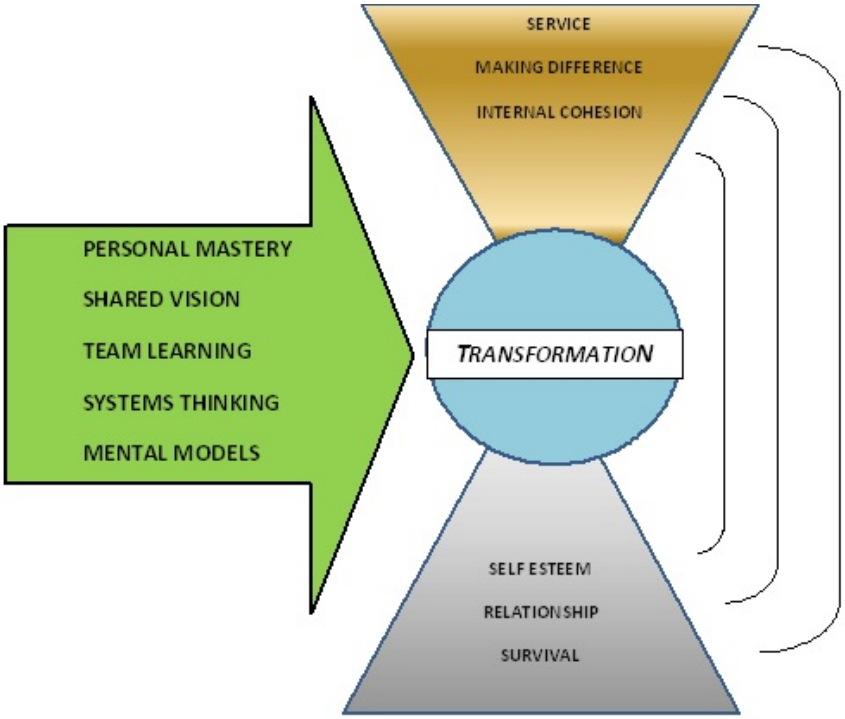

Figure1.1 Modified Model Integrating Barret's New Leadership Paradigm with the Disciplines of the Learning Organization (Adapted from Barret, 2010:1 and Senge, 1999:6)

1.8.3 Donebedian's Quality of Care Framework

The Donabedian framework of Quality of Care (1966) was useful in providing a structured system's approach through which to present the analysed data. The components of the framework are defined as follows:

i. Structure is described as the attributes of the setting where care is delivered.
ii. Process includes the procedures, methods, means or sequences of steps that are followed in examining health services and evaluating healthcare.
iii. Outcomes represent the impact of improvement strategies on the quality health care provision, and health service performance**. (Anyanian & Markel, 2016:206)**

1.9 RESEARCH METHODOLOGY

A brief overview of the research methodology as applied to the study is described here and will be discussed in detail in Chapter 3.

1.9.1 Research design

A qualitative design with a descriptive phenomenological approach was used to explore the clinical staff's experiences and perceptions of the transformational change management

process at an Emergency Community Health Facility. The aim of a phenomenological study is to capture the first hand lived experiences of the participants within the context where the experiences took place (Smith 2008:28).

1.9.2 Study setting

The study was set at an Emergency Centre in a Community Health Centre in Cape Town, Western Cape.

1.9.3 Research Participants

A purposive sample was drawn which included the clinical staff who worked in the Emergency Centre for six months or more during the period of January 2009 to December 2011. This sample comprised of the nursing and medical personnel. Twelve participants eventually took part in individual interviews, which were conducted by an independent fieldworker. Two focus group discussions were also conducted. The focus group was included as a data collection method to enhance the understanding of the phenomenon being studied (Bradbury-Jones, Sambrook &Irvine, and 2009:663). This was facilitated by the fieldworker and a research methodology lecturer from the department of nursing at Stellenbosch University and included six participants from the sampled population. In 2016, the follow-up focus group discussion was conducted with 5 participants. The aim of this focus group discussion was assess whether the perception and experiences of the participants about the transformation process remained the same and/or changed since 2012.

1.9.4 Data collection tool / instrumentation

An interview guide provided a framework of open-ended questions closely linked to the objectives used during the data collection phase. A trained fieldworker conducted semi-structured individual interviews and two focus group discussion to collect the data.

1.9.5 Pilot interview

One participant, having similar characteristics to those of the target population was interviewed as a pilot to the study.

1.9.6 Trustworthiness/ Rigour

The work of Lincoln and Guba (1985: 290) provided the framework for establishing rigour in the study – providing the assurance that the findings of this study are “worth paying attention

too." The application of the criteria namely credibility, transferability, dependability and conformability as was done in this study, are discussed detail in Chapter 3.

1.9.7 Data collection

Informed consent to record the interviews and focus group discussions was obtained from the study participants. A lecturer from the Stellenbosch University assisted the fieldworker during the focus group discussion. Data was collected on two occasions i.e. individual interviews and a focus group discussion in 2012 and another focus group discussion in 2016.

1.9.8 Data analysis

Tesch's (1990) eight-step model was used to analyse the data. To analyse the data the researcher carefully listened to and transcribed the recordings. A thematic approach was applied by coding, identifying sub themes and themes. The researcher being directly involved in the area of the study had an obligation to separate her past knowledge and experiences - a process known as phenomenological reduction. The process of phenomenological reduction entails the use of 'bracketing 'to shunt the experiences and perceptions of the investigator and to allow the authenticity of the participants' accounts to emerge (Bendall; 2006:3) an independent researcher also analysed the data using Atlas.ti® to validate the process. The researcher also endeavoured to apply the process of bracketing while analysing the data.

1.10 ETHICAL CONSIDERATIONS

The Human Sciences Research Committee of the Faculty of Health Sciences at the University of Stellenbosch granted approval for the study (S12/05/116). Endorsement to conduct the study was obtained from the Western Cape Department of Health. The Director of the Klipfontein Sub-district granted permission to conduct the study at CHC. Written informed consent was obtained from the participants. The ethical principles pertaining to individual rights were adhered to, especially the rights to confidentiality and anonymity. The data collected we stored at the university, where the researcher is registered, for safekeeping for a period of five years after which it will be destroyed.

1.11 OPERATIONAL DEFINITIONS

Clinical Staff: Persons who provide direct patient care in an Emergency Centre (Andrea Santiago, 2013).

Medical Practitioner: A person who practice medicine and is registered with the Health Professions Council of South Africa.

Nurse: A person who is registered with the South African Nursing Council as a professional nurse, enrolled nurse or an auxiliary nurse.

Experience: Living through or participating in a series of events, which leads to the accumulation of a set of overt or covert knowledge, skills, values and attitudes. It represents the totality of a person's perceptions, feelings and memories of the events (Collins English Dictionary, 2003).

Perceptions: The way in which experiences is regarded, interpreted and understood. Online Oxford Dictionary (accessed www.oxforddictionaries .com, 2013)

Transformational Change: Riley et al. (2010:1) describe transformational change as a radical change introduced by visionary leaders, which involves a complete rethinking of how the organisation is structured and managed in order to achieve dramatic improvements in quality service and other performance measures.

Visionary Leadership: Leadership, which inspires high levels of achievement in the team and enhances the organisational performance through a shared vision, trust, and commitment (Kirkpatrick, 2011:1615).

Quality: A process of meeting the needs and expectations of patients and health services personnel (WHO, 2000).

Positive Practice Environment: An environment which strives to ensure the health, safety and personal wellbeing of staff, support quality patient care and improved motivation, productivity and performance of individuals and organisations (ICN,2007).

1.12 DURATION OF THE STUDY

Ethics approval was initially obtained in July 2012 and data was collected in September /October 2012. Data analysis was carried out in October 2012 – January 2013. The study was put on hold between the end of 2013 to 2015. The study resumed at the start of 2016, reapplication for ethics approval was made, and approval received at the end April 2016. Another round of data collection and data analysis was done in July 2016.

1.13 CHAPTER OUTLINE

Chapter 1: Scientific Foundation for the Study

This chapter outlines the motivation and background of the study. This includes a brief overview of the literature, research question, research objectives, as well as the research methodology and conceptual framework.

Chapter 2: Literature Review

This chapter describes in-depth discussions of the various schools of thought, literature, and research related to the study.

Chapter 3: Research Methodology

This chapter contains a detailed outline of the research methodology as applied in the study

Chapter 4: Findings and Analysis

In this chapter, the findings and analysis of the study are captured and discussed.

Chapter 5: Conclusion and Recommendations

The interpretations of the results of the study will be presented in this chapter. It also entails recommendations, which are on the outcomes of the study.

1.14 SIGNIFICANCE OF THE STUDY

The study aims to contribute to the body of knowledge in the field of emergency care in the PHC setting by focussing on and describing the lived experiences of clinical staff participating in a transformational change process. The study with its phenomenological approach provided a space for clinical staff to share their experiences and perceptions as formed while living through a transformational change process.

It is hoped that the qualitative exploration of the experiences of clinical staff about transformational change will add to the body of knowledge in the area of organisational dynamics in complex health care settings. The findings and recommendations of the study will be shared with participants, relevant stakeholders and communicated to policy makers within the Department of Health. This may support other mangers and leaders to enhance

their own facility's service delivery and thus contribute to strengthening management and leadership capacity and practice.

1.15 SUMMARY

The goal of health care services is to provide holistic quality healthcare. This is equally true for an emergency care centre. A workforce that is motivated and capacitated whilst facing numerous challenges is considered important. The Health policy reforms based on a client centred approach requires a radical transformational shift to address these challenges. A holistic strategic focus is required, where the core aspects would include the development of a shared vision, improvement in critical systems, technical care, and employee care. Finally, it is important to determine whether such interventions work and how they are experienced by the relevant clinical staff members.

1.16 CONCLUSION

In this chapter, an overview of the rationale, significance, research question, research objectives, and methodology was provided. The models served, as the conceptual framework for this study is included in this chapter.

In Chapter 2 an in-depth review of the current and relevant literature will be reflected on to provide a meaningful backdrop to the problem statement, research question and objectives.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 2 presents the review of the literature pertaining to and relevant to this study. LoBiondo-Wood and Haber (2010:63) define a literature review as aiming to "uncover research and conceptual information including both primary and secondary sources." Burns and Grove (2009:720) emphasise that "the analysis and synthesis of research sources to generate a picture of what is known and not known about a particular situation or research problem further define it".

In this study, the researcher performed an initial review of the literature to explore what is known on the area of interest and how other researchers explored the concepts around the transformational change process. Following an initial assessment and needs analysis of the CHC's Emergency Centre (EC) by the researcher in 2008, it was revealed that several challenges existed, for example, a lack of critical operational systems, gaps in the ability in the EC to provide quality emergency care and a poor work ethic among the members of staff. Interviews with both the nursing and medical staff highlighted challenges related to teamwork, supply chain, human resource management and poor patient care standards. Based on the findings, it was decided that the situation required a comprehensive approach to address the challenges plaguing the Emergency Centre at CHC in 2009. The focus of the literature review in this chapter is aimed at synthesising available literature relevant to transformational change, leadership, and organisational dynamics in the context of the healthcare environment and in particularly the emergency care setting. It also includes the conceptual framework used in this study

2.2 LITERATURE SEARCH STRATEGY

The search for literature was done across databases such as PubMed, Medline, E-journals, search engines, internet publications (through Google); journals; various government documents, books, print media and searching through various reference lists, books and print media. Keywords were used across the databases. This included transformational change, change management, leadership, emergency care, organisational dynamics, organisational culture, nursing care, health care reform, teamwork, quality care, positive practice environment. The available literature in most search areas was extensive and had to be narrowed down to address the objectives in the study. There was however a paucity in the literature search about the use of the transformation change approach in emergency

centres. The study was done between 2012 and 2016 however, as far as possible the researcher attempted to use up to date literature within a range of 10 years.

2.3 BACKGROUND TO HEALTHCARE REFORM

Public healthcare organisations globally are under great internal and external pressure to deliver more and better services with fewer resources and are being challenged with demands for fundamental change (Van Rensburg, 2012:25-30). Chopra, Lawn and Saunders (2009:1) state that the combination of acute and chronic diseases across all age-groups and socio-economic spectra imposes an immense burden on already weak and underdeveloped public health-care delivery systems facing challenges of poor administrative management, lack of funding, low morale and shortage of skilled staff. Operating under such conditions, it is a challenge to deliver high quality, safe, efficient, and accessible care in ways that provide better value to patients and other stakeholders.

Achieving fundamental change will require more than quick fixes and incremental improvements (Brown, 2006:315).Therefore, according to Riley et al. (2010:72-78), public health departments need better methods to improve its performance and proposes transformational change management as important strategy for leaders of public health services to use.

2.4 GLOBAL HEALTHCARE REFORM

The 1978 Alma Ata Declaration (WHO: 1) forms the foundation for directing healthcare reform worldwide. The 1978 Alma Ata Declaration affirms that Health is a basic human right and the achievement of the highest level of health is a worldwide social goal, which requires the collaboration and action of health sectors with other social and economic sectors amongst others.

Globally, healthcare systems are driven to become dynamic and changing through internal and external processes, which are in constant change because of changes related to demographic, geographic, social, cultural, political and economic environments Van Rensburg (2012:16). According to Benetar and Block (2011:1-10), these changes and trends are related to core issues and challenges namely aging populations, changing disease patterns, scientific and technological advancement and growing public demand. In spite of these constant changing conditions, healthcare institutions should continue to strive for greater efficiency, fairness and responsiveness to expectations of people. Thus, there is a demand for healthcare reform that is aimed at universal access to care, cost containment, enhanced quality of care, increased patient choice and satisfaction and obtaining public

accountability and participation (Van Rensburg, 2012:17). Berman (1995:10) defines health sector reform as a sustained purposeful change to improve the efficiency, equity and effectiveness of the health sector.

2.4.1 Globalisation and the Impact on Healthcare

There is a convergence of trends in healthcare systems internationally. We see the decentralisation of national health care systems, the privatisation of healthcare provision and alleviating the financial burden on the state/government, which suggests the globalisation of health, health policy and healthcare (Van Rensburg, 2012:24). The globalisation is, therefore, the process of making the world smaller, more integrated and compressed, rapidly and permanently transforming all spheres of human endeavour i.e. politico-legal, socio-cultural, economic, environmental and demographic and health (Muller, Bezuidenhout & Jooste, 2008:4). According to Buse, Drager, Fustukian and Lee (2002:251), globalisation represents a set of processes put in place to move towards unprecedented interconnectedness and increasing interdependence. This process entails the blurring of boundaries and transforming the nature of human interaction across a wide spectrum of spheres resulting in the emergence of a global community and internationalisation. Therefore, in the health sphere, health and healthcare of populations are directly influenced and determined by global development and trends. The impact of globalisation offers opportunities as well as risks (Van Rensburg, 2012; 24).

2.4.2 The Effects of Globalisation on Healthcare Systems

Healthcare systems across the globe face the challenge of an increased demand for care with shrinking financial resources. This scenario cause healthcare systems to attempt tore-organising healthcare services and sometimes overhaul the entire system (Barret etal.2014:2). To add to this, Van Rensburg (2012:25) reported that globalisation of healthcare holds both opportunities and risks for healthcare. The opportunities of globalisation include greater sharing in the advancement of science, medicine and technology, global focus on the Primary Health Care approach, expansion of social programmes to improve living conditions, enhanced economic growth, the concept of human and health rights. Whereas the adverse effects of globalisation include human and environmental exploitation, economic disparities between the rich, poor, and growing inequalities in health and healthcare (Van Rensburg, 2012:25).

According to the WHO (1998), global treats and risks of emerging and re-emerging infectious diseases are accentuated by changes in human behaviour, changes in ecology

and climate, changes in land use patterns and economic development and tourism and migration. Widening disparities in health and access to basic health care prevail despite major advances in medicine and growth in the global economy. These trends result in many national health systems being “distorted, dysfunctional and unsustainable (Benetar &Brock, 2011:1). Last (2001:870) argues that the world health system has been criticised for not coping with changing health and healthcare needs and threats due to cumbersome bureaucracy, lack of leadership and fragmented ineffective action against pressing health problems.

2.5 HEALTH REFORM: SOUTHAFRICAN CONTEXT

Healthcare reform in South Africa forms part of the broader political and social transformation of the country. The healthcare reform agenda post 1994 was to rectify a culture, which did not include consultation, involvement and participation of communities, the fragmentation of health services. The previous healthcare system was characterised by inequities and disparities in the provision of health care, shortages of resources, inappropriate emphasis on curative services, disparities and inequalities in the health status of the population (Van Rensburg & Engelbrecht, 2012:121-122). In the post 1994 health care reform, the PHC approach was adopted, which included intentions to strengthen district health services so that healthcare delivery is more accessible and equitable to larger groups of the population who has previously been deprived of a wide range of services.

2.5.1 Public Healthcare in South Africa

Public healthcare in South Africa is managed by the provincial departments of health. It is divided into primary health care clinics and level 1 (district), level 2 (regional) and level 3 (central) hospitals (von Holt & Murphy, 2006:2). Each level provides for more specialist and intensive clinical care than the level below it.

Community health clinics are also referred to as day hospitals (Van Rensburg, 2011:432), which are classified in the Public health care system in South Africa as a district healthcare facility. They are sophisticated facilities providing similar services as at a district hospital. The community health clinics usually supply a wider spectrum of services, including emergency and maternity services, which operate for 24 hours a day, seven days a week.

2.5.2 Goals and Challenges: Transformation of Healthcare

The goal of a National Health Plan for South Africa was to create a unitary, comprehensive, equitable and integrated health system. This required developing a comprehensive

programme, which will redress social and economic injustices, eradicate poverty, reduce waste, increase efficiency and promote greater control for communities and individuals over all aspects of their lives. This involved a complete transformation of the healthcare delivery system and relevant institutions. This entailed a total review of all legislations, healthcare related organisations and institutions to

- Move the emphasis to health and wellness and not only on medical care.
- Redress the harmful effects of apartheid on health care services.
- Align comprehensive healthcare practices with international norms, ethics and standards.
- Expand the role of all health workers in the health system, and ensure that teamwork is a central component of the health system.
- Recognise that the most important component of the health system was the Community and ensuring that mechanisms were created for effective community participation, involvement and control (McMillan, 2010: 2)

The National Department of Health (NDOH) developed a new strategic vision reform for the delivery of healthcare in South Africa with the realisation that the current approach is not addressing the Millennium Development Goals. This led to the adoption of the Negotiated Service Delivery Agreement (NSDA) by the NDOH. The key focus areas of the plan are to improve the effectiveness of healthcare delivery and quality of care (NDOH Strategic Plan, 2010:21). This is an example of a strategic approach to address demands for healthcare reform at the national level.

The Department of Health in the Western Cape Province adopted the “Healthcare 2030” policy framework. This framework provides a broad strategic overview of the desired healthcare system by 2030 with the client-centred quality of care at the heart of this vision (Western Cape DOH: Vision 2030: x).

Despite major strides in healthcare reform in South Africa, the healthcare system remains in constant treats resulting from the high burden of disease, budgetary constraints, poor infrastructure, inadequate staffing, failure to address growing health crisis and growing complaints from clients about service delivery.

2.6 EMERGENCY MEDICAL CARE SYSTEMS

The WHO report (2006) on the global burden of disease indicate that non-communicable diseases namely trauma, cardio-vascular disease, stroke and cancer, are the major causes of mortality and morbidity worldwide (Mullins, 2011:5).Patients present with life-threatening conditions requiring critical care throughout the world regardless of location or capabilities of the healthcare system (Murthy & Adhikary, 2013:509). It is reported that acute care and emergency medicine systems improvement, is a necessary strategy in health systems strengthening. This shift in the global burden of disease is also rapidly affecting low- and middle-income countries, whose challenges also include the burden of communicable disease. The Healthcare systems in developing countries are not adequately equipped to deal with these challenges (Mulligan, 2011:5). In addition, to the disease burdens, other challenges faced by these developing health systems include poor organisational planning, lack of trained staff and critical resources, inadequate capacity to monitor, evaluate and treat emergency conditions (Murthy et al., 2013:489).

2.6.1 Review of Emergency Care Systems in Selected low –and middle income Countries in Africa

Several countries in Africa have embarked on establishing and developing acute care and emergency medical systems (Mullins, 2011:6). Recent research indicates that there are continuous efforts made to improve the provision of emergency care services in low-and middle-income countries (Japiong et al., 2015:31). Despite these advancements in strengthening critical emergency care services, most low-and middle-income countries find it challenging to implement high-cost and resource- intensive management strategies. These challenges are due to the disparity in disease burden, patient demographics and infrastructure of the health system (Murthy & Adhikary, 2013:509). Furthermore, the demand for quality emergency health care reform in low-and middle-income countries is critical due to the increase in violence, crime, natural disasters, terrorism, political unrest and war.

Herewith follows a review of emergency care systems in Sudan, Ghana and South Africa, each with similar yet also unique conditions and challenges.

2.6.1.1 Sudan

Sudan is one of the largest countries on the African continent with a population of approximately 43, 6 million people. Sudan is considered a low-income country with 47% of the country living in poverty (Hassan, A-Rahman & Jacquet, 2014: 56). Sudan is plagued by communicable diseases and malnutrition. The major causes of mortality include infectious

and parasite diseases such as TB, malaria, schistosomiasis, respiratory infections, diarrheal disease and malnutrition. Other emerging diseases such as diabetes, hypertension and ischemic heart disease are on the rise. Furthermore, the ongoing internal conflicts and violence add to a burden of traumatic disease requiring emergency care (Hassan, A-Rahman & Jacquet, 2013:56).Healthcare systems in Sudan include primary health care units, dressing stations, dispensaries, urban health centres and rural hospitals (Hassan, A-Rahman & Jacquet,2013:57). Primary health care and emergency care services are free for the citizens as a constitutional provision. Health care delivery is limited and often interrupted due to the ongoing conflict, where many healthcare facilities are non-functional because of damage to infrastructure and lack of equipment (Hassan, A-Rahman& Jacquet, and 2013:58). A pre-hospital Emergency Medical Service is available, which only provides transport due to lack of trained personnel and inadequate equipment. Challenges to the provision of emergency care in Sudan include lack of financial support, poor infrastructure, challenges with equipment, no formal triage system, and lack of sufficient and appropriately trained medical and nursing staff. Thus, there is a need to initiate and maintain high quality emergency services in Sudan (Hassan, A-Rahman& Jacquet; 2013:60).

The high burden of both communicable diseases and non-communicable diseases in Sudan contributes to a high mortality rate. This is further compounded by war and political unrest. Efforts to improve emergency medical care services in this country would be enhanced by the introduction of a formal triage system, the appointment of emergency medical specialists and formalising emergency nurse training.

2.6.1.2 Ghana

Ghana is a country in West Africa with population of 26 million people. A district health system exists with primary health centres and a government or mission hospital (District hospital). Emergency cases are referred to the district hospitals for emergency care and the cases requiring more complex care is referred to the regional hospitals (tertiary level) that have specialist services (Japiong et al., 2015: 31). The secondary hospitals in Ghana experience the emergency care strengthening efforts are mainly concentrated at the pre-hospital level, primary health care centres and tertiary hospitals (Japiong et al., 2015: 30). The patients received by the secondary hospitals which make up the district level hospitals, often have delayed pre-hospital times. These patients usually arrive under resuscitated and require urgent diagnosis and treatment. Nevertheless, the district level hospitals often lack the diagnostic the definitive care resources are often not available. Furthermore, challenges are experienced with infra-structure, inadequate equipment; high patient acuity, lack of necessary medical supplies, appropriate job-specific training and control systems (Japiong

et al., 2015:31). Although Japiong et al., (2015) reported that some physical resources are available and some job-specific training is taking place, the lack of diagnostic equipment, adequate essential equipment and stock items affect the delivery of quality emergency care (Japiong, 2015:33). According to Japiong et al. (2015:36) emergency care capacity and quality of the Ghanaian healthcare service can be improved through in-service training on protocols of triage and emergency care, planning and organising of services and critical resources management systems (Japiong et al., 2015: 37).

Sudan and Ghana being lower-middle income countries in Africa face similar challenges with the burden of communicable and non-communicable diseases and mortality of these countries being high. In Sudan, the burden is compounded due to war and political unrest. Health care systems are in place in the pre-hospital, primary district and secondary level. Sudan also has tertiary level emergency healthcare capacity. These countries are under-resourced and experience similar challenges related to lack of infrastructure, essential medical equipment and stock. The implementation of the emergency care reforms is further hindered by the lack of specialist trained medical and nursing staff as well as the lack of formal job specific training programmes. Bell et al. (2014:1) confirm that emergency health care provision is a developing speciality in many sub-Saharan countries and training programmes for physicians is increasing while there is only a few training programmes in emergency health care for nurses. Recent studies indicate an increased commitment from government in sub-Saharan countries, hospital management and another stakeholder towards improving emergency health care services.

2.6.1.3 South Africa

South Africa is considered a middle-income country. The health care system in South Africa consists of both public and private sectors. The public health care delivery system is based primarily on a district health system based on a comprehensive primary health care approach (Brysiewicz & Bruce, 2007:127).

A study conducted by Hardcastle et al. (2011; 190) indicates that emergency care delivery in South Africa follows a four-tiered level system:

Level 4: Centres at this level are tertiary care facilities providing 24 –hour access to total comprehensive emergency care with access to all the major medical and specialities and include rehabilitation services. These facilities have adequate financial, human and other critical resources to provide quality patient care, leadership in education, research and systems planning (Hardcastle et al. 2011:190)

Level 3: Centres operating at this level provide emergency care in a specific region. It is required to provide initial definitive emergency care irrespective of the severity of the condition on a 24-hour basis covering the common medical and surgical specialities. The extent of the emergency care provided by level 1 centres depends on factors such as location, patient volumes, availability of human resources and other critical resources. Patients requiring advanced, extended surgical and critical care are referred to Level 1 centres for further management (Hardcastle et al. 2011:194)

Level 2 emergency centres, are also referred to as district hospitals. These facilities are expected to have the capacity to provide the initial assessment of a patient, resuscitation services, basic emergency procedures, and stabilisation. These facilities must have access specialist level 1 and level 11 facilities to refer patients who require critical definitive care, standardised treatment protocols and policies for referral pathways must be in place. This is often challenging in remote rural areas due to the distance between the areas. (Hardcastle et al., 2011:194)

Level 1 emergency care centres are based at primary health care facilities and were initially set-up set up to provide basic life support services and referral to advanced facilities for further critical care. Therefore, the level 1 facility must have committed leadership to sustain professional affiliation with the other centres (Hardcastle et al. 2011:194).Although Emergency Centres at the primary health care level are expected to only provide basic acute care, patients sometimes present with serious life-threatening conditions at these facilities. Occurrences such as these place a demand on the capability of these services to go beyond mere stabilising the patient to provide definitive critical care (Adeniji & Mash, 2016a1148).

2.7 CHALLENGES IN EMERGENCY HEALTH CARE SYSTEMS

South Africa, like many low-and middle income countries, face a quadruple burden of disease comprising ,tuberculosis, increased maternal and child mortality, chronic diseases of life style and violence/ crime related injuries (Adeniji & Mash,2016 :a1148). Trauma is regarded as a major burden of disease and a leading cause of mortality in low and middle-income countries (Hardcastle et al., 2016:179). According to Wallis (2011:171), this burden receives low priority due to the focus on primary health care and the disease process. The emergency care crisis is thus duly neglected. Most of the challenges faced in the delivery of quality emergency care relate to inequities related to budgetary constraints, the availability of specialist trained staff (medical and nursing), infrastructure, standardised protocols, essential equipment and medical supplies (Hardcastle & Brysiewicz, 2012:2). However, advancement has been made in the establishment and professional recognition of specialist medical and

nursing training in emergency health care in South Africa since 2008 (Hardcastle & Brysiewicz, 2012:3). The high workloads, unavailability of theatres and brain drain of specialist staff also affect the delivery of quality emergency care services (Hardcastle & Brysiewicz, 2012:3).

Although the emergency healthcare delivery systems are more advanced and structured than most emergency health care delivery systems of the low-and middle-income countries in Africa, it faces similar challenges of inadequate infrastructure, lack of critical resources, staffing and training.

In summary, global research indicates that the growing burden of disease specifically related to trauma together with resources limitations have serious impact on the delivery of quality emergency care services (Carvello et al. 2013: 1278). In high income and high middle income countries, the successes of quality emergency care services are related to the availability of skilled clinical staff, existing infrastructure and technology which is lacking in low-and middle income countries (Murthy & Adhikari, 2013:512). The need for strengthening of emergency health care delivery through policy reform, integration of emergency services into the health systems, standardisation and fixed resource inputs, equity in health financing and efficiency of service delivery is needed in both developed and developing countries (Hardcastle et al., 2016:185; Calvello et al., 2013: 1278).

2.8 CHANGE MANAGEMENT: AN OVERVIEW

Van Tonder (2004:4) regards institutional change as the most significant feature of the last decade.

The global community is evolving at a rapid rate through an increase in global competition, technological innovation and declining resources. Organisations are thus faced with constant external or internal pressures, which require them to adapt to the changing environment. In Healthcare organisations, external pressures, which impose change includes healthcare reform policies, the burden of disease, constraints in financial and lack of human resources (Muller, Bezuidenhout & Jooste, 2008:109).The survival and sustainability of organisations depend on how they respond to the demand for change. In addition to this, Muller et al. (2008:109) stated that healthcare managers need to have the abilities, i.e. knowledge, attitude and skills, to adequately manage change.

2.8.1 Different types of Change management

The literature makes a distinction between different descriptions of change and processes of change. Huber (2010:56) defines change as an alteration to make something different, which can be unsystematic or planned. She identifies terms such as innovation, transition and transformation and suggests that these used interchangeably to describe change. Daszko and Sheinberg (2005:1) argue that people often see any form of change, innovation, process improvement or transition as transformation and that while all transformation is change, not all change is transformation. They state that there are unique distinctions between transforming and changing an organisation. Table 2.1 below outlines the three types of changes.

Table 2.1The Types of Changes

Development		**Transitional**	**Transformational**
Motivation for Change	Better, Faster, Cheaper	Fix a problem	Survival, Environment, World Changes, Breakthrough needed
Degree of Change	Incremental improvements	Transition from old to new; A to B	Revolutionary, Necessary
Thinking	Improve	Change management; strategic planning	Radical shifts in mind-set /thinking/actions
Actions	Manage and control processes	Design the plan; implement the plan	Whole system change, complete overhaul of mind-set, paradigms, culture, communications, strategy, structure, actions, systems and processes, use of data, System of Profound Knowledge, cycles of Plan Do Study Act (PDSA)

Development		Transitional	Transformational
Destination	Improvements; can be limited to improving the wrong things	Projects completed	Continually transforming; no end state
Change Requires	Improvement of skills, practices and performance; often limited to focusing on individual performance rather than the Whole system to make significant differences	Controlled process/ projects managed/ assigned	Senior leadership committed to new thinking, learning and actions; coaching from outside: “a system cannot see itself.” Courage
Outcomes	Improvements, limited	Changes, limited	Sustainable change (with leadership and continual learning and new actions) new system: agile, adaptable, flexible, intelligent, emerging, connected, involved, creative, moving forward; ability to sense and respond.

(Anderson &Anderson 2010:31)

According to Anderson and Anderson (2010:31), it is important to differentiate between the different types of change in order to lead the change process. They make a distinction between three forms of organisational change i.e. developmental, transitional and transformational change.

2.8.1.1 Developmental Change

Developmental change focuses on the improvement, strengthening or correcting of current conditions, such as skills, methods, performance standards in the organisation, which does not meet current standards or future trends. In developmental change, the threat to the survival is low, making it easier to initiate. This form of change applies to individuals, groups or the whole organisation and is normally used for improvement processes such as training, problem solving, conflict resolution, team building, meeting management and others (Anderson &Anderson-Ackerman, 2010: 34-35).

2.8.1.2 Transitional Change

Transitional change is more complex than developmental change. It requires dismantling the existing nature of the organisation and creating a new and improved status in response to major shifts in environmental forces and business demands. Transitional change is often structural or technical with some degree of human and cultural impact (Anderson &Anderson-Ackerman, 2010:35-38).

2.8.1.3 Transformational Change

Transformational change is described as a fundamental significant shift in the nature of the organisation, which requires a shift of culture, behaviour and mind-set for successful implementation. It demands a shift in human awareness and changes the way the organisation and the people view the world, their clients, their work and themselves. The need for transformational change springs from changes and demands in the internal or external environment coupled with the organisation's inability to respond to the demands through the current strategy, organisational design, culture, behaviour or mind-set. The organisation finds itself in a precarious position and will struggle to survive unless it embarks on a transformational process (Anderson &Anderson-Ackerman 2010:39).

Furthermore, Anderson and Anderson (2010: 2) report that one of the reasons change initiatives fail is due to organisations using a change model that does not fit the change that is required.

2.8.2 The Transformation Process

The challenges and demands faced by organisations in the 21st century compel organisations to assess how they are doing business and whether current practices are meeting the external needs. Coupled to this, there are systemic challenges within the organisation that threatens its survival. Hughes and Stricker (2012:190) state that for organisations to respond successfully to the changing competitive threats and opportunities it requires radical organisational transformation to develop the required capabilities. Further to this, organisations that experience increasing difficulties such as stagnation, drop in productivity, decreasing staff morale, inadequate material resources and skills or relentless customer demands, need to heed the call for transformation (Anderson &Anderson-Ackerman, 2010: 41). The profound shift in the leadership's mind-set enables the beginning of transformation and the realisation of a new collective vision (Anderson &Anderson, 2010:41; Hughes & Stricker, 2012:190). The transformation, that is born out of survival requires radical paradigm shifts throughout the organisation, that will challenge existing

beliefs, assumptions, patterns and habits and trust in the future vision (Dasko & Sheinberg, 2005:2).

The process of transformational change requires leading with profound knowledge and courage into an unknown future (Dasko & Sheinberg, 2005: 1). In addition, the process of transformational change is facilitated by a shared vision, collective learning, questioning mental models, radical cultural shifts, personal mastery and developing shared values (Senge, 1990; Anderson & Anderson-Ackerman, 2010& Hughes & Stricker, 2012).

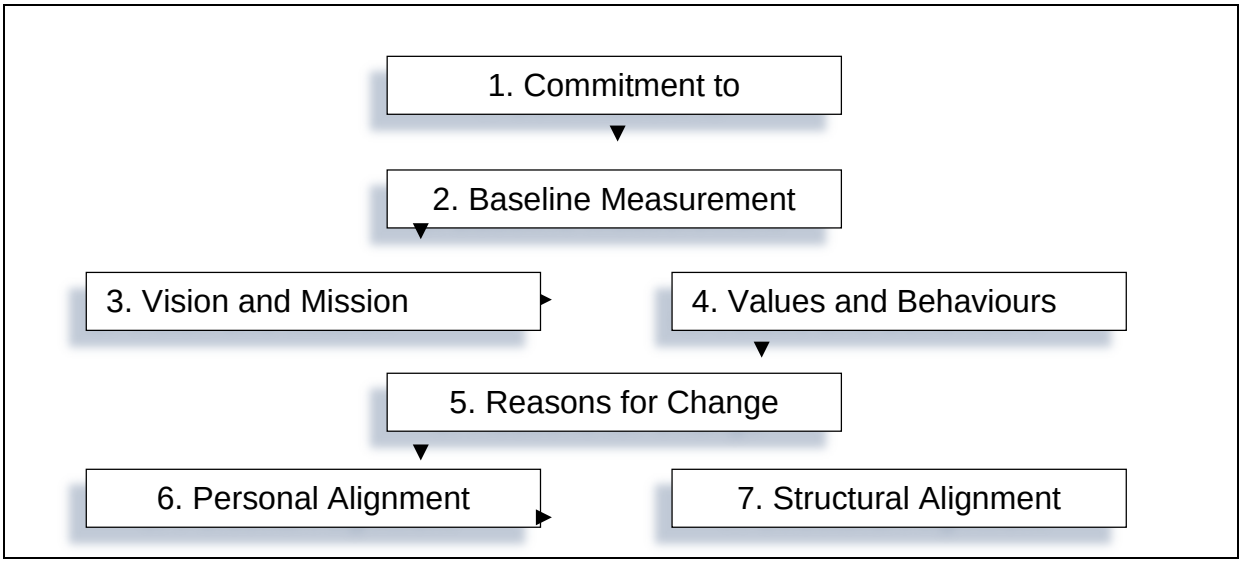

Figure 2.1The process of whole system change

Barret (2010: 373) identifies nine key steps to transformation within an organisation:

Step One: Commitment and Ownership

The process begins with the leader and leadership team making a commitment to transform. This commitment to change leads to a shift in motivation that brings about a shift in values and beliefs, which result in a change in the culture of the organisation. If there is no commitment from the leadership embarking on the change process is futile. The change process cannot be delegated; it must be supervised by the leadership team involved in the change process.

Step Two: Baseline Measurement:

A cultural value assessment must be done to assess the present performance of the organisation and a scorecard must be developed to measure the progress of the systems change process. Aspects of the organisational performance that could be measured include

budget, employee engagement, customer satisfaction, cultural entropy, values alignment and service delivery targets.

Step Three: Vision and Mission

When the baseline measurements performed, it is important to determine the future direction of the organisation. An internal and external vision and mission must be developed by the leadership team to inspire people in making a difference. If there are existing, vision and mission statements then it must be reviewed. The leadership should engage with employees about the vision and mission.

Step Four: Values and Behaviours

The organisational values and behaviours must be defined while developing the vision and mission. There must be employee involvement in determining the shared values. This creates a sense of internal cohesion and capacity for collective action. Internal cohesion in the leadership team and amongst the employees is facilitated by creating a climate of trust.

Step Five: Compelling Reasons for Change

The reasons why the organisation is embarking on whole systems change should be made clear and a common understanding amongst the leadership and employees must be reached. The reasons for change must be real, for instance, to improve performance, to become more adaptable or to build resilience.

Step Six: Personal Alignment

Leadership development is important to prepare everybody in a supervisory position towards personal mastery on how to lead themselves and others.

Step Seven: Structural Alignment

This involves bringing the structures, system, processes, policies, incentives, and procedures in alignment with the desired vision, mission, values, and behaviours of the organisation. It includes systems and processes such as employee selection, recruitment and induction, performance management, leadership development, talent management and values awareness programmes.

Step Eight: Values Alignment

The values and behaviours of the must be shared and adopted by the leadership team and the employees. Opportunities must be created for people to examine their own values and they should be allowed to practice their values – based decision making.

Step Nine: Mission Alignment

The vision and mission of the instilled through a mission alignment process. During the process, people have the opportunity to internalise the vision and mission and decide how they have to contribute and support the vision and mission of the organisation.

2.8.3 Transformational Change in Healthcare

Global challenges in healthcare delivery systems are ongoing. In the quest for the delivery of quality healthcare for all, healthcare leaders are challenged to think about new ways of service delivery in conditions such as resource constraint environments, doing more with less. The ASHP Allen & Ginsberg, (2012:1) states that healthcare is at a critical turning point that creates a demand for transformation. Current healthcare environments are under constant pressures to change. Discontinuous and continual change drivers demanding organisational redesign, new work processes and the creation of new knowledge, there is, therefore, the need to heed the call for change (ASHP Foundation 2012:1). According to Jolley, Baum, Lawless& Hurly (2008), transformational change could be achieved when there is agreement between staff and managers that change is needed. There also need to be a coalition of leaders to drive the change, a statement of goals and vision that is widely communicated and the willingness to confront and overcome barriers to change. A study by Lucas et al., (2007:309) identified the following five elements to be critical to successful transformation, namely the impetus to transform; leadership commitment to quality improvement initiatives that actively engage staff in problem solving; alignment to achieve organisational goals with resource allocation and actions at all levels of the organisation; and integration to bridge traditional boundaries among individual components.

2.8.4 Barriers to Transformational Change

When people are faced with change or are challenged to try something new or do things in a different way, it elicits fear and resistance (Roussel, 2013:140). In a similar way, organisational changes are often hindered by barriers inside or outside of the organisation. In a case study conducted by Skiti (2009: 59), the following barriers to change implementation were identified: lack of top management commitment and involvement, rigid

bureaucratic structure, inhibiting culture towards change, lack of employee engagement, sense of disempowerment, lack of continuous evaluation of the change process, lack of recognition and rewards systems, poor communications systems and inflexible organisational structure and culture. In addition, barriers which have an impact on health systems reform include limited financial resources, employee-related issues, lack of leadership and commitment to change (Jolley et al.2008:38). We could conclude, therefore, that leadership commitment, flexible organisational structures and processes, open, clear communication, employee involvement and empowerment and continuous evaluation of the change process, amongst others, are necessary to mitigate the barriers to transformational change.

2.9 THE ROLE OF LEADERSHIP IN CHANGE MANAGEMENT

It is clear from the literature that leaders and leadership has a pivotal, pervasive role in facilitating change in organisations. In the definition of Riley et al. (2010:72), transformational change is viewed as radical change introduced by visionary leaders, which involve a complete rethinking of how the organisation is structured and managed. Francis-Nurse (2007:1) claims that organisational change in futile without a strong leadership and that managing change requires a strong and steadfast commitment from the leader(s) and the team driving the process. This is supported by the observation of Abbas and Asghar (2010:24) that the role of leader/leadership is important in developing and managing change by creating the suitable atmosphere within the organisation to adopt change. Further to this, Barret (2010: xix) claims that the role of leadership in the evolution of organisations is key to achieving full spectrum consciousness and sustainability of business/organisations. He defines a leader as a person who faces their fears with courage, challenge the status quo, show perseverance in tough times; is willing to take risk for the cause they believe in without any regard for personal gain and is driven by the need to create a new and better future for everyone.

Hacker (2011:10) states that transformation leadership skills are required to facilitate organizational transformation. In addition, Francis-Nurse (2007:4) suggested that successful change efforts need leadership with a compelling vision, which appeals to all stakeholders, and the leadership should communicate a sense of urgency, leading by example, showing strong personal commitment and enabling stakeholders to contribute to their full potential.

2.9.1 Visionary/ Transformational Leadership

The terms visionary and transformational leadership style are used interchangeable. It is, therefore, important to refer to the influence of leadership styles in relation to transformational change management.

