

**The perception of patients  
regarding comprehensive care  
rendered by Clinical Nurse Practitioners  
in the West Coast rural district  
in the Western Cape**

**By**

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for the degree of Magister Curationis  
at the  
Division of Nursing Science, Faculty of Health Science,  
University of Stellenbosch

**March 2012**

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**CO-SUPERVISOR:** Dr EL Stellenberg

## DECLARATION

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## **ØJULIA HANDFORD EDITING SERVICESÇ**

### **DECLARATION BY THE LANGUAGE AND TECHNICAL EDITOR**

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**19 November 2011**

I, **Julia Handford**, herewith declare that I language edited and did the technical care of the thesis of **Petro van Heerden** that is entitled: *“The perception of patients regarding comprehensive care rendered by Clinical Nurse Practitioners in the West Coast rural district”*.

Yours truly,

*JULIA HANDFORD*

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Signature and credentials of language and technical editor

**Julia S Handford** [MBA, BCom (Acc), BSc (Hons), HTD]

# ABSTRACT

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Primary Health Care (PHC) provide a quality, comprehensive health service to the community, based on the principles of equity, affordability, accessibility and community participation. It is a nurse driven service with the Clinical Nurse Practitioner (CNP), a registered nurse specialising in the clinical elements of primary, secondary and tertiary prevention at the forefront.

It is against this background that this study was endeavored to investigate the community's perceptions and lived experiences of the quality of care being rendered by CNPs in the West Coast rural district of the Western Cape. The objectives of this study included the following:

- To explore and describe the perceptions of patients in the West Coast rural community regarding the attitudes, knowledge and skills of CNPs.
- To provide policy makers with feedback and possible recommendations with regards to the implementation of this nurse driven PHC service.
- To provide recommendations for improvement of the existing curricula at nursing education institutions based on whether the current training meets patients' needs and thereby possibly influence curricular change.

A qualitative, descriptive, research design was used. The guideline by Colaizzi (as cited in Streubert & Carpenter, 1999:14) was used for data collection and analysis. Twenty-six participants took part in five different group interviews. Semi-structured, open ended questions were used to encourage the participants to actively partake. Each interview was audio taped and field notes were taken. Thematic analyses was performed to highlight three main themes, i.e. the attitudes of the CNPs, the knowledge and skills of CNPs, and the impact of the current training programmes on the quality of care being rendered by these CNPs.

Written approval from the Ethics Research Committee, University of Stellenbosch, as well as from the Research unit of the Western Cape

Department of Health was obtained. Prior informed consent was further obtained from each participant, after being assured of voluntary participation, confidentiality and anonymity.

Credibility, dependability and transferability were ensured by returning to two participants who validated that the transcripts were a true reflection of their experiences and opinions.

This study concluded that patients perceived CNPs as being unfriendly, uncompassionate and unprofessional. Dissatisfaction with the prevalence of unjust practices due to family members and certain race groups being attended to first by CNPs, were expressed.

Participants found the competency levels of CNPs more than adequate when assessing, examining and providing health information and medicine. However, they expressed the need that CNPs should be able to prescribe a greater variety of medicines and perform more diagnostic tests than currently permitted by the scope of practice as set out by the South African Nursing Council. Therefore, these views of the participants indicated that the current post-graduate training programme do fulfill their health needs, although the need for expansion of the role and function of the CNP were expressed.

Recommendations made included:

- An in-depth investigation into the alleged rude attitudes of CNPs should be undertaken, so as to improve the professional behavior of CNPs towards patients.
- Applicable policy makers should consider expanding the roles and functions of the CNP.
- Enforcing continuous, professional competency through adequate and productive in-service training programmes.

In conclusion, this study showed that CNPs need to be constantly aware that they work with human beings, with feelings and with health needs. The need for a therapeutic environment is thus crucial to the rendering of a quality, comprehensive service to the community they serve.

# UITTREKSEL

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Primêre Gesondheidsorg (PGS) voorsien 'n kwaliteit, omvattende gesondheidsdiens aan die gemeenskap, gebaseer op die beginsels van gelykheid, bekostigbaarheid, toeganklikheid en gemeenskaps-betrokkenheid. Dit is 'n verpleegaangedrewe diens met die Kliniese Verpleegspraktisyn (KVP) wat gespesialiseer is in die kliniese elemente van primêre, sekondêre en tersiêre voorkoming, aan die voortou.

Dit is teen hierdie agtergrond wat hierdie studie aangepak is, ten einde ondersoek in te stel aangaande die gemeenskap se persepsies en geleefde ervarings van die kwaliteit van sorg wat deur KVPs in die plattelandse Weskusdistrik van die Wes-Kaap gelewer word. Die doelwitte van hierdie studie het die volgende ingesluit:

- Om die persepsies van pasiënte, rakende die ingesteldhede (gedrag), kennis en vaardighede van KVPs te ondersoek.
- Om toepaslike beleidsmakers metterugvoer en moontlike aanbevelings te voorsien aangaande die implimentering van verpleegaangedrewe, PGS.
- Om aanbevelings te maak vir die verbetering van bestaande kurrikula aan verpleegopleidingsinstellings op grond van óf die huidige opleiding in pasiëntbehoefte voorsien, en sodoende kurrikulumverandering moontlik te beïnvloed.

'n Kwalitatiewe, beskrywende navorsingsontwerp is gebruik. Die raamwerk van Colaizzi (soos beskryf in Streubert & Carpenter, 1999:14) is tydens data-insameling en analiese gebruik. Ses-en-twintig deelnemers het aan die vyf verskillende groepsonderhoude deelgeneem. Semi-gestruktureerde, oop-einde vrae was gebruik om die deelnemers aan te moedig om aktief aan die besprekings deel te neem. Elke onderhoud is op oudio band opgeneem en veldnotas is gemaak. Tydens analiese is drie hoofemas geïdentifiseer, nl die houdings van KVPs, die kennis en vaardighede van die KVPs sowel as die impak van die opleidingsprogram op die kwaliteit van sorg wat deur KVPs gelewer word.

Skriftelike toestemming vir die studie is by die Etiese Navorsingkommittee, Universiteit van Stellenbosch, asook die Navorsingseenheid van die Wes-Kaapse Departement van Gesondheid verkry. Voorafgaande toestemming is voorts vanaf elke deelnemer verkry, nadat hulle verseker is van vrywillige deelname, konfidensialiteit en anonimiteit.

Geloofwaardigheid, afhanklikheid en oordraagbaarheid is verseker, deur na twee van die deelnemers terug te gaan wat die transkripsies geverifieër het as juis en korrek.

In hierdie studie is tot die slotsom gekom dat pasiënte KVPs as onvriendelik en ongevoeligervaar het. Onbillike praktyke kom steeds voor, deurdat familieledede en sekere rassegroepe voorkeur behandeling kry.

Deelnemers se ervarings aangaande die bevoegdheid van KVPs was as toereikend beskryf aangaande die assessering, ondersoek en voorsiening van gesondheidsinligting en medisyne. Hulle het egter ook die behoefte uitgespreek dat die KVP's 'n groter verskeidenheid medisyne behoort voor te skryf en meer diagnostiese toetse behoort te kan uitvoer as wat tans binne die bestek van praktyk, soos neergelê deur die Suid-Afrikaanse Raad op Verpleging, moontlik is. Hierdie persepsie van die deelnemers impliseer dat die huidige na-graadse opleidingsprogram voldoende is en hul gesondheidsbehoefte aanspreek. Die behoefte vir die uitbreiding van die rol en funksie van die KVP is egter uitgespreek.

Die aanbevelings wat gemaak is sluit in:

- 'n In-diepte ondersoek oor die onbeskofte ingesteldhede van KVPs behoort uitgevoer te word, ten einde die professionele gedrag van KVPs teenoor pasiënte te verbeter.
- Beleidmakers behoort die uitbreiding van die rolle en funksies van die KVP te oorweeg.
- Benadruk voortgesette, professionele bevoegdheid deur toepaslike en produktiewe indiensopleidingsprogramme.

Ter afsluiting: hierdie studie het aangetoon dat KVPs voortdurend bewus moetbly dat hulle met mense werk wat gevoelens het en wat gesondheidshulp

benodig. Dit is uiters belangrik om aan die behoeftes van 'n terapeutiese omgewing te voorsien, ten einde 'n kwaliteit, omvattende diens aan die gemeenskap te lewer.

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- To Julia Handford, the editor who assisted in compiling a professional thesis.
- Last but most importantly – To God who gave me the strength to complete this research and being with me all the way.

*I dedicate this thesis to my late father, Gerrit Burger,  
who died in 1974 when I was only 13years old.*

*His example as a great businessman, dedicated father  
and humble servant to the community, still inspires me.*

*"Pa - ek weet jy sou trots gewees het op my prestasie !!"*

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## KEY ABBREVIATIONS

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CNP	Clinical Nurse Practitioner
NQF	National Qualification Framework
PGWC	Provincial Government, Western Cape
PHC	Primary Health Care
PHRC	Public Health Research Committee
SANC	South African Nursing Council
WCDoH	Western Cape Department of Health
WHO	World Health Organization

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# CHAPTER 1

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## ORIENTATION TO THE STUDY

### 1.1 INTRODUCTION

Primary Health Care (PHC) is the first level of contact that individuals, families and the community have with the health system. It brings health care closer to where people live and work.

In September 1978, in Alma Ata, Russia, the 134 countries being represented on the World Health Organization (WHO) of the United Nations (UN), came together and made a declaration of "Health to all by the year 2000". The philosophy of PHC was introduced as a means to achieve the idea of providing health services closer to the community. With its foundation deeply rooted in equity, accessibility and affordability to the patient and the community, its objectives include efficient service and comprehensiveness (Dennill, King and Swanepoel, 2008:6).

According to the WHO, health can be defined as "a state of physical, mental and social well-being and not only the absence of an illness" (Dennill, King & Swanepoel, 2008:4). It is hence recognised that an individual must be treated in a holistic manner, namely physically, mentally and socially and not only according to the physical illness.

In recognising the need for transforming the health sector in South Africa, the African National Congress (ANC) developed the National Health Plan, based on the PHC principles (ANC, 1994:9). Accordingly, the South-African Government developed the PHC Package of South Africa: A set of Norms & Standards (Department of Health 2001:12), in which it is stipulated that a PHC service should be a nurse driven service, functioning on a one stop approach basis and accessible for at least 8 hours per day for 5 days a week. A comprehensive service, namely primary, secondary and tertiary prevention should be rendered at all facilities at the PHC level.

This chapter is concerned with the formulation of the research problem, the aim of the study, the methodology and the ethical considerations, whilst the limitations of the study are also discussed.

## 1.2 RATIONALE

This study was aimed at determining the perceptions of community members with regards to services rendered at PHC facilities by Clinical Nurse Practitioners (CNPs), within the West Coast rural district in the Western Cape Province. This study thus focused on the effectiveness of nursing interventions and activities to various clients at nurse driven, rural clinic level.

Singh, Haqq and Mustapha, (as cited in the WHO Bulletin, 1999:77) are of the opinion that consumers of the health care system make judgements about quality of care, by assessing the efficiency of the facility they attend. Therefore, by determining the judgement, or perception of the community regarding the quality of care rendered at PHC level, any shortcomings can be identified and used to improve the overall service of PHC facilities.

Mash and Kapp (as cited in the S.A. Family Practice Journal, 2004:46) suggest that further research should be performed on the community's qualitative view about service delivery by CNPs in comparison with a doctor driven service.

In line with this suggestion and due to the researcher's active involvement in PHC for over 20 years, it was decided to explore the perceptions of those communities being served by the Provincial Government of the Western Cape (PGWC) health facilities, with regards to the quality of care rendered by CNP's at PHC level in the West Coast rural district in the Western Cape Province.

The researcher decided to focus this study on the following topics:

- The perceived attitude of the CNP towards patients;
- The perceived knowledge and skills of the CNP; and
- The current post-graduate diploma training programme that contributes towards the expanded roles and functions of the registered nurse, in order

to practice as a specialist in the field of health assessment, treatment and care of patients at PHC level.

This research should provide important feedback to various stakeholders within the Western Cape Department of Health (WCDoh), including the district manager of the West Coast District, and to the head office of the WCDoh, particularly the policy makers. In evaluating the successful implementation of the PHC approach within the Western Cape Province, stakeholders and policy makers could use these scientifically based research outcomes to develop future frameworks for the improvement of health services to the community.

### **1.3 PROBLEM STATEMENT**

Complaints received at the WCDoh head office from patients, visiting PHC facilities within the Western Cape Province, have led to rising concerns as to whether a quality service is being rendered at PHC facilities. These recently implemented procedures allow for complaints by patients and have become an important indicator of the acknowledgement of patients' rights within health facilities, despite health providers still grappling to deal with them.

During the researcher's visits to various PHC facilities in the West Coast region, it was ascertained from the discussions with patients that many problems existed with regards to the quality of services being rendered at PHC level. Patients had various perceptions of the quality of care rendered by clinical nurse practitioners in clinics and community health centres.

Since the implementation of the PHC approach in South Africa, very limited research has been undertaken to assess whether communities' needs and expectations, with regards to the quality of services by CNPs, are being met.

It has hence become essential to investigate the perceptions and lived experiences of those patients receiving health care services at PHC level by the specialist nurse, or CNP.

## 1.4 RESEARCH QUESTION

The aim of this study was to determine and describe the quality of care being rendered by nurses with specialised knowledge and skills to examine, diagnose and treat patients at nurse-driven PHC facilities.

The research question for this study was: *“What are the perceptions of patients regarding comprehensive care rendered by clinical nurse practitioners in the West Coast rural district of the Western Cape?”*

## 1.5 RESEARCH AIM

The aim of this study was to investigate the perceptions and lived experiences of patients attending Primary Health Care facilities, with regards to the quality of care being rendered by Clinical Nurse Practitioners.

## 1.6. OBJECTIVES OF THIS STUDY

Flowing from the above aim, this study focused on the following objectives:

- To explore and describe the perceptions of patients in the West Coast rural community regarding the quality of health services being rendered by CNPs at nurse-driven PHC clinics. This objective includes the perceptions regarding the attitudes, the knowledge and skills of CNPs.
- To provide policy makers in the WCDoH with possible recommendations with regards to a more successful implementation of the nurse-driven PHC policy, as stated in the National Health Plan and Health Care of 2010.
- To provide recommendations to nursing education institutions who offer specialised, post-graduate training programmes, with scientific evidence on how the community perceives health care currently being rendered by CNPs in rural areas, and to possibly influence curricular change based on whether the current training meets patients' needs.

- It was expected that the evidence would institute curriculum changes that would bring about enhanced Primary Health Care that would meet the needs of rural and other communities.

## **1.7 RESEARCH METHODOLOGY**

### **1.7.1 Research design**

During this study, a qualitative, descriptive research design was applied. A descriptive phenomenological method seemed the most appropriate method for obtaining the required information, since the researcher sought to capture the human experiences and perspectives of patients attending PHC health facilities in the West Coast rural area, within the Western Cape. The researcher made use of the principles of Colaizzi (as cited in Streubert & Carpenter, 1999:14) as a guideline to this study.

### **1.7.2 Population and sampling**

The Western Cape Province is divided into six districts, each with its own health manager. Five of these districts are rural areas, namely the West Coast, Overberg, Cape Winelands, Eden and Karoo, with the Cape Metropole being the only urban/city area. The West Coast rural district was the focus of this study, as all services here are nurse driven, comprehensive and managed by the same district manager, currently Mrs CW Bester.

Convenient, systematic, “area-sampling” was used. The researcher interviewed twenty-six participants from five clinics within the West Coast district.

Through the random interviewing of patients on any given day, sampling bias and subjectivity were limited. The researcher made use of inclusion and exclusion criteria to determine the eligibility of the target population. The sample was selected from the accessible population within the target population.

### **1.7.3 Data collection**

Telephonic discussions were held with the district manager and each facility manager of the fiveclinics, to explain the purpose of the investigation and to describe the research process.

The researcher conducted focusgroup interviews with patients that had been seen by CNPs in these fiveclinics. The researcher was primarily responsible for data collection.

Signed informed consent was obtained from each participant, while still in the waiting room,thus before being attended to by the CNP.

The focusgroup interviews wereheld away from the PHC facility, to encourage participants to freely express their feelings, experiences and perceptions.

Every focusgroup interviewwas uniquely coded,whilstevery participant received a unique number. As the West Coastregion ispredominantly Afrikaans speaking, the researcher allowed participants to express their views and inputsin Afrikaans. In so doing, language was no barrier to communication, nor to the expression of participants'opinions.

The researcher facilitated each session by asking openended questions and by encouraging participants to actively partake (see Annexure A). The researcher summarised all feedback to each question, before continuing to the next,in order to ensure that the correct perceptions and feedback wererecorded.

Each interview was also audio taped and field notes were taken.

#### **1.7.4 Instrumentation**

Semi-structured,focusgroup interviews were conducted. Each interview comprised offixed questions in order to maintain consistency and to reduce potential bias by the interviewer (see Annexure A).

Questions were formulated to explore patients'perceived interpretations of the attitudes, skills and knowledge of CNPs. To ensure that each participant has had sufficient exposure to ahealth care facility and therefore to be in a position to contribute towards the focus group discussions, the participation criteria

specified that the patient should have visited the PHC facility at least three times during the past year.

### **1.7.5 Data analyses**

Pollit and Hungler (1998:312) describe data analysis as the process of bringing order and as involving the “breaking up” of data into manageable themes, patterns, trends and relationships.

The audio tapes were marked with the interview date and group reference code. They were kept in a locked safe at the researcher's home. The researcher analysed the possible relationships of the data by transcribing the interviews *verbatim* (see Annexure G). This gave the researcher the opportunity to familiarise herself with the data.

During the actual analysis process, the essence of meaning was grouped in such a way, as to highlight the meaning of elements within the data. Colour coding was used to highlight the emerging patterns. This process led to trends being clustered together to form themes, which enabled the researcher to discover the meaning, as intended by this research, namely whether the community experiences the quality of services being rendered by CNPs, as good, average, or poor.

### **1.7.6 Trustworthiness of the study**

In a qualitative study, according to Guba and Lincoln (as cited in Streubert & Carpenter, 1999:29) trustworthiness serves to ensure that the participant's experience of the phenomenon (quality of PHC services by nurse practitioners) is accurately represented. During the interviews, the researcher established a good rapport with the participants, a sample time during these group sessions was allowed to ensure that the participants responded and verbalised their perceptions and opinions.

The above authors describe four steps or techniques that support the trustworthiness of data analyses.

#### **1.7.6.1 Credibility**

Credibility is the alternative to internal validity and refers to the truth and believability of findings. After the data analyses, the researcher returned to two participants, who validated that the transcripts were a true reflection of their experiences. No personal identification was revealed in the validating documentation, for the purpose of maintaining confidentiality. This method of verifying the data was in accordance with the approach by Colaizzi (as cited in Streubert & Carpenter, 1999:14).

#### **1.7.6.2 Dependability**

Polit and Hungler (1998:435) define dependability as a criterion for evaluating the quality of the data, by determining the stability of the data over time and certain conditions. The researcher used an outside reviewer to scrutinise (audit) the data, the relevant documents and the tapes. This process attributed to establishing trustworthiness of the study.

#### **1.7.6.3 Confirmability**

This refers to the objectivity of the data. The researcher maintained a clear distinction between her personal values and those of the participants, by not allowing her prior assumptions and preconceptions to influence the study outcomes. The researcher used an outside reviewer to scrutinise (audit) the data, the documents and the tapes for objectivity and relevance of the data obtained. The researcher also returned to two participants, who validated the transcripts as being a true reflection of their experiences.

#### **1.7.6.4 Transferability**

Streubert and Carpenter (1999:29) state that study findings must have similar meaning to others. Brink (2000:152) substantiates this by stating that all participants must have concern with this topic and must have similar backgrounds. The researcher attempted to apply this criterion, by using the inclusion criteria when recruiting the sample of representative patients at PHC

level that would be able to reflect on the key issue of the research problem, namely their perceptions of the quality of services being rendered by CNPs at PHC service level.

### **1.7.7 Ethical considerations**

Polit and Hungler (1998:353) report that when humans are used as participants in scientific investigations, as in this study, the human rights of the participants should be protected. This research was conducted in accordance with three primary ethical principles, as stated by Brink (2007:31):

#### **1.7.7.1 *Beneficence/ non-maleficence***

Beneficence means that “Above all, no harm should be done to the participant”. The researcher was continuously aware of any issues that could harm the participant’s physical or mental condition as a patient. The involvement of the participants during this research study did not place them at any disadvantage, nor did it expose them to any exploitation.

#### **1.7.7.2 *Respect for human dignity***

According to Polit and Hungler (1998:358), respect for human dignity implies that an adult with a capacity to decide has the right to determine what may be done to his/her body. In this study, the following applied to ensure respect for human dignity:

- Written approval from the Ethics Research Committee, Faculty of Health Sciences of the University of Stellenbosch, as well as from the Provincial Government, Department of Health, were obtained prior to the study.
- Full disclosure of the purpose and nature of the study was done, before the participants were given the opportunity to give their informed consent.
- Informed consent from participants was obtained after prior assurance that all information would be treated as confidential, and that any material would only be used for the purpose of the research (see Annexure B).

- Participation: All participants were assured that their participation during this study was voluntary and that they had the right to withdraw at any stage, without penalty or justification.

### **1.7.7.3 Justice**

According to Polit and Hungler (1998:326), the principle of justice is upheld by ensuring privacy, confidentiality and anonymity of participants. All the interviews were conducted away from the health facility to minimise any influence that CNPs could have on a patient. This arrangement also assured participants' privacy. Confidentiality was adhered to by coding the names of participants within every coded focus group. A master list of participants' names and matching code numbers, as well as the audiotapes were kept in a secure safe in the researcher's study at her residence.

### **1.7.8 Limitations**

This study was limited to the West Coast district only. The other four rural districts in the Western Cape, namely the Overberg, the Cape Winelands, Eden and the Karoo were excluded because of time constraints, since the vast geographical distribution of these districts would have made travelling very time-consuming and expensive. It was recognised that the perceptions, experiences and PHC facilities of the West Coast population may differ from district to district, due to, for example, socio-cultural and economic differences and that the results and conclusions from this study, would possibly not truly reflect the perceptions and experiences of patients in the other four rural districts.

The researcher was aware that true expression could only be reflected through communication in the mother tongue of patients. As the West Coast rural district is mainly an Afrikaans-speaking community, all of the participants were allowed to express their views in Afrikaans. Although no participants indicated another language preference, the views of patients of the greater South African population, whose mother tongue differs, were excluded during this study.

The vast distances between the identified towns in the West Coast region required excessive travelling and meticulous planning, and the researcher dedicated a week to data collection.