Kirkpatrick (2011:1615) found that visionary leaders not only inspire followers through an inspiring vision, they also have a positive effect on followers' outcomes. This leads to high levels of trust, commitment and high performance amongst the followers, which in turn has a positive impact on organisational performance. Therefore, the key to successful transformation is the leader's ability to articulate a vision for the future, which engenders trust and empowers the followers (Booyens, 2008:437). According to Lacasse (2013: 431), visionary leadership is a collaborative approach and followers need to be provided with information, knowledge and other essential tools.

2.9.2 Attributes of the Transformational Leader

Rolfe (2011:56) identified the following eight attributes of transformational leadership, which contribute to their success. These attributes include self-knowledge, expertise, authenticity, flexibility, vision, charisma, shared leadership and the ability to motivate and inspire followers. In addition, transformational leaders require high-skill in the traditional managerial functions and their capacity to envision the future, to build community, to empower people and to create (Hackner, 2011: 2). According to Jooste (2004: 4), problems in the workplace amongst the followers can arise when leadership attributes are lacking.

2.9.2.1 Leadership Behaviour in Implementing Visionary Change

The incorporation of transformational leadership theory belief and practices into leadership behaviour enhances successful change in organisations and its people (Rolfe, 2011:55). Leadership theories reviewed by Kirkpatrick (2011: 1617) identified the following behaviours displayed by visionary leaders implementing the vision role; modelling, empowerment, image building, supporting adapting, intellectually stimulating, creating and developing organisational conditions for the followers to pursue the vision. Leadership behaviours geared towards developing sound relationships with followers engenders trust, increases motivation and followers are empowered to take ownership of the shared vision and move the vision to actualisation (Rolfe, 2011; Kirkpatrick 2011). Liu (2008:46) is of the opinion that although transformational leadership is strongly related to achieving follower commitment towards large-scale organisational change, leaders who are not transformational can also achieve follower commitment when there change management practices in place and the

change makes significant personal impact on the follower. Liu further suggests that leadership theory and the study of change management must be integrated.

2.9.3 Leadership in Emergency Care Settings:

Leadership between the leader and the employees is crucial in the emergency care settings. This is because emergency care settings are chaotic, unpredictable, rapidly changing, and offering critical care, which requires complex interactions between staff members in providing and organising patient care (Braithwaite 2009:247). Critical questions are being asked by researchers about leadership styles and behaviours appropriate for an emergency care setting. Lin et al. (2011:238) discovered that leading Emergency Centres are complex and requires experience, clinical and technical skills as well as behavioural characteristics and the ability to manage relationships successfully. In a study conducted by Raup (2008:408) it was found that, the transformational leadership style benefits managers and staff in high-stress environments. Although the same study shows that, there is no difference between patient outcomes in the emergency settings between the transformational and non-transformational leadership styles.

Other studies found that the dynamics of leadership in the emergency setting is much more distinct than the traditional transactional models (Lloyd & Clegg, 2016:1). According to Lloyd and Clegg (2016:2), there is no standardised clinical leadership taxonomy in emergency care settings and the focus is mainly on individual leadership theories. They, therefore, suggest that to improve leadership in these unique settings, taxonomy of emergency care team leadership is required. Sarcevic et al., (2011: 227) states that the lack of leadership direction could result in conflict, ineffective team performance, could negatively affect clinical outcomes, and recommends the notion for team leadership development in contrast to an individual leader in the emergency settings.

In summary, the concept of leadership in healthcare settings is mainly focussed on the qualities, skills and behaviours of individual leaders. The complex nature of emergency settings demands a shift away from the individual leader to a focus on a leadership taxonomy that will accommodate both the team dynamics and nature of the emergency healthcare environment.

2.10 ORGANIZATIONAL CULTURE

Organisational dynamics is part of everyday life. It is, therefore, important for managers/leaders to identify and function effectively within diverse organisational structures, delivery systems, professional practice environments and models (Roussel, 2013:216). In

addition, Roussel (2013:217) postulates that the challenges in the nursing environment such as changes in the patient demographics, technological and biological advances, and the distribution of care delivery, urges nurse leaders to identify, develop and implement delivery systems/models which are appropriate for both the nursing profession as well as the patient communities. Furthermore, the Kennedy Group (2013:1) is of the opinion that organisational culture and climate has a strong impact on the organisation during the transformational change. They advise the use of facilitators of transformational change to recognise and balance the cultural as well as the climate dimensions within this process.

Robbins (2007:573) defines organisational culture as a system of shared meaning held by the members of the organisation. This is reflected in a set of key characteristics such as innovations and risk taking; attention to detail; outcome orientation; people orientation; team orientation; aggression; and stability. According to Booyens (2011:195), organisational culture represents the symbols, language and behaviours, which are manifested in the values and norms of the organisation. Del Buena and Vincent (2006:16) stated that policies and practices related to aspects of dress, personal appearance, social behaviour, the physical environment, communication, status symbols, rituals and rules reflect the cultural norms and values of the organisation.

2.10.1 The functions of culture

Robbins and Judge (2007:578) describe the functions of culture as follows:

- Boundary defining in that it differentiates the organisation from other organisations.
- Members of the organisation has a sense of identity to the organisation
- It facilitates commitment amongst the members, which is greater than individual self-interest.
- It serves to stabilise the social system. It holds the organisation together by providing appropriate standards or rules for the employees' behaviour.
- A sense making and control mechanism that guides and shapes the attitude and behaviour of employees.

The functions of organisational culture are deemed mutually beneficial to the organisation and the employees by enhancing organisational commitment and increasing the uniformity of employee behaviour. In as much as culture is beneficial, it can also be a liability when the organisational environment is dynamic and when the shared values are not supported by the

members who can further the organisation's effectiveness. The well-established culture of the organisation may be affected in an environment, which requires rapid change (Robbins & Judge, 2007:579). Therefore, one of the major challenges organisation leaders face is creating a culture that will unify each employee towards the objectives of the organisation during the change process (Skiti, 2009:27).

2.10.2 Organizational Culture of Emergency Departments

Emergency departments, as an environment of constant change and where high level of human interaction takes place, have the capacity to create a unique culture underpinning the beliefs, traditions and values, which exceed the values of the organisation (Person, Spiva & Hart, and 2013:222). According to McClelland (2012:111) the emergency care environment is connected to delivering quality patient care in a highly stressful environment, interfacing with humanity at all levels and having to make complex decisions quickly. Hence, the culture is what needs to be done but how it is delivered. In an ethnographic study conducted by Person, Spiva & Hart (2013:224) the following areas were identified to have critical influences on the organisational culture of the emergency healthcare settings: teamwork, communication, stressful environment, job satisfaction and competency of the leadership. In addition, other studies reveal that the nature of the emergency healthcare environment characterised by high workloads, frequent interruptions, and overcrowding, attracts systemic challenges causing frustration, stress and exhaustion amongst the staff. This in turn adversely affects care and team effectiveness (Person, Spiva& Hart, and 2013:226). Thus, the organisational culture in the emergency care environment needs to promote a culture to create a supportive environment with a focus on team development, conflict resolution, communication strategies and leadership development (Person, Spiva & Hart; 2013:226). Furthermore, attention must be given to the influence of the work environment in the promotion of safe, efficient patient care by removing barriers and improving processes (Person, Spiva & Hart; 2013:226).

Team relations, team effectiveness and communication in the emergency setting is vital for improving patient safety, reducing clinical errors and waiting times (Kilner & Sheppard, 2009:133). The organisational culture in the emergency setting needs to foster and promote strategies and processes, which enhance teamwork and communications.

2.11 QUALITY IMPROVEMENT

According to Muller (2011:596), quality refers to the characteristics or features associated with excellence. The specific characteristics associated with excellence in healthcare are perceived differently according to the perspective of the user. For example, the patient’s

perception might differ from the provider of care. Muller advices that the criteria for healthcare excellence should be created with the perceptions and needs of all stakeholders in mind. The quality of healthcare should be appropriate, accessible, effective, acceptable and efficient (WHO, 1983, in Muller, 2010:596).

Moreover, Muller (2011:599) differentiates between quality "assurance" and quality "improvement." The former denotes that quality is guaranteed, whereas the latter infers that a recognised plan is in place that monitors, measures and evaluates service provision. In addition, "continuous quality improvement" implies that organizational organisational transformation has occurred, including capacity building and empowerment of role players. This is affected by the cyclical implementation of monitoring, measuring and evaluating.

Ideally, quality improvement initiatives should be driven by leaders and practitioners who are visionaries by creating an environment, which rouses the desire in all stakeholders for constant improvement. The empowerment of staff by enhancing their skills with adequate tools and resources is needed to achieve high-quality performance from all staff regardless of their role in health care provision. In addition, good leadership can inspire staff through inspiration, motivation and financial reward (Fallon et al. 2010:4). A strong leadership is, therefore, essential in the transformation process to ensure a culture of quality improvement and it is underpinned by design and the intention to achieve the change (Fallon et al., 2010:4).Threats to quality improvement endeavours are usually associated with complacency and distractions (Grennan, 2013:34). Complacency may be subtle and could be identified in staff members who are resistant to changing the status quo. Distractions occur when budgets are curtailed due to financial stress, affecting resources including adequate staff establishment (Grennan, 2013:36). For public health services to succeed in quality improvement initiatives thereby meeting the needs of the communities they serve, high performance, efficient and evidence-based practices are crucial (Riley, et.al. 2010:7).

In summary, quality improvement in health care organisations should include a whole range of performance indicators. The focus of quality improvement in an emergency healthcare unit should be focused on improving the process of care and mitigation adverse outcomes (Scally & Donaldson 2013:2).Commitment from top management, leadership, teamwork and patient care needs are important.

2.12 CONCEPTUAL FRAMEWORK

There are a number of management theories and leadership theories, which could be appropriate for this study. Given the complex nature of the study, an eclectic combination of different theories was considered. Hernandez et al. (2013:168) found that several

researchers recommend the use of multilevel, multidimensional frameworks in studying organisational change, innovation and implementing quality improvement. Hence, the use of 'The Learning Organization', a leadership and change management model by Peter Senge and 'The New Leadership Paradigm' postulated by Richard Barret are presented in combination as the theoretical framework for this study.

2.12.1 The Learning Organisation

Senge (1990) describes a learning organisation as an organisation where people continually expand their capacity to create the desired results, where new expansive patterns of thinking are nurtured, where collective aspirations are set free and where people are continually learning how to learn together. He further suggests that, an organisation that requires rapid change must develop commitment and the ability to learn together, and through this the flexibility, adaptability and productivity of the organisation may be enhanced (Senge, 2006:4). A learning culture is created by adopting a set of attitudes, values and practices to support continuous learning.

2.12.1.1 Disciplines of the Learning Organization:

Senge identified five disciplines that contribute to developing a robust learning organisation. These disciplines are personal mastery, mental models, shared vision, team learning and systems thinking. According to Senge (1990; 139), these disciplines are interrelated and are vital for the continuous development of an organisation.

2.12.1.1 I Personal Mastery:

This discipline is based on clarifying and deepening of the individual's personal vision, through focusing energies and developing patience with an objective view on reality. It goes beyond competence, skill and spiritual development. Personal mastery is a lifelong process through which people become aware of their ignorance, their incompetence and area of development and develop the self-confidence to continue learning, developing and growing (Senge 1990:142). An organisation will expand when the people in the organisation continue to develop in a quest for personal mastery.

2.12.1.1 II Mental Models:

Senge (1990: 8) describes mental models as deeply ingrained assumptions, generalisations, images that determine how people understand the world. He suggests that mental models impact on behaviour and how actions are taken. This discipline requires introspection,

unearthing the internal picture of the world, allowing it to surface and rigorously scrutinising its influence on personal thoughts and behaviour (Senge 1990:9). Organisations need to identify the entrenched mental models and need foster institutional changes, which will allow people to learn new skills, develop new orientations, distribute responsibility in order to transcend the internal politics, assumptions, generalisations and images which hinder organisational change (Senge, 1990: 273-286).

2.12.1.1 III Shared Vision:

An idea of leadership that inspires organisations throughout history holds the capacity to share a picture of a desired future (Senge, 1990:9).A genuine vision aimed to galvanise the organisation will see people excel and learn because it encourages commitment and enrolment rather than compliance. Furthermore the vision has the power to uplift by encouraging experimentation, creativity and innovation (Senge, 1990:9). Hence, Senge (1990:227) states that by reinforcing the vision through increased clarity, enthusiasm and commitment it will extend throughout the organisation.

2.12.1.2 IV Team Learning:

Senge (1990:236) describes team learning as a process of aligning and developing the capacity of the team to create the desired results. At first, it requires open dialogue, the ability of the team to suspend assumptions and genuine thinking togetherness'. Open free flowing dialogue is key to this discipline as it leads to the discovery of group insights which, when aligned with systems thinking, creates a space to deal with complexities and focus on deep-seated structural issues. This learning further involves the abilities to identify the patterns of interaction in the teams, which undermine learning (Senge, 1990:10).

2.12.1.2 V Systems Thinking

Systems thinking are the approach of the learning organisation as postulated by Senge. The organization is described as a whole system in relationship to the environment. 'Systems thinking' examines the understanding of the linkages and interactions of complex human and non-human components within the organisation. It also examines how the integration and interconnectedness of these components influence the functioning of the organisation (Leadership and Systems). In using the systems theory approach, Senge (1990:12) argues that in focussing on the parts instead of the whole (system) one fails to see the organisations as dynamic system. Furthermore, better understanding of the interrelationships of systems will result in long-term improvement.

2.12.2 Leadership and the Learning Organization

Learning organization requires a shift from the traditional leadership view, which is based on assumptions of powerlessness, lack of vision and the inability to master the forces of change. In the new leadership view, leaders are designers, stewards and teachers. They create organisations where people continually expand their capabilities to understand complexities, clarify vision and improve shared mental models (Senge, 1990:340).

2.12.3 The New Leadership Paradigm

Barret (2010: xix) developed a paradigm to assist businesses/organisations to survive and prosper in the twenty-first century. This paradigm is based on vision-guided and values-driven leadership that embraces universal common good above individual self-interest in pursuit of the success of the organisation. The new leadership paradigm also takes into account the interest of all stakeholders, including employees, consumers, investors, partners, society and the environment.

This paradigm is based on the evolution of human consciousness, which is defined as awareness that the purpose of all physical entities and their group structures is to attain, maintain, or enhance internal stability and external equilibrium (Barret, 2010:26). According to Barret (2010: 26), human growth and development takes place through seven stages of consciousness which he identified being are survival, relationships, self-esteem, transformation, internal, cohesion, making a difference and service. Stage of consciousness is based on an existential need, which is the motivating factor in human affairs. He proposed a strategy of a three stage evolutionary process of mastery, internal cohesion and external cohesion through the seven levels of consciousness in order for businesses/organisations to survive and thrive in dealing with extreme complexities (Barret, 2010:32).

The model focuses on the needs of the organisation as a whole. Levels one to three is considered “lower” level needs which represent the basic needs of the organisation. The fourth level represents transformation representing a shift towards adaptive systems and empowerment. The “higher” level needs, levels five to seven focus on cohesion, alignment, partnerships, sustainability and social responsibility. These needs stimulate entrenched levels of commitment and motivation (Barret 2010:3). Organisations focus only on meeting the lower level needs have an internal focus and does not adapt to external demands and are not healthy workplaces. In the same vein, organisations that mainly focus on the higher level needs lack the systems and processes necessary for high performance (Barret 2010:3). According to Barret (2010:4) when an organisation masters both lower and higher

level needs, it operates from full spectrum consciousness, have the ability to manage complexities, is adaptable and engenders a climate of trust.

Below is an illustration of the Seven Levels of Organisational Change as proposed by Barret in the New Leadership Paradigm.

Stages of Evolution		The Seven Levels of Organisational Consciousness	Motivation
Stage 3: External Cohesion	7	Service	**Social responsibility**: Working with other organizations and the stakeholders of the organization in pursuit of societal objectives that enhance the sustainability of humanity and the planet, while deepening the level of internal connectivity inside the organization by fostering compassion, humility and forgiveness.
	6	Making a difference	**Strategic alliances and partnerships**: Building mutually beneficial alliances with other organizations and the local community to protect the environment, while deepening the level of internal connectivity inside the organization by fostering internal cooperation between business units and departments.
Stage 2: Internal Cohesion	5	Internal cohesion	**Strong cohesive culture**: Enhancing the organization's capacity for collective action by aligning employee motivations around a singular mission, an inspiring vision and a shared set of values that create commitment and integrity, and unleash enthusiasm, creativity and passion.
	4	Transformation	**Adaptability and continuous learning**: Giving employees a voice in decision-making and making them accountable and responsible for their own futures in an environment that supports innovation, continuous improvement, knowledge sharing, and the personal growth and development of all employees.
Stage 1: Team Mastery	3	Self-esteem	**High performance systems and processes**: Creating a sense of employee pride by establishing policies, procedures, systems, processes and structures that create order and enhance the performance of the organization through the use of best practices. Focus on the reduction of bureaucracy, hierarchy, silo-mentality, power and status seeking, confusion, complacency, and arrogance.
	2	Relationship	**Relationships that support the organization**: Building harmonious relationships that create a sense of belonging and loyalty among employees and caring and connection between the organization and its customers. Focus on the reduction of Internal competition, manipulation, blame, internal politics, gender and ethnic discrimination
	1	Survival	**Pursuit of profit and shareholder value**: Creating an environment of financial stability, and focusing on the health, safety and welfare of all employees. Focus on the reduction of excessive control and caution, short-term focus, corruption, greed and exploitation.

Figure 2.2 Seven Levels of Organizational Consciousness

(Source: Barret 2010:345)

The models used in the conceptual framework were pivotal in guiding the initiation phase of the transformational process implemented in the Emergency Centre. The participants' feedback during the data collection phase aligned with a systemic approach which when analysed matched a framework of systems, outcome and processes.

2.13 SUMMARY

An overview of health care reform internationally and nationally, the impact and need for health reform in Emergency setting with particular focus on low-and middle income countries. In addition, discussions on transformational change management and the

pervasive role of leadership including the qualities and behaviours of leadership with reference to the facilitation of a shared vision and organisational change was discussed. A blended conceptual framework using Learning Organization and The New Leadership Paradigm was discussed in detail.

2.14 CONCLUSION

The aim of this chapter was to synthesise the literature various sources relating to the essence of the organisational study of transformational change management in an emergency health care setting. The research methodology will be discussed in detail in chapter 3.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research methodology employed in the study. It includes the purpose and objectives of the study, research design, population and sampling methods, data collection process and data analysis and interpretation methods applied. The strategies applied to ensure the integrity and scientific rigour is also explained.

Research methodology is described by Burns and Grove (2009:719) as the process or plan for conducting the specific steps of a study. The researcher identifies the research problem and the purpose or goal of the research, which then informs on the choice of an appropriate research process or methodology.

3.2 RESEARCH QUESTION

Burns and Grove (2007:115) define a research question as a clear concise interrogative statement containing one or more concepts in order to guide the implementation of both qualitative and quantitative studies. Brink et al. (2012:87) indicate that a clear, researchable question determines the researcher's decisions about the research design, data collection and analysis.

The research question posed in this study was "What are the clinical staff's experiences and perceptions of the transformational change management introduced in the Emergency Centre of a Community Health Clinic in the Western Cape?"

3.3 STUDY SETTING

The CHC used in this study provides a comprehensive package of primary healthcare services to the diverse and mainly impoverished communities of five townships situated on the Cape Flats in the Western Cape, South Africa. The population in this area is approximately 400 000 living in urban areas as well as informal settlements (StatsSA, 2012). Poverty, unemployment and crime are rife in this area. The facility provides a combination of preventative, curative and rehabilitative services to between 23000- 25000 patients overall per month. Approximately 2700-3000 patients, of varied acuity, access the Emergency Centre monthly. The researcher of this study was the manager of the 24-hour emergency centre at that time.

As the manager, the researcher observed that a series of systemic problems existed at the facility, which affected service delivery and the standard of quality of care provided to the community. A transformational change management approach was introduced in an attempt to address the challenges faced by the Emergency Centre. The study explored how clinical staff perceived and experienced the transformational change management approach and whether it had an impact on the delivery of emergency care in this unit.

3.4 RESEARCH DESIGN

Burns and Grove (2009:218) describe a research design as "the blueprint for conducting the study that maximises the control over factors that could influence the validity of the findings." It guides the researcher with planning and implementing the study to achieve the intended goal.

Qualitative research is an approach extensively used to study social phenomena in naturalistic settings (Marshall & Rossman, 2011:3). It is fundamentally interpretative, drawing on multiple methods with a focus on content and representing an evolving and emergent world view (Marshall & Rossman, 2011:2; Maree, 2011:50). According to Brink et al. (2012:121) a qualitative research design refers to broad grouping of research methodologies and resultant methods used to study phenomena of social interaction of which there is limited knowledge or understanding.

Creswell (2013:18) highlights the importance of understanding the philosophical assumptions that underlie qualitative research. These philosophical assumptions are important in formulating the research problem and questions inform the methods applied to answer the research questions. Four main philosophical assumptions are considered in qualitative research:

- **Ontology**: This relates to the nature of reality and its characteristics. Qualitative researchers embrace the idea of different realities.

- **Epistemology**: Qualitative researchers need to gain first-hand information from participants through individual interviews. In order for the researcher to understand the "subjective knowledge" of the participants, the studies need to be conducted in the environment where the participants live and work.

- **Axiology:** This assumption is based on the researcher giving recognition to the study being value-loaded and on actively reporting their values and bias as well as any value-laden information, which is collected.

3.5 METHODOLOGY

Qualitative research is regarded as inductive, emerging, and open – allowing the researcher to immerse in and interact with the data collected and analysed (Creswell, 2013:22). A qualitative design using a descriptive phenomenological methodology was chosen to explore the experiences and perceptions of the participants about the transformational change management implemented in the Emergency Centre of the CHC. De Vos et al. (2008:264) describe a phenomenological study as one which attempts to understand people's perceptions, perspectives and understanding of particular situations. The researcher strives to describe and attach meaning to the everyday experiences of the participants which are obtained through naturalistic methods (De Vos et al., 2011:316).

3.5.1 Phenomenology

Finlay (2004) as quoted in Burns and Grove (2011:75) states that phenomenology is a philosophy as well as a group of research methods which is congruent with the philosophy. Phenomena represent a world of experience which occur when experienced by persons and such an experience is unique to each individual (Burns & Grove, 2011:75). The phenomenologist is concerned with the meaning of lived experiences and researchers need to mirror, describe and to some extent, interpret the essences of the experiences as provided by individuals.

The philosophical beliefs of phenomenologists differ and most nursing phenomenologists based their study methods on the philosophical underpinnings of Husserl (1859-1938) or Heidegger (1889-1976) (Burns& Grove, 2011:76). A distinction is made between descriptive and interpretive phenomenology (Polit & Beck, 2010:268). According to Kleiman (2004:8), Husserl focuses on the phenomenon and the significant accounts of what the participants experience and perceive. Husserl's philosophy leans towards descriptive phenomenological research to capture and describe the "lived experiences" of the study participants (Burns & Grove 2011:76).

Heidegger proposes an interpretive approach or hermeneutics, which involves analysing the data by creating a robust description of the phenomenon as meaningfully interpreted by the researcher (Kleiman, 2004:8). Heidegger postulates that hermeneutics, which is to understand and give meaning to something, is a basic characteristic of human existence (Polit & Beck 2010:268). Hermeneutics have both descriptive and interpretative elements in that it serves to investigate, interpret and describe the phenomena as experienced (Allen, 2003:50).

Since the purpose of this study determine, understand and describe the clinical staff's experiences and perceptions of the transformational change process, descriptive phenomenology was chosen.

3.5.2 The Role of the Researcher

The main characteristics of qualitative research are that it takes place in natural settings and that the researcher is a key instrument of the research process. It is, therefore, important to reflect on the researcher's role in this study. Creswell (2014:187) mentions that qualitative research is characterized as interpretive research where the researcher and participant share a lasting and deep experience.

The researcher is the operational manager of the Emergency Centre and was, with the team, responsible for developing implementing and transformational change management process. This may have influenced strategic, ethical and personal issues within the research process.

The researcher as an experienced manager with an intimate knowledge of the specialization field and the context of care, developed rapport and a trust relationship with the future participants. Although this enhanced the researcher's ability to understand participant responses in context, this might have influenced the freedom of expression of participants and the actual feedback provided. However, numerous measures were taken to encourage free participation and to counteract any bias

3.5.3 **Steps to reduce researcher bias** (This is indicated in italics in the text)

3.5.3.1 Bracketing as a strategy

Gearing (2004:1430) defines bracketing as a scientific process whereby the researcher suspends presuppositions, biases, assumptions, theories and /or previous experiences. According to Creswell and Miller (2000:127), be applied at the start of the research process and continue throughout the research process. Starks and Trinidad (2007:1376) state that researchers must be honest and vigilant in acknowledging and setting aside their own beliefs, knowledge and assumptions without abandoning it. Although there is an on-going debate about the concept of bracketing and its use in hermeneutics, the researcher chose to apply it to reduce the elements of researcher bias and to adhere to ethical considerations in this study (Tufford & Newman, 2010:83)

Husserl (1998) and Heidegger (1996) postulated that the objectivity of the study depends on the rigour and effectiveness of explicating the researcher's subjective experience of the phenomenon (Drew, 2004:215).

I have 37 years nursing experience of which 32 years was dedicated to the emergency care context. My experience was gained working in the Trauma and Resuscitation Unit at a major tertiary hospital for 10 years and a further 13 years in the pre-hospital setting for Emergency Medical Services (EMS) in the Western Cape. In 2008, I was appointed as the Operational Manager of the Emergency Centre at the CHC- the setting of this study. Over the years I gained professional experience in direct clinical care, teaching and management while occupying different ranks and roles. While working at the EMS I was instrumental in starting a critical incident stress-debriefing program for emergency workers and offered training, counselling and support during major incidents and disasters. I have a good understanding of the dynamics of the study setting through the experiences gained in the emergency health care context.

I was an executive member of the national and provincial structures of the Democratic Nursing Organisation of South Africa between 1996 and 2000. Here I gained expertise in employer-employee relationships, labour law, and disciplinary procedures and have represented employees in hearings, investigated disciplinary cases as well as been a chairperson at disciplinary hearings.

As the manager of the Emergency Centre and the part of the leadership team at CHC, I am integrally involved in the transformational change process, which presents potential challenges to my role as researcher in this study. Several strategies were applied in this study to ensure stronger objectivity.

3.5.3.2 Within Data Collection strategies

Qualitative researchers usually collect the data themselves (Creswell, 2014:185). *However, for this study, an independent objective fieldworker was used to do the data collection due to the role and position of the researcher as a manager in the unit.*

3.5.3.3 Within Data Analysis strategies

The researcher and an independent co-researcher analysed the data under the guidance of the thesis supervisor. The researcher used the manual method of qualitative data analysis. *The co-researcher was contracted to do a separate electronic analysis using Atlas.t.i®* and *the two sets of analyses were then integrated – managing differences and similarities carefully.*

3.6 POPULATION AND SAMPLING

A population as applied in research is defined by De Vos et al. (2011:223) as the totality of persons, events, organisation units, case records or other sampling units with which the research question is concerned. The target population for the study comprised of all clinical staff working at the CHC in the Western Cape, South Africa. This would include all healthcare practitioners such as nursing staff, medical practitioners, pharmacists, radiographers, physiotherapists and emergency care practitioners.

3.6.1 Accessible Population

In research, the accessible population refers to a subset of the target population upon which the researcher can meaningfully include in the study but who will still represent the population and conclusions is drawn from this population (Castillo, 2009:2). The accessible population for this study includes the 81 staff members working at CHC. Based on the inclusion criteria for the study, only fifty nursing and eighteen medical practitioners formed part of the potential participants for the study.

3.6.2 Sampling

A sample is a subset of the research population selected for the study (Burns & Grove, 2009:721). Qualitative researchers strive to select participants who can provide the most meaningful information related to the area of interest. Purposive sampling is a form of non-probability sampling technique. A purposive or judgemental sample is a selective sample that involves a conscious selection by the researcher of subjects or elements to be included in the study (Burns& Grove, 2011:313). In contrast to convenience sampling, where participants are chosen for being at the right place at the right time, the goal of purposive sampling is to choose participants who can provide detailed and authentic information on the subject of the study (Burns & Grove, 2011:313). Polit and Beck (2006:274) and Creswell (2013:155) support the notion that the guiding principle in selecting a sample in phenomenological studies is that all the participants must have experienced the phenomenon and must be able to articulate the impact of their experiences.

A purposive sample was drawn from the population for the purpose of this study. The selection of the sample for the study was based on the criteria of intensity and homogeneity. Thus the participants were chosen based on their knowledge and background experience and their ability to provide a diverse range of information on the phenomenon. Additionally, the selection was made by virtue of the fact that they are all healthcare professionals who have been working in the Emergency Centre for a period of six months or more during the

implementation of the transformational change process. A second focus group discussion was conducted in 2016 where a sample of six participants was purposively selected inclusive of the different categories of the clinical staff, apart from being working in the unit in the designated time period.

In qualitative studies the sample size depends on the depth of information required to gain insight into the phenomena as well as the richness of the data collected. It also depends on how broad the scope of the research question is (Burns &Grove, 2011; Polit & Beck, 2010; & Creswell, 2013). Therefore, in the initial planning stages of this study, the aim was to select 10 participants for the individual in-depth interviews and 6 to 7 participants for the focus group discussion. However, during the data collection process, two more candidates were added to the number of individual in-depth interviews conducted to include the non-permanent staff who also met the criteria like the community service nurses and agency staff.

The total study sample consisted of 18 participants from the population of clinical staff who were in active duty at the Emergency Centre of the CHC in Cape Town. Morse (2007), as quoted in Burns and Grove (2011:317), refers to this process of adding participants to those already selected, as “intra project sampling”, which is done to ensure the meaningful development of quality study findings. Polit and Beck (2010; 321) argue that the sampling size is determined by data saturation, i.e. the point of redundancy of information is reached and no new information surfaces. Burns and Grove (2011; 318) citing Morse (2007), Munhall (2007) and Paton (2002), state that sample size is also determined by other aspects such as the scope of the study, the nature of the study area, the quality of the information and the study design. Therefore, based on these aspects the sample size was increased to enhance the quality and credibility of the research findings. A second focus group discussion was done in 2016 and 6 participants from the original sample were chosen to participate.

Participants who met the inclusion criteria for the study were selected. Seven of the selected participants were invited to take part in focus group discussion with the fieldworker and an assistant moderator from the Stellenbosch University.

3.5.3 Inclusion criteria

All the clinical staff that worked and were scheduled to work at the Emergency Centre between January 2009 and December 2011 was eligible for selection. Community service nurses and the locum doctors, although not part of the permanent staff, were deemed

eligible for selection as they fit the above criteria. The same criteria applied to the selection of the participants for the second focus group done in 2016.

3.5.4 Exclusion criteria

Any staff member who had no direct function in the day-to-day operations of the Emergency Centre was excluded. Staff members who joined the establishment after December 2011 were automatically excluded as well as the staff members who did not work in the unit for at least six months.

Pharmacists and physiotherapists were excluded because they had no direct involvement in the emergency care of patients and the day-to-day functioning of the Emergency Centre. The emergency care practitioners (paramedical staff) were also excluded because their contact with the operational functioning of the Emergency Centre is limited.

3.6 INSTRUMENTATION

An interview guide (Annexure 1) was used for the purpose of the study. The scope of and questions included in the interview guide was based on the objectives of the study, the literature review and the researcher's professional experience. The interview guide was validated by the supervisor of the study and an expert in qualitative research at the Stellenbosch University as well as the SU's Health Research Ethics Committee.

De Vos et al. (2011:342) describe an interview as a social relationship designed to exchange information between the participant and the researcher. According to Brink et al. (2012:157), interviews for data collection are classified either as structured or unstructured. Semi-structured interviews are thus in-between these two classifications. For the purpose of this study, the more flexible approach of semi-structured interviews was used. The interviews were done by a trained fieldworker to ensure objectivity and to reduce possible bias during the interviewing process. The interview guide contained questions to elicit responses pertaining to the participants' experiences and perceptions of transformational change management in the Emergency Centre. Where necessary the technique of probing was used to obtain more information about specific areas of the interview and to clarify participants' statements (Burns & Grove, 2009:716).

The fieldworker made notes after each interview to capture non-verbal actions and cues. This captures the complete picture of the experiences of the study participants.

3.7 PILOT INTERVIEW

A pilot study is defined as a small study, which is done before the larger study to determine whether the methodology, sampling, instrument and data collection is adequate and appropriate (Bless &Higson-Smith, 2000:155). Creswell (2013:165) states that the use of pilot study according to Sampson (2004) and Yin (2009) is to refine and develop research instruments, assess the degree of observer bias, frame questions, collect background information and to adapt research procedures. A pilot study or pre-test was done by interviewing one participant with similar characteristics as the target population (Brink et al. 2012:174).De Vos et al. (2011:241) state that a pilot study is done to improve the effectiveness of the investigation and must be done in the same manner as the main investigation. A registered nurse, who met the criteria of working in the unit for more than six months, was selected for the pilot interview.

The pre-test revealed that the fieldworker was not adequately prepared for the process and displayed some lack of understanding for the study. She also did not fully inform and/or reassure the participant in line with health research ethics requirements. Information gathered was perceived to be inadequate due to the lack of probing and not allowing the participant to fully express his or herself during the interview. The researcher then compiled a guide for the fieldworker to use (see annexure 2). Due to the importance of the interviews and the manner in which they were conducted, the outcome of the pre-test interview compelled the researcher to search for a more competent fieldworker who displayed insight into the study and the interviewing requirements. Apart from these matters, comments and suggestions by the participant was taken into account during the main series of interviews.

3.8 TRUSTWORTHINESS

Reliability and validity are regarded as essential criteria for quality in a quantitative study. Alternatively, in qualitative research, the criteria related to the trustworthiness developed by Lincoln and Guba were applied. According to Lincoln and Guba (1985:290), the essential criteria for quality in qualitative paradigms are credibility, conformability, dependability, and transferability. These measures as employed contribute data quality and so-called rigour in qualitative research (Brink et al., 2012:173).

Table 3.1 Guba's Model (1985) of Trustworthiness

CRITERIA	QUALITATIVE PARADIGM
Truth value	Credibility
Applicability	Transferability
Consistency	Dependability
Neutrality	Conformability

Source: Guba and Lincoln, (1985:290)

3.8.1 Credibility

Lincoln and Guba (1985:290) propose credibility as an alternative construct for internal validity. The credibility of the study was based on two aspects: enhancing the believability of the study through the manner in which the study was carried out and the steps used during the process to demonstrate credibility. According to Lincoln and Guba (1985) a variety of techniques can be used to ensure the credibility of qualitative research.

3.8.1.1 Prolonged engagement:

The researcher and the field worker familiarised themselves with the culture of the study group as well as in developing a trusting relationship with the participants (Polit & Beck, 2010:495). Credibility or confidence in the truth was ensured through the fact that the study was done at the CHC (naturalistic setting) where the transformational change management approach was implemented. The participants were selected based on their involvement during the implementation of the transformational change process and consequently, their knowledge of the process as it occurred. Most of the participants worked in the Emergency Centre for a period of three to ten years. The data was eventually collected by an independent fieldworker who is a specialist-trained nurse and also works in an Emergency Centre at another CHC in the Western Cape. Thus, the fieldworker has a good understanding of similar organisational dynamics, culture and operational processes. The fieldworker received training on how to develop rapport and trust with the participants.

3.8.1.2 Triangulation

Triangulation can also be used to improve the credibility of qualitative findings. Triangulation refers to the use of multiple methods of data sources, collection, data analysis and theoretical perspectives (Polit & Beck, 2010:106).

Data in this study was collected using two data collection methods. Twelve individual semi-structured in-depth interviews were conducted by the trained fieldworker and two focus group discussions were facilitated by the fieldworker who was assisted by a lecturer who is a member of the university's research team.

Member checking, an important technique to confirm credibility, was done to authenticate the information (Polit & Beck, 2010:499). Participants were given an opportunity to correct errors of interpretation and to add additional information.

Furthermore, the researcher used various sources and theories of change management as well as experts in the field of management, nursing and research to confirm the feasibility of the study. By applying these techniques as suggested by Lincoln and Guba (1985), the credibility of the study was enhanced within the parameters of the setting, population and theoretical framework (De Vos et al. 2008:346).

3.8.2 Transferability

Lincoln and Guba (1985) describe transferability as the ability to apply the findings obtained from a study to other contexts or participants. This relates mostly to the sampling and meaningful design of the study versus the soundness of the data. In order to evaluate whether the data can be used in other settings, the researcher needs to provide rich, thick descriptions of the data in the research report (Lincoln & Guba, 2013:316). Brink et al. (2012:173) stressed that qualitative researchers are not concerned about the generalisation of study findings. Their focus is to define and bring to the fore observations as made within the specific context. While qualitative researchers are concerned with transferability as oppose to generalisation, De Vos et al. (2011:420) state that the transferability of qualitative studies to other settings may be problematic. They also stated that challenges with transferability may be enhanced by referencing the original theoretical framework which will show how the data collection and analysis is guided by concepts and models. The theoretical models used in this study were based on a Transformational Leadership Model and Senge's Learning Organization (1990). More than one data collection method was used to strengthen the transferability of the study.

The following approaches as suggested by Lincoln and Guba in Brink et al. (2012:173) were used to enhance the transferability of this study:

Purposive sampling was used to harness the range of specific information within the context of this study. By purposefully selecting the participants, based on their knowledge and involvement with the transformational management process in the facility, the research was assured of eliciting meaningful information from the participants who could provide this information.

A thick description of the clinical staff's experiences and perceptions was ensured by collecting conducting semi-structured in-depth interviews. These interview sessions were complemented with focus group discussions. Triangulating the data collection methods and sources allowed for thick descriptions of the phenomenon to be obtained.

Another strategy employed to ensure transferability of the study findings is to ensure that theoretical saturation is attained during the data collection phase. This is the point at which the researcher realised that with every new interview conducted; no new information is elicited from the participant. To achieve this, after each interview, the researcher listened to the recorded version. Thereafter verbatim transcriptions were typed which provided rich and rigorous information.

3.8.3 Dependability

In qualitative studies, dependability is likened to reliability as applied in quantitative research. Dependability refers to the stability of data over time. According to Brink et al. (2012:172), this implies that if the context is similar and the participants are similar then the findings should most likely be similar. The credibility of the study is thus linked to dependability.

The dependability of the study was assured by using the same interview process and interview guide for all the participants and within the focus group discussion. Each interview was audio recorded to ensure the accuracy of the information. *The data was transcribed and the transcriptions were audited and verified by the researcher, the fieldworker and the supervisor of the study. The analysed data was then verified by a fellow researcher who is an expert in the field of qualitative research.* Furthermore, the data was analysed using Atlas.ti© software to enhance access to the complete data set in the same on-line location.

3.8.4 Confirmability

Confirmability refers to the congruency in terms of accuracy, relevance and meaning. It refers to the guarantee that the findings, conclusion and recommendations is supported by the data provided by the participants and not the researcher's own interpretations (Brink et al., 2012:118).

According to De Vos et al. (2011:421), confirmability includes the concept of objectivity. To ensure the objectivity of the study findings, an independent trained fieldworker was used to conduct the interviews to limit the researcher bias during the data collection phase. Member checking was done by the fieldworker to reduce further bias and the participants validated the transcriptions before they were analysed. The researcher applied the process of bracketing during the data analysis phase i.e. while doing the data analysis, the research started by setting aside any preconceived beliefs and opinions she held about the phenomenon (Polit & Beck, 2006:496). This was done by writing down her opinions, thoughts and reflections on a note pad. During the data analysis process, the researcher selected and highlighted quotes from the participants' transcript and wrote down notes. Then, the quotes were classified into categories. Throughout the data analysis process the research remained cognisant of her role in the process, thus, she asked a fellow researcher to adopt the role as a "bracketing facilitator" during the process. The transcripts and the analyses of the data were reviewed by the study supervisor to check for any visible bias or distortions. These processes strengthened the congruence and relatively established the trustworthiness of the data and the interpretations thereof.

3.9 DATA COLLECTION

Data collection was done by an independent fieldworker. The fieldworker was a qualified registered nurse and was employed by virtue of the fact that she is a clinical nurse practitioner working at another health institution and well versed in English and Xhosa.

Brink et al. (2012:159) emphasise the importance of training the fieldworkers for the data collection process. A lecturer in research methodology at Stellenbosch University, Nursing Division trained the fieldworker for this study. The training sessions enhanced the skills of the fieldworker in her interview techniques, listening skills, reflecting and how to build rapport and trust with participants. Two data collection techniques were used in the study, namely individual semi-structured in-depth interviews and focus group discussions.

3.9.1 Semi-Structured In-depth Interviews

In general, the aim of using a qualitative interview as a data collection method is to gain meaningful information about the experiences, ideas, beliefs, views, opinions and self-reported behaviours of participants **(**Maree, 2007:87). During the semi-structured interviews, the participant answers a set of pre-determined questions and allowance is made for probing and clarification of information provided (Maree, 2007:87). Probing relates to follow-up questions and remarks made by the interviewer to obtain more and/or deeper information on a particular question. This could be achieved through "open-ended" elaborations and clarifications or detailed elaborations" (Marshall & Ross 2011:145). According to Marshall and Ross (2011:145), the benefits of interviews include gathering significant amounts of information and developing an understanding of the meaning of the experiences within a relatively short space of time. Following up and probing can be done immediately. There are of course limitations to the interview process. For example in situations where there are language barriers and when participants are not willing or uncomfortable to share information, or there is a perceived lack of the ability to explain the information as requested by the researcher. In these circumstances, the interview process will not be very productive.

The researcher provided the fieldworker with a list of possible candidates, as purposively sampled, and consent forms. The fieldworker contacted the participants to confirm their willingness and availability to take part in the study. The researcher assisted with the logistical arrangements at the facility. Once the fieldworker obtained the informed consent from each study participant, interviews were scheduled at the convenience of the fieldworker and participants. The twelve individual in-depth interviews and the focus group discussion were conducted in a private room at the CHC. The fieldworker also obtained verbal consent from each participant to audio-record the interview.

The interview techniques were considered appropriate because it allowed the fieldworker/ researcher to gather the genuine experiences and perceptions from each participant on phenomenon of interest. Each interview lasted approximately 40-60 minutes. Participants were given the option to respond to the interview questions in a language they are most comfortable in. All the participants chose to answer in English. The fieldworker translated some questions to isiXhosa for certain participants, where necessary, to enhance clarity and understanding of the question. This was not a general occurrence during the interview process and mostly only, a phrase or an expression was related in isiXhosa by either the fieldworker or the participant. After the interview, the fieldworker made short notes to summarise the essence of the interview and any observations made. The recordings and the notes were provided to the researcher directly after the interviews. Each participant was

given a number in the order in which the interviews were conducted. For example, the first person interviewed was given number one.

3.9.2 Focus Group Interview

De Vos et al. (2011:360) describe a focus group as group-type interviews that provide a means to better understand how people feel or think about an issue. According to Marshall and Ross (2011:149), these groups are usually composed of seven to ten people. Discussions with this group of people are held in a supportive environment to encourage dialogue and allow for the expression of diverse opinions and experiences. The benefit of focus group discussions is that it is socially oriented; the environment is natural and generally more relaxed than one-on-one interviews. A drawback of focus group discussions is that the facilitator may have less control over the group (such as very vocal members).Therefore, facilitators of group discussions must be equipped to deal with the general group and power dynamics.

The use of focus group discussions in phenomenological studies is widely debated. Some researchers argue that it is incompatible. However, Bradbury-Jones, Sambrook and Irvine (2009:663) found that the use of focus groups enhances the understanding of the phenomenon being studied in that it stimulates discussion and adds new perspectives on the issues.

A focus group discussion was held with seven participants as a supplementary data collection method. A lecturer in research methodology, from the Division of Nursing at Stellenbosch University, assisted the fieldworker in facilitating the process of the focus group discussion.

The data was collected in 2012 and the study was put on hold due to unforeseen challenges experienced by the researcher. Therefore, another focus group discussion was conducted in July 2016 in order to refresh, reflect on, and validate the study findings and to assess whether the unit is still on transformational change trajectory. The second focus group consisted of six of the original participants of the study and it was facilitated by the same fieldworker. At the start of the focus group discussion, the participants chose their numbers. This process was moderated by an experienced researcher and academic staff member of the Division of Nursing at Stellenbosch University.

3.10 DATA EXTRACTION &ANALYSIS

The purpose of data analysis is to organise, provide structure to and elicit meaning from the data (Polit & Beck, 2010:463). According to Creswell (2014:195), data analysis in qualitative research may be done parallel to the data collection process, for instance, a preliminary analysis and writing of notes could be made on completed interviews. To this effect, the researcher, while listening to the recording apart from working in the unit in the designated times after each interview, made notes to obtain preliminary insights to the experiences and perceptions of the participants. The interviews were transcribed by the researcher during the process; she noted any insights that appeared. The authenticity of the data was maintained by verbatim transcriptions of the interviews. Data analysis was done using a thematic approach as proposed by Tesch (1990:142-149). This process consists of eight steps:

1. Get a sense of the whole. Read all transcriptions carefully. Perhaps jot down some ideas as they come to mind.

2. Pick one document– the most interesting, the shortest, and the one from the top of the pile. Go through it, asking yourself 'what is this about'. Do not think about the substance of the information but its underlying meaning. Write thoughts in the margin.

3. When you have completed this task for several participants make a list of all topics. Cluster together similar topics. Form these topics into columns, perhaps arrange as major, unique and leftover topics.

4. Now take this list and go back to your data. Abbreviate the topics as codes and write the codes next to the appropriate segments of the text. Try this preliminary organising scheme to see if new categories and codes emerge.

5. Find the most descriptive wording for your topics and turn them into categories. Look for ways of reducing your total list of categories by grouping topics that relate to each other. Perhaps draw lines between your categories to show interrelationships.

6. Make a final decision on the abbreviation of each category and alphabetize these codes.

7. Assemble the data material belonging to each category in one place and perform a preliminary analysis.

8. If necessary, recode your existing data.

Source: Creswell 2014:198

The researcher analysed the data systematically using the above systematic approach as follows:

Step 1 -The researcher read through all the transcripts attentively to get a sense of the whole. Ideas where jotted down as it came to mind.

Step 2 -The researcher reviewed the transcripts one by one and searched for the underlying meanings in the text. Notes were made in the margin of the document as preliminary thoughts and insights came to mind.

Step 3 -The researcher then made a list of all the themes and sub-themes. Similar themes and sub-themes were grouped together.

Step 4 -The researcher then applied the themes and sub-themes to the data.

Step 5 -These themes were abbreviated as codes which were written next to the appropriate segments in the text.

Step 6 -To determine whether new categories and codes emerged the researcher developed an initial organising scheme.

Step 7 -The descriptive wordings were attached to the so-called meaning areas or topics and it was divided into categories. The number of themes was developed by drawing relevant relationships between categories. The abbreviation of each category was finalised and codes were alphabetised.

Step 8-The researcher merged all the data that belong to each category and developed a preliminary analysis.

An independent researcher, with a Master's degree in Nursing and expertise in qualitative research methods and training in the application of Atlas.t.i. ®, was assigned to analyse the data using Atlas.t.i.®, to strengthen the dependability and credibility of the results. A similar thematic approach was used analyse the data using the electronic software programme. The independent researcher generated 286 codes which were then arranged into themes and sub-themes. These were then displayed to obtain a thematic graphical illustration of codes as grouped into themes with the related participant quotations linked to the codes. This was collated, integrated and agreed on in the final set of analysis by exploring similarities and differences.

3.10.1 Familiarization of the Data

Burns and Grove (2009:521) state that the researcher needs to become familiar with the data as it is collected. This process of immersion or dwelling with the data involves listening to the recordings, reading and rereading the transcripts and recalling observations and experiences.

In accordance to these instructions, the researcher listened to the recordings a number of times immediately after each interview session to become familiar with the data as it was obtained. *Because the researcher knows the participants personally, she was able to recognise their voices she consciously reminded herself to remain with what is being said rather than who said it.* Bracketing in phenomenology is also about self-discovery and self-awareness and the researcher needs to acknowledge the inherent position of subjectivity (Drew, 2004:222).

3.10.2 Classifying the data

According to Polit and Beck (2006:399), the development of a method to classify and index data is an important step in the analysing analysis. They further stated that after scrutiny, the actual data needs to be converted into more manageable units or categories. This process is known as coding i.e. grouping the data into segments. It is done by using key words, symbols or abbreviations (Brink et. al., 2012:193).

The participants were assigned a numerical code to maintain their anonymity and to enable the researcher to distinguish between the inputs of the individual participants during the analysis phase. Words and colour codes were used. Creswell (2014:198) suggests that attention should be given to the types of codes, which emerge. For example, the codes that are related to the study area, those that were not anticipated at the start of the study and codes which were atypical.

3.10.3 Interpretation and Translation of Research Outcomes

Burns and Grove (2009:552) state that data interpretation is the most important aspect of the study, and it involves examining the evidence, determining findings, forming conclusions, exploring the significance of the findings and determining the implications of the findings.

The researcher compiled a written report of the interpretations of the data analysis. This was reviewed by the fieldworker, her supervisor and the independent researcher to ensure that it reflected a credible account of the findings and confirmed that the interpretations are valid

(Polit & Beck, 2006:436). The report was further enhanced to reflect the richness and rigour of the evidence by including direct quotes from the participants (De Vos et al. 2011:426).

3. 11 ETHICAL CONSIDERATIONS

The right of the researcher to search for truth should not surpass the rights of individuals and communities (Babbie & Mouton, 2001:518). According to Brink et al. (2012:34), there are three fundamental ethical principles that guide researchers, namely, respect for persons, beneficence and justice. Brink et al. (2012:34) state that it must be based on the protection of human rights, inter alia, the right to self-determination, privacy, anonymity and confidentiality, fair treatment and protection from discomfort and harm.

The researcher adhered to the following guidelines to maintain ethical conduct during the study:

3.11.1 Authority to Conduct Research

The proposal for the study was submitted to the Health Research Ethics Committee at Stellenbosch University to obtain ethical approval. Unconditional approval was granted to conduct the study by the Ethics committee (See appendix 1).

The Western Cape Department of Health through the office of the Chief Directorate Metro Health District services granted approval to conduct the study at the CHC (see appendix 2). Arrangements were made with the Facility Manager at CHC to obtain access to a venue and the staff during the data collection phase.

3.11.2 Informed Consent

Participation in the study was voluntary and each participant was given a participant information leaflet explaining the details of the study. Each participant agreed to partake in the study by giving a written informed consent as well as consenting to audio and written recordings of the interviews. Participants had the right to opt out of the process at any point without negative consequence such as loss of privileges.

3.11.3 Right to Privacy, Anonymity and Confidentiality

Ethical principles pertaining to individual's rights were adhered to. The principles of anonymity and the confidentiality of the participants and information were upheld. The identity of the participants was protected by giving each participant a number in numerical order. No information divulged would be linked to any individual. However, because the

researcher purposively sampled the study participants and knew the participants, only partial anonymity could be ensured. *The fieldworker, in obtaining verbal consent for the recordings, explained to the participants that the researcher would receive the recordings for transcription. They understood that only partial anonymity is ensured whereby they had no objection. Further to this the researcher endeavoured to distance herself from, for example, the "source voices" as much as possible and focussed on the transcriptions as used*, allowing the text to speak.

A trained fieldworker conducted the interviews to reduce bias and ensure the rigour. The transcripts are stored in a locked cupboard at the Division of Nursing at Stellenbosch University and will be stored for a period of five years, after which they will be destroyed

3.11.4 Right to Protection from Discomfort and Harm

The potential of physical, psychological, and legal harm exist when conducting social research. Therefore, an ethical researcher should anticipate and prevent risks before and during the research process (Neuman, 2000:92). During this project, the researcher ensured the physical and psychological safety of the participants by ensuring that the interviews took place in a safe, secure, comfortable environment. In the event of a participant becoming emotional or too stressed to continue with the interview, the interviewer was advised to terminate the session. Provisions were made for the resident social worker to offer any psychosocial support as required. No adverse incidents occurred during and after the data collection phase.

3.12 SUMMARY

This chapter includes an in-depth discussion of the research methodology supported by relevant literature in relation to processes and practices. It includes a discussion of the rationale for the study design, sampling, and data collection tool used. It also details the data collection and analysis processes and how rigour and trustworthiness of the study were ensured. Ethical considerations are also discussed.

3.13 CONCLUSION

The length and the breath of research methodology used in this study, was discussed in this chapter.Chapter 4 will present an in-depth overview of the findings of the study.

CHAPTER 4
FINDINGS

"Our clinic had a bad reputation, from the cleaner, the clerk, the admissions, nothing was right. ... The healthcare of the patients is being compromised, there are no systems in place, there are no management systems, and it was chaos. In simple terms, it was chaos…left right and centre. Nothing! The image of the facility was completely damaged." P12.

4.1 INTRODUCTION

Chapter three includes a discussion of the specific research design and methodology that was used in this study. In this chapter, the findings of this study are examined, discussed, and presented according to the themes, sub-themes, and clusters that emerged from the data collection process. The data was transcribed verbatim from the audio recording and then analysed using a thematic approach based on the eight steps model developed by Tesch (1990).

The data is presented in three sections. Section A describes the sample realisation process, which includes the demographics data of the participants. Section B describes the data analysis process, the themes, sub-themes, and clusters that emerged. Section C presents an interpretation and discussion of the findings.

4.2 SECTIONA: SAMPLE REALISATION AND DEMOGRAPHIC BACKGROUND OF PARTICIPANTS

4.2.1 Sample Realisation

A purposive sample was selected from the clinical staff working in the Emergency Centre of a CHC in the Western Cape was defined as someone who provides direct patient care in an Emergency Centre (Andrea Santiago, 2013:1). For the purpose of this study, different categories of medical as well as nursing staff, who worked in the unit for more than six months between 2009 and 2011, were included. Permanent, as well as agency staff, were considered as a representative mix of the different categories of clinical staff selected for the study. The South African Nursing Council (SANC) determines the categorisation of nursing staff according to qualifications and scope of practice (SANC, 2003) i.e. professional nurses, staff nurses and auxiliary nurses. The category of professional nurses is further distinguished as general professional nurses and professional nurse specialists. The nursing

participants in the sample included four emergency nurse specialists, four general professional nurses, five staff nurses and one auxiliary nurse.

The Health Professional Council of South Africa (HPCSA) governs the registration of the medical staff. There are six main registration categories i.e. Student, Intern, Community Service, Medical Officer, Specialist Consultant and Independent Practice. Independent practice includes registrars who are trained in a specific specialty (HPCSA, 2014). The medical staff is ranked as consultants and medical officers depending on the positions they hold in the Department of Health. A Consultant is a medical practitioner with a specialist qualification in one of the medical disciplines and a medical officer is a medical practitioner, with no specialist qualification, but who has completed their community service. A consultant in Family Medicine and three medical officers took part in this study.

4.2.2 Demographics of the Participants

In total 18 members were interviewed for this study. Twelve individual in-depth interviews and two focus group discussions with six participants were conducted. The follow-up focus group was selected from the original sample. Four medical professionals and 14 nursing professionals took part in the study.

4.2.3 Gender and Age Distribution

Gender was not considered as a critical factor for inclusion. Out of the 18 participants, 14 were female and four were males. Nursing is traditionally considered a predominantly female profession, which may account for the higher number of female participants (Barret-Landau & Henle 2014:11).

The ages of the participants ranged between 27 and 59 years at the time of the interviews. The majority of participants (n=8) were between 40 to 49 years, six participants were between 30 to 39 years, two participants between 25 to 29 years and two participants between 55 to 59 years.

4.2.4 Years of Experience Post Qualification

The participants had a collective experience of 179 years after qualifying as health care professionals. Cumulatively, 113 years were spent working at the CHC. The years of experience post qualification of the nursing professionals ranged between 2 to 30 years, of which between 1 to 18 were spent working at CHC. In contrast, the medical professionals had between 7 to 17 years' experience post qualification and 3 to 13 years at CHC.

4.3 SECTION B: DATA ANALYSIS PROCESS

Polit and Beck (2010:463) define the purpose of data analysis as the process of organising, providing structure and eliciting meaning from the data.

A thematic approach was used to code and systematically analyse the data using the framework outlined by Tesch (1990) as discussed in detail in chapter 3 (See section 3.10). The emerging themes and sub-themes were coded to assign symbolic meaning to such and were organised to determine whether more categories and codes emerged (Miles, Huber &Saldana, and 2014:71). Information was further categorised by using descriptive words and the number of themes was reduced by drawing relationships between categories.

4.3.1 Themes and Sub-themes

A theme as described by Saldana (2013:14) is the outcome of coding, categorisation, or analytical reflection. The data collection process through individual interviews and a focus group discussion produced thick descriptions of the experiences and perspectives of the clinical staff of transformational change, which was coded and recoded both manually and electronically. Three main themes emerged providing a plausible categorisation of the data. These themes were used to reflect on the experiences and perceptions of the participants based on the objectives and aim of the study. Through the thematic analysis of the data, the themes were sorted in line with the structure-process-outcome framework of Donabedian (1966:168-206). Structural realities are defined as aspects, which represents characteristics of the health systems, providers and receivers of care. Process realities include aspects of technical and interpersonal processes, which influence healthcare provision. Outcome realities relate to the ultimate measures of effectiveness in the delivery of healthcare services (Coyle & Battles, 1999:7).

The raw data was further categorised into sub-themes, which illustrated clearer connections and linkages between the data and the three main themes. Corbin and Strauss (2008:159-160) refer to themes and sub-themes as high-level concepts developed through a process of conceptualising the raw data and is supported by lower-level concepts which are grouped together into clusters and sub-clusters.

4.3.2 Clusters and Sub- Clusters

The process of coding the raw data involves the extraction of concepts as products of the analysis for interpretation. During the data reduction phase, concepts or codes produced in this study were synthesised into clusters and sub-clusters (lower-level concepts) and linked to form themes and sub-themes.

The conceptualisation of the data for this study was derived from the rich data provided by the participants and categorised by the researcher through the thematic analysis process to reflect the experience and perceptions of the participants on the transformational change process in the Emergency Centre (Corbin & Strauss, 2008:160).

4.4 DISCUSSION AND INTERPRETATION OF FINDINGS

The research produced rich data on the clinical staff's experiences, perceptions, and insights of the transformational change management process at the Emergency Centre. Participants gave their perspectives on how they experienced and perceived the transformation change process in the unit. The "historic or pre-state" refers to the period before the managerial changes were implemented and the "current" state thus refers to the period from 2008 to 2012, when the first set of data were collected. It is during this period that the major strategic and structural changes were introduced in the unit.

The findings also include data from a confirmatory and post analysis focus group discussion, which was done in 2016. This process was aimed at revisiting the findings of the study, validating the original findings and to assess whether further progress and /or other challenges occurred since the original data were collected.

The findings will be illustrated by providing summaries per theme. Sub-themes and clusters as well as direct quotations from the participants to are provided. Through the quotations, the researcher hopes to give voice to the lived experiences of the participants.

4.4.1 Referencing of the Quotes

Each participant received a numerical number at the start of both the individual interview and focus group discussion process. For the interviews, the participants were given arbitrary numbers from1 to 12. Two focus groups were conducted at different times. These are labelled as focus group A for the one conducted in 2012 and focus group B for the one conducted in 2016. The quotes used are identified by the numerical number of the participant and the page number of the transcript for example Participant 1: page 2 (P1:2) and Focus group A or B 1: page 3 respectively (FGA 1:3) for easier cross referencing.

In instances where the full name of the facility mentioned by the participant ,the name of the facility has been replace by CHC or an appropriate word and underlined to ensure privacy and confidentiality for example CHC or facility or here.

The findings are illustrated through a conceptual framework based on the work of Donabedian (1966; 170). This framework seemed to be the best-fit - supporting meaning

and doing justice to the “stories” of the participants (1.8.3:11). The quotations linked to the themes, sub-themes and clusters will, in most instances, describe both the historic and current realities as stated by the participants.

4.4.2 Theme 1: Structural Realities

Structure, as described by Donabedian (1966; 170), is the setting in which healthcare takes place. It may include, and relate to, the physical environment, health system support functions such as financial and human resource management, information management (communication structures), and supervisory provisions. It also comprises of the characteristics of the providers of care like rank, training/ qualifications, experience, beliefs and attitudes. Table 4.1 below summarises the sub-theme and clusters as derived from the participants’ inputs.)**.**

Table 4.1 Theme Structural realities – Sub-themes and clusters

Sub-theme	Cluster
1.Clinical Environment	**1.1 General Set-up**
	1.2 Environmental Hygiene
2.Resources Management	**2.1 Human Resources Management**
	2. 2 Material
3.Clinical Governance	**3.1 Adherence Framework/Policy Guidelines**
	3.2 Standards of Care
	3.3 Infection Control
	3.4 Other Governance Structures
	3.5 Monitoring and Control Mechanisms

4.4.2.1 SUB-THEME 1: CLINICAL ENVIRONMENT

The clinical environment refers to the physical practice environment as well as the operational systems and conditions required to deliver emergency healthcare services to

patients. The participants reflected on how various aspects of the Unit's environment contribute to a safe and therapeutic practice environment.

4.4.1.1.1 Cluster 1: General Set-up

One of the serious issues highlighted by the participants was how disorganised and chaotic this unit was before. One of the participants stated that

> *"The Trauma unit was a mess…a disaster." (P8:2)*

Most of the participants said that poor organisation practices led to a chaotic environment. Apparently, no one was willing or able to manage or support improvement efforts:

> *"When I came, there was a lack of organisation. There were no structures and systems in place to make things work" (P1: 2).*

According to the study participants, lack of equipment and inadequate staffing were key elements that affected the delivery of quality emergency care services. The perceived disorganisation and limited structure were considered key elements, which may have negatively influenced the functioning of the unit.

It was the participants' perception that the appointment of a manager for the unit led to positive changes and improvements. The participants referred to new structures and a range of systems that were put in place to ensure better staff scheduling, equipment acquisition, management and stock control. The participants were impressed with such structural and systemic changes as expressed by these participants:

> *"…putting structure in place…e.g. staff off duties is much more structured according to the needs of the organisation. The stock ordering system is in place…" (P1: 3)*

> *"In terms of infrastructure, the arrangement of the Resus area in the centre dividing the area into a medical section and into a surgical section. There is also an Asthma room" (P6: 2).*

> *"... A lot of things have changed dramatically; qualitatively and quantitatively. Qualitative in the sense that there is some improved quality of care and quantitatively we have a lot of structure, which is needed by the patients themselves." (FGA6:5)*

4.4.1.1.2 Cluster 2: Environmental Hygiene

One of the aspects of creating a safe therapeutic environment for staff as well as patients is maintaining proper environmental hygiene through general cleanliness, infection control and waste management. The participants agreed that the structural environment was not conducive to rendering health services prior to 2009. They described the environment to be "a mess", "filthy" and "unsafe". Reference was also made to cleaners as appointed and that they were not doing their duties to keep the environment clean:

> *"The place was not clean; the cleaners were not pulling …" (P12:4)*

> *"Okay, environmental wise, conditions were really not satisfactory. On my first day, it was filthy. I felt like turning back" (P7:2)*

The participants also explained that they were not co-operative and unwilling to assist with cleaning activities. Patients also complained about the conditions of, for example, the toilets.

> *"Even our toilets, the patients always came to complain and we cannot even approach the GA's (general assistants).Once, I approached one of the GA's to clean, he refused. It was very difficult to approach them" (P4:5)*

The participants noted with satisfaction the changes in the overall environmental hygiene of the unit. They mentioned that a new system of damp dusting every morning was introduced to ensure that work surfaces were clean. In addition, clinical staff assisted with major spring-cleaning efforts every quarter of the year. They also noted a huge improvement in the attitude and willingness of the housekeeping staff, who now ensured that the sluice room and the toilets were kept clean. Furthermore, there was a system in place for overseeing that the unit is clean and tidy.

> *"Keeping the place clean has certainly improved*."(P3:15)

> *"Even our toilets are clean. Every morning they (the GA's) start in the toilet and make sure that there is toilet paper, the toilet is clean and there is soap for the patient if they want to wash their hands. In between we the shift leaders go and check if the toilets are clean and everything is clean" (P4:5)*

4.4.2.1 SUB-THEME 2: RESOURCE MANAGEMENT

Adequate human and physical resources are essential for optimal service delivery. Management of resources requires precise planning, appropriate utilisation and control

systems. It is clear from the inputs shared by the participants that they experienced several challenges with how physical and human resources were managed and controlled.

4.4.2.1.1 Cluster 1: Human Resource Management

Human resources are the most valuable and costly resource in the operations of any organisation. The participants shared their views on staffing arrangements, staffing levels and ancillary management of human resources within the unit. They believed that human resource matters were not dealt with properly in the past and had improved through the transformational change process.

4.4.2.1.1.1 Sub-Cluster 1.1: Staffing Arrangement: Norms and Standards

Staffing arrangement refers to the number, qualification and skill mix of the staff required to sustain service delivery. In general, the participants expressed that there were a shortage of staff and that it was mostly registered nurses who worked at the Emergency Centre. Consideration was not given to the skills mix required to deliver emergency nursing care. In addition, the unit did not have a manager and nobody took responsibility for the management of the unit. It also created confusion in terms of who was leading the unit. These were some of the responses of the participants:

> P5**: "***We were working under those conditions that are short staffed" (P5: 8)*
>
> *P2: "Trauma then, was meant for the registered nurses, yes, no other person, only on night that you (Auxiliary and Staff nurses) will be helping." (P2:3)*
>
> *P5: "When I started here (2005) in Trauma there was no Unit manager. There were just Professional nurses. So we worked under conditions that we won't know who the senior of the unit is." (P5:1)*

These challenges were addressed from 2008 onwards and participants noted that staffing levels improved and different categories of staff were appointed. They added that there was improvement and better structure related to human resource matters, which addressed the concerns of line management, skills-mix and governance:

> FGP1***:"****The staff, the number has improved, there were few nurses in Trauma then compared to now." (FGP1, pg3)*
>
> "*A decision was made to strengthen the complement of staff and to bring different categories to the CHC. They introduced a Family physician, a trauma unit manager,*

additional Community Service Doctors, and additional nursing staff. These categories of staff allowed for more structured skills-mix, line-management, clinical governance and leadership." (P3: 3-4)

4.4.2.1.1.2 Sub-cluster 1.2: Staff Scheduling

This sub-cluster relates to equitable and optimal staffing levels for sustainable service delivery through ensuring a system of staff allocation and shift arrangements to ensure adequate staffing levels on a daily basis. The participants reported that the previous shift arrangements did not cater for the staffing demands and lacked a fair distribution of the different categories of nurses on each shift. They shared that fewer members of staff were scheduled during the busiest time of the day. However, they expressed that they were resistant to change to a new shift system because they were used to the old system:

"The off-duties were haphazard, in a way that we couldn't balance the staff off-duties, and the distribution of the different categories. It was not identified, the busy days, like weekends, when we are busy, that we used to have an imbalance of staff scheduling." (FGA2: 3)

"The people were very resistant to change. I can make an example of the off-duties, because our unit manager wanted to change the off-duties that we were using at the time because it was not working. But we were very resistant, even myself, I didn't want that off-duties, I was used to the old off-duties." (P4:10)

The participants shared that although they were resistant to the shift changes initially, they realised that it would be beneficial to the patients. In addition, their rest days increased and absenteeism was perceived to decline:

"*Yes, the shift that we are having, yes, we are happy. So it was communication and then included our manager, they really listened … to make us happy, because if you are in the facility, we work long hours. At the end of the day we must be happy, in order to give good results to the patients." P9, pg12*

"But now we're working those off-duties, it's nice, we're used to them." (P4: 10)

"People are now more responsible and that helps to reduce the absenteeism." (P7: 7)

4.4.2.1.3 Sub-cluster 1.3 Leave Management

Leave management in the public service is governed by legislative and policy guidelines. In order to ensure proper management of this system, taking into account the rights of the staff as well as service delivery requirements, stringent control measures and co-ordination is required. It became clear during the interviews that administrative duties such as leave planning were not done in advance and policy prescripts were not followed. The biggest problem, according to the participants, was the lack of transparency and their lack of knowledge about these matters. They shared that there was no planning and service delivery needs were not considered. In addition, the system favoured certain individuals for the popular months such as holidays: These are the reactions of some of the participants:

> *"There was no transparency, not at all. (P5: 6)*

> *"The Human Resource Management….I can talk about leave; about leave there was no one…there was no leave planner that time. no one allocated leave, unless for like on April month.... , you see that most people take that April and then December, most people like to take December .... and then it was very bad for us," (P4: 6)*

> *"One would just sign without considering next month's off –duties. They just took leave without considering whether the manager will approve it or not." (P2:10)*

The participants concurred that the implementation of improved unit management systems led to significant changes and that leave planning was now done in the beginning in every year. A quota system was considered to schedule certain number staff per category per leave period. The participants felt that there was more transparency and fairness in the new system. The participants seemed pleased that favouritism was no longer taking place when it came to popular times such as school holidays or December holidays. This is what some of the participants had to say:

> ***"****There was no leave planner that time...but now in January you must know when you're taking your leave. Even mine is in December. It's the first time to get December since I'm here."(P4: 6)*

> *"Hey…. We did not to know up until she came in, and then each and every person was having her own file." (P5: 6)*

> *"What happened is now; starting with leaves, there is a structured way now to have work leave. Rather now we have a yearly planned book whereby somebody plan to take a leave at this time, and the Manager will have to see if ever, is there enough*

people to take the leave at that time or if not. Then the Manager will call you and discuss with you. However, before, people used to take leave as they pleased themselves; no one would consider how many people are at work." (P10: 6)

4.4.2.1.4 Sub-cluster 1.4 Performance Management

Performance management is a critical aspect of measuring staff performance and it includes individual development planning (IDP). It is frequently seen as a threatening process as it is linked to financial remuneration and promotion within the specific system. It became clear that the participants perceived a lack of proper and fair application of the Staff Performance Management System (SPMS) policy. Moreover, it emerged that the participants were uninformed of how the system worked and they felt that there was no transparency in the process:

"You knew nothing about leaves, study leaves, SPMS. We used not to know up until she came in." (P5: 5)

"I'm going to start with the Performance Management – SPMS, the SPMS most of the people never understood what is it all about. Like there was no system where one is being interviewed and then assessed, and then being told what your weak points are, what are your good points, which are supposed to be done." (P7: 6)

The participants indicated that they now had a better understanding of the performance management system and were informed how the performance assessment needs assessment was to be done. Most of them shared that the system is fair and that they have now received their performance bonuses:

"SPMS will forever be a big issue, but I think this time around it's done timeously and properly." (P6: 9)

"When I was assessed for my SPMS, I did not have incidents and she gave me a chance to go and write up my hard work. It was added to my review and gave me a good score I also got a bonus at the end. So, what I want to allude is that things have been transformed, in a way that it is conducive for everybody rather than favouring one personnel." (P10:6)

Regarding Remuneration for Work outside the Public Service (RWOPS), the participants shared that they were not aware that they needed official permission to "moonlight". This

was true in relation to quarterly probation reviews that led to being permanently appointed or not. The participants were of the opinion that with the implementation of change management, they were now informed of the correct processes and they ensured that proper procedures were being followed. These positions are expressed in these words:

> *"And the RWOPS (Remuneration for work outside the Public Service), people here were leaving early, so that they can go and work elsewhere. She introduced the forms of RWOPS and then we knew what was and that we had to sign if we were working for the other company or agency." (P5: 7)*

> *"The probation reports weren't written. She made sure that quarterly, there is an assessment of the staff that's on probation, and then at the end of the year, a report is written so that the person, after a year, is being permanent." (P7:11)*

4.4.2.1.5 Sub-cluster 1.5. Management of Discipline

The participants shared their views on how discipline was managed in the past. They indicated that because rules were not enforced previously, unprofessional conduct, absenteeism, poor performance and poor discipline, was common. The participants were frustrated by this state of affairs and by the fact that when incidents were reported, they were not attended to. It is important to note that Human Resource functions such as Labour Relations were at that time a centralised function, which may have contributed to disciplinary cases not being followed up: These were the reports of some of the participants:

> *"As I said at the beginning, there was practically no discipline when I started here, people would just come and go as they pleased. You know, there's no discipline, just transgress and transgress and there's no consequences." (P1:2)*

> *"I've been there in a long time. People have been complaining, and they complain about these things, but because of the structuring organisation that CHC cases are not handled at the facility they must go to Woodstock... (P6:6)*

> *"I know in the past we also used to report some cases but they just ended up in thin air. Therefore, in future, you end up not reporting any offence because ... it will not be attended to. I think people lost their morale about such things." (P6:6)*

The participants were of the opinion that the newly appointed manager, knowing the disciplinary procedures, trained and supported other managers in the facility on how to manage and apply disciplinary measures. The participants mentioned some of the key problems included drinking on duty, late coming, absenteeism, and poor performance. They

seemed to be pleased that disciplinary actions were taken against members of staff for such behaviour and other forms of misconduct:

"*The unit manager has a very good knowledge of how to discipline. She came with a lot of knowledge, she helped the whole facility, not just Trauma with disciplinary processes and getting us more up skilled and trained in that. Drinking on duty is our most typical issue causing the public protector to investigate us. I mean, the other nurse has now resigned but he was also being disciplined through process of disciplinary procedures because of his behaviour, absenteeism, poor performance. (P1: 6)*

> *"Those things have changed. Now there is a disciplinary committee. If you have acted wrong, you be called, you are given a hearing date, you can even bring your Shop Steward, you see, like there is much improvement in the discipline." (P2: 7)*

Two of the participants cited incidences of some of the members of staff who came on duty under the influence of alcohol and how the management dealt with these individuals:

> ***"****Discipline among staff is better but there are parts that are still lacking. The drinking problem of some nurses, they come on duty drunk, you smell alcohol. It is so embarrassing." (P9: 5)*

> *"My biggest problem is still with the clerks...They do not report to work or come late and when they come, they're drunk. Not all. Two same people. This behaviour affects the whole system." (P6:7)*

4.4.2.1.6 Sub-cluster 1.6 Competence, Training and Capacity Building

In the Emergency Centre, staff is required to be clinically skilled, competent and responsible in order to manage the seriously injured, traumatised and severely ill medical patients. According to the reflections of the participants, prior to 2009, the staffing skills and competencies were poor and skills development programmes were absent. The participants explained that the environment was disempowering and confidence amongst the staff was low. These are some of the excerpts from the participants:

> *"So then, when I was an intern then, they asked for the interns to be withdrawn from the facility. It was too bad to be teaching young Health Professionals in such a setting. (P3: 3)*

> *"The staff competency was also limited and people were second guessing themselves. Even worse than competency being limited was that staff's confidence was very low." (P3: 7)*

> *"Before we never even had "training"... those things didn't happen, you see." (P2: 17)*

The participants were appreciative of how the environment changed with regard to teaching, learning, development, and capability building. They reflected on how in a short space of time, people were able to attend a range of training programmes and how the number of specialist trained emergency nurses increased from zero to six over a span of three to four years. Staff nurses and Assistant nurses were proud to share how they not only benefitted from formal training but also informal training such as short courses and in- service training:

> *"There have also been a lot of nurses sent on training. Trauma specific training and other training has been BLS (Basic Life Support). There has been quite a lot of capacity building in that sense as well. I think, the nurses are much more confident now, both in managing the unit and in managing patients because they have been able to be exposed to the experience of doing it and then going on training courses as well. And you can see the difference in the nurses who have been on training and the nurses who've been specifically mentored along the way; they work in a different way now." (P1: 12)*

> *"The training, that's another thing, it's going in the facility. I would say that sometimes, before you used to have, before the OSD (Occupational Specific Dispensation) I would say we used to have about one of two people that will go for a certain course... now there are more. I am one of them that I was ENA (Enrolled Nursing Assistant) and now I'm a Staff Nurse, yes, I'm a Staff Nurse." (P9: 9)*

> *"And the other thing that is happening on... there will be spot teachings, and also on Tuesdays, Tuesdays there are lectures that are done in the boardroom, by the doctors and all the nurses in Trauma will be there. So you develop yourself there" (P5: 10)*

A few of the participants shared that specialist-trained nurses were encouraged to participate in providing inputs to the in-service training programme:

> ***"**And on those lectures, she encouraged us also to do the presentations. I remember one of the Trauma trained nurses who was doing the lecture for the doctors, and it was powerful, it was very powerful." (P5: 10)*

4.4.2.2 Cluster 2 Material Resources

Material resources, which include financial matters such as budgeting, and the management of equipment and consumable stock like medical supplies, were a concern. The participants reflected on the status of critical resources before changes were introduced as well the status.

4.4.2.2.1 Sub-cluster 2.1 Equipment

Most of the participants mentioned that the unit did not have sufficient equipment to deliver an effective emergency service. They expressed their frustration with life-saving equipment that was either not available or not in working order and that there were no control measures in place such as daily and weekly checking of equipment:

> *"Trauma at the facility was really not up to standard in the sense that there was no proper equipment to cater for the patients that we see there. A priority one Emergency Centre needs to have equipment like ventilators. We need to have monitors for the patients." (P7: 4)*

> *"The instruments, we were having a shortage of instruments for suturing patients. The machines, the machinery, it wasn't there, I think the dinamaps were there…no, it was only one." (P5: 5)*

The participants were happy to report that the situation has now changed for the better with more equipment acquired and proper systems in place for ensuring that equipment are in working condition and well maintained. It was also mentioned that an external audit in 2010 confirmed that all the necessary equipment was available and meeting the relevant standards:

> ***"****Coming to equipment, I was one of the people who was allocated to be responsible for the equipment. To ensure that the equipment are in order. And then as far as I can say, we have new equipment in place, new BP machines, and new ECG machine and there are two Cardiac monitors in the resuscitation room" (P10: 4)*

> *"Everything that is needed in Resus is there. We have the proper emergency trolley, ECG monitors and all that. The standard is really improved." (P7: 4)*

> ***"****On monthly basis as well, our Unit Manager, she would call all of us and teach us about one of the equipment that is being used in the Unit....She also makes effort*

that even after some time, then she will come back and reminds us how to maintain the standard of that equipment." (P8: 2-3)

4.4.2.2.2 Sub-cluster: Consumable Stock

The participants agreed that there were concerns related to the supply chain specifically, the procurement of stock. Centralised control and bureaucracy hampered the system and affected service delivery. Some participants mentioned that this was not unique to this facility, but that it affected other institutions in the Department of Health (DOH). The lack of internal control systems was a cause for concern and an additional frustration:

> ***"****The Supply Chain has always been a problem in all settings due to the tight central control and red tape. But, the challenge in this setting was that one had to anticipate when one would have a stock-out. You can provide the best clinical care, but if you don't have the bandages, the suture materials, the drugs, then what are you going to do, you're just going to just go to be telling patients sorry…" (P3: 8)*

> *"We wouldn't have stock and everybody will just throw their hands up. Nobody would be accountable for getting stock. So we don't have drips...well bad luck...nobody knew who was supposed to order." (P1: 3)*

> *"And coming to the Supply Chain, you would find out that maybe if the order was done, if it was done, it nobody would follow it up, if it came or not." (P7:5)*

The major changes in the management of supply chain and stock, according to the participants, included an ordering and control system for both pharmaceutical products and medical consumables. Although there were still challenges, such as a shortage of stock and delays with the procurement of items, the participants reported improvements in the system due to better internal control and accountability:

> *"Okay, in the Supply Chain, every Wednesday, we know that every Wednesday we must order our consumables so that Friday our clerk from supply chain just delivers our stock and then we check all that stock that is available for the Trauma Unit for the weekend. And also the medication, that is pharmacy, we must order on Wednesday, and our drugs must also be ordered." (P4: 4)*

> *…. But the Operational Manager follow-up on the stock because without that, then it means that our unit will be affected if there is no stock, and I must say, things really improved in terms of the Supply Chain." (P7: 5)*

"When you speak about supply chain problems, which rarely happens these days... There are instances, but not often, where we run short of stuff you may want to use...then you borrow from 'Jooste'." (P6: 4)

4.4.1.3 SUB-THEME 3 CLINICAL GOVERNANCE

Clinical Governance is defined as a framework through which organizations are accountable for continuously improving the quality of their services and safeguarding their services through creating an environment in which excellence in clinical care can flourish (Western Cape Department of Health 2013:75).

4.4.1.3.1 Cluster 1: Adherence Framework /Policy Guidelines

The information provided by the participants suggests that the legislative and policy frameworks governing critical functions in the organisation were not implemented. There perceived lack of knowledge and awareness among the managers as well as the staff regarding such matters. The main areas of concern included the various policies that underwrote labour related and employment conditions. They perceived lack of knowledge and non-adherence to the legislative framework influenced the lack of effective management of employment matters such as the management of leave, performance, and discipline. The participants felt that the situation in the facility was ungovernable:

"*There was no transparency. You knew nothing about leaves; study leaves, SPMS. You just get called to come and sign your thing. What are you going to sign? (P5: 7) (related to SPMS)*

"That time you will just go and demand your leave because you were not aware of HR." (FGA 7: 11)

"There was practically no discipline...just transgress and transgress and there are no consequences. There was a lack of knowledge how to discipline." (P1: 7)

According to the participants, the situation improved meaningfully. They now were more informed on important policy prescripts and how such rules apply. Another intervention was organised workshops with the other unit managers and the senior staff on how to do performance reviews and to conduct disciplinary hearings. The participants felt that they had a better understanding of the management of different types of leave and absenteeism processes:

"We now have some workshops we are attending. People are now being empowered in those workshops." (P10: 9)

"We are now informed about many things...management aspects. You cannot just take leave anytime. The manager will sort you out and tell you according to HR (policy)... (FGA7: 11)

"So we also went to the workshops, for instance, the presentation from HR on how to do SPMS." (P5: 7)

Furthermore, the participants shared that the unit was void of the necessary clinical guidelines and protocols. However, since there was a new approach and focus on quality improvement, these policies, protocols and guidelines were made available and accessible for staff to refer to when needed:

"But that time even if you don't know the procedure, you must go and ask and there was no protocol available." (P4: 4)

"The other thing that was done to improve patient care was protocols and guidelines are available and put up in a visible area." (P6: 8)

4.4.1.3.2 CLUSTER 2: STANDARDS OF CARE

The delivery of quality care to a patient attending the Emergency Centre depends on patient care practices and patient acuity levels. Participants indicated that there was limited if any formal or standardised approach in managing the patients requiring emergency healthcare. The participants mentioned that patients were left unattended, that there were poor clinical supervision and no sense of urgency. The participants also referred to other factors that influenced the delivery of proper care. For example, that there was inadequate clinical staff in attendance and lack of clear guidelines on when to refer the patient to the medical practitioner.

"There was, like no system where the staff know if there is an emergency, what to do, and then what is expected of the nurse and what is expected of the doctor. The doctor will be called after some time, there was nothing urgent, like this is a patient, patient is dying, and all that." (P7: 4)

"The impact on the Patient Care Standard was very poor; the patients were just lying there… (P5: 4)

"The Trauma Unit was not in a good state. My first experience of the Trauma Unit when I was an Intern, having just started my rotation here, I was left unsupervised in the Unit when a patient came in that needed to be resuscitated." (P3:3)

"Or you will find out most of the people would go on tea, and then you find one or two staff member on the floor. And there was no control like tea times and, lunch times. Everything was like you do as you pleased and then leaving the facility whenever the staff pleased. If you want to go off as you pleased, you will just go off." (P7:4)

"And, the waiting period, I'll say it was long for the patients..." (P2: 3)

Participants realised that due to new management practices as well as complaints from many levels that such poor practices could not continue. Therefore, attention was given to develop systems to improve and enhance the standards of emergency care delivery. Formalised care systems and better care load arrangements were introduced to reduce patient waiting time, improve the quality of patient assessment and management, and to ensure better patient outcomes. These are some statements from some of the participants:

"One of those things that we did was to bring the clinical and the nursing staff together. We have a meeting now with the Trauma Manager. She and the Family Physician try to discuss what the problem is, what are the nurses saying? What are the doctors saying? We're trying to put into process some things so that we improve the quality of care" (FGA 6: 16).