## **1.8 CONCEPTUAL FRAMEWORK**

Burns and Grove (2009:126) describe the framework as a logical structure that guides the research study. The findings of the research must be linked to the body of knowledge already existing in the nursing profession. Brink (2008:24) in support states that a framework is the defining of concepts and proposing relationships. It is a specific way of looking at a particular phenomenon by organising ideas. The researcher was thus able to show that the proposed study was a logical extension of current knowledge.

For this study, the researcher applied the conceptual framework of Omachonu and Einspruch (as cited in the Public Sector Innovation Journal Vol. 15(1) of 2010). These authors affirm that one of the driving forces in research is a conceptual framework that provides researchers with the foundation upon which their studies are built. Policymakers and practitioners use it to evaluate their services in ways that are realistic and valuable to the health care system, in order to improve internal capabilities and the quality of care.

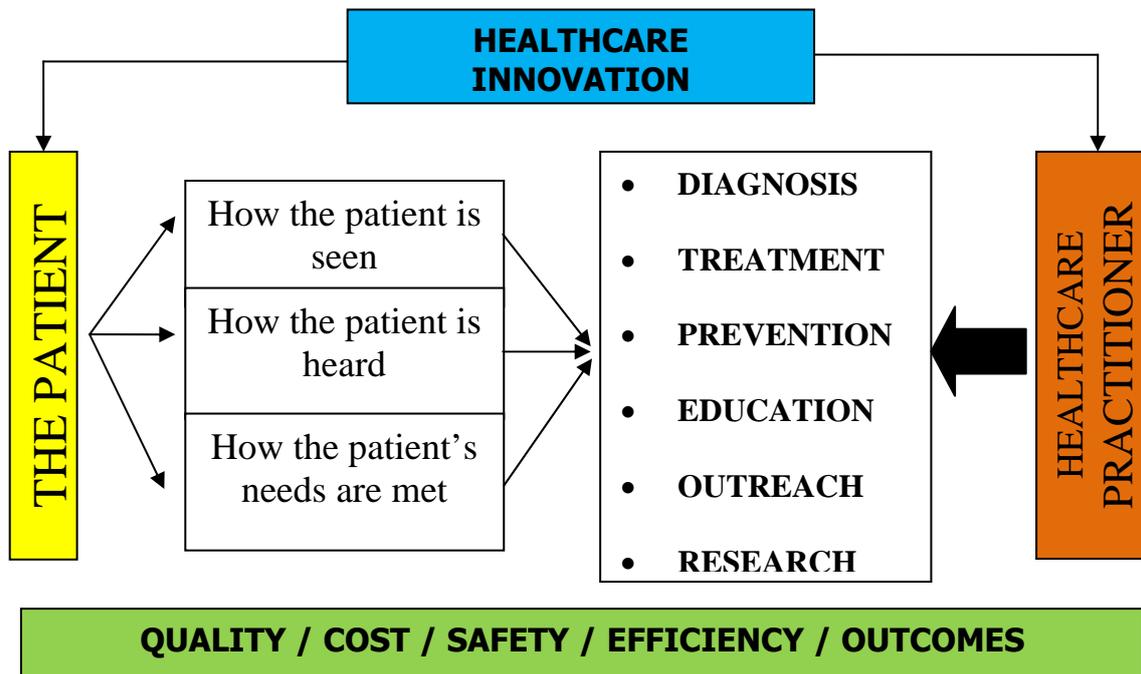
According to Omachonu and Einspruch (as cited in the Public Sector Innovation Journal Vol. 15(1) of 2010), healthcare innovation serves six distinct outcomes, namely:

1. Making a correct diagnosis of the patient's problem.
2. Improving the treatment that patients receive.
3. Educating the patient as to prevent any complications of the health problem.
4. Reaching out to the community in order to meet their health needs.
5. Preventing illness through applicable information to the community concerning current health indicators and trends.

6. Performing continuous research to improve the health services being rendered to the community.

The above outcomes can only be met if the focus remains on three fundamental areas, namely how the patient is seen, how the patient is heard and how the patient's needs are met. *The core of healthcare innovation thus comprises the needs of the patient.* Ways in which the healthcare practitioner delivers care to the client, will determine the quality of the innovation.

The framework below is the core of this study, as the patient must be assessed by looking and hearing what is said in order to diagnose, treat and educate the patient. All these interventions are undertaken by the healthcare practitioner in order to render a service that would meet the needs of the client, by caring for the patient holistically. This innovation should be carried out as a quality, efficient, safe and cost-effective service to meet the outcomes (goals) of the health care organisation.



**Figure 1.1:** A conceptual framework for innovations in healthcare.

## 1.9 OPERATIONAL DEFINITIONS

For the purpose of this study the following definitions applied:

- **Quality of care:** Proper performance (according to standards) of interventions that is safe and affordable to the society in question, so that the care being provided is as effective and safe as possible (ANC 1994. A national health plan for S.A).
- **Perception:** Interpretation and organising of sensory and environmental information, to produce a meaningful experience of the surrounding or situation (SA Oxford Dictionary. 3<sup>rd</sup> ed. 2005).
- **Primary health care:** Conceptual framework for providing public health that includes the delivery of essential, affordable, accessible and acceptable health care to the community, with the emphasis on disease prevention and health promotion, treatment of minor ailments and endemic diseases, monitoring of chronic illnesses and rehabilitation (Department of Health. 2003. Healthcare 2010).
- **Comprehensive service:** Rendering a service as stipulated in the Core Package of Service, including primary, secondary and tertiary prevention. This can be explained as:
  - **Primary prevention:** Keeping the community healthy by adequate health promotion interventions.
  - **Secondary prevention:** Treating a patient who has become ill.
  - **Tertiary prevention:** Rehabilitating the patient as to achieve optimal functioning.
- **Clinical nurse Practitioner (CNP):** Professional nurses trained in the specialty of clinical nursing, diagnosing, treatment and care as stipulated in the South African Nursing Act No 33 of 2005, Article 56.
- **Primary level of care:** First contact between the health system and the community (Dennill, King and Swanepoel 2008).

- **Nursedriven:** Specialised nurses render the service instead of doctors. These nurses fulfil an independent function while still working within the multidisciplinary team (Dennill, King and Swanepoel 2008)..
- **Community:** A group of people who live in a certain geographical area, who shares values, cultures and social problems(Mash and Kapp 2004).

## 1.10 CHAPTER OUTLINE

**Chapter 1** provided an introduction to the study, by describing the background, or setting of this study, the problem statement, the objectives and the significance of the study.

**Chapter 2** presents relevant literature on the quality of care rendered at PHC level, including the process being applied to identify and select the chosen literature.

**Chapter 3** presents the research design and methodology.

**Chapter 4** is concerned with the data analysis, interpretation and discussion of the findings.

**Chapter 5** summarises the findings, recommendations and also identifies problem areas being encountered during the research.

## 1.11 CONCLUSION

In this chapter, the research question was discussed, as well as the rationale for this study, the aims and objectives. Definitions of relevant terms were provided, together with an outline of the study.

In chapter 2, the literature review is discussed.

# CHAPTER 2

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## LITERATURE REVIEW

### 2.1 INTRODUCTION

In this chapter, the findings from the literature review on the perceptions of communities regarding the quality of health care being rendered by Clinical Nurse Practitioners (CNPs) in nurse-driven, Primary Health Care (PHC) clinics, are discussed.

Carnwell and Daly (2001:57) state that the purpose of a literature review is to critically appraise and synthesise the current knowledge relating to a certain topic, as to identify gaps in the knowledge. The necessary steps in this process include a definition of the scope of the review, identifying sources of information, reviewing the available literature and conducting the review.

Burns and Grove (2009:91) describe how a literature review conveys what is currently known about a specific topic, and the importance of obtaining a broad background and understanding of what is already known about a particular problem. There may be gaps in the current knowledge that exist regarding a particular phenomenon. Areas that need to be researched could involve gaps that have been identified from previous research or past research that had been conducted, but the need has arisen for it to be conducted in another country, region or institution.

A computer search of available literature was conducted by the researcher with the help of different library assistants. Various relevant databases were accessed, for example Pub Med, Google, Medline and Cochrane. All literature was read in conjunction with the Department of Health's publications, applicable to this phenomenon, for example the National Health Plan and the Western Cape Province Health Care Plan of 2010. The researcher tried to achieve a broad insight by focusing on literature about research done in the Western Cape Province specifically, as well as research done within South Africa,

regional Africa and internationally. Most publications available on the quality of care by nurse practitioners were from international studies, whilst relevant literature in the South African context, specifically research that had explored the perceptions of rural communities regarding the quality of care being rendered by CNPs, were limited.

## **2.2 EXTENDED ROLE OF THE PROFESSIONAL NURSE**

Earle (2004:22) reports that in the late 1970's, the need was identified in South Africa (SA) for another professional *cadre*, other than the medical doctor, to assist in rendering PHC services to the growing number of patients. The first initiative was for professional nurses to take the patient's history, while the consultation was undertaken by the doctor. This function was later extended to the nurse having to examine patients and manage them by providing health information and treatment. Today, this particular professional nurse is called, *the Clinical Nurse Practitioner (CNP)*.

Earle (2004:24) further states that research conducted by Mclain in 1988 (as cited in Deverease & Salvage, 1991:15), asserted that the quality of care being rendered by CNPs in the United States of America (USA), had led to doctors feeling economically threatened. Patients wanted to be seen by CNPs, instead of by doctors, whereas the success of medical tasks by CNPs had also led to doctors feeling that they had to compete with CNPs for posts.

In 2001, the then MEC of Health, Nick Koornhof, opened the Western Cape Nursing Summit by stating that nursing in the 21<sup>st</sup> century was very exciting as a result of the move towards Primary Health Care. He continued by saying that the nurse driven service would have major implications on the roles and functions of the nurse, due to the larger scope of practice, in addition to the level of responsibility the nurse has to attain. Koornhof was of the opinion further that, since the nurse practitioner formed the first line of contact between the patient and the health service, the Department of Health should protect and nourish this *cadre* of nurses and that the success of the PHC principle would depend on nurses (SA Government Information, 2001:2).

Carryer *et al.* (2001:7) prepared a document for the College of Nursing in New Zealand, about the nurse being the answer to inequalities in the PHC service. This document states that nursing is a combination of many elements, including knowledge, professional codes, skills and attitudes. These authors acknowledge the fact that the attitude of the nurse practitioner plays a major role in the satisfaction perception of patients. Increasingly, nursing has developed a theoretical focus, not just on the causes of the disease, but also on the underpinning determinants of health, such as unemployment, the education status of the community and income. All of these influence the level on which nurse practitioners need to focus their health information sessions.

### **2.3 QUALITY OF CARE**

During this study, the researcher aimed at examining the evidence from previous studies about the quality of care being rendered by CNPs at PHC level. The most applicable definition of quality care for this study was the one by Hays, Veitch and Evans (2005:2), who conducted a multiple-perspective, analytical study on 189 participants in Australia. These authors define quality care as a service rendered that is acceptable, legitimate, efficient and equitable. It concerns the actions done to the patient by special trained practitioners in the course of interacting with a patient.

Findings by Earle (2004:60) proposed that few studies had been done on the CNP within the South African context. According to this author, the practice of the CNP and the expanding role that he/she has to play needs to be researched, especially in light of the changing needs of the community.

Singh, Haqq and Mustapha (1999:4) report that feedback from patients is vital, if deficiencies are to be identified and plans are to be put into action to improve the service. These authors, who undertook a study in Trinidad and Tobago, are of the opinion that consumers make judgements about quality by assessing different factors, such as courtesy, responsiveness, attentiveness and competence. It would thus be important to research the opinions of those people who use health centres, in order to establish their perceptions of the

efficiency, possible ways of improving the facility and the skills and knowledge of staff rendering the service.

A study was conducted in Bristol in the United Kingdom (UK), by Horrocks, Anderson and Salisbury (2002:1), during which randomised, controlled trials and observational studies were performed, by comparing patients' satisfaction at being treated by nurse practitioners and doctors working at PHC level in the UK. The authors found that patients were more satisfied with the care being provided by the CNP, because longer time was spent on consultations, whilst return consultations were less. The conclusion was made that by increasing the availability of nurse practitioners at PHC level, would inevitably lead to higher patient satisfaction and quality care.

A study by Donald, Chapman and MacKenzie (1995:3) on the PHC service being rendered at mobile units in the Orange Free State in South Africa, indicated that nurses measured their productivity as the time that they could spend with a patient, together with providing quality care. 37% of the nurses felt that they were too busy with non-nursing work and that this had a negative impact on the quality of care that they would like to render. Data analyses indicated that some of these nurses spent as little as 16 hours per week on direct patient care, resulting in nurse practitioners self-rating their services as unsatisfactory. The authors concluded that quality care could not be rendered with nurses spending so much time with activities, other than patient care.

Hays, Veitch and Evans (2005:7) reasons that the continued supply of skilled and trained professional nurses appears to affect their abilities to maintain confidence in their levels of service delivery, and that they therefore rate their services as unsatisfactory. Not enough newly trained nurse professionals seem to be available to ease the current workforce demands, let alone to replace those that are retiring or resigning. These have led to a domino effect that is reducing the quality of service to patients.

## 2.4 KNOWLEDGE AND SKILLS OF THE CNP

Qolohlo *et al.*(2006:48)performed a qualitative study on the relationships between doctors and nurses offering PHC at theKwaNobuhlehospital in Uitenhage, in the Eastern Cape, South Africa. A reassuring, common theme that arose from analysing the data was that doctors had felt that the competencies of CNPs were of very high quality and that the knowledge and skills of CNPs were much the same as their counterpart doctors. The evidence showed that the doctors had felt that the competence level of the nurse practitioner had filled the gap as caused by the shortage of medical doctors in the country.

In 1995, Marsh and Dawes (1995:2) established that nurse practitioners could indeed be successfully incorporated into the health team of a private practice and render preventative care, manage chronic illnesses and minor ailments. They were specifically trained to consult and use diagnostic instruments correctly. After observing 696 consultations by nurse practitioners and by conducting post-consultation interviews with these patients, the outcomes of the study indicated that 90% of the patients were satisfied and accepted being examined by nurses. 80% of the patients did not return for the same illness and the doctors indicated that the other 20%, who had returned, would have returned, even if they had been seen by doctors.

Kinnersley *et al.* (2000:46) substantiated the above during their study of measuring patient satisfaction at primary care level among 1,368 patients. The results fromtheir study indicated that although the consultation times of nurse practitioners had been longer than those of general practitioners, the 10% of patients who returned afterwards did so, because the nurse practitioner had requested them to. This outcome led to the conclusion that the knowledge and skills of the nurse practitioner were of a high standard.

In a landmark study by Laurent *et al.* (2004:2) on the possible substitution of doctors by nurses in PHC, it was found that patient satisfaction was higher when seen by nurses, than by doctors. Nurses were used to substitute doctors and not supplement them. This quasi-experimental and observational research

strengthened the views of Horrocks, Anderson and Salisbury (2002:49), namely that patient health care outcomes were the same when seen by doctors or nurses. Patient satisfaction could have been influenced either by nurses spending longer time to consult with patients, or by nurses providing more information to patients on their conditions and on the available medications.

Kinnersley *et al.* (2000:9) confirm that nurse practitioners provide more information to patients and therefore prescribe fewer medicines, which is in support of the nurse practitioner's extended role within the quality PHC service.

In the study by Sixma, Spreuwenberg and van der Pash (1998:215) on patient satisfaction in the Netherlands, the three dimensions of patient satisfaction, including information given to patients, were examined. Results showed that patients were very satisfied with the health information received from nurse practitioners. Older patients, as well as patients having none, or relatively few chronic problems, were more satisfied with the general practices of nurses. The older patients indicated that the nurse practitioner had a more positive attitude towards the democratic rights of elderly patients, and indicated that their knowledge of diseases of that age group was commendable.

The above findings were supported by those of Laurent *et al.* (2009:2), namely that nurses provided more and higher quality health information to patients, than doctors. Results also indicated that patients' health care outcomes had been similar for doctors and nurse practitioners, but that patient satisfaction was higher when seen by nurse practitioners. Twelve cases indicated that the nurse practitioner had provided significantly more lifestyle advice than doctors, whereas 95% of patients had received less prescribed medicines, whilst indications were also that adherence was better in nurse-led care.

A related study by Thandrayed (2001:5) on the quality of child health services, offered at PHC clinics in Johannesburg, resulted in contradictory results. It was found that out of 141 sick children, only 77% had been diagnosed appropriately, whilst 46% of these children had received unwarranted antibiotic medicines. CNPs for example lacked the capacity to manage children with

chronic conditions, such as asthma. The conclusion was made that a radical overhaul in the clinical practice of rendering health care to children, should take place.

## **2.5 ATTITUDE OF THE CNP**

A study by Nielsen and Hillsdale (2005:5) concluded that patients and their families measured the quality of health services in terms of good interpersonal relationships, communication and friendliness of the care provider. Patient satisfaction improved as a result of continuous communication by staff with patients from 44% to 88% of patients interviewed.

Hays, Veitch and Evans (2005:2) refer to Donabedian's theory, by raising key concepts, like efficacy, acceptability and equity of care, to describe the quality of care. Patients would therefore judge the attitudes of staff according to their friendliness, good communication skills and continuous good interpersonal relationships. According to Nielsen and Hillside (2003:337), continuous communication improved patient satisfaction from 44% to 88% over the duration of their six-month study.

The opinion of the above authors is substantiated by Singh, Haqq and Mustapha (1999:8), who state that 92% of the patients expressed that the nurse's willingness to listen to patients' explanations of their problems is of utmost importance when rating the satisfaction of the service, whilst 84% of the patients were satisfied with the health advice nurses had provided.

The study by Gadallah, Zaki, Rady, Anwer and Sallam (2003:422) on patient satisfaction with PHC services in Egypt established that nurses, who allowed patients time to explain their health problems, followed by a thorough explanation of the illness, were rated as having good "bedside manners" by these patients. The exit interviews of 1,108 patients indicated that the majority of complaints had centred on the unavailability of prescribed drugs and not the attitudes of the nursing specialists.

A qualitative study done by Qolohle *et al.* (2006:48) regarding the relationships between doctors and nurses offering PHC in Uitenhage, South Africa, indicated

that patients mostly referred to the attitudes and approaches of doctors and nurse practitioners as pleasant and enthusiastic. An outright view on body language came from a patient who stated: “Just the appearance, facial expression and greeting of the nurse says a lot of her attitude towards patient care.”

Hays, Veitch and Evans (2005:4) confirmed that good interpersonal relationships had led to higher patient confidence and satisfaction. Their study explored the perspectives of 91 patients on the question of what constituted quality of care in a general sense. A qualitative, thematic analysis indicated that patients associated attitude with words like empathy, niceness, helpfulness, compassion, kindness and calmness. One significant statement by a patient included: “Some nurses are so busy with their routine work that they forget that patients are people with concerns and anxieties.”

Two specific themes emerged from the above study. The first was that nurses in small, rural hospitals provided a friendlier, more flexible, accessible and caring service than urban hospital staff. The assumption was made that because of the small or close community, health professionals knew the people they served, which therefore made the service more personal. The second theme concerned the sustainability of the skills of the staff, which is discussed under the next heading, i.e. the training of nurse practitioners.

## **2.6 TRAINING PROGRAMME OF THE CNP**

After the 1976 Soweto uprising, a group of doctors at Baragwanath Hospital, in Soweto, Johannesburg, initiated a clinical training course for nurses. This course of three months was offered to six professional nurses, which ultimately resulted in the founding of CNPs. This notorious event had influenced the future training of nurses and in the early 1980's, the South African Nursing Council recognised a new *cadre*, the “nurse clinicians”. A post-basic Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care course, was stipulated in the South African Nursing Act No 50 of 1978, as amended, Regulation 48 of 22 January 1982

Cuéllar (2004:24) states that by building the capacity of professional nurses through training and development, the clinical nurse practitioner would have a direct and extensive impact on the service to clients.

According to Kapp and Mash (2004:2), the first CNPs in the Western Cape Province were trained in 1978. Immense confusion, however, existed about the roles and functions of the CNP within the comprehensive PHC system and these authors were prompted to conduct a study that was entitled, "Perception of the role of CNPs in the Metropole". This study indicated that of the 88 CNPs interviewed, only 28% functioned in a comprehensive service as they had been trained to. It further indicated that the effectiveness of the CNP's functions was determined by personal motivation, the opportunity to practice immediately after training had been completed, as well as the support by doctors.

Contrary to findings by authors, such as Laurent *et al.* (2004:2) (and others as per section 2.4 above), Geyer (2003:53) states that South African nurses lack the clinical expertise to replace the role and function of the doctor at PHC level and therefore lack the ability to render a good, quality service to the community.

Earle (2004:23) provides a broad history of the training of CNPs within the Western Cape. Dr Turner offered the first course at the Dr Abduraghman Day Hospital in Cape Town, consisting of only one month of in-service training. In 1982 the course was adapted and a four-month, full-time curriculum was developed and presented from the Robbie Nurock Day Hospital in Cape Town.

In 1997, a part-time, one-year certificate course was presented in all four regions of South Africa, under the control of the Human Resource Development and Training Departments, as an in-service-training programme. This South African Nursing Council (SANC) accredited course led to CNPs being authorised to examine, diagnose, prescribe and dispense medicine to patients at PHC level.

Today, with the establishing of the National Qualification Framework (NQF) and the South African Qualifications Authority (SAQA) in 1995, education and training are strictly quality assured. In nursing, this role is performed by the SANC. In the Western Cape Province, the SANC accredited training providers

for this post-graduate diploma course include the University of Stellenbosch and the Western Cape College of Nursing (Earle, 2004:32).

Carryer, Dignam, Docherty, Lightfoot, Ross, and Messervey (2001:13) report that the current, expert training programme in New Zealand is at post-graduate diploma level. These authors express the viewpoint that this education programme should be at masters' degree level and an agreed curriculum should be followed throughout the whole of New Zealand by all training institutions. In the South African context this specialty course is also offered at a post-graduate diploma level and not at a masters' degree level.

Horrocks, Anderson and Salisbury (2002:3) concluded, after completing a study in Bristol in the UK on eleven, randomised, controlled trials, that no consensus had been identified with regards to the level of training and qualification needed for the clinical nurse practitioner to render a quality service in the UK. From a South African perspective, this is not the case, as quality assurance of nurse training, qualification ratings and the scope of practice is determined by SANC.

Laurent *et al.* (2009:2) report the contrary, by suggesting that appropriately trained nurses can provide high quality care and achieve as good health outcomes for patients as doctors. Their review further concludes that the quality of care was similar for nurses and doctors, but it is unknown whether their services would decrease doctors' workloads. They also suggest that nurses require training to extend their roles, as to enhance the quality of health services being rendered, to safely substitute doctors in a wide array of services and to reduce the direct costs of services, due to nurses being cheaper to hire than physicians. It is also recommended that additional research is needed to examine the relationships between training programmes and the outcomes of service delivery in the PHC setting by nurses, trained for these expanded roles and functions.

Qolohle *et al.* (2006:17) are of the opinion that there are diverse and sometimes opposing views on how to bring about improvements in the PHC service. Some doctors in Uitenhage, South Africa, felt that standard protocols could be structured in such a way that the nurse, by undergoing an extended, intensive

training programme, should be able to prescribe and render a more comprehensive service at PHC level. This would then free doctors from “wasting” their advanced skills at PHC level and rather dedicate their skills at tertiary level of care.

According to Carryer and Dignam (2001:8), the nurse practitioner in Primary Health Care in New Zealand has to undertake extended training in advanced assessment and intervention strategies, pharmacology and health policies, in order to assume the responsibility of prescribing and fulfilling the independent roles and functions, as stipulated by the Minister of Health, in their Primary Health Care Strategy. Such training programme must equip the professional nurse with extensive knowledge to make clinical decisions and to provide high quality health care at community level. These authors emphasise the repositioning of nursing within primary health care, by moving beyond the fragmentation that had previously characterised PHC delivery. Expert nursing services could contribute to meeting the trajectory of patient needs, by working within a unit of health teams in the widest context.

Qolohle *et al.* (2006:17) emphasise that the nurse has an ethical responsibility for the patient’s welfare and loyalty to the doctor, since the nurse and doctor must be able to rely on each other. These dependent, independent and interdependent roles should embrace the Patient’s Rights Charter, which requires a good standard of practice and care for patients. This can only be achieved by working within a highly qualified, professional health team.

In accordance with Qolohle *et al.* (2006:17), Kapp (2000:7) believes that medical doctors are overqualified to render a PHC service. Doctors also do not readily want to work in the needy communities, where services are rendered to the broader community. The main reason for training CNPs was therefore to fill the identified gaps and to make quality health care, by suitably qualified professional nurses, more accessible and cost-effective to communities. Kapp is further of the opinion that this highly qualified professional nurse should practice independently, but with the necessary support provided by doctors.

Horrocks, Anderson and Salisbury (2002:5) found that in England, differences in the training of nurses resulted in nurses having a wide range of educational backgrounds at PHC service delivery levels. The authors felt that it was important to study the training, skills and experiences needed for these professional nurses to offer consistent benefits to patients. They also recommended that further research would be required in controlled trials, in order to determine the training needs and gaps, so that the nurse would render a service beyond the current scope of practice. In South Africa(SA), the SANC stipulates the scope of practice of this *cadre* of professional nurses, through the South African Nursing Act No 33 of 2005, Article 56.

## **2.7 CHALLENGES FACING PHC**

Various challenges still exist within the South African context of PHC. The unique and evolving needs of the population, as well as HIV/AIDS have had a major impact on PHC services. It is thus essential that the nurses, who drive these services, need to expand their roles and functions, in order to meet the challenges that this epidemic causes (Keegan & Rollman 2008:27).

A challenge to future quality PHC is that careful consideration of the skills and competencies of the nurse practitioner will be critical to the future success of quality care. De Villiers (1999:8) states that Family Medicine, as a programme within the health service, subscribes to a different paradigm than the biomedical model, mostly used by health services in SA. In order to meet the huge demand for remedial service, however, the PHC family practitioners (medical doctors' specialist in Family Medicine) use the patient centred model. Health services, however, keep vertical health programmes in place, because they are viewed as the best way to improve the health of the community. Within the Department of Health, each one of these vertical programmes are managed and supervised by its own directorate. Vertical programmes include, for example, chronic diseases, HIV/Aids, mother and child care, and reproductive health. These programmes each have its own autonomy and implement policies without the coordination or inputs from a single PHC directorate. The implementation of the District Health System in SA strives to establish an equitable and affordable

health service for all of its citizens. The fact that these programmes are still running vertically, instead of being integrated into the PHC directorate, hinders this ideal.

This viewpoint is emphasised by Kinnersley *et al.* (2000:6) in stating that patients perceive the services rendered by nurse practitioners of higher quality than those of doctors. As mentioned earlier, this stems from nurses spending longer time on consultations, provide more information and render the same examinations and management of diseases. Nurse practitioners are thus reported to provide a high standard of care to their patients, which support their extended roles within the PHC service level.

The sustainability of highly qualified staff still remains a challenge in SA, especially in rural communities. The SA government tried to address this problem by introducing a rural allowance to all health staff working in the rural health facilities. This was aimed at attracting qualified staff, such as the clinical nurse practitioner, to the rural communities. The success of this initiative, however, still needs to be researched and proven.

As the impacts of diseases change and alter the communities we serve, the roles and functions of the CNP should also change to continue to meet the health needs of the community. The family physician is a special category of doctors that was introduced into the health system in 1993. This family physician works in outpatient departments and community-based clinics and health centres (de Villiers and de Villiers 1999:4).

SANC recognised the expansion of the current nurse practitioner's role and function by revitalising the current curriculum of the post-basic diploma course, as stipulated in the South African Nursing Act No 50 of 1978, as amended, Regulation 48. This Clinical Nurse Practitioner would assume an even more extended role and be named the *Family Nurse Practitioner*. Together, the team, consisting of the family physician and the family nurse practitioner, will render a comprehensive, holistic health care service at PHC level.

## **2.8 CONCLUSION**

In this chapter, the outcomes from the reviewed literature, regarding the quality of care rendered by CNPs at primary health care level, was discussed. The literature indicated that the CNP faces many challenges, not least of all from the community, who views the quality of care, and the manner in which that care is rendered, in a critical manner. Future programme inputs would need to assure that quality training would lead to quality service.

The following chapter describes the research methodology being used in this study.

# CHAPTER 3

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## RESEARCH METHODOLOGY

### 3.1 INTRODUCTION

In the previous chapter, various topics from the available literature, regarding the nurse practitioner's role in Primary Health Care, were discussed. The outcomes from the literature review indicated the need for further research regarding the quality of care rendered by Clinical Nurse Practitioners (CNPs) at the Primary Health Care (PHC) level.

In this chapter, the research methodology underpinning this study to address the research question, "*What are the perceptions of patients regarding comprehensive care rendered by clinical nurse practitioners in the West Coast rural district of the Western Cape?*", is described. Included in this chapter, is a discussion of the research design, the problem statement, the population and sampling method, data collection methods, data analyses and the limitations of the study.

### 3.2 RESEARCH DESIGN

For this study a qualitative approach was applied, since, based on the available literature reviewed, little was known about the research question being investigated. The participants' viewpoints were reported in a literary style, rich with participants' comments (Brink 2008:9). This study focused on the subjective experiences or views of individuals (patients), hence their perceptions of the quality of services rendered by CNPs at PHC level.

Brink (2008:113) states that phenomenological studies examine human experience through the descriptions that are provided by the participants. Patients' so-called "lived experiences" are described with regards to their perceptions of the quality of care provided by CNPs at PHC level. A descriptive, phenomenological of essences method seemed the most

appropriate for obtaining the required information, as the researcher sought to capture the human experiences and perspectives of patients attending PHC facilities. According to Burns and Grove (2009:531), such method is an excellent approach in cases where the researcher would contemplate the phenomenon under study, while listening to the tapes and simultaneously reading the transcribed dialogue.

Burns and Grove (2009:35) explain how qualitative research uses inductive reasoning (starting with the detail of the experience whilst moving toward a more general picture of the phenomenon), whereas quantitative research uses deductive reasoning (moving from the general to the particular). In this study, patients provided rich detail of their experiences in their own words that gave form and meaning to their lived experiences. The researcher then used that information to generalise their insights into broad themes, by using inductive reasoning.

The researcher used Colaizzi's (as cited in Streubert & Carpenter, 1999:14) strategy as guideline to this study. The following steps were applied:

- **Intuiting:** Data collection through focus groups and through transcribing the recorded discussions.
- **Analysing:** Relationships and the essence of the phenomenon being investigated had to be identified, by determining common themes and by establishing clusters.
- **Describing:** By classifying all of the essential/critical elements that were common to the lived experiences of the quality of care received, as described by the participants, and by then validating this information, by returning to participants in order to confirm the accuracy of the data obtained.

### 3.3 POPULATION AND SAMPLING

#### 3.3.1 Population

Polit and Hungler (1998:173) describe the population as the entire aggregate of cases that meet a designated set of criteria. Burns and Grove (2009:714) similarly define the population as all elements or individuals that meet the sample criteria for inclusion in the study.

The Western Cape Province is divided into six districts. Five of these districts are rural areas, i.e. the West Coast, Overberg, Cape Winelands, Eden and Karoo, with the Cape Metropole being the only urban/city area. The West Coast rural district was the focus of this study, as all services here are nurse driven, comprehensive and managed by the same district manager, currently Mrs CW Bester. The West Coast district is further divided into five sub-districts, namely Swartland, Bergriver, Cederberg, Saldanha and Matzikama.

In the original proposal, the researcher targeted all five rural districts for the study. On recommendation of Stellenbosch University Research Committee, it was changed to only the West Coast district. The main reasons being that the study will be too labor intensive, the budget too extravagant and too time consuming due to the vast distances the researcher had to travel.

Therefore, for this study, the target population included all patients who attend the five PHC facilities within the West Coast rural district of the Western Cape Province, namely Moorreesburg, Piketberg, Citrusdal, Graafwater and Clanwilliam.

The potential PHC facilities to be investigated were identified as follows:

- The district manager, Mrs CW Bester indicated that at least three of the five sub-districts had to be covered as to be representative of the district. This could provide her with a general perception of the quality of care rendered by the CNP's within the district. Geographically, Moorreesburg falls under the Swartland sub-district, Piketberg under the Bergriver sub-district, Citrusdal and Clanwilliam under the Cederberg sub-district and Graafwater under the Matzikama sub-district.

- The facilities had to be nurse-driven and not have a full-time medical doctor. This principle is based on the population size of the community not being more than 20 000 (Department of Health, Healthcare 2010:2003). Graafwater for instance, has a population of approximately 6 400 (West Coast District Office 2009 statistics).
- The researcher considered the geographical location of these five towns for convenience purposes as to limit extensive travelling and costs. These towns are all situated on/or close to the N7 national road.
- Since all these PHC facilities were managed by the same district manager, standardised policies and protocols existed that enabled consistent PHC services being provided to all patients in this West Coast district. The benefit of standard procedures for all five clinics to this study was that it ensured reliability and consistency, and thus comparability, of the results.

Although the service platform, rendered in these five rural districts was expected to be similar, in accordance with the PHC Core Package of Service, it was anticipated that the experiences and perceptions of the different populations would differ from district to district, due to socio-cultural differences and dissimilar economic backgrounds. It was thus recognised that the results from this study would not necessarily reflect the perceptions of patients in the other four rural districts of the Western Cape.

### **3.3.2 Sampling**

According to Burns and Grove (2008:343), sampling involves the selection of a group of people with which to conduct a study, i.e. selecting a portion of the population to represent the entire population. Polit and Hungler (1998:411) similarly refer to sampling as the selection of a certain portion of the population that will represent the entire population under investigation. A sample thus consists of units or elements that the researcher uses to select the participants for the study. Creswell (1998:64) suggests that for a phenomenological research design, 5-25 participants is adequate to obtain sufficient data as the

essence and meaning of data is required and that a large number of participants do not guarantee the success of the research. The researcher followed this guideline and interviewed a minimum of five participants at each of the five selected PHC facilities within the West Coast district of the Western Cape Province. At the end of data collection, twenty-six participants participated in the five focus group discussions.

In this study, a convenient, systematic, “area-sampling” method was used. The patients, attending the clinic on the day that the researcher would visit each location, would serve as the sample for the purpose of this study. Burns and Grove (2009:687) describe convenient sampling as subjects being included in the study, because they happen to be in the right place at the right time. Polit and Hungler (1998:414) define this method of sampling as accidental and recognise that the participants are unknown to the researcher. Through convenient sampling, the sample is significantly more likely to be representative of the population. This implies that all potential participants in the population would have an equal chance of being included in the sample, as they would conveniently be attending the health facility on the day that the interview takes place.

The researcher also used systematic sampling, which is described by Polit and Hungler (1998:423) as “the method of which selection of every  $k^{\text{th}}$  case from some list or group will be selected”. By using an interval of five, every fifth person in the waiting room was selected. The initial starting point was selected at random, as long as the patient fell within the inclusion criteria, as discussed below.

Specific inclusion and exclusion sampling criteria were used to ensure eligibility in the target population. Inclusion criteria are those characteristics that a subject must possess to be part of the target population (Burns & Grove, 2009:344).

The researcher used focus group discussions as the method of data gathering. The following criteria were set for the inclusion of participants:

- Must be older than 18 years of age.

- Must be able to communicate in either English or Afrikaans. If the participant was Xhosa speaking, an interpreter, who should be a person working in the PHC facility, would be used. The Xhosa-speaking patients would express their views and thoughts in their mother tongue, whilst the interpreter would then transcribe the audiotape recording and provide feedback for field notes.
- Must be able to understand the purpose of this study.
- Must give signed informed consent for study participation beforehand.

Burns and Grove (2009:513) state that participants must have common characteristics. These are homogeneous elements that indicate the degree to which the participants are similar. The common characteristics for purposes of this study included:

- Participants had to attend the CNP with a medical problem (acute or chronic), rather than for a minor service, such as family planning.
- Participants had to have attended the PHC service for at least three times over the past year, in order to increase the likelihood that they had developed a more accurate viewpoint of the services being rendered at the PHC facility.
- Participants had to live within the rural area, rather than having just visited from another district.

Participants were excluded, if they met the following criteria:

- First-time visitors to the PHC facility, as these participants would have inadequate experience of the quality of care being rendered by the CNPs at that particular facility.
- A family member of the PHC nursing staff serving at the five selected clinics, in order to ensure objectivity by preventing bias.

For focus group interviews, de Vos *et al.* (2005:270) recommend that an interpretive inquiry is usually undertaken with a small sample size of up to ten people. Burns and Grove (2009:359) support this by explaining that a small

sample size will suit the researcher who is interested in examining a phenomenon in depth. For the purpose of this study, small groups of five participants each were regarded suitable, since the essence of this study was the quality of the information obtained from the patients. In qualitative research the sample is usually much smaller because of the much richer nature of data collected (Mason 2010:3). There will be a point of diminishing return, meaning that as the study goes on and on, more data does not necessarily lead to more or better information. One occurrence of a piece of data is all that is needed to ensure it becomes part of the analysis framework. According to this author, in qualitative research a very large sample can lead to the data becoming repetitive and superfluous.

Using saturation as a guiding principle, the researcher also elucidated supplementary factors that influenced the sample size. This includes:

- The population was heterogenic
- This was groups with collective interest in the phenomenon, namely the quality of service rendered by CNPs at PHC level of care
- Only one data collection instrument was used
- The limited availability of funding and resources.

### **3.4 PILOT STUDY**

Holloway (1997:121) describes a pilot study as a small-scale trial run of the research where a small number of participants are chosen using the same criteria as for the actual research. A trial run is performed so that problems can be identified and resolved before the research starts. While in quantitative research a pilot study is essential, this author states that in qualitative approaches, it is not necessary because the research has the flexibility for the researcher to “learn on the job”.

Piloting was not carried out by this researcher as there was no lack of confidence especially in the interview questions. This was derived from the intensive literature review indicating these questions as being prominent in

previous studies. The researcher did not propose it in the Stellenbosch University Research Committee accepted proposal, nor did the study supervisor advise the researcher to perform a pilot study.

### **3.5 DATA COLLECTION**

Prior to the field trips, the researcher held final telephonic discussions with the district manager and with each facility manager of the targeted clinics, for the purpose of informing them about the intended study, to discuss the process and to clarify any issues.

According to Patton (2002:387), one can gain much information within a short focusgroup session, compared to individual interviews. Patton believes that it enhances the quality of information, as participants can check and elaborate on each other's viewpoints. This prompted the researcher, who was solely responsible for data collection, to conduct focusgroup interviews with patients that had been attended to by CNPs at the identified PHC facilities. This way the researcher could obtain optimum quality information from the patients.

Brink (2008:147), in addition, is of the opinion that the strengths of interviews lie in the fact that the data collector can observe non-verbal behaviour while conducting the interviews. As the researcher was solely responsible for data collection, she made field-notes during the interviews.

Brink (2008:152) recommends that focusgroup interviews should consist of groups of five to ten people, who all share in the phenomenon being investigated. It is especially useful, where the topic concerns a practical community problem and members have to actively give their opinions about a certain phenomenon. In this research, the community members were asked openended questions about their perceptions of the attitudes, knowledge and skills of the CNPs in the PHC clinics.

Informed signed consent was obtained from each participant after reading and explaining the information on the consent leaflet (see Annexure B). This was done while the patients were still in the waiting area, prior to being attended to by the CNP.

Brink (2008:153) refers to the actual time of the interviewing process, by stating that adequate time is essential for the success of the interview. To ensure adequate time for travelling and for engaging in the planned interviews, the researcher set aside five days for conducting the group interviews.

The focusgroup interviews were held away from the PHC facilities, as to encourage participants to freely express their feelings and perceptions and to, in accordance with Brink (2008:153), seek privacy for the interview. In some instances, the local library, or the occupational therapy facility was used.

Every focusgroup was uniquely coded, whilst every participant was allocated a unique number. Each participant in the focus group was allowed to introduce him-/herself. The researcher was aware that true expression could best be achieved in the mother tongue and therefore allowed participants to express their views and perceptions in Afrikaans, as no participant expressed any other language preference.

The researchers facilitated each session by asking open ended questions and by encouraging participants to partake actively (see Annexure A). The researcher summarised every question before continuing to the next, in order to ensure that the feelings, experiences and viewpoints had been accurately captured.

### **3.6 INSTRUMENTATION**

Burns and Grove (2009:704) note that instrumentation refers to a component of measurement that involves the application of specific rules to develop an instrument for data collection. The authors further state that participants may feel more threatened and anxious within an individual interview setting and therefore fail to express their true feelings. Focus group interviews were thus used during this study to obtain participants' true perceptions and feelings regarding the quality of services rendered by CNPs at PHC level. Interviews were carried out in a setting that was conducive to people expressing

and clarifying their views in ways that were less likely to occur in a one-to-one interview.

### **3.6.1 Semi-structured focusgroup interviews**

Semi-structured focusgroup interviews were conducted for the purpose of this study, during which fixed questions were asked to all groups at the different clinics, in order to standardise the interviews. Openended questions allowed the participants to respond to questions in their own words. The strength of openended questions, as described by Polit and Hungler (1998:195), lies in the fact that it minimises researcher subjectivity. Although it is more time consuming to analyse, the outcome is a more accurate reflection of the subjects' feelings and learned experiences (see Annexure A).

The researcher thus formulated probing, open ended questions based on the findings of the literature review. The questions were formulated to explore the patients' perceptions regarding the attitudes, skills and knowledge of the CNPs. Carryer et al. (2001:7), for example, states that nursing is a combination of many elements, but the major contributing factor to patient satisfaction is the knowledge, skills and attitudes of the nursing staff. Geyer (2003:53) states that South African nurses lack the clinical expertise to fulfill the role and function of the doctor at PHC level of care. These statements and other authors explored in the literature review, prompted the researcher to direct the open-ended question along this avenue. Patients weretherefore asked to describe their feelings, perceptions, thoughts and views of the servicesbeing rendered by CNPs. The exploration of specific responses by patients led to further discussions, until it appeared that the participants had fully expressed themselves. This way, the researcher assured that true feelings and experiences were captured.

### **3.6.2 Digital audiotape recordings**

Each focusgroup interview was audio taped. These tapes were systematically labelled. Every taped group interview was allocated a reference code with the date the group interview was performed. To avoid confusion with the

recordings, the researcher stated, while recording, the file code, together with the date of the interview at the start of each interview. Coding occurred directly after the focusgroup interview was completed, by providing a digital code to each interview. This way easy access to parts of the data was promoted to prevent having to listen to the entire data set repeatedly.

### **3.6.3 Field notes**

The primary source of data acquisition was through face-to-face, audiotaped interviews. Polit and Beck (2004:393) recommend recording field notes during, or directly after interviews. De Vos *et al.* (2005:285) in addition state that field notes must be written with regards to regularity, duration and intensity of responses, whilst the ideal would be to write these observations during the interview.

The field notes made during this study thus included explanations and descriptions of observations made during the interviews, such as body language, gestures, tone of voice, repetition and stammering. Such notes indeed deemed very useful in supporting the verbal information derived during the interviews. The researcher recorded the field notes in a separate notebook, computerised the notes shortly after each interview and filed them electronically under each interview folder number, together with the transcript of the audiotaped interview (see Annexure E).

## **3.7 TRUSTWORTHINESS OF THE STUDY**

Trustworthiness in a qualitative study refers to accurate representation of the participant's experiences of the phenomenon. Burns and Grove (2009:611) regard trustworthiness in a qualitative research study as openness, adherence to the philosophical perspective and thoroughness of data collection and analyses.

Lincoln and Guba (1999:29) describe trustworthiness as a method of ensuring rigour in qualitative research, without sacrificing relevance. Four steps or techniques that support trustworthiness were used:

### 3.7.1 Credibility

Lincoln and Guba (1999:31) report that credibility is the alternative to internal validity. Credibility refers to the truth and believability of findings, mutually established between the researcher and the participants, as a true reflection of their experiences of the phenomenon being investigated.

Brink (2008:118) indicates that various techniques can be used to achieve credibility. One such technique is having the research participants review the data and validate the researcher's interpretations and conclusions. This is done to ensure that the data and facts have not been misconstrued.

During this study, the researcher ensured credibility through prolonged engagement with the focusgroup participants. Active listening during each session ensured continuous evaluation of interviewing techniques and wording of the questions. Trust and rapport were built with the participants, which enabled the researcher to obtain valuable and rich information.

After completing the analyses, the researcher returned to two of the twenty six participants, who validated that the transcripts were a true reflection of their experiences and perceptions (see Annexure F). These two participants were chosen randomly by using the fishbowl technique. All 26 participants' individual identification numbers were put in a bowl and two numbers were drawn.

The prolonged time between data collection and member checking was due to the researcher having time constraints in the transcribing and analyses of the data. The researcher is a full-time employee with the Department of Health and travels extensively for her work. The researcher however found no hesitation from the two participants in remembering what the views were during the group interviews. In fact, they reiterated their views when writing that the status quo still exists. In terms of confidentiality, no personal details or signatures were required on the validating documents. This method of verifying the data was in keeping with the approach by Colaizzi (as cited in Streubert and Carpenter, 1999:14).

### **3.7.2 Dependability**

Polit and Hungler (1998:435) define dependability as a criterion for evaluating the quality of the data by determining the stability of the data over time, and within certain conditions. Brink (2008:119) emphasises the fact that an audit needs to be performed in order to establish the trustworthiness of the study outcomes. The auditor needs to follow the processes and procedures used by the researcher and determine whether they are acceptable and dependable.