"And that is one of those things that make <u>our</u> Trauma Unit an outstanding one in the MDHS today. Good service delivery has resulted to improving patient care and significant reduction inpatients' waiting time." (FGA6: 16)

"I see a huge difference. The box system was put the folders of the patients according to their codes, whereby I would say that it worked so nicely, the doctor didn't have to ask who is red, who is orange and all that, We would put the folders according to the colour codes, yes." (P9: 2)

"And also if there is resuscitation, we know that the staff must go there for a resuscitation room. Not like that time that you would choose not to go in the resuscitation room. So now you must be there helping in the resuscitation room, everybody…you will find that if you were 5 in the unit, the Triage nurse must be in the Triage, but at least 4 of you must be helping in the resuscitation room with the doctor. The one is writing the observation of the patient, the registered nurse is handling the

drugs to the doctor and the other nurse is handling the equipment that the doctor is going to use to intubate the patient and also helping the doctor to put up the IV lines the oxygen, everything." (P4: 12)

4.4.1.3.2.1 Sub-cluster 2.1 Caseload arrangements

Emergency Centres are open 24 hours a day to serve patients suffering from a range of illnesses and injuries. In such a context, it is not possible to predict how many and what type of patient load will be present on a given day. This reality requires suitable systems to deal with the workload as well as assessing patients according to healthcare needs The participants commented on the lack of arrangements to prioritise patients and make sure that patients are seen according to their needs, the long waiting times and poor service.

"Patient care was so poor in the service, the patients were neglected, you would find out there were long queues and the patients weren't attended to on time." (P7: 4)

"…patients would wait outside the doctor's' rooms from early morning till as late as 2 o'clock, while the pile of folders would remain and patients wouldn't be seen." (P3: 3)

"And, the waiting period, I'll say it was long for the patients... whereas this patient needs an urgent attention like the allergic patient who reacts to medication, the asthmatic who became SOB, they will wait and wait..." (P2: 4)

One of the participants, who were appointed in 2006, to introduce the new triaging system, explained that the other members of staff displayed negative attitudes toward them and the system:

"*We started there to go and introduce this Triage to the Primary staff. They were so negative about it... (P9:1)*

The participants' views changed over time with the implementation of the South African Triage System and other measures to ensure that patients are seen according to their level of urgency as well as reduce the waiting times patients with not so urgent health care needs. These measures included a system of communication and improved visibility of staff for patients in the waiting room:

"*Now that there is a triage system, I think that makes things much better, and we even went to a workshop of ...a Triage Co-ordinator; we have three, two Professional Nurses in Trauma and the doctor. So, we were following the patient's folders, doing the ordering on the patient's folders, triage the patients according to their colours that*

is red, orange, then yellow, then green, so this makes things much better... least the period of waiting now it has improved" (P5 : 4).

4.4.1.3.3 Cluster 3: Infection Control

Stringent infection control measures are essential to prevent complications for the patients who frequently sufferer from a chronic illnesses and/or who may present with complex traumatic injuries. A surgically clean environment with sufficient equipment, including effective disinfection and sterilisation facilities, is considered critical to the outcome of patient care. Participants mentioned that adherence to infection control practices and protocols were poor due to the lack of available resources and failure to comply with infection control protocols. This resulted in an increased incidence of complications due to wound sepsis and complaints from the referral hospitals:

"In the past we were struggling a lot with things such as suture material. Even when you managed to assemble some pieces of equipment to make a suture pack, it will not be sterile because there was no CSSD or sterilising machine in the Trauma unit." (P6:6)

"In those days, whatever equipment we had, where you've got four waiting patients to be sutured, they need to wait for those few instruments that need to be rinsed. After rinsed they are again being used for the next person, not autoclaved. There was not much concern for infection control and there were complaints of infections, gaping and septic wounds." (P2:8)

"There was a lot of septicaemia then, because of the instruments. We use to wash them there in the sink, and you put them on the trolley and then you just suture the patient. (P5:5)

Major changes were needed in the area of infection control, including the acquisition of sufficient surgical instruments and an autoclave for the unit. Systems and measures were put in place to ensure the adherence to general infection control protocols. Participants reported that the incidence of wound sepsis had since drastically reduced and fewer complaints were received from the referral hospitals. Awareness and adherence to infection control and universal precautions seemed to have improved amongst the staff. This is what some of the participants had to say:

"Now, having that autoclave, and we are also have packs for day staff and night staff. That is five at night and six during the day. Therefore, we were changing; we would allocate somebody for the autoclaving of the instruments. So, we get rid of septicaemia now." (P5:5)

"The statistical review shows a significant improvement on our infection control. Most of our patients are no longer coming back with septic wounds. We have an infection control team which is functional." (*FGA6:15)*

"There is a lot of improvement with the infection control, the sharp containers ..., and then the cleaning...the cleaning of hands" (P7:10)

"And also, we put all the masks next to the asthma room, for the infection control and the gloves before you touch the patient and also we go for infection control updates .The detergent must be next to the table and also the soap like every tap and every toilet." (P4:14)

4.4.1.3.4 Cluster 4: Other Governance Structures

This cluster refers to the Quality Assurance Committee and the Occupational Health committee, which were established in 2009 as required by legislation and National policy. The majority of participants highlighted the existence of these committees as new initiatives. They appreciated the value it held in terms of providing direction and guidelines for overall quality control and occupational health and safety matters in the facility. These were their points of view:

"From the point of quality initiatives taken at the facility, the formation and running of the QA committee has been of great benefit. We have taken on a number of challenges and managed to make some progress in achieving certain aspects." (P1: 21)

"I wasn't familiar with what infection control is, what occupational health is. She said you're going to do this and here is the information for the agenda. Now we have our meeting every month and each department has an OHS member on the committee...we discuss health and wellness of the staff and do risk assessments" (P5:13)

4.4.1.3.5 Cluster 5: Monitoring and Control Mechanisms

The participants mentioned the absence or lack of monitoring and control systems. It was clear that the auditing of clinical practice, resources, and other aspects to ensure the preparedness of the unit to deliver an effective and efficient emergency service to the community, was practically not existing or poorly conducted:

> ***"****This does not mean some of the things were not there but the system was haphazard and chaotic" (P6:8)*

> *"What was happening to the stock? If it is ordered in January, the stock would come in May or June, and nobody was following it up." (P7:5)*

> *''When the SANC came to check our drug books it was a mess, there were gaps..." (P4:4)*

When control measures and monitoring systems were introduced, the participants reported improvements in the quality of care and the overall functioning of the unit. They mentioned the measures referring to organising structural aspects and aspects linked to direct clinical care such as folder audits and Mortality and Morbidity (M&M) reviews. They also mentioned control measures that were put in place to follow-up ordered stock and the repair of equipment:

> *"When hope was restored, people started asking for tools, for checklists, to order in advance...to ensure that they don't have a problem because you don't want this problem to overshadow your good efforts." (P3:8)*

> *"According to planned care, there has been a lot of improvement, there is like auditing now of folders. We used to tick, what we've done; now nurses are starting to write what they have done for the patient." (P10:11-12)*

> *"After every patient is attended to, you need to clean, you need to check your trolley, you need to check your equipment if it is working and ready for the next patient."(P7: 4)*

> *"I run the Mortality and Morbidity meetings since I started here. The improvements highlighted through the M & M include improved record-keeping, doctors and nurses are writing better accounts of the patient's stay in Casualty" (P1: 5)*

The quality of care has now improved...on the M&M meetings we discuss the cases." (P4: 11)

4.4.2 THEME 2: PROCESS REALITIES

Processes according to Donabedian (1966: 169), refer to the methods by which healthcare is provided. The components of processes include what is done, for example, care provided by whom, where, when, to whom and how. Support activities that indirectly contribute to healthcare delivery can also be included, for example technical, interpersonal and performance aspects. The following process realities emerged from the data analysis as sub-themes: Leadership, Care delivery, Intra and Interpersonal relationships, Information, Teaching and Learning.

Table 2.3: Theme Process realities – Sub-themes and cluster

Sub-theme	Cluster
1. Leadership	1.1 Existence of Leadership
	1.2 Impact of Leadership
2. Delivery of Care	2.1 Implementation of Standards of Care
	2.2 Quality of Care Delivery
	2.3 Professionalism in Care
3. Intra-&-interpersonal relationships	3.1 Professional behaviour
	3.2 Motivation
	3.4 Attitude
	3.5 Team work
4. Information Management	4.1 Communication
	4.5 Reputation
5. Teaching & Learning	5.1 Individual Growth and Development
	5.2 Empowerment and Capacity Building

Sub-theme	Cluster
	5.3 Coaching and Mentoring

4.4.2.1 SUB-THEME 1: LEADERSHIP

Leadership is a key to success of any organisation. The participants discussed their experiences and perceptions concerning the absence and presence of leadership, vision and the impact of leadership on organisational dynamics before and after 2009.

4.4.2.1.1 Cluster 1.1: Existence of Leadership

Prior to 2008, the absence of leadership was evident and nobody was prepared to take on a leadership role in the emergency centre. This created confusion and a form of lawlessness as described by the participants. Some identified the need for change, which could only happen through a leadership with a vision:

> *"There was no In-Charge in the Trauma Unit so I can put it like this way everybody can do whatever they want to do ..."(P4:3)*

> *"There was never a Manager in the Trauma Unit before. Everybody was managing Trauma...no one was managing because as I was saying, before you used to say Sister so and so, they would say go to the next one, you see. So there was no leadership, no leadership at all." (P2:13)*

> *"There was a long-standing strong desire to change things, but there was something missing for that to be successful. It was not just a matter of needing more people. It needed something special. It needed strong leadership. It needed a vision, and it needed a strong will to achieve that vision." (P3:4)*

The participants confirmed that the transformation in facility was directly linked to the filling of critical management positions, including having a manager for the Emergency Centre. The participants shared that the Unit needed leadership with a visionary approach to bring about changes.

> *"With CHC, we've seen a great deal of this transformational change or transformational management. I, in particular, had an opportunity and the privilege of working there before and after. So I can easily compare. There has been such a big change as I said, with the Vision." (P6:2)*

"This CHC can improve because she has done it and she has got visions...Like if they did see the way she saw the things, then things can be better. If they can come to the Trauma and see the improvement for themselves." (P11:16)

4.3.2.1.2 Cluster 1.2: Impact of Leadership:

The participants described how they perceived the changes in the Unit, which were facilitated through leadership. According to the study participants, the impact of leadership stimulated change internally and externally. People started to take pride in themselves and the work they do. The morale improved, which led to better outcomes for the patients:

"...But transformation happened through good leadership, drive, and vision. They quietly realised that there was sufficient momentum for the facility to move forward. The staff started to trust the line management and could begin the process of healing their own wounds. The staff started taking pride in their appearance, wearing uniform etc. There was no pride. But that was restored by the visionary leadership." (P3:3)

"I just think overall the Trauma Unit is functioning at a higher level. The staff is happier, the patients are treated better, it's cleaner and more organised, and you know, it is due in part to the leadership, you know, somebody taking responsibility, taking the reins, having direction, having vision, having ideas of where things should go" (P1: 1)

4.4.2.2 SUB-THEME 2: DELIVERY OF CARE

The main objective of the Department of Health is to provide quality healthcare through a capacitated workforce. Many reports surfaced about the poor delivery of care at the facility and the need to improve was clear.

4.4.2.2.1 Cluster 2.1: Implementation of standards of care

The lack of accountability and responsibility by staff members to meet an acceptable standard of healthcare to the community was a concern:

"The impact on the Patient Care Standard was very poor, the patients were just lying there I remember when we were doing night duty, when you are there as the sister, you all go to be in this tea room, you'll just do your own things" (P5:4)

One of the participants shared her personal experience at CHC as the mother of a patient prior to her becoming a nurse:

> ***"****In 1999, I brought my child here; my child had a fit (convulsions). I came around 10pm and was called at 10am the next morning. The doctor asked me what is wrong with the baby...I told him he had funny movements and he was rolling his eyes...I was not a nurse before.... Nothing was done, my child was not even examined and I was given Panado. I told myself I will never go back to 'there'.****"*** *(P8:3)*

According to the participants, various strategies were introduced to ensure improvement in the approach towards patient care, for example making sure that the Triage System was followed correctly and assigning specific roles and specific duties during resuscitations according to the protocol:

> *"So it started then, there was a Triage system, where the patient was sorted out and got into their priorities, and triaged according to their conditions, so at least the patients were attended to properly."(P7:4)*

> *"Whereas now, when there's resuscitation, everybody has a role, they're keeping records, everybody's doing something, and you can see people are there. And that definitely is just you know, a result of training and skilling and talking and putting in systems..." (P1:4)*

> *"No, definitely I'd say our standards have improved. Ja, just improved. Just basic things like observations of the patients you know, they weren't done well before or weren't done at all, and like you know nursing notes, record keeping, people….patients being re-assessed before getting discharged as appose to you know, patient is here for three hours and nobody sees them and they just go home." (P1:5)*

4.4.2.2.2 Cluster 2.2: Quality of care Delivery

According to the study participants, the delivery of patient care in the past was not conducive or in line with prescribed standards of care. They explained how patients were neglected and the staff did not have any sense of urgency to tend to patients, which at times lead to dire consequences:

> ***"****And you know that's why there was no sort of sense of urgency around real emergencies. Well, it's not specific incident, but more of a general occurrence." (P1:5)*

> *"I don't like to use the word negligence, but there was too much negligence in the Nursing Staff and it caused a bad impact to our community. There were many incidents and a death happening in the waiting room. It was happening as a norm, especially in the weekends and night duty." (P2:4)*

The participants reported with pride that there is a remarkable improvement in the quality of care during the transformation change process. They also referred to the positive patient outcomes and better chance of survival for the patients. One of the participants mentioned that the tertiary hospitals are now commending the centre for excellent management of patients;

> ***"****In general, patient care has improved a lot." (P6:4)*
>
> *"The feedback from tertiary and secondary facilities informs us how excellently we are performing."(FGA7:17)*
>
> *"And the deaths came down because you would find out that the life expectancy of a patient improved between 90 to 98%." (P7:4)*
>
> *"The quality of care now I can say, has improved because even some patients come and give us compliments."(P4:10)*

4.4.2.2.3 Cluster 2.3: Professionalism in Care

The participants spoke about a lack of professionalism in the care of patients that had a direct impact on the clinical management of patients:

> ***"****There was a lot of sort of bad practice clinically both from doctors and nurses and other staff working here."(P1:1)*

The participants indicated that the clinical staff adopted a more professional approach in delivering patient care and services, which led to better patient outcomes. They mentioned that clinical care was reviewed holistically through the mortality and morbidity audits, which indicated improvements in record-keeping, accountability within the team, willingness to learn and take responsibility to deliver better care:

> *"So, there is a lot more accountability again...I know the manager regularly after the M&M, she'll come back and talk about again and re-emphasis to the staff that this was what was shown, this is what we are not doing, this is the consequence of us not doing it, and they understood and took more responsibility for their work, which is really a positive thing." (P1:5)*
>
> *"In 2010, I saw that the system is improving in a positive way, although there were still complaints, but it was improving. The time that the patients were waiting, people were taking responsibility." (P8:3)*

"And also in M&M meetings we discuss the cases especially cases where the patient died during resuscitation. What went wrong for those cases? You'll see that the nurses write their records, they keep their records...you will see that things are now documented." (P4:10)

4.4.2.3 SUB-THEME 3: INTRA AND INTERPERSONAL RELATIONSHIPS

The data obtained through the interviews shed light on how intra- and interpersonal relationships were affected by factors such motivation, staff attitudes and poor work ethics. They described explicitly the influence of these dynamics on staff morale, teamwork, patient care, and professional behaviour.

4.4.2.3.1 Cluster 3.1: Professional Behaviour:

The participants recalled that there was a lack of meaningful intra- and interpersonal behaviour. They described how it affected the functioning of the teams and the influence it had on service delivery:

"When we first started here, there were complaints about the working relationship between the doctors and nurses. Among the nursing staff, there was often a bit of antagonism." (P1:3)

"I will first share with you my experience, when I came to the CHC, it was first as an Intern in 2009, and conditions were very bad then...something was missing and the patients weren't happy, the doctors weren't happy, the work ethics wasn't good here in the facility. Then things reached a critical point, where the unhappiness just couldn't be tolerated any longer." (P3:3)

"Before, we use to take each other for granted, there was no ethics. We used not to respect each other." (FGA7:17)

On a professional level, interactions seemed to have improved during the change management process:

"This professional behaviour has improved a great deal in recent years." (P6:5)

"And off course, respect is broad thing. The staff respects the patients, and also the patient's respects the staff because they see the professional image from the staff."(FGA2:18)

"The behaviour of the nursing staff has definitely improved a lot. They're taking more responsibility and taking their job more seriously." (P1:17)

4.4.2.3.2 Cluster 3.2: Motivation

The participants explained as follows how the unhealthy practice environment demotivated them and affected the staff morale and commitment to care:

"*Previously, the staff was very demotivated and they lost a lot of their pride in how to care for patients because it was just all these bad things happening and it seemed like their good efforts went unnoticed. The staff felt that making an effort was not worth it." (P3:5)*

"The staff morale was down. In the sense that most of the complaints weren't attended to, most of the problems, people felt like they were neglected." (P7:4)

Contrary to this, participants shared that their views on how things had improved during the transformation change process. They reported that staff motivation significantly improved, as they felt valued for their contributions within the team. They also stated that staff morale improved, which had a positive impact on patient care and their commitment to be at work:

"And also, the staff morale improved, because now people are able to share, people are able to ventilates you've got something, every day you're looking forward to your work. So, that really has boosted the morale and absenteeism rate has decreased." (P7:4)

Staff motivations are done; it triggers the sense of being happy about your work...just to be for what you did is motivating. We also motivate the patients."(FGA2:2)

I think the staff is well looked after. People are much happier now. There is improved staff morale." (P6:10)

4.4.2.3.3 Cluster 3.3: Attitude

Participants discussed the attitude of the staff towards patients, their work and towards each other at great lengths. They described how "bad it was" and how it affected patient care and team relationships:

"So, we had a hard time, because that time there was a very bad attitude, to the staff, especially toward the professional nurses from the University... because when you

were asking something from them at that time, you'll see that attitude even their faces and they didn't talk to you." (P4:2)

"I recall, a particular elderly man in an electrical wheelchair, he was vocal and disgruntled with having to wait long in spite of being the first on the list of patients to be seen. He was unhappy with the way in which he was told to wait." (P3:7)

"We knew that the reds must be seen first, the oranges the whatever. But it was not properly done and also saying that it was due to the attitudes of the staff because I am sure we didn't take ownership of the Trauma Unit." (Pre-test interview: 5)

Participants explained that the attitude of staff towards their work, the patient, and their colleagues improved due to some interventions in this area. However, some do feel that there is room for improvement:

"And then the staff attitude, those things were addressed; there were the principles of Batho Pele. The staff was always reprimanded about their attitudes towards the patient." (P7:4)

"The staff attitudes have improved a lot compared to in the past when the number of patient complaints was so high..." (P6:4)

"The attitude, staff attitude improved among ourselves and towards the patients. The staff knows the patient rights and we value the fact that the patients have come because they are ill." (FGA7:17)

"Also now, nobody can say no, I can't work with this staff member because of such attitude. We work harmoniously with all colleagues and all that." (FG7:17)

4.4.2.3.4 Cluster 3.4: Team Work

A fundamental reality that emerged from interviews was the perceived lack of teamwork and how it affected team relations and influenced patient care:

"The team work as I said before, there was no teamwork, not at all, and you'll feel like not to come on duty because you know you are going to be the only one on the floor" (P5:11)

"There was no unity between the nursing staff and the medical professional and other departments, like the clerks and the cleaners. It appeared as if people were not working together..." (P7:2)

Participants reported that teamwork and team relations improved and continue to improve - resulting in shared responsibility and better co-ordination within the team during the transformational change process:

> *"So I mean the team work is definitely much better now, there are people with designated roles. So the nurses seem to work much better as a team and with the doctors as well. There is more sense of co-ordination."(P1:10)*

> *"One has seen great commitment; everybody seems to be geared up to what resuscitations is all about. Everybody including nursing assistants even porters know that they have a role to play. This is the type of team work I was talking about!" (P6:3)*

> *"And then, the team work, people were also encouraged to work together. Before, there was a vast difference. But now its team work, the doctors accept what we say, we accept what they do." (P7:4 & 9)*

4.4.2.4 SUB-THEME 4: INFORMATION MANAGEMENT

The importance of information sharing, open communication channels and intra-personal communication is key to the successful operations and sound team relations any organisation. Good communication strategies is critical in the emergency care context

4.4.2.4.1 Cluster 4.1: Communication

The participants shared that there was a lack of good verbal and written communication in the past and the mechanisms of communication were not in place. Some participants mentioned that intra-personal communication, for example between staff and with the patients, was inherently flawed:

"*First of all, there was a poor communication; there was no communication at all."(P5: 7)*

"The recordkeeping wasn't good." (P1:8)

"What I notice was so different...how they communicate to each other and how they communicate to the patients." (P1:2)

However, the participants reported that a range of communication strategies was introduced, which resulted in improvements in the overall communications. Some of the strategies put in place include regular unit meetings, hand-over rounds, better use of the notice boards and auditing the quality of record keeping in terms of patient notes and general administration:

"She will emphasise on communication. Yes, that is how you keep your teamwork working."(P5:11)

"So Trauma every Wednesdays, we will have a meeting, so we see where are we lacking, where must we improve, you understand. She came with advice with us to put a smile on the patient, and how are we when we communicate with the patient. "(P9:9)

"Read these things first, and then you put them on the notice boards so that everybody can be familiar with it."(P5:10)

"Including Doctors and nurses are writing better accounts of the patients." (P1:13)

"If there is a problem overnight, you've got a book where you report, where you communicate with the day staff that there was this and this, and this needs to be sorted out..." (P7:10)

4.4.2.4.2 Cluster 4.2: Reputation

Interview data revealed that the facility had a poor reputation in the community and that there were often negative media reports concerning poor service delivery and poor staff attitude. The participants said that there were many complaints from the community about the facility and how they were treated:

"No…no…the image of the facility in Site C was completely damaged, people did not want to hear about it, when you speak about the CHC, they say it's a nightmare." (P12:1)

"The Trauma Unit was not in a good state. There was drunkenness on duty. People would complain about being beaten with a mop by staff. The CHC was frequently in the newspapers. There were problems throughout the CHC. However, it wasn't all bad. There were those who were trying very hard to deliver good service, but it's these very bad stories unfortunately, that would overshadow those good efforts." (P3:3)

The reputation of the facility improved - on the contrary, participants indicated that community confidence increased with fewer complaints from the community and less negative media reports:

"The CHC has become less in papers ever since the beginning of the new Management." (P10:2)

"Look, as I am saying, visionary leadership will also make people to have ownership, commitment, to the place. This gesture has really changed the patient's perception of the CHC." (P6:12)

4.4.2.5 SUB-THEME 5: TEACHING AND LEARNING

The findings in this section focus on the different modes of teaching and learning available to the staff. This includes formal and informal training and skills development. The responses of the participants suggest the lack of emphasis on training and staff development in the past. The findings also revealed that continuous professional and personal development became an integral element of the transformational process.

4.4.2.5.1 Cluster 5.1: Individual Growth and Development

Statements from the study participants indicate that staff development was not high on the agenda prior to 2008. Lack of competencies, knowledge and limited learning opportunities resulted in low confidence, low morale, and poor expertise:

"*The staff competency was also limited and people were second guessing themselves. Even worse than competency being limited was that staff's confidence was very low.* And *people would do the wrong thing and be afraid to try to resuscitate…" (P3:7)*

Many of the participants mentioned that they gained more confidence through participating in personal development and learning initiatives. Through this process the staff was willing and able to improve themselves:

"After this transformation, when people started believing in themselves, when people started having pride, staff would sign up then to go for the courses." (*P3:8)*

"I've gained a lot of trust in myself and in the ownership of the Unit. You need to improve you see, to be a better person." (P2:15)

4.4.2.5.2 Cluster 5.2: Empowerment and Capacity Building.

In contrast to past experiences, the participants shared that they felt empowered through the learning opportunities that were made available, as well as being encouraged and supported by the management. They share with pride that the number of staff sent for formal training programmes have increased. Thus resulting in an improved skills mix, which had, in their opinion, a direct influence on the delivery of quality patient care.

"I was an ENA when I was employed here, but today I'm an EN, you see, and we've got about plus minus six Trauma trained nurses." (P2:15)

"Empowering people or the staff is part of improving patient care. I've seen quite a few people going for courses in Trauma as part of their skills development. People know what they are doing because they have confidence and that also means that the quality of care will improve" (P6:3)

"She empowered us. Also the complaints that we used to have, on the patients, it's much better now, because of the skills that we are having." (P9:8)

4.4.2.5.3 Cluster 5.3: Coaching and Mentoring

The more senior nurses shared that they were guided, supervised, and supported to be able to take additional responsibilities for managerial functions in the Unit. They felt that these opportunities broadened their knowledge base, gave them confidence and changed their attitude towards their work in general. Other participants also observed that the process of mentoring led to professional growth and skills development:

"*Some of the more senior nurses have been mentored quite closely and show quite a lot of growth and taking on more responsibility, being able to run the Trauma Unit on their own now. In the past they didn't have the skills." (P1:9)*

"They [management] do support us, like individually and also give us tasks and send us to take courses. Yes, we are empowered now. In 2006 I was a junior now I am a senior now...I am a shift leader... I can sort everything." (P4:11)

4.4.3 THEME 3: OUTCOMES REALITIES

Outcomes realities refer to the product or the result of healthcare delivery (Donabedian 1966: 170). The focus of the study was on the clinical staff's experiences and perceptions of the transformational change process that was introduced in the Emergency Centre of the CHC at the end of 2008. Outcomes indicators of this process as described by the participants related to the effect of the change management process on organisational culture, performance, and reputation. The following sub-themes were summarised in table format following the analysis:

Table 4.4: Theme Outcomes realities – Sub-themes and cluster

Sub-theme	**Cluster**
1. Organisational Culture	1.1 Commitment
	1.2 Work Ethic
	1.3 Recognition, Rewards and Celebrations
	1.4 Staff Wellbeing
	1.5 Impact on Transformation
2. Organisational Performance	2.1 Clinical Outcomes
	2.2 Operational Outcomes
	2.3 Team Work Outcomes
	2.4 Ongoing Challenges
3. Organisational Reputation	3.1 Community Opinion
	3.2 Professional Image

4.4.3.1 SUB-THEME 3.1: ORGANISATIONAL CULTURE

Organisational culture is the system of shared meaning amongst the employees which is representative of the key characteristics of what the organisation view as important and values. It is displayed in through the behaviour, attitudes and traditions in the organisations

4.4.3.1.1 Cluster 1.1: Commitment

There was an overwhelming response from the participants that the transformation had a positive effect on the commitment and sense of ownership among the staff and they felt that it led to improved service delivery standards and quality:

> **"***And you know being an organisation that's willing to change and being dynamic now because of the fact that so many changes have been made, I think, people are more*

accepting of change now, willing to change and improve, so ja, that's where the experiences can be very positive" (*P1:10)*

*"Staff is not going to allow the strengthened values and commitment to be compromised ...So there was commitment to the improvement and change in the facility."(P3:10)***.**

4.4.3.1.2 Cluster 1.2: Work Ethics

Participants reflected on the change in attitude towards their work leading to improvement in work ethics, for example being more accountable and taking responsibility in the unit:

"Now I see the value why I must be here, why I am here...why I am a nurse. *I'm here to serve the communities, I'm here to look after the sick, and I'm here to help them." (FGP1:23)*

"People have defined roles...and they get on with their work...there is accountability again." (P1:9)

"There is more sense of co-ordination and the nurses seem to work better as a team and with the doctors as well." (P1:9)

4.4.3.1.3 Cluster 1.3 Recognition, Rewards, and Celebrations

The participants emphasised that they felt worthy, encouraged and motivated and that they receive recognition for their work efforts. They referred to a system of informal rewards that was introduced. They also shared that time was set aside for celebrations in the Unit to boost the staff's morale:

"*We've got this staff motivations like Nurse of the Month. It's giving something, not that I want an award every time, I expect an award, but just to be recognised for what you did, for an extra mile that you have taken then it really is motivating." (FGA2:24)*

"The nurses feel more valued, you know, they are acknowledged for doing the right thing, they feel more involved. Yes and being recognised for it is an important thing" (P1: 9)

"We celebrate birthdays. Easter, Mother's Day and Women's Day, we receive chocolate and we get cards with encouraging messages on. These are the things that encourage us and boost our morale." (P5: 14)

4.4.3.1.4 Cluster 1.4: Staff Wellbeing:

The participants also focussed on staff wellness and wellbeing as important outcomes of the transformational change process. This appeared not to receive enough attention previously at the facility. The participants shared that they were not aware of the options available to them:

> **"***I would say because even if before there was some of the people that were stressed, but nobody would say, would suggest that you should go for ICAS, if you've got a psychologist, or you need counselling as the staff and all that." (P7:7)*

The participants observed that a focus and concern for staff wellness and staff wellbeing became important during the transformation process. They expressed their appreciation for the services and systems that were available and accessible. The role of management in this outcome was viewed positively:

> **"***The staff members can see that management is taking their wellbeing seriously. "Employees that have problems whether personal or work-related, these are dealt with meticulously and appropriately. This can only translate into better patient care." (P6:3)*

> *"We put in place a staff wellness clinic in which case any staff member who is sick can go to that doctor for optimal care." (FGA7:23)*

Several participants, in particular the nursing group, mentioned that they felt supported and appreciated the concern shown by the manager towards their personal wellbeing. Most of them related incidents where they received support, advice, and guidance when facing personal challenges, illness, and bereavement. These lead them to be motivated and valued and led to improved morale:

> *"Before, there was no one looking out for us. It is easy now, to go to her with your problem because she has an open door. She listens to your problem and she will do something about it." (P5:9)*

> *"The people now know that they have somebody to cry on, they have her (the manager) as individual for counselling, ICAS and there is the staff doctor for the staff wellness clinic. So we know at least they care for us." (P7:8)*

4.4.3.1.5. **Cluster 1.5: Impact of Transformation**:

The participants explained how they experienced the process of transformation and how it shaped the organisation. Although the initiative started at the Emergency Centre, most of the participants observed subtle changes happening in other areas of the facility:

> **"***The change of the unit itself, in this case the CHC, with respect to the total commitment and ownership of the place by the staff of all categories...nurses, cleaners, doctors, clerks and everybody."(P6:1)*

> *"So, the changes that happened in the Trauma Unit probably made the most impact and inherently gained sufficient momentum to sustain the other changes happening in the CHC" (P3 :4)*

> *"It is not only Trauma, it expands to everybody, the new environment, the spirit, the positive spirit has spread all over the whole hospital." (FGAP7: 10)*

> *"And there were other initiatives, and other leaders also emerged..." (P3:13)*

In addition, the participants proudly shared the influence the transformational process had in shaping them on a professional and personal level. A few commented that it improved their commitment to come to work, that they felt appreciated and learnt how to approach patients positively. One of the participant said she is proud to be a nurse in this unit:

> **"***I am very much proud to be a nurse: (P2:21)*

> *"It made me a stronger manager. (P1:17)*

> **"***If things did not change for the better, I would certainly not have been here...I am still here because this change has brought some drive in me again."(P6:11)*

> *"I think I've learnt a lot. I had no idea about vision, values and leadership before I came to this CHC...here I learned about true leadership from those who were instrumental in the change." (P3:12)*

4.4.3.2 SUB-THEME 3.2: ORGANISATIONAL PERFORMANCE

This section describes the findings related to the performance and effectiveness of the organisation and how the transformational change process contributed to improvements in various areas.

4.4.3.2.1 Cluster 2.1: Clinical Outcomes

There is a consensus among the participants that, the change process resulted in improved clinical patient care. They explained that the improvement in patient care delivery is a consequence of a convergence of factors related to the overall transformation on various levels within the unit.

> *"I think the patients are better managed at a better level. We have mostly working equipment. We've got supplies; we've got staff who is more accountable."(P1:12)*

> *"The mortality has dropped significantly. I usually make a cynical comment 'you won't die at here; you'll die outside at other places'." (P6:11)*

> *"Our team approach to comprehensive health care delivery has amounted to improving patient care and significantly reduced the patients 'waiting time, morbidity and mortality." (FGA6:6)*

> *"Our reported mortality shows that most of our trauma associated deaths were inevitable" (FGA6:7)*

4.4.3.2.2 Cluster 2.2: Operational Outcomes:

The participants were of the view that the enhanced performance of the unit and the facility as a whole is directly related to the pro-active management in ensuring that the operational systems are in place and that it is being sustained. This relates to marked improvement in ensuring that staffing levels are adequate, equipment is available and in working order, sufficient supply of medical stock, and regular auditing of operating systems.

> ***"****We are in a more comfortable position now compared to when I first started here. We have a much more steady supply of all the equipment that we need; all the consumables, things are still out of stock sometimes, but it is generally more of a central problem." (P1:5)*

> *"But every morning we know...you must check that your resuscitation unit is checked daily, everything is working. And we got spares now..." (P4:12)*

> *"I think Human Resources are managed well. We are very close to a complete complement of staff... staff are retained for longer. Operational managers are fair with rosters and shifts and they make sure that you have sufficient coverage for the three main components." (P3:11)*

In addition, the majority of participants referred to the improvement in staff commitment, conduct, and discipline. They mentioned that absenteeism has reduced and that staff communicated with management in advance when they were not able to come to work. They suggested that the staff was more disciplined and understood disciplinary action will be taken if necessary:

> *"Even to the staff of CHC is changing a lot because even if I am doing something, I know I'm going to the disciplinary committee. I know my rights even to bring my representative..." (FGA4:16)*

4.4.3.2.3 Cluster 2.3 Teamwork Outcomes:

The consequences and importance of teamwork came through strongly as a theme during the interviews. The participants referred to the role of leadership in facilitating teamwork, the inclusion of the different ancillary workers as part of the team; and the sense of harmony and togetherness that now exist in the facility:

> *"There is togetherness in our unit. Whether you belong from this team, I mean, there's too much improvement in teamwork, because both teams are doing the same. Teamwork includes everything, even the security, the porter, the nursing staff, and the doctors. It is not my doing, it's not somebody else is doing. Because now, what's so nice when you start something on the patient, we do it together, from triaging up to suturing and discharging the patient." (P2:15)*

> *"And among ourselves, we are working harmoniously like brothers and sisters. In the olden days you use to feel that when you arrive at the gate, as if you can turn back again and go home. But now you have that urge to come to work tomorrow because you know you are going to work harmoniously and working as a team, as my colleagues have said, we are a family and we are here for one purpose only, for the patient." (FGA7: 17)*

> *"Teamwork can't function without the leadership and the vision. And when the main role players in Leadership, the Management of the facility and of the Trauma Unit couldn't be around at all times, like at night and after hours but their ethics, standards and how they do things would remain after hours. Staff was not going to allow the strengthened values and commitment to be compromised. So, there was commitment to the improvement and the change in the facility." (P3:9)*

4.4.3.2.3 Cluster 2.4: Ongoing Challenges

It can be deduced that the outcomes of the transformational change process had positive outcomes as voiced by the participants of the study. However, they pointed out that some areas still required improvement. Some participants referred to challenges with supply chain issues while other indicated that the reception staff behaviour was still problematic. Safety and security of staff and patients was also a concern in that participants felt the current measures were inadequate:

> *"My biggest problem is still with the clerks...to work or come late they do not report or if they do come they come in drunk...the same two people occasionally. This behaviour affects the whole system." (P6:7)*

> *"Things are still out of stock sometimes, but are generally a central problem...that the manufacturers aren't supplying us." (P1:5)*

> *"We are safe though it is not 100%." (P5:13)*

> *Problems are still there, challenges will still be there, but at least there is room for improvement."(P7:13)*

4.4.3.3 SUB-THEME: ORGANIZATIONAL REPUTATION

This section relates to the reputation of the organisation in the perceptions and opinions of the different stakeholders during the transformational change process.

4.4.3.3.1 Cluster 3.1: Community Opinion

The participations shared that the community viewed the facility in a negative light and that the reputation was so poor that they would say:

> *"You go to the CHC to die." (P6:11)*

The participants were appreciative that the image of the facility is changing due to the transformation that took place. They reported that the patients were pleased with the services rendered and, in general, that the community was perceived to be relatively satisfied with the change in the attitude of the staff. Here is what they had to say:

"Before we had that stigma...but if you go the suggestion box now, at least the community is starting to recognise that there is a change...there is quality care that is taking place." (P2:19)

"A particular gentleman...he was rather disgruntled with having to wait so long...But as time went by he noticed the change in the staff. I think he saw the improvement and rediscovered pride in the facility." (P3:7)

"Talking from the community, I am also a member of the community...The community is very happy with the Day hospital. They normally feel free to rush the patient to the Day Hospital. They say they get help immediately."(FGA3:19)

4.4.3.3.2 Cluster 3.2: Professional Image

It was apparent that the professional image of the facility was damaged as one reflects on the accounts provided by the participants. As such, higher education institutions and other health facilities did not hold the services rendered in high regard. However, according to the views of the participants the professional image of the facility has improved. A participant said that the facility accreditation as a practice site has been restored for medical, nursing, physiotherapy and dentistry students. (P12: 4)

"*The CHC is one of the best facilities; students from all over are flocking in." (P12:3)*

Furthermore, Tertiary and Secondary hospitals often compliment the clinical team about the quality of care received by patients at CHC.

"We receive reports about from Groote Schuur Hospital, from G F Jooste...There was this burns patient we had to manage the wound eventually and the recommendation from Tygerberg Hospital... they cannot believe this was managed at the CHC. They were so amazed at our standards."(FGA6: 17)

One of the participants, who locums at the facility, remarked:

"It is a good thing to work at this CHC. I heard lots of people wanting to come and work at this CHC...in short these people know it is a good place." (P6: 12)

4.5 VALIDATION FOCUS GROUP

The study was put on hold between 2013 and 2015 due to factors beyond the control of the researcher. A motivation to continue the study was approved for the 2016 academic year. Hence, due to the hiatus in progress, it was imperative to determine whether the findings

from the original data collection was still valid and holds true to the research objectives as stated in 2012. A focus group discussion was conducted with five of the original participants, using a semi-structured interview guide, to refresh, clarify, and validate the research findings. Data was analysed according the thematic model of Tesch (See chapter 3).

Table 4.5: Theme Structural Realities – Sub-themes and Cluster

Sub-theme	Cluster
1.Work Environment	1.1 Structure
	1.2 Working Conditions
	1.3 Safety and Security
2.Critical Resources	2.2Human Resources Management
	2.2 Material Resources

4.5.1 Theme 1: Structural realities:

The findings based on the analysis of the focus group discussion mainly related to the following subthemes: Work Environment and Critical Resources.

4.5.1.1 SUB THEME: WORK ENVIRONMENT.

The participants spoke about aspects related to improvements in the structure and working conditions in the unit.

4.5.1.1.1 Cluster 1.1: Structure:

The participants made mention of the noticeable improvement in the working environment, for example the visibility of signage. It was mentioned that before the presence of signage people struggled to find the clinic. Signage was placed at the road entrance and around the clinic demarcating all the areas to make access easier:

> *"From the road the signs are there. You also see the signs in the emergency area. Every area now has signs. You know where to go." (FGB1:12)*

4.5.1.1.2 Cluster 1.2: Working Conditions

The participants agreed the working conditions further improved and the systems that were put in place are being sustained. The appointment of additional staff and the new shift system were beneficial in addressing service delivery needs and enhanced staff satisfaction.

> *"The working environment is therapeutic for us. We were few staff and we were serving a lot of patients, now everything is better than before."(FGB1:10)*

> *"The quality of care that was rendered was not up to standard. She came up with a plan starting from the shifts...with a nice shift system." (FGB3: 4)*

4.5.1.1.3 Cluster 1.3: Safety and Security

The clinic is situated in a dangerous suburb and there were a number of incidents of crime and violence in and around the facility. Therefore, the participants openly shared their opinions and feelings about safety and security measures. They agreed that the new management put several measures in place to this regard. However, most of them agreed that they were not satisfied with the current security company that served the facility and that there was an increase in criminal incidents. It was reported that on many occasions, nurses needed to intervene and perform the duties of the security officers - placing themselves in harm's way:

> ***"****We are working in a dangerous area. The management tried to put the safety measures in place for example they installed the panic buttons in the trauma unit, the manager's office and at the security gate. They also organised the armed response securities for day and night shift." (FGB1:10)*

> *"Everybody is doing something, I mean management is doing something to have the place secured, but the security (company) don't act the way I expect them to act...To me it's the company that I'm personally not happy with. They can have the 24-hour armed response...but if they don't act, how safe are you at the end of the day?" (FGB2:11)*

> *"I'm also not happy with them [security guards]. I do not know where they come from...maybe they come from working in the malls...we are in a hospital. We sometimes have to intervene and say, 'security please do this'. 'They expect you, the nurse to go out to the escort...you then become a victim." (FGB2:11)*

4.5.1.2 SUBTHEME*:* CRITICAL RESOURCES

The focus group discussion highlighted the presence of structural changes and improvements in the areas of human resource management and material resources

4.5.1.2.1 Cluster 2.1: Human Resources

The participants expressed their satisfaction with the fact that the management adhered to the Human resource policies and that practices continue to improve. Aspects such as induction programmes and probation reports, which were apparently not implemented in the past, were now standard practice. Furthermore, the staff was more aware of their rights and responsibilities. This is what some of the participants had to say:

> *"So we didn't have anybody to do the quarterly review on us and nobody read the employment contract or told us what we are expected to do at work. So now we just observed that for the new appointees, the manager is doing that." (FGB1:9)*

> *"It is only in 2013 that I got clarity on the pensions and beneficiaries. The new appointee now gets that from day one. We have a file, so we can read the circulars. That time it was bad but now everything is very clear to us." (FGB1:10)*

4.5.1.2.2 Cluster 2. 2: Material Resources:

The systems that were put in place to ensure ordering and control of adequate stock in the unit were working and participants observed a marked improvement in the availability of essential stock items. They shared that, despite the general challenges with the Supply Chain Management (SCM), the supply chain clerk was more accessible when they reported shortages and they received regular feedback on enquiries. In addition, they were happy to report that the unit was well equipped and systems were in place for maintenance and the repair of the equipment:

> *"The person of SCM is doing his job we don't get any report that there is no oxygen...if we report to him, he immediately phones Afrox. (to order).The system that we have now has not slipped back...it is that we can see the change." (FGBP4:5)*

> *"Every day we are improving. The last time the ventilator had a problem and I was impressed, surprised when someone said 'I can sort it out'." (FGB4: 2)*

4.5.2. THEME 2 PROCESS REALITIES:

Table 4.6: Theme Process realities – Sub-themes and clusters

Theme 2: Process Realities	
Sub-theme	**Cluster**
1.Leadership	1.1 Presence of Leadership
	1.2 Impact of Leadership
2.Care Delivery	2.1 Quality of Care
	2.3 Professionalism
3.Intra-and Interpersonal Relationships	3.1 Teamwork
	3.2 Teambuilding
	3.3 Professional Behaviour
4.Information	4.1 Communication Strategies
5.Teaching and Learning	5.1 Learning Environment
	5.2 Empowerment and Capacity Building

4.5.2.1 SUBTHEME 1: LEADERSHIP

The discussion in the focus group included the role and value of leadership, which led to improvements in the CHC as a whole. The participants recognised the influence of leadership in the many processes that facilitated and supported change.