To address dependability during this study, the researcher applied the following steps:

1. Throughout the study, the researcher followed the same steps for each interview.
2. Any form of bias, due to the researcher's pre-assumptions and pre-knowledge, was limited by using a semi-structured interview schedule.
3. Digital audio recordings, together with accurately written field notes, facilitated recording of all the participants' verbal and non-verbal cues to ensure a better understanding of the information provided. By using audiotapes during the interviews, a reliable method of data collection was used, which allowed the researcher to return to the raw data and to clarify uncertainties.
4. The researcher used the services of an independent reviewer to scrutinise (audit) the data, the relevant documents and tape recordings, in order to establish trustworthiness of the study outcomes. The independent reviewer was dr E van Wijk, a tutor in Psychiatric Nursing at the Western Cape College of Nursing. This process prevented bias and also ensured that the researcher could not manipulate the results.

### **3.7.3 Confirmability**

Brink (2008:119) states that confirmability guarantees that the findings and recommendations are supported by the data. This is also accomplished by incorporating an audit process. Polit and Hungler (1998:255) refer to it as the

objectivity of the data and the manner in which the findings and conclusions of the study achieve the aim. The researcher must therefore be able to distinguish between his/her prior assumptions, pre-conceptions and personal values and those of the participants.

As the researcher has had vast experiences in PHC, it was especially important to address confirmability. The researcher maintained a clear distinction between her personal values and those of the participants by not allowing prior assumptions and preconceptions to influence the study. The researcher made use of an outside reviewer (see section 3.6.2) to scrutinise the data, documents and tapes for objectivity and relevance of data being gathered. The researcher also returned to two participants after data analyses, who validated that the transcripts were a true reflection of his/her experiences and views.

### **3.7.4 Transferability**

Streubert and Carpenter (1999:29) state that the study findings must have similar meaning to others. Brink (2000:119) substantiates this by stating that external validity, also referred to as transferability, is the degree to which the results of the study can be generalised to other settings. In other words, whether the conclusions of this study would be transferable to other contexts?

The researcher attempted to apply this criterion by:

- Applying the designed inclusion criteria when recruiting a sample, representative of those patients visiting PHC facilities, in order to truly reflect on the key issue of the research problem, i.e. the quality of services being rendered by CNPs at PHC service level.
- Describing the collected data as accurately as possible.
- Using the participants' own words in support of the researcher's interpretation of the data.

### 3.8 DATA ANALYSES

Burns and Grove (2009:524) describe analysis of focusgroup data as requiring both individual and group comparisons, since it is important to analyse the consensus between the individuals within a group and also to compare the different groups to each other.

During this study, the audio tape was firstly clearly labelled with a file, or interview number, together with the date of the interview being recorded on the tape, before commencing with the recording of the actual interview. A letter preceded the interview number in order to distinguish between more than one tape for any one interview, for example A201, A202, etc).

In order to uphold the confidentiality of patients' identities, the audio tapes were securely locked up in a safe at the researcher's residence.

The researcher analysed possible relationships among the data by transcribing the interviews *verbatim* (see Annexure G). According to Burns and Grove (2009:521), the researcher needs to become familiarised with the data on the tapes. During this study, as the researcher read and re-read notes and transcripts, the virtual text 'grew on the researcher' and a deeper understanding of the participants' responses developed.

Watson *et al.* (2008:378) maintain that manual analyses of data are outdated. The researcher argued against this, since in the context of this study it was unavoidable, because by analysing the collected data manually, she could become extensively familiarised with the participants' feelings and expressions. Such understanding would not have been possible otherwise.

Colour coding was used to highlight and group the emerging patterns. Different colour highlighters were used to code all data manually on the transcripts as follows:

- Green was used for good, positive responses; and
- Red for poor, negative responses.

The same process was used for all five interview transcripts, which led to trends being clustered together to form critical themes. These themes were sorted according to the three categories identified in the literature review, namely *attitude*, *knowledge* and *skills* of the CNP and the impact of the training received on service delivery. These themes were coherent with the pertinent questions found in the literature review.

The researcher continuously compared the data being collected from one focusgroup with another in the determination of the final themes. This enabled the researcher to discover the true meaning as intended by this research, namely whether the community experienced the quality of service rendered by CNPs, as being good, average, or poor.

### **3.9 ETHICAL CONSIDERATIONS**

This research was conducted in accordance with the three primary ethical principles, as stated by Brink (2008:31).

#### **3.9.1 Beneficence / non-maleficence**

As described by Polit and Hungler (1998:356), beneficence implies that “Above all, no harm should be done to the participant”. The non-maleficence principle, i.e. to do good to the participant is a fundamental principle of nursing, as stated in the Nursing Pledge (Voungé, van Niekerk and Mogoithlane 2004:2).

The researcher was constantly aware of any issues that could harm the participant’s physical or mental condition as a patient, and she would have stopped any interview, had she been of the opinion that it would be necessary to prevent any harm from occurring to any participant. The researcher, as per the informed consent form, ensured potential participants that involvement of a patient during this research study would not place any participant at any disadvantage, nor would it expose a person to any exploitation. The researcher treated each participant with respect and dignity throughout the interviews.

### 3.9.2 Respect for human dignity

Polit and Hungler (1998:358) explain that respect for human dignity implies that an adult with a capacity to decide has the right to determine what may be done to his/her body. In this study, the following applied:

- Prior ethical approval from the Ethics Research Committee, Faculty of Health Sciences of the University of Stellenbosch, was obtained (see Annexure C).
- Prior consent by the authority over PHC facilities. Before embarking on the research, written permission was granted by the Provincial Government of the Western Cape (Public Health Research Committee) for conducting the study within the West Coast District (see Annexure D)
- Full disclosure. Adequate information regarding the proposed study was conveyed to the potential participants. The researcher fully described the nature of the study to patients, prior to them giving their informed consent to participate.
- Informed consent from participants was obtained after providing the assurance that all information would be treated confidentially and that it would only be used for the purpose of the research (see Annexure B). All participants were capable of comprehending the information, before signing the consent form.
- Participation. All participants were re-assured that their participation was voluntary and that they had the right to withdraw at any stage, without penalty of having to supply reasons.
- Participants were made aware of the use of the audiotape recordings and were informed as to the reason thereof.
- The participants were informed that the researcher was being supervised by the academic institution where this study was registered at, in an attempt to prevent any anxiety or misconceptions about the study and the confidentiality thereof (de Vos *et al.*, 2005:331).

### **3.9.3 Justice**

According to Polit and Hungler (1998:326), the principle of justice is upheld by ensuring privacy, confidentiality and anonymity.

Brink (2008:33) states that the participant has the right to determine the circumstances under which his/her private information may be disclosed. For the purpose of this research, participants were protected by ensuring that CNPs in the clinics did not know who were partaking in the interviews. This was achieved by conducting the focusgroup interviews in venues away from the health facilities.

Brink (2008:33) refers to the researcher taking responsibility to prevent any data being divulged or made available to any other person. This was adhered to by coding the names of participants within every coded focusgroup, for example focus group A202(1), A202(2), A202(3) etc. A master list of participants' names and matching code numbers was kept in a locked safe at the researcher's study at home.

Confidentiality was also maintained during data analyses, by colour coding the responses to the questions and by not identifying the individual names of the participants.

### **3.10 CONCLUSION**

This chapter described the research design, the processes used during sampling and data collection, the steps taken to ensure the trustworthiness of the data collection process, as well as the ethical considerations that were taken into account during the study. The research results, analysis and interpretation thereof will be discussed in the next chapter.

# CHAPTER 4

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## DATA ANALYSIS, INTERPRETATION AND DISCUSSION

### 4.1 INTRODUCTION

In this chapter, the study outcomes are discussed. The data that had been collected during the semi-structured group interviews, held in November 2010, at the five rural clinics in the West Coast of the Western Cape Province, were analysed, interpreted, discussed and presented according to the identified patterns and themes that emerged.

Data analysis entails the categorising, ordering, summarising and meaningful description of the data. De Vos *et al.* (2002:340) describe qualitative data analysis as the search for general statements about the phenomenon and the relationships amongst the categories of data.

For the purpose of this study, Creswell's (as cited in de Vos *et al.*, 2002:340) data analysis model was used. This method comprises of the following steps:

1. Managing the collected data: The first step where organising and sorting of the data takes place, away from the interviews sites.
2. Reading and writing memos: The researcher continues his/her analysis, by developing a feeling for the whole database.
3. Describing, classifying and interpreting: These activities entail category formation.
4. Representing and visualising: Summarising the information into tabular and/or graphic formats.

#### 4.1.1 Managing the data

File numbers were awarded to the interviews, according to a predefined coding strategy, as follows:

- Interview 1 = A201.
- Interview 2 = A202.
- Interview 3 = A203.
- Interview 4 = A204.
- Interview 5 = A 205.

When planning the group interviews, it was decided to allow five participants per group. However, in group A204, the total number of participants were six as one participant had signed consent to join the group, but because she was waiting to see the doctor, a sixth participant agreed to be on standby. Finally, all six participants were allowed to share in the group interview.

The demographic data of the five groups is summarised in table 4.1.

**Table 4.1:** Demographic data of the interview groups

NUMBER OF PARTICIPANTS							
GROUP		GENDER		RACE			
		FEMALE	MALE	WHITE	AFRICAN	COLOURED	INDIAN
A201	5	5	--	--	--	5	--
A202	5	4	1	1	1	3	--
A203	5	5	--	--	--	5	--
A204	6	4	2	1	--	4	--
A205	5	4	1	--	2	3	--

<b>TOTAL</b>	<b>26</b>	<b>22</b>	<b>4</b>	<b>3</b>	<b>3</b>	<b>20</b>	<b>0</b>
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The field notes taken during each group interview were computerised and filed under the relevant interview file number (see Annexure E). This enabled the researcher to organise the data and to ensure that it was easily retrievable. According to Marshall and Rossman (1999:110), this process of preserving the data and meaning on tape, as well as the combined transcriptions, largely increase the efficiency of the data analysis process.

#### **4.1.2 Reading and writing memos**

Burns and Grove (2009:521) emphasise the importance of the researcher becoming familiar with the recorded data on the tapes. During this study, the researcher hence read and re-read the notes and transcripts several times. This allowed the researcher to become absorbed in and extremely familiar with the information and context, and to capture the uniqueness of each participant's lived experiences of the quality of services being rendered by CNPs at PHC level.

The researcher made notes in the margins of the transcripts and field notes to make exploring of the data easier. Colour coding was used to indicate participants' perceived positive experiences (in green) and negative experiences (in red), in order to enhance the data analysis process.

#### **4.1.3 Describing, classifying and interpreting**

De Vos *et al*, (2002:345) describe classifying as the process of searching for categories, themes and different dimensions of information, in order to sort the information into five or six "families". During this phase, the researcher focused her attention on the recurring ideas/themes that emerged during the analytical process. All green and red responses were clustered together and this led to similarities being identified from participants within the same group and also

similarities between the five focus groups. Consistencies were noticed and meaning emerged into patterns.

The researcher thus reduced the data into small, manageable sets of themes, under which all the gathered narratives were grouped as presented in this chapter.

#### **4.1.4 Representing and visualising**

De Vos *et al.* (2002:345) describe this phase as creating a visual image of the information, in which the different levels of meaning of the information are illustrated, with boxes or columns representing the themes. Relationships amongst categories can also be put in the context of the themes and sub-themes.

The researcher developed a comparative table, according to the pre-determined themes, namely:

- Attitudes of CNPs towards patients;
- The knowledge and skills of CNPs to be able to assess, diagnose and manage holistically, by providing health information and/or medicine; and
- The impact of the relevant, post-basic training programme on the quality of care being rendered by CNPs.

The sub-themes were determined through the positive or negative statements, as expressed by the participants during the interviews. For example, all the positive statements and negative remarks regarding the attitudes of CNPs were clustered separately into two groups. Patterns were established, according to which the statements of the participants were categorised.

## **4.2 PRESENTATION OF FINDINGS**

In this section, the findings are presented in two formats.

Firstly, in table 4.2, the patterns, sub-themes and themes that made up the thematic structure of the lived experiences of the participants, with regards to the

quality of care being rendered by CNPs at PHC facilities, are summarised. In the table, the green and pink shadings represent the positive and corresponding negative responses by the participants, respectively. This table hence summarises the interview outcomes and forms the basis of the subsequent discussions of the research findings.

**Table 4.2:** Thematic structure of the lived experiences of community members regarding the quality of care being rendered by CNPs at PHC level

Pattern	Sub-theme	Theme
<ul style="list-style-type: none"> <li>• Friendliness</li> <li>• Compassion</li> <li>• Professionalism</li> <li>• Fairness</li> </ul>	Positive attitude towards patients	Attitudes
<ul style="list-style-type: none"> <li>• Unfriendliness/Rudeness</li> <li>• Lack of compassion</li> <li>• Unprofessionalism</li> <li>• Unfairness</li> </ul>	Negative attitude towards patients	
<ul style="list-style-type: none"> <li>• Competence</li> <li>• Holistic care</li> </ul>	Adequate assessment of a patient	Perceived knowledge and skills
<ul style="list-style-type: none"> <li>• Eagerness to provide health education</li> <li>• Good communication skills</li> </ul>	Providing health education and information	
<ul style="list-style-type: none"> <li>• Suitable prescription</li> </ul>	Correct prescription of medicine	
<ul style="list-style-type: none"> <li>• Incompetence</li> <li>• Illness orientated care</li> </ul>	Inadequate assessment of a patient	
<ul style="list-style-type: none"> <li>• Lack of eagerness to provide health education</li> <li>• Poor communication skills</li> </ul>	Lack of providing health education and information	
<ul style="list-style-type: none"> <li>• Unsuitable prescription</li> </ul>	Incorrect prescription of medicine	
<ul style="list-style-type: none"> <li>• Ability to adequately meet patient health needs</li> </ul>	Ability to perform the roles and functions as per scope of practice and taught curriculum	

<ul style="list-style-type: none"> <li>Lacking ability to adequately meet patient health needs</li> </ul>	Lacking ability of performing roles and functions as per scope of practice and taught curriculum	service delivery
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In the remainder of this chapter, the findings are presented and discussed, according to the identified themes and patterns that emerged from the analysis of the collected data, as summarised in table 4.2. *Verbatim* quotes (“*in Afrikaans*”) (all of the participants were Afrikaans speaking) from the transcribed interviews are presented, together with free English translations [indicated within brackets], as well as relevant data from the field notes, taken by the researcher during the interviews. Following is the discussion of the study outcomes.

#### 4.2.1 THEME 1: Attitude

This theme concerns the attitudes of CNPs towards their patients. The researcher divided this theme into two opposite sub-themes, in order to determine whether the majority of the perceptions favoured the positive or negative attitudes of CNPs. According to Hays, Veitch and Evans (2005:2), patients judge the attitudes of staff members according to their friendliness, good communication and continuously, good, interpersonal relationships.

Therefore, for the purpose of this theme, the researcher used friendliness, compassion and the professional attitudes of CNPs towards patients, as patterns. Each sub-theme is discussed with regards to the positive and negative responses by the participants, for the purpose of comparison.

##### 4.2.1.1 Sub-theme: Positive versus negative attitudes towards patients

##### a) Pattern 1: Friendliness versus Unfriendliness

##### a.i) Friendliness

The word friendly, according to the South African Oxford Dictionary (2005:357), means to be kind and pleasant and not be harmful to a specified person, or

thing. Within the context of this study, it encompasses the expression of good “bedside manners” and not being rude to patients.

When participants were probed as to whether they thought that CNPs’ attitudes were friendly, very few of the participants responded positively. Some of the positive comments were as follows:

- *“Die susters was nooit met my, vandat ek by die kliniek kom, was hulle nooit met my snaaks of sleg behandel nie. En ek ly aan hoë bloeddruk en het beensere. So ek kom baie hierna toe.” (A202)*

[Since I have been coming to the clinic, the sisters have never been nasty to me, nor have they taken care of me poorly. I suffer from high blood pressure and have leg sores. So I come here a lot.]

- *“Hulle is altyd baie vriendelik, álmal van hulle. Ek kan van niemand kla wat lelik is nie. Ons ken hulle as vriendelike susters.” (A201)*

[They are always very friendly, all of them. I cannot complain about anybody being nasty. We know them as friendly sisters.]

- *“Ons is eintlik die Here dankbaar vir daai wit suster, sy is maar ’n lieflike mens. Sy is baie gaaf met ons...maak nie saak wie of wat jy is nie.” (A205)*

[We are actually grateful to the Lord for that white sister, she is a lovely person. She is very kind towards us...does not matter who or what you are.]

#### **a.ii) Unfriendliness**

The following excerpts are from the transcripts of the participants, concerning the unfriendliness of CNPs. It was apparent from their tones of voices and non-verbal communication responses, that this was an aspect that participants really felt strongly about. This was evident from the following quotes by participants:

- *“Ja, baie lelike maniere teenoor die mense. Baie kortaf. Ja, ja. Onbeskof. Maak nie saak wie jy is nie. Dit lyk soms asof sy nie lus is om jou te help nie...net omdat sy haar ‘pay’-tjek aan die einde van die maand wil hê.” (A205)*

[Yes, very nasty manners towards the people. Very abrupt. Yes, yes. Rude. Does not matter who you are. It sometimes looks as if she is not eager to help you...just because she wants her pay cheque at the end of the month.]

- *“Daar is party oggende waar ’n mens nie eers môre gesê word nie...sy is ‘plain’ onbeskof. Kan sien sy het met ’n verkeerde voet uit die bed uit opgestaan en dan haal sy dit op ons uit. Jislaaik, ons is mos ook mense met ’n gevoel.” (A204)*

[There are some mornings that a person is not even greeted...she is plain rude. Can see she got out of bed with the wrong foot and then she takes it out on us. Indeed, we also are people with feelings.]

- *“Dit is die grootste probleem...die feit dat hulle onbeskof is. Hulle dink ons is verleë oor die diens. So hulle kan maak soos hulle wil. Hulle skel mens sommer voor die ander uit en praat so neer op ’n mens. Ek is soms te bang om iets te vra, sodat ek nie geskel word nie.” (A205)*

[...That is the biggest problem...the fact that they are so rude. They think we are reliant on the service. So they can do as they wish. They would scold a person right in front of the other and talk down to a person. I am sometimes too scared to ask, to prevent not being scolded.]

- *“Hulle is onvriendelik vir my. Hoe kan ek sê, ek glo as jy by ’n kliniek of ’n hospitaal kom, dan moet die mense vriendelik wees. Jy kom mos vir hulp, omdat jy probleem het.” (A204)*

[They are in my opinion unfriendly. How can I say, I believe that, if you come to a clinic or a hospital, then the people must be friendly. In fact, you come for help, because you have a problem.]

- *“Sommige dae is hulle sommer suur, partykeer onvriendelik en sommer onbeskof met ’n mens. Hulle groet nie eers party dae ’n mens nie en kyk jou skaars in die oë as hulle met jou praat...kyk net op die lêer waar hulle skryf. Ek praat mos nie met ’n mens se kop nie!” (A205)*

[Some days they are grumpy, sometimes unfriendly and plain rude to a person. They don't even greet a person some days and hardly look you in the eye when they talk to you...only look at the folder they write in. Surely, I don't talk to a person's head!]

- *“Kyk, ons moet verstaan almal staan mos nou nie elke dag met dieselfde gevoel op nie. Maar as jy in so 'n beroep is wat met die publiek werk, moet jy dit wat jou pla by die huiskan los. Moet nie jou probleem op ons kom uithaal nie.” (A205)*

[Look, we understand that not all of us get up every day with the same feeling. But, if you are in an occupation where you work with the public, you must be able to leave what bothers you at home. Do not take your problems out on us.]

The overall finding of Pattern 1 was that the majority of participants, as well as the majority of the groups, perceived the CNPs as being unfriendly, bad mannered and sometimes rude. There were only three participants, one each from three different groups, who expressed that the CNP are kind and friendly towards them. These were far in the minority in comparison to the overall perception of the other twenty three participants.

## **b) Pattern 2: Compassion versus Lack of compassion**

### **b.i) Compassion**

Compassion is when one is sympathetic towards others and concerned about the sufferings of others. A person displaying compassion could be perceived as being a people's person.

Participants shared their positive experiences as to whether CNPs were compassionate towards them as patients, by saying:

- *“Daar is daai een uit 'n duisend uit wat jy kan voel dit is, dit is wat sy wil doen. Dis 'n 'mens mens'. Ons is gelukkig om twee sulke susters hier te hê, wat goed kyk na ons.” (A201)*

[There is that one out of a thousand that you can sense that it is what she wants to do. She is a person's person. We are lucky to have two such sisters here, who take good care of us.]

- *“'n Mens weet sommer sy is daar, oor dit haar beroep is. Altyd bereid om die ekstra ou dingetjie vir my te doen en sal nooit nee sê om mens te help nie. Sy is 'n regte 'nurse' wat meegevoel met mens se probleem het.” (A202)*

[A person knows she is there, because it is her calling. Always willing to do the extra mile for me and will never refuse to help a person. She is a real nurse with compassion for a person's problems.]

- *“Hulle stel belang in my. Nie 'n probleem nie, ek is altyd gemaklik by die suster. Sy gee regtig vir mens om en wys dit ook deur dinge wat sy doen vir 'n mens.” (A202)*

[They care about me. Not a problem, I am always at ease with the sister. She really cares for a person and shows it through the things that she does.]

#### **b.ii) Lack of compassion**

Participants responded with regards to a lack of compassion shown by CNPs, by saying:

- *“Hulle is nie vir my lekker vriendelik nie. Ek meen, jy kan sien hulle gee nie regtig vir jou om nie, hulle is nie lekker behulpsaam nie en dit lyk soms of hulle nie omgee vir jou probleem nie.” (A203)*

[They are not friendly at all, in my opinion. I mean, you can see that they don't really care about you. They are not very helpful and sometimes it seems as if they don't care about your problems.]

- *“Hulle sê, 'wag', hulle gesels nou eers hier binnekant...toe dink ek hulle kan nie eers gesels nie, hulle is mos hier om 'n mens te help. Het hulle dan geen gevoel vir 'n siek mens nie? Hoekom is hulle dan hier?...om mens te help, dis hoekom. Maar dit lyk nie aldag so nie.” (A205)*

[They say, 'wait', because they first need to talk inside...so I thought to myself, they can't be talking while we are waiting, they are here to help the

people. Have they then no feelings for a sick person? Why are they herethen?...to help people, that's why. But, it does not always look that way.]

- *“Dan word jy nou vermaak, ’as jy nie die dokter sien nie, dan gaan jy nie jou pille sien nie, dan gaan jy nie jou pille kry nie’. En dit is ook iets wat ’n mens ‘upset’. Hulle moet nie mens dreig nie.” (A205)*

[Then they try to spite you, if you don't see the doctor, then you will not see your tablets, and then you will not get your tablets'. And that is also something that upsets a person. They must not threaten a person.]

The overall finding of Pattern 2: participants' perceptions compared evenly between the CNP being compassionate and having a lack of compassion towards patients. There was an equal number of responses indicating positive and negative experiences of compassion towards them as patients. This was uniformly across all five groups.

### **c) Pattern 3: Professionalism versus Unprofessionalism**

#### **c.i) Professionalism**

Professionalism within nursing, according to Searle (2008:162), is a scientific service, motivated by a force of compassion, empathy, concern, sympathy and love for one's fellow human beings.

Perceptions and views from participants with regards to professional nurse behaviour included:

- *“Ja, ek dink hulle is baie professioneel en praat nie rond nie. En ons is maar min mense hier in...Ek sal weet as hulle stories aandra en sleg praat van die mense.” (A202)*

[Yes, I think that they are very professional and do not talk out. And we are very few people here in...I will know if they spread stories and talk rudely about the people.]

- *“Ek het nog niks gehoor dat stories van my uit die kliniek rondloop nie. Hulle is baie professioneel daaromtrent.” (A204)*

[I have not heard of any stories about me being spread outside of the clinic. They are very professional concerning that.]

### **c.ii) Unprofessionalism**

Perceptions and views from participants with regards to unprofessional behaviour by nurses included:

- *“Gaan, gaan nou!. Ons werk nie meer nie. Sien, ek vat nie nuwe lêers nie, ek vat net mense wat se lêers ek het. En dit sonder om te vra wat ek makeer! Sies!” (A204)*

[Go, go now! We don't work anymore. See, I do not take new folders, I only take the people whose files I have. And that without asking what is wrong with me! Shocking!]

- *“Die Here bo my kop is my getuie, dan sit die plek vol, dan sit hulle en rook hier agter en drink eers tee. Nie 'n goeie beeld van verpleging nie.” (A205)*

[The Lord above is my witness, when this place is full, then they would sit and smoke here at the back and drink tea first. Not a good reflection on nursing.]

- *“As hulle jou nie regtig goed ken nie, dan stel hulle nie baie belang nie. Dit is mos hulle werk om almal gelyk te behandel, of hulle nou bekend is met die mens of nie. Ek dink dit is uiters onprofessioneel om so op te tree.” (A205)*

[If they don't really know you well, then they're not very interested in you. It is their job to treat everybody the same, whether they know you, or not. I think it is very unprofessional to behave in such a manner.]

The overall finding of Pattern 3 was that, for the participants, professionalism requires not being talked about outside of the clinic in the community, CNPs being there to attend to and seeing the patients as a matter of priority, prior to taking long tea breaks, lunch times or smoke breaks. Participants indicated that CNPs do portray unprofessional conduct. The findings of Pattern 3 indicated that the majority of participants from all five groups were of the opinion that the CNPs were very unprofessional towards them as patients. There was an overwhelming consensus amongst the five groups.

#### **d) Pattern 4: Fairness versus Unfairness**

Injustice is defined in the South African Oxford Dictionary (2005:463), as not behaving according to the principles of equality and justice. In the context of this study, the participants associated unfairness with a lack of fairness of treatment.

##### **d.i) Fairness**

There were no positive reflections or views expressed that could justify the actions by the CNPs towards patients as being fair treatment.

##### **d.ii) Unfairness**

The following views by the participants were voiced during the interviews that described their perceptions of the unfair treatment by CNPs towards patients:

- *“En nog ‘n ding, ons is nie rassisties, hoe sê mens, dan sit ons lank hier in die wagkamer, dan kom die witmense in by die deur. Dan loop hulle reguit in, dan word hulle gehelp en dan moet ons sit en langer wag vir diens. Ek het ook mos die reg om eerste behandel te word as ek lank sit en wag.”* (A204)

[And another thing, we are not being racist, how can one say, then we sit for a long time in the waiting room, then white people come in through the door. They would walk straight in and are helped, but then we must sit longer to wait for service. I also have the right to be treated first when I sit and wait for hours.]

- *“Hulle moet ons almal gelyk vat, wit of nou nie wit nie, bruin of nie bruin nie. Ons staan saam. Dit is dieselfde pasiënte.”* (A202)

[They must help us all the same, be it white or not white, brown or not brown. We stand together. We all are patients.]

- *“Sekere bruin mense kom in en is hulle ‘n familielid, nê, van die suster of die assistant nurse, dan word hy eerste gehelp. Dis onregverdige diens.”* (A204)

[Certain coloured people would come in and because they are family members of the sister or the assistant nurse, then they are helped first. This is unfair service.]

The overall finding in this case was: although no specific questions were asked on this pattern, it emerged strongly in all five of the focus group sessions and could not be ignored by the researcher. Therefore the pattern indicates only negative perceptions and no positive opinions. Patient's perceptions of racism, favourism of family members emerged very strongly in particular two of the groups. The participants strongly expressed their displeasure with regards to incidents that had taken place at the PHC health centres that they attended.

The overall conclusion of Theme 1, concerning the attitude of the CNPs towards the patients, was that the patients perceive the CNPs as unfriendly, rude, unfair but yet compassionate. When respondents were asked to describe their perceptions and experiences of the attitudes of CNPs towards them as patients, the majority of the groups felt strongly that CNPs did not show positive attitudes towards patients. The one group (A204) was very adamant that CNPs were unfair, unjust and unfriendly. This confirms the results of a study by Tshabalala (2002:81) who found that the major concern of patients was the attitudes that health care staff showed and the fact that patients did not experience the health care workers as being polite to them.

Hays, Veitch & Evans (2005:4) found that patients in Australia, who attended PHC facilities, viewed interpersonal aspects as a high priority when rating a service. The participants during this study indicated that the nurses were so busy with their routine work, that they forgot that patients were people with concerns and anxieties. This led to the conclusion that the personal relationships between health staff and their patients were not perceived as being positive. It was established that patients were afraid to disagree with staff members, because of their fear for victimisation and rudeness.

## 4.2.2 THEME 2: Perceived knowledge and skills

Knowledge is the information a person gains through education that makes one well informed about a certain subject. Contrary, skills are mostly seen as practical experience that brings about the necessary competence to perform a certain procedure. The CNP must have the ability to examine, diagnose and treat a patient on PHC level. Therefore, in the context of this study, the researcher aimed at determining whether the targeted community perceived the knowledge and skills of CNPs, as being adequate to perform their intended functions.

### 4.2.2.1 Sub-theme: Adequate versus inadequate assessment of a patient

Assessment of a patient includes the taking of a complete history and examining the patient according to the complaint, as well as the making of a holistic assessment, to establish other potential problems.

The overall responses regarding the assessment of patients by CNPs were viewed as very positive.

#### a) Pattern 1: Competence versus Incompetence

##### a.i) Competence

An agreement was evident that the CNPs were competent when assessing patients from the following positive responses:

- *“Hulle ondersoek baie beter as die dokters. Kyk orals rond en vra baie uit oor die hele lyf.” (A201)*

[They examine much better than the doctors. They examine everywhere and enquire about the whole body.]

- *“Die ondersoek kan ek nie van kla nie. Ja, ja, dit doen hulle. En dit doen hulle gereeld, want ek het hartasma.” (A202)*

[I cannot complain about the examinations. Yes, yes, that they do. And they do it often, because I have heart asthma.]

- *“Ek het nog nie afgeskeep gevoel as ek huis toe gaan nie, want sy doen goeie ‘job’! Soms voel ek beter as wat die dokter dit doen, want hulle kyk orals.” (A204)*

[I have never felt neglected when I leave for home, because she does a good job! Sometimes I feel better than when the doctor examines me, because they (the nurses) look everywhere.]

- *“As ek kom vir ondersoek, ek sal nie klagtes kan sê nie. Kan nie kla oor dit nie, hulle doen goeie werk met die ondersoek en al die vrae.” (A203)*

[If I come for an examination, I have no complaints. Cannot complain about it, they do a good job with the examinations and all the questions.]

#### **a.ii) Incompetence**

Participants expressed their dissatisfaction with the levels of competency of CNPs through the following negative responses:

- *“Kyk, die dokter sê baie keer die suster kon jou gehelp het as sy beter ondersoek het.” (A204)*

[Look, the doctor often says that the sister could have been able to help, if she had examined me better.]

- *“My enkel is al baie lank seer, dit tas my hele bene aan tot dit pyn hier van my hart tot in my niere. Maar sy weet nie wat ek makeer nie. Dit is sleg van haar, sy moet slimmer wees.” (A201)*

[My ankle has been sore for a long time. It affects my bones until the pain goes from my heart to my kidneys. But she does not know what is wrong. It is bad of her, she must be brighter.]

It was decided to disregard these two responses, as it was felt that they could not be taken at face value. The first response that apparently reflected the opinion of the doctor could have been hearsay or idle talk. The second respondent described a pain that may have equally perplexed the doctor.

The overall finding of Pattern 1 was: the majority of the participants voiced their satisfaction with the competency of the CNPs when assessing them. Field notes taken during the group interview indicated that statements made by some of the participants were agreed to by other participants through the nodding of heads and verbal agreement.

## **b) Pattern 2: Holistic care versus illness orientated care**

### **b.i) Holistic care**

Holistic care means that the patient is assessed in totality, namely physically, mentally and socially. In the context of this study, it requires that the patient should be treated as a whole, rather than just the assessment of symptoms.

The participants mostly responded that CNPs should render a more holistic care, when assessing them.

This was evident from the following quotes:

- *“Ek het die vrymoedigheid om terug te kom na hulle toe, want hulle ondersoek ’n mens goed en is altyd bereid om bietjie ekstra te doen as nodig.” (A202)*

[I feel confident to return to them, because they examine a person well and they are always willing to do a bit extra if necessary.]

- *“Hulle kom check orals op jou lyf, al is daar nie fout nie. Kyk na alles. Doen dit baie goed.” (A203)*

[They examine the whole body, even if there is nothing wrong. Look at everything. Do that very well.]

### **b.ii) Illness orientated care**

This implies that the CNP only assesses and manages the main complaint or illness of the patient, and does not treat him/her holistically. The following quotes confirmed this statement.

- *“Klein goedjies kan hulle maar ekstra doen, nét om te sien dat jy heeltemal oraait is. Hulle gaan nie verder nie, kyk net waarom jy kla.” (A204)*

[Small things they could do extra, just to check that you are completely fine. They do not go any further, only look at what you complain about.]

- *“Ja nee, hulle gaan nie verder nie, as jy iets vergeet het, dan is hulle sommer kwaad, want dit was nie op die lêer geskryf nie.” (A204)*

[Yes, they do not go any further. If you forgot something, then they are angry, because it was not written on the file.]

- *“Ek moet gevra het, ‘toets asseblief my ystervlak’, want my ystervlak was die laaste keer laag gewees, nou wil ek net kyk of dit nou reg is. Hulle moet mos teruglees en sulke ekstra goedjies doen.” (A205)*

[I had to ask, ‘please test my iron level’, because it was low the last time, now I only want to know if it is in order now. They must read back in the file and do such extra things.]

- *“Hulle gaan nie verder nie, kyk net waarom jy kla. Ek moet vra as daar iets is wat ek ekstra gedoen wil hê. Dit lyk vir my hulle werk net om klaar te kry.” (A202)*

[They do not go any further, only look at what you complain about. I must ask if there is something extra that I want to be done. It looks to me as if they work just to finish.]

The overall finding of Pattern 2 was that the majority of participants, as well as the majority of the groups, perceived that the CNPs concentrate on the main complaint and do not manage the patient holistically. The patients verbalized that they have to ask for extra assessment or management. This indicates their dissatisfaction with the holistic management performed by the CNPs.

#### **4.2.2.2 Sub-theme: Providing health education and information versus lack of providing health education and information**

According to Dennill, King and Swanepoel (2008:148), health information provides information to the patient to empower him/her to take responsibility for

his/her own health status. It allows individuals to make informed choices about their own health. Health information can therefore be seen as education that leads community members to voluntarily change their behaviour, in order to bring about an improved health status.

**a) Pattern 1: Eagerness in providing health education versus Lack of eagerness in providing health education**

**a.i) Eagerness in providing health education and/or information**

With regards to the eagerness of health education being provided by CNPs, the following quotes refer:

- *“Baie inligting gegee, soos huisrade. Sy het my lekker raad gegee en dit het lekker gehelp, veral toe ek beensere gehad het en dit nie wou gesond word nie. My dogter se kleintjie met maagwerk het ook lekker raad gekry oor die piesang en soutwater.” (A204).*

[She gave lots of information, like home remedies. She gave me nice information and it helped, especially when I had legsores that wouldn't heal. My daughter's child with diarrhoea also received good advice here about the banana and the salt water.]

- *“Ek kry baie sooibrand en toe kom ek ook vir dít, en toe gee hulle nou vir my die medisyne en toe sê hulle wat ek nou nie moet eet nie en sulke tipe goedjies.” (A201).*

[I get frequent heartburn and when I came for that, they gave me medicine and they said what I should not eat and those sorts of things.]

- *“Hulle sê altyd vir my, dís hoe ek dit moet drink, ek moet die drink ná etes, maak die pille klaar, dah-dah-dah!...hulle gee al daai voorligting...ja, dít sê hulle elke keer vir my.” (A203)*

[They always tell me how I should drink it, I must drink it after meals, finish the tablets, dah-dah-dah!...they give all that information...yes, they say it every time to me.]

- *“Ja, hulle gee. Gee lekker voorligting wat jy by die huiskan doen, veral as jou kind siek is. Mens kan sien sy weet waarvan sy praat.” (A205)*

[Yes, they give. Give nice information about what you can do at home, especially if your child is sick. One can see she knows what she is talking about.]

#### **a.ii) Lack of eagerness in providing health education and/or information**

With regards to the negative responses regarding the provision of health education by CNPs, the following quotes were noteworthy:

- *“Is net die pille, dan sê hulle jy moet net so drink. En klaar. En miskien as dit op is moet jy maar net weer kom.” (A204)*

[It is just the tablets, then they say how you must take them. And finish. And maybe, if it is finished, you must just come again.]

- *“En as hulle jou nou klaar geondersoek het, sê die susters nie vir mens wat jy makeer nie...Nee, ek vra! Hulle sê nie sommer nie, ek vra!” (A205)*

[And if they have finished examining you, the sister does not tell you what is wrong with you. No, I ask! They don't bother to tell, I have to ask!]

The overall finding of Pattern 1 was: the majority of participants indicated that health information was being provided by CNPs on a continuous basis and it is of good quality, because it had the desired effect on their health problem. Information by CNPs included the do's and don'ts of an illness, informing the patient about what was wrong with him/her, as well as the necessary information concerning the prescribed medicine. This tendency was detected from all the five groups with very few negative opinions expressed concerning the lack of eagerness in providing health information. These perceptions are in line with the conclusion by Kinnersley *et al.* (2000:47) that nurses have longer consultation times due to the fact that they provide more information to patients, than doctors. The nurse practitioner also provides patients with good quality information, in an attempt to improve their general health status.

## **b) Pattern 2: Good versus Poor communication skills**

### **b.i) Good communication skills**

Information can only be provided through proper communication skills, by enhancing the interpersonal relationship between the health worker and the patient. This includes verbal and non-verbal skills that the CNP requires to convey the message.

With regards to the positive responses about CNPs communication skills, the following quotes by participants should be noted:

- *“Ek, as ek wil iets sê, dan sê ek vir die suster of so, so ek het nou nog nie ‘n probleem gehad nie. So hulle luister wat jy sê.” (A201)*

[If I want to say something, then I say it to the sister or whoever, so I have up to now not had a problem... So, they listen to what you have to say.]

- *“Hulle is op die punt, soos ek wat mos nou elke maand kom, verduidelik elke maand alles en maak seker ek weet wat om te doen.” (A203)*

[They get to the point, like in my case, where I come every month, they explain each month everything and make sure that I know what to do.]

- *“Die suster praat baie mooi met mens as sy vir jou sê wat jy makeer en wat om te doen. Ja, sy praat en luister baie mooi.” (A204)*

[The sister speaks very nicely, when she tells you what is wrong with you and what to do. Yes, she talks and listens very nicely.]

### **b.ii) Poor communication skills**

The following two quotes were the only perceptions expressed from all twenty six participants concerning the poor communication skills by CNPs.

- *“Ek moet sien sy luister, anders praat ek nie. Sy kyk dan nie eers in my gesig nie. So, hoe kan sy luister wat ek sê?” (A204)*

[I must see that she is listening, otherwise I do not talk. She does not even look me in the eyes. So, how can she be listening to what I am saying?]

- *“Nee wat, as sy nie die dag lus is vir jou nie, dan soek sy net wat nodig is. Praat is min, so ek praat dan ook nie. Daai dag, dan vra sy niks vrae nie, so ek sê dan ook net wat nodig is en basta!” (A204)*

[No, if she is not in the mood for you on that day, then she only looks at the bare necessity. Talking is minimal, so then I don't speak either. The day she asks no questions, I only say what is necessary.]

Emerging from analyzing Pattern 2, it became evident that participants perceived the CNPs communication skills as being more of good quality than poor quality. The only negative views were expressed by group A204. The majority view was in favour of the CNPs having good communication skills.

#### **4.2.2.3 Sub-theme: Suitable versus unsuitable prescription of medicine**

According to Tshabalala (2002:85), nurses understand that PHC is a nurse driven service and that they must seek to improve the outcomes of patient care. This could be done by examining the nursing practices through clinical audits. Another measure of quality assurance practice would be through the implementation of a patient complaints procedure.

##### **a) Pattern 1: Correct versus Incorrect prescription**

###### **a.i) Correct prescription**

Correct medicine prescription entails the patient's experience regarding the appropriateness of the prescribed medicine, according to its effectiveness and the information that the CNP conveys, when dispensing the medicine.

Participants responded to the correctness of prescriptions and the provision of medicine, by saying:

- *“Ja die pille het gewerk soos ‘n bom! Baie goed. Ek sal weer terugkom na haar toe, sodat sy weer sulke goeie pille kan gee.” (A203)*

[Yes, the tablets worked like a bomb! Very good. I would return to her, so that she can give me such good tablets again.]

- *“Ja, ja, die suster is goed om te vertel wat jy makeer en watter pille waarvoor sal help. Sy doen dit baie deeglik en maak seker mens weet, voordat jy daar uitstap, wat jy makeer, hoe om die medisyne te gebruik en wanneer om terug te kom.” (A202)*

[Yes, the sister is good at explaining what is wrong with you and what tablets would help for what. She does that very thoroughly and ensures that one knows, before walking out there, what is wrong with you, how to use the medicine and when to return.]

- *“Ek is gepla met sooi-brand, en die medisynetjies help goed daarvoor. Sy gee soms die stroop en soms die pille, maar dit help albei ewe goed.” (A202)*

[I suffer from heartburn and the medicines help a lot. She sometimes gives the syrup and other times the tablets, but both help equally well.]

#### **a.ii) Incorrect prescription**

Participant's dissatisfaction with regards to the unsuitability of prescriptions mostly focused on the legal limitations on nurses to prescribe a larger variety of medicines, as was evident from the following responses:

- *“Ek voel hulle moet meer medisyne kan gee. Dan hoef ons nie so baie dokter toe te gaan nie. Hulle is, voel vir my, net so slim geleer soos die dokters, so hoekom kan hulle nie meer doen vir 'n mens nie.” (A201)*

[I feel that they must be able to give more medicines. Then we won't have to go to the doctor so much. It feels to me, as if they are just as well taught as the doctors, so why can't they do more for a person.]

- *“Daar is van die medisynes wat die dokters net mag voorskrywe, wat ek voel die susters miskien kan doen, dat jy minder dokter toe hoef te gaan. Dit is tydmors om elke keer vir die dokter te moet wag, as die suster dit net sowel kon gegee het.” (A204)*

[There are medicines that only the doctors may prescribe that I feel the sisters should perhaps do, so that one needs to go to the doctor less. It is a

waste of time to sit and wait for the doctor, if the sister could have given it anyway.]

- *“Net dat hier is nie elke dag ‘n dokter nie, so die susters moet meer vir ‘n mens kan doen en medisyne gee. Dit sal baie help.” (A204)*

[It is just that a doctor is not here every day, so the sisters must be able to do more for us and give out medicines. It will help a lot.]

- *“Ek wil weet, as ek daai pille in my mond sit, dan wil ek weet waarvoor dit is, daarom vra ek as die suster niks sê nie.” (A204)*

[I want to know, when I put those tablets in my mouth, then I want to know what it is for, therefore I ask, if the sister does not say.]

The overall finding of Pattern 1 was: comparing the correctness versus the incorrect prescriptions made by the CNPs, it was found that the participants from all the five groups felt the CNPs prescribe the correct medicine for their health ailment. The medicines do help and improved their health status. It was also found that the CNPs explain the usage and compliance of the drugs to the patients. This correspond with the good health information and good communication skills found in theme one.

The general feeling from the participants in all five groups was that the CNP should however be able to prescribe and dispense a greater variety of medicines. The scope of practice is, however, determined by SANC in collaboration with the Medicines and Related Substance Act No 101 of 1986, which states that a CNP may only prescribe schedules one to four medicines. Medicines falling under schedule five and above may only be prescribed by a medical doctor. This is mostly habit-forming drugs.

Gadallah *et al.* (2003:428) support the participants' views that a greater variety of medicines should be prescribed by health care practitioners at PHC level. During this study, 26% of the participants reported that the variety of drugs were inadequate and not always allowed to be prescribed by the CNP. This forced them to see doctors more often than they would have liked, as they felt that CNPs could manage them satisfactory.

### 4.2.3 THEME 3: Impact of training programme

#### 4.2.3.1 Sub-theme: *Ability to perform the roles and functions versus lacking the ability to perform the roles and functions as per the scope of practice and taught curriculum*

One of the most positive forces in promoting quality of care is the continuous education and training of staff. These, according to Tshabalala (2002:85), determine whether clinics render a quality service to the community they serve. Therefore, the perceptions of the participants would be indicative, as to whether the current training programmes being offered as a post-graduate course were successful in fulfilling the health needs of the community.

Although the question was not directly asked to comment on the impact of the training programme on the quality of care rendered by the CNPs, it was evident that participants made comments regarding the quality and impact of the existing training programme, as illustrated in the quotes of opinions expressed by participants during the interviews.

#### a) **Pattern 1: Meeting patient needs *versus* not meeting patient needs**

##### a.i) **Ability to adequately meet patient health needs**

Patients expressed their positive views with regards to CNPs fulfilling their intended roles as follows:

- *“Hulle kennis is goed genoeg...Ja, ja. Dis reg om die regte goed te doen en medisyne te gee. Hulle is wragtig net so slim soos die dokters en gee in elk geval meer vir ’n mens om.” (A201)*

[Their knowledge is good enough...Yes, yes. It is good to do the right things and to give medicines. They are really just as clever as the doctors and besides, they feel more for a person.]

- *“Dit wat hulle móét doen, dit doen hulle goed. Hulle word goed opgelei.” (A203)*

[That which they must do, they do well. They are trained well.]

- *“By die ondersoek is daar nie fout nie, hulle is net soos die dokters.” (A203)*

[With the examination there is nothing wrong. They are just like the doctors.]