4.5.2.2.1 Cluster 1.1: Leadership Presence

The participants shared the contrast of lack of leadership versus their current experiences of having a visible and viable leadership:

> *"When there is no leadership, we are just like stray dogs on the road. I think that for a team to work well you always have a captain in a team. If your captain is faulty, I don't know, if the general is weak what battle are we going to win? "(FGB4:4)*

'At first, the management were not visible to the staff but today the management is more visible to the staff. We have a chance to communicate with them and raise our concerns. Things are working for the betterment of the institution." (FGB3:5)

4.5.2.2.2 Cluster 1.2: Impact of Leadership

The lack of leadership efforts had serious consequences for the organisation and negatively impacted on the functioning of the facility. There was a perceived lack of discipline; the staff became demotivated and the overall performance was poor. The appointment of professionals in management positions with a different leadership positions brought about positive a change in the trauma unit and apparently had a ripple effect throughout the CHC. Various inputs were given to confirm the impact of leadership efforts towards transformation, on both the organisational and personal levels.

"*When I came in here in 2008 compared to now, there were a lot of backlogs. People coming drunk on duty and people not wearing their uniform. We did all those crazy stuff, but the leadership we have in the unit now, she never put the focus on the negativity but she would see what is important to you and try to focus on your strengths. So that really motivated us." (FGB3:4)*

"A good leader will know what to do and how to put the people together. That is what is important. Who can encourage the staff not always finding what is wrong? A leader we can respect ...by the way he/she is working and can lead us to a good achievement. Yes, it takes a lot of commitment from the leadership. It is something good and in 2009 I did not see anyone doing that." (FGB4:4)

"Yes, she inspires us in small things." (FGB5:16)

4.5.2.2 SUBTHEME 2: CARE DELIVERY

The participants in the focus group discussed the improvements in the approach and attitude towards patient-centred care. Some of the major changes were also shared in the initial data collection phase.

4.5.2.2.1 Cluster 2.1: Quality of Care

It was suggested that through the introduction of a systematic approach and through consultation among the multi-disciplinary team and regular clinical audits, there were improvements in patient care outcomes. This is captured in these excerpts:

"The quality improvement the way we render healthcare in Trauma is excellent. We audit our patient care. We were negligent ...urine dipsticks was supposed to be done because of the presenting complaint. So, it is those things we are currently doing that is to improve the quality of care." (FGB3:6)

"The rate of mortality is decreased, seriously. We are on a bus that's moving and I know we still have lots to improve but I have hope." (FGB4:4)

4.5.2.2.2 Cluster 2.2: Professionalism

One of the participants referred to how the professionalism between the medical and the nursing teams changed to become partners- in-care:

"We are proud to have specialist trained nurses, we are proud to have doctors who feel empowered...you are not scared to touch a patient.' I know how to manage. I know the policy. I know where to refer...Today the nurse tells the doctor. 'I think you must try this.' 'Are you sure you want to discharge her.' They are so empowered they are so knowledgeable. We are working together humanely better. And we did not have that before." (FGB4:8)

4.5.2.3 SUBTHEME 3 INTRA- AND –INTERPERSONAL RELATIONSHIP

One of the key aspects of organisational functioning hinges on how the people within the organisation relate to each other and position themselves within the team contexts. As with in initial data collection phase, these aspects where reiterated in this focus group discussion, with a focus on teamwork, teambuilding and professional behaviour.

4.5.2.3.1 Cluster 3.1: Team Work

Aspects of leadership that enhanced teamwork, such as integration, the multidisciplinary team approach and improved team relationships were again pointed out in the discussion:

"We are working to improve our relationship with the staff. And what I like, not only the clinical staff, we have the GA's (general assistants) involved, we have the clerks. So it is the whole CHC working together, the multidisciplinary team. That improves the way we work together for the service delivery to the client." (FGB4:2)

"We're having a lot of integration...now we try to rotate everyone. So when there are staff shortages, I can easily ask someone to help...that allows us to work together as a team in each department." (FGB4:2)

4.5.2.3.2 Cluster 3:2: Teambuilding

The arrangements by the management team to have regular teambuilding events was deemed to have positive outcomes towards improving team relationship and encouraging shared views. As reported by the participants, it created a platform to get to know each other better on a social level and to improve their motivation:

> ***"****Every day, we are trying to organise teambuilding in different units and in different teams. We have a quarterly meeting with the staff from Trauma, ARV, MOU, OPD ...meeting with the facility manager to have that tea or that lunch together. We try to socialise...it's nice that I want to know you better." I think that is a great achievement." (FGB4:1)*

> *We are celebrating our birthdays, International Nurses' day, also Valentine's Day and prizes were given to us. The management supports us by donating money. At least it motivates us." (FGB1:15)*

4.5.3.3 Cluster 3.3: Professional Behaviour

Participants discussed their understanding of professionalism, how it has improved and was sustained in relation to teamwork, discipline, service delivery and professional development. Participants compared their perceptions of a lack of professionalism in the past:

> *"The professionalism doesn't only go with the outfit. The way now, she always emphasises on how our attitudes interfere with patient care...so now we've learned...lets concentrate on the patient." (FGB3:16)*

> *"We are under discipline...so professionalism is kept." (FGB5:16)*

> *"Professionalism ... Dress code is important! Just speak to your colleague ...how do you care about your colleague... though we are humans, there is a protocol and policies to tell you how to manage yourself. We can't behave like animals. We have patients to see!"(FGB4:2)*

4.5.2.4. SUBTHEME 4: INFORMATION

4.5.2.4.1 Cluster 4.1: Communication Strategies:

The participants identified various strategies that were put in place to ensure the sharing of information and maintaining open communication with the staff throughout the facility. This included, for example, a number of functional committees to disseminate and discuss

matters of importance. Participants expressed their appreciation of the different platforms and the open communication between themselves and management as well as the benefits of knowledge sharing and improvements in clinical care:

> *"We now have a resuscitation committee. We never had a resuscitation committee before. We all sit in the mortality and morbidity meetings to discuss what could we do better to improve. We even discuss what we did well to encourage the staff. (FGB4:3)*

> *"Today, the management is more visible...they come here ...within the unit to share tea with us and we have a chance to communicate with them and raise our concerns." (FGB3:5)*

> *"If you go to our unit every week, every Wednesday there is a meeting. Communication is bringing transparency to our management because nothing passes us like before." (FGB5:7)*

They also mentioned that there are daily talks and updates given to the patients and escorts in the waiting room.

> ***"**Before, we used to ignore people in the waiting room, not informing them what is going on. But today, we go there and tell them what is going on. We tell them we are working according to the triage system. Through the information you give them, they understand you. But if you ignore them, they start to make chaos." (FGB3:12)*

4.5.2.4.2 Cluster 4.2: Reputation

The reputation of an organisation involves the views of clients, employees, service providers and the public about the standards and quality of the service or products provided.

Interview data revealed that the facility had a poor reputation in the community and that there were often negative media reports concerning poor service delivery and poor staff attitude. The participants said that there were many complaints from the community about the facility and how they were treated:

> *"No…no…the image of the facility in Site C was completely damaged, people did not want to hear about the facility, when you speak about CHC they say it's a nightmare." (P12: 1)*

"The Trauma Unit was not in a good state. There was drunkenness on duty. People would complain about being beaten with a mop by staff. CHC was frequently in the newspapers. There were problems throughout the CHC. However, it wasn't all bad. There were those who were trying very hard to deliver good service, but it's these very bad stories unfortunately, that would overshadow those good efforts." (P3: 3)

The reputation of the facility improved - on the contrary, participants indicated that community confidence increased with fewer complaints from the community and less negative media reports:

***"**The facility has become less in papers ever since the beginning of the new Management." (P10, pg2)*

4.5.2.5 SUBTHEME 5 TEACHING AND LEARNING

An integral part of the change process, given the many inconsistencies in the practice setting, was to create an environment where teaching and learning take place.

4.5.2.5.1 Cluster 5.1: Learning Environment

The findings of the initial data collection phase indicated that a learning environment was created in the unit. During the discussions, the participants elaborated on the efforts made in maintaining a learning environment where people were trained and retrained continuously:

***"**There was skills development. We had to send people because we realised that when there were resuscitation cases (serious cases), the people did not know what to do. They had to develop everybody...whether the nurses...whether the doctors." (FGB4:8).*

"We are going to have constant training every Tuesday and everybody must come together. This continues, even with the new commserves [nurses and doctors during their community service tell them...if you're open to learning, we're going to skill you, just be open." (FGB4:8)

"In Trauma we have that if I see my colleague is not doing the sterile procedure right, we collect all of them and do spot teaching. We do the demonstrations...they don't have to go outside for small training. We share the knowledge" (FGB3:16)

4.5.2.5.2 Cluster 5.2: Empowerment and Capacity Building

The participants discussed how they felt empowered and how they were growing individually and as a group. They indicated that they now had opportunities to improve their qualifications and to attend continuing education courses and workshops.

> *"I came here as a ENA (enrolled nursing assistant) in 2006, I'm one of the nurses, I'm proud of where I am today, I am a staff nurse. We're so excited that we're also going to the universities because of the improvement that is now taking place." (FGB2:14)*

> *"I am a happy candidate to say under training and development is open up for everybody." (FGB5: 13)*

> *"She saw the potential within me I never saw... put me in Trauma. I started to enjoy Trauma ...an opportunity to study was given to me." (FGB3:6)*

They mentioned that everybody was encouraged and supported to further their studies and to improve their knowledge and skills:

> ***"**In fact our unit manager does develop us. There was a person who used to be negligent, that did not want to do certain things...they were called to order and when they started to do those things, they were also offered a chance to study. She does not look at one category of nursing...ENA's (enrolled nursing assistants) are also encouraged to update their matric." (FGB3:6)*

> *"I have grown up so much. I went for training. I got a diploma. The ones that are coming now, we are teaching them...transfer of skills. I feel empowered". (FGB4:9)*

Some of the participants shared the benefits of coaching and mentoring that took place. Such interventions enabled them to assist with managerial functions and to stand in for the manager when on leave:

> ***"**She allows us to act in the office with her...she teaches us all the admin stuff....like tomorrow I'm going to a training on disciplinary procedure. She teaches us a lot of stuff that we're not aware of." (FGB3:14)*

> *"We were selected, me and number 3, to attend the Nurse Specialist forum meetings. In the forum, we discussed the problems we're facing in our units...there, they guide and advise us. It is very interesting when we go to that forum. We also feel empowered." (FGB1:19)*

4.5 SUMMARY

A qualitative study was done to explore the experiences and perceptions of the clinical staff on a transformational change process implemented in an Emergency Centre. Data were recollected through individual interviews and two focus group discussions using a semi-structured interview tool. A modified tool was used in the second focus group discussion, which was conducted in 2016 to validate the findings collected in 2012. In total 18 participants participated in the research process. A thematic model was used to analyse the raw data, which produced a wealth of information. The findings were organised within a framework of structure, process and outcome realities. The findings were based on the participants' past and present experiences, views, and opinions of the structure, operations, organisational culture, performance, and reputation of the emergency centre.

The views of the participants regarding the past, prior to 2008, mainly reflected that there was lack of structure, poor infrastructure, absence of leadership, lack of vision, poor work ethics and poor discipline. Secondly, the participants reported that the staff was ignorant of the various policies and legislative prescripts regarding employment relations, patient care and other governance matters. The views of the participants on the period between 2009 to 2012, when the transformational change process was introduced, illustrates that change management strategies and interventions were successful in ensuring transformation and improved performance in structural, processional and outcomes realities. On the structural level participants described the changes in matters such as work environment, critical resources such as human resource management, equipment and supply chain as well as clinical governance and legislation. Processional matters that the participants referred to as key aspects of the change process includes leadership, team functioning, delivery of patient care, staff development (Teaching and Learning), staff wellness and communication. The participants reported positive outcomes about professionalism, team relations, patient care and reputation. The participants in the second focus group done in 2016 validated the findings of 2012.They confirmed that transformational change is ongoing throughout the facility and reported on further improvements in areas such as infrastructure, delivery of quality care, clinical governance, distributive leadership development , team relationship and staff wellness.

4.6 CONCLUSION

The findings of the study, based on the experiences and perceptions of the participants on transformational change in the Emergency Centre, were discussed. The findings confirmed that the facility as a whole and the Emergency Centre in particular, required crucial intervention to maintain credibility as a healthcare institution. The participants freely shared their views on the poor state of affairs in the Emergency Centre of the CHC before embarking on a process of transformational change. The participants reflected on how the process influenced change on an organisational, operational, and personal level. A framework for aligning the structural and processional realities to achieve better outcomes on these different levels emerged. The role of leadership emerged as a critical facilitator in the transformational change process.

Discussion of the findings, recommendations and limitations of the study will be discussed in chapter 5.

CHAPTER 5
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

"Something extra-ordinary happened...there was something spiritual...people rediscovered hope in the process of caring for the patient...there wasn't pride but that was restored by visionary leadership." P3

5.1 INTRODUCTION

The Western Cape Department of Health in fulfilling strategic vision to provide access to patient-centred quality care through a capacitated workforce realised the challenge of re-energising the employees and building renewed commitment to the principles and vision of Healthcare 2030. They proposed a change management programme to create an organisation where the employees have a deep sense of belonging in an environment which is stimulating, supportive and where challenges are addressed in a creative way (Healthcare 2030:xv).

A clear distinction between change and transformation is made by several change management experts. Twist (2012, np) is of the opinion that change is volatile and can revert. Transformation does not necessary make the past wrong and does not deny the past. Transformation rather honours the past, strives to make sense of it and opens up new possibilities and new futures.

Exploring the experiences and perceptions of the clinical staff on the transformational change management process uncovered several of the systemic challenges experienced at the grassroots level and highlighted change strategies which were employed to addressed these challenges. In this chapter, the researcher will look beyond the emerging themes presented in Chapter four to explore the crucial significance of the study findings(Creswell 2013:187).

The purpose of the study was to explore the clinical staff's experiences and perceptions of the transformation change management process introduced in the Emergency Centre at CHC. The conceptual framework guiding the study included the principles of the Learning Organization (Senge, 1990:3) and The New Leadership Paradigm (Barret, 2010:24) as presented in Chapter Two. Donebedian's framework of Quality care (1966) emerged during the data analysis phase providing a structured approach through which to present the findings. Senge's theory of the learning organization is used in the study as a transformational change management theory. In re-creating organisations from a state of

survival to adapting to times, trends, change and challenges, it requires adaptive as well as generative learning (Senge, 1990:14). The convergence of the five disciplines of systems thinking, mental models, personal mastery, shared vision and team learning, is displayed in the study when the participants described their experiences and perceptions as active participants in the transformational change process.

Barret's New Leadership Paradigm (2010) is based on the evolution of organisations through three stages, namely mastery, internal cohesion and external cohesion, required to survive and thrive when dealing with extreme complexities. The paradigm is based on a values-driven vision-guided leadership (Barret, 2010:32). This model provides a basis to identify the evolution of the emergency unit at the CHC whilst dealing with the extreme complexities within the transformation process. The framework guides the focus of the study through mastering of both lower level (internal) and higher level (external) needs - aiming to achieve full spectrum consciousness or transformation (figure 2.2:41).The models were not combined as the synthesis and validation of such an artefact was beyond the scope of this study.

However the two models are intimately linked by integration of the different disciplines or levels of consciousness when dealing with complex system change. The congruency in the two models is probably that they are both based on a systems thinking approach with the emphasis on visionary leadership, shared vision, mastery, team development, and shifting of paradigms to transform the organisation from a state of survival into a flexible state of adaptation and evolution.

In general, Donebedian's Framework of Structure-Process-Outcome is used to highlight the components and anatomy of the performance of a system, but it would not be adequate on its own in this study due to the complex and eclectic nature of this study (Dubois et al. 2008:12). The framework enhances the study in providing a structured way to identify, classify and present the themes and sub-themes which emerged from the data. This is in line with systems thinking as it draws structural, process and outcome aspects of the findings together in a holistic manner.

A thematic analysis using Tesch's framework (3.10:17) was used to analyse the data obtained from the individual interviews and group discussions. These findings are presented in Chapter 4. This chapter includes a discussion of the study findings in relation to the aim and objectives of the study and includes recommendations and limitations accordingly.

5.2 DISCUSSION

The experiences and perceptions of the study participants on transformational change in the Emergency Centre will be discussed as it relates to each of the study objectives. The discussion is aligned to the lived experiences of the participants to provide a holistic view of the transformational process and how the care context and its staff evolved through this process. The discussion in this section starts with presenting the concept of transformational change, the role of leadership and teamwork as it relates to the findings and the essence of the study. This is followed by a discussion of the ancillary findings according to the thematic approach used in the study. Relevant literature will be used to confirm and or provide additional views of the findings and conclusions.

OBJECTIVE 1: TO DESCRIBE THE CLINICAL STAFF'SEXPERIENCES OF LIVING AND WORKING IN THE TRANSFORMATIONAL CHANGE PROCESS IN THE EMERGENCY CENTRE

The participants freely expressed their views, perceptions and experiences. They reflected both on the past and present state of the unit and the influence of the changes within themselves, the organisation and the community. It is clear that initially, the situation in the organisation was not conducive or functional to meet all the objectives of the health facility. This is supported by various negative media reports and the report submitted by the public protector in 2009 titled "Cry for Better Health Services." The findings of a systemic investigation lead by the office of the Public Protector supported claims of poor service delivery, poor discipline of staff and other infrastructural inadequacies (Public Protector, 2011:4).

5.2.1 Transformational Change: Identifying the need

The participants described their experiences and perceptions of a unit that was not functional in providing quality patient care. A range of systemic concerns, as mentioned by the participants, contributed to the perceived state of affairs prior to the initiation of a transformational change process, is discussed below.

The clinical staff's experiences and perceptions prior to the transformational change process portrayed that the working conditions were poor, the staff was uncomfortable working at the unit and the patients were unsatisfied with quality the services provided. Participants highlight issues like poor display of professional ethics by the clinical staff without any disciplinary actions to follow the misconducts. The mortality rate increased and the

community reported on the poor services and patient care neglect that took place at the Emergency Centre.

According to the study participants, most structures and systems failed. For example, lack of control systems, poor resource management and poor adherence to legislative and policy guidelines. Patient management systems, although in place were not effectively implemented. Incompetence and lack of knowledge were prevalent and the environment was not conducive for teaching and learning. Participants indicated that the situation was deteriorated to an extent that the Health Professional Council (HPCSA) withdrew the medical students and interns in 2007.

Furthermore, there was a lack of accountability and ownership among the staff as well as management with limited, if any formal leadership system in place. A study done in Brazil confirms that there is a reluctance amongst nursing staff in emergency departments to adopt leadership roles although leadership emerged as important in the successful implementation of quality of care improvements and change initiatives (Dos Santos et al.,2013:3).This led to a limited sense of responsibility towards meeting the Department of Health's objectives. The challenges of interpersonal relationships were evident through the accounts of the participants. They considered relationships to be hampered by power struggles, incidents of racism and poor teamwork. In such conditions, the staff became demotivated - displaying a lack of pride and hope.

The above are characteristics of an unhealthy work environment. Barret (2010:3) describes an unhealthy organisation as one that is attempting to survive in delivering services and responding to the basic needs of the clients in a climate where there is complacency, silo mentality, poor relationships, confusion, internal competition and politics. Furthermore, these organisations are rigid, unable to adapt and do not empower employees. Employees are often frustrated, lack enthusiasm and there is little or no innovation and creativity.

Anderson and Ackerman-Anderson (2010:40) postulate that an organisation experiencing difficulties, such as stagnation in performance, equipment failure, loss of control over information, dips in employee morale, threats from other agencies, inadequate resources and skills, loss of reputation and relentless customer demands, should receive a wake-up call to change. Further to this, they claim that the organisation will perish if it does not change. Given the complexity of the challenges faced by the leadership of this unit, a radical shift or transformation seemed to be the only answer. Twist (2012) states that there is a difference between change and transformation and different questions need to be asked about alternative approaches to enable transformation in the people, the organisation and

the systems. Transformational change which is a radical shift from one state of being to another of which successful implementation requires a shift in culture, behaviour and mind-set (Anderson and Anderson, 2010:39). In addition Ajmal et al. (2015:11) confirms that transformational change is complex, therefore the emphasis needs to be on the people in the organization, their identity and the patterns of human interactions. Furthermore, the organisation needs to enhance its performance and create order by facilitating employee pride, confidence, and ownership through policies, procedures, systems, processes and structures based on best practices (Barret, 2010:1). Contrary to this, the change management process will be ineffective if there is a lack of leadership focus on the complexities of the process, weak strategies and structures, and poor focus on the human dynamics during the change process (Ajmal et al.2015:112).

In summary, the findings illustrated that a process of transformational change was happening in the Emergency Centre with an impact that resonated throughout the facility. Findings from the 2012 and 2016 data collection processes confirmed that structures, processes and outcomes was aligned to address service delivery needs, systemic and employee related challenges. An enabling environment was created that supports ongoing improvement, knowledge sharing, capacity building and empowerment of employees by encouraging the staff to become involved in decision making process and having a sense of ownership for being accountable and responsible to the shared vision (Barret, 2010:2).“*I think Transformation means different things to different people but in the case of the CHC, the change of the unit with respect to the total commitment and ownership of the place by all categories of staff. The result of this being the successful transformation of patient care”* (P6:2-3).

5.2.2 The role of Leadership

The participants shared common sentiments regarding the lack of leadership visibility and lack of a formal leader. The perceived absence of a true and strong leadership was considered one of the major contributing factors to the state of affairs. Participants experienced that the lack of supervision resulted in a state where everybody just did as they pleased. Although there was a strong desire to change, it appeared that something was amiss: *“Something special was needed...it needed a strong leadership...it needed a vision*” (P3:4). Booyens (2008:436) stated that transformational change process could be successfully facilitated through a transformational leadership style. Further to this, Murphy (2005:131) describes the transformational leader as a visionary, a futurist who can navigate complex and rapidly changing healthcare environments with confidence.

In 2008, the DOH as part of its improvement strategy to strengthened the staffing complement and management capacity by appointing more staff. To this effect, a family physician and an operational manager for the Emergency Centre were appointed. This allowed for more balanced skills mix, better line management, clinic governance and leadership. Francis-Nurse (2007:1) believes that organisational change needs strong leadership and needs commitment from the change leader and the team which needs to direct and support the change efforts in creating buy-in and commitment from the stakeholders.

The advent of a new leadership structure in the Emergency Centre provided new ideas, developed a shared vision that ensured buy-in and commitment from staff and resulted in improvements and changes. Staff started to regain confidence and trust in themselves that had, according to the participants, a ripple effect throughout the facility.

The participants shared their experiences of being empowered, motivated, and involved in decision-making and supported through the leadership provided. Successful change management depend on effective leadership who inter alia, aim to motivate and empower the staff to accept the change, to buy into a shared vision and to undertake challenging goals (Francis-Nurse, 2007:2).

The vision and objectives for the unit were identified and clarified, whereby systems and processes were aligned to achieve the provision of high quality emergency patient care. To achieve the organisational goals through a shared negotiated vision, it is important that a relationship of trust and a sense of belonging should be cultivated between the leadership and staff (Rolfe, 2011:54).

Capacity building and the empowering of staff required a focus on the facilitation of personal transformation and mastery. The staff was mentored and coached to increase confidence, knowledge and skills in areas such as the general management of the unit, communication and clinical skills. This leadership capacity improved as other leaders emerged throughout the facility. Senge (1999:464) states that organisational performance is enhanced by leaders who empower the human resources and enable change.

Thornton (2013:13) reports that leaders are ultimately accountable for the success of transformational change, therefore, they need to support and drive the change. The findings of the study confirmed that transformational change at the CHC was facilitated by leaders and leadership. Furthermore, a meaningful case is made for a transformational leadership approach, which fosters attributes that will inspire and motivate the staff in developing a

shared vision through expertise, integrity, building trusting relationships and enhancing commitment and performance (Rolfe, 2011:55). There is thus a need in organizations for continuous leadership development, which will focus on assisting people to become authentic and fully self-actualised by supporting the person in his/ her own evolution as well as supporting the evolution of consciousness of humanity and that of the organisation (Barret, 2010:65)

5.2.3 Teamwork

Teamwork and interpersonal relationships emerged as major areas of concern. The participants expressed that there was limited if any teamwork, unity and poor relationships between the medical and nursing staff and among the nursing staff themselves. This created conflict in the unit, which directly influenced patient care. Heale, Dickerson, Carter and Wenghoffer (2007:928) identified that team dynamics, collaboration among team members and the sharing of responsibility have an influence on team functioning. Zatzick & Zatzick (2013:222) are of the opinion that the influence of teams on the successful implementation of change in highly intense environments such as trauma units, is based on their motivation and ability to work together.

According to the participants, the transformational change process led to improved relationships, a sense of togetherness and team cohesion. Partnerships between the clinical managers (doctors) and nursing team were forged to ensure the achievement of a shared vision. A multi-disciplinary team approach was cultivated which resulted to, team cohesion, mutual respect and a sense of unity developed. The environment now encourages teamwork and a multiple disciplinary team approach. Interpersonal relationships and communication improved, which resulted in a reduction of conflict among within the team. This was further sustained through team learning and teambuilding exercises.

In summary, healthcare workers do not work in isolation and need to develop skills in team collaboration and how to function constructively in diverse group settings (Manion & Huber, 2008: 216). This is supported by Hemeida (2014:303) who states that most of the solutions to the problems faced in an emergency department can be achieved through the collaborative and cooperative efforts of the team. Barret (2010: 2) is of the opinion that to harmonious team relationships can be created, by reducing attributes such as internal competition, blame and all forms of discrimination, and a sense of belonging and loyalty will exist among employees. Efforts to sustain teamwork and good interpersonal relationship in the unit included training, meetings and other teambuilding activities.

5.2.4 Structural Realities

Health systems that function well share characteristics of sound leadership, good governance, effective procurement and distribution systems, sufficient health workers with the right skills and motivation, and sound financial systems. (WHO: 2010). The World Health Organization (WHO) thus, in response to the global need for more effective investment to strengthen health systems to achieve health related goals, developed a strategic framework of six building blocks. This framework includes service delivery, information, medical products, health workforce, health financing leadership and governance (WHO, 2007: iii, v).

The participants perceived the unit to be disorganised and that there were no real structure or functional systems in place. There was a dire need for improvement in the structural components and align it with above strategic framework. Although the depth and the breadth of the study did not include evidence related to every building block, evidence related to the health workforce (human resources), leadership, governance, service delivery and information was found.

5.2.4.1 Human Resource Management

One of the strategic objectives of the DOH is to provide quality patient-centred care through a capacitated workforce. Human Resource Management (HRM) refers to the philosophy, policies, procedures and practices related to the management of an organisation's employees (Inyang, 2011:143).

The HR improvement plan for the Emergency Centre of the appointment of a clinical manager, an operational manager, a number of professional nurses and other categories of nursing staff. The aim was to address the deficits in competencies and to enhancing a diverse skill mix. This contributed to the management and leadership capacity in the different areas as required in the facility. The staffing establishment was further enhanced by creating more posts for medical practitioners. The strategy included a training and development plan in conjunction with the new HR Occupational Specific Dispensation (OSD) policy that required professional nurses to obtained advanced emergency nursing skills training to become specialists in the field. Research supports the recommendation that managers need to align HR strategies and practices, such as the planning, selecting the right people, developing, motivating and maintaining a vibrant workforce to boost the organisation's survival and progress (Inyang, 2011: 141).

5.2.5.1.1 Staffing Arrangements

Shifts System

Staff scheduling is a complex issue in healthcare institutions (Kerfoot, 2015:1).
The participants described the staff arrangements referring to skill mix, daily scheduling and leave arrangements. The staff scheduling did not meet the needs of a 24hours' Emergency Centre. The previous staffing schedule was more suited to the needs of a day clinic (8-hour service), which left the Emergency Centre with skeleton staff during the critical hours from 16H00 to 19H00. This required staff re-scheduling to suit a 24-hour service. This proposed change to the staff scheduling met with resistance from staff and initially, the staff protested against the new off duties.Burgess (2007:S88) proposes that an evidence based approach is applied to staff scheduling due to the fact that shift rotation and night shift work can potentially impact negatively on decision-making. The Basic Conditions of Employment Act 87 of 1997 in a code of good practice prescribes the rules that employers need to take into consideration regarding shift rotation and night shift workers. Aspects such design of rosters, hours of work, occupational health and safety issues, and personal attributes of workers among others needs to be taken into consideration.Through negotiations between management and staff, a new staff schedule was agreed upon that met the needs of the patients staff and ultimately led to better coverage of the clinic. In the absence of staff scheduling and staffing ratio policies or guidelines, the scheduling was based on the acuity of the patients and quality provision of Emergency Care. Mensik (2013:1) confirms that adequate staffing levels can reduce patient mortality, improve patient outcomes and lead to an increase in job satisfaction. Various international studies indicate that factors such as circadian rhythm physiology, age, personal lifestyles, family and childcare responsibilities, social functions, and so forth, can have an adversely effect on the attitude and performance of shift working staff and must be taken into consideration to ensure safe health practices and public safety (Burgess,2007:S91).

Leave Planning

The participants also reflected on issues of leave planning and absenteeism. There was a consensus among the participants that previously, the leave planning was poorly conducted. Most of the senior staff would favour popular months such as school holidays, Easter weekend, and December and January holidays. The rest of the staff had to take whatever was available after that. This caused a lot of unhappiness and discord among the members of staff. Sharma, as quoted by Moleki (2014: 35) states that leave management is a sensitive issue, which can cause strain in the employer-employee relation if not properly managed. He

suggested with the leave policy is required to ensure that sufficient resources are available for service delivery as well as fairness in leave approvals.

Section 21 of the Basic Conditions of Employment (BCEA) Act 75 of 1997 provides legislative guidelines for leave benefits and includes annual leave, sick leave, special leave such as maternity leave, study leave etc. (BCEA,1997:23). The findings show that if there is a system, which allows staff to plan for leave well in advance, and if an annual leave planner is available, leave requests are much better controlled with more fairness in the allocations of leave to individuals and better control over the leave process. A study by Moleki (2014:iv) confirmed that it is important to manage annual leave entitlements of employees through planning, communication and control measures in order to maintain employee wellbeing, productivity and reduce financial implications.

Absenteeism

Absenteeism is a universal challenge in health facilities and one of the biggest problems facing managers. According to Munro (2007:21), it has an impact on service delivery, staff morale and result in financial losses. The study findings indicate that at the CHC the absenteeism rate was above the norm due to lack of commitment, interest, loyalty and relevant control measures. According to the findings, members of staff would stay away from work or leave work with no valid reason. Mudally and Nkosi (2015: 627) identified that family matters, lack of motivation, illness, finance, favouritism, hostile nurse managers, long work hours, increased workload, unsatisfactory work conditions, lack of equipment, unfair promotions and selection of nurses for training, staff shortages, lack of a reward system and unclear decision-making are some of the reasons for absenteeism.

Employees need to be aware of the relevant policies and rules governing absenteeism and employers need to have stringent measures in place to reduce absenteeism in the workplace (Munro, 2007, Adegboyega et al. 2015). Participants reported that although absenteeism remains a challenge there was a meaningful improvement in the attendance rate of staff due to stringent control measures that was put in place. The participants said that everybody is aware that they have to communicate their intention and reason for their absence to the line manager, who in turn may approve or disapprove their absence.

Human Resources departments and line managers are responsible for monitoring patterns and the reasons for high absenteeism as it is costly and affects organisational performance and productivity (Adegboyega, Dele, & Ayodeji 2015: 58). In addition, nurse managers can reduce absenteeism by dealing with the employees' concerns, which in turn can result in

increased productivity, increased staff morale, decline in medical hazards and increase in patient satisfaction (Mudally & Nkosi, 2015: 267).

Discipline and Conduct:

The findings illustrate a general lack of knowledge, understanding and limited implementation of HR policy guidelines including disciplinary processes. The findings show that discipline and conduct was poorly managed. Many of the employees did not follow rules of conduct and were not concerned about the consequences. For example, the staff would leave their posts and would take extended tea and lunch breaks and patients would be neglected. Furthermore, there were numerous accounts within the findings of drinking and working under the influence of alcohol while on duty. According to Lizzer (2015:10), public servants must ensure that their conduct corresponds to the basic values and principles governing public administration. Therefore, it is important to introduce disciplinary measures to hold the staff accountable for their actions. The findings confirmed that disciplinary codes and measures were instituted and communicated during the transformation change process. The Disciplinary Code of the Public service, Resolution 1 of 2003 of the Public Service Co-ordinating Bargaining Council (PSCBC) states that discipline is a management function and must be applied consistently to promote acceptable conduct and to avert and correct unacceptable conduct (PSCBC, 2003:1). Staff behaviours and conduct were closely monitored and a common understanding that misconduct will not be tolerated prevailed. Transgressors were held accountable, disciplinary actions were taken and this resulted in improved discipline at CHC. Although discipline remains a challenge, there is an agreement between management and staff regarding what constitute acceptable and unacceptable behaviour and conduct. Lizzer (2015:88) further motivates that workplace discipline advances effectiveness and excellence at the workplace, which contributes to the advancement and evolution of the organisation.

5.2.4.1.2 Staff Performance Management:

Performance management system is defined as an authoritative framework for managing employee performance, which includes the policy framework and the framework relating to all aspects and elements in the performance cycle, including performance planning and agreement; performance monitoring, review and control; performance appraisal and moderating; and managing the outcomes of appraisal (Department of Public Service and Administration (DPSA) 2007:7).

The staff performance management system (SPMS) is governed by policy and measures performance and development. It is linked to a monetary reward system for above average and excellent performance (Department of Public Service and Administration (DPSA) 2007).The participants claimed that they never understood how the system worked, that they had no knowledge about the policy guidelines. They also felt that the system was not fairly applied and that only certain individuals were benefitted from the system. This contributed to the unhappiness among the staff. Every year, at the end of the performance cycle, the staff would feel discouraged that their efforts were not recognised. During the process of transformation, information sessions were held with all the staff and senior professional nurses were trained as reviewers. The policy guidelines were now applied to ensure recognition and rewards for the deserving staff members. Aspects of staff development were addressed and staff was encouraged to strive towards improving their performance.

Moonlighting:

The term moonlighting refers to holding an additional work/ position apart from one's primary work/position. The Cambridge Business English Dictionary (Cambridge University Press, 2016) describes moonlighting as a global phenomenon due to various demands and in particular financial challenges experienced by staff, especially nursing staff, in a need to supplement their incomes. According to Banerjee (2012:100), holding another form of employment need to be subject to policy regulations and form part of the contract of employment. In South Africa, a policy for remuneration for work performed outside of the public service is in place (WDOH H20/2013:2).This policy requires an employee who wants to "moonlight" to obtain official permission from the employer (DOH). When the employee does not have official permission, it is regarded as a serious misconduct, which can attract disciplinary actions including instant dismissal.

Most of the participants in the study were moonlighting in other private and government facilities and claimed that they did not have knowledge about the existence of this policy. Furthermore, it also became apparent that the moonlighting led to increased absenteeism, and lack of commitment and loyalty towards the facility. Rispel and Bruce (2014/15:117) claim that agency work and moonlighting adds to poor staying power, decreased energy levels, abuse of leave and sick leave; poor nursing care, divided loyalty and accountability, and the erosion of professionalism.

In reference to the transformational change process, the participants expressed that the awareness of the RWOPS policy led to behaviour that is more responsible and they now

annually apply for official permission. There was now improved adherence to the policy and to the required work schedule. Knowledge of the policy and proper implementation, given the serious consequences, reduced the rate at which the staff was abusing the system and reduced absenteeism. A study by Rispel, Chirwa and Blaauw (2014) confirms that moonlighting has an influence on staff turn-over and that different strategies are required to manage moonlighting and to improve the retention of nursing staff. Moonlighting may also have positive effects as the staff could learn new skills, which can benefit the organisation at the expense of the other employer, and it may have a positive effect on retention if the employee can cope with both jobs (Banerjee, 2012: 98).

In summary, it appears that there was poor adherence to and knowledge of matter relating to human resource management. Rispel and Bruce (2014: 12) found that there is lack of awareness of policies between nursing leadership and front-line nursing staff, which is in part due to their exclusion in policymaking processes and inadequate feedback mechanisms. The literature advocates for the importance of legislation and policy to be available as well as the fair application of such. Inyang (2011:142) posits that people are the main organisational asset and need to be managed correctly. The proper management of employees, together with the implementation of appropriate human resource policies, practices and strategies will boost the organisational performance.

5.2.5 Organisational Behaviour, Culture and Characteristics

Organizational Behaviour (OB) relates to all aspects of what people do and how it affects the performance of the organisation (Robbins &Judge, 2007:10).Robbins and Judge (2007) also describe the organisational culture as a system of shared assumptions, values and beliefs that govern how people behave in organisations. These shared values have a strong influence on the people in the organisation and dictate how they dress, act, and perform their responsibilities.

Characteristics of the organisational culture relates to innovation, attention to detail, outcomes, people orientation, team orientation, competitiveness and stability. There is a close link between OB, organisational culture and its characteristics and the how it relates to the organisation’s performance, the employees’ sense of belonging and its reputation or credibility (Nagel, 2006:8). The study participants provided their opinions, perceptions and experiences on these aspects related to the organisational dynamics.

5.2.5.1 Positive Practice Environment

The International Council of Nurses (ICN) believes that the global health workforce crisis could contribute to unhealthy work environments and poor organisational climate. The study participants gave vivid accounts of unfavourable conditions within the CHC related to inadequate structure, lack of systems, poor or absent leadership, poor work ethics and a general lack of commitment and ownership among the staff.

The characteristics of poor practice environments include inadequate supervision, lack of basic equipment and supplies and poorly maintained facilities (Ng'anga et al., 2016:2). It clearly indicated a need for change to improve the organisational climate and culture. Work climate affects staff performance, high absenteeism, reduced interest in their work, lack of initiative are signs of a less than optimal work climate (Miller, 2000:2).In addition, Ritter (2011:32) believes that clinical leadership that lacks vision and is resistant to change contributes to unhealthy workplaces. It clearly indicated a need for change and for improving the organisational climate and culture towards a positive practice environment.

The ICN defines a positive practice environment as a setting that supports excellence and decent work. An environment that ensures the health, safety and personal wellbeing of staff, supports quality patient care and improves the motivation, productivity and performance of individuals and organisations (ICN, 2008:1). Ravangard et al. (2014:3) reviewed several studies and found that there is a significant relationship between work ethics and organisational perceived changes. They concluded that employees with stronger work ethics are more committed to develop the organisation and contribute to organisational change and will not resist change.

Furthermore, Ravangard et al. (2014:3) found that being included in decision-making processes created a better sense of autonomy especially among the more senior nurses. Transparency and including staff in decision-making processes reduce misconception, promote a sense of fairness, reduce hierarchical dominance, may also encourage staff collaboration, autonomy, and shared vision (Tillot, Walsh & Moxham; 2013:30).

Most of the structural and systems matters such as Human Resource Management and equipment and consumables supplies are discussed in the preceding text – inclusive of transformation, leadership, teamwork and team relations. This section will focus on the subsidiary themes, which are related to organisational dynamics that became known in the data analysis.

5.2.4.2 Teaching and Learning

An audit conducted in Great Britain highlighted the need for training and developing healthcare workers to function in complex critical environments (Davies, Jones &Higginson, 2010:239).The study participants reported that the focus on learning, training and competency development appears to have been a grey area in the past and did not receive the attention it deserved. There was a sense that general clinical knowledge and competencies among the staff were limited. This led to a lack of confidence especially among the nursing staff.

Often, emergency nurses work in pressurised environments where they have to perform tasks for which they were not adequately trained or prepared (Brysiewicz & Bruce, 2008:130). It is also reported that the system of selecting and allocation of study leave was inherently unfair with evidence of and favouritism. With regard to the transformational change process, the participants were clear in their reporting of improvements in this area. They referred to systems of formal and informal training being made available. This led to capacity building, upgrading of qualifications and increase in confidence among the staff. Staff was sent regularly for updates appropriate to the environment they had to function in. Training at the facility in the form of in-service training, spot teaching and specialist outreach sessions were now available.

Workplace learning is important to strengthen professional development, support practice and performance and reduce errors (Bhardwaj et al., 2015:e67).Study leaves were approved based on need to capacitate the staff in acquiring the necessary skills and knowledge to function optimally in the clinical environment (WDOH39/2016:1). Employees need to comply with certain criteria. For example, good work attendance, good work ethics, discipline and academic potential. The participants were encouraged by the renewed focus on training and development and the benefits of a fair system.

The study leave system also contributed to an increase in the number of emergency nurse specialists and other categories of nursing staff. The organisation now benefits from a system of expanded learning and knowledge transfer. Healthcare education is aimed at updating knowledge and skills to promote safe quality healthcare through competent staff (Abri &Al-Hashmi, 2007:10). The employees were now eager to sign up for courses and seek new learning opportunities. Furthermore, through the empowerment process, some of the professional nurses gained enough confidence to present topics at the in-service training programme. These opportunities were attended by senior medical and nursing staff.