- *“Kyk, die susters is slim geleer. Kan sien hulle ken die werk. Hulle ondersoek baie goed en gee goeie medisyne vir ’n mens. Veral met die babatjies is hulle goed.” (A205)*

[The sisters are welltaught. It is apparent that they know their work. They examine very well and give good medicines to a person. They are especially good with the babies.]

- *“Ek sal sê, vir hul kennis oor die medisyne, sal ek hulle so vier uit vyf gee. Vir my kan hulle meer soorte pille kan gee. Hulle is al so goed, hulle kan maar meer vir mens doen. Dis al wat my pla.” (A201)*

[I will say that for their knowledge about medicines, I will give them a four out of five. In my opinion, they should be able to give more types of tablets. They are already so good that they can just as well do more for a person. That is all that bothers me.]

#### **a.ii) Lacking ability to adequately meet patient health needs**

Patients, however, also expressed their negative views regarding CNPs' lack of fulfilling their intended roles:

- *“Meer tipe van diens moet hulle ’n bietjie meer kan doen vir die pasiënte, dat hulle nie almal moet wag vir ’n dokter nie.” (A203)*

[They should be able to provide a bigger range of services, so that they can do a bit more for the patients, so that they (patients) don't all have to wait for the doctor.]

- *“Die medisynes is reg, maar ek voel hulle kan miskien ’n bietjie meer gee...leer hulle meer gevorderde goed, sodat ons nie so baie na die dokter hoef te gaan nie.” (A204)*

[The medicines are fine, but I feel that they can perhaps give a little bit more...teach them more advanced things, so that we don't have to go to the doctor so often.]

- *“Daar is mense wat sê hulle moet leer om X-strale byvoorbeeld te neem. Ook, die toets as 'n vrou swanger is, om te sien of die baba gesond is en reg lê in die maag. Dit sal baie tyd en geld spaar.” (A205)*

[There are people who say that they must learn how to take X-rays, for example. Also, the test if a woman is pregnant, to see if the baby is healthy and positioned right in the stomach. That will save lots of time and money.]

- *“Die hospitaal is ver, hmm, so noodgevalle in die nag...dit moet hier gehelp kan word. Die regering sal baie aan ambulans onkoste bespaar, as die susters mens meer kan help.” (A204)*

[The hospital is far away, so for emergencies at night...that must be done here. The government could save lots on ambulance costs, if the sisters can help out more.]

In this pattern, there was an overwhelming and significant perception from all the five groups that the CNPs do render a primary level of care that meets their health needs. Their satisfaction with the knowledge and skills of the CNPs as currently being taught in the post-graduate programme registered with SANC, indicate that the training programme is adequate. The conclusion can be made from the participants' perceptions, that the CNPs can substitute doctors in a wide array of PHC services and so reduce the demand for doctors on PHC level of care. This corresponds with the finding of Marsh and Dawes (1995:2) that nurse practitioners can indeed be successfully incorporated into the PHC health team and deliver an accepted service to the community.

However, during the interviews, it became clear that the community expected the roles and functions of CNPs to be extended, as to better the quality of care rendered by them. The patients expressed their view that the CNP should prescribe a greater variety of medicine. This aspect cannot be accommodated within the current curriculum, as the scope of practice is determined by

SANC. All learning/training programmes are accredited and quality assured by SANC to prevent medico-legal risks within the services. The participants also expressed the wish for the CNPs to be able to perform more advanced diagnostic tests. The implication on the Department of Health's budget will be very significant as very few of the PHC facilities do have the infrastructure and instruments to perform such tests.

Minami and Oulton (2008), at the International Nurses Day Symposium, expressed the view that nurse educational institutions should match the curriculum of training programmes, to meet the needs of the population. These authors further noted that high quality, primary health care and clinical experiences during the training programme would lead to high quality of care to communities. Their viewpoints were confirmed by the participants' perceptions that nurses for example, should be taught in more detail with regards to medicines and more diagnostic tests.

#### **4.3 CONCLUSION**

In this chapter, the data being collected during the interviews was analysed, interpreted and discussed. Clear themes emerged during these processes concerning the attitude, knowledge and skills of the CNP and the impact that the training programme have on rendering quality care to the community.

Although there were few positive views, the overwhelming responses by participants led to the conclusion that the attitude of the CNP was of poor quality. The participants perceived the CNPs as being unfriendly, unprofessional yet compassionate.

Concerning the knowledge and skills of the CNP, the overwhelming perception was that this aspect was of good quality. The CNP provide adequate and continuous health information, perform excellent physical examinations and prescribe medicine that solves the health problems of the patients. From the above, the conclusion could be made that the current training programme fulfills the needs of the community. This is evident from statements made by the participants that the assessment, provision of health information, diagnosing

with corresponding prescription of medicine is of high quality. The lack of professionalism and poor attitude of the CNPstowards the patients need to be addressed within the total training period of nurses. It should be paid attention in under-graduate, post-graduate and in-service training programmes.

To get an overall concise picture the table below summarises the responses of the participants according to the identified sub-themes and patterns.

**Table 4.3:**Overall picture of the participants’ responses

Sub-theme	Patterns	Responses
Positive <i>versus</i> negative attitude towards patients	<ul style="list-style-type: none"> <li>• Friendliness</li> <li>• Compassion</li> <li>• Professionalism</li> <li>• Fairness</li> </ul>	<p>- 2</p> <p>+ 1</p> <p>- 2</p> <p>- 2</p>
Adequate <i>versus</i> inadequate assessment of a patient	<ul style="list-style-type: none"> <li>• Competence</li> <li>• Holistic care</li> </ul>	<p>+ 2</p> <p>- 2</p>
Providing <i>versus</i> the lack of providing health education and information	<ul style="list-style-type: none"> <li>• Eagerness to provide health education</li> <li>• Good communication skills</li> </ul>	<p>+ 2</p> <p>+ 2</p>
Correct prescription <i>versus</i> incorrect prescription of medicine	<ul style="list-style-type: none"> <li>• Suitable prescription</li> </ul>	+2
Ability to perform the roles and functions as per scope of practice and taught curriculum <i>versus</i> the lack of ability to perform the roles nd functions as per scope of practice and taught curreculum	<ul style="list-style-type: none"> <li>• Ability to adequately meet patient health needs</li> </ul>	+2

Key:

-2	-1	0	+ 1	+ 2
Overwhelming negative responses	Mostly negative responses	Equal positive and negative responses	Mostly positive responses	Overwhelming positive responses

The researcher succeeded in exploring, investigating and successfully finding answers to the research question: *“What are the perceptions of patients regarding comprehensive care rendered by clinical nurse practitioners in the West Coast rural district of the Western Cape?”*

In the final chapter, a conclusion and recommendations are made, based on the study outcomes of this research.

# CHAPTER 5

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## CONCLUSIONS AND RECOMMENDATIONS

### 5.1 Introduction

In this chapter, conclusions, based on the scientific evidence being obtained during this study, are drawn with reference to the outcomes from similar studies. The purpose, research question, objectives, as well as the limitations of this study are then briefly discussed. Finally, the recommendations, as derived from this study's outcomes, are presented.

### 5.2 CONCLUSIONS DERIVED FROM THE STUDY

The conclusions that were reached during this research study were based on the outcomes of the interviews at the five Primary Health Care (PHC) clinics, within the West Coast district of the Western Cape, regarding the perceptions of these communities about the quality of care being rendered by Clinical Nurse Practitioners (CNPs) in this area. These included the attitudes, knowledge and skills of this specialised category of registered nurses, as well as the impact of current training programmes on the services rendered at PHC level. A summary of the findings follows.

#### 5.2.1 Theme 1: Attitude of the CNP towards the patient

The results from this study indicated that the majority of participants perceived the attitudes of CNPs at PHC level as unfriendly, rude, unprofessional, and in some instances, unjust.

The overwhelming perception of the participants was that CNPs showed poor attitudes towards patients visiting PHC clinics within the West Coast region. Some participants voiced their dissatisfaction with the unfriendly attitudes of CNPs towards patients, by communicating that they were not greeted by CNPs, while others felt that CNPs should not take their work problems out on them as

patients. Makua (2011) presented an abstract at the recent Nurse Education Conference at Sun City, regarding the nurse-patient relationship in pain management at PHC facilities. During his quantitative study, performed at thirty-six clinics within the Tshwane district, it was found that, irrespective of all the efforts taken by health authorities to improve the quality of nurse-patient relations, more than 50% of the complaints at health facilities still related to staff attitudes.

Makua (2011) further emphasised that the participants had expressed their impressions of CNPs as being unprofessional, by quoting that 'the CNP had a closed contact relationship with them as patients and that CNPs portrayed themselves as being unprofessional by chewing gum in front of us as patients'. Patients from that study further expressed the fact that nurses took their time with tea breaks and lunches, while patients were sitting and waiting. During this research, participants similarly complained that, despite the clinics being full of patients waiting, the CNPs and other nursing staff would sit and smoke and drink tea first, or have conversations, instead of attending to patients needs as a matter of priority. Participants voiced their obvious frustration by stating that such behaviour did not reflect well on the nursing profession.

A significant finding from this research was that some of the participants felt that unfair treatment still occurred in the public health sector. Discrimination between races occurred, due to white patients being attended to immediately, before long waiting, coloured and African patients. At some clinics, the family members of clinic staff were attended to first, before patients having waited for hours in the waiting room. The respondents expressed that they felt angry and dissatisfied with this behaviour of CNPs.

### **5.2.2 Theme 2: Perceived knowledge and skills of the CNP**

The researcher aimed at determining the knowledge and skills of CNPs in rendering holistic care to the patients, i.e. during the assessment, diagnosing and management of the patient.

Most of the participants felt that the knowledge and skills of CNPs were adequate and compared very well with the services provided by medical doctors. The CNPs' questioning and examination techniques were perceived as being of an excellent standard. Furthermore, the participants felt that CNPs provided broader and more detailed health information, and explained the diagnosis and usage of medicine very adequately. These outcomes were in agreement with the findings by Kinnersley *et al.* (2000:46), who reported that patients had felt that CNPs spent significantly longer times with them than general doctors, and that CNPs explained the causes of their illnesses, and ways of relieving their symptoms in more detail than doctors. This author further stated that the patients perceived CNPs as providing high standards of care that reflected the CNPs excellent knowledge and skills when delivering holistic care to patients at PHC level.

Gadallah and Zaki (2002:425) reported that 99.6% of patients were highly satisfied with the performance of the nurse practitioner. They felt that examinations were performed properly, together with adequate health information being provided, whilst 86% of participants indicated that the medicines being prescribed by nurse practitioners resolved the presenting illnesses.

Emerging from the interviews was the opinion by some participants that the variety of medicines that CNPs are (legally) allowed to prescribe was too limited in scope. Participants expressed their wish for the scope of practices, pertaining to the prescription of medicines, as well as for performing diagnostic tests, to be expanded so that CNPs could perform extended roles and functions to patients. The patients felt that CNPs at the clinics should be able to render a more comprehensive service, particularly in the rural districts, where the general doctor and hospitals are far in reach.

### **5.2.3 Theme 3: Impact of training**

As discussed above, the participants during this study expressed the view for CNPs, working at PHC level, to be equipped even more, in order to be able to

perform more extended roles and functions. These same participants expressed their satisfaction with the current knowledge and skills of CNPs, hence implying that the current one-year, post-basic course in Clinical Nursing Science, Health Assessment, Treatment and Care, as defined in Regulation 48 of the Nursing Act No 33 of 2004, is adequate in meeting patients' needs. Some participants indicated that the current training was adequate enough and that CNPs "were just as clever and skilled as medical doctors". It was also noted that the participants felt that the training that these registered nurses underwent, was of sufficiently high quality to enable CNPs to render a preventative, curative and rehabilitative care to patients at PHC level. Therefore, the assumption could be made that the current training programme succeeded in fulfilling the needs of the broader community members, visiting PHC facilities. This constitutes one of the critical steps in the conceptual framework for innovation in health care, as described in chapter 1. This framework accentuates the focus of health care, namely how the patients are seen and heard, and most importantly, how the patients' needs are being met by service providers.

Horrocks *et al.* (2002:1) reported that patients were more satisfied with the quality of care being rendered by the nurse practitioners at PHC level, than by their counterpart doctors and that patients perceived the quality of care by nurses to be similar to that of doctors. Patients' satisfaction ratings were based on CNPs' good communication skills, longer times spent on consultations, accurate diagnosis, comprehensive examinations, and appropriate advice on patient self management and regarding prescribed medicines. According to this author, this high standard of care could have only been achieved through a standardised, educational background of the CNP. Due to the importance of studying the training, skills and experience that nurses require in order to offer the desired benefits to patients at PHC level, in South Africa the training of registered CNPs is regulated and quality controlled by the South African Nursing Council (SANC).

Mash and Kapp (2004:23) report that CNPs regard themselves as nurses and not clinicians and that the average registered nurse enters the post-basic training programme, because he/she is personally motivated and wants to

better serve his/her community. De Villiers (1999:720) agrees, but emphasises the fact that all health workers working within PHC should make a paradigm shift from the traditional biomedical model to the patientcentred model. Nurses are the backbone of the PHC approach within South Africa, and as such, a more patient centred model content should be incorporated into the curricula of the undergraduate and post-graduate training programmes.

### 5.3 OBJECTIVES REACHED

In this section the summarised details are each presented against the specific objectives of this study.

**Table 5.1:** Outcomes relating to each study objective

OBJECTIVE	STUDY METHOD AND OUTCOME
To explore and describe the perceptions of patients from the West Coast rural community, regarding the quality of health services being rendered by CNPs at nurse driven, PHC clinics.	<ul style="list-style-type: none"> <li>• Five group interviews were held in different towns across the West Coast district of the Western Cape, with a total sample of 26 participants.</li> <li>• Open ended questions were asked to explore the participants' feelings and experiences of the services being rendered by CNPs at nurse driven, PHC clinics.</li> <li>• Themes were identified from the collected information and patients' perceptions regarding the attitudes, knowledge and skills of CNPs were grouped accordingly.</li> </ul>
To provide policy makers in the WCDoH with recommendations regarding the successful implementation of nurse driven, PHC policies, as stated in the National	<ul style="list-style-type: none"> <li>• It was planned for various stakeholders in the WCDoH to be provided with evidence regarding the successful implementation of the PHC approach.</li> <li>• The West Coast district manager and the head office of the WCDoH should be informed about patients' views with regards to their experiences of the knowledge and skills of CNPs at nurse driven clinics, as being of high</li> </ul>

<p>Health Plan and Health Care of 2010.</p>	<p>quality.</p> <ul style="list-style-type: none"> <li>• The WCDoH and other stakeholders, such as the SANC, should reconsider the scope of practices of CNPs, as community members were of the opinion that CNPs' scope of practices should be extended, in order for patients to visit medical doctors less.</li> <li>• WCDoH should be notified of the overwhelming perceptions that the community perceived the attitudes of CNPs as being rude, impolite and that injustices in treatment still occurred within the democratic South Africa. These matters needed urgent attention from all the stakeholders, as to investigate these allegations further, in order to draft policies and to implement processes that would change these very negative perceptions of patients.</li> </ul>
<p>To provide nursing education institutions, rendering specialised post-graduate training programmes, with scientific evidence as to how the community currently perceives health care being rendered by CNPs, as to influence the learning objectives of training programmes, by indicating whether the currently taught curriculum meets the needs of patients.</p>	<ul style="list-style-type: none"> <li>• Training providers of the post-basic courses in Clinical Nursing Science, Health Assessment, Treatment and Care, as stipulated in Regulation 48 of the South African Nursing Act No 50 of 1978, provide a comprehensive training programme to meet the needs of the broader communities in the West Coast District of the Western Cape.</li> <li>• Adequate skills concerning the physical assessment of patients by CNPs were expressed by the majority of participants. The health education and information being provided by CNPs were regarded as being of excellent quality and the medicines being prescribed were perceived as appropriate in curing the medical problems.</li> <li>• It should be brought under the attention of training providers that communities expected CNPs to provide a broader scope of services, by being able to prescribe</li> </ul>

	<p>more types of medicines and to perform diagnostic tests, as to aid patients in having to visit the medical doctor less. This aspect should be incorporated into the curricula, as to meet the needs of communities.</p>
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The above objectives were met through an in-depth research study, which aimed at providing answers to the research question, *“What are the perceptions of patients regarding comprehensive care rendered by clinical nurse practitioners in the West Coast rural district of the Western Cape?”*

## 5.4 RECOMMENDATIONS

Based on the findings of this study and following the themes being identified, the following recommendations are proposed to future researchers, policymakers, CNPs and nurse training providers.

### 5.4.1 Recommendations for future research

Due to the relatively limited number of existing studies on the quality of care being rendered by CNPs, the researcher found it challenging to substantiate and discuss the current findings in every respect. Therefore, more research about the quality of service being rendered by CNPs would be necessary in order to address the limitations of the literature.

As is known, this study was directed at the perceptions and experiences of patients regarding the quality of care being rendered by CNPs at the nurse-driven, PHC clinics. The overwhelming perception of the participants was that CNPs showed poor attitudes towards patients. As stated by Sixma *et al.* (1998:212), findings from research indicating the effectiveness of the different dimensions of patient satisfaction should receive more attention. One such dimension is obviously the perceived poor attitudes of CNPs, working in clinics. It is thus recommended that this multi-interaction process between the patient and the CNP should be explored further.

Although this study was limited to one of the five rural districts within the Western Cape Province, significant discrepancies between the perceptions of the different communities, regarding the quality of care being rendered by CNPs at PHC clinics, was expected to be unlikely. However, different cultures, values and socio-economic factors among the various communities would indeed require further investigation of the other four rural districts and the Cape Metropole. Research, involving all the six districts within the Western Cape would be enlightening and the researcher therefore recommends that similar studies to this one should be conducted over the whole province.

#### **5.4.2 Recommendations for policy makers**

According to Tshabalala (2002:80), patient satisfaction surveys are a mechanism to improve the quality of services that the Department of Health renders to the broader community members. This study could hence be viewed as a report of a survey conducted amongst some of the communities of the West Coast district of the Western Cape.

These findings would need to be reported to the necessary stakeholders, so that interventions could be implemented in order to improve the services in those areas found lacking the desired behaviour of CNPs towards patients, such as good attitudes. Feedback from patients is vital, if deficiencies are to be identified and improvements achieved. Nick Koornhof, a previous MEC of Health (2001:2), stated that people who make use of PHC services have the right to expect services that are responsive to their needs and should be treated with respect and compassion. To enable this, South Africa not only needs a talented workforce with excellent skills and knowledge, but also dedicated CNPs, with caring skills that continue to benefit patients on a daily basis.

The following specific recommendations are thus made to policy makers:

- The need to address the in-service training programmes on Batho Pele principles and client care, as to improve the attitudes and professionalism of CNPs.

- The urgent implementation of continuous educational programmes, i.e. continuous professional development (CPD) programmes, in order to address the shortcomings identified during this research.
- Implement a complaints procedure for patients regarding their perceptions of the attitudes and professionalism of CNPs in clinics and use these outcomes as a performance indicator that is linked to the annual performance appraisal system.
- Managers of clinics should be more focused on the professional behaviour of CNPs and other staff members and report to the relevant district manager(s) on a monthly basis, in order for disciplinary actions to be established. Reportable conduct should include discrimination based on race and nepotism, when rendering services to patients.
- Duiker (2011), who presented an abstract at the recent Nurse Education Conference at Sun City, found that, after a study on the relevance of remuneration as motivation to become a trained nurse, 66.6% of the first-year students at SG Lourens Nursing College in South Africa, would not have entered nursing, if salaries were to be removed. Of the 216 participants in his research study, only 48.6% indicated that nursing was their first career choice. They entered nurse training, because they had not fulfilled the entry requirements of other professional training programmes. This may be one of the underlying reasons why patients complained of CNPs just “doing their job” and not showing passionate, empathic attitudes towards patients. This led to the questioning of the selection criteria of nursing as a profession. Since the assumption could be made that nursing was not regarded as a calling and that other motivations existed for people entering the nursing profession, the researcher urges policy makers to relook and revisit the recruitment and selection policies for nurse admission.

### **5.4.3 Recommendations for nursing training providers**

Research findings and evidencebased facts form part of the nursing philosophy and are important elements of the practices of the profession. The outcomes of this research therefore have implications for nursing education providers and the nursing governing body, SANC.

Participants expressed the view that the scope of practices of nurses should be expanded, as to render a more holistic health care service to the community. The SANC, which regulates the training programme through Regulation 48 of the Nursing Act 50 of 1978, should investigate this request, together with other relevant regulating bodies, such as the South African Medicines Control Council. It is known that SANC is currently relooking the different categories of nurses and their scopes of practices. The outcomes from this study at this specific point in time thus provide an ideal opportunity to provide SANC with relevant findings, while they are in the process of rewriting the new curriculum requirements for nurse training.

Evident from this research was that the attitudes of CNPs should be addressed. Nurse students should learn about the importance of a good nurse-patient relationship, of caring and of good interpersonal relationships, not only in the post-basic training programme, but already during the basic training programme. The holistic approach to nursing must be emphasised, since a patient is not only a human being with a physical illness, but also with the physical, mental and social dimensions of well-being. This holistic approach to nursing should be supported by the enduring nursing philosophies of sister Callista Roy who developed a model on coping and adaptation strategies (2010: Nursing Outlook No 18(3)). This, according to Selanders (2010) as sited in the Holistic Nurse Journal No 28(11), supports that which was written by Florence Nightingale, who already in 1860 defined nursing as 'placing nature in the centre of the health system and putting the patient in the middle of nature, in order to render a holistic approach to patient care.

Very recently, Makgoba (2011) expressed his concern during his opening address at the Nurse Education Conference at Sun City, about nursing care

being on a downward spiral. He urged all nurse training providers to relook the current curriculum and to concentrate on the attitudes of nurses, and not only on their knowledge and skills. He stated that 55% of all disciplinary cases at SANC were due to poor or bad attitudes of nurses. This accentuates the urgency for nurse training programmes to be adapted to meet the needs of the communities being served. He stated that patients explicitly expressed the view that CNPs showed poor attitudes towards patients. Training providers thus need to revert to training their students on the basic, attitudinal skills also.

Training programme should be integrated and not only geared at an intellectual level, with the practical aspects being seen as of secondary importance. This could have a negative influence on the skills and attitudes of nurses. There is no better place to learn “bedside manners” than by the patient’s sickbed. The importance of practical experience must therefore never be underestimated and needs to be brought under the attention of the training providers. Practical training should thus never give way to the simulated skills gained in a skills laboratory. Highquality PHC clinical experiences, where CNPs have access to a wide range of experiences and clinical guidance, are necessary to ensure a high quality of care.

## **5.5 LIMITATIONS OF THE STUDY**

The following limitations and problems were encountered during this research study.