In summary, a culture of learning was created in the Unit to become a learning organisation that supports continuous learning within the organisation through an agreed set of attitudes, values and practices (Senge, 2006:3).The learning organisation is built on individuals and teams who create, share and act on shared learning (Senge, 2006:10). Learning took place through empowerment to increase motivation and self-confidence of the individuals concerned. According to Yamoah (2014:139), empowerment enables decision-making and allows employees to explore new ways of thinking and doing. Employees who feel empowered become more responsible for their actions, however, managers must continue to encourage, stimulate and direct employees to draw out their creative potential (Al-Abri & Al-Hashmi, 2007:210).

A culture of learning does not always lead to predictable outcomes of improved motivation, confidence, attitude change and insights influencing future actions (Senge, 2006: 36). Transformation in organisations happens in environments that support innovation, continuous improvement, knowledge sharing, personal growth and development of employees by virtue of which employees become accountable and responsible for their own futures (Barret, 2010: 3).

5.2.5.3 Communication Strategies

The functioning of any organisation is critically influenced by the quality of communication and sound communication strategies. Communication is an investment and is critical to the performance of the organisation and the morale of the employees (Ergen, 2010:4). The study participants perceived that the absence of communication structures and strategies hampered the flow of information. Furthermore, they experienced that interpersonal communication was poor and resulted in interdisciplinary strive and conflict. The importance of effective communication in high-risk, time constraint environments such as emergency departments is deemed fundamental to the delivery of quality healthcare (Pun et al. 2016:121). Their experiences and views regarding communication, in general, changed due to renewed emphasis on the importance of communication as part of the transformation process. The improvement strategies focussed on establishing clear lines of communication, putting communication structures in place, and working on improving the interpersonal communication among staff and with the patients. Booyens (2011:268) states that, an environment with a supportive communication climate cultivates employee participation, allows for sharing of ideas and allows them to ask questions and be involved in problem solving. The flow of information improved through regular meetings, more effective use of notice boards and dissemination of new policies including monitoring processes. In addition, the staff expressed that they valued the fact that platforms were created for the

dissemination of information, consultations and general support for staff. Thomas et al. (2009:287) state that trust and employee involvement is cultivated through information sharing and communication whereby open communication works towards interpersonal trust.

5.2.5.4 Staff wellbeing and Occupational Health

The participants narrated their experiences of poor conditions within the facility that created an unhealthy organisational climate. The unhealthy organisational climate then negatively impacted on the wellbeing of the staff. The participants talked about instances of being hurt, and a loss of pride and respect among them. This further led to low morale, unhappiness, loss of confidence and a lack responsibility and accountability among the staff.

The staff became demotivated and felt no sense of commitment. They described the negative perceptions associated with the conditions that prevailed in the workplace and a general sense of unhappiness that existed among the staff and patients. It was apparent that significant leadership and management were required to turn the situation around. Barret (2010) states that an organisation that is in survival mode needs to create a caring environment by improving working conditions and focus on the health, safety and wellbeing of the employees. The vision of the WDOH includes a focus on improving the patients' health care experience as well as strategies to boost staff morale and wellbeing (WDOH Healthcare2030, 2012:77).

Staff Wellness

Several strategies and activities were introduced to bring about and to sustain improvement in the organisational climate. Examples, as shared by the participants, were increased management visibility and their availability to the support staff, a staff wellness clinic, regular teambuilding activities and events arranged to celebrate achievements, birthdays and other significant events. The participants described a sense of spiritual fulfilment, which gave them hope in having their dignity restored. Furthermore, they experienced a sense of empowerment, belonging, pride and self-worth.

Staff recognitions and Rewards

Recognition and rewards, formal or informal is an effective form of motivation to reinforce employees positive actions, efforts and behaviour and speaks to the intrinsic psychological need of appreciation (Human Capital institute, 2009:1). Besides the staff performance management system, the members of staff are also rewarded and given recognition through initiatives such as the employee of the month, awards for clinical excellence at the annual

Nurses day event and commendations slips for good work during the month. Results of study done by Baskar and Prakash (2014:1646) confirms that giving employees recognition leads to increased employee engagement, motivation productivity, job satisfaction, and improved job performance. The greater the rewards, the higher the motivation and job satisfaction and performance. They also found that during a process of transformational change when there are conflicts between the performers and non-performers efforts should be made by the organisation to rectify the situation (Baskar & Prakash, 2013:1647).

Social Support

The findings revealed that employees perceived the management to be very observant, supportive and showed genuine concern for the wellbeing of the employees. The participants said that they were also encouraged to offer support to their colleagues during illness and bereavements. Booyens (2011:364) emphasises the importance of social support in the work place as related to job satisfaction and productivity. Employees appreciated having a platform where they could express themselves, be supported, empowered and valued. They expressed that their sense of pride, interest and commitment towards their work improved. Mannix et al. (2013:19) who reviewed the role of clinical leadership found that effective clinical leadership is essential to ensure quality care, healthy workplaces and the promotion of staff wellbeing. However, numerous challenges with ineffective clinical leadership can have a negative impact on patient care and the employee wellbeing.

Occupational Health and Safety

Within the context of emergency care, occupational health and safety are considered very important. An occupational health and safety committee was established. This committee was responsible for all aspects of staff and patient health and safety and disaster management. The Occupational Health and Safety Act of 1993 stipulate that employers must ensure a safe and healthy working environment. The Act also prescribes the establishment of health and safety committees (Bezuidenhout, 2009:32).

The findings confirm that systems were put in place to ensure the adequate immunisation of staff and the improvement and continuous monitoring of the environmental hygiene in the facility. A staff wellness clinic service provided staff with acute and chronic care when required. The clinic organised some staff health and wellness days and a formal system to provide psychosocial and emotional support for the staff on referral basis was available. Several participants mentioned that they found these services of great value and much needed.

Safety in the Workplace

The exposure to workplace violence and other safety threats is a reality for employees working in an Emergency Centre that deals with patients under the influence of alcohol and recreational drugs. The presence of gang and interpersonal violence in a highly stressed environment exposes the Emergency Centre staff to potential physical and psychological harm. According to Freeman et al. (2014:10), such conditions raise concerns about safety and security in health care. The findings highlighted such concerns - indicating that although security measures such as panic buttons and other safety awareness measures were in place, the services provided by the security company was considered inadequate.

After a recent incident in 2015 where a security guard was shot at the CHC, the chairperson of the Health Forum told the media that the residents are afraid of losing quality health services because the staff is “rattled” and reluctant to come to work (Fokasi, 2015:2). A study conducted by Munyewende, Rispel and Chirwa (2014:14) supports the concerns of employees at clinics who perceive their workplaces as unsafe and being exposed to threats of violence from patients and community members. Their recommendations suggested the use of basic security infrastructures such as security fences, alarms and working telephone systems. The ICN (2007, np) recommends the creation of safe enabling practice environments by also addressing challenges of physical and psychological workloads.

5.2.5.5 Professionalism

The findings confirmed the perception that there was a lack of professionalism and a poor work ethics among the clinical staff. In addition, there was a lack of discipline, a limited sense of accountability or responsibility and a lack of staff dedication. The clinical staff is regulated by professional bodies such as the South African Nursing Council (SANC) for nurses, midwives, and the Health Professionals Council of South Africa (HPCSA) for medical practitioners. Such bodies determine the professional codes of ethics for the respective professions and practitioners are required to behave in accordance with the rules and principles as stated by the profession (Muller, 2009:12). Further, the SANC (2014:3) determines that nurses need to be aware of their own personal values and how it influences their professional conduct. The personal values of the practitioner are expected to be aligned to the ethical principles and values of the profession.

The participants reflected on a change of attitude and the resurgence of professionalism among the nursing staff. The nurses started taking pride in their appearance and adhering to the prescribed dress code. Their professional conduct improved as they seemingly re-

embraced their professional values such as respect, accountability, competence and commitment. The findings further highlighted improved professional behaviour towards colleagues and members of the multi-disciplinary team. Research by Girard, Linton& Besner (2005:1) indicates that an important factor for job satisfaction is an environment, which enables nurses to practice the “philosophical underpinnings” of their profession.

5.2.5.6 Reputation

Research indicate that reputation, meaning how the public, clients, employees and suppliers perceive the organization, is associated with the quality of clinical care. This may then provide some protection against legal action and may help to attract and retain talented professionals (Mira et al., 2013:93). Historically, the CHC had a poor reputation within the community due to the perceived low quality of services as experienced by the patients. These also received regular negative reporting in the media. A few of the participants who were also members of the community recounted personal accounts of negative experiences of poor and inadequate service delivery in the past. Other participants reported that a general feeling of unhappiness and apprehension existed among the patients. Newspaper reports painted a grim picture of care delivery at the CHC. In an article in the Cape Argus dated 2nd of March 2008, patients described their fear of the nursing staff: “I would rather die on the hospital benches than approach them, they are very rude” (Mapoza, 2009:1). Another regular patient informed the same reporter that people allegedly died while waiting, due to the long queues and lack of care. Participants reflected on the perceived change in client perceptions and experiences within the facility due to the concerted efforts to improve service delivery and the patients ‘healthcare experience. It was stated that the number of complaints has decreased and that several compliments were received relating to how the services rendered at the facility has improved. The participants also reported that the patients were now having confidence in the facility. They also reported on compliments and recommendations, which were received from different referral hospitals concerning the quality of care now being provided. Factors such as ethical conduct, sound management and leadership practices, improvement in quality of service delivery and perceptions by patient of safe quality care contributes to a positive reputation (Mira et al. 2013:94)

Further to this, the participants expressed a sense of pride in serving the community and in restoring the image of the facility within the community. In the healthcare environment, the provision of quality care is not the cause of a good reputation. According to Montag (2015), the key to creating a good reputation, client confidence and satisfaction relies on dedicated, accessible, and motivated employees.

OBJECTIVE 2: TO EXPLORE THE TRANSFORMATIONAL CHANGES AS LIVED IN TERMS OF ITS VALUE AND CONTRIBUTION IT HADONTHE PROVISION OF QUALITY HEALTHCARE IN THE UNIT

5.3 QUALITY PATIENT CARE

The Emergency Centre is an unpredictable, high-velocity and critical care environment which involves a complex interaction between staff members in providing and organising patient care (Creswick, Westbrook & Braithwaite 2009:247).

The aim of any healthcare facility is to provide high quality healthcare to patients and the community at large. For many years, a general perception existed among various stakeholders including top management, staff and the community that the CHC was failing to achieve this aim. Hardcastle et al. (2011:190) state that most emergency centres are under-resourced in terms of adequate trained staff and essential medical equipment, which have a direct impact on the standards of care they deliver. Eygelaar and Stellenberg (2010: 2) found that the quality of care is influenced by shortcomings in human resources, professional development, medical supplies and equipment. The then Provincial Minister of Health, Mr T Botha (2013), said at a media briefing “at present, our staff at hospitals is buckling under pressure. Our emergency centres are treating many more patients than they were designed for. The conditions of the patients coming through the doors of the emergency centres are a direct result of the burden of disease, such as inter-personal violence, road traffic accidents, and risk factors of chronic disease” (Fokazi, 2013:2).

The study findings confirmed that high volumes of complaints about poor service delivery and poor patient care were received and reported in the past. The mortality and morbidity rate in the facility was considered high. The facility failed on various accounts to execute the primary health care philosophy and achieve healthcare goals. These perceptions were confirmed by the statements of the participants that clinical practice was poor, and that the conditions were not conducive to deliver proper healthcare, especially emergency care. The participants also reported that patient care standards were low and that negligence during patient care was high. There was a lack of regard and concern for the well-being of the patients.

The participants expressed a lack of knowledge, skills and confidence to deal with major emergencies. Together with the negative attitudes, these led to poor service delivery and an increased mortality and morbidity. The facility was considered unfit for the training of medical and nursing students. There was also an ignorance and reluctance among the staff to

implement good standards of patient care and to adhere to emergency medical protocols. The participants also provided real-life scenarios of the negative experiences of patients of such unsatisfactory conditions endured when seeking health care at this facility. The findings indicated that the community perceived the conduct and behaviour of the clinic staff (nurses and doctors) as unprofessional. The participants suggested that the clinical staff was not visible in the clinical areas, spent most of the time in the tearoom sleeping and displayed total lack of concern and sense of urgency in providing healthcare services.

The new leadership opted for a firm approach to ensure the adherence and execution of the mandate to provide high quality emergency care. They adopted a multipronged approach to improve on and guaranteed better services, positive experiences and outcomes for the patients. A study by Lin et al. (2011:245) found that a leader in the Emergency Centre needs to be both task and employee-oriented to positively affect the Unit's performance and the work satisfaction of employees. A strategic systems approach was adopted to ensure alignment of the structural and process aspects to achieve better outcomes. The outcomes of this approach were viewed positively by the participants who perceived the improvements to be because of a shared vision, ownership, buy-in and teamwork by all categories of staff.

5.3.1 Structural Realities

Equipment and Stock

The participants in this study reported various issues regarding the state of the equipment in the Emergency Centre prior to 2009. They claimed that the equipment was old and not of a good standard, inadequate and not appropriate for the unit. They also experienced a shortage of critical items such as suturing material and that equipment disappeared regularly. The lack of basic and clinical equipment contributed to challenging working conditions and this also influence job satisfaction (Rispel &Chirwa, 2014:10).

A systematic review on the availability of equipment in the Emergency Centres in India shows that essential equipment was not available due challenges with procurement and equipment breakdowns. Interventions were put in place to improve the availability of such essential items. This included improved procurement and stock management and strengthening service contracts and local repair capabilities (Shah et al. 2014:370).

The findings of this study revealed improvements in the quality of the equipment as well as the systems of ordering, maintaining and controlling the equipment. Essential equipment such as cardiac monitors, electronic vital signs monitors, defibrillators, a ventilator and fluid warmer were made available. Employees became more knowledgeable about the

functioning of the equipment and took pride in keeping the equipment in good working order. Specific staff members were given the responsibility to ensure the availability of and checking the working order and maintenance of the equipment. Consultation between the manager and the staff regarding the procurement of equipment and new equipment took place and were ordered accordingly.

Consumable Stock

Participants experienced a lack of a proper system for ordering supplies and to control medical consumable stock. There were also several challenges with the central supply chain management system (SCM). A lack of knowledge and sense of urgency within the procurement system about critical items required by the Emergency Centre was perceived. At the facility level, the staff did not take the responsibility to order the essential consumables like oxygen masks, bandages, needles etc. This led to regular stock shortages and nobody was considered accountable.

Interventions were put in place to improve the system of stock management and control. For example, weekly ordering, monitoring of stock usage and stock shortages. The storeroom was rearranged to improve accessibility and availability of consumable stock. Senior staff members were charged with the responsibility of the weekly ordering of stock from the main store. Minimum and maximum levels were determined with the implementation of weekly audits of supply chain matters. Participants however, indicated that there were still some challenges within the supply chain system at the central level.

The availability of essential equipment and medical consumables contribute to the ability of the clinicians to provide safer and quality emergency care. The participants appreciated the improvement in the availability of consumable stock. Results from a study in Ghana confirms that the availability of essential equipment and medical consumables is required to improve the quality of patient care in Emergency Centres (Kennedy et al., 2015:36).

Structural Lay out of the Unit

The Australian College of Emergency Care (2014:5) states that the design of emergency departments needs to be practical and reflect how health professionals manage and treat the patients. It should take into consideration factors such as space, the interaction of staff, patients and relatives and flow of clinical care. In addition, it needs to allow for re-arrangement of clinical areas to match future needs.

Participants indicated that structural changes to the layout of the unit such as demarcated areas for the management of asthma, trauma cases, medical emergencies and a dedicated resuscitation area were more practical and user friendly. Each of these areas was equipped with the relevant equipment and stock for the assessment and management of the specific conditions. The designated area is also available for triage. A box system was introduced where patients' folders were placed after being triaged and arranged according to the triaged priority. This was considered to make the flow and management of the patient more practical.

5.3.2 Process Realities

The study results revealed a dismal situation in the delivery of patient care, which was marked by patient neglect, lack of concern and a limited sense of urgency, as well as high mortality rates. Trauma is the second highest cause of death in South Africa and it is critical to reduce the overall rate of trauma emergencies and to improve the medical care of such victims (Wallis, 2011:171)

Triage System

The findings confirmed that prior to the transformational change process, the SA Triage System was not adhered to and the sorting of patients was inadequate and patients were not prioritised according to their acuity. This resulted in delays in the treatment of patients with life-threatening conditions. However, this system was corrected and patients are now assessed and treated according to their acuity and those with life-threatening conditions receive priority. Gottschalk (2004:325) describes the characteristic of an ideal triage system to include being able to quickly assess many patients, identify patients with life threatening conditions, and determine appropriate treatment fit for medical and trauma cases and reduce waiting times. This requires minimal training. The use of a triage system with clinical discriminators has contributed to reduction in health expenditure, improvement of quality care and a reduction in waiting time (Dos Santos et al., 2013:6). A triage training task team was established at the CHC, consisting of a medical officer and two specialists trained nurses was made responsible for the training of all the staff as well as the quality assurance of such processes.

Co-ordinating Resuscitations

A system was developed to improve the resuscitation of the critically ill or injured patient. This was based on teamwork and each person having a definite role and responsibilities during the resuscitation process. Regular team training and simulations were scheduled in

the Unit. A study by Capella et al. (2010:439) confirms that structured trauma resuscitation team training supplemented by patient simulation exercises improves team performance and results in better patient outcomes. Staff confidence and attitudes improved through training.

Subsequently, the findings of the 2016 focus group revealed that a resuscitation committee was established. The terms of reference of the committee are to ensure that the resuscitation capacity throughout the facility is up to standard in terms of equipment, CPR training and current protocols. The committee is further responsible for the auditing and quality assurance of resuscitation quality.

Clinical Governance

Clinical governance is a system of accountability for quality improvement and the safeguarding of high standards of care to create an environment towards excellence in clinical care (Scally & Donaldson, 2013:1). Communication between the doctors and the nursing staff improved and a platform was created to discuss matters of clinical governance as well as to encourage team learning.

Processes to achieve buy-in and ownership of the staff members led to the restoration of professionalism, responsibility and commitment. This gave rise to the improvement of patient management systems, patient assessments and review, recordkeeping and resulted in improved patient care outcomes. It is now experienced that patient care standards are very high, patient education takes place and teamwork has improved.

The delivery of high quality care in the trauma and emergency department depend as much on the leadership skills of the medical staff as the nursing staff, thus, mechanisms need to be in place ensure that everyone is part of effective clinical audits and platforms for open communication between the teams (Scully & Donaldson,2013:4).

The findings confirm that a Quality Assurance Committee was established at the facility that follows the national guidelines and objectives, which concentrate, on all aspects of ensuring patient, staff and technical quality. In addition, that Mortality and Morbidity (M&M) reviews supported by folders audits, six monthly triage audits and reviews of the resuscitation cases were done. The results confirmed that through the monitoring and evaluation processes, there were major improvements in clinical care, record keeping and continuity of care.

The findings illustrate that the participants positively experienced and perceived the regular M & M reviews as a good yardstick for assessing the standards of patient care provided and as a platform for learning and initiating improvement strategies. They felt that taking learning

points from each review led to an upturn in patient care standards and expansion in critical problematic areas or deficiencies such as record keeping and documentation and systematic management of the patient. It also provides empirical evidence of how mortality rate has decreased, indicating that the patients have better chances of survival and improved quality of life. The participants also credited the improvement in the team relations, role clarification and better communication as factors, which contributed to improved quality of care provided.

The participants were of the opinion that the focus of complaints by patients shifted from poor clinical care and service delivery to long waiting times, staff attitudes and issues related to environmental hygiene. Results from the WDOH complaints hotline in 2013 proved that out of the 1728 complaints received sixty four percent was about waiting times and twenty eight percent related to staff attitude (Fokazi, 2013: 2).It is also known that the facility is receiving compliments about the changes and the improvements from patients as well as from other health facilities.

5.3.3 Outcomes Realities

The researcher is of the opinion that the key drivers to improve and maintain high quality patient-centred care is having a shared vision to improve the standards and practice through competent leadership, a capacitated workforce, good clinical governance and the availability of the necessary technical resources. The study revealed that the nursing and medical leadership in working together reached a common understanding of what is required to achieve this. Workforce capacity and competencies were enhanced through training and development.

Various studies emphasise that adequate training of all the members of the emergency care team is important for the success in quality care of the emergency patient (Kennedy et al. 2015 & Martel et al. 2014). The results confirmed that six professional nurses qualified as emergency nurse specialists since 2008. This proved to have had a direct positive impact on the improvement of emergency care standards and nursing governance. According to Curtis and Crouch (2014:1), research evidence confirms that emergency nurse specialists contribute to the improvement in quality of care, reduction of complications and length of in-hospital stay. Various formal and informal learning takes place through the skills development programme. The participants revealed how they have benefitted from the teaching sessions. They said it has increased their confidence, motivated them and are they are skilled to deal with the patients' care needs and challenges in the Emergency Centre.

In summary, the overall standards of quality emergency care improved in the Unit through the adoption of a shared vision, team learning, quality improvement initiatives and improved clinical governance. Wallis (2011:171) posits that “South Africa has islands of trauma care excellence in a sea of otherwise poorly planned, poorly co-ordinated, poorly resourced services.” The optimal functioning and provision of quality emergency care require well trained, highly skilled staff, adequate medical supplies and compliance with minimum equipment standards coupled with a multi-disciplinary team approach in patient management (Hardcastle et al. 2016:179).

5.4 RECOMMENDATIONS

5.4.1 Administration

5.4.1.1 Critical Resources

Emergency care at PHC level is often seen as a low priority, yet trauma is a major burden of disease. The acuity of patients at emergency centres range from minor to life threatening emergencies. It is, therefore, important that Emergency Centres are adequately resourced with specialist trained staff, appropriate equipment and sufficient medical supplies to address community needs. The recommendation includes improvement in procurement systems and supply chain operations.

5.4.2 Practice

5.4.2.1 Leadership development

There is strong evidence for the value and role of visionary leadership in leading and navigating change within the organisation. The study supports the shift to a new leadership paradigm, which is based on value-driven principles, integrity, passion and vision. It is thus recommended that healthcare organisations need to facilitate the development of leadership skills at all levels within the organisation through formal programmes to equip leaders to manage change and challenges effectively.

It is further recommended that the transformational leadership skills and emotional IQ of management applicants should be assessed during the recruitment and selection process.

5.4.2.2 Inter-professional Team approach.

Improved teamwork and team relationships contributed positively to the improvement in patient care, working conditions and job satisfaction at CHC. Managers need to foster inter-professional team relationships and functioning.

Strategies to enhance team functioning is needed for example the development of appropriate policies, the orientation of new members into the team context, enhancing team collaboration through leadership and role clarification for each member of the team.

5.4.2.3 Discipline

A gap has been identified in the knowledge and skills of the managers regarding maintaining good discipline. A lack of knowledge about the disciplinary code and procedures existed and there appears to be reluctance among managers to take disciplinary action. Managers need to be skilled in the disciplinary process and apply discipline consistently.

5.4.2.4 Positive practice Environment

Staff Wellness Initiatives

It is important to include a formal system of regular psycho-socio-emotional debriefing sessions and resilience training for emergency centre staff as a staff wellness initiative.

Safety and Security

Staff safety must be taken seriously and stringent security measures needs to be in place to counteract the physical and psychological threats that the healthcare staff is exposed to daily.

Rewards and Recognition

Research indicates a possible correlation between job satisfaction, motivation, productivity and performance. It is therefore recommended that systems of formal and informal rewards and recognition form part of the organizational culture.

5.4.3 Teaching and Learning

5.4.3.1 Mentoring and Coaching

Formal and/or informal mentoring and coaching is found to be beneficial in ensuring continuous capacity building and empowerment and should thus form part of the individual development plan of employees at all levels.

5.5 NEED FOR FURTHER RESEARCH

The focus and findings of the study were relatively broad – it may be of value to focus on or zoom in on specific matters, for example, discipline within such a context, maintaining a positive practice environment and the uniqueness of teaching and learning in such a fast-paced environment.

A second critical area of research relates to the patient or recipient of care and their significant others. Although the staff expressed some instances of such feedback, the voice of the patient and their significant others needs to be sought and heard in a systematic manner.

Leadership within the emergency care context is complex and requires unique skills. Research into what makes a good leader in such a context would be interesting. Is it truly different from what is needed in other complex settings of healthcare?

5.6 LIMITATIONS OF THE STUDY

The study was done on a micro-level in a very specific setting with a unique history. It may thus not be representative of the broader emergency care landscape within the DOH and in the Western Cape. The study also used a qualitative research design following a descriptive phenomenological methodology – generalising very limited, if not impossible.

Although the focus of the study was to explore the experiences and perspectives of the participants with regard to changes that took place through the implementation of a transformational change process, a limitation to the study could be related to the fact that the researcher was instrumental to and part of the transformation and change process. This could have introduced some researcher bias. In addition, because the researcher is a senior member of the Emergency Centre where the study took place and the participants knew that the research project was conducted by her, it could have introduced some respondent bias.

Mechanisms were put in place to minimise such influences to maintain the integrity and

Objectivity of the study. For example, the use of an external fieldworker to conduct the interviews and facilitate the focus group discussions. A co-researcher was introduced to independently co-analyse the data. A follow-up focus group was conducted by another experienced researcher to explore and confirm findings.

Data collection was done twice – the initial and main collection followed by a later focus group where several of the original participants took part. Although congruency was clear from the findings, it is not possible to deduce all such similarities from the initial transformation processes enacted. Other factors such as policy changes, staff movement, new interventions and so forth could have also played a role.

This study did not seek the experiences and views of patients. Here and there, participants referred to such experiences as communicated or overheard. These, however, remained secondary sources. If one accepts the recipients of care critical in such research, then further studies to obtain such insight is considered important.

5.7 CONCLUSION

The study highlighted the need for and value of a radical transformational process in an Emergency Centre where poor practices and quality of care was evident and publicly known. The transformation process required vision, staff commitment, teamwork, teaching and learning initiatives, clearly communicated standards of care and the application of human resource management principles. The willingness of the employees to buy-in and take ownership for the change process contributed largely to the successful turnaround of the Unit.

Barret (2010:7) states that the adoption of a new leadership paradigm can facilitate the evolution of the organisation, of leadership itself and of teams through a journey of personal mastery, internal and external cohesion. These principles are considered important in the micro and macro spheres (such as global) of leadership crises.

This study underlines the value of a committed and visionary leadership team and the implementation of transformational team development, cohesion and other practices to turn around a service and healthcare in peril –the experiences of staff in this process being largely appreciative and positive. The voice, work and experiences as related to the study belong to the participants and the researcher as passionate nurses, managers of care and human beings – in the words of van Manen (1990: 35):

"*A lived experience does not confront me as something perceived or represented; it is not given to me, but the reality of lived experience is there-for-me because I have a reflexive awareness of it because I possess it immediately as belonging to me in some sense. Only in thought does it become objective".*

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APPENDICES

APPENDIX 1: ETHICAL APPROVAL FROM STELLENBOSCH UNIVERSITY

Ethics Letter

25-Apr-2016

Ethics Reference #: S12/05/116
Title: The experiences and perceptions of the clinical staff about transformational change management at an emergency centre.

Dear Miss Shahnaz Adams,

The following progress report was reviewed through an expedited process and approved on 25 April 2016:

Progress Report dated 01 April 2016

The approval of this project is extended for a further year.

Approval date: 25 April 2016

Expiry date: 24 April 2017

If you have any queries or need further help, please contact the REC Office .

Sincerely,

REC Coordinator
Francis Masiye
Health Research Ethics Committee 2

If you have any questions or need further help, please contact the REC office at 0219389657.

Included Documents:
Synopsis
Protocol
Consent Form
Checklist
Application Form
Investigators Cv

Sincerely,

Franklin Weber
REC Coordinator

Appendix 2: Permission obtained from institutions /department of health

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
healthres@pgwc.gov.za
tel: +27 21 483 9907; fax: +27 21 483 9895
1st Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RP 105/2012
ENQUIRIES: Dr Sikhumbuzo Mabunda

17 Ashtown Street
Oakdale
Bellville
7530

For attention: Ms S Adams

Re: The Experiences And Perceptions of Clinical Staff About Transformational Change Management At An Emergency Centre.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries.

Gugulethu CHC	**Dr K Murie**	**(021) 460 9100**

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 report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (healthres@pgwc.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

DR NT Naledi
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 7/8/2012

APPENDIX 3: PARTICIPANT INFORMATION LEAFLET AND DECLARATION OF CONSENT BY PARTICIPANT AND INVESTIGATOR

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

THE EXPERIENCES AND PERCEPTIONS OF CLINICAL STAFF ABOUT TRANSFORMATIONAL CHANGE MANAGEMENT AT AN EMERGENCY CENTRE.

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR: Ms Shahnaz Adams

ADDRESS: 17 Ashtown Street, Oakdale, Bellville, 7530

CONTACT NUMBER: 0824961582

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

This study has been approved by the Health Research Ethics Committee (HREC) 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.

What is this research study all about?

The study will be conducted at CHC. Ten participants will be selected for individual interviews and six to seven participants will be selected to form a focus group.

The study aims to gather your experiences and perceptions regarding the transformational changes management approach that was used to bring about changes in the Emergency Centre.

Individual interviews will be conducted with 10 participants by a fieldworker and 6-7 participants will be interviewed in a focus group.

You were purposely selected for this study in order to explore your perceptions and experiences in the Emergency Centre while working there.

Why have you been invited to participate?

All the participants taking part in this study were involved with the unit during the transformational change management process and contributed to the process in one way or another. You have first-hand experience and knowledge about the transformation which took place in the unit.

What will your responsibilities be?

As participant your responsibilities will be arrange a venue and time which will suite both you and the fieldworker. The fieldworker will ask you questions related to your experiences in the unit and you have to answer the questions honestly.

Will you benefit from taking part in this research?

The participants will benefit indirectly through contributing to research outcomes which will ensure:

- Further improvements in the unit,
- Improvements in quality of care and in assisting
- To identify aspects which will lead to creating a better work environment?

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

- No risks involved in this study.
- If you do not agree to take part, what alternatives do you have?
- There are no alternatives involved in this project. Either you take part or you don't take part.
- Who will have access to your medical records?
- No medical records are required.

- The information will be collected by means of a tape recorder. This information will be treated as confidential and protected. If it is used in publication or thesis the identity of the participants will remain anonymous.

The participants are ensured of confidentiality and anonymity. Only field worker will have access to the identity of participants. No names will be used in the findings and research reports. Participants will be identified by a different number.

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

You will only be involved in an interview with no potential risk of injury or harm.

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

There will be no financial benefit for taking part in the study. There is also no cost involved. To you if you do take part in the study.

Is there anything else that you should know or do?

You can contact:

1. Dr E.L. Stellenberg on 021- 938 9036 if you have any further concerns or problems

2. The Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by the researcher.

You will receive a copy of this information and consent form for your own records.

Declaration by participant

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

I declare that:

I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

I have had a chance to ask questions and all my questions have been adequately answered.

I understand that taking part in this study is voluntary and I have not been pressurised to take part.

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

I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…….. On (*date*) ……..…….. 2009.

Signature of participant Signature of witness

.....…….. .....……..

Declaration by 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

I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) .....…….. On (*date*) ……..…….. 2009.

Signature of investigator Signature of witness

.....…….. .....……..

Declaration by interpreter

I *(name)* ……..…… declare that:

I assisted the investigator (*name*) …….. to explain the information in this document to (*name of participant*) ……..…….. Using the language medium of Afrikaans / Xhosa.

We encouraged him/her to ask questions and took adequate time to answer them.

I conveyed a factually correct version of what was related to me.

I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

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

Signature of interpreter

.....…….....……..

Signature of witness

.....…….....……..

APPENDIX 4: INSTRUMENT / INTERVIEW GUIDE / DATA EXTRACTION FORMS

INSTRUMENTATION

GUIDELINES FOR QUESTIONS TO ASK INDIVIDUAL PARTICIPANTS

You have been working/involved in the Emergency Centre between January 2009 to December 2011 .The unit and the facility has gone through significant changes over the last four years.

1. Could you reflect on the changes you have observed and share your experiences giving some examples?

2. Please give some examples of how you experienced these changes and what it meant for you?

3. Reflecting on the areas below, could you describe the changes that happened, how you experienced them and what meaning it holds for you.

3.1 Human Resource management

3.2. Teamwork

3.3. Employee Wellbeing

3.4. Working Environment

3.5. Other critical resources such as Supply Chain and Equipment.

4. When reflecting on standards and quality of care, how would you describe the changes that took place by giving examples of what you experienced and what it meant to you?

5. Can you describe whether the process changed you or your approach in terms of your mind-set, values and /or feelings about your work?

Probing words which will be used for example:

- **Client care, values, image, training and development and professionalism**
- **Performance management (SPMS)**
- **Leave management and Staff scheduling**
- **Discipline**
- **Salary Issue**
- **Staff Wellness**

INSTRUMENTATION

FOCUS GROUP DISCUSSION

GUIDELINES FOR QUESTIONS

You have taken part in the initial research project in 2012 about your experiences and perceptions regarding the transformational change process in the unit between 2009 and 2012. In an effort to clarify and valid the research findings we would like you to reflect on your experiences and perceptions regarding the conditions in the unit since 2012.

4. Please relate your experience and perceptions about the change process in the unit since 2012.

5. Reflecting on the areas below, how in your experience would you describe the current situation regarding:

    - Critical Resources
    - Human resources
    - Quality Improvement
    - Work Environment
    - Leadership
    - Communication
    - Standards of Care
    - Interpersonal Relationship (Teamwork)
    - Communication
    - Empowerment and Capacity Building (Teaching and Learning)
    - Reputation.

6. Please give some examples of whether you experience further changes and what it meant for you

7. Can you relate to me what impact has being part of this change process had on your professional development?

APPENDIX 5: EXTRACT OF TRANSCRIBED INTERVIEW

4th Interview: Participant 3

Fieldworker: Good Afternoon, I am Sr. Tiki

Participant 3: Hi Sr.

Fieldworker: Yes, I'm the fieldworker for this research. How are you today?

Participant 3 I'm well thank you, thank you for asking and you?

Fieldworker: Okay, I'm fine today. So I see you have signed you completed your consent form which is here and what I would like to inform you about, even if you know, there will be a confidentiality here and also a privacy, there will be no names that will be mentioned, you'll be the Participant 3, so there will be no names and also the recording will be destroyed after the transcriptions have been typed and then the transcription will come to you and then you will view it. If ever it's what you have said, and you want to add anything on it.

Participant 3: Okay.

Fieldworker: Yes, also you've got a right to opt out if you want to. Yes those are our ethics. So, now I do have the…my questions like the guideline questions that I would like to get it from you concerning with the experiences and also the perception in the Transformational Change Management in facility or in the Emergency Centre, as a clinical staff which I think you were also involved in it. Can you just share with me your experiences and also perceptions of the Transformational Change Management in the Unit.

Participant 3: I will first share with you my experience, when I came to this facility, it was first as an Intern in 2009, and conditions was very bad then. A lot of the same staff that we have here today were employed then, the patient numbers were the same, the staff complement were the same but there was something was missing and the patients weren't happy, the doctors weren't happy, the work ethic wasn't good here in this facility. Then things reached a critical point, where the unhappiness just couldn't be tolerated any longer. And a decision was made to bring in some new people after that point had been reached.

Fieldworker: What was happening actually before?

Participant 3: Patients would wait outside the doctors' rooms from early morning till as late as 2 o'clock, while the pile of folders would remain and patients wouldn't be see. They became very angry; the patients would frequently toi-toi. This co-incided with the

Xenophobic attacks in Cape Town. Some of the staff working here weren't South African. Patients were taking out their anger about the poor service delivery while mixing up emotions about xenophobia, which made the situation even worse. The Trauma Unit was not in a good state. My first experience of the Trauma Unit when I, as an Intern, having just started my rotation here was left, unsupervised in the Unit when a patient came in that needed to be resuscitated. The Patient eventually died in my care. The matter was reported and that set many things in motion: The interns were withdrawn from CHC by the HPCSA. That's just one example of how severe things were. There was drunkenness on duty. People would complain about being beaten with a mop by staff. The facility was frequently in the newspapers. There were problems throughout the CHC.

However, it wasn't all bad. There were those who were trying very hard to deliver good service, but it's these very bad stories, unfortunately, that would overshadow those good efforts.

So then, when I was an intern then, they asked for the Interns to be withdrawn from CHC, it was too bad to be teaching young Health Professionals about…. in such a setting. And, then District and Sub-District Management made a decision to strengthen the complement of staff and to bring different staff categories and particular individuals to the CHC. They introduced Family Physician, a Trauma Unit Manager, additional Community Service Officers and also additional the nursing staff. These categories of staff allowed for more structured skills-mix, line-management, clinical governance and leadership. .

Only then, things started to improve. At the end of our Internship, a group of five interns then applied to come back to the facility and try a collective effort to try to make things better. It was a multi-prong approach: There was some support for from Management to say that we would not be on our own if we came back as a Cosmos.

, you'll have other support. So that was, Ja, there were new people there, However this was not the first time that there was an effort to turn things around at this facility, I think about a year prior to that, there was a turn-around strategy, which was well documented, but failed. There was a long-standing strong desire to change things, but there was something missing for that is to be successful. It wasn't just a matter of needing more people. It needed something special. It needed strong leadership. It needed a vision, and it needed strong will to achieve that vision. There were a lot of efforts from different directions: from the OPD, from the Club, but the strongest change came from the Trauma Unit. Because that was the most resource intensive area: there's always staff on duty there 24/7. The Trauma Unit was and still is actually regarded as a Safe Haven in the broader community. Where things go

wrong in families, when they go wrong in the Community, even though Apartheid, it was a safe haven for the people. Retired sisters will testify to how the Trauma Unit staff had to mop up the blood of people, and how the Trauma Unit staff had to provide safety to people, how the Trauma staff had to help people with personal problems. Because the Trauma unit had the capacity to have the biggest impact on the Community, it was (and still is) the area where improvements would be most palpable and visibly recognized.

So, the changes that happened in the Trauma Unit probably made the most impact and inherently gained sufficient momentum to sustain the other changes happening in CHC.

Do you just want to repeat your question again so that I can check.

Fieldworker: It was the experiences and also your perceptions on the Transformational Change Management, ja.

Participant 3: Yes, so in terms of my perception, there was definitely something extraordinary that happened, and went beyond the documented records of just the staff component, or the strategy, those minutes of meetings. Something more than that happened. And, there was…I think there was something spiritual that also happened in this facility, because people rediscovered hope in the process of caring for patients.

Previously, staff was very demotivated before and they lost a lot of their pride in how to care for patients because it was just all these bad things happening and it seems like if the good efforts went unnoticed. Staff felt that making an effort was not worth it,

But when transformation happened, through good leadership, drive and vision. Staff quietly realized that there was sufficient momentum for the facility to move forward. Staff started to trust line management and could begin the process of healing their own wounds.

Staff started taking pride in their appearance, wearing uniform etc. Previously you couldn't tell who was a cleaner, who was a clerk, who was a nurse, who was a doctor, who was a patient; you didn't know who was who. Patients could have thought that they were being treated by anyone off the street. There wasn't pride.

But that was restored in by the visionary leadership.

The club patients are the ideal cohort to testify to the changes that occurred at the facility.. My experience with Club was initially unpleasant because I perceived the patients to be a rather miserable bunch of people. But after the transformation of this facility, I looked forward to seeing Club patients, as there was happiness. The quality of care improved. The respect

towards the patients and the two-way relationships had improved so much. It became a joy today to work in this facility.

Fieldworker: So Doc, how do you view now this change. Is there any impact on the patient's care standard, equipment, supply and Supply Chains and I will give patient care standard, how do you view now, is there any impact equipment, Supply Chain, Human Resource Management. How it now, Employee Wellbeing, while you were here, and also the teamwork.

Participant 3: If we look at the folder audits were being performed objectively by outsiders, one can see that there has been improvement in our HAST audits here in the clinic, as well as our Chronic Disease Audits. There it is documented and you can see evidence of the improvement in quality of care.

But, also you can experience the change in the softer measures of quality: In the relationships with patients, which is very instrumental to patients' perception of care. That has also improved. I can only give a subjective account of that improvement. As I said earlier, just gauging the happiness of the patients, and their satisfaction with the care, and how they related to staff also improved.

Fieldworker: Not interrupting you, if every there is any incident that you can remember, you can tell me. You can just….

Participant 3: I will…I mean….

Fieldworker…related to what is happening and then.

Participant 3: I recall patients that I treated For example a particular elderly man in an electrical wheelchair, who was a great patriarch in his family and was very respected in the community. No matter what time he arrived, he would always be seen first. The patients would organize themselves so that he would be the first one seen. There was a profound level of respect for him among patients and staff.

When we started our community service, he was rather vocal and disgruntled with having to wait long in spite of being the first on the list of patients to be seen. He was unhappy with the attitude with which he was told to wait.

But as time went by, and in spite of the rotation of doctors and CNP's, he noticed the change in the staff. He could see the change in the staff as they made confident eye contact with one another, and with him. I think he saw the improvement, the rediscovered pride in the

facility. He, in turn, extended himself toward becoming more understanding of the times when he needs to wait to be seen. Where there's something more urgent, he's a lot more accommodating and understanding and also started then adopting the pride of the staff and would then start referring to the staff as *my* nurse, *my* sister and *my* doctor. Very joyfully he would take their hands as if to say, "This is where I belong. You are my health care worker." There was trust.

Fieldworker: I accept you….

Participant 3: Trust that was established. And he'd since passed on, just before we left. His family would still talk about how he valued the changes in the system, how he valued the improvement, you know, in his late years of having, you know It's not nice if you're sick and you're old and having poor quality of care, and that in his late life, there was an improvement, and that not just for him but also for his wife, who was also sick and could also then benefit from the improvements at the facility. So, that's one story of a patient and a family who can testify about to the changes at the CHC. I won't mention his name…

Fieldworker: Of course….

Participant 3: Ja that was a good story of how the changes here impacted on patients. The quality of care in terms of the equipment also improved. You previous had to resuscitate patients without endotracheal tubes, without support staff, you know what was going on. The available IV fluids were all wrong. You'd only have dextrose available for an IV line. It was very frustrating. The staff competency was also limited and people were second guessing themselves. Even worse than competency being limited was that staff's confidence was very low. And people would do the wrong thing and be afraid to try to resuscitate…nobody would go into the resus area. Staff was afraid to go to the resus for fear of being shouted at, for doing the wrong thing…

Fieldworker: Shame man….

Participant 3: So then it's just you and maybe one of the experienced sisters that were a little more confident who would be part of the resus while the rest would stand back. Not because they didn't care about the patient, but because of their woundedness. It overshadowed perspective and staff couldn't really come to terms with the value of "the patient comes first". That value was out of the door. There was too much damage done for people to understand what that meant. The old saying "you need to love yourself before you can love anybody else", was really the case back then.

After this transformation, when people started believing in themselves, when people started having pride, staff would sign up then to go for the courses. The trollies would get checked to ensure that the correct equipment was available on the resus trollies and they would order more equipment in time. The Supply Chain has always been a problem in all settings due to the tight central control and red tape.

Fieldworker: Yes, of course….

Participant 3: But the challenge in this setting was that one had to anticipate when would have a stock-out. You need to order before the time and staff didn't have that vision, of or that foresight to understand that "I'm using my last two adrenalins now, or I am on my last box. I need to order because it's going to take a week for it to get here." There were just too many other things that distracted staff from these very important processes. Staff were going to be unhappy in any case, patients were going to be dissatisfied, so no-one saw the point of trying to make a difference.,

But when hope was restored, people started asking for tools, for checklists, to order in advance, buil up relationships with the Supply Chain Manager, with the Management of the facility, to ensure that they don't have a problem because you don't want this problems of stock-outs to overshadow your good efforts. You can provide the best clinical care, but if you don't have the bandages, the suture materials, the drugs, then what are you going to do, you're just going to just going to be telling patients sorry…

Fieldworker…can't do it…Ja…

Participant 3: So that improved. The auxiliary staff, about if there is something wrong, then one can go see one of your colleagues, you don't have to run to another facility. There is a culture that has been created here by the Facility Management that we don't talk out and about one another's personal things. The only time we talk is when Staff Wellness, a few programs have been launched. There is an understanding between staff; the clinical and we are concerned if somebody is clearly unwell, or when somebody's in need of help. Then this staff will mobilize to try and assist that person and if necessary, respect need for if a staff member needs to get help elsewhere as well. Ja, it's very resourceful here, there's absolutely no need for staff or staff's family to be at the bottom of having access to health.

Team work is something that we talk about easily; it's not easy working in a team. It's nice to just say we must do teamwork, but you'll always have somebody that knows more, somebody that thinks they know more, somebody who's not as enthusiastic as the rest of the people, and that is true for all settings. But what's very unique here in this facility, is that

there is a desire to hold onto the hope and the dignity that have been regained, you don't voice your frustration around issues of those imbalances in the teams, and you help one another along, you encourage and motivate, so it's very constructive, because you can't jeopardize. We can't go back to what it was like before, it's not an option. You do what you need to do to get the job done, and you work with who you need to work to get it done.

Fieldworker: So how is it now at least?

Participant 3: Much better now. People pull their weight…now and then there would be an incident of ill-discipline or absenteeism.

Fieldworker…so it's not only for doctors?

Participant 3: No, incidents would arise, but it wouldn't lead to a a catastrophe, and it would heal over, and we will do better next time because we can't lose what we have gained, so we're not on the brink of anything falling apart. Or anything, it's of improvement and quality check, like quality improvement cycle that's ongoing. Staff can now put the incidents into perspective without the fear of having the quality of working environment compromised.

Fieldworker: Okay, while you were here, how did you keep this teamwork going? What activities were you doing just to keep that teamwork going?

Participant 3: Teamwork can't function without the leadership and the vision. And when the main role players in Leadership, the Management of the facility and of the Trauma Unit couldn't be around at all times, like at night and after hours, but their standards would be well adhered to in the unit. Their ethics and how they do things would remain after hours. Staff is not going to allow the strengthened values and commitment to be compromised. So, there was commitment to the improvement and the change in the facility.

Fieldworker: And Human Resource Management, how was….

Participant 3: I think the Human Resources were managed very well. We're always very close to a complete staff complement. So if the post goes vacant, it's advertised timeously and there's a good relationship with the District and the substructure, Substructure visits if…well at least in a transformation period or the period that I was here that I can speak of, would constantly be visiting and being engaging with the needs of the facility and the people and ensure that the appointment of the staff are responsive to those needs. Sometimes you need to shift people around, as is necessary and as the workload demands. And it was a give and take between management at that level, management here at facility level and at the unit level as well. When it came to rosters and moving people and keeping things fair,

good balance between patient needs and staff needs, I think, was handled very well. Is there anything else?

Human recourses are largely controlled centrally, but the operational management is now of such a nature that we can retain staff for longer. Operational managers are very fair with rosters and shifts.

Fieldworker: Anything that you can tell me in concerning with the Human Resources, how it was maybe anything that may be, you know….

Participant 3: I think the management of the leave was very good. We'd never be sitting...you know in some places you'd have around Christmas, those are always the problem then you would sit with a reduced staff complement and there was a good understanding that we can't all go on leave. The roster was fair. Staff could participate in filling the roster with good oversight you know, to just keep an eye on any imbalances. The off duties were well looked after. From the doctor's side, as well we made sure that you had sufficient coverage for the three main components of the Clinic: for Trauma and for the Club, for the OPD. There was seldom a problem.

Fieldworker: Even before or you said at least now?

Participant 3: Now there isn't a problem, before…before and as I told you in my first account, when there was nobody in the Trauma Unit, because there could be multiple of staff on leave, or training and there would be gaps on the roster and overuse of locum / agency staff.

You needed a core group of people to continue service delivery and people put their own needs above those of the clinic and of the patients which was not on. That changed and improved.

Fieldworker: While you were here, how was the staff performance? There are those things now, SPMS, and so on…do they according to their scope of practice, do they do it, is it transparent, or …..

Participant 3: I wasn't very involved in that except in assisting some staff in providing evidence for their achievement above, and the system has also changed in the meantime. Where before people write lots of reports and then it moved to a system of an outcomes based appraisal. You had to provide evidence in a different way. SPMS is not applied very well in many settings. This can become a dangerous thing that fragments the staff. They want to know who got bonus, who didn't and then it leads to a lot of unhappiness and in-

fighting. But, I think over here it has been fair, and transparent. The performance agreement is done early, and you had to provide the evidence, if you don't provide the evidence then well, sorry, even if you are very hardworking and so this was our agreement, and there isn't favouritism, you know the dinosaur that came to the fall, it worked quite well.

Fieldworker: Wow. Can you tell to me your experiences and perceptions according to your visionary leadership approach related to you?

Participant 3: My approach to visionary leadership?

Fieldworker: Yes.

Candidate 4: Relating to this facility here now?

Fieldworker: Yes.

Participant 3: I think I've learned a lot. I had no idea about vision, values and leadership before I came to this facility. I think I came from a background of leadership but that was more focused towards processes, knowing what needs to be done, but not really with a clear understanding of where it is we are going, we do need to go on a journey, but we don't know where to? I used to think that leadership was about telling people what to do. That is where I came from when I started. And I think here I'd learned about true leadership here, especially from those who were instrumental in the change. I started to understand what it means to see the end goal and just to intuitively know what is important and what is not that important.

I learnt how to walk with my team rather than tell the team where to walk.

So when things went wrong, when you are having a very bad day or just having a bad time, one could for yourself and for your team members, and other people that you are working with, keep an eye on the goal post. It's something that developed and emerged here. Visionary leadership was something new for me, It was a privilege to see it in action and experience the process of Transformation.

I think that it was instrumental in my capacity now today that I have got a new leadership style and a new understanding of how to work with people and a new way of dealing and interacting with colleagues and with other people of the care team.

Fieldworker: Is this process, this visionary approach facilitated there with the processes of empowering and also any capacity building?

Participant 3: Yes. You lead by example and show people that the difficult challenges can be overcome. Well certainly, if you…when you enter an environment where that is…where it is quite broken, at you start bringing with your message and your style, you walk in there with a belief of that you can change things.

Then you show people that things can be changed and then furthermore, you sustain the change. You not only give people hope, but you teach people that it is possible and you plant the seed in people's minds that you know what, if somebody else can do it, then, so can I.

Fieldworker: So you did see that happen?

Participant 3: And there were other initiatives, and other leaders also emerged, our health promoter emerge as a very strong leader in the community during a time when she was going through difficult things at home, family that was unwell, but then started doing challenging tasks of getting the community to march for wellness, to toi-toi for health,

She gave hope that we can sustain the change that we can do better and they decided lets go, let's do it…let me also try to make a change. And we've also had one of the Nursing Cosmos who committed to a project of addressing the early bookings, which was a problem at our MOU. But our Trauma Cosmo Sisters took on the challenge to take to the streets and get the pregnant mothers to book early, and our numbers went up. The Nutrition Component, we had people coming from overseas who came to evaluate the program, there was so much initiative that was taken towards chairing those outcomes that the facility performed quite well in that program. The trauma unit manager took initiative to expand woman's health services to after hours. She designated trauma staff to perform Voluntary HIV Counselling and Testing as well as pap smears and other services.

Our OPD HIV wellness clinic has also got a Sister that sometimes works in Trauma, sometimes in OPD but mainly then in the HIV patients, and she also emerged as a very strong leader in setting standards in quality of care for HIV, ensuring that we would get their pap-smears, ensuring that CD4 counts and quality issues are up to date and getting the necessary stationary. She is well known and respected in the community.

Fieldworker: The one in HIV side?

Participant 3: Yes.

Fieldworker: Okay Emmmm we are about to finish. Can you explain to me whether this transformational change in visional leadership had an impact on the outcomes of quality care

and work environment? We can start with the quality care, just the impact that it has got it, this transformational l change and also this visionary leadership and patient care.

Participant 3: I think I've mentioned some of these things already about patient care of how that improved.

Fieldworker: How is the morbidity and mortality as compared to before in terms of patient…the quality of care now?

Participant 3: Well it's certainly, before, if a patient was in trouble, and you needed to be resuscitated, and you came to the unit before, the chances weren't very good for you here. Now our resuscitation rate is much better, the patients definitely have better outcomes. Before, people would not even bother to try, you know, if there was just too much bleeding, too much trauma people were afraid to get their hopes up with resuscitation efforts. That was a mixture of not knowing how and just being overwhelmed and demoralized in the previous situation. And now there's such an urgency to do your best for this patient, to ensure that the tube is secure, that the catheter is in, that the patient is packaged and that you've logged the patient, you did you secondary survey and everybody is committed to that. Your junior nurses prompt the new doctors, they prompt the senior sisters, the patient is getting cold, can we put another blanket on, those finer aspects, the family is waiting outside, could somebody go and calm the family down, those other things that weren't thought of before, besides doing the right thing giving the right medication, and all of that that's much better now. I mean we've got full stock of drugs and all the things that we need to, we've got clinical guideline charts on the walls and get them laminated. Doctors and nurses reference it to ensure that they are doing the right thing. But beyond that, they also people are working on their relationships, during their relationships there can be the softer side of that quality of care. Maintaining patient dignity and wellness and making patients happy, because now it's rewarding, patients come back and say thank you. It's happening now it was never.

Fieldworker: Yes, someone did mention that.

Participant 3: Yes, patients say thank you.

Fieldworker: There was no thank you before but now there is. Okay, about the work environment?

Participant 3: The work environment has certainly improved and the two go hand in hand. You can put on a lovely smile, you can give good quality care to people, and best of your knowledge, but if it's in an untidy environment, you may still end up with a dissatisfied

patient, Staff no longer wait for the department of public works to fix things. The trauma operational manger would arrange for someone to paint the walls, clean the working area, and ensure there's signage so that patients know where they need to go.

And when staff wears their name tags, they are identifiable and accountable. Keeping the place clean as well, has certainly improved. The floors get cleaned regularly. We have a lot of feet moving through the facility so in winter, it does have challenges, you know as the mud comes in. Before, people just leave it till the end of the day, but now, the floors are cleaned regularly through the day.

Fieldworker: At least it's a compromise now

Participant 3: Yes, and anybody can carry a pan for a patient who needs it., Or pick up litter. And the place looks good now. The staff took initiative to grow a garden in front, in the spring start making flower beds. In certainly, we've got a couple of regular patients that regard this as a second home and you'd see them throughout the day, every day, you see them just walking around the facility. These are "CHC mense".

Fieldworker: Shame man.

Participant 3: Our pride.

Fieldworker: Is there anything that you can tell me about the values, image, because also a little bit about the professionalism, yes of cause you said at least now….

Participant 3: Yes there is professionalism. I think so; I would like to add to, I think, more clearly articulate what that Transformational Change, that leadership of what exactly that is or what it was, I mean I have been touching on it through all the questions. It's really difficult to really explain because there is so much spirituality in there. But from what one can observe from the outside, you know, of somebody that's still learning about transformational changes, that it seems to be approached as it happens, when somebody believes in a better place and better change and a better people, and then commits and does whatever it takes to get there. I think Transformational Change also embodies a lot of bravery; you have to be very brave to take it on because it's not easy. When you see staff who is so despondent and so broken, it's not easy to bare. It sometimes even leads to sub-conscious self-sabotage. We've seen it here where staff will be on last written warnings, and still do the wrong thing: Take a drink. And then one has got to just push through, you can't allow it to destroy everything that you have worked for, destroying the dream and the vision. But the real prize is when those who still believe and try to defend that vision, still extend their compassion and

their caring to the perpetrators who seek to destroy the vision. You can either work against staff out, who don't seem to fit in with what you want, or you can take them along with you. You can show them if they don't understand what it is that you are working towards. You can then show them in the times most vulnerable, when they are in need of your understanding, you can show them the rewards in store for them. Some receive many more chances the rulebook would allow. But just sufficient compassion to get them onto the right path and show them that they are still part of the team and the bigger picture.

Fieldworker: What can you say about professionalism, how is it now?

Participant 3: It has, certainly improved. I think the professionalism is about pride in who you are and pride in your work, and the quality of your work. One can see the improvements, one can feel the way people talk to you that you are valued, that they value you, they are speaking to you as in the same tongue they speak to a patient, so you've value your patient as much as you value your colleague or your senior. And you speak to someone as if you are interested in them and you are proud of who you are. You can talk to people with an open face and that's more than just professionalism, it's a lot more.

Fieldworker: Okay, before you left it here, you have seen this Transformational change happening, how did the process influence your mind set, like the old men were left at his late years which we can say should he rest in peace because he knows that at least I've seen some changes happening where my family or where my generation will attend it. So how did, this Transformational Change has made an impact just in you, in your mind-set, you profession like when you left because you are no longer here.

Participant 3: From my point of view it has taught me that it's worth it, it's worth it to fight; it's worth it to pursue transformation, the rewards great indeed. You can't…once you've seen it and once you've experienced it, you can't go back! And it teaches you to stand behind your beliefs. And to apply it in different aspects of your life. You can even apply it in your personal life, of things that just seem to have been the same going over and over it, you can also apply those lessons that you can make those changes and it's worth it to fight for it, the benefits are all around for anyone to see.

Fieldworker: Is there anything Doc you wanted to add it more?

Participant 3: No….no that's sufficient.

Fieldworker: As I said before, they will come with the transcription to you and then if ever there is anything, when you walk to your car, you went out, no I forgot this thing…

Participant 3: I'm sure we will….yes…

Fieldworker: Then you will just add it on it. Then ja all and all what you said when summarizing, when you come here before this Transformational Change Management, there was no vision, there was no even leadership, or there was leadership but somewhere and somehow….

Participant 3: Leadership without vision.

Fieldworker: O okay….no thank you so much Sir for your time.

Participant 3: Thank you very much.

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Participant 3

8th Interview: Participant 7

Fieldworker: Good morning MY candidate number 7.

Participant 7: Good afternoon.

Fieldworker: Is it good morning? No it's afternoon, wow, good afternoon my dear how are you?

Participant 7: I'm fine and yourself?

Fieldworker: I'm fine thanks. I'm just cold, but it's bit warm here. First of all, I'm the Fieldworker, Sr, I'm doing this interviews for this research which is done by Sr Adams, it's all about the Transformational Change Management that has been taken place in your Emergency Centre, so the first things that I would like to do, is ethics, or ethical rules, everything that you will be hear, will be confidentially and private, and there will be no names that attached on as I called you with your new name, candidate 8. Tape recorder will be destroyed after transcriptions, when I mean transcriptions, all that we are going to saying it here, is going to typed, is gonna come back to you, you read it, if it's what you said, if it is something that you didn't say, you've got a right to say no I didn't say that and then it's opt out and then or else if you said o no, it's okay but there is something that I forgot on that day, then you add it on it. So, this is the purpose of the recorder. All the transcriptions will be destroyed after 5 years. So all in all, our topic is all about Transformation which as you know mos, is to turning a Unit inside and outside, so you do everything in there, so, then the first question that I would like to throw it to you, you will just say whatever you want to say it, it's all about the experiences and also your perceptions of the transformational change in your Unit which is the Emergency Centre at CHC.

Participant 7: Okay…can I start?

Fieldworker: Yes

Participant 7: Okay, I started here at 2007, July, from Private, and I arrived here at the Day Hospital CHC July the 8th. If I can share my experience on my arrival, I would say clinically, okay environmental wise, the conditions weren't really satisfactory. On my first day it was, I remember, it was the day when it was after the weekend and a busy weekend. It was, if I may call it, it was so filthy, and to the extent that if there as new visitor, I felt like turning back. So environmental wise the conditions weren't conducive to my assessment. And then, the staff, my experience as being received, okay, it was good, but what I noticed the attitude

of the staff was so different to what I was used to. In terms to how they communicate to each other, and how they communicate to patients, but basically, that was it when I came. Okay and the things went by because all those things were like affecting the patient care and then staff moral and then the environment itself and the community at large.

If I may touch the patient care, patient care was so poor in the service, the patients were neglected, you would find out there were long queues and the patients weren't attended to on time. And then if you pass the patients would complain and then pass remarks because they felt that we were moving up and down, where we are not addressing them. We were not even explaining and basically the principles of Batho Pele weren't there. And, there were long queues as I said, but there was no system in place on how to attend to the patients, on how to satisfy the patients, ja, so the patient care was really down. The standard actually, the standard of patient care was really down. And what I also noticed, still on the patient care, if there was a lot …it was like most of the days there would be like a death in the Unit, because of the staff, poor attendance to the patient. There was, like no a system where the staff will know if there is an emergency, what to do, and then what is expected of me as the staff, what is expected of me as a doctor. The doctor will be called after some time, there was nothing urgent, like this is a patient, patient is dying, and all that. Or you will find out most of the people would go on tea, and then you find one or two staff member on the floor. And there was no control like tea times, lunch times. Ja, everything was like you do as you pleased, and then going off time if you wanna go off as you pleased, you will just go off.

And also on the scheduled, what I noticed also, there was off duties that were really not suiting the 24 hour, because you will find out there were mostly people go off at 4 p.m., and yet this is a 24 hour unit. And then maybe people that were left on the floor after 16:00 will be one or two sisters, and then ENA, and then that really also affected patient care because if you think about the number of people that are senior, and compared to the number of staff that is allocated then the ratio was really not in it.

Fieldworker: So, as compared to now, when this Transformational Change came in, how are the things now?

Participant 7: Okay, starting with the control, the management, the control of the staff I would say, the staff control for off duties were changed, from 4 o'clock to 7 – 5, and 7 – 7, and the number of the staff allocated after 7, went up to 5. So, it mean that two Registered nurses, one EN and two ENAs. Okay.

And also the Triage system, it was not there, so the patient weren't sorted out as I said the number of people that was there was not enough. So it started then, there was a Triage system, where the patient was sorted out and got into their priorities, and triaged according to their conditions, so at least the patients were attended properly. And the deaths also came down because you would find out that the life of a patient improved by 98 or 90% expected, and life expectancy is about 90%. So and also the tea times, the lunch times, as I said, was not controlled, it was controlled now, it went back to 30 minutes of the tea time and then each time you'd find staff in the Unit.

Fieldworker: No abscondments?

Participant 7: No abscondment here. And the knocking-off time was also monitored. And then the weekends, there were more staff that is allocated on weekends, to cater for the number of patients, about 7 to 8 people for the weekends. Whereas first it was like you have 5 people over weekend, even though it's busy.

And then the staff attitude, those things were addressed, cause now there was the principles of Batho Pele that attended to. Staff was always reprimanded about their attitudes towards the patient, and needed to address the patient, explain to the patients what is expected of them, and whatever you gonna do to that patient, that it was explained. And also, the staff morale improved, because now people were able to share, people were able to ventilate, not just go absent when they've got a problem, there was a line of communication. They knew who to contact, the Operational Manager, if you got a problem, directly. And if I need to go off because there is a problem that cropped up, you know, you know that you need to notify your Operational Manager, not just vanish, like it was. And then each every individual were attended to, like people what affected most, the staff morale was down., In the sense that most of the complaints weren't attended to, most of the problems, people felt like they were neglected, but now this time, the people were attended too.

Fieldworker: Employees wellbeing, the staff wellness, ja…wow

Participant 7: And then, the team work, people were also encouraged to work together., It was like everyone was allocated, delegated to duties, like if you are responsible for the stock, you are responsible for the ordering of equipment and supplies. Each one of us was, you know, every month that you are responsible for this, or for this, and for ordering and all that is to ensure smooth running of the unit.

Fieldworker: Tell me more about your equipment, before this Transformational Change, how was it and how is it now?

Participant 7: Trauma at CHC, before this Transformational was not really up to the standard in the sense that there was no proper equipment to cater for the patients that we see in here. According to the patients that we see, you are supposed to be an Emergency priority 1 Emergency Centre, which means that we need to have the equipment that is really in for the standard like the ventilators. We need to have a monitors for the patients that we see here, And then with all this transformation, the ventilators, Oxilog, we have one and then we've got cardiac monitors to monitor our patients, we've got fluid warmer, because most of the patients that need to be resuscitated, we give them even if they are shocked, we gave them cold fluids which was really not good for the patients, and then so the equipment that was there was not …You would find out there's always complaints from the Tertiary Institutions that are our patients are not really well resuscitated as they arrive there. We as primary service supposed to resuscitate the patient…and sometime the ambubag is not even there and there's not even working, we have to bag, and introducers, nothing, they get lost like no control. You'll find out when the people are resuscitating, they leave the equipment there dirty, nobody is looking after it. And with the transformational you know, after each and every patient, you need to clean, you need to check your trolley, you need to check your equipment if they are function, so that get ready for the next patient. So everything that needs in the Resus, it is there, ne. and we even had the audit from the Red Cross, a doctor who was very happy to see our standard of equipment in our Emergency Centre, ne, with this and we have the proper Emergency Trolley, we have the equipment like ECG, monitors and all that. And then, the standard is really, really improved.

And coming to the Supply Chain, the Supply Chain, you would find out that maybe if the order was done, if it WAS done, it nobody would follow it up, if it came or not.

Fieldworker: Before?

Participant 7: That was before. Now the system is like you order on Tuesday, for the stock and then you get the stock on Friday. And then for the Supply Chain, every month there is an order and then there is a guy who is responsible for ordering. But the Operational Manager does make a follow-up for the stock because without that, then it means that our Unit will be affected if there is no stock, and I must say, things really improved in terms of the Supply Chain. Ja, and then, if not, then we know that it is Jooste that we need to go and check what is happening with the stock, it's not like we leave it there. Cause you find out it was like, if it's ordered in January, the stock would come May, or April, and nobody was following it up before. But now every month there is a follow up on the stock that was done, if the list was in January, then it's a turnover of three weeks and then it's checked, ja, so…

Fieldworker: Jo…one said to me that they use to, if there is nothing, they will say there is nothing…

Participant 7: There's nothing and it ends there…ja. It ends there, it's not like you need to do something about it. Ja, but with this with the management now, you know, either you as the staff member, you know who to contact, you know what to do if there is no stock, and you know by Friday, that everything must be there for the weekend, whoever is responsible, take responsibility, and then if there is no stock, you know you've got resources, you got other Day Hospitals to order, but there is no way that you can just sit there without equipment. And then with the Oxygen supply also, there was a problem because one time when they will say there is no oxygen, there's no oxygen and nobody was following up. We didn't even know who was responsible for checking of oxygen, and then it comes out now the porter is responsible. But it doesn't also end there, the staff that is in Trauma needs to know if the oxygen is there, and the oxygen maintenance and all that. Then it is the duty of the Sr that is in Trauma Unit, to check ja. So now it's not like you just leave it there with the porter or so. Ja. And then, the training of the staff, ja the training of the staff, starting from 2009, most of the staff was trained and I think we are having the third group now that went for Trauma Training, the Trauma Training specialist, so, most of the staff in Trauma now, is Trauma Trained, ja, so that also improved the patient quality.

Fieldworker: Quality Care?

Participant 7: Yes, the quality care because people know what to do, ja, and the patient also they really appreciating even they are still need to wait, because you can never really, but you can see that people come with confidence, people even the staff that is working, they happy because they know now what to do, it's not like you go to work and you don't know what to do.

Fieldworker: Somebody said that at least in our suggestion box, there are compliments, though there will be some, and people come back and say thanks, they can say thank you so much, yes…

Participant 7: Yes, ja.

Fieldworker: Can you tell me more about is there any impact on the HR Management, how does this transformational change has an impact on Human Resource, Human Resource like what you can tell me about the how you conducting the leave, the leaves, the disciplines, Performance Management, what you call SPMS, all that.

Participant 7: I'm going to start with the Performance Management – SPMS, the SPMS most of the people never understood that is it all about. It was written if you may say, who do I favour, it was not really based on the reality. Like you are supposed to assist an individual and all that. But there was no process of doing it. Because they would write end of the year, but not even understanding why am I giving you this score that I am giving but because I know it's who is who I need to give. But it wasn't like there was no system where one is being interviewed and then assessed, and then being told what your weak points are, what are your good points, which are supposed to be done. If I am writing the first quarter, then I know that this is your weak point, you need to improve on this and then for the second quarter, it was not done like that. So now when this Transformational Change came, people would sit and then each and everyone was delegated, if you are RN you would have 3 candidates to assess and then you know that and then the training was given, to those individuals so that they understand what is SPMS all about.

Fieldworker: So all and all, transparency?

Participant 7: Transparency, yes. And how do you go about it, and be realistic, you know what I mean, not allocate a score because who it is, it's because you deserves it, you know what I mean. And also there was also somebody that was arranged to train people, to explain to people about this SPMS, so that also brought a clue, and clear understanding of what it is. Because it use to confuse people and people would fight and feel bad if one gets, gets this SPMS and no, this bonus, knowing very well this person was not performing the way it was said, you get what I mean. So but now people really could see that and then could see that people really deserve what they get is what they deserve. Because also, in the floor, if you notice, people have improved because they want to get the SPMS, they want to be allocated to get the bonus, so their performance also improved gradually, it's like now, I know I also need to get it, it's not like I am sitting there and I know I'm getting it…

Fieldworker: And there is somebody that is assisting me….

Participant 7: There is somebody that is watching me, actually and seeing what is going on. So it's really a challenge and becoming clearer in being understood.

And then in terms of discipline, discipline in terms of there was a problem with alcohol intake at work, ja. And at that time there was no system in place for the discipline. I would do as I am pleased, I'd come on duty and nobody will report me, and if I'm caught, then it ends there, but there was no system like how to go about the discipline. But now, people know

that there is a disciplinary action involved if you are caught drunk on duty, and if you are absent without any reason, there is a discipline involved, on that.

And then the leave how you manage your leave, also, there is a policy in place regarding the management of leaves. So if you know that you don't have days, the you know that you'll have leave without pay or you gonna have to pay the time back. Unlike before, people would have days, even if nobody was checking on that you just sign you leave if you want to, you just sign and you get your days. Nobody was really following up to check with the HR that does you really have the days that you claim to have. But now Shahnaz makes sure that if you say, I request 10 days, make sure that she check with HR do I have this 10 days that I'm claiming to have. And if I'm from the leave or anything from sick leave, I know first day I need to sign my Z1. So that is the system that is on that, and it's really going well. People now are more responsible they know that they cannot just stay at home as they pleased; they know that they must report. And that makes to reduce the absenteeism. Even if it is still there, it is a challenge, but I mean it's really controlled, under control. It's really under control.

Fieldworker: Wow. Any impact on the Employees Wellbeing?

Participant 7: I would say because even if before there was some of the people that were stressed, but nobody would say, would suggest go for ICAS, if you've got a psychologist, or you need counselling as the staff and all that. But I am telling you now, you know very well, she will say ICAS is the best and if you use ICAS. The people know now that they have somebody to cry on, they've got her as an individual to counsel, they've got ICAS to counsel and then also there is a staff doctor for the staff wellness clinic, we've got a doctor there.

Fieldworker: They call it the Care of Cares yesterday.

Participant 7: Ja, so we've got that, we've got that, so we know at least now they care for us. Ja. Which wasn't there before.

Fieldworker: How do you keep your teamwork going like as doctors and nurses and so on?

Participant 7: You know, before there was a vast difference. Doctors would act his or her own way, and then the nurses do their own thing but now if you look at it, it's like the teamwork is intact. Because as a nurse, I know I can suggest, if there is something that doesn't go right with the care of the patient, as done by the doctor or you can see you are not happy, you are able now to call the doctor and say this is what I'm thinking, this is what I suggest. Even during your resus you can you are welcome to suggest, it's not like you fight

about it, and all that. But it's team work, the doctors accept what we say, we accept what they do. And then we delegate, like if you know that you are busy over weekends, doctors also suture, it's not like only the nurses do, because I know for a fact like before, suturing was for the nurses not for the doctors, no doctor will suture. They will just prescribe, so now if it is busy, then we help each other it's not like this is for the nurses only.

And then there is also the meetings, M & M which is a morbidity and mortality meetings every month. I think, first week of the month if I'm not mistaken. Where we get the feedback on the resuscitated cases and the management. Which also does improve our care because now you know o I didn't do well there, so I need to improve, not for to criticize, but to improve our care. So now, and also doctors they in that meetings, doctors also ventilate there if there is something that we didn't do well, they vent., We also voice out what the doctors didn't do, in a way to as a teamwork as to improve the team spirit, ja, not to criticise each other, in a negative way but even if it's in a negative way, but in a way you just take it as constructive criticism.

Fieldworker: So the teamwork is there, really. Okay, about Professionalism, is there anything that you can tell me; yes you did tell me that at least now the staff's attitude…

Participant 7: Ja, the staff attitude, the dress code that was initiated. One of the staff members initiated the colour for the uniform where we can be presentable and then the dress code and then the IDs are there which wasn't there before. You would be treated to as according to Batho Pele, but you were supposed to be treated by the person that has been identified, so that was really something that was checked on. Ja. So now we've got identification cards, we've got and then we make sure that our devices, like if you are a professional nurse, you've got your devices, if you are the Enrolled Nurse you've got your white epaulets so that you can be properly be identified and be presentable.

And then, in terms of how you address people and all that, at least now it's really improved because you wouldn't really call the people like with their ….you would address the patients like with their names, it's not like the patient with that so I think, professional wise we are getting there.

And also we still continue with the Education of the Training, In Service training with all the courses like we had last year we had Patient Care or was it the Customer Care course, ja. Customer Care course that most of the people attended. So that is how to deal with the patients.

Fieldworker: So do you feel the whole approach which is this Transformational Change of Management, it has facilitated is it empowered you guys in the Unit or how do you feel about it?

Participant 7: It has really empowered because now you've got every day you wake up you looking forward to doing something. You always, everyday you've got a challenge if you are somebody who's got a vision, you will really strive to improve. You get to the unit, you've got something to do, you know that every day there must be something that you have done. It's not like you go to work, come back, treat the patient, go home, you know you've got a challenge you've got something. And then it's like today if now I'm on duty, and normally there must be something that I am educating others or addressing my people, my patients. It's not like no education and all that, it's in-service training, ja, so you've got something, every day you're looking forward to your work. So that really has boosted the morale and absenteeism rate is really has decreased because I mean, if you do have something and nothing to look at then really that increases the absenteeism rate.

Fieldworker: I am just going to go back quickly to the work environment, like how is the work environment, how is it now, is there an impact that has made after all this change has been done on your work environment.

Participant 7: Work environment hygienic was really improved. Before, like before, you would as a Nurse you wouldn't really bother to damp dust and all that, you would feel that is a General Assistant to do. But since this Transformational Change, everybody knows I cannot treat the patient in a bad area, in blood, share a table with dust because the General Assistant is not there. So everybody mornings the duty of the person on duty to damp dust in the morning, to clean the walls where there need be, it's not only the General Assistant's job, and you supervise where need be. You call the General Assistant, which was not approachable before, but now they know if allocated in Trauma Unit, I have to be there every hour to check if there is blood on the floor, if not the sister or the person who is in Trauma is able to call the General Assistant to say can you come and help me here, which was not there before. And ja, so it because of the building we need to improve the painting, the walls and all that, but generally there is a lot of improvement.

There is a lot of improvement with the Infection Control, the sharp containers, the General Assistant know that they have to check they're full and change them, and then the cleaning, the cleaning of hand cleaning. There's a Sister that has been allocated as an Infection Control Sister, so it's looking after that if there is checking about the Infection Control, the

Sharp Containers, the bins, really check if they've got the caps, and then there is some control. Checking the Infection Control.

Fieldworker: So the work environment has really improved?

Participant7: Yes, it has really improved, and ja….

Fieldworker: Can you tell me anything about the salary issues.

Participant 7: The salary issues, before when most of the people were their report, the report they were supposed to write on probation so that if one is on probation and has not been written report that means that you will stay on probation. Nobody was checking on that, nobody checked that. Now I've got this staff member who's a year now, I need to write a report so that it can be changed to for salary on the 15th. So now with this Transformational Change, the Manager that is here, made sure that whoever was on a back-log and was not getting paid on the right date, which is the 15th, and the probational report weren't written, then they started to write that and now since then, the process just goes on and on. She make sure every quarterly, there is an assessment of the staff that's on probation, and then end of the year, a report is written so that the following the person after a year, is being permanent and getting paid on the right date.

Fieldworker: So there is a lot that she came with.

Participant 7: She came with ja. So this monitoring, the OSD it was still in process, the people that was due for the 3%, The Manager is following it up, most of them got and then those outstanding, there is something done about that. So the OSD and the people who was supposed to be on the Speciality and Primary Health Care are also getting their salaries accordingly.

Fieldworker: Okay, a little bit about the staff wellness, socially meetings?

Participant 7: Ja we've got also with the staff once, I don't know if it's really applicable but we've got the system where we choose every month the Nurse of the Month, so where you get, before you used to get a present but now the present is like get a day off, so also that also improved the people's morale. And then if you've got a birthday, you also do something about that, we organise tea and cake, ja. For those that are their birthday month. And then we've got outings, it's being organised by the Manager.

Fieldworker: And the End year function?

Participant 7: Ja, the End Year Function, every year there is an end of year function, what they used to do there, they used to get that money that is allocated by the at the office and they used to do a braai, somewhere here and then you dish. But now what is done, it's either we go out far, so it's like a sort of outing for the day, or we organise a hall and then we do the End of Year function.

Fieldworker: How was the whole process changed your mind? Or the whole approach change your mind set, your feelings even about your work, how was the whole process have changed your mind? Or the whole approach have changed your mind set, your feelings even about your work, even salary about how did it change?

Participant 7: You really feel you belong somewhere. You looking forward to meet, like we working in teams, and then we only meet each other on Wednesdays, so you ever looking forward to get to that Wednesday so that you can see others and not miss out. And Wednesday we've got meetings, for the unit, then it's when we choose our Employee of Month. Everything we do on Wednesdays, where we all are on duty, ne. So you really feel with this system, even the off duties, most of the people are very happy with the off duties, the shifts, because you know you are working weekends, you going to be off Monday, Tuesday you coming back Wednesday, Thursday, Friday, and then again you are off and then there's no way that you'll say that you are feeling tired, because you've been working from Monday to Friday and or maybe there were 2 people on duty so you are overworked. No there is always enough staff members on duty. So that makes you feel happy, that makes you feel satisfied with your job, and then the challenge is though still with the patient's attitudes. Sometimes there are challenges which we also work on it, because every attempt is being made by the Management to make us control our temper, to be professionals, and all that, not to fire on the patient, to tolerate the behaviour because the community that we are serving is really difficult. So you have to know how you feel it's not like you gonna backfire on the patient like before, you are working with that patient and you know how to control your temper, you know how to be professional, we encourage that. And you know how to deal with the complaints, you know how to deal with the compliments, there is a system in place for everything. For most of the things, ja. But I wouldn't say there are no challenges, there are challenges though but we are getting there. The image of the facility has got signage as pointed out by the Public Protectors. Most of the things that would touch on that. We are striving to improve this, signage, there is a 24 hour signage outside, so it helps people to know where to go to, the signage on the out-patient departments. And then ja, the image is really and even if you even get in, the floors are shining and you know where to go and you know who to contact. Before you wouldn't even know who is the Manager, you

ask this one, and this one will tell you it's that one, that one will tell you it's that one, now there is signage, you know where to go, there's a Facility Manager, there's an Operational Manager, and there's a door where you go to. And the patient know now, you know how to channel the patient.... with the Triage, you know which patient comes to Trauma during the week, you know which patients go to out-patient department during the week, of course weekends, and evening, everybody is seen there. But there is a system, you know how to delegate it, it can be how busy, but at least it's under control. And they let you know to go and check in the waiting room, patients that are there of like before, you used to let people die in the waiting room because nobody bothered to go there. There are books that tell you to go and visit the people, what did you do about the problem, did you address people, who come and sign, and what time did you go and visit the waiting room and what did you do about the problem that was there, how did you solve it, we've got a system in place. If there is a problem overnight, you've got a book where you report, where you communicate with the day staff that there was this and this, and this needs to be sorted out.

Fieldworker: Wow. All in all….okay, is there anything that you want to added it more to what you have said?

Participant 7: All that I can say is the improvement at the facility made me feel so confident and so, I would say it really improving my image and my interest in nursing, because in my profession there is a lot of challenges. But what I would say, I've grown, I've grown a lot within this period because now even no matter how I can have a problem, but I know where to refer and how to solve that problem. If not, there is somebody that we can lean on, ja, there is a system that gives us help, there is a system, you don't just leave things hanging, you know where to go. Ja. Problems will still be there, challenges will still be there, but at least there is a room for improvement. Ja.

Fieldworker: Wow, no all and all to what you have said, for me, you said, it's like if I can summarise whatever you have said, before there was no system in place, that's it…

Participant 7: There was no system in place.

Fieldworker: O, thank you so much my Candidate number 7, as I said you can add it more maybe there are things, that when you walk out, you won't remember o, okay there is something that I didn't say, then you've got a chance when they transcription come back, then you can add it more. Okay Mam, thank you so much.

TRANSCRIPT: FOCUS GROUP

DATE: 4 JULY 2016

VENUE: BOARD ROOM CHC

Facilitator: Yes, we got consent and everything we say here is confidential. We have those numbers and we do not have name as our moderator says. We do have a tape recorder so that the researcher can also retrieve information.

What we are here for today is a reflection of what you said in 2012. What are your experiences now into transformational change process in the unit between 2009 and 2012? We want a reflection as from then, as you have told us what it then and what it was in 2012. We want a clarification and to validate the research findings. What we going to touch on is relate our experience and perception on the change processes in the unit. As the moderator says each and every one, we going to touch on critical resources e.g. Supply Chain, equipment, human resources, quality improvement, work environment, communication. Everyone is expected to say anything about the change in the unit… This research is all about transformation. The ball is in your court …any one can say either Number 1 or Number 2 or Number 3…any one can say.

Participant 4: Ok, what I can say…I can touch on any point we can talk about the relationship of the staff, the teambuilding that is been improving every day. I remember when we were in 2009 and 2012 that is something we are able to maintain. Every day we are trying organizes teambuilding in different units and in different teams. Then we still have our quarterly meetings for the whole CHC where we meeting the staff from Trauma, ARV, MOU, OPD and all the doctors and nurses …and meeting together with facility manager to still share that tea or that lunch together. And currently what we are doing while we have the lunch the HOD, Head of Department, come in each unit. Until then we doing it together, it quite a big deal and everyone must leave, we meet here for two hours per team, per unit in the boardroom. Currently it is just the HOD meeting the different teams in their departments. What I like and we still trying are everyday I'm meeting the same people I'm working with. It is a time I don't want to talk about work related issues. We just try to socialize. The nice is I want to know you better. We not talking about patients and what's missing in the ward. That I think it something that is a great achievement. And I am happy that it will continue… maybe this time we having lunch. I don't know what we going to next year. We still have the teambuilding, is quite reduced because of the funding as the department's budget is very tuff. But I think we will be able to organize with our money the end of year function where we

all come together, for those who can attend…ja even you in the team of the doctors, what is happening now, everyone is working together The HOD'S came together and we having a lot of integration, in the previous time the doctor who is in OPD work in OPD and the doctor in ARV work alone. But now we are trying to rotate everyone. So when there is shortage of staff, I can easily ask someone to help. That is very good. That allows us to be together to work as a team, even in each department …Sorry maybe I am talking too much.

Field Worker: No you are not what is important in the focus group is that we reflect what had happen before and then the things that you've said that have improved are they continuing, as you are saying, the communication is still continuing and you are trying to do teambuilding, and so on and so on. So we reflecting are those things that you have said are they improving and continuing and are they more now.

Participant 4: As mentioned communication, we are working to improving our communication, improving our relationship with the staff. And what I like, not only the clinical staff, we have the GA's involve we have the clerks. So it is the whole CHC that works together. The multidisciplinary team. That improves the way we work together and the service delivery to the client. I can feel and I can care about the other person and feel the affection on the service to the client. At the all, the levels we are trying to work together. It is not easy working with people but the positive is every day we try and we trying talk about it and there is systems put in place to allow that.

Fieldworker: Is there anything you can say about the resources SCM, equipment and so on. How are they now.

Participant 4: I don't want to talk about 2009. That was a very dark zone. We all know we have problems in Supply Chain (SCM) but now and then I know where to go and request, now and I know what to request what from whom. And I can go and I get feedback, and they will tell me I now I did that. I know that it is coming. I know where to go

Field Worker How is the Unit. How is the Trauma Unit in all things, the equipment and so on than in 2009?