### **5.5.1 Time constraints**

The Western Cape Province is geographically one of the largest provinces in the country. Due to the vast geographical area, it was impossible for the researcher to visit all five rural districts in the Province within the allocated time-frame of five days. Therefore the researcher could only focus the study on one rural district, namely the West Coast district as it was the nearest to her place of residence in the CapeMetropole. In accordance with Colaizzi’s procedural steps as cited in Streubert & Carpenter, 1999:14, the researcher had to return to

two participants in order to validate that the transcripts and findings were a true reflection of his/her experiences. The time being allocated to conduct the data collection in the West Coast district was one week and the return visit for validation, another 2 days. It would thus have been timeconsuming and expensive to conduct interviews and return to the other four rural districts also. Therefore, this study was limited to the West Coast rural district of the Western Cape Province only. The researcher does not claim that the findings from the interviewed groups of patients would equally apply to similar groups from the other districts. However, it is possible that the basic findings and similar experiences may be probable, rather than comparable to the other districts.

The recruitment of participants took place in the waiting room of the clinic. The group interview only took place after the patient was seen by the CNP. Time was being wasted as the researcher had to wait for all the participants to come to the allocated focus group venue. Some of the participants who had been recruited and who had signed consent did not attend the focusgroup interviews, due to factors, such as having to wait to see the doctor, having to wait in front of the pharmacy for their medicine. As the group interviews were held away from the PHC clinics, the participants could not easily travel between the clinic and the interview locations. The researcher hence had to ask other patients to participate to assure that the sum total of the sample for interviewing was a minimum of five per interview group. Much time was thus wasted on recruitment, which led to some group interviews inconveniently taking place late in the day.

### **5.5.2 Language and cultural constraints**

Group interviews were all held in Afrikaans, as it was the mother tongue of all of the participants in the communities in this district. It could be argued that other language groups, for example English and Xhosa speaking participants, may have expressed other views regarding the quality of care being rendered by the CNPs at PHC clinics.

Cultural influences could also have impacted on the experiences of other ethnic groups that were not represented in this study. Although all gender groups were covered by the twenty-six participants of the group interviews, the proportions were not representative of the racial distribution of the country. The majority of participants were from the coloured communities of the West Coast region.

### **5.5.3 Ambivalence**

Due to the long involvement of the researcher in the nursing profession, specifically at PHC level, and her passion for providing quality care to the community, she found it difficult to stay objective at all times, e.g. when hearing about participants expressing their views regarding the unprofessionalism and poor attitudes of CNPs. Real constraint in not providing participants with the necessary information regarding the avenues available to them through which to submit complaints had to be applied. In one of the group interviews the participants asked whether the researcher could not submit the information to the PGWC had office in order to “get rid of this woman”. The researcher, however, succeeded in distancing herself from the complaints and maintained the aim of objectivity during this research, despite finding herself ambivalent, due to conflicting interests. The researcher took specific steps to prevent bias, namely i) by adding nothing to the written reports of comments made by the participants, ii) using another academic subject expert for the interpretation of data, and iii) returning two participants (selected through the fishbowl method) to check the authenticity of transcripts (research member checking).

## **5.6 CONCLUSION**

This study involved examining the lived experiences of twenty-six patients regarding their perceptions of the quality of care being rendered by CNPs at PHC clinics, within the West Coast region of the Western Cape Province. The formulated themes were categorised according to the attitudes, the knowledge

and skills of CNPs, as well as the impact that training programmes had on meeting the needs of communities.

The main conclusion being made was that the attitudes of the CNPs towards patients were of poor quality and of huge concern. Patients expressed views, such as rude, impolite, unprofessional and unfriendly. This aspect would thus need to be addressed by all the role players, including the nurse training providers, policy makers and the management of the West Coast region.

The second important conclusion being made was that the patients in the rural districts wished for the roles and functions of CNPs to be extended, as hospitals and doctors were far in reach. On a gratifying note, patients regarded the knowledge and skills of CNPs as being of excellent quality and therefore did not understand why CNPs could not provide a broader scope of services, with regards to prescribing a better variety of medicines and performing diagnostic tests.

Through conducting this research study, the researcher hopes that her unique contribution to the nursing profession would be to “go back to the basics” and bring caring and nurturing back into nursing. A shift from being illness oriented, to a broader community based focus, is needed. Hopefully, the results from this study would indicate that nursing is lacking the core function of caring, as it appeared that quantity is playing a greater role than quality.

PHC provides a valid and universally applicable approach to reducing health inequity and improving access to essential health care by all. Thirty years after the Alma-Ata Declaration as stipulated in Dennill 2008:4, South Africa is still facing huge challenges with regards to access to health care and quality of care. The country's CNPs represent a formidable force in the global endeavour to achieve the Millennium Development Goals, and providing quality, easily accessible health care to all. With proper investment and an enabling legislative and practice environment, CNPs can play a key role in improving the health status of the country's population.

## BIBLIOGRAPHY

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African National Congress. 1994. A national health plan for S.A.Government Gazette: Pretoria.

Brink, H. 2008. Fundamentals of research methodology for health care professionals.Cape Town:Juta & Co.Ltd.

Burns, N. & Grove, S. R. 2009. The practice of nursing research.Philadelphia: W.A. Saunders Company.

Carryer, J., Dignam, D., Docherty, B., Lightfoot, R., Ross, J. & Messervey, L. 2001. The nursing answer to inequalities in primary health care. Primary Health CareNetwork of the College of Nurses, Aotearoa (NZ) Inc.

Creswell, J. 1998. Qualitative inquiry and research design: Chosing among five traditions. Thousand Oaks, CA:Sage.

Cuéllar, C.J. 2004. Quality assurance in the Jordan primary health care system: best practices. HashemiteKingdom of Jordan and the United States Agency for International Development.

Currie, V., Harvey, G., West, E., McKenna, H. & Keeney, S. 2005.Nursing: autonomous practice and knowledge.*Advanced Nursing Journal, UK, 51(1):73-82.*

Dennill, K., King, L. & Swanepoel, T. 2008. Aspects of primary health care: community health care in Southern Africa. Oxford University Press: South Africa.

Department of Health. 2003. Healthcare 2010: equal access to quality health care.

De Villiers, J.T. & De Villiers, M.R. 1999. The current status and future needs of education and training in family medicine and primary care in S.A. Department of Family Medicine and Primary Care, University of Stellenbosch.

De Villiers, M.R. & Sandison, K. 1998. A Qualitative evaluation of integration in a CHC: to determine factors influencing the integration process. Department of Family Medicine and Primary Health Care, University of Stellenbosch.

De Vos, A.S., Strydom, H., Fouche, C.B. & Delport, C.S.L. 2005. Research at grass roots. Pretoria: Van Schaik.

Donald, T.M., Chapman, R.D. and MacKenzie, J. 1994. Primary Health Care rendered from mobile units: Can computers help? *Curationis*, 17(2):35-38

Duiker, L. 2011. How significant is remuneration as a motivating factor to train as a nurse? SG Lourens Colleges.

Earle, M.C. 2004. 'n Evaluering van die praktyk van die kliniese verpleegpraktisyn werksaam in primêre gesondheidsorg instansies van die Metropoolstreek van die Wes-Kaap: 'n verpleegkundige perspektief. Universiteit van Stellenbosch.

Gadallah, M., Zaki, B., Rady, M., Anwer, W. & Sallam, I. 2003. Patient satisfaction with primary health care services in two districts in lower and upper Egypt. Faculty of Medicine, Ain Shams University, Egypt.

Geyer, N.2003. Dispensing nurses: new legislation. *Nursing Update*,27(9):17-19.

Hays, R.B., Veitch, C. & Evans, R. 2005. The determinants of quality in procedural rural medical care. James Cook University, Australia.

Holloway, I. 1997. Basic Concepts for Qualitative Research. Marston Book Services Ltd., Australia.

Horrocks, S., Anderson, E. & Salisbury, C. 2006. Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. University of West of England, Bristol.

Kapp, R. and Mash, R.J. 2004. Perceptions of the role of the clinical nurse practitioner in the Cape Metropolitan doctor-driven community health centers. Department of Family Medicine and Primary Health Care, University of Stellenbosch.

Keegan, K. & Rollman, S.M. 2008. A Perspective on primary health care in South Africa. School of Public Health, University of the Witwatersrand, Johannesburg.

Kinnersley, P., Anderson, E., Parry, K., Clement, J., Archard, L., Turton, P., Stainthorpe, A., Frase, A., Butler, C.C.& Rogers, C. 2000. Randomized controlled trial of nurse practitioner *versus* general practitioner care for patients requesting “same day” consultations in primary care. *British Medical Journal*, 320:1043-1048.

Koornhof, N. 2001. Opening address by the Western Cape MEC of health at the summit proceedings of the 2001 Nursing Summit, West Coast, Cape Town. The office of the MEC for Health, Western Cape.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R. & Sibbald, B. 2009. Substitution of doctors by nurses in primary care. The Cochrane Library, Issue 1.

Lincoln, Y.S. & Guba, E.G. 1999. Human development. South Africa: Kagiso.

Makgoba, M.W. 2011. Key note speaker at the conference proceedings of the 2011 Annual Nurse Education Conference held at Sun City, South Africa.

Makuamr, M. 2011. Linking nurse patient relationship to pain management in primary health care facilities. University of South Africa.

Marsh, G.N. & Dawes, M.L. 1995. Establishing a minor illness nurse in a busy general practice. *British Medical Journal*, 310:6982.

Marshall, C. & Rossman, G.B. 1999. Designing qualitative research. London: Sage Publications.

Mason, M. 2010. Sample size and saturation in PhD studies using Qualitative Interviews. *Forum: Qualitative social research*, Vol 11(3), Article 8.

Mash, R.J. & Kapp, R. 2004. Perceptions of the role of the clinical nurse practitioner in the Cape Metropolitan doctor-driven community health centers. Department of Family Medicine and Primary Care, University of Stellenbosch.

Mellish, M. 1984. Primary Health Care: the role of the nurse. *Curationis*, 7(1):35-38.

Minami, H. & Oulton, J.A. 2008. Delivering quality, serving communities: nurses leading primary health care. International Nurses Day.

Mouton, J.2001. How to succeed in your master's and doctoral studies: a South African guide and resource book.Pretoria: Van Schaik.

Omachonu, V.K. & Einspruch, N.G.2010. Innovation in healthcare delivery systems: aconceptual framework. University of Miami, Florida, USA.

Patton, M.Q. 2002. Qualitative research andevaluation methods.London:Sage Publications.

Polit, D.F. & Hungler, B.P. 1998. Nursing research: principles and methods.Philadelphia: Lippincott.

Qolohle, M.D., Conradie, H.H., Ogunbanjo, G.A. & Malete, M.H. 2006. A qualitative study on the relationship between doctors and nurses offering primary health at KwaNobuhle (Uitenhage). Medunsa, Pretoria.

Salvage, J. 1994. Nurse Practitioners working for change in primary health care nursing. London: King Fund Centre.

Searle, C. 2008. Professional practice:a South African nursing perspective. Heinemann Publishers:South Africa.

Sekabate, M.E. 2004. Factors influencing the utilisation of the curative component of primary health care in the Ekurhuleni Metropolitan Area.University of South Africa.

Singh, H., Haqq, E.D. & Mustapha, N. 1999. Patients' perception and satisfaction with health care professionals at primary care facilities in Trinidad and Tobago. WHO, 77(4).

Sixma, J.J., Spreuwenberg, P.M.M. & van der Pash, M.A. 1998. Patient satisfaction with the general practitioner: atwo-level analysis. Netherlands Institute of Primary Health Care, Utrecht.

South African Oxford Dictionary. 3<sup>rd</sup>ed. 2005. OxfordUniversity Press: New York.

South African Nursing Council. Nursing Act No 33 of 2005. Government Gazette No 28883. Pretoria, South Africa.

South African Nursing Council.Nursing Act No 50 of 1978 as amended.Government Gazette No 7977. Pretoria, South Africa.

South African Pharmacy Council. Medicine and Related Substance Act No 101 of 1965. Government Gazette No 32148. Pretoria, South Africa.

South African Quality Authority (SAQA) Act No 58 of 1995. Government Gazette No 1521. Pretoria, South Africa.

Stanhope, M. & Lancaster, J. 2008. Public health nursing: population-centered health care in the community. Mosby: Elsevier Inc.

Streubert, H.J. & Carpenter, D.J. 1999. Qualitative research in nursing: advancing the humanistic imperative. Lippincott:Philadelphia.

Thandrayen, K. 2008. The quality of child health services offered at primary health care clinics in Johannesburg. University of the Witwatersrand.

Tshabalala, M.K. 2002. Quality improvement in primary health care setting in South Africa.University of South Africa.

Van der Pasch, M.A. 1998. Patient satisfaction with the general practitioner: atwo-level analysis. Netherlands Institute of Primary Health Care.

Voung, A, van Niekerk, C.F. and Mogothlane, S. 2004. Juta's Manual of Nursing. Juta Publishers, South Africa.

Watson, L., Irwin, J. & Michalske, S. 1991. Researchers as friend: methods of the interviewer in a longitudinal study. *Qualitative Health Research*, 1(4):497-514.

World Health Organization. 1978. Declaration of Alma-Ata. Conference proceedings of the International Conference on Primary Health Care held in Geneva. Conducted by the WHO, Geneva.

World Health Organization and United Nations Children's Fund. 1978. Primary health care: Report of the International Conference on Primary Health Care. Geneva: WHO.

**ANNEXURE A**

QUESTIONNAIRE  
(English and Afrikaans)

**TITLE : Perception of patients regarding comprehensive care rendered by Clinical Nurse Practitioners in the West Coast rural district of the Western Cape**

**1. CONFIRM INCLUSIVE CRITERIA**

↑ 18 years	At least 3 visits to PHC facility	Health problem was attended by the CNP	Address within this rural community	Consent signed	Coding of group and participant

**2. DEMOGRAPHIC INFORMATION**

NAME : .....

GENDER :

 M

 F

ADDRESS

.....

TEL CONTACT NUMBER : .....

RACE :

 W

 A

 C

 I

**3. QUESTIONS**

**3.1** TELL ME HOW WILL YOU DESCRIBE HER/HIS **ATTITUDE** TOWARDS YOU?

- EXPLAIN YOUR FEELING ABOUT THE INTEREST THE SISTER SHOWED IN YOU AS A PATIENT?

- EXPLAIN IF YOU FEEL YOU COULD COMMUNICATE FREELY WITH THE SISTER?

**3.2** EXPLAIN YOUR EXPERIENCE ABOUT THE **EXAMINATION** HE/SHE PERFORMED ON YOU

- IS THERE ANYTHING YOU FEEL SHE/HE COULD HAVE DONE TO ASSIST MORE IN THE DIAGNOSING OF YOUR HEALTH PROBLEM (DECIDING WHAT IS WRONG WITH YOU)?

- CAN YOU EXPLAIN WHAT THE SISTER SAID WAS WRONG WITH YOU?
- DO YOU FEEL ADEQUATE **HEALTH EDUCATION** WAS GIVEN TO TAKE CARE OF YOURSELF AT HOME?

**3.3 DID THE SISTER PROVIDE YOU WITH ANY MEDICINE?**

 YES NO

- IF YES, EXPLAIN WHAT SHE/HE SAID HOW YOU SHOULD USE THE MEDICINE.
- IF NO, DO YOU FEEL YOU SHOULD HAVE RECEIVED ANY MEDICATION?

**4. CONCLUSION**

4.1 Thank participant for interview

4.2 Summarize the views expressed by the participant during this focus-group

**5. DECLARATION OF PARTICIPANT:**

I, ..... (code identification) declare that the information obtained during this interview is my personal opinion and have not been influenced by any other person.

Signed at (*place*) ..... on (*date*) ..... 2010.

.....

**Signature of participant**

.....

**Signature of researcher**

**TITEL: Patiënte se persepsie aangaande die omvattende sorg gelewer deur Kliniese Verpleepraktisyns binne die WeskusPlattelandse Distrik van die Wes-Kaap.**

**1. BEVESTING VAN INSLUITINGSKRITERIA**

↑ 18 jaar	Minimum van 3 besoeke by PGS fasiliteit	Gesondheidsprobleem deur KVP hanteer	Woonadres binne hierdie plattelandse gemeenskap	Toestemming geteken	Kode van groep en deelnemer

**2. DEMOGRAFIESE INLIGTING**

NAAM : .....

GESLAG:

 M

 F

ADRES:

.....

TEL KONTAKNOMMER: .....

RAS:

 W

 A

 S

 I

**3. VRAE:**

**3.1** Vertel my hoe u haar/sy **gesindheid** teenoor u sal beskryf?

- Verduidelik u opinie omtrent die belangstelling wat die suster in u toon as pasiënt?
- Verduidelik of u die vrymoedigheid het om vrylik met die suster te kommunikeer?

**3.2** Verduidelik u ondervinding t.o.v die **ondersoek** wat die suster op u uitvoer?

- Is daar enigiets wat u voel sy/hy kon gedoen het om die diagnose van u gesondheidsprobleem aan te help (besluitneming wat verkeerd is met u)?
- Kan u verduidelik wat die suster gesê het wat met u verkeerd is?

- Voel u dat voldoende **gesondheidsvoorligting** gegee was sodat u tuis u toestand self kan hanteer?

**3.3** Het die suster aan u **medisyne** gegee?

- Indien ja, verduidelik sy/hy vir u hoe u dit moet gebruik?

- Indien nee, voel u dat u medisyne moes ontvang het?

#### **4. AFSLUITING**

4.1 Bedank deelnemers vir deelname.

4.2 Som op die sienings uitgespreek deur die deelnemers gedurende die fokus-groep.

#### **5. VERKLARING VAN DEELNEMER:**

Ek, ..... (kode identifikasie) verklaar dat die inligting wat verkry is gedurende die onderhoud, my persoonlike opinie is en nie beïnvloed is deur enige ander persoon nie.

*Geteken te(plek) ..... op (datum) ..... 2010.*

.....

**Handtekening van Deelnemer**

.....

**Handtekening van Navorser**

**ANNEXURE B**

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

Group code:

Participant code

**TITLE OF THE RESEARCH PROJECT:**

**The perception of patients regarding comprehensive care rendered by  
Clinical Nurse Practitioners in the West Coast rural district in the  
Western Cape**

**REFERENCE NUMBER US ETHICAL COMMITTEE : N10/03/098**

**REFERENCE NUMBER PGWC : 18/19/RP119/2010**

**PRINCIPAL INVESTIGATOR:**

Mrs Petro van Heerden

**ADDRESS:**

Andries Pretoriusstreet 8

Upper-Oakdale, Bellville

7530

**CONTACT NUMBER:**

Office (021) 6841254

Sel 0822 9696 83

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 any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved.

Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

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

### ***1. What is this research study all about?***

*Sites : within a district of the West Coast*

*The clinic at .....was identified*

*Number of participants :5 participants at each site will be recruited to contribute through a focus*

*group interview. This will give a total of 25 participants for the rural districts*

*Aim of project : 1. to determine the quality of care rendered by the Professional*

*Nurse trained to*

*provide this special care*

*2. to identify gaps where improvement of service to the patients can be identified*

Procedure :

- *when conceding to partake, you will be following the normal procedure of the clinic*
- *after consultation with the Professional Nurse, you will be collected and taken to a facility outside the clinic*
- *the researcher will conduct a group interview with you and the other 4 participants by asking applicable questions that need to be answered honestly*
- *this group interview will be audio taped and these tapes will be kept in lock-up cupboard for the duration of this research study and then destroyed*
- *there will be no interventions or tests conducted*

**2. Why have you been invited to participate?**

- *randomly every 5<sup>th</sup> patient in the waiting room has been selected to partake – complying with the inclusive criteria*
- *you have been invited to participate because you have visited this PHC clinic several times in the past year and have a medical problem*

**3. What will your responsibilities be?**

- *to answer the questions honestly and truthfully*
- *not to evaluate the service in general, but the quality of care received from the CNP(Clinical Nurse Practitioner) inside the consulting room*

**4. Will you benefit from taking part in this research?**

- *there are no personal benefits to you as patient*
- *hopefully patients in future will receive improved care after the results of this study*

**5. Are there in risks involved in your taking part in this research?**

- *there is no risk to your health, body or mind partaking in the study*

**6. If you do not agree to take part, what then?**

- nothing will be held against you if you do not want to partake = it is all at own choice

**7. Who will have access to your medical records?**

- *The information collected during the interview will be treated as confidential and protected.*
- *Your name, clinic, town will nowhere be used or published*
- *A coding system will be used to protect the identities of the participants*
- *If it is used in a publication or thesis, the identity of the participant will remain anonymous.*
- *It is therefore just the researcher that will have access to the information gathered from the interviews*

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

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

**9. Is there anything else that you should know or do?**

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

**Declaration by participant**

By signing below, I ..... agree to take part in this research 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 pressurized to take part.
- I **may choose to leave the study** at any time and will not be penalized or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the 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*) ..... 2010.

.....

**Signature of participant**

.....

**Signature of witness**

**Declaration by investigator**

I Petro van Heerden (researcher) declare that:

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

Signed at (*place*) ..... on (*date*) ..... 2005.

.....

**Signature of investigator**

.....

**Signature of witness**

**Declaration by translator**

I (*name*) ..... declare that:

- I assisted the investigator Petro van Heerden, to explain the information in this document to (*name of participant*) ..... using the language medium of 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*) ..... 2005.

.....

**Signature of translator**

.....

**Signature of witness**

**ANNEXURE C**

**ETHICAL APPROVAL :STELLENBOSCHUNIVERSITY**



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY  
jou kennisvenoot • your knowledge partner

23 September 2010

**MAILED**

Mrs P van Heerden  
Division of Nursing  
2nd Floor  
Teaching Block  
Tygerberg Campus

Dear Mrs van Heerden

**The perception of rural communities regarding comprehensive care rendered by Clinical Nurse Practitioners in the Western Cape Province**

**ETHICS REFERENCE NO: N10/03/098**

**RE : APPROVAL**

A panel of the Health Research Ethics Committee reviewed this project on 27 May 2010; the above project was approved on condition that further information is submitted.

This information was supplied and the project was finally approved on 22 September 2010 for a period of one year from this date. This project is therefore now registered and you can proceed with the work.

Please quote the above-mentioned project number in ALL future correspondence.

Please note that a progress report (obtainable on the website of our Division: [www.sun.ac.za/rds](http://www.sun.ac.za/rds)) should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit. Translations of the consent document in the languages applicable to the study participants should be submitted.