Participant 4: We are far much better that 2009, although we still need to improve. But every day we are improving. Last time the ventilator had problem and I was impressed, it was over the weekend, and I was surprise that someone said I can sort that out. We have improved in our trolley, the resus trolley and we know what is available. We had an audit to see what we need. And With every case we have. There is a resus committee currently set up; we now have a resus committee, before we never had the resus committee. But the

more people are complaining this is going wrong. And the more we sitting in that mortality meeting, we all sit together doctors, the trauma staff, nurses and operational managers. We all sit together in the M & E meetings, the mortality and morbidity meetings, to discuss ., we call people come from like the paramedics to discuss what could we do better to improve. We even discuss what we did very well to encourage the staff to again more. We discuss it with the Resus committee who is responsible to ensure that that each of the staff is well trained. As we can see how many trauma nurses do have there…how many do we have?

Participant 2: We were nine trauma specialist nurses and two resigned. Sr Damesi

Participant 4: The good thing is we still have one at the course. There is improvement in that. Equipping the people, the staff who are working. There is a big achievement. We can't send everybody at the same time unfortunately operational needs need to be considered. We are doing very well in the training of the staff and you can see there is a lot of continuous education happening at the facility where the cases the scenarios we encounters are being discuss doctors, nurses are sitting together. We even see there is planned some demo where everybody the cleaner, the porter, everybody who is in contact with the patient will come. I think I'm happy with that. Equipment we are improving, ja I can't tell you a lie we came from a dark area… I can't say we are already there but we are improving and continuous efforts are made in place. It's not like we smiling all the time. Sometimes it could be with tears, but ja

Moderator: What do you mean with tears?

Participant 4: It's lot of effort that the Operational, the HOD will have you need to remind you, assisting putting…it's constant…to remind your staff to apply discipline ,..take absenteeism and correction as someone is just trying to cheat the system. It is not always pleasant and I know people hate being in disciplinary hearings but it is for the good of the place. That is where someone does not understand then it becomes animosity amongst people. At the end of the day we doing it for the good of this place and the best treatment we want to give the client. And you have many sleepless nights went you try to organize something contacting. You don't always have the support from the…. You don't have all the resources remember we are working in a resource limiting environment. Where sometimes you have to pop up from your own pocket money to organize pamphlets, especially for the CAIR Club things. Innovation came from your side, if you want it to work, you need to put everything of your sweat and your pocket money, everything. I remember in the unit the HOD pops money from their pocket, it does not come from the institution… to organize lunch for the staff… just to say thank you… to recommend them. It does not come from the

government, Department of Health there is no money for that. It does not comes from a separate budget and image your give your money for that. Image that you have to give from your own money for that That is your money and your time and at the same time you still expected to be at work ran the service. When do find the time to organize that?

Participant 4: Yes, It takes a lot of the commitment from the leadership. It is something good and in 2009, I did not see anyone doing that.

Moderator: So you saying there is a lot of good things that happened. It takes a lot of commitment from the leadership especially to maintain that. When you talking about a team coming together is it all the staff and their leadership working together can you maybe explain or expand on that.

Participant 4: I think for the team to work well you always have a captain in a team. If your captain is faulty, I don't know (laughter) if the General of the Army is weak, what battle are we going win? It take a lot of discipline and strength in the leader to be able to communicate, to be able to recognize what is needed in the team, to be able to work regardless of the…(interjection by fieldworker…"criticism") Not only criticism ,regardless of the personality of each individual…What they do what is strong and what is weak. "I want to work on your strength." It takes a good leader to know that, to know your strength .A leader who leads by example. To be on time. A good leader will know what to do and how to put the people together. That is what is important. Who can encourage the staff not to always find what is wrong. We don't need this kind of leaders. A leader that we can respect. And how do we respect a leader? A leader that present himself to me. That let me see how its, by the way he is working and he can lead us to a good achievement.

Participant 3: The first speaker, number 4, mentioned almost everything. I will try to touch on other points. When I came here 2008 compare to now. In our unit there were a lot of backlogs, people coming drunk on duty, people not wearing uniform. We do all those crazy stuff, but the leadership that we have in the unit now, came… she never put the focus on the negativity of us but she would see what is important of you and try to focus on your strength. So that really motivated us a lot… in a way that we saw for us to continue with this thing, urhh urhh man, it does not get us anywhere. The quality of care that was rendered to the people of the CHC is not up to standard. She came up with a plan, of like umm starting from the shifts. The way we use to work, the way we were working was not the correct numbers of hours as required by the substructure. So she came up with a nice shift system that make us that make the both teams meet on Wednesday and have more staff meetings. The management was at first not visible to the staff but today the management is more

visible to the staff. Today the management is more visible. As speaker number, four said, in a way as HOD's just come up here and go within the unit to share the tea with us. And we have chance to communicate with them and raise our concerns. And without a fight you find out that in this way solutions usually comes and you find out that things are working for the betterment of the institution. That everything is going right.

Starting from critical resource, we had these challenges with SCM and we find that there is no stock but we needed to deliver a service. So the person at the head of the SCM is doing his job. We don't get any report now that there is not oxygen. If we report the oxygen to him, he immediately phone AFROX and he know we explain to him and ask " did you see we expecting a delivery " and even we don't get a delivery that I can be a witness as he phone in front of me. But before that there was days that we will take the cars and borrow all over the facilities. And that we do not do no more because everything is well planned now. The system that we have now hasn't slipped back. It is that we can see that change.

Our HR is doing well at the moment even our financial resources. We are getting paid our overtimes now on time. Unlike before when you working overtime in November than you don't get it on time. (Interjection from another participant …like Sunday Claims that we never got from 2oo6 …really now). Those challenges we not experience them at the moment.

Let me come to quality improvement, You know in trauma it used to be so chaotic, that you you…people was not supporting each other, in a way that maybe when there was a resus…. There were no Shift leaders at first. But then OPM came up with it. She took us through leadership and then now you know you are a leader. So whenever there is a resus you need to coordinate your team. There must be somebody that is scribing, there must be somebody available to airway, there must somebody for the drugs. And if we do that way, you know, we can do magics for the patient. There is hands now available but at first there were no such thing. Now what she did as well, she also took everyone that works in trauma including the porter, she arranged CPR training. CPR can tire you a lot and to have somebody else like the porter can assist, and is doing it very good and it helps a lot

And before I use to see the patterns of the study leave. It was the almost same people going for the study leave and then they drop out and were given another chance. But when this new management or when this transformation change started… people was equipped and there was no longer any favours. But for you to qualify for this study leave you need to work hard, you need to be present and punctual and adhere to the dress code and the code of conduct. All those things were, you know. Before it was given to certain individual repeatedly even though they were dropping out, it is those things the transformation change came up

with, and we appreciated it. I am still new within nursing and I thought by now I will change three or four jobs but I feel this CHC is still the place to be. You learn, you grow and chances to you develop yourself are availed to you. Its up to your own not to go to school. Image we were told we could management. The former managers are afraid that if your do management you will be in a position to take “my position”. (Laughter by the group) Now all these opportunities are given to us. We appreciate them. The RN who qualified with me, working at another facility, has not been given a chance to go and study. Meanwhile I already been there 4/5 year ago. It is those things that is given to us that keeps us to stay at this township.

Moderator: Did you mean to me you were developed? Can you explore to us.

Participant 3: A lot. When I came in here, I came in as com service. So I thought I would just thought I would do the year one contract and leave because I was seeing the tendencies but eventually when our OPM came in… I use to like work in injection because I know in trauma in chaos. And I use to work there alone, but then she saw that there is potential within me that I never saw. She start putting me in trauma and I started enjoy trauma. An opportunity to study was given to me. And I was still three years but then I got a chance to go and study and it was something I did not expect. Seeing from other area you must work eight years before they get an opportunity to study. So it was those things I saw within myself, if you stick here you are going to go far, far, far. You going to go way beyond. In fact our unit manager does develop us. There was a person who used to be negligent, that didn’t want to do certain things. But those people when they were called in to order, they were taken down and talked. They also saw that if they say that “I don’t want to suture”… that it is not going to help them or help the patient and “I’m putting myself in danger”. When the manager talk to them those people and they started to do those things, they were then also offered a chance to study. So it is something that we should applaud our manager. She just does not look at one category of nurse. In the older people now ENA’s are encourage to go and update their matric. She is flexible. She wants their timetable so that she gives them day off on the time of writing. Where as in other units I don’t see this happening. It is only when they go to trauma, we see this happening …so…we say, come here, eh, eh, eh

The quality improvement the way we render healthcare in trauma is excellent. There is also two month audit like, I almost said the name, number 4 said … our M & M where audit our patient care. Where we pick up ok no man we were negligent …urine dipsticks were supposed to be done because of the presenting complaint. So it is those things that where currently not happening before and sometimes they are helping to improve more the quality of care. I will talk later some other time .I don’t want take up all of the time.

Participant 5: Good afternoon Ladies and one gentleman. I would like to go to the improvement, as I am part the people when they talk about the improvement. When I was employed here I was as an ENA. They always say curiosity never kills the cat. But when the present OPM came I was also coming back from the EN course. What surprise me, sometimes you do something not knowing someone is noting or checking. She came and I worked my two year, and she organized a booklet because she called me my colleague, she sees the potential that we might go to the bridging courses, the bridging course is the enrolment from EN to registered nurse. I won't lie to you that were2011 no not 2011 it was 2010. She brought us a booklet. She said that she put the name on without telling us. I was not ready. The second year up until the third year I thought maybe this is my time. Because she was trying to improve me, not only me also the quality of care of the patient that we render in this facility.

And if I may quote under communication, before management there were never, ee, ee, managers they were never visible, you see them in passing. They were not as visible, they were never as visible. They never communicate with the staff as compared today. If you go to our unit every week, every Wednesday you will be bored that we always sit and have an open up meeting, that this has happen, this is going to happen, this might, this must. We are doing it now. Every Wednesday is a meeting. Whether it is a handover she went to attend. It ….E Communication is bringing the transparency of our management because nothing passes us like before. Even if something happened or needed to be said. Even if it something I said about you that I not happy, she allows you to…

Participant 4: Can I add something…It's true… I remember the hospital was always in the news for some not professional ways for treating a client that that were coming here. I remember at the time we were having resusses, people did not know what to do. Therefore, you have a case and you don't want to look for any reason to become upset for not wanting to touch the patient. The problem was people didn't know what to do. And nobody new about that. In auditing, people didn't know the management of clients coming to us. It was good with the new OPM, the management team that was coming at the time. There was people that was having two jobs. Working here and working somewhere else. And the floor was left alone, while were people registered in the institution to work but they were not available. They were working elsewhere. There was a lack of discipline. I, myself came to work, I did not know at 08h30 and I could give all the excuses and I will see people leaving at 14h00. Ok clinic is finish, I was new and I was left alone on the floor. Where were the other people? It was chaos. We were always on the news. Of course, we lost a lot of lives with that because there is no order. There was no professionalism. I did not know all the policies

myself until… yes; I did not know the policies. Then the team came. It is not only the OPM they brought somebody else. Ok let see what is wrong here. The first thing helping people to come on time. To be on time at work. You coming on duty after your manager, your leader. What would you do? Your manager saying “I’ve been waiting for you guys. No shouting .no disrespecting you. The policy say…clear policy. You will come on time, just respect yourself. The policy is there.

When there is no leadership, we are just like strayed dogs on the road. So we started with that. Then there was a focus on even in their attitude. And people with two jobs were discipline. It was like a joke. It was like a joke. They was about to lose their jobs. It was like a joke. We re-adjust the work. We all did that in 2010. They changed that Dress code was an issue. The lack of professionalism was so clear.

We had to send people, because we realized that there is resusses and people didn’t know what to do. Ok there were courses available and had to send everybody. There were skills development .They had to develop everybody …whether in the nursing staff, whether in doctor staff. Put meetings… we going to have constant training every Tuesday and everybody must come together; it is not only the doctor that sees the patient the nurse must also attend. It started like that.

Today we are even proud to sit here and we are proud to have specialist trained nurses, we are proud to have doctors who feel really empowered, you are not scared to touch any patient, that is your job, I’m not scared .I know how to manage and I know where are the policy and where do I refer to . I know all that. Today the nurse telling the doctor “I think…” “Try that”…. “Think well about that”…. “Are you sure”. Now we can come together and there is no frustration that doctor will ask me who am I. We work together humanly better. We work every day in trauma. We have new doctors who come, and the nurses say “doctor are you sure you want to discharge her”. They are so empowered, they are knowledgeable and we did not have that. This carries on, this continues, even with the new commserves, you tell them look I was at your place four year ago. If your open to learn, we going to skill you, just be open. Professionalism.

The was a time they sent a lot of staff for front line training because of the way we speak to the client, so you are going to send them for to training skill development to just know how to speak to the client. Learn how to support each other if you have difficult client, we are human, we can lose and we are helping you not losing it. Because remember this is business and we mean business.

I remember things can happen and the rate of mortality is decreased, seriously. We are in a bus that is moving and I know we still have lots of to improve but I have hope because where we came form in 2007. We came from the dark era. I was part of that dark era. Even though we suppose to come at 07:30…everybody comes here at nine. And people would disappear at 11h00. That was reality. Today people come at 07h00 / 08h00 and knock off at four o clock. Finish to see the clients ok there are other things that can be done. Where can you support. Organize the day of tomorrow; organize the planning this and that.

You feel like you are human and the system that we respect. Professionalism, dress code is important, just speak to you colleague how do you care about your colleague. Thou we are human, there is protocol and there is policies to tell you how manage you thing otherwise we all become animals. We can't be like animals we have to see the patients.

Absenteeism has improved. We just need discipline. We needed leader/leaders who were disciplined. Who wanted to make a change. Because some other came and they couldn't. It takes the effort. That's why I said they (the leaders) were not laughing. Because sometimes you get the staff that comes back to you. Saying "you can't tell me anything I have been here for so long". That's why I say you need discipline.

I have grown up so much. I went for training. I got diploma. I've accumulate it. I cannot even manage my small unit sometimes without fear but one thing I like I the respect of my colleagues. Regardless of the rank we can sit and chat together and laugh and work together. As long as we remember they taught us "Remember you are here to save a life". So ja… I know there is room for improvement .May that will be in heaven. We become perfect. Because every day there is people coming. The ones that are coming now we teaching them what to learn. Transfer of skills. One just wants to say "I am not coming" No.no! "Why are you not coming? Everything has been planned". They are well organized, the managers. The way they are doing their leave plans everything is clear we need to be fair. We sending not the same people you have to give everyone a chance. I feel empowered. I feel like somebody cares about me and I am happy to work here.

Fieldworker: Other numbers?

Participant 1: I am number one. I am going to add on the Human Resource management. I arrived here 2006 but that time I did not go for an induction. The new appointee was sent for induction and I did not know what was going on there because it didn't go at that time.

And there are quarterly reports and they are making the new appointee to sign every quarter before they get them to be permanent. So we didn't have anybody do the quarterly review on

us. And nobody read the employment contract or tells us what we are expected to do at work and what is not expected, that time. So now, new managers, we just observe that for the new appointees, the manager is doing that.

Another thing about the pension we are having that employees, nobody explained to us that we must fill in the form where we must chose the beneficiary for your money if something happen to you, that time. As I came in 2006 I just went. It is only by 2013 that I got clarity on the pensions and beneficiaries from the new manager. The new appointee now gets that things the 1st day when they came to the unit and signed all the forms.

And the circulars that are available for us. We have a file so that we can read all the circulars. Our HR manager was not also available us so that we can ask the things. Now when we talk to our managers they can even arrange a meeting for us to talk with our HR about our pensions and SPMS. Really, really that time it was bad but now everything is very clear.

And adding on that quality improvement, that time it was only the doctors and they must apply plaster of paris (POP) to the patient. Now in our trauma we are having a POP specialist, that is a porter. He was sent to GSH for training. So he does the miracles in that trauma unit to apply plaster of paris. It also had a fracture on my foot and he apply the plaster of Paris on my foot. When I went to Melomed (hospital), I got a compliment there that it was a very good POP. The doctor doesn't want to prescribe a moon boot for me because of the POP…it was very good.

And other thing I can talk about is on that environment, ja, working environment, I can say that the environment is very, very therapeutic for us. Because that time we were, a few staff and then we were serving a lot of patients. We were just doing whatever just to push up the work, now really; otherwise, really everything I can say it is better than before.

Fieldworker: Besides being therapeutic eh, eh, control E infection environment .I am not trying to lead them Ms Moderator… We are trying to explore the environment in trauma and sometimes there are messes, as people will come with their escort and their dramas. Explain to us the safety of the security besides being therapeutic and you can even control the infections. But your safety and security how was it? How is it now? We still want to know if thing are continuing still as 2012.

Participant 1: The safety of this place. We are working in a dangerous area. So but. The company that we had before it was very good. The contract was finished and then the current company when they arrived we were having a lot of incidents. Even then the

management tried to put the safety measures on place for example they install the panic buttons in trauma unit and in the managers room and in the security's gate. And also they organize the two armed response securities for day shift and for night shift. So at least they tried although this area is very dangerous.

Participant 5: I'm going to jump The management has done much for the environment for the staff and the patients but it depends individually as much as I can mention now this morning we has a guy who came in with a gunshot and as much as we were trying to stabilize him, he refused everything as there are people who are following him. In a minute I informed the security. Everyone is doing something I mean for management is doing something to have place secured, but the securities don't act the way I expect them to act. Because we have an open door that they don't keep an eye. Anyone can go in while they are seated. You as a nurse are keeping an eye. You are looking at this patient, you are keeping an eye for any intruder who entering the wrong side. I mean really! Up until you must say security where is the person coming from. They are known to be positioned to each and every corner, but you must also interfere where as they know they need to protect the area. As I was mentioning this morning's incident, this guy said that there will be people coming for him. Within minutes, there was a group of people waiting for him. As much as he went out and because we never know what may happen. It started from the gate and they open up for everyone who comes in but they don't have the guards to take the whole group. You can expect the person to have one or two escorts. Not more like a group. To me it's the company that I'm personally not happy with. They can have the 24hrs armed response but it the action of the one that is on the spot. But if they don't act how safe are you at the end of the day?

Participant 2: Just to add the security or environment the improvement. At the entrance of trauma, we did not have that security gate. We used to have an in and out, it's patients. Now we have a security gate. At least we can control the escort that we foresee in the trauma unit. As number 5 said we can only have two escorts or one escort inside the unit. Number 5 yes mentioned the company, the recent company that we have now, I'm also not happy about them. Shame, I don't know where they come from. Like maybe where they come from, like they working in the malls. They are now familiar with the facility. We are in a hospital. We sometimes have to intervene and say "like security please do this. The escort her inside please take them out". They expect you like a nurse to say go out, to the escort. And if you say go out, you become a victim. You understand. As I mentioned if the security would do their jobs and say "this is the policy, it is not me that say go out it is the policy that say one escort or maybe two at a time per patient". I also just to touch up on the work

environments like for instant, like our toilets, our patient's toilet even our staff but mostly our patient's toilets in the environment. It used to be dirty but now it is clean. The environment never use to welcome you but there is improvement now, there is a lot of improvement, teamwork on our staff. Like they have to know the patient toilets have to be clean. And I remember when they visited us because our facility was too dirty. Was it the director? When was that now was it twenty…, any way I can't remember but there is a lot of improvement of among those things.

Moderator: From what I'm hearing you guys are saying a lot and for this to work and continue working there should be a lot buy in from the all staff. Everyone needs to come together, the security the cleaners, the nurse, the management needs to visible. Everybody needs to come together to continue to make it work. Ok

Participant 1: I want just to add the environment, the signs. Like before when you came to this clinic, if you don't know this clinic. You would get lost and you don't know where it is situated. But now from the road the sign there is a Clinic and by the gate "what are those signs" for the disability people we didn't have those signs before for the disabled people. You also see the signs in the emergency area: for the ambulance and the trauma area. Even when you get inside the Trauma Unit. You see the Triage Room. That is the room that you should go for vital signs, then Consultation room. Room 45 that is the trauma area, and then the resuscitation area, the medical side, the tearoom, the Club room. Every area now is having the signs. You know where to go now.

What I want to add now…

Participant 3: As I was say, really, from 2009 until now there is really a lot of change. I'm thinking now, In Trauma before we use to ignore people in the waiting room not informing them what is going on. But today we have a book in the unit and we go there and tell them what is going on. They wait with hope because with hope it's when they get better. But if you ignore them they start to make chaos outside. During the week if it's not busy or if it is a little bit busy, we go to them and tell them that her we working on the triage system: Red you won't wait here you must go straight inside. An orange can't wait here you must also go straight inside. Yellow can be wait here and be seen within an hour and the green been seen within 4hrs. Through the information you give them its then when they understand you. And with that information we got the true knowledge we never had before. So I like the speaker when she said that without knowledge you become angry and create chaos because you do not know what to do and you don't want to be embarrassed. Since the new management

came and saw potential in us… you now became better people and gained better knowledge and give better health care to the community in the drainage area.

Field Worker: Not interrupting. So what you mean you use not apply the Batho Pele principle and now you back on that like transformation, information. Now really, when you sit with a patient they need to be informed. They need to know what to do. So you mean the Batho Pele principles are in place now.

Participant 3 Ja It's in now!

Participant 5: The Batho Pele was there but in action when we came, they were not practiced. You must follow you can't just come in and change. Number 3 said that we did not inform the client that he must wait. Now the client care has improved so much. You can ignore certain ones who come in drunk because you will explain and explain. Those who will listen will calm down and tolerate whatever, up until we explain. Then we interact with the doctors, "No Doctor this patient was long waiting. Then they also manoeuvre. The client care has improved so much. Because whether you know they going to moan so much. Then you need to identify yourself and explain end of the day. And after you say your say, they will say thank you .at least I mean before really when we came in it was not done. I won't say we didn't do. When we came, it wasn't done. The patient will sit there. They will just sit there.

Participant 1: Just to add one point. I remember 2006 I was a new appointee from the University that time. So was no hand-over when we came on duty. We would just come in put your bag in the tea room and just sit in the tea room, putting your lunch in the microwave, sit down and eat. After that you just sit. The patients sit in the waiting room. Nobody start to do the observation. I even heard, one of the nurses, that time they were very resistant to change that time. One sister was asking them, approaching them to do the vital signs. We were using the baumanometers that time. That nurse said she is having the arthritis and otitis media. She can't put the stethoscope on her on her due to arthritis. You were not to approach them. But now everybody is approachable. I can approached number 2, 3 or 5, everybody. Even the juniors they can approach us anytime. They can ask: "Sister can you please do this and this". At the end of the day you are doing it for the patient.

Participant 5: Under Training and development: I would say I am very proud. Not that I was chosen or favourite. At least I got a chance. As I said before the current OPM tried the past two years before I personally was ready. So I hope went I get my result I will be developed because I have done my training for two years. Where I was also in a training 2008. I mean in other institutions: you go to the big tertiary hospital they will tell you "No I'm 10 years in

this category. How do you people do it?" Then I'll say "come to the clinics". Not all the clinics are doing what is happen here. To say the honest true it is only the people that say "I about to leave I won't go to school". There is an opportunity that she has open up her door, you ask and then she will as much she will follow. I was about to resign and do the four year course as I was not passing the pre-test. Up until the 3rd year, because she had been trying. Then I succeeded by passing the pre-test and went to do the bridging. There are chances for everyone. Even if I could come up with the other thing, she will investigate, no you qualify and no you don't qualify rather than to shut you and say "No I want you on floor". Every day is not the same but she gives you that chance to explain. I am a happy candidate to say under that training and development is open up for everybody. Before those colleagues who are about to retire, they will tell you "No I was not so and so's favourite. It not about being favoured now. Because if you go and check people who came with four year they got extended (*extension*). There that circular ne that I didn't know. There is courses that is about to be done now, this course that have been done now, this CPR and all the computer courses that I have not done in the past two years. There is another one, man. Is just that I forgot the name .It about the CPR thing, Yes the BLS, I'm about to go on that course now. She give you a chance to go an attend. Who has been and who has not been. So under the training it is "Nca" (Good)

Participant 2: I would like to add what my colleague just said. I came here as an ENA in 2006, I am one of nurses I proud of where I am today, I am a staff nurse and I'm heading…there is courses that is going to be done. I don't know whether it is going to 2017 or 2018, but they still researching it. As we will be going and come back with midwifery and a general bar. So I am so excited and I know I am one of the nurses that will want to go. And if I would I want to go I will be given the opportunity… due to the transparency because she shared that with us. Also the ENA's will go also and they will come back with midwifery and do two years. Everybody is excited and she is sharing everything with us. They said they are still doing a research and will come back to us with the full information of what's going on of what is the criteria. The schools that we are going to; they have mentioned CPUT, University of Stellenbosch. We so excited that we also going to the universities because of the improvement that is now taking place.

Participant 3: Really our unit manager, she played her part, you know. Her management style is one where you wish every manager was like this. She gets us…more especially her specialties: she allows us to act in the office with her. Meanwhile in some other units you don't see that happening. When we are with her she teaches almost all the admin stuff. Even if she not there but the level of care rendered to the community continues. She is one of the

supporting persons to the Facility manager because our facility manager is not a nurse background. But her part is to ensure that all things are done. I even remember when there are disciplinary processes done, by either the administrator, they always consult her. She is more experience and she even train us. Like tomorrow I going to training at Kromme Rhee which is about the disciplinary procedure. And it's things that you don't get anywhere, you know. Really, we are impressed with our manager. And at the moment the processes of change she brought within the unit and in this institution, we are sustaining them as they are the best at the moment and they give us the results we looking for. There haven't been any fallouts… because I'm thinking the people come drunk on duty, there nothing like that anymore. At first it was normal during our lunch times; we spend them at Makullu's Place, coming back lekker drunk (*laughter from the group).* And then now our attitude we going to have with the patient! We will be in the newspaper every time. But those things don't happen anymore. Mostly things that we get now, is compliments and no complaints. And that shows the standard of care. Also we are motivated because if you work hard, she advises you to collect evidence as you go by. Before things like SPMS used to be for certain people those people were not doing the work. They were just there writing. So now if you want to get SPMS, you to provide evidence. Whatever you do provide evidence and with this evidence you will be rewarded.

Fieldworker: Not only through evidence, also through your hard work. Is she always in the unit?

Participant 3: She is always within the unit. Even if she in the office, she does have her way of observing us. She even notices the tea times. She complains at times about things. But she doesn't make a fuss. And we are trying our best not to trigger her in a negative way. And one thing that I admire about our manager is that she ensures that there is continuity of care. When we come in the morning, we must be on time. We must take over from the night staff. We must be aware of what is happening in the unit. Even if there is complaint, we know what has happened and what to do.

The support she gives to us is amazing, you know. It is as if you going through a burial she is always there, she supports us. She give us support that you don't even get from your family at time, you know. She teach us a lot of stuff that we not aware of. It's like the channels of communication. At first when we were not coming on duty, we used not to report. We did not know what to report but now we know what the channels of communication are. If you don't get her hold of her then you must phone the second in charge. And from there she gets the message. She takes the message and understands the message without seeing you. So such a manager is manager you don't just get anywhere.

We are happy to have our manager. And indeed she is doing a great job in the institution and at large.

Participant 1: Just to add on. We get motivated because of our manager. Because we are celebrating our birthdays in trauma unit. When it March it my birthday, I know that all the March babies should meet together and do something for the others .Which did not happen before. Also we are celebrating the Nurses day. It is in May, we know that and that day we are treated special. So the management supported us by donating their money. So we donated the money and we celebrated that day. International Nurses Day. Also, we do celebrate Valentine's Day and prices were given to us. At least it motivates us. And on October month, where we are have the Emergency week. So we know on that week from Monday to Friday, the two nurses must go to the waiting room trauma club room outpatient department to educate the patient about the topic they going to choose. So that we can empower the patient also not only the staff. So we really appreciate what she is doing us. We did not get it before.

Participant 5: I can also add, from 2005 up until I get the certificate in 2014. The Nurses day was always on the 12 May, but it was never celebrated at this institution. It was never celebrated. But 2014 I received a certificate. I was the best nurse of whatever in trauma. Whatever she tries it depends how we also take it. If you are not recognized. You come in you get your salary. You come in you get your salary. Small things… *(IYou means it's about the appraisal. She inspires*) Yes, she inspires us in small things. (*Yes. yes*,) It not just about the SPMS, but also to notice that you are doing something different. Like there is this CAIR Club thing, we also got certificate. And you don't know she observe you and how you interact with the patient. But she got that eye. You also get motivated that at least I wasn't rude and that someone notices me …how I interact with the patient. Under the discipline she tries her best because we are different individuals. But I won't lie to you, we are under discipline. No one come in as before…I also hate this term "as before". Ever since there is, discipline in this facility. And you get different departments, but for trauma area and if you know that you won't take this patient, you somma say sorry number 2 will you attend, because you know that you also reaching the… (*Laughter in the group*) You tell yourself let me rather, because at the end of the day you know she's got an open door for each and every report from the community and from whoever , she's got that open door. So U discipline you always maintain in trauma and E professionalism also. We always have nametag (it's a pity it is off now), identification, because the patients' right, mos. They need to be nursed by an identified nurse. So professionalism is kept.

Participant 3: The professionalism doesn't only go with the outfit. The way now, she always emphasizes how our attitude interfere with patient care So now we've learnt that if you coming through the you leave you problems at the gate or in the car. Let's concentrate on the patients who are coming to attend. And at first it was not happening. You somma take your anger out on the patient, which result in complaints and the media writings and things. And all those things were discrediting our institution. So really, really we applaud the work our unit manager has come up with. And I so wish that we sustain it until we get something better. The support that she gives to us in trauma, it is really amazing, you know, is really amazing.

Participant 5: Hi it is. We can talk a lot.

Participant 3: There was this capacity building and empowerment that we didn't touch on. In trauma we have that if I see that, my colleague is not doing the sterile procedure right, we collect all of them and do spot teaching. They do things without knowing why they do things. If they see the need why and it is important for us to tell the person the reason why it is not for me to see you do it right… but it is for that patient wound to heal faster, without it delay, you causing more damage to it. We have our yellow book and we do that demonstration so that people are also empowered. They don't have to go outside small training. We share the knowledge

Fieldworker: So you do the in-service training in the unit. WOW

Participant 3: Yes. That is the result we have knowledge now unlike before we didn't have knowledge. Now our reputation has… we don't have that bad tradition anymore that "OH IF YOU GO TO THAT FACILITY YOU going to die there".

Participant 5: They come more to the facility!

Participant 1: They change their addresses.

Participant 3: I'm looking at the stats my unit managers recorded the M&M: the death before in the month of October was about 6-7 and at the moment there are zero for this month and 1 in that month.

Fieldworker: And something there is DOA's. You know those ones.

Participant 3: That means for that number to decrease so much… that means quality of care rendered in that unit is up to standard.

Participant 1: And the knowledge also.

Participant 3: Without repeating one thing all the time, I think really, I am happy to be at this facility and I happy to give service to the community. And without her support I don't where I would have been. Because I'm one of the lucky people. I was wearing dreadlocks (group *laughing*). Not because I wanted to but I was trying to not be part of what was going on in the Trauma unit that time, so I isolated myself. Then she saw no she saw potential and I thought "Hey this Mamma why is she's seeing another person all together". Then I tried to be the person she saw. And hey, today I am happy to be this person.

Lots of laughter from the group.

Participant 5: Ja ne second in hand…second in charge.

Participant 3 Laughing Hey, hey, hey, Ja. Ja ….

Field worker: I think we have touch everything that you have mentioned before and in 2012 because our meeting for today is to reflex what you have said in 2012 and what is happened now. So for me I think we did get what is happening now. And to what you have said for me there is a continuation of transformation. And it's still there and for more it has been improved. You once mentioned you are nine trauma specialists. You said the others were EN's now they are PN's like in skills development and empowerment. You said that you have a Resus committee. Which I don't remember them mentioning before Miss Moderator.

So you can see instead of thing going down, they going up, I can say it in the graph as they were saying. Meaning which, the transformation process instead of going down it's going up.

Number 3 has also told us about the reputation. There are no more media now that they want to know. The M&M reports are fine and there is a lot of them decline in mortality rate, also.

HR, you did also touch. And the quality improvement is a committee.

And communication, Ms Mod you are a witness, the meeting t they do have it in the unit on Thursdays …on Wednesday. Where they will touch on what we haven't done, what we need to do and what we need to do to improve.

They touched on leadership and they fine with it. Work environment umhh. The only thing that I didn't hear but which I think you might have it. Yes you did say that the environment here is very therapeutic. The infection control committee.

All: Yes we do have

Fieldworker: You didn't mention it…I'm not trying to lead you but…

Participant 3: Thank you, Thank you facilitator… We do have our infection control committee lead by a CNP from the OPD but then we have champions within our unit. Within the first few times she has been there, she is doing wonders. Now we know what to put in this bin and what to put in that bin. We know that this bin is being paid so we do not put POP things in a red binin cause it going to be very heavy. It things we did not know. Now we've got the D-germs, we've got sanitation what, what. The infection control committee is doing wonders. They now under Occupational Health and Safety. They go on regular meeting to the substructure, telling them the adherence to National Core Standards. Of which there are audits happening in our the unit. And every time there is an audit in our unit, I won't say it's because the champion in our unit…she tell us what to do. We always pass the audit. she also told us was to do. Without say much our infection control is doing wonders. We even have a file that is to do with the policies of infection control, so if the new person can go to file and be equipped on what is happening in that committee.

Participant 1: Just to add just one thing. Since I arrive here, I didn't get any Hepatitis vaccine and now since we having the infection control champion in trauma unit we did get vaccinate now.

Interviewer: I think Ms Moderator we have touch all things that we wanted to hear. As I was saying it is just a reflection of was they said. To me everything has been mentioned. Number 4 even mentioned about the teamwork between doctors and nurses. She said it is so fantastic now. I think we touch everything and what I was expected to hear, we did hear from them.

Participant1: I want also to add this point. We were selected me no1 and no.3. We know that there is a Nursing Specialist forum that we must attend in Tygerberg Hall, Karl Bremer. So in that forum that is where we are discussing the problems that we are facing in our unit. So the other units also advise us. So we go and visit and how do they put their resus trolley especially the paediatric one. The Peads resus trolley, the one we don't finish to organize it. They also guide us how to do it. It is very interesting when we go to that forum, we also feel empowered.

Field worker: There are new developments

The nursing directorate supported participant 1 on the nursing side and it.

Number 3: The NSF is a well-recognized body; it is a link with us staff with the department. They discuss things that need to go to the department. The Resus committee we got that idea from the Inner Serv. The NSF says that I could not do the National Core Standards there should be a Resus committee and from there then it came down to us. And then we did get a Resus policy from GSH. That is more expectable to the National Core Standards. But for our institution we changed it because we don't have everything. The NSF also helps draft the SOP's. For example, we got an SOP from Delft. That if you putting POP in the arm it must stay how many weeks and all that things .Before that we didn't have those SOP's. It is also helpful. Now they are discussing about the Triage training. Since our Triage trainer left, Dr Dalvie, there have not being any Triage training at our institution. And somehow we do pick up some new staff making mistakes in the Triage. NSF has nominated me, number 3, to do the Triage training. I become the trainer for trainees of this institution, so that faul up on those areas. And every staff is required to attend it, more especially the ENA and EN's, even the RN's. Triage training is for everybody.

Fieldworker: Anything any one.

Moderator: Yes maybe we can just go around and every one can just say what they want to add.

Participant 2: For the closure I will say I happy to be one of the nurses working at the CHC. Something also motivated me as I was saying to my manager in Trauma. About the reward of the SPMS. I said to her it was not because of the money that it was just to be recognized. I feel like my work since 2006 have been recognized. Not to say it was not being recognized .But is motivates you and keep you going. I am on the road going to be a Professional Nurse. So it motivates me, so being here I'm happy.

My manager also, her door is always open. Is it a personal thing, is it staff related. She supports you. I'm one of the nurses. Now, now, now, I recently was down. I feel like I want to resign. I wanted to somewhere. I was on a sick leave and I can back early, she called me. We were having one on one. She was a mother, she was a manager. She said are you ok, why did you come back early. Did you miss your colleagues? If I can say I'm happy that you are here because you can see we are having a shortage of staff. But if you not well go. So I really felt that support from my manager. Thank you.

Participant 3: Also, to wrap up I think I am going to repeat as well what Ester said. I having that opportunity to work with her in the office makes me feel when she's not here. One day I can step in. There is still a lot to learn from her but she also gives us… for the very first time I

be a chairperson within in the panel. I first went be in the panel and now there is going to be interviews for two ENA post and I'm going to be the chairperson. All I'm going to do there I learnt from her. Even though the style is not mine yet, but I have adopted it from her. She got a certain way of doing things that come up positively. In a person you want to copy what is good for the benefit of yourself and the growth of your own. So really I am lucky I am under her management. I think now, looking at pharmacy, when the OPM of pharmacy resigned, there started to be long lines. The way the pharmacy manager was managing, he was managing in a corner. No one can take over when his not there. But in Trauma even when she goes on leave, everyone knows what to do. We know what to do on Mondays, how to deal with this one and that. If we experiencing any problems, we talk on WhatsApp. Maybe we will phone her and apologise for disturbing her in her leave. She also doesn't want to see the unit go backward when she's not her. We need to sustain what we have well in this place here. That's all from me.

Participant 5: At first, I use to hate working in this facility. But now I am proud to be part of the facility staff. Due to change from the staff, due to development that we get as the staff. It not that we are copying and repeating, his got his own personal issues, she got her own. But individually she respect one when you go to her office. It will take the whole day to talk about myself and what she has done. Under her management, I am very happy. She sometimes a sister, sometimes a manager, and sometimes a mother. She is just unique if I may put her. She got her days like anybody else but individually she respects you if you go to her, she respects you. If I can open up I can take the whole day talking about the same thing and the things she have done to me. But one thing about her defends her nurses. Because before if it's strong to you, you got to stand. But now she will …"No, NO Doctor… She backs you up as the manager. If you got a personal problem which I sometime have a lot. She once even referred me to ICAS due to my personal problems. I sat down with her and she told me you must to this and you must do that and I want an outcome. And I told her, I took her…she is just …I don't know but under here management I am very happy. And if I may say just before I wrote my exams I was called in … She reminds me of my mother. She treats us individually. She is just someone, I don't know how to explain but I am very happy to be under her wing.

Participant 1: Lastly I'm going to say almost the same the other people said. January I had a fracture on my foot as I said before. She called me and said "Sister can you please come in because there is a form that you must fill in". That was the incapacity leave form that I did not know because the management as they were here before they didn't explain to me. She explained to me how does it works. She explain to me because I was out of work for six

weeks and then she said you don't have leave The way I counted my sick leave it was only 20 days that I took, the knowledge that I have. And then she said no you finished all your sick leave. So you must take this form to the doctor and he must fill it in for temporary disability leave. So I didn't know that before. She supported me that time and saw that my mood was very down when I arrived at work. She called me in. She wrote down the name of the tablets that you go the pharmacy to buy; those tablets will boost my mood. She gave me a one table and she say I use to use these tablets when my mood is not right. So can you take one and she gave me one. She asks do you have any problem. I said no, the problem that I have is that I feel vulnerable at home because I am alone and I can't do anything. This was the only problem that I had. And then she supported me a lot. And every day she would come in and ask me how are you today and tried to talk to me. She supported to me and I worked with her the six month in the office until my foot was better. So this is our manager that we have. So we are so happy.

Fieldworker: Nothing much I'm going to say I'm just the fieldworker and listening to you. Just to thank you guys once more for your time also especially your availability. Cause others I know other you are on leave and others you are off. But you have come. It really shows you are proud of being the facility team. Beside of being on the unit. If ever you were not inspired as you are saying, you always looking forward to be here, you know. When those things are not happening at work, Mrs Moderator, you started to have a hurt when it comes to work. You to say to yourself ha aa, I wish I cannot go there. But if there are those thing that are motivating and you are recognized because it is not all about money as Number 2 was saying. It is the person and the way she recognized you. And those certificates Number 5 was talking about. Those certificates keep us going as nurses and those breakfasts that Number 4 was talking about. They keep motivation the personnel so they can have the Oomph to go back to work. So thank you so much for you time and availability to be here. And the info that you given to us in this research. It shows that transformational chance is there and it's growing. Thank you>

APPENDIX 6: MODERATOR'S REPORT FOR FOCUS GROUP 2

29 August 2016

Report: Focus group, 4 July 2016, Gugulethu CHC

Research topic: Experiences and perceptions regarding the transformational change process in the unit (Emergency Unit at Gugulethu CHC) between 2009 and 2012.

Purpose of focus group:

- To clarify and validate the research findings collected in 2012 regarding the experiences and perceptions of participants regarding the transformational change process in the unit between 2009 and 2012; and
- To reflect on the experiences and perceptions of participants regarding the conditions in the unit since 2012.

Facilitators:
Ms N Tiki (B.Nursing Degree (UWC) and Diploma in Primary Health Care (US). She is appointed as a Clinical Nurse Specialist(CNP) at Gugulethu CHC.
Ms T Crowley (MCur and lecturer (Master of Nursing), Division of Nursing, Stellenbosch University).

Participants: Five participants were purposively selected by the primary investigator (Ms S Adams). These participants participated in the research study in 2012 and included one medical officer, two emergency nurse specialists (professional nurses) and two enrolled nurses. One of the enrolled nurses were an enrolled nursing assistant with the first round of interviews in 2012. All the participants knew each other and appeared to be comfortable to share experiences in the group.

Venue: The focus group took place in the boardroom of Gugulethu CHC. Participants sat around the boardroom table.

Procedure: Ms N Tiki introduced the topic to the group, gave each participant a number and asked open-ended questions based on the study objectives throughout the group discussion. Ms N Tiki allowed participants to voice their views and reflected and summarized responses. Ms T Crowley managed the audio recorders and ensured that each participant had an opportunity to contribute to the discussion. Each participant in the group had a chance to participate in the discussion and were very open in sharing their experiences. The atmosphere was very relaxed. The medical officer had to leave the discussion early, but participated in the discussion for at least 40 minutes.

The focus group was 105 minutes in duration and audio recorded. The focus group ended when both facilitators agreed that all the study objectives were explored. At the end of the focus group, Ms N Tiki again summarized what was discussed in the group and each participant had an opportunity to add final comments.

End of report.

Talitha Crowley
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APPENDIX 7: DECLARATIONS BY LANGUAGE AND TECHNICAL EDITORS

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To whom it may concern

This letter confirms that the manuscript detailed below was edited by the professional English-language scientific editing staff. Commissioned to us by the manuscript author, it has been edited for English language, grammar, punctuation, and spelling by Knowledge Cloud editing brand.

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