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

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

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

23 September 2010 12:06

Page 1 of 2



Fakulteit Gesondheidswetenskappe • Faculty of Health Sciences



Verbind tot Optimale Gesondheid • Committed to Optimal Health

Afdeling Navorsingsontwikkeling en -steun • Division of Research Development and Support

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

**CONSENT : DEPARTMENT OF HEALTH**



# DEPARTMENT of HEALTH

Provincial Government of the Western Cape

## COMPONENT

claudabr@pgwc.gov.za  
tel: +27 21 483 9907; fax: +27 21 483 9895  
1<sup>st</sup> Floor, Southern Life Centre, 8 Riebeeck Street, Cape Town, 8001  
[www.capegateway.gov.za](http://www.capegateway.gov.za)

**REFERENCE:** 18/19/RP119/2010  
**ENQUIRIES:** Dr N Peer

**8 Andries Pretorius Street  
Upper-Oakdale  
Bellville  
7530  
Fax: 021-6371317**

**For attention:** Mrs P van Heerden

### **The perception of patients regarding comprehensive care rendered by Clinical Nurse Practitioners in the West Coast rural district, Western Cape**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact:

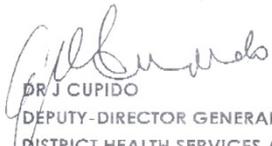
Dr D Schoeman                      022 487 9212    [Daschoem@pgwc.gov.za](mailto:Daschoem@pgwc.gov.za)

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](mailto: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 J CUPIDO**  
 DEPUTY-DIRECTOR GENERAL  
 DISTRICT HEALTH SERVICES AND PROGRAMMES  
 DATE: 20/09/2010



**ANNEXUREE**

**EXAMPLE : FIELD NOTES**

④ Group A 204.  
Town = Graafwater.

Intro = all friendly / willing to assist in research.

- Smiling.
- nice mix of participants.

Q1 ∴ facial expressions changed

- frowning — talking a lot + inbetween
- finger pointing.
- big eyes!
- lots of nodding when other speak
- acknowledgement ⇒ yes / ✓
- very loud / one gets out of chair to explain.

Q2 ∴ - feeling more calm

- lighter tone of voice
- much more positive
- examination good.

Q3 ∴ - medicine provision good - too little

- everybody agree

## FIELD NOTES TAKEN DURING GROUP INTERVIEW.

**GROUP** : A 204

**TOWN** : XXXXXXXXXX

Introduction	<ul style="list-style-type: none"> <li>▪ Very friendly</li> <li>▪ Willing to assist in research</li> <li>▪ Smiling</li> </ul>
Question 1	<ul style="list-style-type: none"> <li>▪ Facial expression changed</li> <li>▪ Frowning</li> <li>▪ All talking together</li> <li>▪ Finger pointing</li> <li>▪ Big eyes</li> <li>▪ Tone of voice very loud</li> <li>▪ One participant got out of chair to express his opinion on the rudeness and unfair treatment</li> <li>▪ Lots of nodding when other participants speak</li> <li>▪ Acknowledgement with others perceptions</li> </ul>
Question 2	<ul style="list-style-type: none"> <li>▪ Atmosphere change</li> <li>▪ More calmness</li> <li>▪ Lighter tone of voice</li> <li>▪ Much more positive attitude</li> </ul>
Question 3	<ul style="list-style-type: none"> <li>▪ Agreement amongst participants that provision of medicine is good</li> </ul>

**ANNEXURE F**

**VERIFYING OF DATA**

MEMBER CHECKING: VALIDATION OF INTERPRETED DATA

I ..... (PARTICIPANT IDENTIFICATION NUMBER: .....

AGREE / DO NOT AGREE

WITH THE INTERPRETATION OF THE VERBATIM TRANSCRIBINGS OF THE INTERVIEW.

THE WAY MRS VAN HEERDEN INTERPRETED THE FINDINGS IS CORRECT / NOT CORRECT

ACCORDING TO WHAT WAS SAID.

COMMENTS:

.....  
.....

DATE: ..... SIGNATURE: .....

EK ..... (DEELNEMER IDENTIFIKASIE NOMMER: *A202(5)*)

STEM SAAM / STEM NIE SAAM

MET DIE INTERPRETASIE VAN DIE VERBATIM TRANSKRIPSIES VAN DIE ONDERHOUD. DIE WYSE  
WAAROP MEV VAN HEERDEN, DIT WAT GESÊ WAS TYDENS DIE ONDERHOUD, GEINTERPRETEER  
HET, IS KORREK / ~~NIE KORREK~~.

KOMMENTAAR:

*Goie studie wat mevrou van Heerden doen.  
alles is reg wat sy hier se. Net jammaer nog  
niks het verander nie.*

DATUM: *6 September 2011* HANDTEKENING: .....

MEMBER CHECKING: VALIDATION OF INTERPRETED DATA

I. [REDACTED] (PARTICIPANT IDENTIFICATION NUMBER: A202(3))

AGREE / DO NOT AGREE

WITH THE INTERPRETATION OF THE VERBATIM TRANSCRIBINGS OF THE INTERVIEW.  
THE WAY MRS VAN HEERDEN INTERPRETED THE FINDINGS IS CORRECT / NOT CORRECT  
ACCORDING TO WHAT WAS SAID.

COMMENTS:

.....  
.....  
.....  
.....

DATE: ..... SIGNATURE: .....

EK ..... (DEELNEMER IDENTIFIKASIE NOMMER: .....)

STEM SAAM / STEM NIE SAAM

MET DIE INTERPRETASIE VAN DIE VERBATIM TRANSKRIPSIES VAN DIE ONDERHOUD. DIE WYSE  
WAAROP MEV VAN HEERDEN, DIT WAT GESÊ WAS TYDENS DIE ONDERHOUD, GEINTERPRETEER  
HET, IS KORREK / NIE KORREK.

KOMMENTAAR:

Dit is hoogtyd dat iemand kom navorsing doen oor  
dien by klinieke. Die inligting is presies wat  
ons gesê het. mense se houding moet asb.  
net verander. Ons is ook mense met gevoelens.

DATUM: 6 September 2011 HANDTEKENING: [REDACTED]

**ANNEXUREG**

**EXAMPLE OF TRANSCRIBING**

**(Group A 204)**

## **Group A204**

Ondervraer: Goeie middag almal. Net vir rekordhouding: dit is groep A204 en vandag is die 25ste van November 2010. My naam is Mev., van Heerden, en soos ek verduidelik het doen ek navorsing oor die kwaliteit van diens wat die susters in die klinieke lewer. Kom julle stel gou vir jouself bekend asseblief.

[Name word nie genoem op transkripsie vir konfidensialiteit]

Ondervraer: Die eerste vragie wat ek by julle wil weet is, hoe is die susters se gesindheid teenoor julle?

Deelnemer: Van hulle is vriendelik...

Deelnemer: Ons kom, ons sê mekaar môre soos jy inkom. Nou kom ek/hulle, hulle trek so een-een in want ons weet nie eintlik wie het die sleutel om oop te sluit nie, dan kom daai suster - daar is party oggende waar nie eers môre gesê word nie...

Deelnemer: ....daar is een wat ek ook nou kan sê...sy is met almal ombeskof - werk, werk ek noem dit/hulle. Daar is nie vir ombeskoftheid tyd in die sort werk tyd nie....

Deelnemer: Daar is nogal, but die een groet môre en die ander ene, dan moet jy groet môre dan groet sy nie weer vir jou as jy môre groet nie.

Deelnemer: Dan sê ek 'môre', dan voel hulle tóg aaklig en sleg as mens dit doen.

Deelnemer: Hmm! Ja dit is soos jy daar sê. Daar is party oggende waar 'n mens nie eers môre gesê word nie...sy is 'plain' onbeskof. Kan sien sy het met 'n verkeerde voet uit die bed uit opgestaan en dan haal sy dit op ons uit. Jislaaik, ons is mos ook mense met 'n gevoel.

Deelnemer: Ja oraait, ja dit is. Hulle is onvriendelik vir my. Hoe kan ek sê, ek glo as jy by 'n kliniek of 'n hospitaal kom, dan moet die

mense vriendelik wees. Jy kom mos vir hulp, omdat jy probleem het.

Deelnemer: Of jy voel jy gaan maar 'eerder dan weer huis toe want ek is nie eintlik welkom nie. Ja baie keer voel mens so.

Deelnemers: Hmm!! Ja, ja.

Deelnemer: En in sommige gevalle wil jy nie 'n onderonsie met hulle hê nie, dan - soos ek byvoorbeeld, as ek hier kom en ek het môre gesê en ek kry nie 'n 'môre' terug nie, ek voel 'n bietjie 'down', ek het nie gekom met 'n 'gees' om kwaad, lelik te wil wees nie, dan 'drop' ek die 'subject' en dan kom sit ek maar hier en ek wag my tyd af, of ek nou gehelp word of te nie - sometimes is dit 'n bietjie irriterend want jy los soggens jou huis omtrent nét so om hier te kom sit, verstaan?

Ondervraer: Dit was eintlik die tweede vraag gewees...

[Praat gelyktydig]

Ondervraer: Nee, nee, dis als reg!! Kan hoor dit is 'n saak wat baie na aan julle hart is. Ek verstaan van julle antwoorde dat die suster nie baie vriendelik is met julle as pasiënte nie. Kom ons gaan aan!! Die tweede vraag is eintlik of jý die vrymoedigheid het om dit wat op jou hart lê, met die suster te bespreek?

Deelnemer: Wel in sommige gevalle kán 'n mens dit bespreek, maar dan kom dit weer in, jy weet nie hoe is die vrou se gees nie.

Ondervraer: Hmm, hmm.

Deelnemer: Verstaan? En jy as pasiënt, jy wil al weér nie aan die korste ent trek nie want kom ek sê vir u of die vrou nou daar is of te not....

Deelnemer: Eenkeer, ek kom elke maand hierso, elke keer as ek hier kom jy word deur verskillende personeel lede gehelp...

Deelnemer: Ja.

Deelnemer: ....en as dit nou die spesifiéke persoon is wat daaí vrou nou van praat het dan wil ek dit vanoggend noem - ek het hier gekom, ek sal, ek kan nou nie; maar dis hier voor by die (dade) - jy sien op 'n ses maandelikse basis sien jy 'n dokter. Okay, nou sê die persoon vir jou, jy moet dokter sien, nou sê jy vir haar maar "dit is ontmoóntlik vir jou, kan jy nie op 'n ander dag kom nie?" Dan word jy nou vermaak, 'as jy nie die dokter sien nie, dan gaan jy nou die jou pílle sien nie' 'dan gaan jy nie jou pílle kry nie' verstaan? En dit is ook iets wat 'n mens 'upset'.

Deelnemer: Ek kry soms die gevoel sy werk omdat dit haar beroep is.....nie dat sy omgee vir mens nie. Nie álmal nie, hoor....dis net daai een ís daar vir die werk en die ander een is daar oor sy, dit is sy beroep, dis sy wat omgee....maar hulle is maar skaars.

Deelnemer: Hmm.

Deelnemer: Verstaan jy? "Nou sy moet maar hier werk omdat dit nou die enigste werk is". Hier in die platteland is nie baie werk om van te kies nie. Kry julle soms die gevoel dat dit so is.

Deelnemer: Uh hmm!

Deelnemer: Definitief.

[Praat gelyktydig-1min 48sec]

Deelnemer: ....net daai een uit (hier)die duisend uit wat jy kan voel dit is, dit is wat sy moét doen....maar die ander maak nie mooi met mens nie.

Deelnemer: ....ja, soms kry jy `n mens-mens.....

Deelnemers: Hmm!!

Deelnemer: ....maar die ander moet jy amper sommer so behandel soos sy jou behandel.

Ondervraer: Is daar nog iets wat julle wil sê oor die gevoelendheid, die gesindheid van die susters? Dame, jy het nog min gesê?

Deelnemer: Nee, ek het nou nog nie 'n probleem met hulle ondervind nie. As ek wil iets sê, dan sê ek vir die suster of so; so ek het nou nog nie 'n probleem gehad nie...

Ondervraer: Voel u dat u vrylik kan kommunikeer met die susters?

Deelnemer: Ja. En ek moet sê, ek het nog niks gehoor dat stories van my uit die kliniek rondloop nie. Hulle is baie professioneel daaromtrent.

Deelnemer: Ja; maar so vêr - daar is party goetjies wat mens hoor buite die kliniek, maar sal mos nou nie weet....wie praat uit?

Deelnemer: Ek moet ook net noem dat hulle moet luister wat mens sê, anders weet sy nie wat jy makeer nie.

Ondervraer: Okay, kom ons nou by die ondersoek, Verduidelik vir my u ondervinding t.o.v. die ondersoek wat die susters op julle uitvoer.

Deelnemer: Ek kan nogal nie kla nie....

[Praat gelyktydig-2min43sec]

Deelnemer: Hulle kom check jou goed uit. Het nog nie afgeskeep gevoel as ek huis toe gaan nie, want sy doen goeie 'job'! Soms voel ek beter as wat die dokter dit doen, want hulle kyk orals.

Deelnemer: Ja. Kyk, die dokter sê baie keer die suster kon jou gehelp het as sy beter ondersoek het.

Deelnemer: Klein goetjies kan hulle maar ekstra doen, nét om te sien dat jy heeltmal oraait is. Hulle gaan nie verder nie, kyk net waaroor jy kla.

Deelnemer: Ja nee, hulle gaan nie verder nie, as jy iets vergeet het, dan is hulle sommer kwaad, want dit was nie op die lêer geskryf nie. Mens kan mos ook maar vergeet.

Deelnemer: Ek het al twee keer gekom vir keel infeksies, sê maar die, uh tonsils.... dit gaan mos gepaard met die keel infeksie, ek het

nog tot sovêr toe 'n goeie ondersoek gekry, die tablette wat ek gekry het was goed gewees, dit werk soos 'n bom.

Ondervraer: So; okay dis, dis okay, oraaait; as hulle vir julle klaar ondersoek het sê hulle vir julle wat makeer?

Deelnemer: Daar kan ek nou vir jou sê as ek mos nou kliniek toe kom ek, ek ken mos selwes, as ek voel deur die nag ek het ontsettende hoofpyne gehad, dan kom ek mos nou na die kliniek toe, okay, ek sal probeer om 'n pilletjie te drink as ek dit het, maar ek gaan nog altyd na die kliniek toe kom. Dan word ek geneem daar na die observasie kamer waar my bloeddruk en alles mos gedoen word, en daarvandaan word ek getransfer, sit eers eers hier, suster roep my mos nou, nou vra suster vir my, hmm, wat is my probleem nou sê ek "suster ek het laasnag 'n ontsettende hoofpyn gehad"; ek gee familie geskiedenis, daar was miskien diabetes in die familie, hoë bloeddruk soos dit nou wél die geval is, maar die eintlike rede hoekom ek hier is, my keel is die probleem, en dan as die keel probleme veroorsaak dan somtyds laat dit jou hele liggaam vergif....

Deelnemer: Ja sien sy vra baie vrae....nou sien en daar volgens gee ek my hele history....

Ondervraer: En dan sê sy vir jou, 'kyk na die ondersoek vind ek jy het Mangel infeksie' of....

Deelnemer: Ja!

Ondervraer: ....of jy't net 'n keel infeksie met die keel wat rooi is van die hoesery.

Deelnemer: Jy, jy kyk mos in my keel in af dan kan sy mos sien die rooiheid en dan vra sy ook vir jou, 'hoe sluk jy? Hoe voel jou ore...

Ondervraer: Hmm! Sy noem elke keer wat is fout met jou.

Deelnemer: Jy sê ja....'jou blindederm is nie reg nie of jou galblaas het infeksie of wat, wat' so hulle sé dit vir julle?

- Deelnemer: Hulle sê, ja. Hulle het goeie kennis.
- Ondervraer: Mooi nou weet ons die ondersoek is goed en die susters noem wat u makeer. As hulle nou vir julle sê wat julle makeer, gee hulle vir julle gesondheids opvoeding? Sê hulle vir - inligting wat jy by die huiskan gaan doen, hoe moet jy dit doen by die huis?
- Deelnemers: Ja.
- Deelnemer: Ja, Hulle gee nogal dit.
- Deelnemer: Ja, hulle, hulle verduidelik - soos ek het eenkeer, maar ek is nou af van die suiker, toe het hulle vir my 'n..pamflet ook gegee.
- Deelnemer: ... pamflet gegee, en hulle verduidelik alles.
- Deelnemer: Soos ek sê, ek het nie eintlik klagtes nie. Hulle verduidelik alles mooi vir mens.
- Deelnemer: Ek het die ander keer so baie sooibrand en toe kom ek ook vir dít, en toe gee hulle nou vir my die goed en toe sê hulle wat ek nou nie moet eet nie en sulke tipe goetjies. Die suster praat baie mooi met mens as sy vir jou sê wat jy makeer en wat om te doen. Ja, sy praat en luister baie mooi.
- Ondervraer: So ek hoor by julle dat die susters goed is met inligting gee?
- Deelnemer: Ja, hulle is. Gee baie inligting gegee, soos huisrade. Sy het my lekker raad gegee en dit het lekker gehelp, veral toe ek beensere gehad het en dit nie wou gesond word nie. My dogter se kleintjie met maagwerk het ook lekker raad gekry oor die piesang en soutwater.
- Ondervraer: Baie mooi, baie mooi! Want 'n mens probeer altyd vir die pasiënt sê altyd, 'probeer eers dít, voordat jy kom' want hier kom party mense so onnodig kliniek toe, hulle weet nie wat om met hulle self lyk my by die huis aan te vang nie, 'ons sit maar by die kliniek vandag.'

Deelnemer: Uh!!! Partykeer is dit net die pille, dan sê hulle jy moet net so drink. En klaar. En miskien as dit op is moet jy maar net weer kom.

Deelnemer: Nie altyd....hoe sal ek nou sê....ek moet sien sy luister, anders praat ek nie. Sy kyk dan nie eers in my gesig nie. So, hoe kan sy luister wat ek sê?

Deelnemer: Nee wat, as sy nie die dag lus is vir jou nie, dan soek sy net wat nodig is. Praat is min, so ek praat dan ook nie. Daai dag, dan vra sy niks vrae nie, so ek sê dan ook net wat nodig is en basta!

[Giggel]

Ondervraer: Nou is ons by die medisyne, Gee die susters vir julle medisyne en indien ja, help die goed wat hulle vir julle gee?

Deelnemer: Ja.

Ondervraer: Sy't gesê "ja" die pille het gewerk soos 'n bom.

Deelnemer: Ek kom maar net vir my hoë bloed, so..... Daar is van die medisynes wat die dokters net mag voorskrywe, wat ek voel die susters miskien kan doen, dat jy minder dokter toe hoef te gaan. Dit is tydmors om elke keer vir die dokter te moet wag, as die suster dit net sowel kon gegee het

Deelnemer: Ja.

Deelnemer: Myne help ja.

Ondervraer: Nou as julle ander probleme het? Soos jy nou gesê het van die sooibrand?

[Praat gelyktydig-3min56sec]

Deelnemer: Ja dan sé ek, dan kry ek daar by haar medisyne en dit werk....

Ondervraer: Okay; dan gee hulle vir jou iets daarvoor?

Deelnemer: Ja.

Ondervraer: Sê hulle vir julle mooi hoe om die medisyne te drink?

Deelnemer: Ja.

Ondervraer: Verduidelik hulle dit vir julle?

Deelnemer: Ja, hulle is op die punt; soos ek wat mos nou elke maand kom, verduidelik... alles is op die punt omtrent die medisyne. En álles is daarop geskrywe.

Deelnemer: Ek voel net dat hier is nie elke dag 'n dokter nie, so die susters moet meer vir

'n mens kan doen en meer verskillende soorte medisyne gee.

Dit sal baie

help. Hulle moet mos ook verduidelik vir die ander mense wat ook mos nou nie verstaán nie of nie kan lees nie.

Deelnemers: Hmm!! Die medisynes is reg, maar ek voel hulle kan miskien 'n bietjie meer gee...leer hulle meer gevorderde goed, sodat ons nie so baie na die dokter hoef te gaan nie.

[Almal stem saam]

Deelnemer: Daar is tog van die mense as hulle weet daar is iemand in ons se straat wat nou mediese kennis het van, - en baie kere sal hulle nie sommer eers kliniek toe kom nie, hulle gaan eers 'n bietjie navrae doen, en as hulle dan nou sien maar die medisyne wérk nie vir hom nie dan - óf jy, as dit iemand anders kan hulle 'recommend' na die dokter toe, as die man mos die finansies het, as die man dan nie na die kliniek toe kom nie.

Ondervraer: Okay, so julle gevoel is dat hulle moet meér medisynes kan voorskryf?

Deelnemer: Ja, partykeer as ons daar aankom - soos, soos as ek met die kind kom dan gee jy net die antibiotikum as hy miskien 'n verkoue het, dan moet jy nou, die koorsstroop moet jy aankoop by die, by die, by die Apteek en jou hoesstroop, hulle gee net, nét dié.

[Praat gelyktydig-1min18sec]

Deelnemer: En kyk 'n ander ding....die hospitaal is ver, hmm, so noodgevalle in die nag...dit moet hier gehelp kan word. Die regering sal baie aan ambulans onkostas bespaar, as die susters mens meerkan help.

Deelnemer: En dan kyk hier ons staan tot Desember maand, nou kry jy twee maande, soos nou vándag, twee maande se pille, en verlede jaar toe was daar 'n tekort, so dit kom óók van bo af; ja, toe kon hulle dit nie weer gee vir twee maande nie.

Deelnemer: ....ja, nou daai, dan help dit vir dít wanneer ons nie werk nie; jy kan maar liewers daai tyd opoffer om hier te kom sit as wat jy nou met daai klomp geld wat jy nie het nie om vir die dokter te betaal.

Ondervraer: Hmm, okay, dit was nie so erg nie, was dit?

Deelnemer: Nee!

[Lag]

Ondervraer: Nou, nou kan ek gou vir julle sê, want ek eindig altyd hiermee af, as jy nou 'n punt moet gee vir die susters in die kliniek, een beteken baie swak, vyf beteken baie goed, oraaít? Watse punt sal julle nou vir hulle gee? Dis nou overall né? Nou nie net vir een spesifieke mens nie, dis nou vir die diens.

Deelnemer: Ek sal van my kant af sê ek 'n vyf (5)....

Deelnemer: Ek sê 'n vier (4) vir die behandeling.

Ondervraer: ....dis reg! Dis reg!

Deelnemer: [Onduidelik]....ander dag, so ek kan, ek kan ook nie 'n vyf (5) gee nie.

Ek weet nou nie, tussen 'n vier (4) en 'n drie (3).

Deelnemer: Ja meer drie (3) sekant toe..

Ondervraer: Baie dankie julle! Julle was baie dierbaar om my te help met my navorsing. As ek net kan opsom..... die gesindheid van die susters is nie goed nie; die ondersoek word goed gedoen en dan sê hulle vir julle wat jy makeer. Is ek reg sover?

Deelnemers: Ja, ja dit is wat ons gesê het. Ons voel sy moet nie so kortaf wees met mens nie. Ons is hier om gehelp te word

Ondervraer: Die voorligting is soms goed maar soms voel julle dat hulle meerkan gee. Die medisyne wat hulle gee help, maar julle voel dat hulle behoort meer voor te kan skryf sodat julle nie so baie dokter toe hoef te gaan nie.

Deelnemers: Dis korrek dit is soos ons voel.

*[Einde van onderhoud]*